UNITEDHEALTH GROUP®

United States Senate Committee on Finance

"Progress in Health Care Delivery: Innovations from the Field"

Testimony of Richard Migliori, MD
Executive Vice President for Health Services
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Thank you Chairman Baucus and Ranking Member Hatch for holding this important and timely hearing and allowing UnitedHealth Group to provide you with our perspective on how to improve the health care delivery system. My name is Dr. Richard Migliori, and I am the Executive Vice President for Health Services at UnitedHealth Group, a diversified health and well-being company based in Minnetonka, Minnesota. UnitedHealth Group serves more than 75 million people through its health benefits and health services businesses and operates in all 50 states. The company has the unique ability to engage in all aspects of the health care delivery system and apply lessons learned at full-scale in the marketplace. As a result, we view health care delivery and benefit design through multiple lenses. Our findings are informed by our experience with:

- 16,000 physicians, nurses, and clinical practitioners on our staff;
- Direct relationships with 754,000 health professionals, 5,400 hospitals, 66,000 pharmacies, 900 labs, 400 life science organizations, 300 commercial insurance companies and health plans, and 300 government agencies;
- Managing more than $300 billion in health care annually;
- Processing 80 billion transactions a year, including 750 million transactions through our Web portals and mobility devices;
- Processing more than 2 million claims and more than 1 million calls per day;
- Operating Health Information Exchanges for eleven states; and
- Managing over 24 million Personal Health Records.

I. Challenges and Opportunities in the Current Health Care Marketplace

Sustainable access for Americans to high quality, affordable health care is put at risk by factors that will persist until the health system is modernized. These factors include:

1. Variation in Quality of Care and Resource Consumption: Though our health system is remarkably talented, its outcomes and resource utilization performance can vary greatly across regions, among physicians and institutions, and across specialties. This results in measurable evidence of overuse, underuse and misuse of medical treatments across the system.

2. Fragmentation of Information: Much of American medicine is practiced in small groups of physicians, and the adoption of automated clinical and administrative systems has been comparatively slow. Even with broader adoption of enterprise Electronic Health Record (EHR) systems, interoperability to enable inter-institutional information exchange is suboptimal. As a result, the level of adoption of automated information within health care lags behind other sectors of our economy. This fragmentation and suboptimal information may interfere with a physician's ability to gather information during the evaluation and treatment of a patient, increase administrative costs, and slow the adoption of new innovations in care.

3. Increasing Burden of Chronic Disease: The changes in American lifestyle behaviors have contributed to the more than doubling of obesity rates since the early 1990's. It is well established that the prevalence of many chronic diseases, such as diabetes and its

complications – coronary artery disease, osteoarthritis, and hypertension, increase as a function of body mass index. These increased prevalence rates place an additional burden on the health system that is already facing challenges of capacity – a burden that can be relieved by modification of lifestyle behaviors.

These factors and their consequences contribute to a health care experience that is inconsistent in its quality, create waste that leads to ongoing cost trends that threaten its sustainability, and result in a care experience for its consumers and providers that is less than its full potential.

In our role as one of the nation's largest payers for health care, managing and coordinating care for 75 million people across a vast network of physicians, hospitals and other health care entities, we have had the privilege of being able to measure and document these trends and to introduce innovative approaches to improve access to high quality and affordable care. Over the last 18 years, we have worked to foster a health system that is more connected, better informed, and better aligned in its objectives and incentives to continuously improve the safety, timeliness, effectiveness, efficiency, equality, and patient focus of the health system. Our approach leverages health data and analytics, technology, shared accountability, cost saving measures, and collaboration among providers, payers and patients across the health care delivery spectrum.

The challenge to modernize the health system that provides for better health and higher quality of care at an affordable cost is evident to those who seek care and those that provide it –

the system's patients and physicians. Through a national survey we recently conducted, we found that only a quarter of physicians (26%), around a third of consumers (38%), and half of hospitals (50%) believe that – absent new action – their local health care community is on course to becoming more sustainable. As result, UnitedHealth Group is working with partners in both the private and public sectors to address the following identified key challenges:

1. The Health Challenge: While doctors think that patients always or often receive needed preventative health care 50% of the time, patients believe they receive it one third (33%) of the time. Although this shows that both doctors and patients suspect that more preventative care could be delivered, patients are more skeptical and believe they are not receiving the full breadth and scope of the preventative care they could benefit from.

2. The Quality Challenge: 47% of consumers said they believe there are significant differences in the quality of care provided by doctors in their local area, while 64% of providers said that was the case. Clearly, there is a transparency gap between what patients believe and their physicians know.

3. The Cost Challenge: U.S. adults believe that health care costs in their community could be cut by between a quarter and a third (29%) without having a negative impact on quality. This shows consumers, who would normally be apprehensive about cutting health care budgets, know there is room for reform in the system.

This information guides us on how we engage with the health system, the investments we make and the innovations we bring to the marketplace. We identify ideas we think might work, test them and, if they are demonstrated to work, we bring them to full-scale in the marketplace. We rely on the market feedback loop to learn. There are times when our investments don't work, but when they do, we can transform how health care is delivered and see powerful results in the areas of quality, care coordination, and maximizing the system's potential.

The opportunities that exist today are core to our mission to help people live healthier lives through our benefits business platform – UnitedHealthcare – and to help the health system work better through our services business platform – Optum. We need to increase care coordination in the U.S. health system as consumers, doctors, and hospitals are increasingly finding that the health care delivered in their communities is not coordinated. There is an opportunity to increase the use of technology and leverage its capabilities better. Today, fewer than half of the Electronic Medical Records in use allow doctors to share their patients' medical records electronically with hospitals, and only a third of physicians report having a computerized system in place to track patients with chronic conditions and ensure appropriate monitoring and follow-up care. We need to align incentives and create a more transparent system for physicians and patients.

Delivery System Reform must incorporate the tools to empower consumers and providers to achieve a common goal: transparency so informed decisions can be made and alignment of incentives so the system can reach its full potential. These tools will not only improve health outcomes but also reduce costs.

UnitedHealth Group's health care delivery efforts are targeted to address the core challenges and opportunities of the heath system outlined above. We do this by:

- Embracing wellness and prevention programs and fostering behavioral changes to improve the health status of the entire population by preventing avoidable diseases and the complications that result from the progression of these diseases;

- Empowering health care consumers with decision support tools through various transparency initiatives to help those that need to access the health system so they can do so with greater insight and make informed decisions; and

- Aligning incentives and driving outcomes through the use of data analytics and payment reform to empower health care providers with the technology and services they need, enabling them to better serve their patients.

Underlying all of these capabilities is our proficiency in gathering, protecting and analyzing diverse forms of health data and sharing our insights with participants in the health system – those who seek, deliver, regulate, and finance health care. Through our investment of over $2 billion annually in technology, including new development, we collect, dissect, analyze, and apply data to predict health care needs, identify areas of improvement, and protect program integrity.

Through our health services business, Optum, we provide services to 60 million individuals. Optum's customers include hospitals, physicians, health plans and their members (UnitedHealthcare and others), and other health care stakeholders. Over the past 15 years, Optum has created products and services which provide consumers and clients with complete solutions for a modern and evolving health care marketplace. We help physicians achieve greater consistency in their clinical performance and patient outcomes, build stronger individual consumer engagement and better health for people, drive down unnecessary costs, adapt to quality-focused compliance mandates, and help the alignment of participants across the health industry make the transition to new funding and payment arrangements.

Our benefits business, UnitedHealthcare, serves 26.4 million Americans, including employer-sponsored health plans, of which 3 million workers and their families are sponsored by small business health plans; 8.9 million seniors; and more than 3.6 million Medicaid beneficiaries (including 2 million children in 24 states and Washington, D.C. in acute and long-term care Medicaid plans). UnitedHealthcare utilizes innovations, strategies, and resources to steadily transform the way health care is delivered and financed. As a result, we offer consumers a simpler, more affordable health care experience that serves their needs through every stage of life. We are looking forward to providing benefits administration and services for 2.9 million active duty and retired military service members and their families in the TRICARE West Region starting in 2013, and bringing many of our innovative best practices and approaches to the TRICARE Program.

Our deep clinical expertise across these broad populations, exemplified by our robust medical management programs which apply evidence-based medicine, has led to reduced hospital readmissions, length of stays, and inappropriate emergency room utilization. We have enhanced quality while managing the cost trend. Improvement in quality outcomes for our UnitedHealthcare plans is exemplified by a dramatic reduction in readmission rates of 7.1% for our Medicare Advantage members in the past 2 years, and a 15% conversion of unnecessary hospitalizations into outpatient observation status. Preventing unnecessary admissions and readmissions helps to reduce waste in the system and deliver better outcomes for consumers.

We appreciate the opportunity to provide the Committee with our insights regarding what has worked for us in meeting the needs of our customers and individuals across the health care system and our recommendations for application of these innovations to Medicare and Medicaid as areas for potential collaboration and partnership. The tools and innovations I will outline are not currently broadly available in the Medicare and Medicaid programs. That is where the greatest opportunity lays for the Federal Government to change the health care delivery system and prepare it for today and tomorrow's consumers and health care participants. While not comprehensive, below are some of the best performing and highly successful tools and innovations we are deploying today to address various health care challenges and create an innovative, efficient, high quality, consumer-responsive, and provider-supportive health care system.

II. Embracing Prevention Programs and Fostering Behavioral Changes

The vast information and knowledge we have collected has helped us to learn more about who is consuming health care, why they are consuming it, where they are consuming it, and how their care may vary from published evidentiary standards of best medical practices. These insights are clinically significant and also have an economic impact. We have learned that gaps in the system exist and there are often significant differences between the care people receive and the care they should have received based on the published clinical guidelines and evidence. Informing the consumer of these gaps, educating them and making them a smarter and more empowered health care consumer is critical to creating opportunities to improve care delivery.

The benefit of using this data is seen in our wellness programs, where we work to identify the risk of disease in its earliest stages and to inform lifestyle modification programs that reduce the likelihood of disease. It helps us engage people with established chronic diseases in programs that address and potentially reverse the progression of that chronic disease.

We are proud of the investments we have made in these programs and the results we are achieving in decreasing the prevalence of chronic diseases. I'd like to touch on a few specific UnitedHealth Group initiatives:

Preventing the Onset of Chronic Diseases Such as Diabetes:

Working in partnership with the Centers for Disease Control and with nontraditional providers such as the Y-USA to deliver the Diabetes Prevention Program (DPP), we work to help delay the onset of diabetes. Our results from the DPP include a 5% mean weight loss for

participants, an average of 13 sessions attended out of the 16 sessions, and nearly 75% of the participants that attend at least one session will go on to complete the program. With 50% of seniors entering the Medicare program with pre-diabetes, we estimate that the Medicare program could save $67 billion over ten years by reimbursing for programs like the DPP. We have two specific programs designed for those who are already combating Diabetes. Our Diabetes Control Program (DCP) partners with pharmacies like Albertsons, Kroger, Rite Aid and Walgreens to provide private one-on-one consultations with local pharmacists to increase compliance with medications and care plans. Our expectations from the DCP include increased compliance with the American Diabetes Association's guidelines, 75% compliance for A1c, and an increase in Rx compliance while slowing the progression of the disease. Our commercial business, UnitedHealthcare, has designed the Diabetes Health Plan to help consumers manage their diabetes while reducing their out-of-pocket expenses by as much as $500 annually through enhanced benefits in exchange for compliance with preventive care guidelines.

The Diabetes Health Plan is an example of a value-based benefit that incents consumers to practice healthier behavior. Consumers receive richer benefits, or lower out-of-pocket costs, if they commit to fulfilling the American Diabetes Guidelines such as receiving blood sugar tests at least twice annually or diabetic retinal exams once annually. In exchange, they receive lower out-of-pocket costs, such as no copays for their diabetes, hypertension or cholesterol –lowering drugs.

Considering the high costs associated with managing chronic diseases, investments in prevention are worthwhile for all parties involved. Working with the Federal Government on

ways to increase medication and care plan compliance and preventing the onset of Diabetes will be key to addressing this chronic disease.

Implementing Employer-Sponsored Healthy Rewards Programs:

The CDC estimates that roughly 50 percent of a person's overall health stems from daily lifestyle choices. To encourage healthier lifestyles and behaviors, we have developed UnitedHealth Personal Rewards, a program that rewards people for making healthy choices in their daily routine. Created by UnitedHealth Group in 2010 and adopted by over 40 large employers, the program serves more than 2 million people. The program has led to greater awareness of an individual's health, better care seeking behaviors such as wellness program enrollment, a reduction in Emergency Room use, an increase in PCP wellness exams, and weight loss. We saw a 19.6% reduction in diabetes-related complications, a 12.3% decrease in coronary artery disease costs, a 3.3% reduction in hospital admissions, and a 5% reduction in Emergency Room use. The investment in the health of our employees helps us keep a productive workforce and helps our employees and their families live high quality lives. As we look to modernize the Medicare and Medicaid systems, we should consider how we can incent the population, similar to what employers are doing in the private marketplace, to make the right behavioral changes and informed care decisions.

Leveraging Telehealth Capabilities to Increase Access to Primary Care:

Through enhanced models of telemedicine, we are working to expand access to America's health system and increase the use of preventative services and ensure individuals get the care they need when they need it. The NowClinic, a telehealth program established by UnitedHealth Group to meet the lifestyle needs of today's consumers, is an online tool that

provides patients with real-time access to licensed physicians in their state and facilitates through secure, live conversations between patients and physicians. Available in 18 states (Arizona, California, Connecticut, Illinois, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, New Mexico, New York, North Carolina, Ohio, Pennsylvania, Utah, Wisconsin, and Wyoming), people can log into myNowClinic.com and get access to physicians, and, in select states, our nurses, regardless of insurance coverage. This capability brings primary care to the individual's home or office, removing yet another obstacle to accessing a physician.

As individuals' lifestyles continue to change and access to providers becomes even more difficult because of demands on the system, the Federal Government can play a role in encouraging innovative care delivery that leverages technology and is an efficient use of providers' time.

Leveraging Technology and Mobile Apps to Increase Care Compliance:

Our Medicaid benefits business, UnitedHealthcare Community and State, recently launched an initiative – Baby Blocks – designed to engage pregnant women with an online mobile tool to drive the understanding of appropriate pre-natal and post-partum care and well-baby care. By using email reminders for scheduled appointments and offering an incentive program to encourage engagement in their care and the care of their babies, we believe that women will experience fewer complications and that their babies will be healthier. If proven effective, compliance with this program should result in Medicaid savings to the State and Federal Governments.

III. Empowering Health Care Consumers Through Transparency and Decision Support Tools:

UnitedHealth Group has been at the forefront of developing transparency tools and decision support services that help people make better decisions as they access the health system. Examples of the most important and effective tools include:

Transparency on Costs:

UnitedHealthcare's Health Treatment Cost Estimator provides our consumers a comprehensive view of how treatment costs differ from doctor to doctor. The tool delivers personalized cost estimates for various treatment options. It covers a broad range of care options, provides cost and quality data for more than 400 geographic areas covering 116 diseases, 90 different types of surgeries and procedures, 500 individual services, lab tests, and radiology tests, and more than 3,000 medications. Utilizing significant amounts of data from a variety of sources, including our own in-network fee schedules and data licensed from the independent not-for-profit FAIR Health, this tool equips our consumers with personalized information to make informed decisions on where to seek care. Empowering consumers with this information allows them to be more confident about the quality of their care and in control of the economics surrounding it.

Creating Customized Health Care Tools:

Optum has taken the concept of providing the right care at the right time to the right people even further with the creation of our eSync Platform. This powerful technology helps build a detailed health portrait of each patient and then delivers customized health care management tools to individuals directly and via their care providers. By combining, in a

HIPAA compliant manner, a wide range of health data such as medical claims, health and lifestyle choices, and demographic factors, UnitedHealth Group can turn this information into a practical blueprint for effective, personalized plans based on a member's actual health care needs. Through a combination of outreach by Optum's nurse, direct mail, mobile applications and Health eNotes, our consumers receive information about an upcoming medical procedure, or a reminder to schedule an annual exam, or tips on starting an exercise plan, all based on their personal needs. Optum's eSync also powers the ability to proactively reach out to high-risk customers and offer them the opportunity to participate in programs specifically designed to help them reduce their health risks.

For nurses, clinicians, health coaches, physicians, and others, the eSync platform also provides enhanced visibility into a patient's medical history and real-time medical profile which can result in better health management and potentially significant savings for individuals, their employers, and the health care system as a whole. Medical care designed for the individual is critical to creating an efficient, effective, and consumer-friendly health care system.

Adoption of technology in a manner that allows communication across the health care system, regardless of payor or provider, and is critical to reforming the health care delivery system in a manner that decreases costs without impacting quality. In addition, it provides an opportunity to empower both consumers and providers with the information they are seeking to improve outcomes. The Federal Government's role in requiring the adoption of Health Information Technology is critical to increasing its widespread use.

IV. Aligning Incentives and Driving Outcomes Through Technology and Payment Reforms:

Our data analytics allows us to serve the important needs of physicians and institutions that care for consumers, customers, and their patients – providing insights into everything from physician practice patterns, to gaps in care, to the full cost of specific care episodes. Our technology and investments enable us to provide tools and solutions to more than 250,000 physician practices of varying sizes and more than 5,400 hospitals. In addition, we partner with the provider community through Accountable Care Organizations and Medical Homes. In addition to the eSync platform I discussed earlier, we are working with the hospital and provider community to develop new ways to deliver health analytics directly to the point of care, aligned with physicians' regular workflow, to enable better, real-time decision making between physicians and patients. Optum developed the Optum Care Suite for patients, physicians, and other health professionals to access essential health intelligence and collaborate in making medical care decisions to improve health outcomes. Managed via Cloud technology, in a secure environment that protects patient privacy, Optum Care Suite marries clinical data from electronic medical records with related health claims, patient-reported outcomes, and Optum's powerful analytics. Pilots conducted with small group primary care practices in Arizona have demonstrated that sharing of information bi-directionally with physicians, measuring clinical outcomes, and moderate financial incentives that are reimbursed effective to their ability to close the gap in care, led to a ten-fold increase in the rate at which the evidence-based medicine gaps were closed.

Creating Meaningful Use to Securely Share Information:

Our investments include operating Health Information Exchanges in more than 11 state-wide programs, multiple regional programs, and several hospital-specific health systems. The connectivity established across these health systems is further enhanced with administrative - and clinical – information based decision support systems. Optum's Axolotl Discover Program delivers powerful analytics to the Health Information Exchange, converting vast amounts of raw data, almost instantly, into critical health insights for physicians and other care providers who participate in the Exchange. The Quality Health Network (QHN) and Optum partner together to deliver a Health Information Exchange in Colorado. Using Optum's Elysium Exchange platform deployed by QHN, the independent hospitals and physicians of Aspen and Montrose counties are electronically connected to each other and with other independent hospitals and physicians in Grand Junction, Colorado. The real time clinical messaging infrastructure allows authorized physicians to share clinical data at the point of care between and among disparate hospital and Electronic Medical Record (EMR) systems. The Exchange has been identified as a model for quality improvement and cost efficiency.

Innovative Program Designs:

Our commitment to being a leader in modernizing America's health care system is also evident in our program designs and our leveraging of nurse practitioners. Utilizing appropriate, evidence-based clinical interventions through our Evercare Program and the Senior Care Options Program in Massachusetts, Medicare and Medicaid Eligibles have experienced:

- A greater than 50% reduction in inpatient utilization;

- A 26% bed-day reduction over a three year period;
- A 64% reduction in Medicare inpatient admits;
- A 52% reduction in Medicare costs; and
- A 60% reduction in emergency room visits.

In our Medicare Advantage programs, with the use of high-risk case management, advanced illness transitional care, and post-acute transition programs, seniors experience:

- 30% fewer hospital readmissions than Fee-for-Service;
- 50% fewer hospital readmissions in institutional settings;
- A reduced length of stay in the Skilled Nursing Facilities by 2 – 4 days, resulting in over $1,000 in savings per case; and
- Savings of $2,400 a year per member through the use of high risk management tools.

We all benefit when care is delivered in the right setting, when gaps in care are narrowed, and complications are identified earlier and treated effectively.

Innovative Payment Reforms:

Payment is another important method in aligning incentives and driving quality outcomes. We have a strong commitment to modernized reimbursement systems with physicians and hospitals that pursue evidence-based care when conventional Fee for Service systems could create ineffective outcomes. The UnitedHealth Premium Physician Designation Program empowers our members across the Country to make physician selection choices based

on quality and cost efficiency. Started eight years ago, our Premium Designation Program is perhaps the nation's broadest and deepest transparency tool for physician performance and assessment. This program provides physicians with valuable feedback on their performance while at the same time enabling patients to make informed health care decisions. We use the extensive data we have from claims, pharmacy, laboratory and other administrative data sources, and analyze care patterns using sophisticated episode-grouper analytic software. This approach analyzes patient care by condition across settings and time, thus representing a more patient-centered view of care.

Our program is grounded in the principle that performance measures should be developed by expert physicians in each specialty area and approved by nationally-accredited bodies. As such, we incorporate performance measures that have been reviewed and endorsed by the National Quality Forum and the National Committee for Quality Assurance, as well as performance measures developed in collaboration with medical specialty societies and reviewed by committees of practicing physicians. The Premium Designation Program evaluates physician performance on quality and efficiency across 21 different areas – including primary care and specialties such as cardiology and orthopedics.

The Premium Designation Program analyzes the performance of physicians against both quality and efficiency benchmarks. Quality is measured first and only those physicians who meet or exceed quality benchmarks are then evaluated for cost-efficiency. Quality is assessed using more than 300 national standards and metrics developed by physician specialty societies. Efficiency is measured using more than 230 measures and benchmarks that are risk-adjusted and

tailored to each physician's specialty and geographic area to account for differences in average costs. On both dimensions, performance is measured relative to other physicians. Results are displayed in our provider directories using a "star" format, with one star for quality and another for efficiency. This online system has been well-received, with positive feedback from physicians and medical societies. Key outcomes associated with our Premium Designation Program include:

- For all 21 physician specialties in the Program, the incremental savings between Premium Designated Physicians and non-designated physicians is 14%;

- Cardiologists who earn a quality designation have 55% fewer redo procedures and 55% lower complication rates for stent placement procedures than cardiologists who did not receive the quality designation; and

- Orthopedic surgeons who earn a quality designation have 46% fewer redo procedures and a 62% lower complication rate for knee arthroscopy surgeries than other orthopedic surgeons who did not receive the quality designation.

Another example of a unique provider reimbursement model is our Cancer Care Reimbursement Model which reimburses oncologists up-front for an entire cancer treatment program, as well as for the margin between their costs of purchasing medication and the retail price charged. By paying medical oncologists for a patient's total cycle of treatment rather than

a number of visits and the amount of chemotherapy drugs given, this new program promotes more patient-centric, evidence-based care with minimal loss of revenue for the physician.

Payment reform is an important tool to create greater efficiency and high quality outcomes in the health care system. The Federal Government should look to adopt payment models that align incentives and reward high quality medical outcomes.

Collaboration with Providers:

Working closely with various health care providers in local markets and communities, our business and effectiveness is driven by the recognition that care delivery needs to promote a collaborative network aligned around the concept of total population health management and outcomes-based reimbursement. In close coordination with local integrated care delivery systems, we deploy a core set of technology, risk management, analytical and clinical capabilities and tools to assist physicians in delivering high-quality care across the populations they serve. Our coordinated post-acute care services augment primary care physicians to deliver services outside of hospitals to vulnerable, chronically ill populations. Specifically, two of the systems Optum partners with, Monarch HealthCare and AppleCare Medical Group, both in California, are currently taking part in CMS' ACO demonstrations and initiatives.

V. Opportunity for Public-Private Partnerships:

UnitedHealth Group partners with federal and state governments in a variety of ways. We serve approximately 300 federal and state government agencies. Currently, we administer the Multi-Payer Claims Database for CMS and the Data Warehouse for the Office of Personnel

Management. We are in the final discussions with CMMI to participate in its Comprehensive Primary Care Initiative in Colorado and Ohio. In addition to serving as the largest provider of Medicare Advantage Plans and Medicaid Managed Care Plans in the country, we are proud of our partnerships with the Federal Government in the following capacities:

- Federal Employee Health Benefits Program, Office of Personnel Management;
- TRICARE West Region (a*warded in 2012, for Contract Beginning in 2013);*
- A Blue Button participant with HHS and the Department of Veterans Affairs;
- Community-Based Care Transitions Program for CMS;
- Development and testing of imaging efficiency measures for CMS;
- Contract with TRICARE's North Region on predictive modeling;
- Reserve Health Readiness Program for the Department of Defense; and
- Clinical disability exams for Military Veterans for the Department of Veterans Affairs.

We continue to look for ways to partner with the government and bring our private sector innovations to the public marketplace. Delivery System Reform is a ripe opportunity for collaboration.

As the Senate Finance Committee and Congress continue to evaluate how to implement Delivery System Reforms and create a high quality health care system that is efficient and responsive to consumers' needs, I urge you to invest in the application of Health Information Technology, leverage existing data and information capabilities in the health system today, and apply those private sector best practices that are proven and delivering results, to federal and

state health programs so that Medicare and Medicaid beneficiaries have the benefit of what is available and working in the broader marketplace. The innovations I have outlined for you today are examples of these best practices. They are proven and operating at full-scale in the marketplace today, yet Medicare and Medicaid beneficiaries generally don't have access to them. Medicare and Medicaid modernization is a tremendous opportunity for our nation and addressing the dually-eligible Medicare and Medicaid population will be critical to addressing some of our greatest health care challenges. UnitedHealth Group appreciates the opportunity to testify today and the Committee's recognition that Delivery System Reform is needed to truly modernize America's health care system. We look forward to continuing to be a resource to the Committee.

Thank you for your leadership on this important issue.