

**SEIZING THE NEW OPPORTUNITY
FOR HEALTH REFORM**

HEARING
BEFORE THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
ONE HUNDRED TENTH CONGRESS
SECOND SESSION

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SEIZING THE NEW OPPORTUNITY FOR HEALTH REFORM

TUESDAY, MAY 6, 2008

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:05 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Rockefeller, Bingaman, Kerry, Lincoln, Wyden, Stabenow, Salazar, Grassley, Smith, and Bunning.

Also present: Democratic staff: Bill Dauster, Deputy Staff Director and General Counsel; Liz Fowler, Senior Counsel to the Chairman and Chief Health Counsel; Catherine Dratz, Health Policy Advisor; Shawn Bishop, Professional Staff—Health; David Schwartz, Health Counsel; Billy Wynne, Health Counsel; and Elise Stein, Detailee. Republican staff: Mark Hayes, Health Policy Director and Chief Health Counsel; Kristin Bass, Health Policy Advisor; and Rodney Whitlock, Health Policy Advisor.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The hearing will come to order.

The German poet Goethe said, “Art is long, life short, judgment difficult, and opportunity transient.” The title of today’s hearing is “Seizing the New Opportunity for Health Reform.” Today we have a new opportunity to achieve what previous Congresses and presidents were unable to do. We have an opportunity to agree on how to provide access to affordable high-quality health care for all Americans. But as Goethe said, opportunity is transient.

For at least a century, our country has debated health care reform pretty much every generation. In the early 1900s, the Progressive party pressed the case. In the late 1930s and early 1940s, there was the Wagner-Murray-Dingell bill. President Truman tried in the late 1940s. In the early 1970s, President Nixon proposed what, by today’s standards, was a progressive plan, and in the early 1990s President Clinton proposed the Health Security Act.

None of these efforts succeeded; each, for its own reasons, failed. But these past attempts at reform must not scare us off. Past failure does not mean that reform is impossible. It means that the issues and challenges have endured. It means that the need for reform remains. So we must seize the opportunity. We must try again. This committee must prepare for the challenge of building consensus, and I am confident that this time we will succeed.

Why is health reform important today? It is important because the problems in our health system are so great. The problems are greater than the incremental solutions that Congress has tried to date. The problems are getting worse. Since the year 2000, nearly 10 million more Americans have joined the ranks of the uninsured. Since the year 2000, insurance premiums have increased by 75 percent. That is more than 6 times as fast as the growth in median income.

Families are grappling with high health care bills. According to a new survey, nearly a third of Americans report that paying for health care and health insurance is a serious problem, and more than 4 in 10 Americans have gone without medical treatment due to costs.

Businesses large and small are struggling to afford coverage for their workers and retirees. Between 2000 and 2007, the share of employers providing health benefits for their workers declined from 69 percent to 60 percent. That is, in large part, due to rising costs.

America spends more than \$2 trillion a year on health care. That is 16 percent of our economy. But the quality of care is not as high as it could be, nor are the financial incentives in our system aligned with the best interests of patients.

The moral and economic case for reform has never been stronger. There is abundant common ground for reform. As I read through the reform proposals on the table, I see many shared principles. I see commonality among major health care stakeholders, interest groups, coalitions, and even presidential candidates.

To start, there is widespread agreement that we must strive for universal coverage. We must cover the uninsured. And there is widespread agreement that reform should do more. We must also slow the growth in health care costs. Value-based purchasing, comparative effectiveness, greater use of health information technology, and electronic health records are just a few proposals that can transform our delivery system. These ideas could help Americans get better value and quality of care.

There is also widespread recognition that our health insurance marketplace is broken. The individual market, in particular, leaves too many people behind. It encourages risk selection and it tolerates pernicious behavior by insurers. The practice of rescinding coverage to avoid paying claims is just one example. There is broad interest in pooling risk, streamlining the application underwriting process, and guaranteeing that even the sickest can purchase affordable coverage.

Achieving these goals will not be easy. They have stymied many before us. Although the areas of consensus have grown, there are still many difficult decisions to make. Should we mandate that everyone must have health insurance? How should universal coverage be financed? What roles should the Federal Government, States, employers, and families play?

I do not have all the answers, but I know that to achieve our goals we must work together and we must be inclusive. I also know that the Finance Committee will play a central role in answering these questions. We have jurisdiction over Medicare, tax subsidies to finance health care, and our Nation's health care safety net programs, so there is much work for us to do.

Today's hearing is the first in a series. We have designed these hearings to prepare us for the opportunity to engage in a national debate over health reform. That debate awaits us in the next Congress.

What better way to start than to hear from two distinguished former Secretaries of Health and Human Services? Both have appeared before this committee numerous times, and I am very, very honored that they are here today. I would like to welcome Secretary Donna Shalala and Secretary Tommy Thompson. They served us admirably as leaders of our Federal health agencies, and they can offer us deep insights and lessons so we can move forward.

Recognizing that life is short, let us now begin to address these difficult judgments and seize this new, but transient, opportunity for health care reform.

Senator Grassley?

**OPENING STATEMENT OF HON. CHUCK GRASSLEY,
A U.S. SENATOR FROM IOWA**

Senator GRASSLEY. As the chairman has just done, I welcome you to our committee to bring your expertise—Secretary Thompson, as Governor with Badger Care, and when you were Secretary, Part D prescription drug programs, administering Medicare and Medicaid; and Secretary Shalala, a predecessor of yours, during her time in the Clinton administration, being involved very deeply in Medicare and Medicaid, as well as when the State Children's Health Insurance Program was up and running. Your insights will be very helpful to the Congress and this committee in what we do in helping with health care problems that we face.

Despite everyone's best efforts, health care costs continue to grow rapidly. As health care has become more expensive, by definition health insurance has as well. If insurance were more affordable, many of the Nation's 47 million uninsured people would have insurance. It was hard for people to afford health insurance coverage before, but now, with the economy slowing and gas prices rising, it is even more troubling.

In Iowa, farmers, small businesses, and many others are getting priced out of the market. Iowa has lower health care costs than many parts of the country, so, in those other parts of the country, things are much worse. It is a growing issue, and Congress needs to take some steps to make sure that people can buy insurance.

We know that people without insurance often cannot afford health care, and people with insurance are anxious about losing it. We need to figure out a way to make the health insurance market work better so that people can buy insurance that suits them. It makes the most sense to build on the private health insurance system. As you all know, people are used to their employer providing health benefits. They like their employers' work and they do not want us to disturb that. They like that their employers take care of their billing, and by and large they are satisfied.

We learned 14 years ago during the Clinton health plan debate that, even in the midst of call for change, many people like what they have. So health reform should not up-end the system and do harm while trying to help folks without insurance. I also think we

need to be prudent in taking on new obligations through government. This committee should take a look at what the tax code does and does not do when it comes to health insurance and the American people.

Some of my colleagues want to expand health care benefits through government. They also believe that such an approach will make health insurance more affordable. I think we need to look into whether we can expand health care coverage by making the current unlimited income tax exclusion for employer-provided health insurance more equitable, while increasing the tax benefits for taxpayers purchasing non-group insurance.

This should not only increase coverage, but it should help low-income taxpayers better afford health care. There could be ways to increase the tax benefits for low-income workers receiving employer-provided health insurance, while placing middle- and upper-income taxpayers in the same tax position they hold under current law. We can simultaneously provide taxpayers purchasing insurance on the non-group markets with substantive tax benefits for the first time. Tax policy is a powerful force that can be used to expand coverage, but a powerful force in making things affordable as well.

There are serious inequities in the tax system. These inequities make insurance much cheaper for rich people and more expensive for low-income people. So it just is not right that someone buying health insurance for himself must pay with after-tax dollars, while a person getting insurance through work pays with pre-tax dollars.

So I think we need to look at the tax system and whether we can make changes there that would enable more people to buy insurance. Any health care reform must be bipartisan. Everyone has an interest in health care, and it is very important that we come up with ideas that people like and buy into. We need to help rural people, as well as urban people who cannot afford coverage. At the same time, we need to look at the health care delivery system to encourage it to be more efficient. Obviously these are tough policy problems. I am encouraged that the issue is back on the table.

Thank you very much.

The CHAIRMAN. Thank you, Senator.

I would now like to welcome our witnesses. Again, we are just very honored to have today two former Secretaries, and we thank you very much for taking the time. They are very, very busy people, lots of responsibilities, but at heart, also, servants. They want to help the American people and tell us what they think makes sense, basically based upon their experience.

Also, a little change of rules here. We'll give you each 10 minutes. Usually it is 5, but each person will get 10 minutes. If you want to take a few more minutes, that is fine. But basically 10 minutes, and your statements will automatically be included in the record.

I do not know whether to call you Secretary Shalala, President Shalala, all the titles. But President Shalala, your current title, why don't you go ahead?

**OPENING STATEMENT OF HON. DONNA SHALALA, FORMER
SECRETARY OF HEALTH AND HUMAN SERVICES, MIAMI, FL**

Secretary SHALALA. Thank you very much, Senator Baucus, Ranking Member Grassley, members of the committee, and old friends. I am delighted to be here. With your permission, I will submit my full statement for the record and simply summarize it. My good friend, Secretary Thompson and I—we have worked together for almost 2 decades, I think—agree on a number of the issues, and I will forego going into detail on the issues that he is going to talk about.

I would like to start by talking about the polls, because one of the things that the committee asked me to do is to talk both about the politics, as well as the substance of health care reform. Since I still have bruises on my body from a number of fights, and I teach the politics of health care, I thought it would be useful for me to talk both about the political context, as well as some experience in trying to get comprehensive health care reform.

Let me start by talking a little about the polls, because health care has actually dropped in the polls. When Americans are asked what issues are important to them, they start with the economy now, then go to Iraq, and health care has been slipping from number two to number three. That is misleading.

The Kaiser Family Foundation, which I am a director of, and Drew Altman in particular, have looked at the polls at some level of detail. It looks very clear that when Americans talk about their economic concerns they are talking about health care. They are integrated issues for them. They are concerned about health care cost as part of what is happening to the economy. So we should not believe that health care is fading as an issue, just that there is a broader context for health care. It is very much seen as part of the economic concerns that Americans have now. So middle-class people, for lower middle-income folks, both issues are linked for them.

Second, I talked in my paper about a strategy for universal coverage. I very much believe that most of the things that we want to do, including containing costs, have to be done in the context of universal coverage. But I talk about a strategy for universal coverage so that I do not get caught in some hole about either a single-payer system or one strategy versus another. I think it is important to talk about a strategy for getting to universal coverage.

I also want to suggest that the committee needs to look not only at the uninsured, which at this moment are 47 million, or at employers dropping health insurance, which is increasingly happening, but also at the under-insured, that increasingly our fellow Americans have lousy insurance. They are paying a larger portion of it. Their employer is trying to contain costs. I am an employer. The largest private employer in Miami is the University of Miami, and we are struggling to contain costs so that we can manage our bottom line so we can do all the other things that we need to do in terms of investments at the university.

So, as employers shift costs to employees, as they drop coverage, in some cases, in some aspects of that coverage, we are beginning to see lousy coverage for people. That has to be included in, and has to be part of the justification for, trying to get some framework around universal coverage.

Senators, Secretary Thompson will talk about electronic medical records. Most of us believe that it will not only improve communications between physicians and enhance surveillance and monitoring, but we also believe that it will help to decrease unnecessary services and allow us to monitor health care at a level of detail and to catch those who would abuse the system.

The VA has done a very good job. We have learned a lot from the VA experience. I want to point out, particularly with Senator Rockefeller here, that they need additional investment. That system is going to become old if the VA does not continue to have investment in upgrading their system. But we have learned that we can contain costs with that information, that we can certainly provide more quality care if we can track it with the most modern electronic medical records system.

The Dartmouth study has pointed out to all of us that we waste a third of the \$2.3 trillion that we spend. Much of that cost comes from the disorganization of the system and the lack of information for the professionals in the system.

We could also, when we seriously introduce IT, introduce a system of comparative effectiveness. All of us in the health care business believe that it is extremely important that we not continue to pay the same rate for low-quality care versus high-quality performance, that we need more transparency in the system.

I have also recommended in other places that we need major investments in ARC, in the National Institutes of Health, to do these kind of comparative effectiveness studies that will make a difference in terms of cost. We need to compare the effectiveness. This is not an effort to ration health care, but rather to get independent research that tells us the most effective treatment for a patient. We have to have the guts to do that, even though there are strong political forces that would prefer that we continue the current payment system.

Finally, I would like to make a point that I think Senator Grassley has made. We have to be careful as we are putting together comprehensive health care reform that we recognize that 80 percent of Americans like what they have, but they want lower costs. That was the same percentage in 1993. We ran into a buzz saw in 1993 because our proposal affected everyone.

I am not suggesting that you should not prepare a proposal that affects everyone, but we all have to be particularly sensitive to people who have health care that they like and who want the option of keeping that health care. There are employers that want to keep that for a competitive reason, and there are others that would just as soon move into another system. But the one "beware" I would have is of challenging this group without making a very clear case about how they would be better off, particularly on the finance side, because, while they like what they have, they really are unwilling to continue to pay rising costs at the same time. All of our polls show that.

I would like to make one final point about social policy, since the chairman made a point of trying to help us to understand the history of social policy in giant steps. We have never, in this country, taken a giant step in social policy unless there was agreement about the definition of the problem and agreement about the solu-

tion. Many of us have misread the politics because we went out and polled the public and they were very unhappy with the problem.

In fact, there was a lot of agreement about the problem, how the system has broken down. But we forgot that there also had to be consensus about the solution. In every time we have taken a giant step, whether it has been welfare reform or the introduction of Medicare or Social Security, there has been consensus about the problem and consensus about the solution. In many cases there was not a private sector alternative or there was and we combined it—that is in the case of Medicare—where we made a decision the government would pay for it, but we also agreed on a private sector delivery system for it.

So I would emphasize that point: in designing a system, we should not be misled, because there is widespread agreement in this country that we have a broken system. We also have to focus very carefully on the stakeholders and getting a buy-in into whatever the solution is. That is not just political consensus, it is much broader than that.

I would urge the committee to continue their attention on this issue. I can think of nothing more important to our future, whether it is our economic competitiveness or continuing this golden age of biomedical research, to take extraordinary science and bring it to the bedside of every American in a way that is fair and just.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Madam Secretary, very much. We deeply appreciate that. That is very, very helpful. Thank you.

[The prepared statement of Secretary Shalala appears in the appendix.]

The CHAIRMAN. Secretary Thompson?

OPENING STATEMENT OF HON. TOMMY THOMPSON, FORMER SECRETARY OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Secretary THOMPSON. Thank you very much, Chairman Baucus. It is an absolute honor for me personally to come in front of this committee. Thank you, Senator Grassley, for your tremendous leadership. The two of you have been noted for your bipartisanship in coming together. I had the privilege of working with both of you on the Medicare Modernization Act, and I cannot tell you how pleased I was with the bipartisanship and the leadership both of you showed in that regard, and I thank you.

To all the members of this committee, this is an honor for me, a privilege, to talk about health care. I thank the Senate Finance Committee for inviting Secretary Shalala, my friend of many years, and one who believes as passionately as I do that health care needs to be transformed. Ladies and gentlemen, you are the ones who have to do it. We can help you. We can advise you. But it is going to take the government, and this committee, I believe, is the impetus to really transform health care.

I have submitted my speech, and I am going to summarize some subjects that I feel very, very passionate about. I am going to offer some solutions and suggestions on how we can handle them.

I also am chairman of the Center for Health Solutions for Deloitte that we have just done a survey on, and I will submit that,

a recent consumer survey on the trends in health care. I will be submitting that to the committee.

[The survey appears in the appendix on p. 56.]

Secretary THOMPSON. But ladies and gentlemen, when you look at health care, you have to look at it in several different ways. The first one is, you have to look at what is really causing the turmoil. This happens to be an issue out there about which both political parties, for the first time, are saying something has to be done. We have never really had a presidential campaign in which we really fought the issue of health care.

There are differences in views, but the truth of the matter is, when you look at the presidential candidates, all three of them, there are a lot of similarities, commonalities that I think really allow us to forge a bipartisan solution to health care.

The first thing we have to address, however, is Medicare, because Medicare starts going broke in the years 2012–2013, and it is going to be a huge kind of dampening impact on health care because the Congress does not have the money to subsidize it. There are 30-some years of IOUs that have to be paid back, and there is no way that we are going to be able to fund it without a complete transformation of Medicare.

I do not know if Congress, without the help of a bipartisan commission, made up of an equal number of Republicans and an equal number of Democrats, making recommendations—because you are going to have to look at age, you are going to have to look at benefits, you are going to have to look at funding, and that is going to require a bipartisan, really introspective look at Medicare.

I really think a commission, appointed by the President immediately after the election, whomever he or she is, that can advise the Congress as to how to make those tough decisions, is going to be necessary. You are not going to be able to transform health care without first addressing Medicare. That is the big 800-pound gorilla.

The second one is, you have to go where the money is. When Willie Sutton was asked, why do you rob banks, he said, that is where the money is. If you are going to change health care, you are going to have to go where the money is, and that is in chronic illnesses, 75 percent of the cost. The nice thing about it is, both political parties are talking about wellness and prevention. But that is going to require a change in reimbursement, because right now we have a disease system. We do not have a wellness system in America.

We do not have a medical system, we have a disease system. We have to change the reimbursement formula, because doctors right now are only paid for the procedures they make. The average time that a doctor spends with a patient is 9 minutes, and that is not enough to get a real in-depth finding of how a person acts, reacts, or an inventory of that person's illness. So you are going to have to change the reimbursement formulas.

The second thing you are going to have to do is, you are going to have to address chronic illnesses. One hundred and twenty-five million of us have one or more chronic illnesses, and that is costing the medical system 75 percent. If you really want to look at it, you are going to have to somehow instigate a procedure with companies

in America to instill wellness and prevention and smoking cessation in the workplace.

That is going to require some kind of a tax credit, or if you are going to allow for the tax deduction you are going to have to require a company that is going to get the tax deduction to put in smoking cessation as well as some kind of tax credit in order for those employers to start a wellness and prevention program.

I have done it in the company that I run in La Crosse, WI, and it is working out extremely well, but you are going to have to do that. Smoking is big. Four hundred and forty thousand Americans died last year. You are going to have to address that. There is no question that nicotine should be monitored by FDA.

A lot of you, including myself, take a baby aspirin every single day. I am not going to ask for a show of hands, but a baby aspirin is regulated by FDA. If every man, woman, and child took an aspirin, you would reduce the deaths by 88,000 in America today each year, 88,000. Yet, nicotine, which kills 440,000 Americans, is not regulated. It just does not make any sense.

The biggest one, and the growing one that is causing the biggest changes in the marketplace is diabetes. Eighteen million Americans last year had Type II diabetes; this year, 21 million Americans have Type II diabetes. Forty-one million more Americans, some in this room, are pre-diabetic. In 5 years, that is going to be 62 million. That is going to go from \$145 billion to \$400 billion. It really gets down to the fact that there is a way to change diabetes. One out of eight dollars now spent in the medical system goes to treat diabetes, and that is going to go up to 1 out of 5 unless we address diabetes.

The National Institutes of Health, when I was Secretary, did an exhaustive study. They found out that if you walk 30 minutes a day, lose 5 to 10 percent of your body weight, you reduce the incidence of Type II diabetes by 60 percent. That is not that difficult. There are certain ways to cause it, but you would really have a way to improve the quality of health care and reduce the cost.

The other big one, and the driving one for cardiovascular and diabetes, is the fact that we are all a little overweight. You know, chunky is good but slim is better. I come from the State of Wisconsin, where every meal is better with beer, brats, cheese, and cream. [Laughter.] But instead of eating two brats, you eat one brat and you lose weight. Instead of two Millers, you have one and you are able to reduce weight. That is a recipe.

There are no food police in America—yet—that require you to clean up your plate, even though our grandmothers told us to do that. But there are ways in which we can get information out on nutrition, which we really have to do, especially with minorities. Being overweight leads into diabetes, which is an epidemic in Native Americans, Latinos, and African Americans. We have to do something about it.

The next one is disease management. Twenty percent, especially in Medicaid, where the dual eligibles use up about 80 percent of the costs. Now, if you intensely manage the 20 percent, you could have a tremendous opportunity to reduce the costs of health care in America, but you have to go in and—you just cannot call them up and say, are you taking your meds? You have to see them and

have interaction. It costs more money for the doctors and the dentists or doctors and nurses, but you would have a tremendous way to change that.

The third one is information technology. The Institute of Medicine said that 98,000 Americans died last year from medical mistakes, and 50 percent of those were made because individuals had the wrong medicine at the wrong time or in the wrong amount. Only 8 percent of the doctors are e-prescribing. One out of five prescriptions has to be rejected, modified, or changed. If, in fact, you went to e-prescribing you would reduce those deaths by 50 percent overnight.

It is so much simpler to have e-prescribing than having handwriting. Every doctor has to get straight As to get into medical school except for one grade, and that one grade is handwriting. Still, 92 percent of the scrips are written out, and the doctor's handwriting has not improved at all.

The next one is electronic medical records. If one of you esteemed Senators had a stroke today and was unconscious and went down to the hospital, how long would it take for the emergency room doctor to know what caused the stroke, if you had a stroke, what medicines you are on, what sort of things you are allergic to. The doctor does not want to cause any harm to you, but it is going to take hours before he gets your records.

In Taiwan, little Taiwan, 24 million people, they hand out a medical card to every man, woman, and child. It tells you your whole record. The chip has your whole record on there. We have the technology, ladies and gentlemen. If you run out of money in Beijing or St. Petersburg or any other place, what happens? You go down to the ATM machine and you get your money.

With the electronic medical record, we cannot even have the Senate and the House of Representatives have an electronic medical record, or the employees in the Federal Government who can absolutely have interoperability from one hospital to the next.

The next subject is the uninsured. The uninsured, we pay for it. The uninsured go to emergency rooms for their primary care. It does not make any sense. We should require every State to have a pool and allow every insurance company—not licensed necessarily in that State, but any State in America—to be able to bid on the uninsured. We saw that in the Medicare Modernization Act. We had more bidders than we ever thought possible come out. The same thing would happen in every particular State if you had a pool of the uninsured. For those individuals under 125 percent of poverty, give them a tax credit and you will be able to really have a lot of individuals—most of the individuals—covered by health insurance and you would save money.

The last two quick subjects I want to talk about, every one of us knows what a W-2 is. The Federal Government is a large employer. Every single individual in the Federal Government and every single individual in General Motors, virtually every single individual in the University of Miami, or a small ma-and-pa grocery store fills out the same W-2.

The most complex employment system in the world, and every employee fills out the same W-2. How many forms does it take to get in to see a doctor? How many forms do you need to get to see

your insurance company? How many of us receive those, “This is not a bill,” statements of benefits? I have drawers full of those and it does not mean anything. What I am saying is, you could require some statistics or some kind of standards on filing a claim, and you will reduce the cost. If we went paperless—and we have the technology to do it—we would save \$195 billion. That is 10 percent of the cost of health care.

What I am telling you, ladies and gentlemen, there are ideas out there, some exciting ideas, innovations to change and transform health care. Just to give you a couple of examples, Allegiant Health Care system has a system right now where Senator Baucus, as a member of Allegiant, he just, on his computer, says he is going in for appendicitis. Immediately it comes up, the cost of appendicitis by the hospital system, what the insurance company is going to pay, and what Senator Baucus has to pay, on all procedures. That is done in Omaha, NE. It could be transformed all over.

We have nursing homes that have to put in quality standards at CMS, and everybody now can check them there. We can do the same thing for hospitals, for doctors on quality and have complete opportunity for transparency. You would improve the quality through the opportunities. There are many different things. Three percent of Americans now are looking to go overseas for health tourism. Another 22 percent are looking at that 3 percent that went this past year.

We have tele-docs. You can call somebody. You could be traveling. You pay a fee and have a doctor within 40 minutes who could prescribe, and they are 95 percent accurate, much more accurate than you would think in a regular doctor’s office.

You have MDVIP that has specialties that are putting up doctors’ offices throughout America to really do wellness and prevention, really putting the emphasis on that. Then you have people, insurance companies putting in wellness and prevention plans. What I am telling you, ladies and gentlemen, is it is exciting to be in health care right now. We have to change it, we have to transform it, and it can be. It is going to take the leadership of the Senate Finance Committee, the Senate, and the House in order to do it.

I know Secretary Shalala and myself are absolutely thankful to be here. We appreciate you taking on this tremendous responsibility, and I know that both of us in our differing capacities, even though we do not agree on every political issue, we certainly know that health care has to be transformed and we want to help you, and we want to give you the best information we possibly can so you can make a bipartisan decision to transform health care.

Thank you again for allowing me to be with you.

[The prepared statement of Secretary Thompson appears in the appendix.]

The CHAIRMAN. Well, thank you both. That was very interesting, one of the better hearings we have had, frankly. I deeply appreciate it.

The question I have is whether you both agree that, if about 80 percent of Americans are comfortable with the health plan they have, with the health service they have, but are not comfortable with the costs that they have to pay, why is the answer not basi-

cally to keep somewhat the same system we have, but to be very aggressive in addressing some of the cost problems? My assumption is, some of the points made by Secretary Thompson will go to reducing costs, that is, to wellness, the e-prescribing, electronic records, focusing on obesity and tobacco cessation, et cetera. I am asking you the degree to which both of you tend to agree that that is a basic approach that makes sense, or would you modify it in some way?

Secretary Shalala?

Secretary SHALALA. Well, that is one alternative, to just take the 20 percent and figure out how to cover the 20 percent. The problem is—

The CHAIRMAN. No, it would not be just the 20 percent, because 20 percent—

Secretary SHALALA. I mean, the 47 million plus whatever the other.

The CHAIRMAN. Right.

Secretary SHALALA. The problem is that, even though they are satisfied, to get their costs down is not easy to do without transforming the entire system. That is, while they are satisfied with what they have, it is difficult to get them where they want to be, and that is to make that health care cheaper without transforming the entire system. So it is just hard to do what they want to do, because what they would like, the simplest thing to do, is have someone pick up some of those costs.

But, in fact, the people who are paying those costs cannot pick up one of those costs. Those are the employers that do not see that they can pick up more costs. So it is not so easy just to satisfy them by finding someone to pay the larger bill.

The CHAIRMAN. Senator Thompson?

Secretary THOMPSON. Thank you for the question. I think it is a very good question, and I think that cost is very important. When you look at the \$2.1 trillion of spending right now, 16 percent of the Gross National Product, we cannot afford that. It is going to double in the next 6 years unless we do something about it. So, cost is very important.

But I agree with Secretary Shalala that you cannot just pick out cost and solve the problem. It would be nice if you could, but there has to be a whole transformation. It is not only cost in Medicare, because Medicare is going to have to have some kind of infusion of dollars. You are going to have to look at the age of Medicare, and you are going to have to look at eligibility and benefits. That is big. You are talking about some very tough political decisions.

The CHAIRMAN. With respect to Medicare, why is it not a better approach not to address the symptoms, but to address the causes? That is, why is the Medicare trust fund in such dire shape? Why are the costs going up so steeply? It is not just for Medicare patients, it is for all Americans, basically.

Secretary THOMPSON. Well, there is no question about that.

The CHAIRMAN. So is it not more important, therefore, not to just slice Medicare, the age requirement, for example, or the level of benefits, means testing, all of which are very important issues and have to be addressed, but why is it not more important to just

focus in on the underlying reasons for the increase in costs of health care generally, which by definition will help to—

Secretary THOMPSON. Senator Baucus, I think you are right. I think cost has to be the driving force as to, how do you make the system more efficient, how do you make it more transparent, how do you make it use technology, and so on. But you still are going to have to—I do not want to come here and say, if you just deal with cost you are going to solve the problem.

The CHAIRMAN. Right. Right.

Secretary THOMPSON. You are not going to.

The CHAIRMAN. Right.

Secretary THOMPSON. You are going to have to have a complete transformation of the health care system.

Secretary SHALALA. The only point I would make about Medicare, if I might, Senator, is that you would be surprised how much the private sector follows Medicare. So you control the Medicare piece. If you drive through electronic medical records, if you do all of these things in Medicare, you will get a bump in the rest of the private sector. So it is very important, as part of the strategy, to use what you can control, and that is the Medicare system.

The private sector very much follows the reimbursement rates, the requirements. The same doctors who do Medicare are also doing private sector health insurance. So, if you drive some of those changes through the Medicare system, I would not—and in fact we tried to do it—try a bunch of experiments out there. Every time you try experiments, whoever is in that community does not want to be the experimenter. You have to drive the changes across the system. But it is very important to use Medicare as part of the wedge to transform the entire health care system.

The CHAIRMAN. My time is expiring. But you are saying, therefore, as we formulate and frame a universal coverage strategy, that part of that should be Medicare?

Secretary SHALALA. Absolutely.

The CHAIRMAN. In about 10 seconds, what should the other parts be?

Secretary SHALALA. Well, obviously we have made a series of recommendations, including being able to have the information that we need on what are the best practices, as well as, what is the best treatment system. You can make investments in creating that kind of a system. The doctors and the nurses need information, and they need more accurate information that they can use for best treatments and best practices. That is part of the transformation. The IT system is another part of the transformation of the system. The prevention investments that you make are part of the transformation.

The CHAIRMAN. Thank you very much.

Senator Grassley?

Senator GRASSLEY. I am going to start with Secretary Shalala. This is based on the proposition of studies that say paying extra and getting more services, unlike maybe other industries than health care, does not necessarily provide extra high-quality care.

You mentioned Dartmouth and the fact that one-third of the money in health care might be wasteful. Dartmouth researchers also have said that, if every hospital treated chronically ill patients

as effectively as the Mayo Clinic, the Nation would have saved \$50 billion in unnecessary and redundant care.

Do you think that we should try to set the incentives so that we encourage more hospitals and all health care providers to deliver care as efficiently as the Mayo Clinic, and how do you think we can do that?

Secretary SHALALA. That is a very interesting question, Senator. I spent some time at Mayo. They transformed their culture. They do not buy every piece of technology. I think the point the Dartmouth people made, and that you are making, is that we are driving up—health care is an area in which we absorb new technology that does not save us money. One of the few ways we save money is with some prevention things like vaccines, where we can actually show that we saved money on treatment.

But the genius of Mayo is that they sit around and they do not adopt every technology. The story that I told you about going in to see an orthopedic specialist about a tennis injury, and he was writing a prescription for an MRI. I asked whether an X-ray would do as well, and he said, yes. Then he looked at me and said, I have never had a patient say I want an X-ray instead of an MRI. I said, my question is about quality. Can you get as much information with this particular injury from an X-ray as you can from an MRI? The answer was yes.

At Mayo, and increasingly at integrated health systems, they ask those questions. They create a culture in which what you are focused on is the quality of the decision for the patient, gathering that information, and being much more tough-minded about the adoption of the latest fad.

Now, you are also under pressure from the patients. You well know my position on advertising and drugs. I think it drives the patients to demand from their doctors the latest stuff. The word is, Americans want the best health care in the world, they do not want to pay for it. We need a culture, focused on the patients, of best practices. That is what both Mayo and what Dartmouth is talking about.

Senator GRASSLEY. Secretary Thompson, in regard to the tax code and using it for health care incentives, I am interested in ways in which you can reform the tax code to make sure it is fair in how it treats health care insurance. We are all interested in that. But how might, for you, the tax code, as you see it, be structured to hold down costs and make insurance more affordable? How would you envision the program working?

Secretary THOMPSON. I will give you three examples, Senator Grassley. I would use the Federal power of taxation and credits in order to improve the quality of health care.

The first one is, I would pass a proposal law that would require companies that are going to get a tax deduction for the premiums that they pay on health care to have to instill wellness, prevention, and smoking cessation in the marketplace. There is a quid pro quo: if you are going to get a tax deduction for paying the premiums, you have to provide wellness and prevention and smoking cessation. It will drive down costs and it will encourage businesses to make their employees' quality of health better, therefore the quality of life for their employees.

The second thing I would do, Senator, is I would provide for \$5,000, or whatever the credit is, for individuals who do not have insurance, the 47 million. I would require the States to put every one of the uninsured in their particular State into either a group or a single policy and allow every insurance company that sells health insurance in the country to be able to bid on it, the same way we did with Medicare, and you would be surprised how many individual companies would bid on that. Then for those individuals under 125 percent of poverty, I would allow a \$5,000 credit to a family, and \$2,500 for a single person to be able to buy in to that either single or family group policy in the State.

The third thing I would use is a little bit away from the tax code, and this is for transformation of technology. I would set up a Hill-Burton mini-technology fund, and I would take the fraud and abuse money. Each year it goes up. This past year we had \$2.5 billion collected, and it was sent over to the Department of Justice. I would take that \$2.5 billion in fraud and abuse and put it into a mini Hill-Burton Baucus-Grassley technology fund.

The CHAIRMAN. He is good. [Laughter.]

Secretary THOMPSON. And I would use that \$2.5 billion in order to transform the electronic medical record, require the doctors and the hospitals to match it 1:1. You immediately would have a \$5-billion fund and you would be able then to completely energize and change technology. Then the optics would be great: take from bad providers to give to good providers, bad doctors to good doctors, bad hospitals to good hospitals. Those are three quick examples of how I would use the tax code and the power of the government to transform health care very quickly.

Senator GRASSLEY. Thank you.

The CHAIRMAN. Thank you very much.

Senator Stabenow?

Senator STABENOW. Thank you, Mr. Chairman.

Welcome to both of you. It is wonderful to see you and to have your input. Lots of questions. I am going to say for my friend and colleague Senator Wyden, who I know is going to talk about the Healthy Americans Act, I am sure, but I do want to indicate that I am very pleased to be part of a truly bipartisan coalition in the Senate that is focused—seven Democrats, seven Republicans, including Senators Grassley and Crapo, who are on the committee with us, and hopefully others as well who are looking at a comprehensive approach.

I did want to talk specifically, though, about health IT. Senator Snowe and I chair the Senate Health IT and Quality Improvement caucus, and I could not agree with you more about the emphasis on technology. People start, I think, with the idea of just using it to eliminate paperwork. We know that about 31 cents on every health care dollar relates to administrative costs, but, as you indicated, it is so much more. It really is about quality.

I wanted to share one thing for the record. In Michigan, because we have large employers doing the right thing providing insurance, they have really tackled these issues around cost because they are looking for every opportunity they can. One I do not know if you have looked at, but General Motors, Ford, Chrysler, Blue Cross, Medco, others have come together around an e-prescribing initia-

tive that has been in place since 2005. It has had some dramatic results in a very short amount of time. They have about 2,500 physicians now writing electronic prescriptions, and they have written some 282,000 prescriptions.

But they found, in looking at just a couple of years, that in putting this system in place, that they have had 423,000 times when they changed the prescription or canceled it based on more adequate information about other prescriptions that someone was on, or allergic reactions, medical alerts, and so on. It has really been quite extraordinary.

I want to thank the chairman particularly for embracing and working with us on e-prescribing, with Senator Kerry and myself, to move that ball forward. I really appreciate the chairman's support on that, and we hope to see something happen there.

My question, though, relates to the broader incentives. We know that most of the financial benefit goes to the payer for us; Medicare saves money, Medicaid saves money, private sector insurance saves money, more than the provider. But we have to have the provider involved. We have to have the physician involved, even though the physician has costs but may not get as much of the savings as we do, as the Federal Government, or as private plans, and so on.

So when we look at this, what would you suggest in terms of incentives? We are looking at incentive payments on e-prescribing through Medicare as we look at physician payments. What more should we be doing in terms of incentivizing that?

Then the second thing I would ask, Secretary Thompson, you talked about the Santa Barbara information technology exchange in your testimony, which was an effort that actually was in place for 8 years and then ceased in 2006 at the end of the year because, according to those who looked at this and studied it, there was a lack of compelling value proposition for potential investors.

So when we look at what should happen in terms of both the right market incentives for health information technology, as well as public sector investments, how do you see us moving forward? Because I do not think we can get to quality comparativeness or the other cost issues that we are talking about, savings, without really embracing information technology.

You are welcome, either of you.

Secretary THOMPSON. Well, it is a subject that I am absolutely passionate about, because you are absolutely correct. You cannot get transparency, you cannot get interoperability unless you really, really set up a system.

The first thing we have to do as a government, we have to have national standards. It is too bad that we do not. I asked the President, before his last election, to make the statement that we are going to have an electronic medical record in 18 months. He came out for 10 years. As a result, we have not been able to get there. We need action, but we need standards.

The second thing you have to do is, you have to take what I said about fraud and abuse. Set up a fund so that people can download and take the money and be able to invest it.

The third thing is, the incentive for people to do it is the fact that you save money. There is a new company that has come out that puts out a double auction, Senator Stabenow, one that puts

out if you have a drug—if you have Lipitor, you type in “Rx” and you go in and you have any pharmaceutical company immediately bid on that. It is an auction. It is a double auction. It is immediate.

Any generic that is the same as Lipitor can bid on it, with the same amount. You can watch the prices actually go down. Then you can have a second auction for the pharmacists in the area: who will deliver, and at what cost will they deliver it? It is an incentive. You can see the pharmaceutical costs actually go down. It is an exciting new company.

The fourth thing is, by getting quality—Allegiant Health Care, which I mentioned—it is a wonderful way to see exactly what it is going to cost and when you can get in and be able to have the operation or the procedure.

Secretary SHALALA. Senator, you asked specifically about, how do we reward providers? Right now they do not get rewarded very much because low-quality and high-quality get paid the same amount. So it is extremely important that the new design rewards quality, whether it is centers of excellence or individual performance. Quality is not how many patients you see in a day, quality is outcomes kinds of measures. Increasingly, there are providers out there and health care companies that are trying to figure out a way in which there can be some cost sharing when there is savings, but the people are actually rewarded for producing quality outcomes for their patients.

Electronic records systems can support those kinds of decisions and those kinds of activities, and that is where we want to get to. We also need to make certain that whatever is designed includes nurses. For those Senators who particularly come from rural areas, they are very used to advanced practice nurses, nurses playing a much greater role. It is so uneven across this country.

It is a tragedy that in some States, because of lobbying efforts, they can restrict what nurses can do, where in another State nurses have much broader responsibilities. I believe, whatever the Federal framework is, it has to recognize that this is a team effort and that we have to integrate the role of nursing and other health care professionals into our overall strategy. That includes pharmacists. A lot of people get their information from pharmacists and from nurses. We just have to get over the uptightness about not seeing health care as a team effort, and that has to be part of the quality movement in this country.

Senator STABENOW. Thank you.

The CHAIRMAN. Thank you very much, Senator.

Senator Bunning, you are next.

Senator BUNNING. Thank you.

Welcome, both, Madam Secretary and my good friend, Tommy.

I am concerned about entitlement spending in our budget. We did not touch entitlement spending in 2011. We did not touch it, specifically how Medicare, Medicaid, and Social Security will consume the entire Federal budget by the year 2030. You brought out the fact that Medicare will go belly-up by 2013. Social Security goes negative in 2017. So that means that, unless we do something, we are going to have some huge tax increases to pay for those programs.

The reforms that you have made, or suggested, are excellent. But what about dealing with the entitlement spending? Is that the only thing that we can do, the reforms that you have mentioned? What else can we do? That is what I am looking for.

Secretary SHALALA. Well, we can do a lot of things: making the health care system more efficient, slowing down the growth of costs in the Medicare system. There are a number of things that both Secretary Thompson and I have recommended. We have not talked about fraud. One of the efforts, when you do a big-time effort on fraud, you can actually slow down the growth of Medicare. We demonstrated that over and over again.

We need a full court press on fraud. I live in an area in South Florida where we have done demonstration after demonstration, and there is a huge amount of fraud in the system, particularly in Medicare. Whatever we do about health care efficiency, about introducing IT, we need to knock the fraud out of the system. That is slowing down the growth of Medicare. There have been trustee reports that actually identified the additional years tied directly to our ability to reduce the amount of fraud in the system.

On Social Security, there have been a number of recommendations, as you well know, on tweaking the system to extend the number of years. But I would suggest to you that healthier Americans who work longer, where we do not see age as a barrier, and everything we can do in terms of prevention, wellness, and getting more efficiencies in the health care system, helps the entire entitlement world. But simply shifting more costs to the individuals, we have tried all the incremental kinds of things.

We are talking about fundamental change in the way the health care system works, which will also have an impact at the same time on how long people work, how healthy they are, how dependent they are on Social Security alone, and how we transform that piece. There are specific recommendations that I could give you on Social Security, but on health care, and Medicare in particular, I think there are lots of things we can do to actually—

Senator BUNNING. Maybe we need to implement the Inspector General's report that was done in April on Social Security, just the things that were passed by the Congress and never implemented by the Social Security Administration.

We are looking at CDRs (Continuing Disability Reviews). Right now there are 750,000. In 1996, we passed a specific budget allocation of \$350 million to reduce, at that time, a \$250,000 backlog in disability claims. They did not spend it. They did not spend it for that purpose. So how do we get through that maze to get those kinds of things done? One of them is Social Security, but the other—Tommy?

Secretary THOMPSON. Senator Bunning, Social Security is not nearly as bad off as Medicare. Social Security is—

Senator BUNNING. Medicare is. Even the report—

Secretary THOMPSON. Social Security does not start going broke until 2029, and finally is bankrupt in 2041. Medicare starts going broke in 2012 and is finally completely bankrupt in 2018 or 2019. That is why I think you are going to have immediate—just to give you a couple of quick figures: Medicare, right now, takes about 2.5 percent of the Gross National Product.

In the next 75 years, it will go up to 15 percent. Social Security takes 5 percent of the Gross National Product today; in 75 years it only goes up to 7 percent. The unfunded liability of Social Security in 75 years is going to be \$12 trillion. The Gross National Product today in America is \$13 trillion. The unfunded liability for Medicare in 75 years, Senator, is \$65 trillion, completely unsustainable.

What you have to do is, I think you will have to have a bipartisan commission of an equal number of Republicans and Democrats, because here is what you are going to have to do. First off, you are going to have to have the age increased somewhat, something a politician—

Senator BUNNING. It does not cost anything.

Secretary THOMPSON. But you are going to have—

Senator BUNNING. It saves a lot of money.

Secretary THOMPSON. It saves a lot of money. You are going to have to do it. The second thing you are going to have to do is, you are going to have to put in some laws as to when new procedures, new medicines, new devices are going to be able to be given, and when and who is going to be eligible for that.

The third thing you are going to have to look at is, you are going to have to look at the limitations on revenue. Those are three big things right away. But immediately what you have to do in Medicare is take care of looking at some of the things like, who are the people going into Medicare? I will give you a factoid that really shows me, and it is something that we could address quite easily, that we have to do it. One-third of seniors this year who are age 64 and going into Medicare at 65 are diabetic. Fifty percent of the one-third do not know they are diabetic.

Now, if we just had a physical—we do have a voluntary physical—but if we had a physical for every senior, to go in and get those individuals, that 50 percent of the one-third who are diabetic, and start treating them before they get so chronic that it costs hundreds of thousands of dollars, you are going to be able to start changing it. That is just one. That is diabetes.

The CHAIRMAN. Senator Wyden?

Secretary SHALALA. Senator, I would strongly point out that just that fact should caution you against extending the age for Medicare.

Senator BUNNING. I thought he was talking Social Security. But he was talking Medicare?

Secretary SHALALA. Yes. I think extending the age for Medicare is a very dangerous issue because, as people get older, they get sicker, and that is the last thing that we want to do in our society. What we do want to do is to make sure that, as people get older, that they are healthier than they currently are, and diabetes is a perfect example. I agree with the Senator.

Senator BUNNING. Thank you.

The CHAIRMAN. Senator Wyden? Thank you very much, Senator. Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman.

It is great to have both of you, two people I admire so, so much. Secretary Shalala, congratulations on the terrific work you have recently done for our veterans, more incredible public service to the

American people. And Tommy Thompson, you are one of my role models on prevention. You use it as a bully pulpit, and it is so very important.

I have been talking to some of those who have been through 1993 and 1994, the Clinton years. Senator Dole has been extraordinarily helpful in terms of giving his counsel, constantly stressing bipartisanship. When I went to see John Dingell, he said much the same thing. For the first time now it is possible to use the words “universal” and “bipartisan” in the same sentence. You have 14 Senators, 7 Democrats, 7 Republicans, ready to go with Senator Grassley, Senator Crapo, Senator Stabenow.

We have tried to focus on two things. First, to make sure that the financial underpinnings add up. The Congressional Budget Office gave us great news essentially in the last week. They said the proposal will pay for itself over the first couple of years, and then generate some surpluses.

Then we have tried to be sensitive to the point that Secretary Shalala has mentioned this morning, and that is to try to address the concerns of people with coverage. What we focused on there is trying to make sure that there are fresh strategies for those people to hold down their costs, but to do it within the context of a system where they can keep what they want.

So my question to you, first, Secretary Shalala, is on this point of the confidence people have in our system. Most workers do not know that their wages are not going up because health care is eating up everything that might give them more take-home pay. Any ideas for getting the word to those folks about how, unless you control health care costs for everybody, transform the system for everybody, we are not going to be able to fix this?

Secretary SHALALA. Well, as you well know, it is a tough case to make. I am not sure that that 80 percent loves the system. I think they love their doctors and the way in which they use the system, and their nurses, that they know where they are going to go. It seems simple and straightforward to them. So, I may have overstated the case. I just feel the whiplash on my neck about the experience of 1993.

So I think transparency is extremely important, bringing people along so that they understand what they currently have and how that is put together and how much they end up paying, and the relationship between their wages and health care. You talk to some of the labor leaders in this country. They would very much like to see a different system because they cannot negotiate wages anymore. They are negotiating health benefits, not wages.

So you talk to some of our labor leaders where their populations are growing, they are very frustrated with the current system and with their ability to do that. I did want to congratulate you on your own plan. I found it very thoughtful, the bipartisanship, the comprehensiveness. That is, in the long run, as you shape the future, where we obviously need to go.

Senator WYDEN. A question for both of you at this point. Senator Dole and Congressman Dingell, as we talked about 1993 and 1994, particularly looked at that Congressional Budget Office situation, because back in 1993 and 1994 the Congressional Budget Office did not give it a favorable review. We got a very positive report last

week, and it seems to me that in this economy, where people are concerned about deficits, concerned about economic uncertainty, getting a good Congressional Budget Office analysis is probably even more important than it was in the past.

Secretary THOMPSON, any thoughts on this?

Secretary THOMPSON. I do not know how much more I could add to that. I think it is absolutely correct. I have not had a chance—I have been traveling; I just got back this morning to DC—but I would love to read the report. But what you tell me is, we could have the coverage necessary for all Americans. I tend to believe that, because I think, when you look at the 47 million Americans, we are paying for it, we are paying for it now, hospitals, providers are paying for it, taxpayers are paying for it. Where do a lot of the individuals go for their care? The emergency room. What is the most expensive care? Emergency room.

If we could set up a system where poor individuals who are uninsured have the opportunity to go to their clinics and their doctors for their periodic tests, you are going to make them healthier and you are going to save money in the long run. So, I tend to believe it. I would like to read it, but I tend to believe it, and I think you are absolutely correct. If you have a good CBO score, you have a good chance of getting it passed. So, congratulations.

Senator WYDEN. Thank you.

I will have some additional questions in the second round.

The CHAIRMAN. Thank you.

Senator Salazar?

Senator SALAZAR. Thank you very much, Chairman Baucus. I appreciate this committee looking at something that is comprehensive as opposed to some of the work we do around here, which is very important. I sometimes feel on the health care issue we are putting Band-Aids and baling wire around an issue that does require this kind of attending, so I appreciate Chairman Baucus's leadership in getting us thinking ahead of this whole deal.

My question to both of you, Secretary Shalala and Secretary Thompson: you have grappled with this issue for a very long time. You saw what happened in 1993 and 1994, major efforts that really did not go forward. I am wondering if what we end up doing here is, we try to take a bigger bite than we can chew. I think back in my days of baling hay and running a baler, and sometimes a particular baler was too fast, and what ended up happening is you would get too much feed into the baler and you would end up breaking your shiv bolts and messing up your baler.

Are we doing nothing here in the context of health care because of a desire of wanting to do something comprehensively, where there are lots of things where we already have an agreement that we can work on here? Secretary Shalala, and you Secretary Thompson, were talking about how we know that there are things that we can do on information technology, and we should start making those investments and creating the kind of tax credits and incentives there. Do we take on the issue of wellness and prevention and start doing something there as opposed to trying to put together the whole package and essentially moving forward in what is going to be a very, very difficult process to try to get everybody together?

Secretary SHALALA. Senator, my answer would be: been there, done that. That is, we have done a lot of the incremental things that we know how to do. All of the other things that we would like to do would be helpful, but probably would not stop this huge growth of the uninsured and the huge growth of the underinsured. As much as we talk about IT and as much as we talk about other efficiencies that you could build into the system, we need a much more comprehensive, more integrated strategy to get everybody covered. It is just easier to do all those other things if you get everybody covered.

But I think that the State experiments are interesting because they tell us a lot about the politics and how you put the politics together, but frankly we are at the point where the Congress itself knows on what elements they could build a bipartisan reform. It has to be very transparent with the American people and has to simplify the system, because one of the things we learned in 1993 was that complexity killed us. It was not simply that we scared people who already had good health insurance, but the complexity. I had to testify on that bill, and I am very good at complexity, and I had a heck of a time explaining it to anyone.

Senator SALAZAR. And maybe that is part of the reason that it died: that it was seen as too complex. Maybe the American people were not ready for it. So now, fast forward. We are in 2008, trying to pull together a similar kind of effort. How would you do it so that it does not die by its own weight? I would like to hear your thoughts as well here, Secretary Thompson.

Secretary THOMPSON. Well, Senator Salazar, I am a farmer. During a thunderstorm that is coming, a tornado, whether you are in the plains of Colorado or the hills of Elroy, you want to get that hay field in, so you are working darned hard to get it in before the thunderstorms hit, before that hay gets wet. Even though you are trying to crowd and you do not want it to clog up the machine, you want to get that hay in. That is where we are today.

The thunder clouds are out there. We are doubling the cost of health care in the next 6 years. We have uninsured at 47 million. We are having employers pull out of offering health insurance.

Senator SALAZAR. So, Secretary Thompson, would you try to then pull together a comprehensive package that would address all the facets of health care that you just addressed, or would you try to take them one at a time, for example, the Medicare—the information technology, prevention, try to take those?

Secretary THOMPSON. You may be able to have information technology as a separate piece, but overall you have to transform health care. One piece is not going to do it, Senator. It is too broken. We have to transform health care. The beauty is, all the stars are lining up correctly. All three presidential candidates are talking about it, Congress is talking about it, this committee is talking about it, the leadership.

The fact of the matter is, costs are up. People are almost demanding that we do something. Now is the time to act. Two thousand-nine, as I say in my speeches, is going to be the best year for transforming health care ever. I am from the State government perspective, where I believe in incremental things like we did on

welfare. I just think health care is so broken we have to have a total fix.

Senator SALAZAR. Well, thank you both for your service to our country, and for your testimony.

Secretary THOMPSON. Thank you, Senator.

The CHAIRMAN. Senator Kerry?

Senator KERRY. Thank you, Mr. Chairman.

Welcome to both of you. Thank you for your many years of input on this subject.

I listened to and read both of your testimonies. I thought they were very interesting, and appreciate the perspectives that you bring to it.

Secretary Thompson, I just want to ask you, you made the point, and you have made the point in your testimony, about the need to sort of have a commission or something to begin to deal with the Medicare piece. I find that hard to square with what you have just said right now about the need for a comprehensive fix, et cetera.

Peter Orszag has made it clear that the only way to deal with the growth of the cost of Medicare and Medicaid over a long period of time is to bring down the cost of health care, and that you cannot deal with Medicare and Medicaid separately from the rest of the system. You are going to have to drop those prices, and therefore deal with a number of different things, ranging from everything—I heard Senator Stabenow and other people questioning about IT, we have our e-prescription effort, a whole bunch of things. They all have to happen, do they not, simultaneously?

Secretary THOMPSON. Oh, absolutely. But Medicare is so broken, Senator, it is going broke in—

Senator KERRY. I understand. In 2012 we go negative, and in 2019 it is bankrupt. I have the picture.

Secretary THOMPSON. And we have to move on it. Medicare, as Secretary Shalala has mentioned previously, has an impact on most decisions in the private sector as well, hospitals, reimbursement of doctors, and so on. They use that to help—

Senator KERRY. Oh, I understand. That is why it seems to me you cannot sort of have a separate commission out here and be trying to do—

Secretary THOMPSON. Senator Kerry, the only thing I am saying is that, it is so political. You are going to have to raise more money, you are going to have to look at the age question; Secretary Shalala and I disagree on the fact that you are going to have to address it. You are also going to have to address what benefits are available, when they are available, and to whom. These are tough decisions, and most individuals in the Senate and the House really do not want to deal with those things.

Senator KERRY. We are going to have to deal with them.

Secretary THOMPSON. That is why I think an equal number of Republicans and Democrats sitting down, making some tough decisions, then passing it on to Congress, is the way to go.

Secretary SHALALA. Yes. Senator Kerry, I spent an hour and a half trying to figure out where I was going to disagree with my good friend, Secretary Thompson. On the use of a blue-ribbon commission, I actually think the history of those commissions is that

they work when it is very specific things that they need to address, not something so integrated and comprehensive.

So I think that the Secretary and I disagree on this one, and I would separate myself out. You use a blue-ribbon commission when you are dealing with a Walter Reed situation, as the President did, something very specific, like the Social Security issue, where you are in and out, you tweak the system, you get a few more years.

But on Medicare, because it drives many of the changes, it is going to have to be done by the political system, but specifically by the Congress. The one thing we learned in the executive is, unless it is a team effort, working with Congress, the President could lay out his or her principles on how we wanted to do it, we could look at bipartisan bills, but my sense is that you all ought to take the lead, start the ball rolling, and that the executive ought to come in, but we ought not to use well-intentioned citizens on this one because of the need for—

Senator KERRY. I could not agree with you more. Not to go backwards, but had the outcome been different in 2004, I can guarantee you my plan was to ask Ted Kennedy, Orrin Hatch, Max Baucus, and Chuck Grassley to come down to the White House, sit there, and say, all right, you guys have to fundamentally help put this together and we have to do it jointly. There is no way to do it otherwise. I think, hopefully that is the way we are going to proceed on this thing because of the politics, et cetera.

But let me put a couple of the other thorny things on the table. I think it is absurd, frankly, and I intend to try to do something about it separately if necessary, that we are encouraging Americans to go out and, on the spur of a fanciful, attractive advertisement, go out and ask their doctor to do something, which the doctor then feels, if they do not do, they could be sued for if something else happens, or they just make their client unhappy and they go away and go somewhere else.

The higher cost of health care—I have had more doctors tell me that there are more people who come in to them and say, well, I want this, I saw this on TV, you have to give me this, whatever it is. It seems to me that medicine, and the whole concept of curing people and dealing with this, sure, patients deserve to have information and knowledge, but I do not think we should be encouraging a specific drug of one kind or another, which is just unbelievably costly in terms of the whole system.

Would you comment on that, please? I know you commented a little bit earlier.

Secretary SHALALA. Yes, I did a little earlier. I strongly opposed that part of the FDA reauthorization and held my ground all night. I think Senator Frist now admits that that may have been the wrong thing to do at the time. But I want you to know that we knew better, and we told the Senate authorizing committee exactly what we thought was going to happen: it would run up health care costs, it would transform the health care system in a way that was inappropriate. I still oppose it. I hope that at some point you could roll that back.

Senator KERRY. Secretary Thompson?

Secretary THOMPSON. First off, I would like to just quickly go back one step, because you and I agree as to whether or not a blue-

ribbon commission—if, in fact, the President of the United States comes down and says that to Senator Baucus, Senator Grassley, and to the other two leading Senators, that is fine. I just do not think that is ever going to happen. That is why I am saying a blue-ribbon commission is probably the most—

Senator KERRY. I disagree with you. I think it is going to happen.

Secretary THOMPSON. All right. If it does, that is fine. We have not seen it yet.

Senator KERRY. Well, I think that is—

Secretary THOMPSON. And it is immediate. It is an emergency.

In regards to advertising, you have the Constitution, you have the legal—I think a better way to approach it is, pharmaceutical companies should be required to advertise, if they are going to advertise, and put out information on nutrition, on wellness, and prevention along with any drugs out there and start educating America. This is where we are lacking. We are not getting information out on diabetes, on general subjects, on wellness and prevention. This is where you are going to save the dollars, much more so than hawking one particular pill over another.

The CHAIRMAN. Might I ask both of you your thoughts on how to get to universal coverage? Secretary Shalala, you mentioned a strategy with Medicare. Just kind of sit back a little bit. I guess, first of all, it is a matter of definition. I presume you are not talking about single pay, because that is politically so difficult in this country, and also has other problems. But how would you move toward universal coverage, and what would some of the elements of that strategy be? How important is the mandate, for example, the individual mandate? How much of the solution is in the public sector versus the private sector? Just your thoughts when you are driving to and from work, thinking about this stuff. I mean, what do you think?

Secretary SHALALA. Well, I think it depends on how—

The CHAIRMAN. I am going to ask both of you.

Secretary SHALALA [continuing]. How much political muscle you have at the time. I mean, there are ways of putting the pieces together, simply building on the existing system. The problem with that, as we demonstrated, is that you will continue to pay for poor performance. Even though any kind of system will have electronic records, we will not have the kind of quality of care that we want while at the same time getting universal coverage.

Getting everybody covered and not transforming the system in terms of how we pay, in terms of efficiencies, in terms of the standard of care, I would not recommend to anyone. Some of the elements involve deep subsidies for those who cannot pay, and these transformational elements that pay based on performance and based on quality, as well as the IT components, you want in, as well as some kind of a mandate. I do not see a way around those kinds of incentives.

What I have been interested in is that there have been bipartisan coalitions built around individual mandates. Candidates are talking about it, if you look at Massachusetts and look at some of the other States. So, I would want to look at those elements. I think all of the elements that we have seen in a number of dif-

ferent plans, including the bipartisan plan that is up here, are ones that ought to be considered. But you ought to pick and choose.

The one thing I have learned from government is that no one ever thinks about simplicity. It is extremely important that we can explain the six things that we have done that will transform the system as opposed to 1,228, and that we pick the transformational elements for the new plan and that everybody is in. We have to be in this together. We also have to have the kind of simplistic and simple information that we now give people for Social Security.

You get it at a certain age, but you can pick up the phone or on-line you can ask for where you are in the Social Security system. You ought to be able to get that basic information in health care, what you pay, what the government pays, what your employer pays. You ought to be able to get straightforward information. So whatever the elements are, there ought to be a limited number of elements. You ought to pick the ones that make the most difference, and everybody ought to be covered. So, those are the principles that I would follow for the system.

The CHAIRMAN. Thank you.

Secretary SHALALA. And I would absolutely get away from, if the government is going to do part of it, they ought not to be paying more than the private sector for anything.

The CHAIRMAN. Secretary Thompson?

Secretary THOMPSON. Thank you very much, Senator. I have probably five points, very quickly. First off, you are going to have to change the reimbursement formula or else you are going to have a system that is not going to function very well because you have fewer people going into internists and family doctors.

The CHAIRMAN. Big-time. A big problem.

Secretary THOMPSON. A big-time problem. You have to change the reimbursement formula so you can get young doctors to go in there. You have to change the formula so that you can get nurses, people who get their Ph.D.s so they can start teaching. We have a lot of young people wanting to become nurses but we do not have the professors. The constraint is the fact that we do not have enough instructors and professors. That is structural, and that has to be changed.

Number two, I would demand that every State require all the uninsured to be put into a group, both family and single, and then allow every insurance company in the health care arena to bid on it like we did on Medicare Modernization. You would be surprised how many insurance companies would come in and bid on it.

Third, I would give every couple a \$5,000 tax credit if they are under 125 percent of poverty to buy into it, and for a single person, \$2,500. I would also allow them to buy into the Medicaid system using that tax credit to do it, or buy into the health insurance system.

Fourth, I would do a lot of education in schools, at the medical schools in regards to making sure that nutrition, wellness, and prevention are taught. Doctors coming up really have a paucity of knowledge about nutrition, as well as exercise and prevention. You have to teach it, and you have to educate. Those are the points I think you have to have in order to have universality.

The CHAIRMAN. I think we all agree that the reimbursement system is out of whack, for a lot of reasons. It does not pay for performance, really. It is procedures, it is volume, all that kind of thing. How do we get from here to there? I mean, how do you get the medical profession to agree, yes, we have to pay for performance here or that the primary doctors need to be reimbursed more than the subspecialties? We all talk about that, we all know it is important. But any thoughts on what the dynamics are as we are putting something together so we accomplish it? We know the Jack Wennburg study problems, for example. That should be addressed as well.

Secretary THOMPSON. We put pay-for-performance in the Medicare Modernization Act, and I think it is working. I think it is the first small step towards getting to that quality and pay-for-performance that is necessary, and I think Congress has to just put in the laws, and CMS has to implement the rules and regulations in order to accomplish pay-for-performance in quality and transparency.

The CHAIRMAN. Madam Secretary?

Secretary SHALALA. I agree with that. There are lots of different things that have been tried. Some of them have worked pretty well. The one thing about pay-for-performance is that the private sector insurance companies are very interested in this, for good reason. They have put some things in place. I think there are enough elements out there. One of the reasons I believe we can get to comprehensive health care reform in this country is because we have tried lots of different pieces. It is really a question of scaling up and implementing, but everybody has to understand it and buy into it. That is my fundamental point.

The CHAIRMAN. Thank you very much.

Senator Lincoln?

Senator LINCOLN. Thank you, Mr. Chairman.

Thank you, Madam Secretary and Mr. Secretary, for being with us. We have a monumental task ahead of us, and it is getting further ahead of us than we need it to. Our hope is that we will be able to look at some of the common-sense things we can do now that will help us create more comprehensive, I think, solutions for overall health care.

I am sorry that I am late. I know you all have both touched on the roles of employers in encouraging healthy behaviors in their workers. I agree with that. I think it is critical to preventive health—smoking cessation, the obesity epidemic. We see an awful lot of those in smaller rural States like mine, and I think the encouragement that we can provide there is really critical in what we need to do.

The private sector does have a role to play. I do not know how much you all have talked about that. Maybe you can expand a little on what you have already said, perhaps. I know in our State, Wal-Mart has saved its customers more than \$1 billion in terms of the \$4 prescription drug program that they started in September of 2006, and they have even furthered that this week in added savings and greater access, longer coverage periods, up to 90 days now, and specials for particularly women's health. But looking at ways that the private side can be helpful and how you all might

encourage that, particularly the opportunities and innovation and economic development, like health IT.

I do not know if you all have talked about the e-prescribing and some of the competitive natures there. But it is something you all might want to expand on. I am very interested in knowing how we can encourage the private sector to be more innovative, more involved in this, and any of those innovations, how they can be fostered in health reform while still putting downward pressure on health care costs.

Suggestions?

Secretary SHALALA. Well, I think we both talked at length about IT systems, but there are some very interesting private sector bottoms-up experiments going on in this country. I describe them now as experiments. Putting clinics inside of pharmacies.

Senator LINCOLN. We have some of those.

Secretary SHALALA. Putting them in Wal-Marts. That is probably the first new innovation, privately financed, not necessarily by people, in some cases, who knew a lot about health care. But the use of nurses, which I think both the Secretary and I feel very strongly about. I have complained that it is so uneven across the States depending on what kind of restrictions States place on nurses' ability to provide health care, but in rural States, they have a much stronger role.

In these clinics around the country, with physician back-ups—and my university is involved in ones that are family practice, where an advanced practice nurse, a nurse practitioner is providing those services—

Senator LINCOLN. A nurse practitioner.

Secretary SHALALA [continuing]. Limited as they are by whatever they are allowed to do. But there, what you are seeing is there is a standard of care. They do not go beyond the certain procedures and illnesses where there is a clear standard of care, and then use the backup, and then someone can get an appointment. The first studies in California showed that people with insurance were using those places, and that tells us a lot about access. So by the time you get to a major discussion about health care reform, we are going to know a lot about different kinds of innovations and the way to do the preventative part, to provide widespread access, the role of clinics, the role of federally qualified health care providers, where we could perhaps describe a system in which there were different points of access with different providers providing that, in which what you are going to be talking about is a framework for all of this.

But I think I am with Secretary Thompson. There are an awful lot of exciting things going on out there that can transform the discussion that you are going to have, and there are experts in each of these areas that could be helpful. We would be happy to be helpful in identifying some of those things that are going on.

Senator LINCOLN. Well, you brought up the nurse practitioners. I think that is important in a State like ours, but making sure that, again, like Secretary Thompson said earlier, we have the training going on and we have the professional—not just the clinical folks, but we have the academic folks who are going to be able

to train. We have folks who want to start nursing school, a lot of them out there, who do not actually—

Secretary SHALALA. Once they get their degree, if the medical establishment that they go into does not see them as an equal partner and see them as part of the solution in the long run, is not prepared to give them a stronger role as a part of the health system, we will continue to have nurses who leave the profession. The fact is, we could solve the nursing shortage in this country if we could bring back to nursing positions all of those who have left and been discouraged about the way it is organized. So, we have big challenges in this country, but there is no question in my mind that there is something out there that is going to allow real leadership, particularly by this committee, to bring us together.

The CHAIRMAN. Senator Wyden?

Secretary THOMPSON. Senator Lincoln, if I could answer your question. I agree with Secretary Shalala, but I would like to just expand a little bit. I mentioned it before you were in here. In my capacity as chairman of the Center for Health Solutions for Deloitte, we made a survey and we found that 62 percent of the Fortune 500 companies are going into wellness prevention this year, and next year an additional 31 percent. That is a giant step forward.

The second thing is, in my capacity of going around the country speaking on health care, I have come in contact with some really nifty ideas. Tele-doc is one in which you pay a fee and, anyplace in the country, you can tele-doc, call up and telephone a doctor. They are 95-percent accurate in their diagnoses and can give treatment, and can also give a prescription.

The third one is the MDVIP, a company out of Florida that is putting doctors in cities all around America in clinics, based strictly on wellness and prevention.

Then there is Allegiant Health Care out in Omaha, NE, which I talked about, an exciting thing on transparency using technology. Senator Lincoln, if you were a member of Allegiant, if you needed whatever procedure you wanted, a mammogram or what, you just type in on your computer at home “a mammogram” and they would tell you immediately, instantaneously it comes back, you can come in and have your mammogram, what it is going to cost, what your insurance company will pay, and what your co-pay will be. So this is the kind of transparency and quality that needs to be exported throughout America. These are just some. I have many examples of these where there are some really wonderful, innovative things coming in that are just very helpful to transform health care.

The CHAIRMAN. Thank you very much.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman.

With Secretary Dole, on this question of the Congressional Budget Office, I think what I have been struck by, Secretary Shalala, is the point that we now have something that indicates that we can pay for a universal coverage proposal 2 years in and then start generating surpluses. It seems to me as I look back on 1993 and 1994, if there had been something like that—and I get this from Senator Dole and Congressman Dingell—that that might have been

a game-changer back in 1993 and 1994 if they had had a document like the ones Senator Bennett and I got last Thursday.

Can you tell us what happened back then with the Congressional Budget Office?

Secretary SHALALA. Well, we expected a better mark from the Congressional Budget Office, and it was devastating because of the costs and their estimates. And while we argued with them for a while, that just compounded both the sense of the complexity and our inability—it changed the momentum of the discussion.

So, if you start with a kind of revenue neutrality, that is, you make some up-front investments and then there are payouts, you just take a giant step, there is just no question about it. Would it have made a difference? Yes. But there were some other elements, as you all know, during that point of time. I think we learn from our mistakes. Obviously you all have thought a lot and have talked to people who were the players to try to learn from those mistakes.

Senator WYDEN. Let me go now, for the two of you, to something we have not talked about, and that is the role of the States in fixing American health care. I have come to the conclusion that we have this terrific set of Governors and State legislators, people with terrific ideas and thoughts.

But the reality is, the States cannot fix problems they did not cause. The States are not responsible for the tax code, the biggest expenditure in American health. States cannot do anything about the big self-insured plans. They obviously cannot touch Medicare and have limited control over Medicaid. In fact, I think the story of the States is what a terrific job States do, given what little bandwidth they really have to operate in. So what Senator Bennett and I do with our group is, we try to give the States a wide berth, but we recognize we are going to need a new Federal/State partnership to fix health care.

I would be interested, from our last question, Secretary Thompson, in your thoughts on the role of the States in fixing health care, and then you, Secretary Shalala.

Secretary Thompson?

Secretary THOMPSON. Well, I think you said it as well as anybody can, Senator Wyden. States are doing a great job. We started, and I am happy to say I was one of the originators of, welfare reform and we made successes, and then other States were able to build upon that. The same thing is happening on health care. I was able to give Governor Romney a waiver, and they started the Massachusetts program on covering everybody. Since then, Oregon has tried health care, California, Wisconsin, Illinois.

A lot of States are trying innovative things, and they are asking for waivers to try them. But the truth of the matter is, if in fact you are able to, Senator Wyden, on a bipartisan basis, give States a wider bandwidth, you would find a lot of innovation, a lot of exciting things bubbling up that you could see take place.

I just do not think at this point in time—and I have been a Governor for over 14 years, and I think those people do a wonderful job, like you have said. I just do not think, right now, health care can afford the experimental kinds of programs at the State levels to bubble up. It is too immediate. I think the Federal Government—I hate to say this, coming from where I come from—but I

really think the Federal Government has to take this particular problem on, on health care, because you have to deal with Medicare, and then broaden the base, give States the opportunity in your framework to fix it. But I really think this is immediate, and the Federal Government has to deal with it.

Senator WYDEN. Secretary Shalala?

Secretary SHALALA. I basically agree with that. As much as I love State experimentation, we have not given Secretary Thompson enough credit, not simply on welfare, but SCHIP, for example. The first movement on that came out of his State, and a couple of other Governors'.

It is just that we have so federalized the big purchasing, that it is very difficult. Because plans do not have to pay attention to State law, you almost have to rewrite the relationship of States over health care. Sorting out that federalism is going to be a very important part of the plan that you eventually work out: what is the role of States and what is the role of the Federal Government? That is why I raised the issue of nurses.

Your framework is not simply a Federal framework, it is a Federal/State framework. Sorting out what the States ought to be doing as part of this and what the Federal Government ought to be doing is going to be very important as part of this exercise. We know that they are talented out there and they are anxious to cover. They have told us a lot about their ability to bring in employers and about buy-ins and how much glue money it takes to put it together, as California recently found out. They did not have enough glue money to put theirs together.

That also is another indication of the politics, and that is, there are a lot of people out there at the State level who want to see this done. I think making them partners will be a very important part of this.

The CHAIRMAN. Senator Kerry? Thank you.

Senator KERRY. First of all, I agree with both of you on that. Massachusetts, which we are proud of in terms of the experiment we made, is, I think, not a model for the rest of the country by itself, for a couple of reasons. One, we got a huge waiver with a lot of money that came in, allowing us to do things with Medicaid so we had extra money. Number two, we had a demographic that was different from that in California and other States in terms of the numbers of uninsured. Number three, we had a huge uncompensated care pool which also allowed us to make it up.

What we are finding is, the Massachusetts experiment is proving that the real population difficulty that you have to cope with in any of these plans is your low-income uninsured and how you would cover them. So I think that we have to look at this larger thing.

Then there is the other problem. As the States proceed, you get into these variations in what the benefits are that are mandated in the States, and that causes all kinds of problems in terms of costs, State boundary pools, and things. I think we are going to have to deal with that.

But let me come to two other fundamental questions I want to ask. I have a daughter who is currently a first-year intern at Mass General in Boston. She keeps reporting to me, as do other young friends who are doing the same thing that she is, on the primary

care crisis. There is just a crisis of finding primary care doctors. None of her friends who get out of medical school can afford to go be primary care doctors because of their loans and burden. I would like you to comment on that.

Second, the defensive practice. I am a lawyer. I have carried some of those cases previously. I do not want to see people's rights of access for redress lost. I certainly do not want to have an open-ended system where you do not have accountability. But you cannot avoid owning up to the reality that there is an enormous amount of defensive practice, an enormous amount of cost shoved onto the system by people who are just afraid not to do X-rays, no matter the appropriateness of them. I met with a bunch of radiologists recently, and we were talking about appropriateness criteria and how you begin to make those determinations. Can you share with us how you deal with those two issues in the context of this sort of macro reform we are talking about?

Secretary SHALALA. Well, on the first issue of primary care doctors and loan forgiveness, we can do this. We can do the same thing on nursing if we need more nursing faculty members. I mean, it is not a very expensive enterprise to incentivize people so that those who want to go into primary care can go into primary care and not end up with a huge burden that they have to pay off. We also have to make sure—and I run one of the great academic health centers in this country—that we ourselves are encouraging people to go in.

I have a young family member who went to one of the great medical schools, an Ivy League institution in this country. He was the most brilliant student they had, and everybody discouraged him from going into family medicine. Now, he is in family medicine today, but it was overcoming the opposition of his faculty members to go into family medicine.

On the issue of tort reform, which you bring up, I am one of those Democrats who believes that we ought to have tort reform. The sense of medicine and the studies of defensive medicine have not been conclusive about whether we are practicing so much defensive medicine. Our system is so messed up that it is hard to measure that in a way in which we can come to a firm conclusion, but we need a better way, whether it is arbitration—we need a faster and fairer way. Here is what we do know from the study, that those who really need to get some kind of a settlement are probably not the ones who are getting it. It is so uneven in terms of the court cases.

I am in a State in which my faculty are burdened by litigation. But we also know that the right cases ought to be settled, people ought to have opportunities. It probably is not a court system that will do that for us. There are some alternatives that can be adopted, whether it is limits on a certain amount of the payments. But we certainly want to make sure that justice is served, that the system is fairer, and it has to be a system other than going to a court and going to a jury and a system that is—

Senator KERRY. Well, in Massachusetts, one thing we did was put in place a tribunal system, where you have a doctor, lawyer, and judge, and you clear cases before they even get in. There are

a lot of ways to do it to hold onto the rights of people, which is important to be able to have that adjudicated, I think.

Secretary SHALALA. I agree with that. I think that our party in particular has to be willing to look at some of those alternatives and build a bipartisan coalition as part of this.

The CHAIRMAN. Senator Lincoln?

Secretary THOMPSON. Could I answer the question?

The CHAIRMAN. Very briefly.

Secretary THOMPSON. This is a tough process here.

The CHAIRMAN. All right, Mr. Secretary, go ahead.

Secretary THOMPSON. Number one, we have to change reimbursement forms, Senator Kerry. It just is not financially practical to have a family doctor. Thank you for your daughter being in Mass General. But to have a family doctor in a medical school owing \$200,000, making \$100,000 a year and seeing patients only for 9 minutes—the reimbursement form has to be changed.

Second, we have to encourage hospitals and companies to allow nurses who want to, to get their Ph.D.s so they can teach, because we have a lot of young men and women who want to go into nursing and they cannot go into it. We are going to have a shortage of 350,000. We have a huge shortage of gerontologists coming out, and family doctors. All of this is going to require the Federal Government to stimulate it.

The second quick thing on defensive medicine, I love what Secretary Shalala says, I agree with her. I think the Democrats do need to change their policy on tort liability, but I think all of us do. I am being a little bit cute there, and I am sorry about that. But I really, truly believe that what we have to do is we have to set up a system of arbitration, Senator Kerry, that is going to get these cases handled quickly and be able to solve the situation much faster.

The CHAIRMAN. Thank you.

Senator Lincoln?

Senator KERRY. Thanks, Mr. Chairman. Can I just say quickly—I am sorry. I apologize.

Senator LINCOLN. That is quite all right. Not a problem.

Senator KERRY. I think you said something very important, which is, we both have to. Some try to use it as an excuse just to get rid of everything altogether and have no accountability. I think it is the balance.

The CHAIRMAN. Thank you.

Senator KERRY. Thank you.

Senator LINCOLN. Thanks, Mr. Chairman.

I have three quick questions, and I am going to try to get them out there.

I just think it is critical to address our need for comprehensive and accurate data in health care, particularly with seniors and more people who are living with chronic illnesses. I have introduced a bill, the Geriatric Assessment and Chronic Care Coordination Act, which I think is critically important as we see more and more of our population obviously in the older category.

Would either of you—whatever recommendations you might have on improving on the quality of data that exists for coordinated care models, efficient care delivery settings like home care, hospice. I

had a man walk up to me just yesterday who said thank you for working on hospice. It is understood. How do we do that? How do we get the data there that is important, that it reflects?

I know Senator Wyden brought up the issue of CBO and the scoring. We know that there are cost savings, that it provides cost savings in the long run, but we run up against that problem. The other thing is, one of the things we know is we are going to have some costs involved in here. I guess one of the things we have talked about is looking at Medicare Advantage.

I know that we are certainly seeing that, subsidizing these plans on an average of 13 percent or more than regular Medicare, and seeing it growing. Do either of you all have an opinion on whether or not that should be a part of our discussion on meaningful system reform in terms of Medicare Advantage?

I think the last thing that I wanted to ask is, Secretary Shalala, you mentioned that one reason for the failing of the last Clinton health reform plan was that America was in a recession at the time and was not ready for that drastic kind of health care reform.

We are finding ourselves now, obviously, with great concerns of our economic state. It is not exactly ideal. Would it make sense now to walk before we run, or are we going to hit that same situation that you mentioned in terms of the Clinton plan?

Secretary SHALALA. I do not think I mentioned the recession as part of my statement. I think both of us see elements of where there is a build-up in one of those opportunities that we would not want to miss. The fact that there is a very good CBO report on a specific plan gives you some hope that you could, whether it is that one or some variation that we have suggested here in terms of elements, I think this is the time to move. I think Senator Baucus recognizes that, and the chairman's willingness to take this on will be very important in the future.

You asked a bunch of other questions. I want to yield to Secretary Thompson. I am sure you are going to be looking at Medicare Advantage. Everybody is eyeing it for a variety of offsets. It is true that it does pay more. It is also true it is not clear how many more benefits people are getting besides it. But one of the reasons to do Medicare reform now is because everybody is going to be looking at that to offset some other kinds of things that need to be solved in health care, including physician payment and some other issues.

So I do not think there is any question about some over-payment there. The question of whether there are additional benefits being offered, there are lots of studies and lots of people who are more expert than I am in that area.

Secretary THOMPSON. First off, let me thank you, Senator Lincoln, for what you are doing in hospice, home health, and that. I would also like to introduce Bill Pierce and Jennifer Young, and Jorge and Tony. They are working in a bipartisan way in order to get more attention to wellness and prevention in the handling of chronic illnesses. They have 175 organizations, bipartisan, trying to influence politics and the government to make sure that they are going to be able to be heard.

Senator LINCOLN. I hope they have looked at our chronic care bill.

Secretary THOMPSON. They will. They have, and they are supportive of parts of it. So you should sit down and talk to them.

The second thing, in regards to Medicare Advantage, as you know, it was a successor to a previous program. You are going to look at it. I think everything in Medicare has to be looked at. I do not think there are any sacred cows. Medicare needs to be absolutely looked at and it has to be overhauled.

The third thing is, I really sincerely believe that, if we are going to have an opportunity to transform health care, it has to be done on a bipartisan basis and everything in the whole health care system has to be looked at, and hopefully we can forget about the partisanship and come up with a bipartisan conclusion.

The CHAIRMAN. Thank you all very, very much. I know that you have deadlines to meet. Thank you for taking the time to come. This has been a great kick-off of our inquiry as to how to find a solution here. You have both really helped make this work very well. Clearly we have to have bipartisanship. We need to do something more than incremental, and we need universal coverage. I just thank you very much.

I think we are probably going to be calling upon you often in the future, because clearly you have thought an awful lot about this and have a lot of good ideas.

Thank you very much.

The hearing is adjourned.

[Whereupon, at 12 p.m., the hearing was concluded.]

A P P E N D I X

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

The Future of Health Care Reform

Testimony of Donna E. Shalala, Ph.D.

**For Hearing on Seizing the New Opportunity for
Health Reform**

Before the United States Senate

Committee on Finance

May 6, 2008

Chairman Baucus, Ranking Member Grassley, and members of the Committee on Finance, thank you for the opportunity to testify today on the topic of health care reform.

I have purposely not commented on the plans of the presidential candidates or member of congress. Rather, I chose today to talk about why we need a universal coverage strategy and the political challenges of achieving our goal.

In many ways, the United States health care system is the envy of the world. Our hospitals are filled with world class technology, our doctors, nurses, physical therapists, and other professionals are dedicated and well educated. Our dynamic innovative pharmaceutical industry consistently produces drugs to extend the length and quality of human life.

Underpinning our success is our world class investment through NIH and NSF in our extraordinary research universities, which are simply unmatched in their brilliance.

But, while America leads the world in these aspects of health care and science, statistics show that we as a country still face many health care challenges, particularly when it comes to properly insuring our population. At last count, nearly 47 million Americans, including 9 million children, are without health insurance and an additional 17 million are considered underinsured.

Nearly 80 percent of this uninsured population holds full time employment or lives in a family with at least one full time worker. These are low and middle class Americans that get up and go to work each and every day, but are simply not employed by a company that offers health insurance or the insurance that is offered is too expensive for them to afford.

Even for those fortunate enough to have health insurance, the premiums for these plans are continuing to rise and show no sign of leveling off. With gas approaching nearly \$4.00 a gallon and a world economy showing signs of recession, money is stretched thinly in every working family and our families are increasingly facing difficult decisions with regard to the cost and availability of health insurance.

When the Henry J. Kaiser Foundation pollsters asked Americans: What issues they would like the presidential candidates to talk about, they put health care in the number three slot after the economy and Iraq. However, a closer review by the Foundation analysts revealed that our fellow citizens are linking the economy and healthcare.

Drew Altman, President of the Henry J. Kaiser Foundation reported last week:

"When we asked the public about the types of problems they were experiencing as a result of the economic downturn, serious problems paying for health care

and health insurance ranked in a statistical tie for second along with job issues, behind paying for gas which was named by far and away the largest share of the public. More people reported serious problems paying for health care than paying for food, their rent or mortgage, credit card debt, or losing money in the stock market; all pocketbook issues you would expect people to care a lot about.

“Problems paying for health care extended well into the ranks of the middle class. Moreover, significant percentages of the public told us that the problems they were having were rippling through their family budgets, affecting their ability to pay other bills, using up their savings, or making it hard for them to pay for food or other necessities...premiums have risen wages have not kept pace, so it's not surprising that people are feeling the pinch.

“The costs of health care and health insurance are also important in political terms. Our polls show that these costs, more than expanding coverage, are the health issues independent voters care about most, and they are the voters the candidates will be courting most in the upcoming election.

“When you see the polls over the next two years that show the economy number one, Iraq number two, and health number three and potentially even falling a little, remember that health is not necessarily a fading issue, because it should be seen as part of the public's broader and rising economic concerns. The rise of economic worries and problems, rather than becoming a reason to defer action on health could present an opportunity to reframe the issue as the public sees it: as a single overarching problem of the affordability of care, and not as we health policy people think about it, as separate challenges of controlling costs and expanding coverage. And with paying for health care ranking up there with job issues and gas prices for the public as daily economic problems, elected officials might want to think about addressing the public's health care concerns differently too; not just through the lens of health reform, but as economic policy as well.”

According to the Centers for Medicare and Medicaid, (CMS), the United States in 2006 spent approximately \$2.1 trillion, or more than \$7,000 for every American man, woman, and child, on health care. That figure represents a 6.7% increase in health care spending over 2005. If America's spending patterns remain relatively constant and continue to increase by approximately 7% each year. The Centers estimate that by 2017 America will spend nearly \$4.1 trillion each year on health care services.

As a country we are spending 16% of our annual GDP on health care, but still have more than 47 million Americans uninsured. This represents a serious and profound challenge for our country's leaders.

Other industrialized countries around the world have successfully developed universal health care programs for their citizens, ensuring coverage for all while costing significantly less than the American model. Countries such as Switzerland, the United

Kingdom, France, and Taiwan have proven that universal health coverage can work, and perhaps equally important, is economically sustainable.

While these programs cannot and should not merely be grafted onto the American system, they do illustrate the availability and viability of other programs besides our own.

Here at home, states like Massachusetts, Vermont, and Maine have begun to implement universal health care systems in the hopes of covering the growing number of individuals without adequate health insurance.

With nearly two million individuals losing health coverage each month and thousands dying prematurely each year because they lack adequate health care access, it has become clear that something must be done.

Only with the successful implementation of a universal health care strategy, will the United States have the potential to not only extend quality coverage to the millions of Americans currently uninsured, but also have the opportunity to save billions of dollars in the process. While this might seem counter intuitive, the low cost preventative care afforded by universal coverage will help America to save the billions of uncompensated dollars currently spent each year treating uninsured individuals. Although the United States may spend more money at the outset to cover the uninsured, in the long run our society will benefit from the implementation of a universal health care strategy.

Not only will we as a country have a health care model that is more affordable and economically viable, but our economy will benefit from the infusion of a more productive labor force.

In order to be ultimately successful, a strategy of cost containment must also accompany any plan for universal coverage. Although some analysts have called for America to forgo a system of universal health care and instead introduce cost containment alone to reduce the billions of dollars of waste, in order to be truly successful, both strategies must be implemented--parallel to one another. Though a short term cost containment program may look promising, it is nevertheless a strategy still rooted in our current fragmented system. When combined with a system of universal coverage, however, cost containment has the potential to maximize effectiveness and cost savings while also cementing long-term positive changes to our health care system.

Once all individuals are insured, it will become immeasurable easier for the health care community to find and eliminate the billions of dollars of waste that continue to weigh us down. Although cost containment has been a goal for decades in the health community, when enacted within a system of universal coverage, the overhead costs of achieving savings will be lower. Meanwhile, we should begin by ending the outrageous cost of everything from wheelchairs to oxygen in Medicare.

As compared with our current approach, cost-control methods utilized in conjunction with a strategy for universal coverage will not only help to lower costs and improve quality for patients, but will also benefit health care providers and the insurance industry as well.

Another area for increased savings and cost control is the sphere of information technology. We live in a world of rapid technological innovation. This innovation has infused and enriched our culture, helped extend the length of human life, and allowed us to communicate in ways previously unthinkable.

But, while technology has been instrumental in the development of new and often expensive medical equipment and treatments, its usefulness as a tool of cost savings has only begun to be tapped.

The clearest starting point in beginning to reap the cost savings rewards of information technology is the development of electronic medical records. Electronic medical records have the potential to dramatically cut health care costs by improving communication between physicians, enhancing the capacity of health care providers to efficiently perform surveillance and monitoring of care delivery, and decreasing the utilization of care by patients who chronically abuse the system.

Tests will no longer have to be retaken because results may have been lost, medical errors and the costly medical liability which accompanies them will be lowered, and most importantly, patients will have a greater chance of receiving the proper care they need at the time that they need it.

To see the benefit that such a system of electronic medical records can have within a complex and technologically advanced health care system, one need only look as far as the Department of Veterans Affairs.

Since the early 1990s, the VA has been a pioneer in adopting information technology, utilizing an integrated medical recordkeeping system called VistA to promote high-quality, cost-efficient care. The VA has heavily invested in its system of electronic medical records and that effort has paid off. In a recent study published in the *New England Journal of Medicine*, when researchers used 11 measures to compare VA patients treated in the VA's own hospitals with Medicare patients treated in a mixture of private and public hospitals, the VA's patients were in better health and received more of the treatments professionals believed they should.

These researchers attributed the majority of this success to the VA's enthusiastic support and implementation of electronic medical records.

Although electronic medical records have been able to increase the quality of care provided at VA facilities, they have also helped the VA lower the costs of treating patients. With a system of electronic medical records in place, every x-ray image taken,

lab note written, or drug prescribed for a particular patient can be found in one central and easily accessible location.

Researchers at Dartmouth University recently found that America wastes as much as a third of the \$2.3 trillion it spends on medical care each year and that much of the waste comes from disorganization and lack of information. With the implementation of a comprehensive electronic medical recordkeeping system such as the VA's VistA program, the civilian health care sector will finally be able to eliminate much of this waste.

Building upon the foundation of electronic medical records, America's health care system could further expand its cost savings by utilizing the strengths of information technology to introduce a system of comparative effectiveness.

American society as a whole embraces technological innovation, and the health care sector should be no different. While all patients undoubtedly want the most up-to-date equipment and to benefit from the most cutting-edge tests, oftentimes older medications and equipment can be as effective, or even more so; all while costing a fraction of the price. Just because something is newer and more expensive doesn't always make it better.

The United States must in the coming years develop a system of comparative effectiveness so that the health community can adequately establish the cost/benefit ratios of new treatments and determine how they can be implemented most successfully.

Past comparative effectiveness trials have shown that while an expensive treatment may be very effective when used as a first-line therapy, it might have limited effectiveness in other advanced cases. Additionally, older and less expensive anti-psychotic drugs have been shown to be just as effective as newer and often more expensive treatments. As Secretary Levitt has pointed out recently:

"Doctors, hospitals and other medical providers are paid at the same rates for low-quality or high-quality performance. Physicians, who take measures that prevent acute flare-ups of chronic conditions, are paid no more than those who don't. Skilled nursing facilities that prevent unnecessary re-hospitalizations are paid the same as those that don't.

In fact, poor quality is often rewarded. When patients contract preventable hospital infections, costs skyrocket and in most settings, the hospital profits from it. Not only is our current system quality-indifferent, we reward poor quality!

Patients deserve to know the quality of the care they receive according to standards set by the experts. The information should be transparent, and most of all, we should reward quality."

It is important to note that comparative effectiveness is not care rationing. It is simply a method of tackling our country's growing health care expenditures by determining, based on independent research, the most effective course of treatment for any particular patient based on his or her individual needs. If we want to continue and make permanent the cost savings gains to be reaped from the implementation of universal health care and the adoption of electronic medical records, then America must also develop a system of comparative effectiveness so that health care providers can quickly and efficiently compare varying treatments, both those cutting edge and more traditional, to determine which will produce the greatest outcome for the patient.

Finally, a vigorous campaign against fraud and abuse is vital. Center for Medicare and Medicaid (CMS), The Department of Justice, the Department of Health and Human Service's (HHS) Inspector General, local and state law enforcement must be given and held accountable for billion dollar yearly goals to continue to tackle fraud in our healthcare system.

When working towards health care reform, we cannot forget the painful lessons of the past. At his 1993 State of the Union speech, President Clinton set forth one of the major priorities for his new administration when he called for "America to fix a health care system that is badly broken...[and give] every American health security - health care that's always there, health care that can never be taken away."

While Americans were initially quite receptive to the President's plan, over time that support diminished considerably. Although a majority of the population was excited about the creation of a system of health coverage for the uninsured, during the course of the debate over the plan those individuals who already had health insurance became increasingly cautious.

While these individuals held a deep and powerful belief that costs were too high and that the health care system needed reform, they also feared that the newly proposed Clinton system might radically alter the way they were used to receiving medical care.

As is true today, in 1993, 80% of individuals with health insurance described themselves as satisfied with the quality of the health care they received. While these individuals supported plans to provide affordable health insurance to those currently uninsured, they were relatively happy with their own plans and did not want that coverage threatened. However, they did want to see their premiums lowered and co-pays reduced. It was also clear the insured did not want to have to see different doctors or take different medications because the government altered the terms of their coverage. If legislation supporting the enactment of a universal coverage strategy is to be successful this time around, we must learn from the failure of the Clinton health proposal and ensure that those already with health insurance do not come to view efforts at reform as having a negative impact on their own care. This is not to suggest that individual mandates or tax breaks are not useful – just a reminder that past history

should make us very wary of beginning any new discussion of a reform strategy by challenging those who are happy with their current insurance plans.

One final point on the politics: if you look at the history of giant steps in social policy in this country--Social Security, Medicare and Medicaid, Welfare Reform – two things were present. First, there was consensus among Americans on the definition of the problem. Second, there was consensus on the solution – in many cases an expanded government role. In the case of Medicare, a compromise was struck with government as the payer and the private sector providing the delivery system. Both agreement on the definition of the problem and solution must be present if we are to succeed.

As we look to the future of health care, we often need look no further than health care professionals themselves. They have begun to innovate a variety of methods and techniques that will ultimately help augment a system of universal health care. Many are commonsense improvements being developed by nurses on the front lines of care and are helping transform the fundamental way that medical care is delivered in this country.

In hospitals, universities, and health centers all over the country, nurses are devising new strategies to get patients and their families care that is safe, affordable, coordinated, and effective. Through a new campaign called *Raise the Voice*, the American Academy of Nursing is highlighting these nurse-led models of care that result in lower costs and a healthier population.

In conclusion, I believe it is fair to say that the United States health system is currently at a crossroads. Even while America spends significantly more on health care than any other nation in the world, 47 million Americans remain uninsured.

Given the current slowdown in the economy and the challenges that can create for employers, we likely will see the number of uninsured in this country rise substantially over the coming months.

With costs rising and coverage waning, strong political leadership is needed to ensure that America's health care system can provide coverage for all Americans at an affordable price.

Achieving a universal coverage strategy will be a milestone in our nation's history and one that will only help to further facilitate the implementation of other cost saving measures such as electronic medical records.

Although any strategy for universal coverage will undoubtedly see many revisions before its final form, we as a nation must recognize the benefits that such a system can and will have for our country and begin a new chapter in our health care history - one with healthier citizens, a more robust economy, and billions saved.

While we as individuals may differ on the details of how such a strategy should ultimately be shaped, I believe we must set the bar high and accept universal health care coverage as an idea whose time has finally come.

I appreciate the opportunity to have testified before the Committee today and welcome your questions. Thank you.

STATEMENT OF SENATOR GORDON H. SMITH

U.S. Senate Committee on Finance
“Seizing the New Opportunity for Health Reform”
May 6, 2008

Good morning and thank you all for being here today.

I would like to welcome The Honorable Tommy Thompson and The Honorable Donna Shalala to this morning’s hearing. Both have served as Secretaries of the Department of Health and Human Services and their combined experience gives us over 12 years of expertise in running our country’s federal health programs and working with Congress to improve the health care system. I look forward to hearing their testimonies.

I also would like to thank Senators Baucus and Grassley for jumpstarting the Committee’s examination of reforming the health care system and for their efforts to make it a priority of this Congress, and next.

Every American deserves access to quality, affordable health care coverage. This begins with strengthening and protecting federal programs like Medicare, as well as vital safety-net programs like Medicaid and the State Children’s Health Insurance Program (CHIP). This committee has done a great deal of work to improve these programs and I look forward to continuing our efforts in this area. It also is important that we focus our attention toward crafting new solutions that will support those who lack health care coverage in the private market.

It should be noted that 60 percent of the 47 million individuals who are uninsured – more than 27 million are small business owners, their employees and their families.

Yet, small business owners and their employees are disproportionately burdened by the current structure of our health care system and health care costs.

Under current law, they do not enjoy the same tax breaks, coverage or pooling options as large businesses and corporations, and on average, they pay 18 percent more for the same healthcare benefits.

Before becoming a Senator, I managed a small company called Smith Frozen Foods. I was fortunate to be able to provide health care to my employees. I do, however, understand the difficulties small business owners face in offering quality health care coverage to their employees without bankrupting the business.

I know that small business owners want to provide health care they just need an affordable way to do it. Over the last year and a half, I have been working on a proposal that I hope will shape the debate of this issue in the Senate. It provides national direction to the problem of small group market reform, but relies upon existing infrastructure forged by states and the private market to provide new coverage options to small employers. The proposal also includes

provisions to offer insurance coverage through the program to sole proprietors and individuals who wish to join in.

One of the key principles of my plan is regional cooperation. Congress needs to provide the both the framework and incentives for states to work together to more consistently regulate insurance products sold to small employers. The result: the overall market becomes more stable and efficient in the long-run.

By focusing on small businesses, we can cut the ranks of the uninsured in America by more than half.

While many proposals have been introduced in this Congress that would overhaul how health care currently is delivered, it's important to point out that America's health insurance system was established in stages.

Reflecting on that history, it seems to me that to make improvements we may need to do so incrementally.

It has been over 15 years since the last time Congress tried to tackle broad health reform. In 1994, one party held the White House and had comfortable majorities in both houses of Congress, yet health reform never came to a floor vote in neither the Senate nor the House.

You would think this would have been the perfect formula for change, yet, it did not happen. I believe that is because Congress tried to do too much, too quickly.

Again, I am committed to the goal of providing quality health care in this country that is accessible and affordable for all Americans. And, I understand that finding real solutions requires the cooperation of diverse, bipartisan groups willing to work together for change.

I hope this Committee can focus on important, achievable reforms that will help those in need.

I thank the witnesses for coming today, and I look forward to a productive discussion. With that, I'll turn it back to Chairman Baucus.

Testimony of
Tommy G. Thompson
Secretary, United States Department of Health and Human Services, 2001-2005
Governor of Wisconsin, 1987-2001

“Seizing the New Opportunity for Health Reform”

Before the Senate Committee on Finance

Introduction

Good Morning Chairman Baucus, Ranking Member Grassley and members of this distinguished Committee. Mr. Chairman and Senator Grassley, I want thank you for your continued leadership on so many issues that are vitally important to the American people, including the topic that this Committee is examining this morning, transforming America’s health care system. Thank you for the opportunity to share some of my thoughts and ideas on how to build a healthier and stronger America.

It is a particular honor to be here with my long-time friend, Donna Shalala. Even though we are members of different political parties, I have always been honored to call Donna a friend. And even though our approaches differ slightly, Donna and I both agree that fundamental changes must occur in our healthcare and that America is ready for those changes. While Donna is a Miami Hurricane for now, she and I both have Badger Red flowing through our veins.

The Problem

I’m here today to talk about something this distinguished Committee knows all too well: The health care system in America is a mess. We are sprinting headlong into a crisis that will fundamentally cripple our ability to provide care to those who need it most – the elderly, the uninsured and the underinsured.

This is a direct result of rising health care costs that simply are not sustainable – not for businesses, not for government and certainly not for families. America is ready for answers. America is ready for solutions. And America is ready for policymakers to put their differences aside and work together.

The problem is neither with caregivers nor with the quality of care itself. To the contrary, America has the finest health care professionals and the finest caliber of medical treatment of any nation at any time in history.

The problem is the means by which care is delivered or paid for. Our health care delivery system has simply not matured at the same pace as the technologies and treatments now available.

How big is the mess?

- Nationally, we spent more than \$1.9 trillion on health care in 2004 – nearly \$6,300 per person. That will rise to \$3.6 trillion by the year 2014 – or more than \$11,000 per person.
- As a share of our gross domestic product, it is projected to reach 19 percent by 2014 – up from about 16 percent in 2004.
- Medicare outlays will exceed income for the first time in 2012 – leading to a 75-year unfunded liability for Medicare of \$68.1 trillion. *Trillion.*
- U.S. private employers spend more than \$330 billion a year on employee health insurance. That includes more than \$10 billion by the auto industry alone – more than they spend on steel.

That said, the American health care system remains the best in the world. As most realize, the United States will never embrace a single-payer system, even as government pays for a larger chunk of health care each year. Nor should we take that route. A competitive market is vital to ensuring that the U.S. health care system continues to innovate and provide the best care in the most efficient manner in the world.

I have some ideas that I'd like to share that will go a long way toward slowing the growth of health care spending while reducing the cost of health care for families. Taken together – these steps will lower taxes, increase access to health care and, in some cases, make the health care system a stimulant to the economy – instead of a drain.

Solutions

1. Medicare

Simply put, without significant reforms, Medicare is on the path to collapse. Government spending on health care is likely to double by 2017 to more than \$2 trillion. A recent study by the government predicts that Medicare Hospital Insurance Trust Fund will begin to take in less than it pays out by 2013 and become completely insolvent by 2019. These latest projections should serve as a wake-up call.

A good part of the problem is plain-old demographics. Today, 12% of the population is 65 or older. By 2030, almost 20% of the population will be 65 or older. The number of working people per Medicare beneficiary is sliced nearly in half, from 4 to 2.5. We have not prepared for this long-known truth – America is getting older and there will be fewer young people to pay for the health needs of more older people. We have not prepared for our aging population.

What can we do about it? There will be no easy choices. We will need to increase revenue and we need to decrease spending. We will likely have to raise the age of Medicare eligibility similar to Social Security. How should we make these difficult decisions? I am calling for the creation of a bipartisan commission, similar to the base-

closing commission. This Commission should be charged by Congress and the next President to recommend solutions. 2017 is not that far away.

2. Wellness, Prevention and Disease Management

The first and best way to reduce health care costs – and improve people’s health – is to keep them from getting sick in the first place. I call this the low hanging fruit of the health care debate, and we can all stand to pick – and eat – some low hanging fruit.

As a matter of economic, health and personal policy, we must do all that we can to promote the cause of prevention – living healthier lifestyles by eating right, exercising more and stopping smoking. This is a cause I adopted as HHS Secretary and one that I continue to feel passionately about.

In America, we’re too darn fat. Our poor eating and exercise habits are literally killing us.

In the book, “What the World Eats,” the authors note that Americans eat 3,774 calories each day (per capita, per day). That’s more than any other nation, with France second at 3,654 calories per day and Great Britain third at 3,412.

More troublingly, however, the authors report that Americans eat 158.2 pounds of sugar and sweeteners each and every year – or the equivalent of a healthy, 5-foot-7 man. That’s 47 pounds more than the second place country (Mexico).

Not surprisingly, after eating the equivalent of a whole additional person, we have the highest percentage of overweight people – an estimated 70 percent of American adults are overweight or obese.

What does this mean for the health care system?

- Obesity costs the American economy \$117 billion a year.
- About 75 percent of our health care dollars are spent treating chronic diseases such as heart disease, cancer, and diabetes. And \$75 billion of that treats obesity alone.
- These chronic illnesses—many of which can be prevented by healthy lifestyles—cause seven out of every 10 deaths.

Diabetes: 18 million have it today, 21 million will have it tomorrow, and 41 million Americans are pre-diabetic. On an annual basis, the Federal government spent \$79.7 billion alone to treat those with diabetes. That amount is roughly equivalent to the total annual budget of the Department of Education.

But what can we do? All businesses – large and small – should encourage their employees to take up the cause of prevention. Your employees will be healthier, happier and more productive. That will be good for their waistlines – and businesses bottom line. In fact, I have a radical idea in this area. For employers, I believe we should cut off

access to tax deduction for health insurance, unless they have in place a wellness prevention and disease management plan that includes smoking cessation.

Businesses can do more. For example, they should work together with their insurance companies to structure insurance and benefit programs to encourage employees to adopt healthier eating and exercising habits. In auto insurance, for example, safe drivers who haven't had an accident or tickets are given better rates than those who bang up their car every few months. Shouldn't we similarly reward people who don't submit their bodies to undue wear and tear?

I just can't understand why we wait for people to get sick and then spend thousands and thousands of dollars trying to make them well again. Why not focus on keeping them from getting sick in the first place?

The impact of chronic disease on the U.S. economy is an issue of particular relevance today, given the ominous economic clouds on the horizon. According to a Milken Institute report: *"An Unhealthy America: The Economic Burden of Chronic Disease"*:

- The annual economic impact on the U.S. economy of the seven most common chronic diseases is calculated to be more than \$1 trillion, which could balloon to nearly \$6 trillion by the middle of the century.
- According to the study, seven chronic diseases – cancer, diabetes, hypertension, stroke, heart disease, pulmonary conditions and mental illness – have a total impact on the economy of \$1.3 trillion annually. Of this amount, \$1.1 trillion represents the cost of lost productivity.
- Assuming modest improvements in preventing and treating disease, Milken Institute researchers determined that by 2023 the nation could avoid 40 million cases of chronic disease and reduce the economic impact of chronic disease by 27 percent, or \$1.1 trillion annually. They report that the most important factor is obesity, which if rates declined could lead to \$60 billion less in treatment costs and \$254 billion in increased productivity.
- Looking even further ahead, the report measures the possible cost to future generations if escalating disease leads to lower investments in education and training. In a snowball effect, the report warns, this loss of human capital and skill building could reduce the nation's economic output by as much as \$5.7 trillion in real GDP by the year 2050.
 - Prevention has been proven to significantly reduce absenteeism and presenteeism, which account for over in \$1 billion in lost productivity each year, according to a 2007 study by the Milken Institute.
 - The Milken Institute study also found that the U.S. could save close to \$900 billion in indirect costs in 2023 by preventing rising chronic disease rates.

Several recent U.S. studies have shown that the lifetime health care costs of healthy weight adults are significantly lower than of those who are obese.

- According to research from the Rand Corporation, and newly published work by University of Florida researchers, the lifetime health care costs of normal weight adults with no co-morbidities are 20 to 40 percent lower than obese adults and adults with one or more co-morbid conditions.
- This lower spending occurs despite the fact that healthier, normal weight adults live longer lives than obese adults with multiple co-morbid conditions.

We must act aggressively to make prevention a centerpiece of America's health care system, beginning with our government run health care programs, Medicare and Medicaid.

Disease management is an exciting new field of care that we need to continue enhancing with the latest technological innovations. It can improve health and save money. A patient with a chronic disease might stick his finger into a home machine every day, knowing that his blood sugar levels would be instantly transmitted to his doctor. Armed with this current data, the doctor could send advice to the patient, and know when to call him in for a checkup.

3. Health Care Information Technology (HIT)

One of the keys to transforming America's health system - and improving care, reducing errors and, over the long term, saving money - is to incorporate information technology fully into the health care delivery system.

Virtually every other sector of the economy is charging ahead into the 21st century, and it is time for the health care industry to catch up.

For example, you can use your bank card in virtually any A-T-M in the world, from Bangkok to Moscow to Elroy, Wisconsin, to get your money and find out what the balance is in your checking account. But if you show up at an emergency room even 50 miles from home, you'll have to scramble to track down your medical history. A good health information system could save our economy \$131 billion a year. That's about ten percent of our total health care spending.

It's time to make big, radical changes and transform our health care system. For HIT, the twenty-first century starts today.

We need a health information system that will reduce errors. Our doctors make more decisions in the exam room than pilots make when landing a plane - yet we provide pilots with scores of instruments and warning systems to prevent errors. We must give our

health care professionals the tools they need to detect and prevent errors - before they happen.

Today, Only 7 percent of doctors are e-prescribing and 30 percent of pharmacies are not able to receive electronic drug orders.

A 2006 Institute of Medicine report estimated that medication errors injure at least 1.5 million people every year, causing \$3.5 billion in extra medical costs. IOM estimates that 400,000 preventable drug-related injuries occur each year in hospitals and another 800,000 occur in long-term care settings. Many of these errors, including patients taking the wrong medicine, wrong dosage are easily preventable. A nurse who reads a script "myoo-jee" as an "MG," could administer too much of a drug-milligrams instead of micrograms. Some unrelated drugs have similar names. For example, when a drug called Losec was introduced, confusion with Lasix led to patient deaths. Writing or reading a decimal point in the wrong place also causes far too many medical errors.

We need to speed the rate at which we are integrating electronic health records into our health care system. To do to this I am advocating that we take fraud and abuse money and develop a HIT fund.

We must improve the systems in which our hard working, dedicated health care professionals provide care and services. To do so, we should focus on increasing the use of informatics and other tools; enhancing communication between frontline caregivers and all members of the health care team; and using evidence-based interventions in medical care and health promotion.

We need a health information system that will improve quality. Our biomedical research is the envy of the world, but even our best hospitals fail to give some patients the latest treatments, years after they've been proven appropriate. NIH says it takes from 10 to 17 years for new discoveries to be routinely used. That's shocking.

We need a health information system that automatically gives health professionals access to the patient-specific medical knowledge required for diagnosis and treatment - the latest research results from medical journals, the most up-to-date guidelines, the appropriate public health notifications. Our doctors then will not have to depend on their great memories any more.

We need a health information system that empowers consumers - that allows them to communicate with their doctors electronically, to receive their own test results, perhaps even to record what they eat and when and how much they exercise. We need a health information system that can do all these things regardless of where the physician and patient are - so that an illness or injury while traveling can be handled as safely away from home as it is at home.

We can have such a health information system and improve efficiency at the same time.

We know that lack of timely information creates huge, unnecessary costs - unnecessary tests, unnecessary x-rays, unnecessary doctor visits, even unnecessary hospitalizations. All of these events happen routinely because providers lack complete patient data. A good information system can save at least \$100 billion a year- and probably more.

In places like Santa Barbara County in California and the Regenstrief Institute in Indianapolis, communities are sharing health information electronically and demonstrating improved safety, increased quality, and lower costs. In the federal government, the Veterans Administration and the Department of Defense have been leaders in applying information technology effectively in their health care activities.

We know it can be done - because it is being done. But it's too slow and too scattered. It's only being done in a few places where there are committed community leaders with high levels of expertise - and a lot of persistence. We need to develop our health information systems everywhere - not in just a few places. And we need to do it now. Health care markets need to develop and adopt more advanced information technology.

4. Uninsured

Today, it is estimated that 47 million Americans are uninsured. This number is unacceptable and must be addressed. However, I am not convinced that the individual mandate is the correct approach. We have seen in Massachusetts that the individual mandate approach is not effective at covering the most vulnerable part of the population, that part of the population which needs coverage the most.

I am a strong believer in creating opportunities for access and creating a marketplace for competition. A great example of success in this area is the new Prescription Drug benefit. I had the privilege of working with many of the members of this panel to enact this legislation. One significant premise of the program was to create a market in which insurance companies would educate consumers and compete for their business. What we discovered with the Part D benefit was that while there were initial struggles that you might expect with the creation of an entirely new program, we were able to provide coverage to the vast amount of people and those people were happy with their coverage. Why were we able to reach people and why are they happy with their coverage? I believe the answer is robust competition.

Like the Part D benefit, I believe that competition is the answer for the uninsured. I strongly support the creation of risk pools, one for individuals and one for families, in large geographic areas and creating a marketplace whereby insurance companies can compete for their business. Medicaid would continue to cover up until 125% of poverty and then people would have access to the risk pools above 125% of poverty. How do individuals then pay for the premiums? Senator John McCain has proposed refundable tax credits for individuals and families and I support that approach.

Conclusion

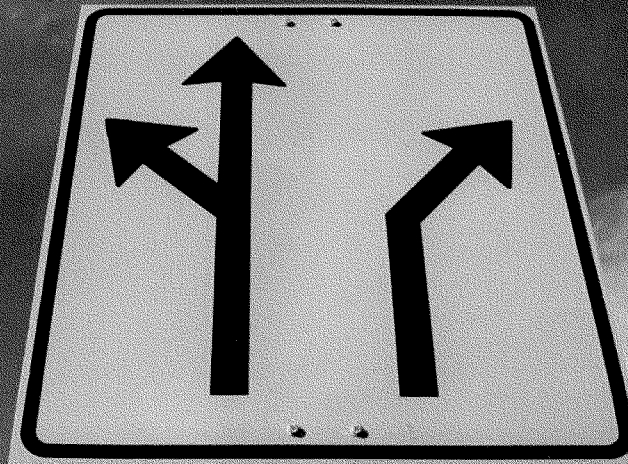
Mr. Chairman, Senator Grassley, these are just a few of the areas in which we need to address in order to improve America's health care system. Thank you for your leadership on this critical issue. I look forward to answering any questions that you or members of the Committee may have. Thank you.

Deloitte.

2008 Survey of
Health Care Consumers

Executive Summary

Produced by
the Deloitte Center for Health Solutions



Audit • Tax • Consulting • Financial Advisory

Foreword

In recent years, the role that consumers play in the U.S. health care system has become a prominent theme as employer- and government-sponsored insurance programs promote consumerism and policymakers focus attention on healthier lifestyles and more prudent use of the system.

This research study by the Deloitte Center for Health Solutions, part of Deloitte LLP, provides an important and timely perspective on health care consumerism. It features a comprehensive assessment of consumers' behaviors, attitudes and unmet needs related to health, health care and health insurance. It also points to six discrete segments of the overall consumer market, providing a profile of their key characteristics and differences.

The conceptual framework upon which this research is built reflects what we consider to be the five major domains of health care consumer activity: use of traditional health services from medical professionals and hospitals, use of alternative and non-conventional approaches to care, self-directed care, information seeking and financing.

We believe that consumers will play a significant and increasingly important role in the U.S. health care system's efforts to improve quality, reduce errors, increase access to services, reduce unnecessary costs, and promote laws and campaigns that address its issues and challenges.

William Copeland, Jr.
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Introduction

Health Care Consumerism: The Conceptual Framework for this Study

In recent months, many U.S. health care reform proposals have focused on increasing consumer responsibility for clinical and financial decisions related to health care for themselves and their family members. The purpose of this study by Deloitte¹ was to assess the behaviors, attitudes and unmet needs of adult consumers to provide health care industry leaders and policymakers with a comprehensive perspective on the current state of health care consumerism.

The study was designed to address five distinct zones of consumer activity, with the understanding that consumers have different approaches, attitudes and preferences related to each (Figure 1). Across these zones, the survey included a broad range of questions related to health, health care and health insurance. To optimize objectivity, the questionnaire first inquired about consumers' behaviors, then asked about their attitudes and unmet needs (Figure 2).

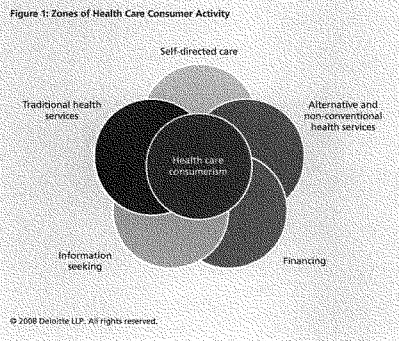


Figure 2: Examples of Behaviors, Attitudes and Needs by Zone of Activity

Zone	Behaviors	Attitudes	Unmet Needs
Traditional health services	Use of physicians Use of hospitals Use of prescription drugs Use of devices and implants	Attitudes and satisfaction related to traditional health services	Desire for services, programs, and tools provided by physicians, hospitals and allied health professionals in traditional settings
Alternative and non-conventional health services	Use of alternative providers Use of natural remedies Use of services in non-conventional settings	Attitudes related to alternative treatment approaches, therapies and practitioners used instead of or in addition to conventional services	Desire for services provided by alternative practitioners and in non-conventional settings
Self-directed care	Self-initiative in interactions with doctors Adherence to prescription drugs Use of self-monitoring devices Use of self-care tools, programs and aids	Attitudes related to decision-making, adherence to treatment recommendations, and use of self-care solutions such as wellness programs and self-monitoring devices	Desire for services, programs, and tools to support better self-care and more informed decision-making
Information seeking	Use of information resources to assist in clinical decisions Use of information resources to compare quality and price Use of information resources to select insurance	Attitudes related to the importance and usefulness of information used in making decisions about self-care, treatment, health services, and insurance	Desire for information resources and online tools to assist in decision-making about self-care, treatment, health services, and insurance
Financing	Enrollment in health insurance programs and plans Use of health plan customer service resources	Attitudes and satisfaction related to insurance programs and plans Understanding of insurance coverage Opinions about financial security related to future health care expenses	Desire for insurance programs that accommodate personalization Desire for assistance in selecting insurance products, health services and treatment options

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¹As used in this document, "Deloitte" means Deloitte LLP and its subsidiaries. Please see www.deloitte.com/us/about for a detailed description of the legal structure of Deloitte LLP and its subsidiaries.



Each zone of activity represents a distinct set of behaviors and attitudes that reflect the opportunities and experiences consumers have in seeking health care services from providers, choosing specific treatments and selecting insurance programs. Combined, they present a holistic view of health care consumerism that facilitates an understanding of potential inconsistencies between actions and opinions, preferences for services not perceived to be readily available, and perspectives on the importance of price, quality and service to consumers' purchasing decisions.

Survey Methodology

A nationally representative sample of 3,031 adults ages 18 years and older was surveyed between September 10 and 23, 2007, using a web-based questionnaire. The results were weighted to assure proportional representation similar to the U.S. Census across all major demographic groups (Figure 3). The sample size allows for estimation with a 1.8% margin of error at the .95 confidence level.

Using factor analysis to examine the relationships and variation among 173 variables reflecting salient behaviors and attitudes, the population was segmented into six discrete segments of the U.S. consumer market – each with unique behavioral and attitudinal characteristics.

Figure 3: Comparison of the Survey Sample to the U.S. Census

	Unweighted Survey Data	U.S. Census (2006)	Weighted Survey Data
18 to 29	18.30%	22.20%	22.40%
30 to 49	44.30%	38.30%	38.70%
50 to 64	22.20%	23.10%	23.10%
65 or older	15.20%	16.50%	15.70%
Male	44.50%	48.60%	48.30%
Female	55.50%	51.40%	51.70%
Midwest	23.00%	22.90%	22.60%
Northeast	18.90%	19.00%	18.90%
South	35.80%	35.60%	36.20%
West	22.30%	22.50%	22.40%
Hispanic	9.40%	13.00%	12.60%
Black/African American	8.10%	11.80%	11.70%
Asian	2.20%	4.80%	2.50%
Caucasian/White	83.60%	76.20%	77.90%
Alm. Indian or Alaskan Native	0.30%	1.40%	0.40%
Native Hawaiian /Pacific Islander	0.30%	0.20%	0.30%
Other	3.00%	5.70%	4.20%
Under \$30,000	23.50%	24.90%	24.70%
\$30,000 to \$49,999	23.90%	19.10%	19.40%
\$50,000 to \$99,999	37.10%	33.10%	33.90%
\$100,000 to \$149,999	11.00%	13.00%	21.90%
\$150,000 to \$199,999	3.10%	4.40%	Included in 100+
\$200,000 or more	1.40%	4.30%	Included in 100+

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Key Findings

Overview of the Health Care Consumer Market

Consumers use the U.S. health care system frequently (Figure 4). Consumers' experiences with doctors, hospitals, health plans, prescription drugs and other health care services form the basis for their attitudes and beliefs about how the system performs and which areas might need to be improved.

Figure 4: Selected Behaviors in the Five Zones of Health Care Consumer Activity*

Traditional Health Services	Self-Directed Care	Alternative/Non-Conventional Health Services	Information Seeking	Financing
<ul style="list-style-type: none"> 82% currently have a PCP 60% currently use prescription drugs 15% had a hospital stay 21% switched treatments or prescriptions 18% switched doctors 	<ul style="list-style-type: none"> 14% delayed a recommended treatment 13% decided not to pursue a course of care altogether 30% questioned their physician about a treatment recommendation 28% expressed a brand preference for a medication to their physician 65% say they adhere to Rx recommendations 	<ul style="list-style-type: none"> 20% used an alternative approach to treatment 12% consulted an alternative provider 9% substituted an alternative therapy for a prescription medication 21% purchased medications through mail order or online 16% used a retail clinic 3% traveled outside the U.S. for care 	<ul style="list-style-type: none"> To compare quality, 26% used a health plan web site, 11% used a hospital site, and 9% used a physician site To compare prices, 22% used a health plan web site, 6% used a hospital site, and 5% used a physician site For health information, 30% used a physician web site, 22% used a plan site, and 14% used a hospital site Consumers use online resources and pharmacists for information about new prescriptions 	<ul style="list-style-type: none"> 88% currently have health insurance of some kind 3% have a high deductible plan/consumer-directed plan 19% called their plan to inquire or complain about care

*Reported behaviors occurred in the past 24 months unless noted as current

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- 82% of consumers report having a primary care physician (PCP), and 92% of these consumers say they had visited their PCP at least once in the last 12 months. 15% of consumers report having had an overnight stay at a hospital in that same period. 60% currently take medications. 88% report having some form of health insurance, either directly or through their spouse or partner (insurance types included medical coverage through Medicare, Medicaid, and various commercial plans such as preferred provider organizations, health maintenance organizations, and traditional fee-for-service plans, as well as specialty coverage for dental, eye, and long-term care and unspecified supplemental coverage).
- Significant percentages of consumers modified a treatment recommendation, used alternative and non-conventional modes of care, and sought information to assist in decision-making in the last 24 months.

It is important to consider these behaviors in light of the various circumstances in which consumers typically have an opportunity to engage directly in decision-making. Physicians are often chosen based on recommendations from friends and family more than on price or quality information, which is usually limited. Hospital choice usually reflects the physician's preference, not the consumer's. Medications are "prescribed" by physicians, so consumers typically have little influence over which alternatives are considered. Insurance programs are frequently offered through employers or the government, with limited consumer choice. Therefore, it is notable that considerable percentages of consumers are engaging in behaviors that reflect direct consumer decision-making.

Consumers' attitudes are derived from personal experiences rather than a "studied" view of the system, and vary widely as a result (Figure 5). Personal characteristics such as health status, along with underlying beliefs and values such as one's predisposition toward traditional or alternative approaches to care, are also major determinants of attitudes.

Figure 5: Selected Attitudes in the Five Zones of Health Care Consumer Activity

Traditional Health Services	Self-Directed Care	Alternative/Non-Conventional Health Services	Information Seeking	Financing
<ul style="list-style-type: none"> Satisfaction with doctors, hospitals and plans is relatively high Quality differences are perceived – perception of physician differences is highest 3 out of 4 want physicians to provide online services to get test results, schedule appointments, exchange e-mail, access medical records (1 out of 4 say they would pay more) 	<ul style="list-style-type: none"> 88% are interested in using in-home monitoring devices that could reduce doctor visits and allow them to be more active in their care 2 in 3 are interested in participating in a wellness program to improve their health and/or save money (1 in 4 say they would pay more) 	<ul style="list-style-type: none"> 19% prefer natural remedies 40% are open to using an alternative treatment approach 32% might use an alternative therapy as a substitute for a prescription drug 44% say they are comfortable with the accuracy, safety, and quality of care offered in a retail clinic 39% say they would consider having an elective procedure in a foreign country 	<ul style="list-style-type: none"> Internet is the most useful source of information to all – sites providing more functionality are frequently used Consumers like resolving questions about medicines, facilities and health plans using information from "their" doctors, hospitals and plan 	<ul style="list-style-type: none"> Only 52% say they understand their health insurance coverage Only 7% say they are financially prepared for future health care needs 78% want to customize their insurance Re coverage, out-of-pocket costs, and reputation of network providers are key purchase factors when comparing plan benefits 84% would choose a generic over a brand name drug

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Given the variation in consumers' behaviors and attitudes, the health care consumer market is clearly not homogeneous: It is composed of six segments, each distinguished by a unique set of behaviors and attitudes (Figure 6).

Figure 6: Profile of the Six Health Care Consumer Segments

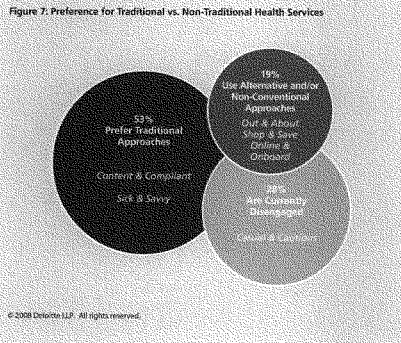
Factor	Content & Compliant	Sirk & Savvy	Online & Onboard	Shop & Save	Out & About	Critical & Cautious
Segment size	29%	24%	8%	2%	9%	28%
System use	Medium	Highest	High	Medium	Medium	Lowest
Preferences regarding care	Traditional	Traditional	Traditional, but open to non-conventional settings	Traditional, but open to alternative and non-conventional settings	Alternative approaches and non-conventional settings	Disengaged, but currently leans toward traditional
Dependence on providers	Accepts what doctor recommends	Takes charge of own care	Leans toward relying on self	Leans toward allowing doctor to make decisions	Makes own decisions/independent	Leans toward relying on self
Compliance with treatment	Most compliant	Compliant	Compliant	Less compliant	Least compliant	Less compliant
Satisfaction with providers and plans	Most satisfied	Satisfied	Satisfied	Less satisfied	Least satisfied	Less satisfied
Other important distinctions	Less likely to seek information; less likely to use value-added services; least interested in shopping for and customizing insurance	Seeks information; sensitive to quality; uses some value-added services; wants to shop for and customize insurance	Seeks information; uses online tools the most; sensitive to quality; maximizes use of value-added services	Makes changes to insurance; price-sensitive; uses value-added services; most likely to travel for care	Seeks information; sensitive to quality; uses some value-added services; wants to shop for and customize insurance	Price-sensitive; unprepared financially for future needs; less likely to seek information; less likely to use value-added services

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The six segments differ along several dimensions: key differentiators include the degree to which consumers prefer or use traditional services versus alternative and non-conventional services; the extent to which they are inclined toward self-dependent decision-making versus doctor-dependent decision-making; and the level at which they seek information via online tools and use various value-added services. The segments were not determined based on demographics, but important demographic differences are noted below.

- The **Content & Compliant** segment (29%) includes consumers who tend to prefer traditional approaches to care and accept what doctors recommend. Consumers in this segment, on average, are more compliant and satisfied than others. Content & Compliant consumers are less likely to seek information or use value-added services offered by doctors, hospitals and health plans. They are least interested in shopping for and customizing their insurance. 26% of the Content & Compliant consumers report annual household income of \$100,000 or higher, compared to 22% or less in the other segments.
- The **Sick & Savvy** segment (24%) includes the highest percentage of consumers who report having one or more chronic conditions (52%). This segment uses the health care system more than other segments. Similar to the Content & Compliant, the Sick & Savvy prefer traditional approaches to care. However, Sick & Savvy consumers take greater charge of their own care, preferring to rely on themselves more than their doctors when making care-related decisions. They are more sensitive to quality differences among providers than the Content & Compliant, and also seek information, use value-added services, and want to shop for and customize their insurance to a greater extent. Also similar to the Content & Compliant, Sick & Savvy consumers adhere to treatment decisions once they are made and are generally satisfied with the care they receive. These two segments are somewhat older than the other segments, with mean ages of 48 years (Content & Compliant) and 49 years (Sick & Savvy). They also include the highest proportions of Caucasians among all the segments (81% of the Content & Compliant, 85% of the Sick & Savvy). Gender is a key difference: The Sick & Savvy include a higher percentage of women (61%) than the Content & Compliant (48%).
- The **Online & Onboard** (8%) segment includes high users of the system who prefer traditional approaches but who are also receptive to care provided in non-conventional settings. Consumers in this group lean toward relying more on themselves than their doctors in making decisions and use online tools and value-added services more than any other segment. Online & Onboard consumers seek information and are sensitive to quality differences. They tend to be compliant with treatment decisions and satisfied with their care. The Online & Onboard segment includes a high percentage of consumers who report having one or more chronic conditions (47%), but does not stand out with respect to any of the key demographic characteristics: Mean age is 45 years, 53% are women, 92% are insured, 69% are Caucasian, and 19% report annual household income of \$100,000 or higher.
- **Shop & Save** consumers (2%) are prone to switching doctors, treatments and health plans, and make changes to their insurance far more than others. This group is more sensitive to the prices of health care services than others. Consumers in this segment tend to prefer doctors who use traditional approaches and lean toward allowing doctors to make decisions for them. However, Shop & Save consumers are open to alternative approaches and non-conventional settings and are much more likely than others to purchase prescription drugs through mail order or online sources, use a retail clinic, and travel outside their community and the U.S. for care. They take advantage of value-added services offered by doctors, hospitals and health plans, but tend to be less satisfied and less compliant than others. This segment has the lowest average age (38 years) and includes the largest proportion of men (64%) and lowest proportion of Caucasians (62%).
- The **Out & About** segment (9%) uses alternative approaches to treatment, consults alternative health care practitioners, and substitutes alternative or natural therapies for prescription medications more than the other segments. Consumers in this group are independent, generally preferring to make their own decisions. They tend to be sensitive to quality, seek information, use some value-added services and want to shop for and customize their insurance. The Out & About segment is the least compliant and least satisfied of all the segments. Gender is its most notable demographic distinction: 64% of Out & About consumers are women. This segment is similar to other segments with respect to age (mean of 43 years), race (70% Caucasian), income (18% report annual household income of \$100,000 or higher) and health status (43% have one or more chronic conditions).
- The **Casual & Cautious** segment (28%) is the healthiest segment, with only 19% having one or more chronic conditions, and nearly the youngest segment, with a mean age of 40 years (the Shop & Save segment is slightly younger, with a mean age of 38 years). This group is also the least-insured group – only 80% report having insurance compared to 89% or more in each of the other segments. This group uses the system and seeks information less than others; it appears to be waiting for the need to arise. The Casual & Cautious are sensitive to the price of health services more than all other segments except Shop & Save. More than all other segments, the Casual & Cautious feel less prepared financially to deal with their future health care needs and fewer say they understand their insurance. These consumers currently lean toward preferring traditional approaches, but are inclined to rely somewhat more on themselves than doctors when making decisions. They also generally report being less compliant and satisfied than others. In addition to being relatively healthy and young, just over 55% of Casual & Cautious consumers are men, nearly 75% are Caucasian, and 21% report having an annual household income of \$100,000 or more.

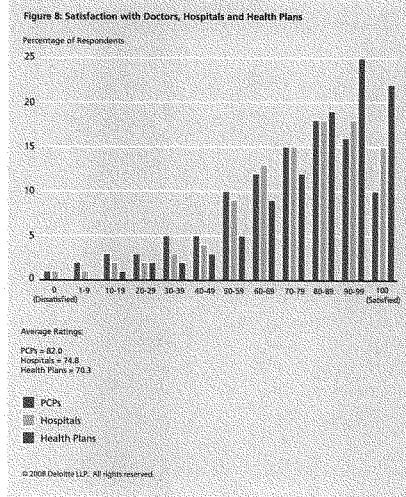
Preference for traditional versus non-traditional health services is an important dimension of difference among the segments (Figure 7).



- Two segments (Content & Compliant and Sick & Savvy), representing 53% of U.S. consumers, lean toward the status quo, generally preferring traditional approaches. Half of this more traditional group, however, is taking advantage of opportunities to become better informed, more engaged consumers. The Sick & Savvy segment (24% of the U.S. population) actively seeks information, is sensitive to quality differences among providers, and wants to shop for and customize their insurance.
- Three segments (Online & Onboard, Shop & Save and Out & About) include the 19% of U.S. consumers who are inclined in various ways to take advantage of innovative, non-conventional and alternative approaches.
- The sixth segment (Casual & Cautious), representing the remaining 28% of U.S. consumers, is currently disengaged from the system, using health care services infrequently.

Overall, consumers are generally satisfied with the doctors, hospitals and health plans they use.

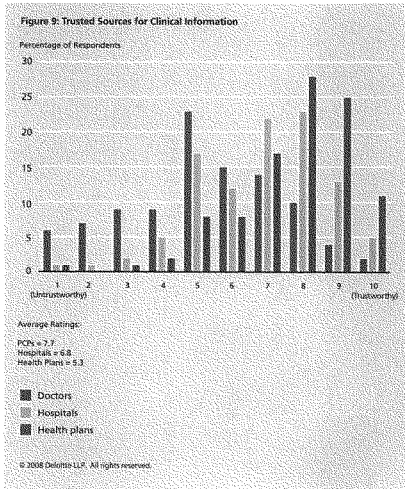
- On a scale from 0 (completely dissatisfied) to 100 (completely satisfied), average satisfaction ratings are 82 for primary care physicians, 75 for hospitals and 70 for health plans (Figure 8).



- Consumers across all segments generally believe that doctors, hospitals and plans do relatively well in providing services. (The survey question referred specifically to the consumer's satisfaction with his/her primary care physician, not the specialist(s) he/she may see, so ratings of other types of physicians might be different.)
- Average satisfaction with doctors is highest among the Content & Compliant (mean = 89), Sick & Savvy (mean = 85) and Online & Onboard (mean = 82) segments.
- Satisfaction with doctors was somewhat lower among the Casual & Cautious (mean = 75), Out & About (mean = 71) and Shop & Save (mean = 69) segments.

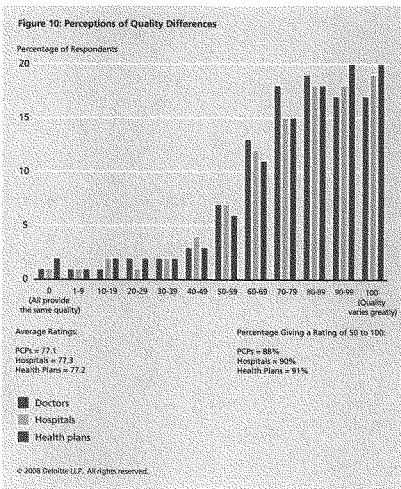
Physicians are viewed as the trusted source for clinical information about health conditions and treatments, while health plans are viewed as credible sources for non-clinical information.

- Physicians hold an edge in "trust" for health-related information (Figure 9). Consumers in all segments trust doctors more than hospitals, plans, government, online web sites and other sources of information about best treatments. However, the large gaps that exist between the percentages of consumers who have used various information sources and tools and the percentages who are interested in doing so suggest that doctors and hospitals do an inadequate job of providing useful information about treatment options and self-care tools.



Consumers believe that quality differences are important considerations when comparing doctors, hospitals and health plans, and they perceive modest differences today.

- While quality can assume different meanings in the context of doctors, hospitals and health plans, it is consumers' perception and level of concern with quality – however they define it – that is important to assess in the context of consumerism. The survey data suggest that consumers do perceive differences in quality among doctors, hospitals and health plans (Figure 10). 88% of consumers believe quality of care varies among doctors, 90% believe quality of care varies among hospitals, and 91% believe quality of coverage and service varies among insurance companies.



- Health plans are viewed as credible sources for non-clinical information. More consumers have sought price and quality information from health plans than from doctors or hospitals. However, the percentages that have done so (26% for quality information, 22% for price) are low, and interest in using quality or price information is high for all three entities, suggesting that the opportunity to fill the information gap is open to health plans, hospitals and doctors.
- Online & Onboard, Sick & Savvy, and Out & About consumers are the heaviest users of Internet-based tools for decision support, while Content & Compliant consumers are least inclined.

- Consumer interest in using quality information provided by health plans, doctors and hospitals is moderately strong for all three sources (7.0, 6.6, and 6.5, respectively, on a 10-point scale).
- When forced to indicate whether quality or cost would drive their selection of a doctor to treat a serious condition requiring specialized medical care, consumers generally lean more toward choosing the best doctor they can find, even at higher cost, than choosing the doctor who would cost them less. At the two extremes, sizable percentages are driven strongly by quality (24% versus cost (13%).
- Few consumers have used hospital or doctor web sites to find information about quality (11% and 9%, respectively) or price (6% or 5%, respectively), but 2 out of 3 consumers are interested in doing so. 26% of consumers have used a health plan web site to look up information about the quality of care provided by doctors or hospitals.

- 23% of consumers have compared doctors' qualifications before choosing one (45% are likely to do so in the future), and 16% of consumers have compared hospitals before choosing one (47% are likely to do so in the future).
- Use of web-based tools to compare doctors and hospitals is a strong theme across all but two segments (Content & Compliant and Casual & Cautious), and especially for the Shop & Save and Online & Onboard segments. While both price and quality are of some importance to all, price is a critical differentiator for the Shop & Save segment; quality is more important to the Sick & Savvy and Out & About segments. Online & Onboard consumers seem to pay equal attention to both price and quality.

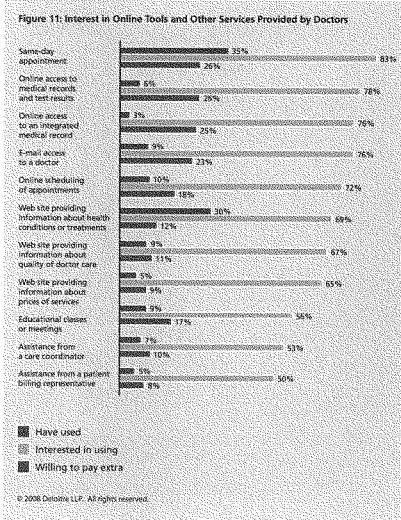
Behaviors, Attitudes and Unmet Needs Related to Traditional Health Services, Non-Traditional Health Services and Self-Directed Care

Most consumers are satisfied with their doctors and hospitals but want better service and improved value.

- On a scale from 0 (completely dissatisfied) to 100 (completely satisfied), average satisfaction ratings are 82 for primary care physicians, 75 for hospitals and 70 for health plans.
- When asked what improvements they would most like to see in their experiences with their primary care physician, 31% of respondents note a desire for service improvements including more time with the doctor, shorter waiting times, faster appointments and faster answering of the telephone.
- From hospitals, consumers are looking for service improvements – especially more time and attention from staff – in addition to better amenities and shorter waiting times.
- The Content & Compliant and Sick & Savvy segments are generally satisfied with the care they receive from traditional providers; however, the Sick & Savvy tend to search for alternatives and express dissatisfaction more readily than the Content & Compliant.

A significant gap exists between the service consumers expect and what they receive from their physicians.

- In general, consumers want access to more information, are looking for better service, and believe their physicians should make better use of information technologies.
- Expanded use of Internet-based tools and communication between physicians and patients is strongly desired (Figure 11). Nearly 80% of consumers are interested in gaining access through their doctor to an integrated medical record that combines information about all of their test results, doctor visits and hospital stays. 3 out of 4 consumers want physicians to provide online services to schedule appointments, exchange e-mail, get test results and access medical records (1 in 4 say they would pay more for these services). For the Online & Onboard segment in particular and, to a great extent, also the Out & About and Sick & Savvy segments, a physician's use of web-based tools for appointment scheduling, access to medical records, lab reporting and e-mail communication with patients is a major differentiator. A growing number of consumers appear to be aware of distinctions between practices that use electronic medical records and those that do not.

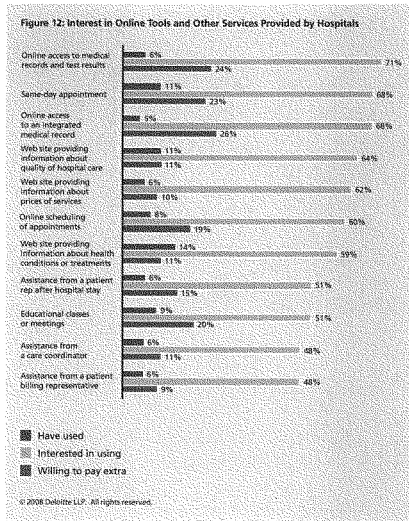


- 2 out of 3 consumers are interested in using their doctor's web site to get information about health conditions or treatments, quality of care or service prices.
- 56% of consumers are interested in educational classes or meetings sponsored by their doctor's office to help them with a health problem, treatment approach or recovery process.
- 83% of consumers are interested in same-day appointments.
- 50% or more of consumers report interest in receiving assistance from a care coordinator or patient billing representative assigned to them by their doctor's office.

Consumers believe that hospitals are an important community resource and see distinctions in care quality when comparing them.

- Similar to physicians, consumers express strong desire for hospital services that assist consumers in choosing physicians, making treatment decisions and managing personal health information.
- 90% of consumers believe that care quality varies among hospitals, with nearly 2 in 5 indicating they perceive wide variation. Just 16% of consumers have compared hospitals before choosing one, but 47% say they are likely to do so in the future. To date, few consumers have used hospital web sites to look for information about the quality of care provided by the hospital (11%) or the prices of services provided by the hospital (6%), but 2 out of 3 consumers are interested in doing so.

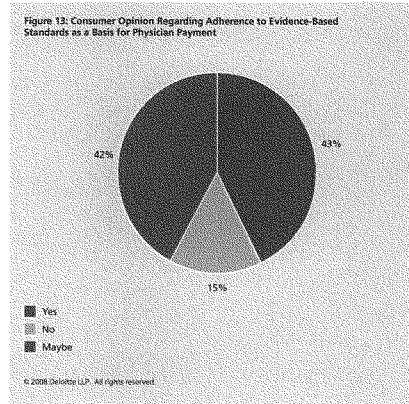
- Consumers desire greater online access to information through hospitals (Figure 12). Over 70% want their hospital to provide online access to an integrated medical record that combines information about all of their test results, doctor visits and hospital stays (1 in 4 are willing to pay extra for this access). Consumers are interested in using hospital web sites to look up information about the quality of hospital care (64%), the prices of hospital services (62%) and health conditions and treatments (59%).



- Seeking convenience, 68% of consumers are interested in same-day hospital appointments and 60% are interested in online appointment scheduling.
- Over half of consumers would be interested in receiving assistance after a hospital stay from a patient representative assigned to help them coordinate care with other organizations and care givers, while just under half would be interested in receiving assistance from a hospital care coordinator to help with treatment decisions and appointment scheduling. Assistance from a patient representative assigned to help in understanding service charges and deal with hospital bills is of interest to 48%.

Consumers are receptive to programs that reward physicians for better performance.

- Consumers support the concept of physician pay-for-performance (Figure 13). 84% or more of every segment favor or might support a national program that provides incentives for doctors to adhere to evidence-based practices. Support is especially strong among consumers in the Online & Onboard and Shop & Save segments. Support is somewhat stronger among men than women, and among Hispanics compared to non-Hispanics, but otherwise, opinions do not vary significantly by age, race, health status or insurance status.



1 in 5 consumers chose not to follow a physician's recommendation, in some cases choosing an alternative based on their personal preferences or study of treatment options.

- 14% have delayed a course of treatment recommended by a doctor (33% might do so in the future).
- 13% have decided not to follow a course of treatment recommended by a doctor (32% might do so in the future).
- While 20% of consumers still strongly prefer to have their doctor make treatment decisions for them, 17% strongly prefer to make treatment decisions themselves (63% are in the middle).
- 30% have questioned their physician about a recommended course of treatment, either asking about a specific treatment they have learned about from another source or asking about alternatives to the treatment the doctor recommended (45% are likely to do so in the future).
- While less than 20% of consumers have sought a second opinion, 52% say they might do so in the future.

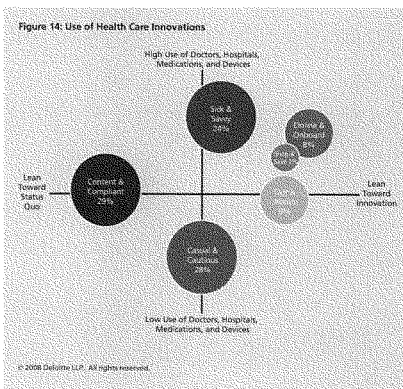
Many consumers use alternative services and therapies and express strong preferences over traditional approaches.

- 20% of consumers report treating a health problem with an alternative approach to traditional medicine, such as acupuncture, chiropractic, homeopathic, naturopathic, bio-electric therapies, etc. Twice that many (40%) are open to doing so in the future.
- 12% have consulted an alternative health care practitioner, and 38% might do so in the future.
- 9% have substituted an alternative or natural therapy for a prescription medication, and 32% might do so in the future.
- While 68% prefer to choose doctors with an orientation toward traditional or conventional medicine, 32% prefer to choose doctors with an orientation toward holistic or alternative treatments (7% strongly prefer such doctors).
- The Out & About segment is distinguished by its comparatively high use of alternative approaches (49%), practitioners (37%), and therapies (36%), and relatively strong preference for doctors with an orientation toward holistic or alternative treatments (23% strongly prefer, and an additional 49% prefer such doctors). The Shop & Save segment also reports high use of alternative approaches (44%), practitioners (35%), and therapies (35%), but prefers to choose doctors with a traditional orientation (71%) versus doctors with an alternative orientation (29%). Half of two other segments (Sick & Savvy and Online & Onboard) and one-third of two others (Casual & Cautious and Content & Compliant) say they are open to using alternative approaches and practitioners in the future.

Consumers are receptive to innovations such as retail clinics, online medication ordering, customized insurance programs, in-home monitoring, medical tourism and computerized personal health records.

- 16% of consumers have used a walk-in clinic located in a pharmacy, shopping center, store, or other retail setting, and 34% say they might do so in the future. 44% of consumers say they would be comfortable with the accuracy, safety and quality of care offered in a retail clinic that is staffed by a nurse practitioner. Slightly more (45%) say they would be comfortable if the nurse practitioner uses a computer-based system that enables him/her to access electronic patient records, check for drug and allergy interactions, confirm treatment recommendations, etc. Nearly half (48%) of consumers say they would be comfortable if the nurse practitioner is affiliated with a local doctor's office.
- 21% have purchased prescription medications through mail order or online sources, and 37% might do so in the future.
- 13% currently use a monitoring device, but 88% say they would be interested in using a self-monitoring device at home if they were to develop a condition that required regular monitoring (33% say they are extremely interested).

- 78% of consumers express a preference for customizing their insurance product by selecting the benefits and features they value and, in doing so, increasing or decreasing the overall cost of their coverage. Only 22% prefer selecting from a few pre-packaged products with defined benefits and features.
- While only 25% of consumers report maintaining a personal health record of any kind, including paper-, computer-, or web-based files, nearly half (46%) say they would be interested in using a software program or web site to create a personal health record.
- For 19% of the consumer population – the Shop & Save, Online & Onboard, and Out & About segments – use of health care innovations is especially high (Figure 14). These innovations appear to be accepted without concern. Sizable percentages of the other segments, especially the Sick & Savvy, but also the Casual & Cautious and Content & Compliant, indicate interest in using these innovations in the future.



Medicare enrollees are receptive to innovations.

- 93% of Medicare enrollees are interested in using a self-monitoring device at home if they have or were to develop a health condition that requires regular monitoring.
- 36% of Medicare enrollees indicate they are open to using a retail clinic (11% have done so already).
- 1 in 3 Medicare enrollees have ordered prescription medications online or through mail order sources.

Consumers want programs and tools to help them improve their health.

- Nearly 2 out of 3 consumers are interested in participating in wellness programs that are designed to help them improve their health (1 in 4 consumers are willing to pay extra for a wellness program).
- 61% of consumers want tools that would provide personalized recommendations to improve their health, and 55% of consumers are interested in tools that would help them assess, monitor or manage their health (12% would pay extra for these tools).
- 56% of consumers are interested in attending educational classes or meetings that address a health problem, treatment or recovery (17% would pay extra for these).
- 53% of consumers are interested in using a health/lifestyle coach (20% would pay extra for this).
- While there is strong interest in getting assistance with maintaining a healthy lifestyle, only 17% report participating in a wellness program in the last 24 months and even fewer (less than 1 in 10) have used the other services and tools noted above. The gap between preference and actual use appears to be wide.

Consumers want care management programs and services that help them facilitate chronic care management and assist in decision-making with their physicians.

- 56% of consumers are interested in special programs to manage their own health condition (19% would pay extra for these), and 47% are interested in special programs to help manage the health of an aging family member (14% would pay extra for these).
- 53% of consumers are interested in receiving assistance from a care coordinator to help them with treatment decisions and appointment scheduling (10% would pay extra for this).
- 55% of consumers are interested in tools such as computerized decision-making programs to help them decide among treatment options (10% would pay extra for these tools).
- 50% of consumers are interested in receiving assistance from an assigned patient representative who would help them understand service charges and deal with bills (8% would pay extra for this).

Consumers want convenience and may be willing to pay for it.

- 83% of consumers are interested in access to same-day appointments, and 26% are willing to pay extra for that access.
- 65% of consumers are interested in a nurse call line, and 18% are willing to pay extra for the service.
- 16% of consumers have used a walk-in clinic located in a pharmacy, shopping center, store or other retail setting, and 34% say they might do so in the future.

Consumers are willing to travel for care, either to a hospital they perceive to be of higher quality or to save money for an elective procedure.

- Nearly 1 in 5 consumers have chosen to go to a hospital other than the one nearest to their home (nearly 2 in 5 anticipate doing so in the future).
- Almost 90% would consider leaving their community or local area to get care or treatment for a condition if they knew the outcomes were better and the costs were no higher.
- 3% report having traveled outside the U.S. to consult with a doctor or to receive treatment, and 27% said they might do so in the future.
- Nearly 40% would consider having an elective procedure performed in a foreign country if they could save 50% or more and be assured that the quality was equal to or better than what they can have in the U.S.
- Shop & Save and Out & About consumers are more inclined toward medical tourism than other segments.

**Behaviors, Attitudes and Unmet Needs
Related to Medications, Medical Devices and
Alternative Therapeutic Interventions****60% of consumers (adults) currently use one or more prescription drugs and frequently change prescriptions.**

- 20% use four or more prescription drugs and 2% reported using more than 10.
- 35% of consumers expect to switch treatments or prescription medications in the future (21% have done so in the last 24 months).
- 20% of the population (or 34% of those taking medications) order his/her medications online or through mail order sources.

Adhering to their prescription medication regimen is a challenge for many consumers.

- 65% of consumers say they fill almost all of their prescriptions.
- 83% say they almost always take their prescription medications as directed.

Consumers have concerns about the safety and effectiveness of prescription medications.

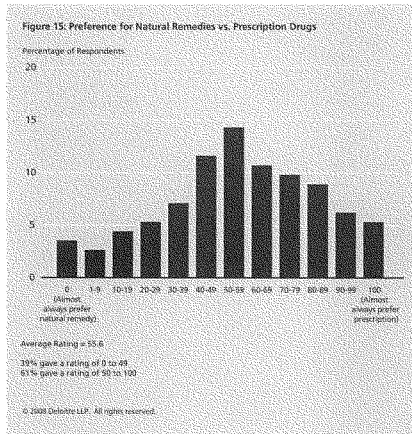
- Only 61% of consumers rate the safety and effectiveness of prescription medications at the higher end of the confidence scale (giving each a rating of 70 or higher on the 0 to 100 scale).
- 33% of consumers have asked a pharmacist for his/her opinion about a medication prescribed by a doctor (38% might do so in the future).

Consumers are comfortable with generic drugs.

- 84% of consumers say they would be more likely to choose a generic equivalent than a brand name drug if given the choice.

A substantial number of consumers prefer alternatives to traditional pharmaceuticals.

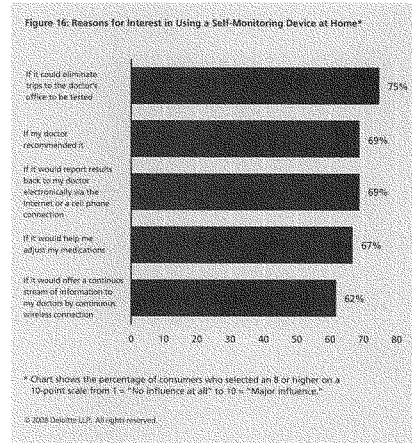
- While consumers generally prefer prescription medications, 2 out of 5 consumers lean toward preferring natural remedies (Figure 15).



- 32% of consumers say they are inclined to substitute an alternative or natural therapy for a prescribed medication in the future. 9% of consumers have done so recently.
- Currently, only 14% of consumers have heard of biologic drugs, defined in the survey as drugs that use human cells to create the drug instead of chemicals (as in traditional pharmaceutical drugs). Consumers do not express a clear preference between the two drug types.
- Segments most inclined toward natural remedies and biologics are the Out & About and Casual & Cautious segments and, to some extent, the Sick & Savvy segment. The preference for natural remedies correlates with lower confidence ratings for prescription medication safety and effectiveness among the Out & About and Casual & Cautious consumers. For the Out & About and Sick & Savvy segments, the preference also may be linked to their comparatively higher use of online web sites and search engines as sources for information about medications.

Consumers are highly receptive to devices and self-monitoring systems that permit them to monitor their own health condition and care at home.

- 13% indicate prior use of one or more medical devices for monitoring a condition for themselves or a family member.
- 7% of consumers report expressing a preference to their physician about a specific branded device.
- 88% of consumers say they would be interested in using a self-monitoring device at home if they were to develop a health condition that required regular monitoring. 33% said they were extremely interested.
- Reasons for consumers' interest include the elimination of trips to the doctor's office (75%), the convenience of reporting results to the doctor electronically (69%) and the ability of the device to help in adjusting their medications (67%) (Figure 16).



Health-related web sites are trusted sources for information about medications and devices.

- When prescribed a new medication, 1 out of 3 consumers have used a health-related web site or search engine to look for information about the medication, while nearly that many (32%) have consulted a pharmacist either in person, by phone or through e-mail. 1 out of 4 consumers report consulting a doctor either in person, by phone or through e-mail before taking the new medication.
- Consumers also report consulting friends or relatives (22%), health plan web sites (11%), government web sites (9%), medical journals or books (8%) and news sources (6%) for information about a medication that has been newly prescribed for them.
- The most common sources of information regarding devices or implants are doctors (22%) and health-related web sites or search engines (22%), followed by friends or relatives (12%), health plan web sites (9%), pharmacists (8%) and government web sites (8%).

Direct-to-consumer (DTC) advertising for medications and devices impacts consumer brand preferences and prompts many to express a brand preference to their physician.

- 38% of consumers have asked a doctor to prescribe a particular drug by name or brand or asked whether it would be a better choice than the one he/she prescribed. Over half (51%) of these consumers report that advertising on TV, in print, or on the Internet played a role in their mentioning the drug to their doctor.
- 7% of consumers have asked a doctor to prescribe a specific device or implant by name or brand or asked whether it would be a better choice than the one he/she prescribed. Nearly half (47%) of these consumers report that advertising on TV, in print, or on the Internet played a role in their mentioning the device or implant to their doctor.



Behaviors, Attitudes and Unmet Needs Related to Health Insurance (Commercial, Medicare and Medicaid)

Use of health insurance programs is high.

- 88% of consumers report having some kind of insurance (insurance types included medical coverage through Medicare, Medicaid, and various commercial plans such as preferred provider organizations, health maintenance organizations, and traditional fee-for-service plans, as well as specialty coverage for dental, eye, and long-term care and unspecified supplemental coverage).
- The likelihood of having insurance rises with age. The proportion of consumers who have insurance ranges from 84% of Gen Y consumers to 94% of seniors.²

- Insurance status does not vary by gender (89% of men and 87% of women report having insurance), but does vary by race and ethnicity: 90% of Caucasians, 89% of Asian Americans, 83% of Hispanics, and 78% of African Americans report having insurance.
- The types of insurance consumers report having vary: 47% say they are enrolled in a preferred provider organization (PPO), 29% say they are enrolled in a health maintenance organization (HMO), 6% say they are enrolled in a traditional indemnity or fee-for-service plan, 4% say they are enrolled in a point-of-service (POS) plan and 3% say they are enrolled in a high-deductible or consumer-directed plan.
- 11% of consumers report having a health savings account (HSA), health care reimbursement account (HRA), or flexible spending account (FSA). Casual & Cautious consumers are least likely (8%) and Sick & Savvy consumers are most likely (13%) to report having one of these types of accounts. Boomers (16%) and Gen X consumers (12%) are more likely to have a health-related account than Gen Y consumers (8%) and seniors (4%).

² The generations were defined as follows: Gen Y includes consumers born between 1982 and 1989 (18 to 25 years at the time of the survey); Gen X includes consumers born between 1965 and 1981 (26 to 42 years); Boomers include consumers born between 1946 and 1964 (43 to 61 years); and seniors include consumers born in 1945 or earlier (62 and older).

12% say they do not own health insurance of any kind.

- 26% of the uninsured in this study are under the age of 30, while 68% are between the ages of 30 and 64. 6% of the 65+ population reports being uninsured. Viewed another way, 17% of Gen Y, 15% of Gen X, 12% of Boomers and 6% of seniors report being uninsured.
- 56% of the uninsured are women and 44% are men.
- The uninsured cohort includes disproportionately high percentages of African Americans (22% of African Americans report being uninsured compared to 11% of Asians and 10% of Caucasians). Hispanics are also more likely to report being uninsured (17%) than non-Hispanics (12%).
- The likelihood of being uninsured declines as income rises. Consumers in the lower-income categories are more likely to report being uninsured than consumers in higher-income categories.
- More of the uninsured have chosen not to see a doctor when they were sick or hurt (53%) than the insured (46%). Proportionally fewer of the uninsured (28%) versus the insured (37%) report currently undergoing treatment or participating in a program to help them manage a chronic condition. 21% of the uninsured versus 16% of the insured believe their overall health is below average for people in their age group. Statistically similar percentages of the uninsured (24%) and insured (21%) believe the effort they make to maintain or improve their general health is below average.
- Casual & Cautious consumers are the least likely to have insurance. More than 20% of this segment reports being uninsured, while just 8 to 11% of the other segments report being uninsured. The Casual & Cautious segment (28% of all consumers) is a relatively young segment of consumers who generally are not heavy users of the system. This is in contrast to the Sick & Savvy segment (24% of all consumers, 92% of which report being insured), who are generally older consumers and who report the highest use of physician and hospital services.
- 63% of consumers say they would (29%) or might (34%) favor increasing taxes to help provide coverage for those who do not currently have it.
- 66% are supportive (36%) or might be supportive (30%) of state mandates requiring individuals to have health insurance.

The attitudes and preferences of the uninsured mirror those of the insured. Affordability is an issue, but both perceive quality differences, want more information and are looking for access to online tools.

- Both the uninsured and insured perceive quality differences among doctors, hospitals, and health plans, but ratings of the variation were higher on the 0 to 100 point scale among the insured compared to the uninsured (e.g., average rating of 78 for doctor variation among the insured vs. average rating of 72 for doctor variation among the uninsured).

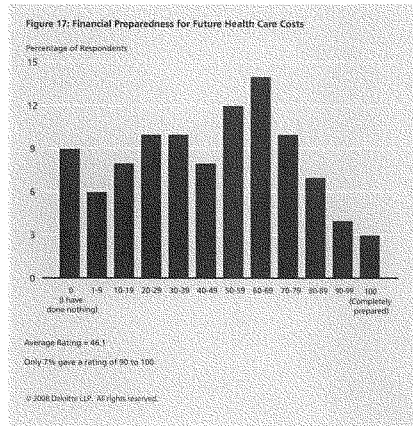
- Interest in using web sites providing information about care quality and information about health conditions and treatments is similarly high among the uninsured and insured, while interest in web sites providing information about service prices is higher among the uninsured compared to the insured.
- Interest in online appointment scheduling, e-mail access, and online access to medical records and test results is equally high in the uninsured and insured groups.
- When choosing among doctors, the uninsured are more inclined to choose the doctor who costs less, while the insured are more inclined to choose the best doctor they can find, even at a significantly higher out-of-pocket cost.
- Consumers in both the insured and uninsured cohorts would generally be more likely to choose a doctor with a traditional orientation than a doctor with an orientation toward holistic or alternative treatments. Similar percentages of both groups have used an alternative approach to treat a health problem and consulted an alternative health care practitioner. More of the uninsured (13%) than the insured (8%) have substituted an alternative or natural therapy for a prescription medication.
- Fewer of the uninsured have traveled outside their community for care compared to the insured (8% vs. 12%, respectively), but slightly more of the uninsured have traveled outside the U.S. for care (5% vs. 3%, respectively). Similar percentages have used a retail clinic (17% of the uninsured and 16% of the insured report doing so).

Insured consumers, including those covered by Medicare, are generally satisfied with their health plan.

- On a scale from 0 (completely dissatisfied) to 100 (completely satisfied), health plans received an average satisfaction rating of 70 among all consumers and 77 among Medicare enrollees.
- Content & Compliant, Sick & Savvy and Online & Onboard consumers express higher satisfaction with their health plans compared to Shop & Save, Out & About and Casual & Cautious consumers.
- Medicare enrollees (12% of the overall sample) are disproportionately represented in the Content & Compliant and Sick & Savvy segments (39% of Medicare enrollees are Content & Compliant, while 31% of Medicare enrollees are Sick & Savvy). In addition to generally being more satisfied with their health plans than others, Medicare enrollees also tend to be more satisfied with their doctors and hospitals, more likely to choose doctors with a traditional orientation, and less inclined to prefer to make decisions for themselves. Medicare enrollees consult web-based sources for information about hospitals, doctors, health problems and treatment options somewhat less, and appear less sensitive to pricing for physician and hospital services than commercially insured consumers.

Only 7% of consumers say they are financially prepared for their future health care needs. By contrast, 93% say they are insecure about their ability to pay for their future health care needs.

- Only 7% of consumers say they are completely or nearly completely prepared financially for their future health care needs (Figure 17).



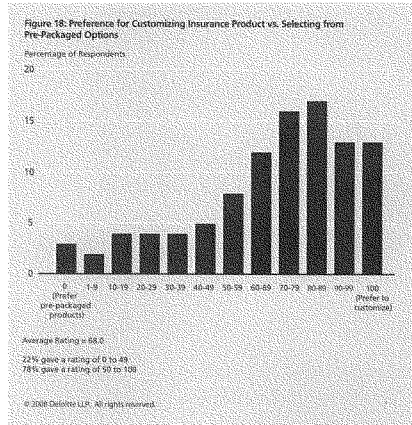
- Medicare enrollees generally feel more financially prepared than the commercially insured, who in turn feel more financially prepared than Medicaid enrollees. Financial security increases with age, with seniors feeling more prepared than Boomers, who feel more prepared than Gen X and Gen Y. Caucasians and Asians report feeling more prepared than African Americans and others, but there is no difference between Hispanic and non-Hispanic consumers and no difference between men and women. As would be expected, financial security is higher in the higher-income categories.
- Casual & Cautious consumers, as well as Out & About consumers, feel the least prepared to handle their future health care costs, giving average ratings of 38 and 39, respectively, on the 100-point scale. Shop & Save consumers feel the most prepared of all the segments, but their average rating is only 54. Average ratings for the other segments (Sick & Savvy, Content & Compliant, and Online & Onboard) hover around the mid-point, at 51.

52% of consumers with insurance say they understand their insurance coverage, but less than 1 in 10 consumers are confident they understand their coverage well.

- Only 52% say they understand their primary insurance coverage. Only 8% indicate they feel certain they understand everything they need to know.
- Medicare enrollees are more likely to say they understand their insurance compared to those with commercial insurance and Medicaid enrollees. Average levels of understanding increase with age, starting low among Gen Y consumers (55 on the 100-point scale) and rising to 73 among seniors.
- Understanding is lowest among Casual & Cautious consumers (the youngest segment) and highest among Content & Compliant and Sick & Savvy consumers (the older segments).

Consumers want to customize their health plan. Gen Y, Gen X, and Boomers are especially interested in policies that are customized to their needs.

- 78% of consumers express a preference for customizing their insurance product by selecting the benefits and features they value and, in doing so, increasing or decreasing the overall cost of their coverage (Figure 18). Only 22% prefer selecting from a few pre-packaged products with defined benefits and features.



- The desire to customize is high among consumers in all of the insurance groups (commercial, Medicare and Medicaid). Seniors are somewhat less inclined to want to customize their insurance than younger generations, and women are somewhat more interested in customizing their insurance than men. The preference to customize does not vary by race, ethnicity or income.
- The Out & About and Sick & Savvy segments are most interested in customizing their insurance, with average ratings of 75 and 73, respectively, on the 100-point scale. Consumers in all other segments express a preference for customization, as well, with average ratings of 68 (Online & Onboard and Shop & Save) and 65 (Casual & Cautious and Content & Compliant).

Consumers are split on their preferences for sponsorship of their health insurance. The younger generations are happy to get their insurance through an employer, while Medicare enrollees and other seniors are interested in shopping for it on their own.

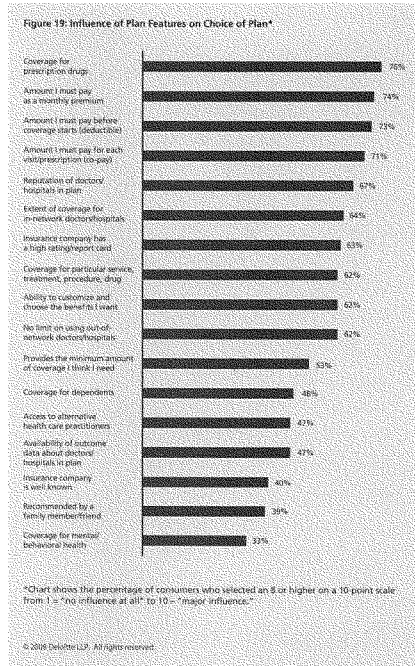
- When given the choice between getting insurance through an employer or shopping for it on their own, 54% of consumers indicate they would prefer to get it through an employer, while 46% say they would prefer to shop for it on their own if the cost would be the same.
- The younger generations (Gen Y and Gen X) are inclined to prefer employer-sponsored plans, as are Boomers, while seniors indicate a preference for shopping for insurance on their own.
- Content & Compliant consumers are the least inclined to want to shop for insurance on their own, while Out & About consumers express the greatest preference to do so.
- Nearly 1 in 4 consumers say they might change jobs to get better health insurance (4% said they have done this recently).
- Nearly 1 in 5 consumers say they anticipate turning down a job offer from another employer to be able to keep their current health insurance (3% say they have done this recently).

30% of consumers anticipate switching insurance companies or health plans in the future. Even higher percentages anticipate switching physicians and medications.

- While only 6% of consumers report having recently switched either to a different insurance company or different health plan, 30% say they might do so in the future. The Shop & Save segment is especially prone to switching: 75% switched to a different insurance company and 83% switched to a different plan offered by the same insurance company within the last 24 months. Far lower percentages of the other segments (in the range of 3 to 10%) report doing so.
- 41% of consumers anticipate switching doctors sometime in the future (18% have done so in the last 24 months).
- 35% of consumers expect to switch treatments or prescription medications in the future (21% have done so in the last 24 months).
- Shop & Save and Out & About consumers are more inclined to switch doctors, treatments or prescription medications than other segments, followed by Sick & Savvy and Online & Onboard consumers. For instance, 49% of Shop & Save, 37% of Out & About, 26% of Sick & Savvy, and 24% of Online & Onboard report switching doctors within the last 24 months. In contrast, only 11% of the Casual & Cautious group and 8% of the Content & Compliant group report doing so.

Key factors that consumers use to compare health plans include prescription drug coverage, out-of-pocket costs and the inclusion of providers in the plan's network. Deductibles are a key differentiator; however, consumers consider deductibles along with total premium and out-of-pocket costs in assessing the cost of their insurance program.

- 3 out of 4 consumers say coverage for prescription drugs would influence their choice of a health plan (Figure 19).

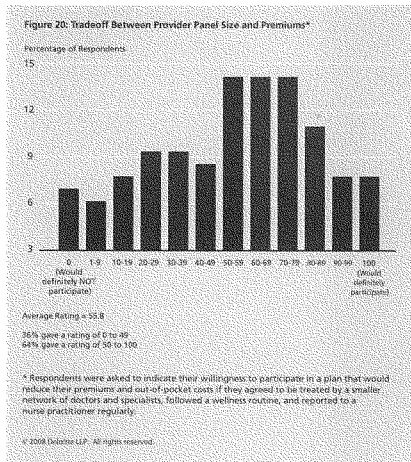


- Nearly that many say that the amounts they must pay in premiums, deductibles and co-pays are factors that influence their plan choice.
- Reputation of the providers included in the plan's network is an important consideration for 2 out of 3 consumers, while coverage for specific services and providers, along with ratings of the insurance company, are important to almost as many.
- 62% of consumers indicate that the ability to customize and choose the benefits they want would influence their choice of a health plan.

- If given the choice, nearly 60% of consumers say they would be more likely to choose the low-deductible option with relatively lower co-pays and a high premium, while over 40% say they would be more likely to choose the high-deductible option with relatively higher co-pays and a lower premium.

Many consumers will accept a smaller provider network for a reduced premium.

- 64% of consumers indicate they would be willing to participate in a plan that would reduce their out-of-pocket costs and premiums if they agreed to be treated by a smaller network of doctors and specialists; to follow a routine that might involve diet, exercise and taking all medications as directed; and to report to a nurse practitioner regularly (Figure 20).

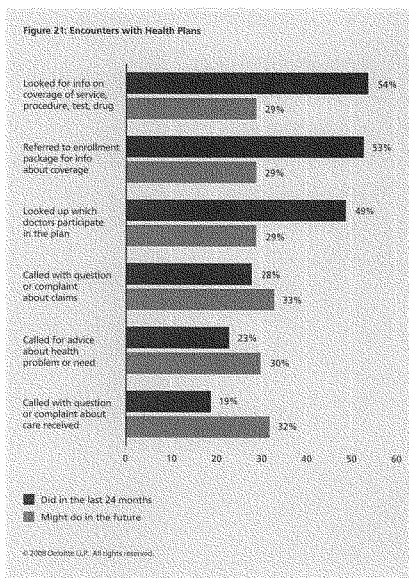


Health plan web sites are a critical source of information for enrollees. Most want their plan's web site to expand its web offering to provide more information about provider quality and pricing, treatment options and claims status.

- Nearly 3 out of 4 consumers are interested in accessing quality or price information from their health plan, whether it is through a web site or other means (12% of consumers are willing to pay for access to these types of information).
- 2 out of 3 consumers are interested in accessing online health education and reference materials from their health plan (fewer than 1 in 10 say they would pay more for the access).
- 2 out of 3 consumers are also interested in online claims management (1 in 10 say they are willing to pay extra for this service).

Insured consumers want plans to address their questions and concerns about coverage, claims and health care experiences. Many also seek advice from their plan about health problems and needs.

- Nearly half of consumers have sought information from their plan about coverage for particular providers (Figure 21).



- 28% have called their plan with a question or complaint related to claims, and 19% have called their plan with a question or complaint related to the health care they or a family member had received. 1 out of 3 consumers anticipate calling their plan for these reasons in the future.
- Nearly 1 in 4 consumers have called their health plan to seek advice about a health problem or health care need (30% anticipate doing so in the future).

Consumers are interested in health plan-sponsored wellness programs, especially those that are tied to reduced premiums.

- 17% of consumers report participating in a wellness program offered by their employer, insurance company or health plan in the last 24 months.
- 83% express interest in participating in a wellness program offered by their employer, insurance company or health plan that would entitle them to reduced premiums or lower co-pays.
- 65% of consumers say they are interested in participating in a wellness program sponsored by their insurance company or health plan, and 26% are willing to pay extra for the opportunity.
- 61% of consumers want tools that would provide personalized recommendations to improve their health and 55% of consumers are interested in tools that would help them assess, monitor or manage their health (12% would pay extra for these tools).
- 53% of consumers are interested in using a health/lifestyle coach (5% would pay extra for this).
- 1 in 2 consumers report taking preventive measures such as exercising and eating a healthier diet to reduce their need for health care, and 1 in 3 report doing so to lower the cost of health care for themselves or their family.

Consumers use health plan web sites for information about prices and coverage of doctors, hospitals and medications. They are interested in accessing additional information about the quality of these services. However, for clinical information, consumers turn to providers and online health sites more than health plans.

- Consumer interest in using price information provided by health plans, doctors and hospitals is moderately strong. Health plans are viewed as the “logical” place for pricing information; physicians and hospitals the place for “clinical” information.
- 23% of consumers have called their insurance provider or health plan to ask for advice about a health problem or health care need, and 30% say they might do so in the future.
- Only 17% of consumers view their health plans as trustworthy sources of information about the best treatments for certain conditions, compared to 31% viewing online health sites, 40% viewing hospitals, and 63% viewing doctors as trustworthy sources.

Looking to government to help address concerns about receiving and paying for high-quality health care, consumers consider health care to be a major factor in the 2008 Presidential campaign.

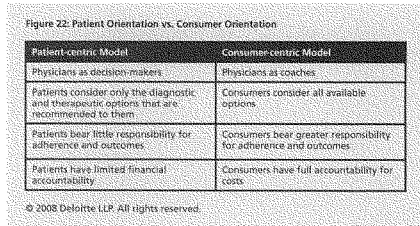
- 79% of consumers say health care issues are likely to influence their vote in the 2008 Presidential election.
- 46% say that health care issues will be among the top three issues affecting their vote.

Conclusions

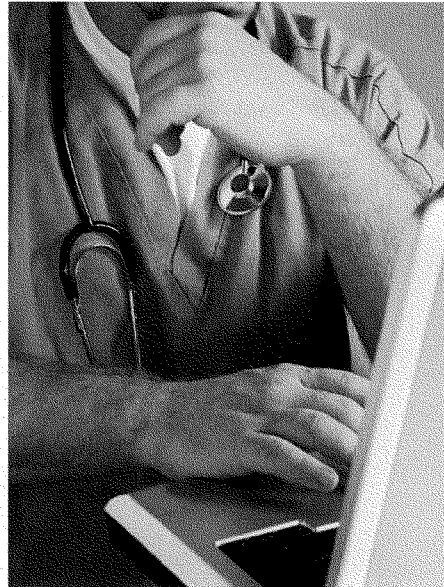
The 2008 Survey of Health Care Consumers provides a comprehensive assessment of consumer behaviors, attitudes and unmet needs related to health, health care and health insurance.

These findings add insight to the public discussion about health care consumerism, a trend that has significant implications for providers, health plans, life science companies, policy makers and employers. In our view, there are four key themes that reflect the depth, salience and relevance of these findings:

- **Health care is a consumer market.** Health care providers might be inclined to think of consumers as “patients” – passive, somewhat inactive, dependent on doctors to make decisions for them, and often non-adherent to treatment recommendations. That perspective is short-sighted. This study’s findings point to clear signals that consumerism is a significant trend that all industry stakeholders must consider. Many consumers already are activists in decisions about their care – they use substitutes for traditional health services, search for price and quality comparisons and switch doctors, hospitals and plans. Many more are eager to become activists – they want greater access to information, online tools and services that would enable them to actively manage their care. The distinction between a patient orientation and consumer orientation is, therefore, important to recognize (Figure 22). Moving to a consumer orientation means viewing physicians as coaches rather than decision-makers, enabling consumers to consider all available options, shifting more responsibility for adherence and outcomes to consumers, and expecting consumers to be fully aware of and accountable for spending.



- **The consumer market is not homogeneous: it is a complex and demanding market comprised of six unique segments.** The U.S. health care market has six distinct segments, each characterized by a unique set of attitudes and behaviors. These segments navigate the health system very differently, reflecting different levels of interest in and comfort with innovative approaches. The degree to which price matters in making purchasing decisions is relevant, as is service and quality, but in varying degrees and in varied forms across each segment. Each segment wants greater personalization of services and programs, but each defines key features differently. All are looking for better service – they want high-touch service from their doctors, hospitals, and health plans as well as tools to assist them in decision-making. However, the segments vary on the types of tools and service “pressure points” they are most interested in.
- **Consumers want to make their own decisions and they want tools to help them do this. The source for these tools is up for grabs.** Consumers want doctors, hospitals and health plans to provide better information specific to their needs. They want to learn more about health problems and treatment options, and they want to compare providers based on price and quality. They have an insatiable appetite for information, and they are looking for a source that provides what they need in a useful and timely manner. For most of this information, they believe that Internet-based tools are an important resource: for the vast majority of consumers, including seniors, online information searching is already a routine part of their lives. However, the gap between what consumers want and the tools currently available from doctors, hospitals and health plans is wide. Consumers are looking primarily to doctors and hospitals, but also to plans, to provide tools to help them make clinical decisions. By contrast, they are looking largely to plans for tools to help them compare prices and manage claims, but they also are interested in accessing price information directly from doctors and hospitals. Consumers are seeking a trusted source that can provide both sets of tools in a personalized format. The race to provide those tools is “up for grabs” – doctors, hospitals and health plans are all viewed as potential sources.
- **Consumers are embracing innovations that are “disruptive” to stakeholders who provide traditional health services and health plans.** The majority of consumers see a need for better value, better service, increased transparency and personalization of services from doctors, hospitals and health plans. They are receptive to innovations in how services are delivered and paid for. Nearly half say they are comfortable with non-traditional therapies and are embracing alternative medicine in large numbers. The vast majority want to customize their insurance with unique coverage and pricing features. Consumers want better service, better value and increased options, and some are willing to pay more. They want changes in the health system – innovations that improve its performance and accommodate consumer needs and wants. Many of these innovations pose serious threats to the status quo.



Implications

The transition from a patient orientation to a consumer orientation has far-reaching implications for all stakeholders in the U.S. health care system. The convergence of price, service delivery and quality lends itself to value-based purchasing programs where consumers make decisions for themselves and their family members with a clear view about all three factors in advance of the transaction.

This study undermines some myths about the consumer's role in health care. The most prominent of these are:

Myth	Reality
Consumers believe that the majority of doctors, hospitals and health plans are essentially alike and that care and service quality doesn't vary considerably.	Consumers see distinctions in quality. They are paying attention to differences and want more information to make comparisons.
Consumers are generally comfortable with the traditional clinical approach to care in the U.S. health system: Allopathic medicine is widely accepted and trusted by consumers.	A substantial number of consumers are increasingly drawn to non-allopathic (holistic, natural) approaches to care and to interventions that are less "chemically" based (biologics). Integration of non-allopathic and allopathic medicine is sought.
Consumers trust their doctor to make decisions for them.	The majority of consumers want to share decision-making with their doctor; only 20% are content to let their doctor control those decisions unilaterally.
Consumers pay little attention to prices for health care services.	Consumers are paying attention to prices for their prescriptions, office visits, hospital services and insurance premiums. They want tools to help them know in advance what those costs will be.
Consumers with health insurance think they're covered and don't worry about health costs.	Fewer than 10% of consumers feel secure about their ability to handle their future health care costs.
Consumers are not paying attention to health care in the 2008 Presidential campaign.	Consumers believe health care is a key political issue and many will vote based on health care issues alone.
The attitudes and expectations of the uninsured vary dramatically from the insured.	Both the uninsured and insured desire improved service, greater access to clinical information and tools to compare costs and quality, and performance-based payments to providers.
Medicare enrollees are content and compliant: They don't shop for services, they don't use the Internet and they depend on doctors to make decisions for them.	Nearly half of Medicare enrollees are self-directed activists in their care, seeking information about health concerns, treatment options, quality and price; they are prone to engage in shared decision-making with their doctors.
Consumers believe the government should pay for the uninsured.	Nearly 90% would be in favor of increasing taxes to help provide coverage for the uninsured; another third are not sure, only 37% oppose.
Consumers prefer to stay close to home for their doctor and hospital services.	Consumers will travel across state lines or country borders to save money or get better quality. They recognize that close at home may not mean "best at home."
Consumers are afraid to use the Internet for clinical transactions in health care, fearing loss of privacy and security.	Consumers are comfortable using the Internet to exchange clinical information with their doctor, especially if it results in better coordination of care and improved service. (They believe their doctors should make greater use of the Internet to provide access to medical records, test results and other types of information.)

For key stakeholders in the health care system – doctors, hospitals, health plans, employers, pharmaceutical companies, biotechnology companies, health care information technology companies, policymakers and elected officials – these are compelling findings. They suggest that stakeholders should re-formulate business strategies to focus on improved value, improved service, consumer-oriented tools, enhanced innovation, behavioral and attitudinal segmentation of marketing strategies, and collaboration with entities previously thought to be outside the traditional system of care. Each stakeholder's application of these findings will vary. The certainty is that strategies and implementation will change, as a result.

Health care consumers want improved service, personalized programs, predictable costs and demonstrated results. They embrace innovation and technology-enabled solutions and are acting on their beliefs and desires in significant numbers. They are neither "patients" nor patient. They are consumers and they expect to be heard.

Contributors

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COMMUNICATIONS

Statement for the Record

American College of Physicians
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United States Senate Committee on Finance

Seizing the New Opportunity for Health Reform

May 6, 2008

The American College of Physicians (ACP) is the largest medical specialty society in the United States, representing 125,000 doctors of internal medicine, residents and medical students. ACP commends Chairman Max Baucus for holding this hearing to better understand the problems of today's health care system so that we may achieve effective health care reform. The College advocates that all Americans should have affordable health insurance coverage.

To determine how to achieve a high performance health care system with universal health insurance coverage, the College examined the U.S. health care system and compared it to health care systems in other countries.ⁱ The analysis revealed lessons that could be learned from high performance health care systems in other industrialized countries. Based on these lessons, ACP proposes recommendations to achieve a more efficient, better functioning health care system in the USA with health insurance coverage for all.

The U.S. health care system spends far more on health care than any other country. Costs continue to rise at a faster pace than spending in the rest of the US economy. Yet, an estimated 47 million Americans (15.8%) lack health insurance protection.ⁱⁱ These Americans are much less likely than those with insurance to receive recommended preventive services and medications, are less likely to have access to regular care by a personal physician and are less able to obtain needed health care services. People without health insurance live sicker and die younger.ⁱⁱⁱ Even among those with health insurance coverage, wide variations exist in terms of cost, utilization, quality and access to health care services. Rising costs are creating financial burdens for individuals, government and employers, resulting in reduced access to care, and adding to the number of uninsured.^{iv}

Additional problems in the U.S. include disparities in health care based on race, ethnicity and geography; an insufficient supply of primary care physicians for an aging society; a dysfunctional system for paying physicians; and excessive administrative and regulatory costs.

Our analysis of health care systems in twelve other industrialized countries included an overview of each country's healthcare system, its advantages and disadvantages, and possible lessons to be learned for the USA. Criteria developed by the Commonwealth Fund were used for measuring the performance of health care systems.

Although many individuals in the United States receive exemplary health care, international comparisons on most key indicators of the public's health have shown that the United States has poorer health outcomes in the aggregate than many other industrialized countries. Major improvements are needed in the health care system in the United States to achieve performance levels attained by health systems in other countries.

The following lessons and recommendations were identified for improving health care in the United States:

Lesson: Well-functioning health systems guarantee that all residents have access to affordable health care. Some countries achieve universal coverage with a system funded solely by the government. Most, however, have opted for models that include a mix of public and private sources of funding.

Lesson: Global budgets can help restrain health care costs but do not provide incentives for improved efficiency unless they are set reasonably and targeted to small enough groups.

Lesson: The use of government power to negotiate prices can achieve cost savings but may result in shortages of services subject to price controls, delays in obtaining elective procedures, cost-shifting, and creation of parallel private sector markets.

Recommendation: Provide universal health insurance coverage to ensure that all people within the United States have equitable access to appropriate health care without unreasonable financial barriers. Health insurance coverage and benefits should be continuous and not dependent on place of residence or employment status. ACP calls on policymakers to consider adopting one of the following two pathways to achieve universal coverage:

- A single-payer system in which one government entity is the sole third-party payer of health care costs. The advantages of single-payer systems are that they generally are more equitable, have lower administrative costs, have lower per capita health care expenditures, have high levels of patient satisfaction, and have high performance on measures of quality and access than systems using private health insurance. The disadvantages of this system include potential shortages of services subject to price controls and delays in obtaining elective procedures.

- A pluralistic system in which government entities as well as for-profit and not-for-profit organizations ensure universal access while allowing individuals the freedom to purchase private supplemental coverage. The disadvantages of this system are that it is more likely to result in inequalities in coverage and higher administrative costs. Pluralistic financing

models must provide a legal guarantee that all individuals have access to coverage and sufficient government subsidies and funded coverage for those who cannot afford to purchase coverage through the private sector.

Lesson: Cost-sharing designed so that low-income individuals pay no or nominal amounts can help restrain costs while assuring that poorer individuals are still able to access services.

Recommendation: Create incentives to encourage patients to be prudent purchasers and to participate in their health care. Patients should have ready access to health information necessary for informed decision-making. Cost-sharing should be designed to encourage patient cost-consciousness without deterring patients from receiving needed and appropriate services or participating in their care.

Lesson: Societal investment in professional medical education can help achieve a health care workforce that is balanced, well-trained, and in sufficient supply. Investment in primary and preventive care can result in better health outcomes, reduce costs, and may better assure an adequate supply of primary care physicians.

Recommendation: Develop a national health workforce policy that includes sufficient support to educate and train a supply of health professionals that meets the nation's health care needs. To meet this goal, the nation's workforce policy must focus on ensuring an adequate supply of primary and principal care physicians trained to manage care for the whole patient. The federal government must intervene to avert the impending shortage of primary care physicians. A key element of workforce policy is setting specific targets for producing generalists and specialists and enacting policy to achieve these targets.

Lesson: Effective physician payment systems include support for the role of primary care physicians, incentives for quality improvement and reporting, and incentives for care coordination. Establishment of performance measures, financial incentives, and active monitoring of performance can encourage higher quality of care. Countries that organize care around the relationship between a primary care physician and the patient through a patient-centered medical home have better outcomes at lower cost.

Recommendation: Provide financial incentives for physicians to achieve evidence-based performance standards. The United States should revise existing volume-based payment systems to create care coordination payments for physicians working with health care teams to provide patient care management and maintain a fee-for-service component for separately identifiable visits. Redirect federal health care policy toward supporting patient-centered care and the patient-centered medical home.

Lesson: Uniform billing systems and electronic processing of claims improve efficiency and reduce administrative expenses.

Recommendation: Support with federal funds an inter-operable health information technology infrastructure, create a uniform billing system for all services, and reduce regulatory burdens.

Lesson: Insufficient investments in research and medical technology result in reliance on outdated technologies and medical equipment, and delay patients' access to advances in medical science.

Recommendation: Encourage public and private investment in medical research and assessments of the comparative effectiveness of different medical treatments.

Conclusion

The American College of Physicians appreciates the opportunity to provide the Finance Committee with this summary of our views on health system reform. We recognized that although we can learn much from other health care systems, any solution for the United States must be unique to our political and social culture, demographics, and form of government. Many factors make it unlikely that we can simply adopt systems used by other nations, particularly those that involve a substantial expansion of the power of the federal government to regulate health care. Nevertheless, we believe our examination of the evidence identified several approaches that are more likely than others to be effective in achieving a well-functioning health system that could be adapted to the unique circumstances in the US.

Additional information on ACP's analysis and proposals for improving access to health care can be found on our website at:

http://www.acponline.org/advocacy/where_we_stand/access/#access

The American College of Physicians would welcome an opportunity to provide further details of our findings and recommendations or to answer any questions.

ⁱ American College of Physicians. Achieving a High-Performance Health Care System with Universal Access: What the United States Can Learn from Other Countries. *Annals of Internal Medicine*. 2008;148:55-75 (accessible at <http://www.annals.org/cgi/content/full/0000605-200801010-00196v1>)

ⁱⁱ Organization for Economic Co-operation and Development. Total Expenditures Per Capita, June 2006.

ⁱⁱⁱ U.S. Bureau of the Census. Income, poverty, and health insurance coverage in the United States: 2006. U.S. Department of Commerce (P60-233). August 2007.

^{iv} American College of Physicians--American Society of Internal Medicine. No health insurance? It's enough to make you sick. Philadelphia: American College of Physicians--American Society of Internal Medicine; November 1999.



NATIONAL ASSOCIATION OF
CHAIN DRUG STORES



STATEMENT

Submitted By

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To the

Committee on Finance
United States Senate

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“Seizing the New Opportunity for Health Reform”

May 6, 2008

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Pharmacies. The face of neighborhood healthcare.

**Senate Committee on Finance:
“Seizing the New Opportunity for Health Reform”**

The National Association of Chain Drug Stores (NACDS) appreciates the opportunity to share with the Senate Finance Committee the Association’s perspective on healthcare reform. NACDS commends the Committee for holding its hearing today, titled “Seizing the New Opportunity for Health Reform.” This title captures the sense of urgency and the creativity that will be required to revolutionize healthcare. Because NACDS is confident in pharmacy’s ability to help improve the accessibility, affordability and quality of patient care, we are taking this occasion to announce our recently adopted NACDS Principles of Healthcare Reform.

NACDS represents traditional drug stores, supermarkets and mass merchandisers with pharmacies. Its approximately 200 chain member companies include regional chains with a minimum of four stores to national companies. NACDS members also include approximately 1,000 suppliers of pharmacy and front-end products, and approximately 100 international members representing more than 30 countries. Chains operate more than 39,000 pharmacies, and employ a total of more than 2.7 million employees, including 114,000 pharmacists. They fill more than 2.4 billion prescriptions yearly, and have annual sales of over \$700 billion.

Recently, NACDS launched a new initiative to emphasize the role of pharmacies as the “Face of Neighborhood Healthcare.” This reflects our renewed commitment to promote the ways in which pharmacies can improve lives, while making healthcare more efficient and affordable. Sometimes, this commitment requires us to speak out when public policy threatens pharmacy. Members of the Committee are familiar with our support of S. 1951/H.R. 3700, the Fair Medicaid Drug Payment Act, to prevent the dramatic Medicaid pharmacy reimbursement cuts that would force between 10,000 and 12,000 pharmacies out of business. At other times, this commitment manifests itself as a call for proactive action to improve healthcare, as exemplified by our support of S. 2408/H.R. 4296, the Medicare Electronic Medication and Safety Protection (E-MEDS) Act, which would foster the benefits of electronic prescribing.

Today, our commitment to communicate the role of pharmacy in healthcare takes the form of the announcement of our NACDS Principles of Healthcare Reform, which are attached to this letter. NACDS again thanks the Committee for its focus on this topic, and looks forward to working with the Committee and with the Congress to ensure the value of pharmacy is contemplated in any effort to achieve the opportunities for healthcare reform at this unique time.

**PRINCIPLES OF HEALTHCARE REFORM
AS APPROVED BY THE NACDS BOARD OF DIRECTORS, APRIL 26, 2008**

WHEREAS,

- Pharmacists are among the most trusted professionals in the nation, and are recognized as the most accessible healthcare providers. Community-based pharmacies offer the valuable combination of healthcare professionalism in a consumer-focused environment.
- The health and wellbeing of current and future generations requires improvements in the quality, affordability and accessibility of healthcare.
- Failure to take prescription medications as prescribed harms patients. It also inflicts direct and indirect costs on the system of an estimated \$177 billion per year. These costs include unnecessary emergency room visits and catastrophic care, reduced productivity, and a general decrease in overall health and well-being for non-compliant patients. Education on the appropriate use of prescription medications through community-based pharmacy services is an important part of maintaining patients' life and health.
- Appropriate use of medications is a critical component of treating the seven most common chronic medical conditions. These chronic conditions result in an estimated cost of \$1.3 trillion on the nation's economy in terms of lost productivity, reduction in quality of life, and morbidity. This cost could grow to potentially \$6 trillion by mid-century.
- Pilot projects have found that utilizing pharmacists in the management of medication therapy, disease state management, immunizations, healthcare screenings, and other professional healthcare services improves the health of patients with chronic diseases, and reduces overall healthcare costs.

NACDS SUPPORTS THE FOLLOWING PRINCIPLES OF HEALTHCARE REFORM:

- Providing high quality, affordable and accessible health care coverage to as many Americans as possible should be the goal of any healthcare reform proposal.
- The reformed healthcare infrastructure should consist of a combination of private insurance plans augmented by existing public insurance programs, rather than a single-payer model.

- The value of prescription drugs and retail pharmacy professional services should be recognized in health care reform, and patients should be able to choose where to obtain their prescription medications and pharmacy services.
- Financing mechanisms for reform initiatives should be broad-based, fair, and proportionate. They should be crafted to avoid negative consequences, such as creating excessive burdens on employers that might lead to the elimination of jobs, raise the prices of consumer goods, and negatively affect the overall economy. The flexible and nationally uniform framework for employer provision of healthcare benefits through the Employee Retirement Income Security Act (ERISA) should be maintained.
- Patients should have access to the most appropriate cost-effective medication to treat their particular medical condition. Lower cost, equally effective generic medications should be encouraged when appropriate.
- Preventive services, such as medication therapy management, should be encouraged. The medication and healthcare expertise of the pharmacist should be reflected in any efforts to facilitate collaboration in patient care.
- Methods of evaluating the costs of legislation and regulations should take into consideration the role of pharmacy professional services in preventing poor health and acute health care events that result in more costly forms of care.
- Cost-sharing, such as patient co-payments, should be set at affordable levels that encourage the use of the most cost effective medications. However, cost sharing should not prevent patients from seeking appropriate medical care, or create barriers to accessing providers.
- Reimbursement to healthcare providers should be equitable to prevent access limitations that result when providers are forced to reduce or eliminate services. In the case of pharmacies, reimbursement should include those costs related to dispensing medication and pharmacist-provided care, as well as medication costs, both of which should be determined fairly.
- Non-pharmacy health care and educational services such as in-store clinics and healthy living presentations should be explored, in collaboration with other healthcare providers including the physician community.
- A robust and standardized health information technology system, including e-prescribing and electronic medical records, should be the backbone of healthcare reform. Speeding the adoption of this technology will increase the likelihood that patients will take their medications as prescribed, helping to prevent medication errors, and enhancing medical decision-making and collaboration.