Testimony of William Vaughan
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before the
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
June 24, 2009

on

The Tri-Committee Draft Proposal for Health Care Reform: Pharmaceutical Provisions

Mr. Chairman, Members of the Committee:

Thank you for inviting Consumers Union to testify on the pharmaceutical aspects of the Tri-Committee Draft health care reform proposal.

Consumers Union is the independent, non-profit publisher of *Consumer Reports.*[1] We not only test consumer products like cars and toasters, we evaluate various health products, and we apply comparative effectiveness research that can save consumers hundreds and even thousands of dollars in purchasing the safest, most effective brand and generic drugs.[2]

> --Since 1939 we have been advocating for an affordable, secure, quality health insurance system for everyone. That year, Congressman Dingell, we endorsed your father's bill, the Wagner-Dingell Act.
>
> --Our May 2009 issue features an article on "hazardous health plans," and points out that many policies are "junk insurance" with coverage gaps that leave you with a financial disaster. One of the most prevalent stories we have heard from our readers is that they thought they had good insurance—until they had a major health problem, and then it was too late.
>
> --Our about-to-be-released August issue includes a 10-page special editorial feature, using examples of families across the country, on why American

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[1] Consumers Union, the nonprofit publisher of *Consumer Reports*, is an expert, independent organization whose mission is to work for a fair, just, and safe marketplace for all consumers and to empower consumers to protect themselves. To achieve this mission, we test, inform, and protect. To maintain our independence and impartiality, Consumers Union accepts no outside advertising, no free test samples, and has no agenda other than the interests of consumers. Consumers Union supports itself through the sale of our information products and services, individual contributions, and a few noncommercial grants.

[2] See www.ConsumerReportsHealth.org/BBD

consumers so desperately need comprehensive reform. We've attached a copy of this special issue.

Tri-Committee Draft

Therefore, we strongly endorse the approach taken in the Tri-Committee draft, assuming that additional cost containment or progressive financing will be added to ensure that it is budget neutral.

We believe the Draft is a plan that would at long last ensure access to affordable, quality, "peace of mind" health insurance for every American.

The Draft has too many major improvements to list separately. In Attachment I, we provide a table that lays out our health reform principles from our August magazine issue, and how the Draft would dramatically advance these key consumer issues. Attachment II includes a few suggestions to make the Draft even better, but these are minor suggestions compared to the important reforms proposed in the bill.

The Need for More Savings

The American people are desperately worried about the high—and rapidly inflating—cost of health care. Our national polls have frequently shown that the high cost of health care is one of the greatest concerns for consumers, and many fear they would be bankrupted if a major medical problem hit their family. Climbing health costs threaten our national future. Last week The Economist (June 13-19) editorialized the issue well:

> "America has the most wasteful [health] system on the planet. [America's] fiscal future would be transformed if Congress passed reforms that emphasized control of costs as much as the expansion of coverage that Barack Obama rightly wants."

The Draft bill has done an excellent job in identifying big and small savings, but more needs to be done in this bill.

Why?

--The Draft includes the vital reform of requiring private insurance to be guaranteed issue with no pre-existing conditions;

--These needed reforms will only work for private insurers if everyone has to buy health insurance (and can't just wait till they are sick, and then buy it);

--We can't mandate that people buy insurance unless it is a good product and is affordable;

--Many unemployed, lower-income, and working Americans will need subsidies at least to the 400% level for the mandated insurance to be affordable;

--The subsidies cost money, and in a budget neutral bill, that means finding savings or finding taxes.

--The documentation is overwhelming that our health care 'system' is very inefficient and that enormous savings are possible. Thus we hope you will make savings a priority.

Pharmaceuticals in the Draft

We endorse the pharmaceutical changes you have proposed, but many additional savings have been left on the table and should be re-considered. We especially urge you to consider reforms that will answer the industry's favorite lobbying technique—that if you question our profits, we won't do any more research. The fact is that the drug industry is not doing enough efficient, effective research on breakthrough life-saving medicines.[3] Congress can achieve savings that also focus more resources on important breakthroughs.

PhRMA's Pledge

We note the recent reports that PhRMA has agreed to find $80 billion in savings over the next decade in drug discounts, largely to fill in the Medicare Part D donut hole. If true, that is good news. It is a major step forward and we congratulate PhRMA.

But as Ronald Reagan said so often, 'trust but verify.'

Some of the Members were here for the Carter-era fights over hospital cost containment. The hospitals defeated containment legislation by pledging to hold costs down. Congress trusted them. The public was betrayed.[4] The thought of trusting a savings pledge from a for-profit trade association (assuming that PhRMA can get past the anti-trust issues) is like watching Lucy holding the football--you know what's going to happen.

Therefore we hope you will legislate the policies on which the pledge is based in a CBO-score-able way. If the savings off baseline are not achieved, company-specific rebates to Medicare, Medicaid, and the Health Insurance Exchange could be legislated. For companies that fail to meet the savings for ERISA/private sector plans, various tax breaks could be reduced (and the savings placed in a compensation fund for the health plans).

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[3] FDA data shows that only about 15 percent of new drug approvals are for breakthrough or new molecular entities. The rest are 'me-too' type drugs that bring some competition to the marketplace, but generally little or no medical advance.

[4] Karen Davis, Commonwealth Fund, May 26, 2009, "Bending the Health Care Cost Curve: Lessons from the Past": "The [hospital] coalition set a 1978 goal of reducing the rate of increase by 2 percentage points below the 1977 rate of increase; that goal of 13.6 percent increase in 1978 was met. All subsequent goals, as well as goals related to holding down increases in the number of beds and employees, as well as increases in capital investment were substantially exceeded...."

Pharmaceutical Provisions in the Draft

Comparative Effectiveness Research (CER)(page 423ff):

We strongly endorse the AHRQ-based CER Trust Fund that, when fully operational, will provide $375 million a year for this key safety and efficiency research.

Attachment III is a sample of our Best Buy Drug work on proton pump inhibitors (anti-heartburn medicines). The CER data is from the Oregon Health and Science University. As you can see, several of the medicines are very similar. But one is 1/10 the cost of the heavily advertised brand drug. As a consumer, why not prefer the $20 a month drug rather than the $200 a month product? If it doesn't work, after talking to your doctor, try one of the others. This is what CER can do to help hold down costs. Clearly, in this example, most of us could save $180 a month.

Many are worrying that comparative effectiveness research (CER) may lead to limits of what is covered. We believe CER will help us all get the best and safest care. It makes sense to give preference to those items which objective, hard science says are the best, especially if the research takes into consideration relevant differences such as gender, ethnicity, or age. But if a drug, device, or service does not work for an individual, then that individual must be able to try another drug, device, or service without hassle or delay. The key to this is ensuring that the nation's insurers have honest, usable exceptions processes in place. A "model exceptions and appeals"-type legislative effort is where we should be putting our energy to address the otherwise legitimate concern of many people about CER.

Physicians Payments Sunshine Provisions (page 560ff)

Including this anti-fraud type provision in the bill should score for savings and reduce the level of unsavory 'gifting' that is flooding the medical world. In recent years, there has been phenomenal growth in various forms of financial transfers to those doctors and hospitals who are responsible for ordering drugs, devices, and supplies. These financial incentives are given many names and justified in many ways, but we all know 'there is no such thing as a free lunch.' These financial 'gifts' are designed to encourage, subtly and not so subtly, the increased use of the givers' products.

When disc jockeys were given gifts by record companies, it was called payola—and it was a scandal. It should be equally disturbing to patients and health policymakers to see so much money transferred to physicians and hospitals, because it can distort medical judgment and increases utilization of the most expensive products which are not necessarily the best products.

Closing the Doughnut Hole Division B, Section 1182, p. 307):

We strongly support closing the Medicare Part D donut hole. Congress took a major step by enacting a prescription drug benefit. But it can be made better. Beneficiaries in the donut hole—this year a gapping hole of over $3400—frequently stop taking their medicines or cutback on doses. The health of some of our most vulnerable beneficiaries could be improved by closing this gap. The Draft takes about a decade to achieve this, and with additional resources (ideas described below), we hope you could end this insurance anomaly sooner.

Improving low income access to medications: Division B, Title II, Subtitle A (pages 316ff). These sections which raise asset tests and make it easier to enroll in the low-income subsidy programs will make a major difference in the ability of the most vulnerable to take advantage of the promise of Part D and actually obtain their medications.

Protecting Medicare Part D beneficiaries from mid-year formulary changes (Division B, section 1185, pages 312-313): We support this section permitting beneficiaries to switch plans if the plan makes formulary changes that impact the enrollee. In our monitoring of the program, we have found that a much more serious problem is year-long price increases in various drugs that can badly disrupt a senior's budgeting plans. These often dramatic price increases appear to be a form of bait-and-switch. We urge you to consider an amendment that if the price of a drug increases by more than X percent of the advertised price during the open enrollment period, then the beneficiary may switch plans.

Drug rebate reforms in Medicaid and Medicare (Division B, Sections 1842, 1843, and 1181; pages 708ff): These sections achieve major savings of about $20 billion over ten years in Medicaid and in the Medicare dual eligible programs.[5] These changes seem very appropriate, particularly closing the loophole whereby a minor change in a drug can cause it to be treated as a new formulation that is exempt from rebates owed because of excessive inflation. Rebates on Medicaid and dual eligibles in Medicare managed care plans will also correct for the fact that Medicaid plans do not seem to be obtaining the same level of savings as the Medicaid program previously obtained directly from the companies.[6]

Additional Savings to Consider

Stop Brand Company payments to Generic Companies to delay entry of generic drugs (reverse payments); Eliminate other Brand-Generic abuses such as 'authorized generics.' CBO should score Congress with billions in savings if the current Hatch-Waxman Act abuses identified by the FTC and independent researchers are stopped. HR 1706 (by Rep. Rush and 7 others on this Committee) should be included in the reform package.

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[5] CBO, Budget Options, Volume I,: Health Care, pages 138-143.

[6] Center for Health Strategies, Inc., "Comparison of Medicaid Pharmacy Costs and Usage Between the Fee-for-Service and Capitated Settings," January 2003. Also, the Lewin Group, "Extending the Federal Drug Rebate Program to Medicaid MCOs: An Analysis of Impacts," May, 2003.

Create a pathway for follow-on biologics (FOBs). A way must be found to end the endless monopoly that now exists for biologics. They are an increasingly costly and inflationary part of the health care economy. We have endorsed Chairman Waxman's bill (HR 1427). CBO clearly shows that huge savings are possible in this field.

If agreement cannot be reached on the period of exclusivity, then other ways should be found to help consumers and taxpayers obtain savings. The June 2009 MedPAC report discusses the idea of reference pricing[7] or payment for results, where a drug's payment is linked to beneficiaries' outcomes through risk-sharing agreements with manufacturers.

We note that the MedPAC report says that the EU's FDA had approved as of last June more than ten FOBs[8]. Medicare could achieve billion dollar-a-year savings if the U.S. FDA certified that these EU biologics were safe and were not causing adverse events and if their importation were permitted.

Promote research while controlling costs: Require drug rebates to Medicare for drug inflation in excess of population and CPI growth, <u>except</u> no rebates would be required on new breakthrough drugs (as defined in the FDA approval process), thus controlling costs while encouraging drug innovation. Under this proposal there would be a cap on growth in spending on pharmaceuticals, but it would reward companies that had the most truly innovative products.

Help consumers and advance comparative effectiveness research: Amend the FDA laws to require that new drugs be tested against the best practice in the field, not just against a placebo;

Re-importation: After ensuring safety, permit the importation of drugs (Berry, et al, HR 1298), including biosimilars;

Permit Medicare to negotiate on drug prices (Berry, et al., HR 684)[9]; special attention should be given to negotiating prices on selected biologics;

For safety and savings, enact a two or three year moratorium on the direct-to-consumer advertising of newly approved prescription drugs (proposals by DeLauro and others); require rebates for the increased high-cost drug utilization caused by such advertising.

Encourage savings for consumers and taxpayers through mail-order pharmacy use of maintenance drugs. There may be data that mail-order pharmacy is safer (fewer errors in

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[7] MedPAC, June, 2009, p. 106. "Set a drug's payment rate no higher than the cost of currently available treatments unless evidence shows that the drug improves beneficiaries' outcomes."

[8] MedPAC, June, 2009. Page 114.

[9] This provision receives an amazing 86 percent support in the Kaiser Family Foundation Health Tracking Poll of April, 2009.

refills) and our own data shows savings of up to several hundred dollars on a common package of five drugs through Part D plans.

Encourage generics: Require rebates from the 20 percent of Part D plans that have the lowest generic drug substitutions rates, in cases where a generic is exchangeable with a brand;

Conclusion

We thank you again for this opportunity to testify.

The American health care system must and can be fixed.

The Tri-Committee proposal will bring us to the goal of affordable, quality, dependable health care for all, and we hope you give consumers even more tools to help drive the system toward quality and cost savings. The proposals in the pharmaceutical sector make important improvements and savings. Even more savings are possible and can be directed toward spurring breakthrough research.

Appendix I

Consumer Union Goals in Health Reform	Tri-Committee Draft
Ensure health access to every American: Make insurance simple by creating a national health insurance exchange where one can always go—regardless of one's health or situation in life-- to choose a private or public plan, with sliding scale subsidies based on income to make it affordable.	The Health Insurance Exchange, with reformed private policies (guaranteed issue, no pre-existing conditions) and a public plan option, with premium and cost-sharing subsidies phasing out at 400% of poverty, achieve this goal. Those who have good plans today can keep what they have.
The insurance offered should be comprehensive, bringing financial security and peace of mind.	The minimum standard benefit package (and at least 2 distinct, more valuable options), with no yearly or life-time limits and with out-of-pocket catastrophic protection at $5,000 for an individual and $10,000 for a couple, would achieve this goal. The low-income get even more protection.
Coverage should be especially good for preventive care.	The packages all include comprehensive preventive services; Medicare is improved to make preventive care more affordable; and a new Wellness and Prevention Trust Fund would help spur community wellness.
Eliminating pre-existing conditions and guaranteeing issue can't work for insurers, unless everyone has to have insurance. But we can't force people to buy policies they can't afford or that are inadequate, so subsidies are needed. And a public plan option working on a level playing field can use competition to minimize the need for subsidies by holding costs down and driving quality up.	The individual mandate to have at least the 'Essential' benefit plan, coupled with subsidies, and efforts to control cost, achieve this goal. Cost containment includes the public plan option, medical loss ratio requirements, comparative effectiveness research, form simplification, stepped up anti-fraud, stopping drug and device company 'gifts' to providers, new ways for doctors to deliver quality coordinated care, and implementation of MedPAC recommendations. Consumers Union urges even more be done to control costs.

Increase quality and help consumers choose quality, by making error rates public, particularly infection rates (largely preventable infections kill 100,000 Americans per year).	Division B's Section 1151 reduces payments for hospital readmissions due to poor quality and section 1441 establishes a new center to set priorities for quality improvement. State Medicaid plans are rewarded for not paying for poor care such as infections. We hope it is clearer that infection rates are to be public on a facility specific basis, and that more is done to report 'never events,' and require periodic quality recertification of providers, per the recommendations of the IOM.
Encourage care based on quality, not just quantity, and help spread the use of electronic medical records.	Efforts to develop accountable care organizations and medical homes will help ensure better care coordination. The Stimulus package HIT monies should help productivity over time and improve quality.
Encourage more primary care doctors.	The Draft's major sections on the workforce, graduate medical education, and increased payments to primary care doctors should all help.
Help small businessmen get affordable health insurance for themselves and their employees.	The Health Insurance Exchange will make policies more affordable; subsidies to small and lower wage firms will make it affordable.

Attachment II

On quality

We urge that you more clearly help consumers encourage quality, by increasing the public reporting of infections and other medical errors. Consumer pressure can inspire providers to focus more on preventing infections and other errors—but first, consumers need to be informed.

Ten years ago, the Institute of Medicine issued its report, To Err is Human, noting that medical errors were killing up to 98,000 people a year and costing the health system tens of billions in unnecessary costs. The CDC now says that 100,000 are dying just from largely preventable infections, which add an extra $35.7 to $45 billion per year in treatment costs. No one can say whether anything has really improved over the last decade: the IOM's recommendations have been largely ignored.

We urge you, in addition to the 7 hospital re-admission conditions discussed on page 222 of the Draft, to include public reporting of healthcare-acquired infections such as MRSA and other deadly conditions. We also hope you will take another look at the IOM report, and move to require public reporting of 'never events' (like surgery on the wrong part of the body) the way Minnesota has done. It is way past time to adopt the IOM's proposals for periodic quality re-certification of providers. We retest pilots and others for competency—we should retest providers on a periodic basis. Finally, we urge you to consider some of the excellent language in the Senate HELP bill to improve our nation's failing Emergency Medical Systems.

Do More to Help the Consumer in the Health Insurance Exchange

The honest, sad truth is that most of us consumers are terrible shoppers when it comes to insurance. The proof is all around you.

> --In FEHBP, hundreds of thousands of educated Federal workers spend much more than they should on plans that have no actuarial value over lower-cost plans.[10]
>
> --In Medicare Part D, only 9 percent of seniors at most are making the best economic choice (based on their past use of drugs being likely to continue into a new plan year), and most are spending $360-$520 or more than the lowest cost plan available covering the same drugs.[11]
>
> --In Part C, Medicare has reported that 27% of plans have less than 10 enrollees, thus providing nothing but clutter and confusion to the shopping place.[12]

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[10] Washington Consumers' Checkbook Guide to Health Plans, 2008 edition, p. 5.
[11] Jonathan Gruber, "Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?" (prepared for the Henry J. Kaiser Foundation) March, 2009.
[12] SeniorJournal.com, March 29, 2009.

The Institute of Medicine reports that 30 percent of us are health illiterate. That is about 90 million people who have a terrible time understanding 6th grade or 8th grade level descriptions of health terms. Only 12 percent of us, using a table, can calculate an employee's share of health insurance costs for a year.[13] Yet consumers are expected to understand "actuarial value," "co-insurance" versus "co-payment," etc.

If Congress wants an efficient marketplace that can help hold down costs, you need to provide more consumer tools in that marketplace. The Health Choices Administration and Insurance Ombudsman are a good start. We hope you can flesh out their powers and duties as follows:

We believe standard benefit packages (and definitions) are the key to facilitating meaningful competition. The Draft bill provides 3 broad categories of policies, and we appreciate the fact that these broad groupings will be helpful to consumers. But like Medigap policies A-L, we urge you to make the policies sold in each of these broad categories identical, so that consumers can shop on the basis of price and quality, and not on tiny, confusing differences (10 rehab visits v. a plan with 12, etc.). If someone wants to buy extra bells and whistles, they can do that outside of the exchange. To only require these broad groupings to be 'actuarially equivalent' is to invite a Tower of Babel of tiny plan differences, designed by the insurers to attract the healthy and avoid the most expensive—and with the end result of confusing the consumer.

Consumers want choice of doctor and hospital. We do not believe that they are excited by an unlimited choice of middlemen insurers.[14] Fewer offerings of meaningful choices would be appreciated. There are empirical studies showing that there is such a thing as too much choice, and dozens and dozens of choices can paralyze decision-making.[15]. The insurance market can be so bewildering and overwhelming that people avoid it. We think that is a major reason so many people having picked a Part D plan, do not review their plan and fail to make rational, advantageous economic changes during the open enrollment period.

√ Require standardization of insurance definitions so consumers can easily compare policies on an "apples-to-apples' basis. This is key. Hospitalization should mean hospitalization. Drug coverage should mean drug coverage, etc. Attached on the last page of this testimony is an article from our May magazine which demonstrates what radically different coverage two similar sounding policies can provide. It is not clear that the

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[13] HHS Office of Disease Prevention and Health Promotion

[14] "Nearly three-fourths (73 percent) of people ages 65 and older felt that the Medicare Prescription drug benefit was too complicated, along with 91 percent of pharmacists and 92 percent of doctors. When asked if they agreed with the statement: "Medicare should select a handful of plans that meet certain standards so seniors have an easier time choosing," 60 percent of seniors answered in the affirmative." Jonathan Gruber, "Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?" (prepared for the Henry J. Kaiser Foundation) March, 2009. Page 2.

[15] Mechanic, David. Commentary, Health Affairs, "Consumer Choice Among Health Insurance Options," Health Affairs, Spring, 1989, p. 138.

"benefit standards defined" (p. 29, line 11) will guarantee comparability of terms among plans.

√ Require insurers to clearly state (in standardized formats) what's covered and what's not in every plan offering, and to estimate out-of-pocket costs under typical treatment scenarios. The Washington Consumers' Checkbook's "Guide to Health Plans for Federal Employees (FEHBP)" does a nice job showing what consumers can expect, but even in FEHB policies they find it impossible to provide clear data on all plans.[16] HR 2427 by Rep. DeLauro and Rep. Courtney and 23 others is excellent language on how to design such scenarios.

√ Maintain an insurance information and complaint hotline, and compile federal and state data on insurance complaints and report this data publicly on a Web site. The States would continue to regulate and supervise insurers operating in their state, but with the continual merger and growing concentration of insurers, consumers need a simple place where complaints can be lodged and data collected, analyzed, and reported nationally concerning the quality of service offered by insurers. This type of central complaint office may have allowed quicker detection of the UnitedHealth-Ingenix abuse of underpaying 'out-of-network' claims.

√ Institute and operate quality rating programs of insurance products and services. This would be similar to the Medicare Part D website, with its '5 star' system.

√ Manage a greatly expanded State Health Insurance Assistance Program that would provide technical and financial support (through federal grants) to community-based non-profit organizations providing one-on-one insurance counseling to consumers. These programs need to be greatly expanded if you want the HIE connector to work. The SHIPs should be further professionalized, with increased training and testing of the quality of their responses to the public.

√ Require plans to provide year-long benefit, price, and provider network stability. In Medicare Part D, we saw plans advertise certain drug costs during the autumn open enrollment period, and then by February or March increase prices on various drugs so much that the consumer's effort to pick the most economical plan for their drugs was totally defeated. This type of price change—where the consumer has to sign up for the year and the insurer can change prices anytime—is a type of bait and switch that should be outlawed.

√ Make consumers fully aware of their rights to register complaints about health plan service, coverage denials, balance-billing and co-pay problems, and to appeal coverage denials. We appreciate the requirement in Sec. 132 for 'fair grievance and appeals mechanisms,' but urge that the Commissioner, perhaps with the help of the NAIC, develop a **model** system that all participating insurers have to use.

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[16]Op. cit., p. 68.

Attachment III—Comparative Effectiveness Research Example

Proton pump inhibitors (PPIs) are a class of drugs used to treat heartburn, gastroesophageal reflux disease (GERD), and ulcers. Heartburn and GERD are quite common. Between a quarter and a third of adults in the U.S. will have GERD at some point in their lives. There are five medicines in this class. One is available as a relatively inexpensive nonprescription drug.

To help you and your doctor choose a PPI if you need one, *Consumer Reports* has evaluated the drugs in this category based on their effectiveness, safety and cost. This two-page brief is a summary of a 14-page report you can access on the Internet at www.CRBestBuyDrugs.org. You can also learn about other drugs we've analyzed on this *free* Web site. Our independent evaluations are based on scientific reviews conducted by the Oregon Health and Science University-based Drug Effectiveness Review Project. Grants from the Engelberg Foundation and National Library of Medicine help fund *Consumer Reports Best Buy Drugs.*

DO YOU NEED A PPI?

If you have heartburn only occasionally and have not been diagnosed with GERD, you probably do *not* need a PPI. Over-the-counter antacids and generic prescription drugs will very likely provide relief. See the Our Recommendations box on this page for mention of several such medicines. If you have chronic heartburn or get diagnosed with GERD, your doctor is highly likely to prescribe a PPI.

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Not everyone with heartburn needs a PPI drug. Several of the PPIs have been widely advertised to consumers and heavily promoted to physicians, and this has led to overuse of the drugs in the treatment of "garden variety" heartburn.

If you suffer from only occasional heartburn and have not been diagnosed with GERD, nonprescription antacids such as Maalox, Mylanta, Rolaids, and Tums, or acid-reducing drugs such as cimetidine (Tagamet), famotidine (Pepcid), nizatidine (Axid), and ranitidine (Zantac) will very likely provide relief.

Talk with your doctor about the role that dietary and lifestyle changes can play in alleviating heartburn, too – such as eating smaller meals, weight loss, and avoiding alcohol.

If, however, you experience heartburn twice a week or more for weeks or months on end, have frequent regurgitation of food into your throat or mouth (with or without heartburn), or if your heartburn is not relieved by the drugs mentioned above, you may have GERD and need a PPI. GERD is a condition that makes you prone to acid reflux and can, over time, cause damage to your esophagus.

The five available PPI medicines are roughly equal in effectiveness and safety, but differ in cost. One – omeprazole (Prilosec OTC) – is available as both a prescription and nonprescription generic drug.

Taking the evidence for effectiveness, safety, cost, and

other factors into account, **Prilosec OTC** is our choice as a *Consumer Reports Best Buy Drug* if you need a PPI. You could save $100 to $200 a month by choosing this medicine over more expensive prescription PPIs.

If you have health insurance, find out if your plan helps pay for Prilosec OTC. If not, talk to your doctor about taking the PPI with the lowest out-of-pocket cost to you.

Safety note: A few studies have linked PPIs to a higher risk of pneumonia and infection with a bacterium called *C. difficile,* and in December 2006 a study found that long-term use of PPIs may be associated with an increased risk of hip fractures. Talk with your doctor about these risks, especially if you must take a PPI over a long period of time. People aged 65 and over, and people with chronic medical conditions, who take a PPI should get vaccinated against pneumonia and get a flu shot every year.

This summary was last updated in January 2007.

Esomeprazole
20mg Nexium NA$_3$87%
(84%-91%) 87%
Esomeprazole
40mg Nexium 73%
(65%-82%)
90%
(88%-92%) 93%
Lansoprazole
30mg Prevacid 70%
(61%-80%)

86%
(83%-90%) 91%
Omeprazole
20mg Prilosec 65%
(54%-76%)
85%
(81%-88%) 86%-92%
Pantoprazole
20mg Protonix 77%
(70%-84%)
77%
(65%-88%) 55%-86%
Pantoprazole
40mg Protonix 72%
(62%-83%)
89%
(86% to 92%) 78%
Rabeprazole
20mg Aciphex 69%
(52%-86%)
82%
(76%-89%) 89%

1. Effectiveness data presented for PPI dosage strengths that have been studied to date.
2. Data from individual studies. Ranges given reflect multiple studies.
3. NA= Data Not Available

PPI W2 0207

1. "Generic" indicates drug sold by generic name.
2. Monthly cost reflects nationwide retail average prices for September 2006 (except where noted), rounded to nearest dollar.
Information derived by *Consumer Reports Best Buy Drugs* from data provided by Wolters Kluwer Health, Pharmaceutical Audit
Suite.
3. This is a nonprescription (over-the-counter) version of omeprazole available at any drug store. The shelf price of this medicine
varies widely. It may be least expensive at large discount stores and at Internet pharmacies. The cost for a month's supply
given in this table ($19-$26) is based on a spot check of prices at Internet online pharmacies on October 30, 2006.
4. Generic omeprazole is generally available at a lower price at large discount stores. In some cases the price may be half of
that reflected in this table, which presents nationwide average prices.

UNDERSTANDING GENERICS: A generic drug is a copy of a brand drug whose patent has expired. In
this table, only omeprazole is available as a generic. It is also sold under its brand name, Prilosec. A nonprescription
version, Prilosec OTC, is also available. The remaining PPIs are sold only as brand name
drugs.

Esomeprazole 20mg tablets Nexium No $193
Esomeprazole 40mg tablets Nexium No $181
Lansoprazole 15mg delayed-release tablets Prevacid No $145
Lansoprazole 30mg delayed-release tablets Prevacid No $131
Lansoprazole 15mg delayed-release capsules Prevacid No $184
Lansoprazole 30mg delayed-release capsules Prevacid No $186
Omeprazole 20mg[3] tablets Prilosec OTC[3] Yes $19-$26[3]

Omeprazole 10mg sustained-release tablets Prilosec No $125
Omeprazole 20mg sustained-release tablets Prilosec No $153
Omeprazole 40mg sustained-release tablets Prilosec No $265
Omeprazole 10mg[4] sustained-release tablets Generic Yes $116[4]
Omeprazole 20mg[4] sustained-release tablets Generic Yes $89[4]
Omeprazole/sodium bicarbonate 20mg/1100mg Zegerid No $138
Omeprazole/sodium bicarbonate 40mg/1100mg Zegerid No $146
Omeprazole/sodium bicarbonate 20mg/1680mg Zegerid No $170
Omeprazole/sodium bicarbonate 40mg/1680mg Zegerid No $176
Pantoprazole 20mg delayed-release tablets Protonix No $159
Pantoprazole 40mg delayed-release tablets Protonix No $146
Rabeprazole 20mg tablets Aciphex No $189

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www.CRBestBuyDrugs.org

Treating Heartburn, Ulcers, and Stomach Acid Reflux:

The Proton Pump Inhibitors

Comparing Effectiveness, Safety, and Price

Proton pump inhibitors (PPIs) are a class of drugs used to treat heartburn, gastroesophageal reflux disease (GERD), and ulcers. Heartburn and GERD are quite common. Between a quarter and a third of adults in the U.S. will have GERD at some point in their lives. There are five medicines in this class. One is available as a relatively inexpensive nonprescription drug.

To help you and your doctor choose a PPI if you need one, *Consumer Reports* has evaluated the drugs in this category based on their effectiveness, safety and cost. This two-page brief is a summary of a 14-page report you can access on the Internet at www.CRBestBuyDrugs.org. You can also learn about other drugs we've analyzed on this *free* Web site. Our independent evaluations are based on scientific reviews conducted by the Oregon Health and Science University-based Drug Effectiveness Review Project. Grants from the Engelberg Foundation and National Library of Medicine help fund *Consumer Reports Best Buy Drugs.*

DO YOU NEED A PPI?

If you have heartburn only occasionally and have not been diagnosed with GERD, you probably do *not* need a PPI. Over-the-counter antacids and generic prescription drugs will very likely provide relief. See the Our Recommendations box on this page for mention of several such medicines. If you have chronic heartburn or get diagnosed with GERD, your doctor is highly likely to prescribe a PPI.

Table 1. Comparative Effectiveness of PPIs[1]

Generic Name And Dose Per Day	Brand Name	Complete Symptom Relief at 4 to 8 Weeks, Average Percent of Patients (Range)	Esophageal Healing at 8 Weeks, Average Percent of Patients (Range)	Relapse Prevention[2]
Esomeprazole 20mg	Nexium	NA[3]	87% (84%-91%)	87%
Esomeprazole 40mg	Nexium	73% (65%-82%)	90% (88%-92%)	93%
Lansoprazole 30mg	Prevacid	70% (61%-80%)	86% (83%-90%)	91%
Omeprazole 20mg	Prilosec	65% (54%-76%)	85% (81%-88%)	86%-92%
Pantoprazole 20mg	Protonix	77% (70%-84%)	77% (65%-88%)	55%-86%
Pantoprazole 40mg	Protonix	72% (62%-83%)	89% (86% to 92%)	78%
Rabeprazole 20mg	Aciphex	69% (52%-86%)	82% (76%-89%)	89%

1. Effectiveness data presented for PPI dosage strengths that have been studied to date.
2. Data from individual studies. Ranges given reflect multiple studies.
3. NA= Data Not Available

Our Recommendations

Not everyone with heartburn needs a PPI drug. Several of the PPIs have been widely advertised to consumers and heavily promoted to physicians, and this has led to overuse of the drugs in the treatment of "garden variety" heartburn.

If you suffer from only occasional heartburn and have not been diagnosed with GERD, nonprescription antacids such as Maalox, Mylanta, Rolaids, and Tums, or acid-reducing drugs such as cimetidine (Tagamet), famotidine (Pepcid), nizatidine (Axid), and ranitidine (Zantac) will very likely provide relief.

Talk with your doctor about the role that dietary and lifestyle changes can play in alleviating heartburn, too – such as eating smaller meals, weight loss, and avoiding alcohol.

If, however, you experience heartburn twice a week or more for weeks or months on end, have frequent regurgitation of food into your throat or mouth (with or without heartburn), or if your heartburn is not relieved by the drugs mentioned above, you may have GERD and need a PPI. GERD is a condition that makes you prone to acid reflux and can, over time, cause damage to your esophagus.

The five available PPI medicines are roughly equal in effectiveness and safety, but differ in cost. One – omeprazole (Prilosec OTC) – is available as both a prescription and nonprescription generic drug.

Taking the evidence for effectiveness, safety, cost, and other factors into account, **Prilosec OTC** is our choice as a *Consumer Reports Best Buy Drug* if you need a PPI. You could save $100 to $200 a month by choosing this medicine over more expensive prescription PPIs.

If you have health insurance, find out if your plan helps pay for Prilosec OTC. If not, talk to your doctor about taking the PPI with the lowest out-of-pocket cost to you.

Safety note: A few studies have linked PPIs to a higher risk of pneumonia and infection with a bacterium called *C. difficile,* and in December 2006 a study found that long-term use of PPIs may be associated with an increased risk of hip fractures. Talk with your doctor about these risks, especially if you must take a PPI over a long period of time. People aged 65 and over, and people with chronic medical conditions, who take a PPI should get vaccinated against pneumonia and get a flu shot every year.

This summary was last updated in January 2007.

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PPI Cost Comparison

Generic Name and Dose per Day	Brand Name[1]	Available as a Generic?	Average Monthly Cost[2]
Esomeprazole 20mg tablets	Nexium	No	$193
Esomeprazole 40mg tablets	Nexium	No	$181
Lansoprazole 15mg delayed-release tablets	Prevacid	No	$145
Lansoprazole 30mg delayed-release tablets	Prevacid	No	$131
Lansoprazole 15mg delayed-release capsules	Prevacid	No	$184
Lansoprazole 30mg delayed-release capsules	Prevacid	No	$186
CR BEST BUY Omeprazole 20mg[3] tablets	Prilosec OTC[3]	Yes	$19-$26[3]
Omeprazole 10mg sustained-release tablets	Prilosec	No	$125
Omeprazole 20mg sustained-release tablets	Prilosec	No	$153
Omeprazole 40mg sustained-release tablets	Prilosec	No	$265
Omeprazole 10mg[4] sustained-release tablets	Generic	Yes	$116[4]
Omeprazole 20mg[4] sustained-release tablets	Generic	Yes	$89[4]
Omeprazole/sodium bicarbonate 20mg/1100mg	Zegerid	No	$138
Omeprazole/sodium bicarbonate 40mg/1100mg	Zegerid	No	$146
Omeprazole/sodium bicarbonate 20mg/1680mg	Zegerid	No	$170
Omeprazole/sodium bicarbonate 40mg/1680mg	Zegerid	No	$176
Pantoprazole 20mg delayed-release tablets	Protonix	No	$159
Pantoprazole 40mg delayed-release tablets	Protonix	No	$146
Rabeprazole 20mg tablets	Aciphex	No	$189

UNDERSTANDING GENERICS: A generic drug is a copy of a brand drug whose patent has expired. In this table, only omeprazole is available as a generic. It is also sold under its brand name, Prilosec. A non-prescription version, Prilosec OTC, is also available. The remaining PPIs are sold only as brand name drugs.

1. "Generic" indicates drug sold by generic name.
2. Monthly cost reflects nationwide retail average prices for September 2006 (except where noted), rounded to nearest dollar. Information derived by *Consumer Reports Best Buy Drugs* from data provided by Wolters Kluwer Health, Pharmaceutical Audit Suite.
3. This is a nonprescription (over-the-counter) version of omeprazole available at any drug store. The shelf price of this medicine varies widely. It may be least expensive at large discount stores and at Internet pharmacies. The cost for a month's supply given in this table ($19-$26) is based on a spot check of prices at Internet online pharmacies on October 30, 2006.
4. Generic omeprazole is generally available at a lower price at large discount stores. In some cases the price may be half of that reflected in this table, which presents nationwide average prices.

SPECIAL VIEWPOINT ON HEALTH REFORM

An excerpt from the August 2009 issue of CONSUMER REPORTS

ConsumersUnion

A prescription for health care

A prescription for health care

Almost all agree the health system is broken. Here's how Consumers Union would fix it.

This summer, for the first time in 16 years, Washington seems poised to address the problems plaguing American health care. Take the fact that your medical costs are soaring at about twice the rate of inflation, for starters. Even if you don't pay the bills directly, you see the increase in higher insurance premiums, deductibles, and copays. And what are you getting for your money? A system that often limits your choice of doctors and hospitals, forces you to satisfy a complex web of rules to get reimbursed, locks you into a job for fear of losing coverage, and strands you without affordable protection if you lose insurance while suffering a chronic condition. No wonder that in recent years, medical bills or illness have contributed to 62 percent of all U.S. bankruptcies, and 46 million people go without any coverage at all.

If the problems are self-evident, the solutions are less so. On the political right, you'll find conservatives for whom "reform" is just the first step toward European-style socialism. You've seen their ads pop up on TV, sponsored by groups you've never heard of, full of scary warnings about faceless bureaucrats standing between you and needed care (as if you didn't have that now from insurance companies).

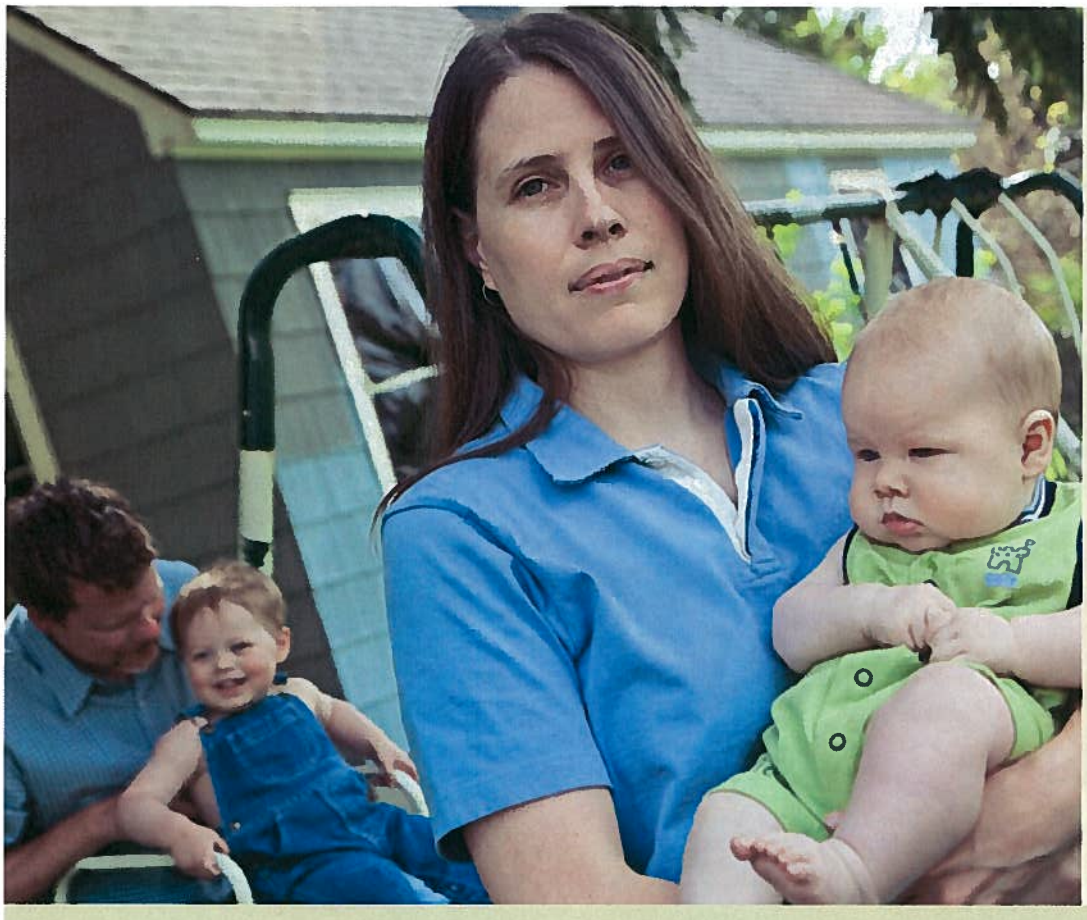
On the flip side, you'll hear some left-leaning commentators claim that the only solution is to nationalize health care as the British and Canadians have done. Consumers Union, the nonprofit publisher of CONSUMER REPORTS, has long argued for stronger government protection for consumers. But that doesn't mean we'd favor creating a huge new federal bureaucracy to manage an industry that constitutes a whopping 18 percent of the economy.

The right solution in today's environment lies somewhere between those poles. And it must be a truly American solution, one that takes advantage of our traditional ingenuity and entrepreneurship while preserving freedom, fairness, and choice.

In this special expanded Viewpoint column, we present Consumers Union's views on health reform. Rather than offering up a dense policy treatise, we divide the article into seven sections like the one at right. Each section opens with a person talking about his or her health-care experience. They're a diverse group—a waitress, a retired Air Force captain, a doctor, a business owner, and others—who, together, have seen the best and worst of today's care. And each section closes with one of our key goals for change, along with details about how we think a reformed system should work. (For a complete report on our policy positions, go to PrescriptionForChange.org.) We also lay out the facts behind some common fears about reform (see page 18). And we follow two women who beat breast cancer, but with very different financial consequences.

Not every reader will agree with each position here, of course, and we respect those differences of opinion. Regardless of your views, we urge you to contact your legislator, talk to family and friends, and volunteer to help the reform group of your choice. For more about our reform efforts or to share your story, go to Consumers Union.org and click on Health Care.

Fixing health care will take hard work by many and some degree of sacrifice by all. But Americans have faced, and conquered, bigger challenges in the past. Consumers Union thinks the effort is well worth it. And we support reform as an essential investment in our country's future, one that will result in lower costs and better health for you, your family, and the generations to come.



'Some people would think I'm being irresponsible not having insurance, but do I pay monthly for health care I really can't afford or take that money and use it for my family? It would be great for us all to be on one plan and not have to worry about it if something goes wrong.'

— Amanda Buchanan, 32, of Weiser, Idaho, with her husband, Jason Vlcek, 35, and sons, 2-year-old Kwei and Merin, 5 months

Health reform should make insurance simple

Parents like Amanda Buchanan and Jason Vlcek have plenty to keep them busy without worrying about health insurance for their children.

Yet the couple, from Weiser, Idaho, were trapped by one of the Catch-22s that abound in the current system. To get coverage for their first child, Kwei, now 2, they chose a so-called catastrophic plan with a steep $3,000 deductible and 30 percent copay. It was all they could afford on Vlcek's $34,600 salary as a second-grade teacher. So when their next child was on the way, they checked into the federal/state CHIP program that is supposed to cover children who lack other protection.

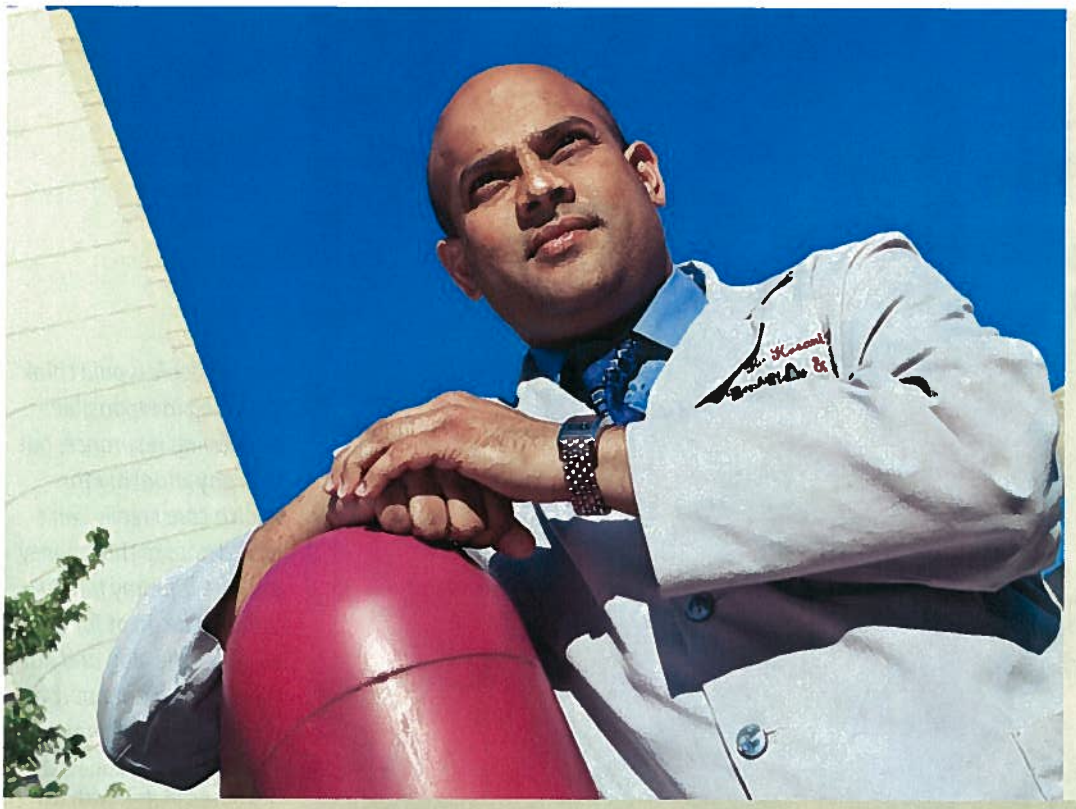
Problem was, Buchanan and Vlcek fell through a crack. "We totally qualified financially," Buchanan says, "but would never be accepted because Kwei was already insured, which somehow meant we could afford it even though we really couldn't." So in March, the couple canceled Buchanan's coverage so that they could continue to insure new son Merin. That saves $280 a month—but leaves Buchanan without protection.

CU recommends

Consumers Union supports health reform that would end those headaches. We favor the creation of a National Health Insurance Exchange, for example, that would function something like a big insurance store. Couples like Buchanan and Vlcek who either couldn't get or couldn't afford insurance from their employers could buy it directly from a private or public insurer through the exchange, with sliding-scale subsidies based on their income to help make it affordable.

Every policy sold through the exchange would provide at least a standard set of comprehensive protections. That means it would cover all major expenses, including immunizations, checkups, and screenings. And each new baby would be automatically included.

Best of all, there wouldn't be the tangle of bureaucracies and rules that forced this couple into a no-win situation. A reformed system would give them, and everyone, the peace of mind of having good coverage that couldn't be taken away. And it would put simple, affordable coverage within reach of every family.



'The insurance companies are getting away with murder. If a patient develops some condition, he's either dropped for some excuse or other, or the premiums go higher.'

—Ajit Kesani, M.D., 36, of Chicago

Health reform should cover everyone—even the sick

It sounds like a joke—pleading for insurance to cover those who are ill. But insurers today typically refuse individual insurance to anyone with a chronic condition or serious past illness, even if the person is a doctor, like kidney specialist Ajit Kesani of Chicago.

Kesani's crime? He developed type 2 diabetes while at his first job after medical training. That was fine as long as he stayed put. But when he changed practices a year later, no private insurer would touch him. The only coverage he found was a state-mandated "conversion" policy at a steep $18,000 a year.

Like many, Kesani decided to roll the dice. He went without coverage for three years until he could join a group plan for hospital affiliates, earlier this year, at $320 a month. Now if he sees an uninsured patient, he may suggest that the person seek coverage before getting a diagnostic workup. "If they get labeled as having kidney disease," he says, "they may not ever be able to get insurance."

CU recommends

We think it's an outrage that those who are sick have the hardest time getting and keeping insurance. Even well-intentioned previous "reforms," like the conversion policy Kesani was offered, turn out to be mirages. If a young doctor balks at paying $18,000 for insurance, how many others will be able to afford it in a country where the median household earns $50,000 a year?

Solving this problem would be a step forward, but the fix can't be one-sided. If insurers had to accept everyone, but individuals could decide whether or not to buy, people would wait until they got sick before joining. That would send the price of coverage through the roof and drive insurers out of business.

A fair solution would be to couple the above reform with a rule requiring everyone to have coverage. Those with good employer-based insurance could keep it. Others could buy it at an affordable price through the insurance exchange described on page 13. Besides private plans, the exchange would also include a public insurance option offered by the government. The public plan would get no special favors or funding. But its administrative costs would presumably be lower because it would operate on a nonprofit basis, and its presence in the market would help keep overall premiums down. Then physicians like Kesani wouldn't have to ask about your health coverage before determining what care you need.

'I lay in my hospital bed watching my stomach turn black and purple and rot. It looked as if I had been snapped in half by a shark.' — **Alicia Cole, 46, of Sherman Oaks, Calif.**

Reform should make it easy to get information on quality

When Alicia Cole learned she needed surgery for benign fibroids, she did her homework on the surgeon and the hospital. "I looked at HealthGrades, Leapfrog, Hospital Compare, and other Web sites," says Cole, a 46-year-old actress from Sherman Oaks, Calif. "But one thing I didn't check was the hospital's infection rate."

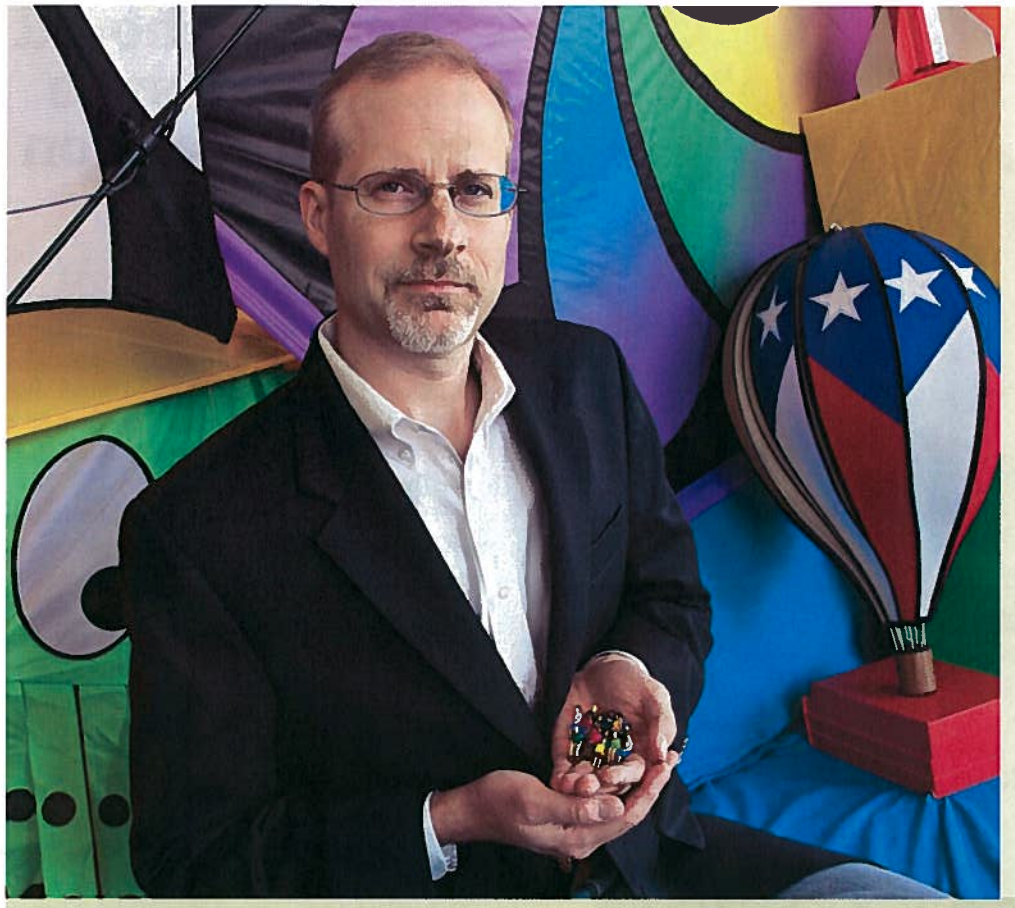
Even if she had tried to check, California hospitals didn't have to make such data public, and hers didn't. Cole had the operation there anyway. During her hospital stay, she came down with a post-surgical flesh-eating infection that turned her entire midsection into something worthy of a horror movie. After two months in the hospital and two years of painful rehabilitation, she still can't work. "The skin and scar tissue is so delicate that the least pressure will tear or scratch it," she says. Federal inspectors subsequently found unsterile conditions in the hospital's operating area.

Enraged by her experience, Cole joined the fight against hospital infections and helped persuade the California legislature to pass a law requiring public reporting; she now sits on the advisory board for the law. Did she ever learn the hospital's infection rate? Sadly, no. The law has not yet been implemented. "What we really need is a national law," Cole says, noting that hospital-acquired infections are a leading cause of death in this country. "It's the elephant in the room," she says.

CU recommends

Health reform should make it simple to get good information on health-care quality. You should be able to find data not only on infection rates, a reform we've backed for years, but also on doctors, drugs, treatments, and errors. Yet most states still allow doctors to shield a history of malpractice settlements. And infection rates, if reported at all, are often kept secret, which doesn't provide enough incentive for improvement.

What does work is disclosure. Pennsylvania, which passed the first statewide reporting law, remains the only state to require disclosure of all major types of hospital infections. And infections there have dropped 8 percent in the last two years.



'When I started offering health benefits in 1994, the cost was low enough that I paid 100 percent of the premium for a good plan. Now the cost has tripled, we only pay 50 percent, and still we have had to switch to a high-deductible plan. We're seeing employees put off preventive care that's going to cost them money.'

— Michael Brey, 45, of Annapolis, Md., owner of Hobby Works stores

Reform should help employers offer better protection for workers

The proportion of small-business employees who have health insurance at work dropped from 58 percent in 2001 to 52 percent last year, according to the Kaiser Family Foundation.

If you're wondering why, just ask Michael Brey. He is president and CEO of Hobby Works, a chain of four hobby-supply shops in Maryland and Virginia. Like most business owners, Brey, 45, wants to give his employees good coverage. But his health premiums have gone up 31 percent in the past three years, despite his switch to a high-deductible plan. He says the burden on the company and employees has grown, and many employees are dropping out of the plan.

"At one time, I believed that having more skin in the game"— paying a larger share of costs out-of-pocket—"would force people to be smarter health consumers," Brey says. "But in practice, that's not what happens. Cost-shifting drives them to put off preventive care in favor of urgent care." So they get help in the most-expensive, least-effective way—after they're sick, rather than while the illness might be avoided.

CU recommends

Small-business owners remain the job-growth engine of the economy. Brey, for example, wants to expand his chain of stores. But health-care costs make it more expensive to add employees. And in today's economy, that could mean little or no growth.

Under the health-care reform that we support, small firms that couldn't otherwise afford coverage could buy it—with a subsidy, if needed—through the same National Health Insurance Exchange available to individuals. The price they would pay wouldn't depend on the health of their workers, as it does today. And insurers couldn't jack up the cost if an employee or family member got sick.

The results? Better care for employees and fewer obstacles for entrepreneurs who want to build a business.

'The whole process was incoherent. ... I didn't understand why she was being admitted to the hospital, but we just went along. They didn't have any history on her, and a nurse blew one of my mother's veins while trying to insert an IV.'

— Eloise Kay, 57, of Gainesville, Fla., and her mother, Mirium Kay, 87

Reform should reward great care, not 'procedures'

The episode began, Eloise Kay recalls, when her mother's doctor ran a test to check on her rectal ulcer. The results suggested possible Crohn's disease, and a gastroenterologist prescribed drugs. Soon after, Mirium Kay began having abdominal pain and another doctor put her on a different drug. But when the pain worsened, both doctors suggested she go to the emergency room, where a hospitalist, a physician who practices only inside a hospital, took over.

"The hospitalist was great," Eloise Kay says, "but I don't think she had records on my mother. I'm a psychiatric nurse practitioner, so I could give a history. But with somebody who didn't know anything about health care, the history would have been sketchy."

After three days of interrupted sleep, hospital food, and diagnostic tests, it turned out that Mirium Kay had a duodenal ulcer that was easily treatable with inexpensive oral antibiotics. "But they also found a bacterium that is often associated with hospitals," her daughter says, so Mirium Kay got another antibiotic that cost $400. Total tab: over $11,000.

"I still don't understand why hospital resources were needed for the diagnosis," Eloise Kay says, "to say nothing of the cost and delays."

CU recommends

Today, insurers pay a fee for every test, pill, consultation, and procedure—which means that the more care given, the more providers get paid. Even without questioning anyone's motives, it's easy to see how such a system is biased toward overtreatment. And indeed, studies show that those who get more care don't necessarily do better, and often do worse, as a result.

Under patient-centered reform, doctors, hospitals, and labs would earn a combined flat fee for managing an "episode of illness." They'd be rewarded for quality of outcome, not quantity of care, so their main incentive would be to work together to make you well. Electronic records would ensure that with your permission, any doctor could access your history. Together, those reforms would help improve care and reduce costs.

Reform must let doctors be doctors

As a family doctor in a 70-person practice affiliated with Thomas Jefferson University Hospital in Philadelphia, Victor A. Diaz Jr. grapples daily with irrational insurance coverage rules. For example, many insurers will cover only 15 minutes of a doctor's time for follow-up visits, he says. "We're doing such a great job of helping patients live longer that they get to be older and develop co-morbidities like arthritis, high cholesterol, diabetes, depression," Diaz points out. "If you're going to address those issues, plus things like cancer screening, you'll never get everything done in 15 minutes."

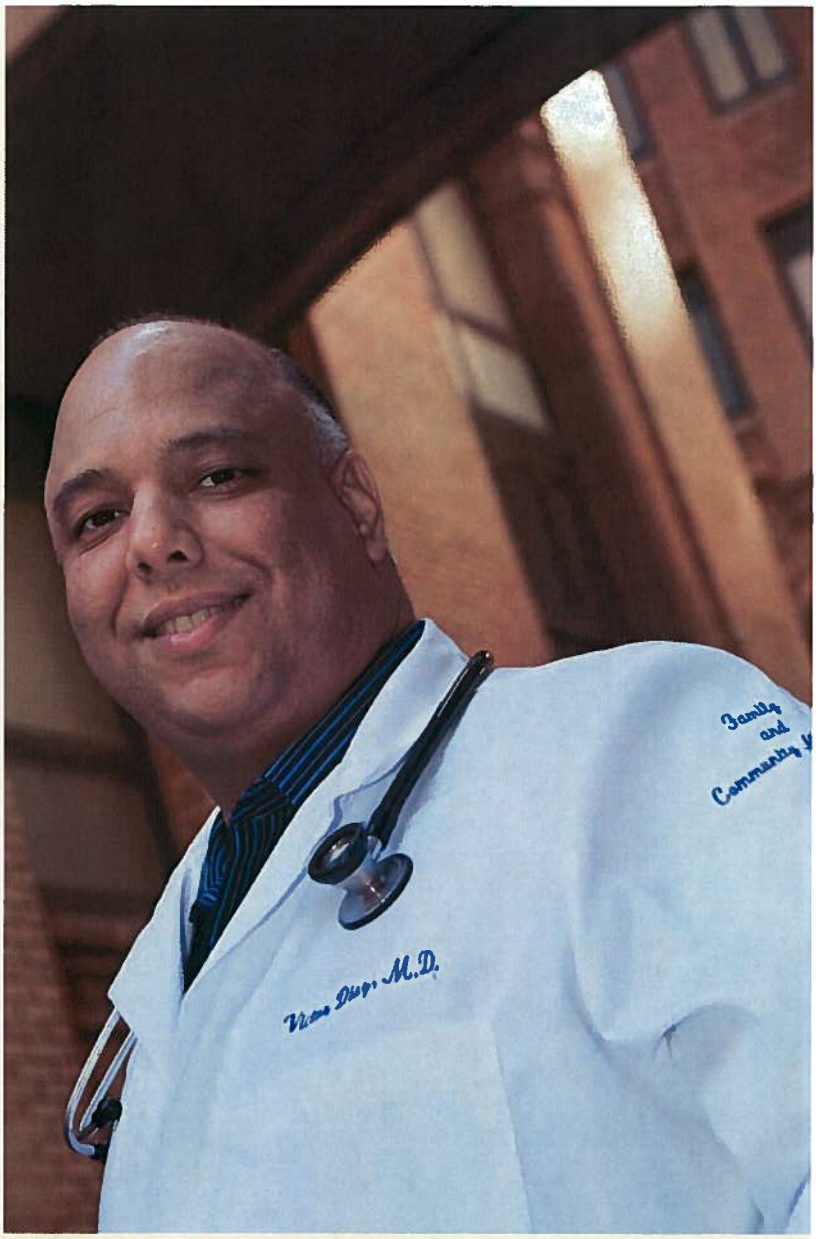
Then there's the question of group- visit therapy. Diaz and his colleagues find it's an excellent way to encourage people to lose weight, eat smarter, and take up exercise—all things that could really help improve their health. But "the insurance billing code for group visits is ill-defined," he says. "To get reimbursed, we see each patient individually first, and then we gather them together in a group."

Diaz adds that as a salaried faculty physician, he can leave the billing and collection headaches to others. His colleagues in private practice can't always do that. The cumulative effect, he says, is to drive medical students away from primary-care medicine and into higher-fee specialties just to pay off their medical school debt.

CU recommends

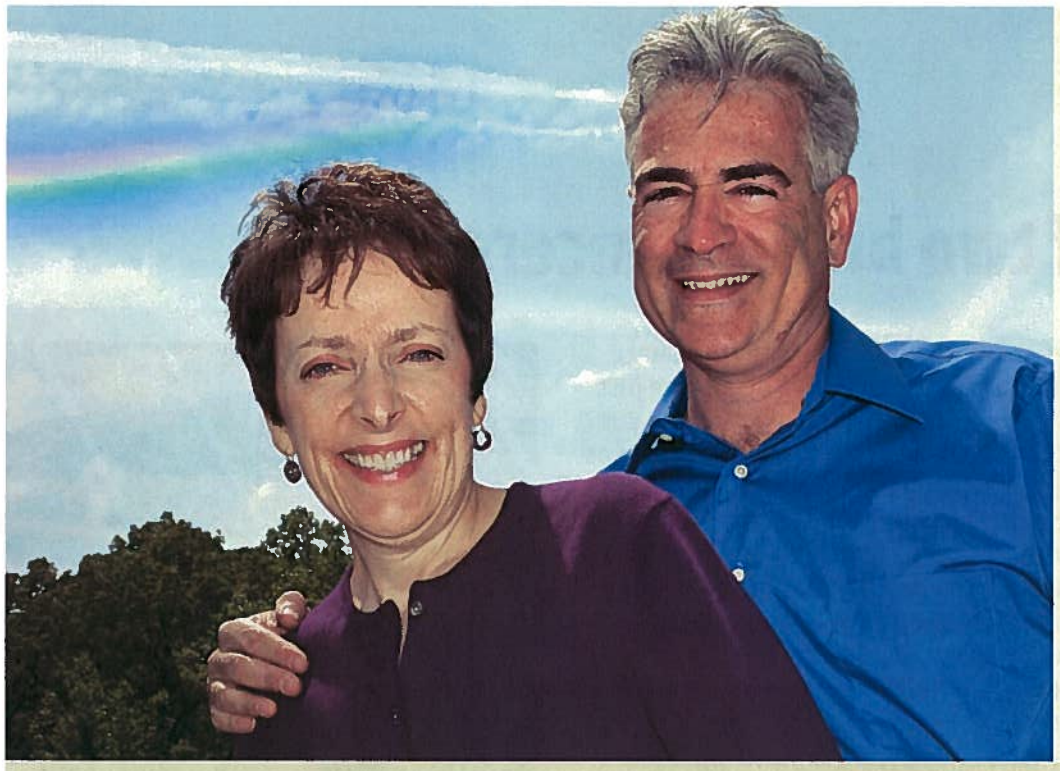
Many people's idea of good care is a super-specialist using the latest high-tech equipment. But what most people truly need is a dedicated family physician like Diaz. Such a doctor would keep you healthy as long as possible and manage any chronic conditions. Just as important, he or she could coordinate any specialist care you might need—which would help the "episode of illness" payment system described in the previous section.

Not that we have anything against specialists. They're essential. But as CONSUMER REPORTS noted in its July 2008 report "Too Much Treatment," patients in areas with a lot of specialty care actually fare worse than those where primary care is more common. In fact, if the focus were on primary care throughout the U.S., costs would drop an estimated 20 to 30 percent.



'We've had to struggle to get diabetic patients covered when they see a nutritionist to learn to manage their diet, even though it's certainly cheaper than having to go on dialysis or having a toe removed. Our system is disease-oriented, not patient-oriented.'

—Victor A. Diaz Jr., MD, 46, of Philadelphia



'Every American deserves a health plan like mine. If we all had health care that nobody could take away, it would open up a flood of creativity in this country.'

— Mike Marks, 49, of Huntington, W. Va., and his wife, Mary, 55

Health reform should give you the freedom to choose

The number of people with generous workplace coverage is dwindling. Out-of-control costs are forcing employers to trim or scrap coverage. And in this recession, millions are confronting a grim side effect of job loss: By 2010, one in five people under age 65 will be uninsured.

That's no worry for Mike and Mary Marks of Huntington, W. Va. Thanks to his 20 years of service, Marks, a retired Air Force captain, and his wife are covered under Tricare, a system for active and retired military personnel. They pay just $460 a year (that's not a misprint) and love its flexibility. "If we lived near a base, we'd get treated there for free," he says. "But we don't, so we use community facilities in the network."

As a result, Mike Marks, now a licensed physical therapist, can choose jobs without health benefits. "Right now, I'm working full time as a replacement for a woman who's on maternity leave," he says. "I didn't have to ask about health care." Compare that with the situation of Marks' brother, "a wizard with wood. He's been a general contractor and a boat collier, but some of his family have medical issues, so he's working at a factory to stay insured."

With truly portable coverage, Marks believes, Americans would feel freer to pursue their talents. "You could start a business without being afraid of not being able to provide health care for yourself or your employees," he says. Economists say job mobility would increase by as much as 25 percent if people didn't have to worry about coverage.

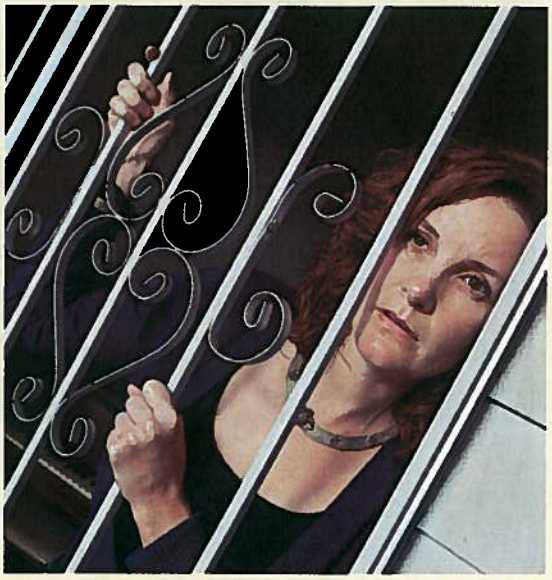
CU recommends

Under health reform, Americans would enjoy not only a wider choice of careers but also a wider array of health plans to choose from, including the public insurance plan described on page 14. Opponents of reform like to vilify the public plan as "government takeover" of health care. We disagree. It's simply another insurer that uses the same private providers to deliver care. It would bring competition to the many markets now dominated by just one or two private carriers. And though the plan could never be as inexpensive as Tricare (provided in return for military service), programs like it demonstrate that public insurance can work. So we think a public plan would be an important element in comprehensive reform that gives every American the peace of mind of affordable, portable, quality coverage.

A tale of two breast cancers

Getting breast cancer at age 27 was certainly unfortunate for Jaclyn Michalos, but the fact that it was diagnosed just after Massachusetts changed its health-care system in 2007 turned out to be fortunate indeed. Michalos was working as a waitress in Randolph, Mass., and had no health policy. But the new law required everyone to have coverage, and those like Michalos who couldn't afford it could join the statewide Commonwealth Care plan. That plan eventually paid the $125,000 cost of her treatment. "If I hadn't had that insurance, I never would have made the doctor's appointment that turned up my cancer, and I might not be alive today," Michalos says.

Catherine Howard of San Francisco also had insurance when she learned she had breast cancer. But as a freelance film producer, she couldn't afford a good comprehensive policy. Instead she had chosen a plan with low premiums but a high $2,500 deductible and 30 percent copay. It promised to limit her out-of-pocket costs to $7,500 yearly. But that figure didn't include all charges. "I remember staring at the needle of one shot that cost $2,000 and thinking, 'I owe $600 for this,'" says Howard, 36. She still owes $40,000 for her $160,000 of treatment.



CURED **Jaclyn Michalos, 29, (far left, with sister Julie) and Catherine Howard, 36, (above) were treated successfully for breast cancer and are cancer-free today. But because they lived in different states, Howard is still paying medical bills, while Michalos emerged debt-free.**

5 common fears about health reform

Now that health-care reform is a possibility, the forces of opposition are gearing up. Anti-reform campaigns with names like Patients United Now, Partnership to Improve Patient Care, and Conservatives for Patients' Rights are trying to make meaningful reform sound dangerous. Here are five of the worst fears you might hear—and the facts as we see them under the reforms we recommend.

FEAR Health reform will let faceless government bureaucrats come between you and your doctor.

FACT Private health insurance already comes between you and your doctor. And because each company sets its own rules, it's hard to imagine a more bureaucratic system. Some insurers decide which doctors you can see, which hospitals you can visit, and what drugs you can take and still be covered. And they may require copious paperwork before approving a treatment you and your doctor want. Health-care reform would standardize claim procedures to cut down on all of that. And it would protect you from other abuses, like being rejected for coverage or paying exorbitant premiums if you get sick.

FEAR Health reform will take away the good coverage from your job.

FACT If you're satisfied with your job-based coverage, you would be able to keep it. Employers who don't offer insurance would either start to provide it or contribute to a fund that helps employees buy it on their own. Some small businesses would be eligible for subsidies to offset the cost. And every policy would offer at least a standard, easy-to-understand, comprehensive set of benefits like those your congressperson now enjoys.

FEAR Comparing the relative effectiveness of treatments and drugs will lead to rationing.

FACT This issue flared up because Congress recently approved more funding for "comparative-effectiveness research." The term refers to studies to evaluate which drugs or treatments work best for different medical conditions and different patients. That's one more piece of information—based on science, not drug-company advertising or sales reps pushing pills—to help your doctor and you decide what's right. Consumers Union has long argued for better health-care information. For an example of our work, go to ConsumerReportsHealth.org and click on Best Buy Drugs. You'll find free advice based on comparative-effectiveness research into which drugs work best for some two dozen conditions, ranging from heartburn to heart disease. That's not rationing. It's just being smart. And if you suffer from one of those conditions, you may find you could choose a better medicine with fewer side effects and save thousands of dollars a year.

FEAR Health reform means a government takeover of medicine as in England and Canada.

FACT The system we support would look nothing like those in England and Canada. Both of those countries finance health care out of general tax revenues. England goes even further. The government owns and operates most of the hospitals. We support a specifically American reform that would build on the current employer-based insurance while ensuring affordable comprehensive coverage for those who lack it.

FEAR Health reform will be too costly; it will raise your taxes and could even bankrupt the country.

FACT The real threat to your finances is the health system the U.S. has now. A recent study concluded that today's $2.4 trillion annual health-care tab would jump to $4.4 trillion by 2018 if nothing is done to rein in expenses. Consumers Union thinks reform is the best hope for getting costs under control. It would cut down on waste, overhead, and price gouging, and reduce inappropriate care and preventable errors. We fully understand why some people are apprehensive about reform: Any change is scary. But we also see the shameful damage caused by the current system. Americans deserve better than this, and can have it.