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HEALTH CARE: Hillary Remarks on Reducing the Cost of Health Care

Click here to read Hillary's plan to lower health care costs.

Well, thank you very, very, much. I am delighted to be back at GW and I want to thank President Trachtenberg for his kind introduction, but he and his wife Francine have been leading advocates on behalf of higher education and so many other issues for as long as I've known them, and that goes back many years. And as Joel said, we shared the experience of our children in high school, and that was indeed an experience we both survived, so we're grateful to tell the tale.

I want to thank Dr. Williams, and, of course, Dr. Becker. I want also to recognize Russ Ramsey, the chair of the board, Dr. Scott, Dean of the Medical School and the CEO of GW Medical Faculty Associates, Stephen Badger. It is an honor to be back at GW in order to talk about one of the most important issues facing the health care community, and of course, our country.

As I travel around America, I have talked with people from all walks of life about the challenges that our country is facing: from ending the war in Iraq to ending our dependence on foreign oil -- from improving our education system to reducing our deficit. And no matter where I go or with whom I talk -- whether it's small business owners or CEOs, doctors or nurses or patients -- I hear growing concern about the crisis in our health care system: exploding costs, declining coverage and shortcoming in care and prevention.

Now, I've tangled with this issue before -- and I've got the scars to show for it. But I learned some valuable lessons from that experience. One is that we can't achieve reform without the participation and commitment of health care providers, employers, employees and other citizens who pay for, depend upon, and actually deliver health care services. I think we finally have a recognition that everyone sees there is an economic imperative to rein in costs. There is a moral imperative to extend coverage to all Americans. And, there is a practical necessity to promote wellness and prevent illness wherever possible. I plan to put those lessons to work to ensure every single American has quality, affordable health coverage.

There are three parts to my approach. First, lowering costs for everyone. Second, improving quality for everyone. Third, insuring everyone.

Today, I will focus on the challenge of lowering costs.

Health care costs are spiraling out of control. Premiums have almost doubled since 2000 -- increasing four times faster than average wages.

Every day, parents choose between paying the premium for themselves or their children. Small businesses wonder how they will stay afloat when their health care costs eat up their profits year after year. CEOs of major American companies worry about how they will succeed in the global economy when they're competing with foreign companies that spend significantly less on health care.

We spend 16 percent of our gross domestic product - $2 trillion -- on health care. And by 2016, health costs are scheduled to exceed $4 trillion, or almost 20% of GDP.

That means that within less than 10 years, 20 cents out of every dollar produced in America will be spent on healthcare. No other country spends more than 12%, a difference of more than $500 billion. All other wealthy countries spend even less. We spend $5,711 per patient. The next highest spending country, Switzerland, spends $3,847 on patients. Yet, they cover every single one of their citizens and have an average life expectancy that is three years longer than ours.

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Now, how have our costs spiraled out of control like this? Well, about 30% of the rise in health care spending is linked to the doubling of obesity among adults over the past 20 years. In other words, if our obesity levels had remained at 1990 levels, we would be spending 10% less on health care today -- a savings of $220 billion. About two-thirds of the rise in health care spending is associated with a rise in the prevalence of treatable disease - like diabetes, asthma and heart disease. 75% of all health care spending -- roughly $1.5 trillion -- is associated with the 4 to 5 percent of patients who have multiple chronic illnesses and require ongoing medical management over a period of years, or even decades. And 10-12% of the total health care budget is spent on end of life care.

Our administrative costs are by far the highest in the world. Today more than one in four health care dollars goes to administration. 64% of private insurance plans' administrative costs are dedicated to underwriting health risks, sales, and marketing. Every man, woman and child in America spends $412 on health care administration, nearly six times as much as other countries. According to a recent report by McKinsey, the United States spends 98 billion more than other countries on excessive administrative costs that have nothing to do with delivering good health care.

Too much of the money we spend is wasted on care that doesn't improve health. A study in Santa Barbara, California found that one out of every five lab tests and X-rays were conducted solely because previous test results were unavailable. A recent study reported in the Atlantic Monthly found that for two-thirds of the patients who received a $15,000 surgery to prevent strokes, there was no compelling evidence that the surgery actually worked.

At the same time, in situations where the benefits of intervention are clear, many patients still don't receive the care they need. A recent study in The New England Journal of Medicine found that, overall, Americans get needed care only 55 percent of the time.

If we spend so much, why does the World Health Organization rank the United States 31st in life expectancy and 40th in child mortality -- worse than Cuba and Croatia?

Our health care system is plagued with under-use, overuse and misuse. It is, simply put, broken. As President, I will make it my mission to fix it, starting by helping the 250 million people with public or private insurance who face skyrocketing costs, inadequate care, and bureaucratic obstacles to coverage.

Today, I'm announcing a seven point plan to lower health care costs for all American and again to make our healthcare system, without doubt from any corner, the best in the world. Building a national consensus around these cost savings is the first crucial step to cover all Americans with quality, affordable healthcare.

First, we're going to focus on prevention -- on wellness, not just sickness. Under my reforms, all Americans will have access to comprehensive preventive care, which will save money in the long run.

Today, we pay doctors and hospitals to treat diseases and injuries, but not to help prevent them from occurring in the first place. Only 38 percent of adults receive recommended colorectal screening, and roughly 20 percent of children do not receive recommended immunizations. In fact, our country spends only an estimated 1 to 3 percent of national health expenditures on preventive health care services and health promotion per year. That is about the same percentage we spent in the 1920s.

For example we have many more adults and young people being diagnosed with type 2 diabetes. While, the costs of caring for them are increasing exponentially, many insurance companies won't pay for someone who's pre-diabetic or who's been diagnosed with diabetes to go to a nutritionist to learn how to eat properly, to get

preventive medicine or to go to a podiatrist to have their feet checked. But the companies will pay if you have to have your foot amputated. The insurance companies will actually tell you they don't want to pay for preventive health care because the patient might change insurance companies, and the original company won't get the benefits of the money they invested. But if a patient's doctor tells them that a foot needs to be amputated, well the company is kind of stuck with that. Talk about a system that is upside down and backwards.

We clearly need a new approach. We know we can save money if we give insurance companies incentives to cover preventive care and wellness services -- and my plan will do exactly that. Keeping people healthy today will not only keep our costs down in the future, but improve quality of life as well.

We know that preventive care works. I could cite thousands of examples, but just consider the following: The incidence of diabetes was 58 percent lower among adults with elevated blood sugar were enrolled in a lifestyle intervention program than the control group that was only given drugs. Among those aged 60 and older the reduction was 71 percent. And some of the research that was done leading to these outcomes was right here at GW.

Or look at what the private sector has tried to do. Safeway has made a conscious decision to focus on prevention. It pays 100% of all appropriate preventive care services, and it offers a 24-hour hotline staffed by registered nurses, and provides services to help people manage chronic conditions and incentives designed to promote healthier lifestyles.

Again, the results speak for themselves. While average costs went up 7.7% across the country. Safeway its health care costs will be flat. And they aren't the exception: Motorola's wellness initiative showed savings of almost $4 per every dollar invested.

Under my plan, all insurers who are already participating in a federal health program like Medicare or Medicaid or the federal employee's health benefit plan will have to cover prevention as a condition of doing business with the Federal government. Insurers would encourage both individuals and providers to use prevention services by paying for benefits like cancer screenings and immunizations.

My plan also pools and coordinates federal spending on prevention to help redeploy high-priority preventive services. Working in collaboration with the private sector, this initiative would pay for preventive care initiatives in schools, workplaces, supermarkets, churches, communities. It would fund and train new health prevention outreach workers, who understood the language, understood the culture of various constituencies around our country. Now, we still have so many people, and I'm sure you see it in the hospital, who come in unable to speak English, often times bringing a child to interpret. And we're just not doing a good enough job in getting information broadly available to people who need it.

Now, of course, you can have the best insurance plan in the world, but if you don't take the medicine your doctor prescribes, or follow lifestyle advice your doctor recommends, you aren't going to improve your health. If we're going to reduce costs through prevention, all of us all must take responsibility for taking better care of ourselves and I will have more to say about that later.

The second way to bring costs under control is to bring our health care system's record keeping into the 21st century, finally leaving behind paper records and outdated, obsolete, 20th century information technology. Right now, if you're rushed to a hospital with a medical emergency, they may not be able to access your medical history or to find out what medications you're taking, what surgeries you've had -- or even what your blood type is. Electronic medical records would change that.

This is also important in the event of catastrophes. After Katrina, medical records were under water, never to be recovered. A lot of people who were taking prescription drugs who fled their homes or were rescued didn't even know the names of the drugs they were taking. Only, those who had been buying drugs from drug stores that had electronic medical records could immediately access to find out what the drug was and what the prescription should be.

Modernizing our system will improve quality of care and reduce costs. Today, processing paper claims costs an average of $1.60 to $2.20 per claim. It costs 85 cents for an electronic claim. A RAND study found that, as a nation, we could save more than $77 billion annually through the widespread use of electronic medical records, and these savings could double with the addition of prevention and chronic disease management. If the use of information technology impacts our health care system as much as it has impacted other sectors of the economy, like for example, the wholesale and retail industry, we could see savings as high as $346 billion annually or over 15% of health care spending.

There is no reason why people's health files -- their test results, lab records, X-rays -- can't be stored securely and confidentially on a computer file accessible from a doctor's office or hospital. In fact, if all hospitals used a computerized physician order entry system, an estimated 200,000 fewer adverse drug events would occur, saving roughly $1 billion per year.

We can also use information technology to disseminate research. A government study recently showed it takes 17 years from the time of a new medical discovery to the time clinicians actually incorporate that discovery into their practice at the bedside. Why not 17 seconds, the moment we know the discovery improves care?

The Veterans medical system provides a perfect example of a fully automated health information system that supports the needs of patients, clinicians, and administrators. Its computerized patient record system (CPRS), contains every detail of a patient's health record, including laboratory test results, medical images, bar code medication administration, progress notes, and appointments, all accessible from anywhere within the VA system.

The VA started modernizing its programs in 1993, using health IT as well as other care management techniques. And it delivers some of the best quality health care in the United States with amazing efficiency. Between 1999 and 2003, the number of patients enrolled in the VA system increased by 70 percent, yet funding (not adjusted for inflation) increased by only 41 percent. So the VA has not only has become one of the health care industry's best quality performers, it has done so while spending less and less on each patient. Health care spending per capita averages, as I said, over $6,300 in the U.S.; at the VA, however, the per-patient cost is $5,000, and 20% lower than the national average, even though the average age of a VA patient is 60.

Last year I was at the hospital here at GW announcing legislation that has since passed the Senate that promotes the use of information technology so we can end the paper chase, limit medical errors and reduce the number of malpractice suits. It would allow us to use IT to develop a nationwide, interoperable system, to streamline our healthcare costs, and, I believe, reduce errors as well. Now, I'm proud of my legislation, we didn't get it passed in the House last year, we're going to try again this year. But if we don't get it passed, I will have it as one of my highest priorities as President. I'm going to build on that legislation by requiring health providers that participate in federal programs, which is nearly all of them, to adopt private, secure, and interoperable technology. And to help hospitals and doctors modernize their systems and promote the widespread adoption of health IT, I would invest $3 billion a year in grants to help ramp up the system. No more yellowing paper records -- no more trying to decipher messy handwriting.

Third, we're finally going to coordinate and streamline the care our chronically ill patients receive. Americans with chronic disease such as heart disease and diabetes account for an astonishing percentage. When I first saw this, I couldn't believe it---- that it was 75 percent of our national health care expenditures. And improving the quality of their care will help limit costs, and improve health.

To that end, I propose establishing medical "homes" similar to those operating right now in Oregon. Dr. David Dorra, a primary care physician, spoke at the Senate Aging Committee, on which I serve, two weeks ago about the success of these medical homes. He told the story of a patient, Ms. Viera, a 75 year-old woman in Oregon who suffered from five chronic illnesses, including diabetes, high blood pressure, and mild congestive heart failure. She also had difficulties remembering what bills to pay and

what pills to take.

Now, in most clinics across this country, Ms. Viera would receive care from qualified, capable doctors and nurses. But her care would likely not be coordinated -- her providers wouldn't be talking to each other, making sure that the treatments they were prescribing were working together. This ends up raising costs and increasing the chances that she will suffer complications or end up back in the hospital. Anyone who has ever tried to coordinate their own care, or the care of a loved one, knows that this is all too common situation.

Fortunately, her care was addressed comprehensively through Care Management Plus in Oregon, an IT system with trained care managers in primary care clinics to treat older adults with complicated conditions. She's is in good hands. Her care managers and her primary care physician addressed her symptoms early, preventing problems rather than treating them after they occurred. And she is helped to navigate the system.

Under this program, seniors with complex diabetes have had a 20 percent reduction in mortality, a 24 percent reduction in expensive hospitalization, and up to 42 percent improvement in control of their disease.

Every patient should have access to a system with outcomes like that. That's why my proposal would require that Americans with costly, hard to manage illnesses have access to state-of-the-art chronic care coordination models under federally-funded plans, like Medicare and the Federal Employees Health Benefits (FEHBP) plan. This proposal would permit multi-specialty clinics (GW, Mayo Clinic, Johns Hopkins, Partners Healthcare), provider-sponsored organizations and private plans to bid on and provide services such as care coordination amongst and between providers, drug management, diet and exercise control and the promotion of individual patient responsibility.

We know that this coordinated care model would result in significant cost savings. A recent RAND study concluded that chronic disease management, preceded by prevention and backed by information technology, could save $147 billion annually. Another study found this model could reduce the cost of diabetes care alone by 3 percent, saving us $4 billion dollars.

Fourth, my plan will offer will offer individuals and small businesses market access to larger insurance pools that will lower costs and end insurance company discrimination against people with pre-existing conditions. As part of a plan for universal coverage, which I will discuss in detail in the coming months, we would create large insurance pools that lower administrative costs for small businesses and individuals by spreading the risk. In a system of universal coverage insurance companies cannot as easily shift costs through cherry picking and other means.

In fact, according to a recent McKinsey report, insurance companies in America spend tens of billions a year figuring out how not to cover people -- doing complicated calculations to figure out how to cherry pick the healthiest persons, and leave everyone else out in the cold. That is how they profit: by avoiding insuring patients who will be "expensive" -- and then trying to avoid paying up once the insured patient actually needs treatment.

I see this all the time. My office spends countless hours arguing with insurance companies to get my constituents the health care they have paid for. For example, a father called me from northern New York -- his son had a rare illness. Now he and his son were well insured. He'd worked for many years for the same employer who provided a good policy. But when his son needed a special operation -- that could only be performed at one place in the country -- the insurance company said, sorry, that's out of network, we're not going to send you to have that done.

So my office intervened. And in the end they got permission for the operation. But I don't think people should have to go to their United States Senator to get their insurance company to give them what they've paid for.

As President, I will end the practice of insurance company cherry-picking once and for all by allowing anyone who wants to join a plan to do so and prohibiting insurance

companies from carving out benefits or charging higher rates to people with health problems. I also will call for rating reforms to ensure that older and other vulnerable populations are not discriminated against. The whole point of insurance, lest we forget, is to spread risk across a group of enrollees. It's one of the reasons that the administrative costs of Medicare are so much lower; because they are actually insuring everyone. Everyone is in the pool, and we have to figure out how to better control the costs within Medicare but they start with an advantage because they have such a considerably lower administrative cost.

Finally, insurers would be required to prove they were spending much less on marketing and schemes to avoid providing insurance to high-risk Americans, and more on direct care-giving. Now most businesses and some states have become tough purchasers of health insurance, insisting on fair marketing and cracking down on high overhead. We should follow their lead. One of the things I've advocated now for 14 years is a common vocabulary and a common form that every insurance company must use. This sounds like a pretty common-sense idea---so you can actually compare and contrast what you're paying for---but when I proposed in back in '93 and '94 it was, shall we say, vigorously objected to. Because we need more transparency and we need that common vocabulary in order to get costs down, and that's opposite of what the insurers want to happen. By insuring all Americans through accountable public and private plans, we can get rid of administrative costs that do nothing but add to insurance companies' bottom line. In such a reformed system, risk would be widely spread and we could reduce administrative costs by as much as $20 to 30 billion a year.

Fifth, I will work to improve the quality of care which will also help us drive down costs. I'll start by establishing an independent public-private Best Practices Institute. This Institute would be a partnership among the public and the private sector, to finance comparative effectiveness research, so that doctors, nurses and other health professionals -- as well as consumers and businesses -- would know what drugs, devices, surgeries and treatments work best. This would reduce the use of inefficient and ineffective treatments, and I believe that it would have tremendous benefits because we could get evidence-based medicine into the bloodstream of the country much more effectively. I spearheaded a similar proposal to authorize the Agency for Healthcare Research and Quality to start doing research on comparative effectiveness at the Department of Health and Human Services. Eight reports have been released and dozens more are underway.

One of the things they're finding is a lot of these so-called "blockbuster drugs" are no more effective, and sometimes less effective, in treating conditions than old standbys that have been around for a long time, and don't have all the advertising of, you know, people running through fields of wildflowers that convince patients that they need the new drug, as opposed to the one that has worked well.

Too often, doctors and patients don't know which medical interventions are most effective -- and which have little benefit. A recent study by Dartmouth researchers shows that close to one third of the $2 trillion we spend goes to care that is duplicative and fails to improve patient health -- in fact, the researchers posited that it may even make health worse. More care is not necessarily better care, and inefficient care may do more harm than good.

My plan will provide incentives to encourage doctors to keep up with the research and prescribe the most effective treatments. The University of Michigan and Pitney Bowes are doing just that -- linking out of pocket drug costs to clinical benefit for patients. The more effective the medication, the less that patient has to pay for the drug. As of 2005, Pitney Bowes had saved more than $3.5 million dollars using this method.

Another innovative idea is the Geisinger Health System's suggestion of a medical warranty: it charges a flat fee for surgery that includes 90 days of follow-up treatment. Currently, there is little incentive to seek out the most effective treatments, because if a treatment regimen or surgery doesn't work, the patient simply returns for more costly treatments. The warranty is an incentive to do it right the first time, because there is no extra billing if more care is needed. Geisinger doctors have identified 40 essential steps to bypass surgery, and they've established

procedures to ensure they're always followed.

The Best Practices Institute will empower with information and evidence those who have to make the decisions. It will not only be beneficial with respect to pharmaceuticals but also medical devices and even practice protocols and I think that it will give a lot of doctor's ammunition against insurance companies, drug companies and even sometimes patients about what works better than other options. The Oregon drug effectiveness review founded by Governor John Kitzhaber in 1999, is a collaborative partnership between states and non-profits that conducts reviews of widely used drugs to promote the most effective ones. North Carolina has used such reviews to educate providers, saving the state an estimated $80 million in 2003 alone. Now I can't extrapolate how much we would save as a nation, but I believe it would obviously be in the billions.

Sixth, if we want to get health care costs under control, we need to get prescription drug costs under control. We know that Americans pay the highest prices in the world for prescription drugs that we have already in most instances funded the research on funded the clinical trials on, done the FDA evaluation of, then we put it into the market place and we end up still paying the highest prices . Studies have shown that brand drug prices are 35 to 55 percent higher in the U.S., and top-selling medications a full 2.3 times more expensive compared to other industrialized countries. Over the past decade, prescription drugs accounted for 15 percent of the total increase in health spending, even though they account for only about 10 percent of what other countries spend.

Let's start getting drug costs under control by allowing Medicare to negotiate for lower drug prices and to lower those costs for everyone. We also have to crack down on the overpayments in Medicare to private plans. These Private plan payment rates are around 12 percent higher than Medicare traditionally pays to treat the same beneficiaries. Reducing these overpayments could save Medicare $10 to $20 billion dollars a year. Seniors don't want to lose the benefits they have under these plans, but under my reforms they would not.

We should also allow the importation of drugs from certain countries to lower costs and let's remove barriers to generic competition. While 53 percent of all prescriptions are generic medicines, they account for only 12 percent of total pharmaceutical costs. A one percent increase in the use of generics could yield $4 billion dollars in government savings.

We need to break the monopoly that biotech pharmaceutical companies have over their products, which can cost us so much money. Most Americans have no idea that right now, under current law and FDA practice, generic biopharmaceuticals are precluded from going to the market. And businesses and consumers are paying for that. You know the cost differential between generic and non-generic drugs is astounding: in 2003, the average cost for a one-day supply of non-generic drugs was $45.00, but only $1.66 for generic drugs.

There is bipartisan support for providing the long overdue authority for the FDA to approve generic products that are the biologics. Already, an unprecedented coalition of patients' groups, labor, business, pharmacists, governors and a number of forward looking biotech companies have united to support legislation that I introduced with Senator Charles Schumer and Congressman Henry Waxman. Providing such competition is projected to save $5 to $7 billion dollars a year in savings to businesses and consumers.

The final point that I would make today about lowering costs is to reduce costs through medical malpractice reform. While some have overstated the role that malpractice insurance plays in the health care crisis, I think we can all agree that we need reform that works for doctors and patients alike.

I have offered one solution that has been used successfully at the University of Michigan Hospital system. It's called the National Medical Error Disclosure and Compensation (MEDiC) Act as I have borrowed it from the University of Michigan to put it into law. It's a novel approach to improving patient safety and the quality of health care while protecting patients' rights, reducing medical errors and lowering

malpractice costs. This Act would encourage physicians, hospitals and health systems to provide liability protections for physicians who disclose medical errors to patients and offer to enter into negotiations for fair compensation. At the University of Michigan, these policies have already resulted in greater patient trust and satisfaction, more patients being compensated for injuries, fewer malpractice suits, significantly reduced administrative costs and between one and three million dollars in litigation cost savings.

The rise in malpractice rates has spurred states like Texas and Nevada to allow doctors to create their own risk retention companies as an alternative to traditional liability insurance. Because a large percentage of actual malpractice is committed by a very small percentage of doctors who won't be included in insurance groups that other doctors control, thereby lowering malpractice rates for all.

Now as I have made clear in these seven points, we know that if we continue on our present path, health care costs in the U.S. will double within a decade, we know that we will spend increasing amounts and we aren't sure, and I think it is fair to say we know, that we won't improve quality and outcome.

Now how will this actually work? Well it has to be implemented over time according again to Rand who has been studying healthcare costs intensely now for several years. We could save $147 billion dollars from the information technology changes I have recommended, $20 to $30 billion dollars in administrative savings every year, $25 billion in savings from overpayments for pharmaceuticals and health plans, and there are billions more in countless other inefficiencies that could be rung out of our often wasteful health care system. We also will have to move toward a system where it is doctor-patient centered and consumer driven if we expect to really get the results that we need. Now there is no question that at least $120 billion dollars in projected savings that I have included in my plan are not only reasonable, but extremely conservative.

Now I know that a lot of this is kind of overly wonky, which is why I am glad there is an audience of people here today who really understand a lot of these issues, but I imagine, you know, many people wonder what all this adds up to. Well the Business Roundtable has recently estimated that just with a system that used information technology, the typical family would save $2,200 dollars, and I think that is a pretty impressive outcome for us doing what we need to be doing anyway.

The money we save from the waste we eliminate and the way we change how we care for people should be used to help finance coverage for the 45 million Americans who have no insurance. Also, when you insure everyone, it will maximize the impact of the prevention programs I have recommended -- with earlier care as opposed to emergency care -- as well as cutting administrative costs.

Our present system is outdated, ineffective, and unsustainable. We know how to do this. Many of you in this audience could give me ten more suggestions that we need to do immediately. Well the key is to develop the political will to make it happen through a coalition of those who are most directly affected. The people who deliver care, our doctors, our nurses our pharmacists and others, the people who pay for care, our business and our government and the people who receive care which is all the rest of us, because I know very well that every one of these recommendations will run into considerable opposition from forces that do not want change in our system.

So I believe that equally importantly to having a plan, we have to have a political consensus and that is what I am trying to develop as I talk about healthcare and engage in a conversation with the American people because I think Americans are ready for change. They are ready for a healthcare system that produces better results at lower cost and ends the shame of us not covering 45 million plus of our fellow Americans.

I look forward to your ideas about how we can pursue these goals and I hope you will join with me in being part of this broad based, national coalition that will not only talk about and demand change, but work to make sure, starting in 2009, that our political system actually delivers the changes we all know our healthcare system desperately needs.

Thank you all very much.