TESTIMONY OF E.J. (NED) HOLLAND, JR.

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BEFORE THE UNITED STATES HOUSE OF REPRESENTATIVES

COMMITTEE ON ENERGY AND COMMERCE SUBCOMMITTEE ON HEALTH

THE HONORABLE JOHN DINGELL, COMMITTEE CHAIR

THE HONORABLE JOE BARTON, RANKING COMMITTEE MEMBER

THE HONORABLE FRANK PALLONE, JR., SUBCOMMITTEE CHAIR

THE HONORABLE NATHAN DEAL, RANKING SUBCOMMITTE MEMBER

Mr. Chairman and distinguished committee members:

I am E. J. Holland Jr., Senior Vice President of Human Resources and Communications at Embarq Corporation, with headquarters in Overland Park, Kansas. Before I begin, I should make clear that, while I am responsible for health care purchasing at Embarq, my testimony here is provided on my own behalf and does not necessarily reflect the views of Embarq, its shareholders, its board members, its management, or of any of the health care organizations on whose boards I sit.

It is my privilege to testify before this distinguished committee of the United States House of Representatives on what I believe to be the most pressing economic issue of our time. I believe I was invited here today because I am an employer representative

who favors reform of the health care system and let me be clear about that. I am absolutely persuaded that reform of the health care system is critical for my company, its shareholders and its employees and, in fact, our country as a whole. The burden of providing health care coverage has created a tremendous competitive disadvantage to American employers. It has caused chaos in several industries — steel and automobiles come to mind — and it is well on its way to causing similar chaos in other industries, including my own: telecommunications.

My perspective has been shaped by a rather diverse professional background, about which I will share more in a moment. In my comparatively broad view, there is no silver bullet that will put an end to this country's health care system nightmare. I believe that successfully reforming the system will not come in the form of a revolution but rather through a deliberate series of evolutionary steps, and I believe that among those key steps should be:

- Invest in our information technology infrastructure for health care.
- Establish national quality standards for health care.
- Adopt appropriate physician reimbursement incentives.
- Expand the participation pool as much as possible while allowing for policy experimentation at various levels.

In the testimony that follows, I will expand on each of these opportunities, share with you some examples of how health care continues to create business challenges at my company and what we're doing to address them, and I will offer my views of the health care system overall. But first, I should tell you something about the professional background that has shaped my perspective on the subject.

My background

I am a graduate of Rockhurst College in Kansas City, Missouri, and of Boston College Law School in Boston, Massachusetts. I practiced law for 24 years with a firm that represented physicians and health care organizations. During that time, I provided services to the Kansas City Area Hospital Association, The Missouri Hospital Association, The American Hospital Association, and dozens of individual hospitals. In addition, I served on two separate hospital boards, chaired one of them; and chaired the Kansas City Area Hospital Association, the hospital industry association in the greater Kansas City area. Sixteen years ago I left the practice of law and took a position in a Fortune 500 company. Since that time I have been responsible for health care purchasing, among other things, at three successive Fortune 500 companies.

I was said to have "changed sides," but the truth is, there really are no sides on this issue. Since becoming a purchaser, I have served on a variety of boards, including the National Business Group on Health and the Mid-American Coalition on Health Care and I have been involved actively in Better Health Care Together and Care Focused Purchasing, which I helped to found.

Currently, I serve on the board of Joint Commission Resources, a subsidiary board of the Joint Commission on Accreditation of Health Care Organizations in Chicago. This subsidiary operates Joint Commission International, providing accreditation and other services to hospitals throughout the world. I also serve on the board of the Kansas Health Policy Authority, an independent board charged with setting health policy and overseeing all health care purchasing in the state of Kansas, roughly $2.5 billion a year. I chair that organization's Finance and Audit Committee and have

chaired its CEO Search Committee. Finally, like most of us will be sooner or later, I have been a patient in our health care system.

Sometimes I think this varied background constitutes a series of conflicts of interest. On the other hand, I hope it gives me a broad and somewhat sympathetic view of the various interests that inevitably arise as we discuss how to resolve the health care emergency in this country. I was appointed to the Kansas Health Policy Authority and recently reappointed by the very able Republican President of the Kansas Senate, Senator Steve Morris. When he approached me about serving, we discussed the sometimes partisan nature of the health care debate, but Senator Morris observed that health care is not a partisan issue. I completely share his views on that and have worked both with him and our Democratic Governor, Kathleen Sebelius. At the same time, I reminded Senator Morris that I had served many years as an active advocate for the hospital industry. He suggested that that would give me a useful insight into several sides of the issue. I continue to serve at Senator Morris' request, and I treasure the opportunity to have worked with him as we try to address some of these issues, at least in Kansas.

How health care continues to create business challenges at my company

The health care purchasing in which I have been involved most recently has been for a combination of Sprint and Embarq, which is a Sprint spin-off. With Sprint we purchased health care for up to 80,000 employees and at Embarq we have purchased for up to 20,000 employees. You need to multiply those numbers by a relativity factor between 2.25 or 2.5 to determine how many employees, spouses and dependents we actually served, which is somewhere around 200,000 at Sprint and somewhere around 50,000 at Embarq. At Sprint we purchased in 50 states and at Embarq we purchase in 39

states. Both provide multiple plan choices for employees, with up to five in any given market. Both have a variety of plans ranging from indemnity plans through PPOs, EPPs, High Performing Networks, and Commercial HMOs. At Sprint and Embarq, we require our employees to participate in our health care plan or provide evidence that they are covered by another employer-sponsored group health plan. We simply believe that everyone should have coverage.

I invest my time advocating for health care reform for many reasons, perhaps most immediately because it is critical for the health of my company. As employers fight the never-ending battle for improved productivity needed to compete in an international economy, we also are working to meet budget targets that routinely are down year-over-year. The one aspect of our budgets that has been totally uncontrollable in recent years has been health care. To use my own company for a current example, we are in an increasingly competitive, almost cut-throat, business. The days when the local phone company was a monopoly and earned a regular and guaranteed rate of return are long passed. My budget this year is lower than my budget last year, and my tentative budget for next year is lower than my budget this year. However, we have had an incredibly difficult time with health care this year. At the end of the first quarter, our health care purchasing trend rate was at approximately 20 percent, causing a budget deficit in excess of $20 million. For us that is an incredible problem, and I am in charge of solving it.

We are a fairly sophisticated purchaser, and we have lots of data at our finger tips. We know, for example, that there are two primary causes for the looming deficit for the year. The first is that our employees are visiting health care professionals far more often than in the past and, in our case, more often than the norm. The second is that

health care professionals are ordering more tests and procedures for our employees than they have done in the past, or than are the norm. Ironically, at the very same time, we know that the acuity of illness among our employees and their families is down markedly. Thus, our healthier employees are using services more frequently and are incurring higher costs. I have some theories as to why that might be the case, but they are no more than theories, and I will not burden the committee with them. The point is that the expense increase simply is unsustainable, and I am unable to explain it to my CEO or my CFO. Thus, in the coming year, we will have to find ways to rectify the financial situation. To do that, we will be required to increase premiums, increase co-pays, increase deductibles and increase out-of-pocket maximums for my employees. Once again health care costs for the company and our employees will rise faster than wages or general inflation. There are a few things that we will be able to do to attempt to decrease costs, such as negotiate more aggressive discounts with the providers; but overall, the adjustments primarily will be felt in cost shifting to employees of whom, of course, I am one.

What we are doing to try to combat the health care problem at EMBARQ

Having anticipated this problem, we have been taking advantage of our technological capabilities to engage in a dialogue with our employees on health care issues. I personally have a health care blog that I update regularly and respond to employee questions and comments. It is far and away the most active blog we operate on our company intranet. I have received literally hundreds of employee comments with ideas, complaints and occasional simple grousing. I don't dismiss any of it, even the grousing, because I know just how frustrating this problem is. Unfortunately, I have yet

to receive an idea from an employee that we have not already considered, but I keep hoping for some mystical magic bullet.

I find it distressing that, with increasing frequency, employees suggest to me that we should charge more to people who use the system than to people who do not and we should charge yet more, the more they use it. My concern is that this points to a hole in the fabric of the social contract — one that easily could lead to a rending of the contract altogether. To be sure, responses from some colleagues indicate their understanding that the health care plan is intended to spread risk and protect each of us when we have a particular problem. However, many comments I receive are that people who are overweight or who smoke or who have an unhealthy lifestyle — or who simply are sick — should pay more. Obviously, if we took that to its logical conclusion, we simply would give people the money to buy their own health care without any sort of intervention. As I see it, the problem is that without some sort of systemwide reform, an every-man-for-himself inclination will prevail and leave us in a situation that is even more dysfunctional than the one we are in today. In fact, as a practical matter, the cost shifting in which employers increasingly are forced to engage, is just another form of moving the costs shared by any common group — whether a company, the community or the nation — onto individual users. In the end, I really don't think that is in the nation's interest.

I assure you, we have been very creative and aggressive health care purchasers. We self-insure 95 percent of our plans (with very few isolated commercial HMOs available to some of our employees). We design our own benefits structure, eliminating such things as bariatric surgery, fertility treatments, non-sedating antihistamines, over-

the-counter drugs and various elective pharmaceuticals, as well the usual cosmetic surgery and the like. For several years while I was at Sprint we bought direct in Kansas City. That is, we purchased directly from doctors and hospitals and effectively created our own network of providers without an insurance company intermediary. During that period of time, when we were large enough to do it, we actually bought health care services 11 percent more efficiently in Kansas City than we did anywhere else in the country, simply because we cut out the middle man in the system.

At a previous employer, we instituted an in-house claims payment system, directly paying our providers and cutting out yet another intermediary in the process and saving large sums of money. Frankly, neither of those efforts is rocket science, but they require a sufficient number of covered lives to justify the investment.

We have carved out pharmaceuticals to purchase more effectively, collaborated with other employers to engage in that activity, designed alternative plans to attempt to provide appropriate incentives to employees, installed a wellness and disease management program — essentially all the bells and whistles you hear about. Still we are facing a 20 percent trend rate in 2008.

At Sprint, we even installed an on-site clinic which was very successful, but still it served only half the population eligible to use it. In fact, therein lies one of our problems; people frequently don't use what we provide them. For example, we provide non-smoker premium reductions, but not everybody who we are certain would be eligible for them takes advantage of them. We provide nurse advocate lines to assist employees in addressing this complex system, but less than 6 percent of our employees utilize them. We provide a health risk assessment with incentives to participate, but only 14 percent of

our employees utilize it. We provide complex case management, not to try to keep employees from getting health care, but to help them get the correct care. But again, we have one tenth of 1 percent usage. Frankly, we are beginning to look at replacing the various carrots with sticks of different sorts. Perhaps we will penalize people who don't take the health assessment. Perhaps we will double the deductibles for those who decline to participate in disease management. We are not yet sure, but those are the sorts of things at which we are looking.

Wellness programs clearly are the right thing to do. We installed one at Sprint, and we have one at Embarq. No responsible person would suggest that these are not a good idea. They are something like motherhood and apple pie. But, frankly, they produce marginal economic results that wouldn't convince a chief financial officer and simply are not the silver bullet to health reform in this country. Certainly, they satisfy the admonition attributed to Hippocrates, "First, do no harm," but they will not solve our problems. The calculation of the return on the investment in these programs makes calculus look like child's play. Our own projection is about $8 million savings over three years, but that is only about 1.3 percent of our cost each year and it is up against next year's projected trend of greater than 15 percent. These programs do no harm but will do only modest good. A real challenge with these programs is that, for any individual employer, it is difficult, perhaps impossible, to demonstrate that the investment is helping the employer and its shareholders. The problem is that, if I help an employee to be healthier, it may not serve our shareholders today but instead serve the shareholders of a company down the road, when the person leaves for a different job. The only real way to bring the value of broad-based wellness programs to the system is to install them on a

much wider community basis, an example of why the participation pool in general needs to be broadened.

One other thing to say about these wellness programs is that we actually receive complaints from employees when we aggressively promote the effort. Employees prefer to be left alone and they do not want to hear from some "insurance company." They wish to hear from their own physician. In fact, I have been working for several years on a project with the California Health Care Foundation investigating how to communicate with employees about evidence-based benefits and medicine. One of the clear things we have learned from that project is that employees do not wish to hear from their employers or their unions about health care. They wish to hear primarily from their own physicians, and that is understandable; and for employers to engage in the presumptuous theory that we can educate employees about how to behave in the health care system is questionable at best.

We have used health reimbursement accounts, but again, participation has been relatively limited; approximately 19 percent of the eligible employees participate. We have not used so-called consumer-directed health care plans or health savings accounts, although we have studied them carefully and we have watched their development. But frankly, we see them primarily as another means of cost shifting to employees and primarily as useful for the young, the healthy or the rich. From what I can tell by talking to my colleagues around the country, they work well only as a full replacement for all other health insurance alternatives, and our employees are accustomed to having choices in their health care plans. Frankly, we know how to drive employees from one plan

design to another. They will seek the lowest premium in droves every time and ignore the back end cost risks.

Again, employers can implement all the program and cost-control measures known to man and still end up facing the kind of deficit we are at Embarq this year. To sum it up: The problems are far larger and more complex than anything employers and employees can solve.

My views of the health care system overall

Let me turn for a few moments to the health care system itself. One thing I want to say about the interests involved in health care is that there really are no villains. Far too often, I hear employers somehow being cast as the villains. Without lecturing this distinguished panel, I do want to remind us all that employers' participation in health care in this country is an historical accident born of wage price controls during World War II. Most other countries have no such phenomenon. Over the years, while I have been on both sides of the issue, a substantial percentage, clearly a majority, of the creative things that I have seen done to try to contain costs have been done by major employers like General Electric, IBM, the auto companies and others. I like to think that my last three employers have been in those ranks.

I am fully aware that, when I offer a critique of the system, I am critiquing some of my own work and advocacy over almost a quarter of a century. Perhaps there is truth to that old saying that we get too soon old and too late smart. In any event, in the business world, when we engage in a new project, one of the very first things asked of us is to "benchmark," that is to study what others have done with respect to the issue at hand. Benchmarking our health care system against the rest of the world, as my father would

have said, is a "non-habit-forming activity." We spend more — more per capita, more as a percentage of the gross domestic product — than any other country, but our results demonstrably are among the worst among the western industrial democracies. To be sure, in this country, you can get the most sophisticated treatment for the most esoteric disease, and we can increase your odds of surviving something that you would not survive anyplace else in the world. The question we must ask ourselves is whether those individual outcomes can justify our societal investment. If we did a business case using the facts the health care system presents, no business I know would undertake the project.

There are some common fallacies that I would like to point out. One is that competition somehow will solve all our problems. I wish you could come with me to our corporate headquarters at the corner of Nall Avenue and Interstate 435 in Overland Park, Kansas. I can look out my 10th floor window and see half a dozen physician-owned or physician joint-ventured, stand-alone medical facilities. For some reason, which is not clear to me (perhaps simply our lack of certificate of need legislation), Kansas is one of the hotbeds of this sort of activity. The Kansas Health Policy Authority recently commissioned a study on the free-standing, largely physician-owned clinics. The facts are fairly clear. Competition has not driven down costs; it has driven them up. More to the point, the availability of these clinics inevitably causes increased usage. This industry is a classic example of "build it and they will come." It is the only industry I know of in which the laws of supply and demand are turned upside down. In health care, unlike what we were taught in Econ 101, supply drives demand rather than vice versa. Even worse, to whatever extent these facilities are successful, they take the highest-margin work from our community hospitals which, ultimately, most of us will need. The result is that the

community hospitals must increase their unit charges and in the end, we pay twice. When we were building our own provider networks and purchasing directly in the Kansas City area, we simply excluded these facilities from participation in our plans.

Nor is this a problem of cuts and scrapes or kids' visits to ERs (although ER visits by the uninsured are a problem). Like most of the systems, some 15 percent of our employees consume 85 percent to 90 percent of our health care dollars. Unfortunately, however, the 15 percent changes every year. Nearly three quarters of the expenses we incur are caused by chronic illness. In fact, we have about 10 percent of our population that does not have any medical spend year after year. We believe that if we are to solve this problem, we must have far more fundamental reform.

Reforming the system through evolutionary steps

I would like to talk about a few things I think we can do to move the system forward and I think it is non-productive to argue for blowing the system up and starting over. There simply are too many people and groups with vested economic interests. My friend, Dr. James Mongan, with whom many of you are familiar, likes to say that Americans are "raging incrementalists." Pardon the oxymoron but what he means simply is that we won't tolerate radical reform all at one time. I accept that as a given. We urgently do need, as I stated previously, at least four important things:

- Invest in our information technology infrastructure for health care.
- Establish national quality standards for health care.
- Adopt appropriate physician reimbursement incentives.
- Expand the participation pool as much as possible while allowing for policy experimentation at various levels.

Let me take those one at a time.

Investment in our IT infrastructure for health care

I have never seen an industry that has so resisted implementation of electronic systems. One hospital CEO actually told me a couple of years ago that they could not install a computerized physician order entry system because the doctors wouldn't learn the pass codes to get into the system. I told him he should get other doctors. We simply don't ask our staff whether they will learn their pass codes to get into our systems and no one could work for us without being technologically savvy. The variations and practice patterns, variations in diagnosis, and variations in treatment plans simply are irrational and unacceptable. We need the decision support tools developed on the basis of national standards. If we did telecommunications technology the way the health care industry has done its technology, we would be providing you tin cans with twine strung between them.

However, we should not put more money into the already bloated system. That means no new hospitals or and no new doctors' buildings. There is enough waste in the system to fund anything we need, including the complete digitization of the health care system, an improvement that could save billions more, and one on which we should insist. I am impatient with providers who acknowledge this need but want someone else to fund it. This afternoon I will get on a plane and return to Kansas City but I won't be paying extra for a plane that is equipped so it won't crash.

Establishment of national quality standards for health care

With respect to quality standards, I probably should not belabor things that are well known. Since the famous report from the Institute on Medicine, people have paid continuing attention to it and I actually think we are making some progress. Simply put

we should not pay for medical errors including so called “never events” and we need to agree upon ways to pay for quality more effectively.

Likewise, we should ban the age-old “Community Practice” language from our lexicon. That is a relic of medical malpractice litigation, and it gets us caught up in an assumption that things are different in the far northeast than in the far southwest. In fact, open-heart surgery should not be done differently in Bangor, Maine, than it is in San Diego, California. It should not be done differently for the minority population than it is done for the majority population. It should not be done differently for men and women (except, of course, to the extent that actual biological differences prevail).

I believe that physicians should develop recognized standards, and they should do it now. I was in a meeting a couple of years ago at the Institute of Medicine during which I witnessed a learned debate about the difference between a registry and a double-blind study and how it would take 10 years to complete a certain analysis. Quite Frankly, I told the very able people who deal with this academic issue that we can’t wait 10 years because those of us who pay for health care all will be broke in the meantime. That is true of much of what we do here. While many of the wonders we accomplish through our health care system are a result of rigorous academic discipline, the problems we face need to be resolved more quickly than normal academic discipline would call for. This is not about the Nobel Prize; this is about bankruptcy. Several years ago I was with my own personal physician, receiving a check up, and I attempted to have a conversation with him about designing our network and what we are required to pay. He told me that he didn’t want to be involved; he “hates HMOs” and he advised me to talk to his business people. I told him that was fine, but that if he did not want to be involved in making the decisions,

people like me would make them. I don't think that is the optimal answer, but if others decline the responsibility, they cannot be surprised when those of us who pay for the results choose to make decisions. By the way, not long after that conversation, we did revise our network and I needed to find a new primary care physician myself.

Revised appropriate physician reimbursement incentives

With respect to reimbursement incentives, I have some quite specific suggestions for you. We need physician reimbursement reform. The so called RBRVS "Resource Based Relative Value Scale" is outdated and inappropriate. Essentially, we pay the mechanics rather than paying the designers. If I paid my engineers less than I pay my field technicians I would be out of business. But we insist upon paying procedural practitioners more than we pay cognitive practitioners, that is those who design the care we provide to our patients. We also should be paying physicians in ways that will encourage efficient practice. For a small example, when I call my lawyer or send an e-mail, I begin paying her when she picks up the phone or when she opens my e-mail. I have no objection to that. However, many of our reimbursement systems refuse to pay physicians for similar activity. I am fortunate to have a personal physician who knows me well and who will engage me on that basis but he really doesn't get paid for it, and I think that is unfair. We also have to increase coordination of care substantially between and among the multitude of professionals who take care of us in any given incident of illness. Meanwhile, we need to squeeze practice pattern differences out of the system. Look no further than the groundbreaking Dartmouth work to see this problem in detail. I am not talking about "cookbook medicine" as some in organized medicine call it; I am talking

about the kind of decision support and consistency that all other professional disciplines seek and utilize.

Finally, I believe strongly that we need to arrest the growth in the system, particularly those specialty hospitals about which I spoke earlier. The way to find a hospital in the Kansas City metropolitan area is to look for the construction crane. Each not-for-profit hospital board believes it has the manifest destiny to provide for the health of the entire community. Unfortunately, none of them really can do that without coordinating what they do and build, and they end up duplicating facilities and providing their staff incentives to fill or otherwise utilize those facilities. We indeed need to put a stop to that.

Expansion of the participation pool and experiment

I hear from far too many people, including our employees that we should narrow risk pools, let people get "skin in the game," be personally responsible, and take care of themselves. I am persuaded that simply won't work and the extent to which we already have done it by creating around 46 million uninsured people helps demonstrate that it won't work.

During our work on health reform at the Kansas Health Policy Authority, we did a very detailed analysis of different sorts of reform initiatives. A couple of significant foundations paid for the services of an actuarial firm, Schramm-Raleigh of Phoenix, which did detailed projections. Among the things we asked them to do was to assess what we called "the mountain." In effect, we asked the consultants to price what it would cost Kansas to insure all its citizens, if we did it the way Embarq or Sprint or Boeing does — with a self-insured and self-administered plan that simply would provide care for

everyone who lived in the state. All of the other alternatives which we studied were calculated to decrease the future cost increases modestly. Only "the mountain" actually generated an overall decrease in projected costs, reducing roughly $800 million a year on an $8 billion base. Now this was not so much about who runs the system or how they run it, but rather about who is in it. While we did not seriously advocate this approach to the Kansas State Legislature, I think it is worth noting that the economics of the matter were quite compelling.

Frankly, I have no need to advocate a specific design alternative. We could have a federal answer; we could have a state answer; we could have regional purchasing cooperatives; and we even could have a robust individual market. Any of those is acceptable to me as long as it results in improving the care we deliver my employees and discontinuing the excess costs. It is my view that we must get everyone into the system, because, although I do not particularly like the insurance model as an intellectual way to approach the system, to the extent we use it, we must get everyone in the risk pool in order to be able to take advantage of both ends of the risk bell curve.

As we work to expand participation, we ought to encourage experimentation, until we come up with national standards and expectations. While I don't believe multiple state solutions will solve the problem, I do believe that our federal system was designed to permit, perhaps even encourage, states to serve as public policy laboratories to develop solutions to what may be national problems. Unfortunately, that has not worked well in the health care arena because of the impact of the Employee Retirement Income Security Act (ERISA). Now make no mistake, this was important and thoughtful legislation. It is ERISA that permits my company to provide nationally structured and funded benefits to

employees in 39 states, and I in no way wish to mitigate that salutary effect. However, I believe that we could construct a system for exemptions or "waivers" just like what has been done under the Medicaid program to permit state-level experimentation. Waivers could and should be constructed to allow multi-state employers to continue to provide benefits nationally. We are being responsible and we should not be penalized for that.

At the same time, ERISA has been used to dampen and interfere with all sorts of other less salutary activities. I am not talking about punitive state activity aimed at a single employer like we saw in Maryland. I don't believe that is productive activity. However, I have watched with interest as a variety of states, including my own, have addressed health reform alternatives and underlying every one of those health reform debates is the thread or the threat of ERISA. I simply think we are being short sighted if we resist all such experimental efforts. Carefully constructed waivers could protect what was intended to be protected by ERISA and still allow states to experiment in productive ways. While I believe strongly in adopting national standards and consistent national solutions, I believe that responsible state experimentation lead by groups like Robert Wood Johnson's State Coverage Institute can make a difference and might actually develop an ultimate national solution. With all due respect to the federal government, it actually could benefit from state-based or local experimentation. Massachusetts, San Francisco, even little Kansas might have things to teach us.

In the end, again, although I have views, it makes no difference to me what system is chosen. I have lived with different ones. However, unless we have fundamental reform, we are going to continue to drive employers out of the business of providing their employees with health care. We already have discontinued providing our retirees who are

over the age of 65 with health care support. They were not all happy about that, but we believe that the availability of Medicare plans allows them reasonable access to alternative coverage, and therefore, have reserved our retiree coverage to those under 65. Ultimately, if we don't have fundamental reform, employers will continue to send jobs overseas; they will move divisions overseas; they will do more business overseas — all of which will reduce the number of good jobs for Americans — while performing our fiduciary duty to protect our shareholders from irrational costs.

In conclusion

I am grateful to this distinguished committee for the opportunity to represent an employer's perspective on the need to reform the health care system in this country. The need is real and it is urgent. The current system impairs American business as it struggles to stay competitive with the rest of the world. It is enormously wasteful in a time when wastefulness can kill an economy. Many of the system's processes, practices and business models are inexcusably archaic when compared to the state-of-the-art medicine it is intended to deliver. If we can:

- Invest in our information technology infrastructure for health care
- Establish national quality standards for health care
- Adopt appropriate physician reimbursement incentives
- And expand the participation pool as much as possible while allowing for policy experimentation at various levels,

Then I believe we can put the U.S. health care system on an evolutionary path toward the noble purpose for which it originally was conceived. Thank you very much. I will be pleased to answer any questions the committee may have.