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for businesses in America

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> ILLUSTRATION BY JON KRAUSE

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# GOOD MEDICINE OR A BITTER PILL?

Implications of health care reform for businesses in America

BY ROBERT W. CLARKE > PAUL H. KECKLEY AND STEVEN KRAUS  
> ILLUSTRATION BY JON KRAUSE

America seemed to collectively exhale on March 30, 2010 when President Obama signed final revisions to the Patient Protection and Affordable Care Act (PPACA) into law. Whether hopeful, angry, excited or fearful about the act's potential effects on the nation's health care system, many citizens seemed grateful for a breather after 14 months of arduous congressional debate and emotional public dialog.

Other issues and events may have since replaced health care reform in daily headlines. But the impact of, and debate about, this landmark legislation continues to reverberate in the media and boardrooms, workplaces, kitchen tables and government corridors.

The full implications of the PPACA, and other legislative and regulatory initiatives affecting health care, will unfold over the next decade and beyond. But the journey to a new health care system has begun, with enormous implications for businesses in America. In fact, reform affects the majority of American businesses because of their role in funding and providing health care for employees and employees' families.

For one group of businesses, reform presents a double challenge. Health sciences companies – health insurers, health care providers, and life science companies – will need to adapt to both the changes affecting them as employers and the transformation of the health care delivery system in which they play key roles.

While many of the most dramatic changes will occur in 2014, important milestones this year will demand the urgent attention of business leaders. This article explores our view of the current and future path of health care reform and examines the resulting effects, both certain and possible, across the business spectrum – from employers who may now bear an even greater burden of responsibility for providing health benefits to employees, to the health industry stakeholders that are front-line providers of care. And it offers considerations for business executives in their efforts to address their organizations' transition to the new health care order.

#### HEALTH CARE REFORM – NOT A ONE-ACT PLAY

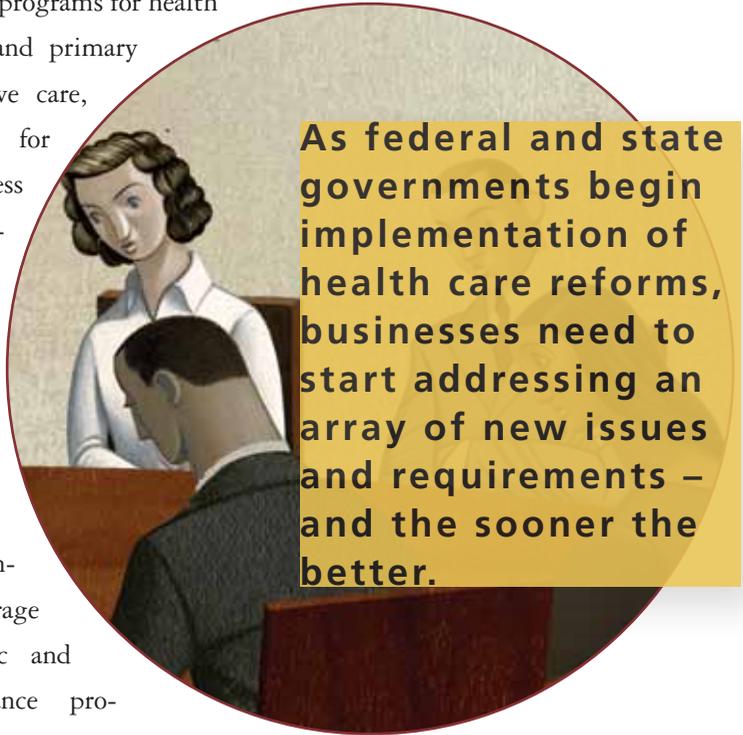
Generally speaking, health care reform has three goals: expanding health coverage to the uninsured, improving health care quality and access, and stemming the growth in health care costs.

With the passage of the PPACA, the first goal should be attained in 2014, with approximately 32 million uninsured Americans becoming covered.<sup>1</sup> The other two goals are more aspirational, to be influenced by many factors. At this stage, whether health care reform will contain or lower costs is conjecture, dependent on successful demonstration projects and pilot programs in the bill, and efficient management of services for an aging population and the newly insured.

The PPACA is the centerpiece of health care reform today, but it is not the only element:

- Provisions in the American Recovery and Reinvestment Act (ARRA) of 2009 provided additional funding for Medicaid, expansion of health benefits for the unemployed, and development of health care information technology.<sup>2</sup>
- New clinical coding standards described in the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) are scheduled for U.S. implementation in 2013.<sup>3</sup>

- The Obama Administration’s proposed federal government budget for fiscal year 2011 contains reform-related provisions, including changes in Medicare and Medicaid reimbursement and funding for comparative effectiveness research, public health programs, targeted programs for states to reign in health costs, programs for health centers to expand primary and preventative care, and programs for expanding access to care in medically underserved areas.
- Efforts are also underway at the state level, such as expanding insurance coverage through public and private insurance programs, health savings accounts, premium support, and support for development of electronic data exchanges.<sup>4</sup>



Federal rulemaking will clarify a number of provisions in the PPACA. The words “The secretary shall” preface over 1,000 provisions, which the U.S. Department of Health and Human Services (HHS), led by Secretary Kathleen Sebelius, must address. Many different federal agencies will issue PPACA-related rules, including HHS, the U.S. Food and Drug Administration, the Center for Medicare and Medicaid Services, the National Institutes of Health, and the Centers for Disease Control.

Another uncertainty is how states will fulfill their roles in implementing health care reform. Much of the heavy lifting falls to the states, including establishment of health insurance exchanges intended to provide a resource “where individuals and small businesses can compare and purchase health insurance online at competitive prices.”<sup>5</sup> While HHS will provide funding, guidance and information systems to help states comply with reform mandates, the states are likely to respond in different ways.

As federal and state governments begin implementation of health care reforms, businesses need to start addressing an array of new issues and requirements – and the sooner the better. Mandated changes in employee insurance coverage go into effect in fall 2010.<sup>6</sup>

#### IMPLICATIONS FOR EMPLOYERS: NEW COVERAGE AND REPORTING REQUIREMENTS

A recurring debate during the health care reform deliberations centered on whether the United States would or should adopt a government-operated, national “style” of health care system similar to Canada, Europe and many other countries to replace employer-sponsored insurance. With passage of the PPACA, the United States is arguably moving in the opposite direction. If anything, the act solidifies the role of employers in providing health benefits to their employees.

Employers seem generally amenable to this, provided there is a competitive playing field for companies throughout their business sector and that all are held to the same requirements. Major concerns remain among employers – will enough younger, healthier individuals enter the insurance market to offset retiree Medicare costs? Will the government impose additional restrictions and costs of compliance on employer-sponsored plans? And long term, how will Employee Retirement Income Security Act (ERISA)-exempt plans be impacted?

The “new normal” for employer-sponsored insurance benefits is likely to include:

- Substantial consolidation in the hospital and health insurance industries as stronger players absorb weaker players, with a resulting strengthening of their bargaining position for prices for their services.
- Substantial cost increases by hospitals and other providers as underlying medical costs increase from an aging population, new technologies are introduced, and demand for services increase, all resulting in greater price pressure on insurers and employers.
- Substantial pressures from employees and dependents for expensive technologies and treatments that might work for some but not all.

More than 20 areas in the PPACA are likely to impact employers, taking effect in coming years (see “Health Care Reform – Employer Timeline” next page.) Some of these provisions with more immediate deadlines have come into sharp focus. All employers, especially larger companies, should analyze these provisions as they begin to redefine their employee health benefit strategies in light of the new law.

## HEALTH CARE REFORM – EMPLOYER TIMELINE

### Effective for plan years beginning six months after enactment

#### (1/1/2011 for calendar year plans)

- Prohibit lifetime limits on the dollar value of coverage. Grandfathering does not apply.
- Coverage must be available to dependent children (married or unmarried; student or not) to age 26. Grandfathering does not apply.
- Prohibit pre-existing condition limitations for children. Grandfathering does not apply.
- Annual limits on the dollar value of coverage must be reasonable (as defined by regulation to come). Grandfathering does not apply.
- Subject to regulations, require most employers to automatically enroll new full-time employees into a health plan option. Employees may choose to opt out.
- For non-grandfathered plans, preventive health services must be provided without cost sharing ('A' or 'B' rated by the U.S. Preventive Services Task Force).<sup>7</sup>

### Effective 2011

- Over-the-counter medications not reimbursable through a Health Reimbursement Account (HRA) or Health Flexible Spending Account (FSA); prescribed medicines, drugs and insulin still qualify.
- Non-health HSA distributions taxed at 20 percent.
- Employers required to disclose on Form W-2 the value of health benefits.

### Effective 2012

- Employers must distribute a uniform summary of benefits and coverage explanation prior to enrollment or reenrollment.

### Effective 2013

- Medicare Part A tax increased to 2.35 percent for earnings over \$200,000 (individual return) and \$250,000 (joint return).
- Employer tax deduction for Medicare Part D retiree drug subsidy eliminated.
- Health care FSA contribution limited to \$2,500 annually (indexed).
- Employers required to notify employees of the establishment of health insurance exchanges in 2014.

### Effective 2014

- Individual mandate applies (may increase enrollment in employer plans).
- Exchanges open.
- Annual limits on the dollar value of coverage prohibited.
- Waiting periods cannot exceed 90 days.
- Pre-existing condition limitations for adults prohibited.
- "Essential benefit provisions" (determined annually by the Secretary of HHS) apply to new plans; regulations will determine when plan changes are significant enough to trigger "new" plan provisions.
- Employer mandate and potential penalties begin.
- Employers may offer rewards to employees who participate in wellness programs, limited to 30 percent of the cost of coverage.
- Employers required to furnish an information return to employees and to the government identifying coverage periods, the portion of premium paid by employer and other information.

### Effective 2018

- 40 percent tax on high-value plans (over \$10,000 for individuals and \$27,500 for families).

Key considerations include:

### *How and to what extent “grandfather” provisions of the PPACA apply*

During the health care debate, President Obama repeatedly assured Americans that if they like their health care coverage they won't have to change it. The PPACA does in fact include a grandfather clause for employer plans in existence as of the date of the act's enactment.

With the exception of some insurance reforms—such as barring coverage denials for pre-existing conditions and shortening allowable waiting periods before extending coverage—employer plans in existence on the date of enactment will not have to be changed to comply with other parts of the PPACA. Regulatory guidance on how much an existing plan *can* change and not lose grandfather status is expected later in 2010. This will be a critical issue for businesses as they weigh the effects and costs of other provisions, because loss of grandfather status could force employers to broaden their benefits plans and potentially incur higher health insurance premiums, both of which might result in higher overall health benefits costs.

### *Health plan changes resulting from insurance reforms and creation of the “essential health benefit package”*

If a company has a health plan that loses grandfather status, or it is creating a plan for the first time, it will likely be required to establish an “Essential Health Benefit Package.” Effective in 2014, this is a groundbreaking provision, as the federal government has never previously mandated that a set of services be included in employer plans.

Which services will be required in an Essential Health Benefit Package is yet to be determined, and a comprehensive set of services will be established annually by the HHS secretary. However, if the experience in individual states is a guide, additional services not covered historically by employers, such as acupuncture and homeopathy, could potentially be included in the package.

### *Workforce planning implications of new eligibility and coverage provisions*

The PPACA establishes minimum standards for insurance eligibility and coverage for the first time. Effective when regulations are issued, new full-time employees working at least an average of 30 hours per week during a month must be enrolled automatically in an employer-sponsored health plan. Employees can opt out and instead obtain coverage from their state's insurance exchange. In addition, while the PPACA does not explicitly require that an employer offer its full-time employees acceptable health insurance, employers with at least 50 full-time

equivalents will generally face penalties, beginning in 2014, if one or more of their full-time employees obtains a premium credit through an exchange.<sup>8</sup> While not a mandate, these provisions may have a similar effect.

The PPACA standards will significantly affect industries that employ part-time, temporary, seasonal and float-pool workers extensively. In addition to the 30-hour provision, employers will only be allowed to impose a maximum 90-day waiting period before full-time employees

become eligible for benefits. This

maximum is significantly less

than the competitive norm

in certain industry sec-

tors. Also, employers

that previously of-

fered coverage only

to employees will

now need to offer

coverage to em-

ployees' dependents.

These changes

could dramatically af-

fect industries such as

retail, hospitality and health

care. Many retailers, for example,

require that employees work 35 to 40

hours per week before being considered full time and eligible, as well as going

through a waiting period of 180 days or longer before receiving health coverage.

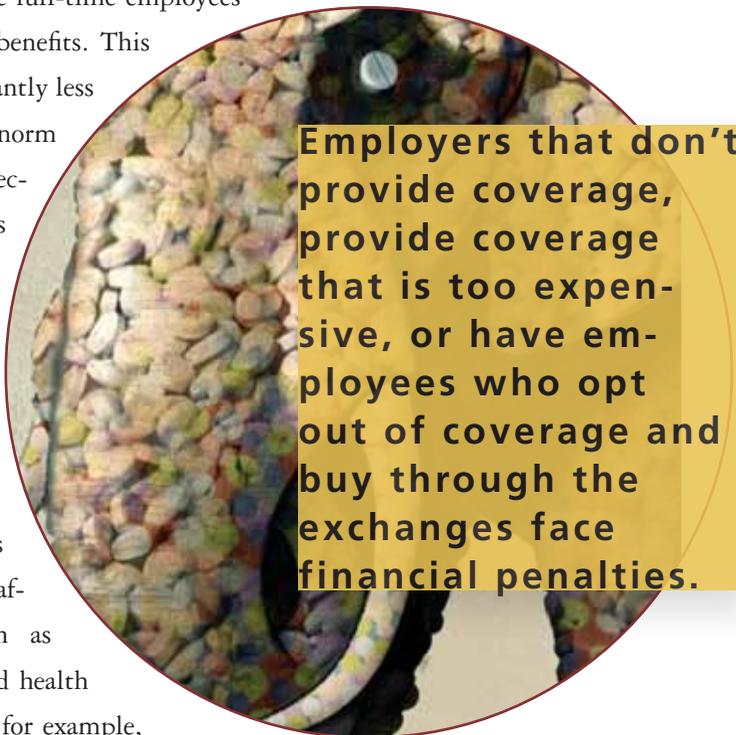
Such employers should consider assessing their workforce profile in light of the

new eligibility and coverage realities of the act.

### *Compliance and reporting requirements*

The PPACA imposes an “individual mandate” requiring everyone in America to have health care coverage obtained in one of three ways: from an employer, from a governmental plan like Medicare and Medicaid, or purchased from one of the state insurance exchanges to be established in 2014. Employers that don't provide coverage, provide coverage that is too expensive, or have employees who opt out of coverage and buy through the exchanges face financial penalties.

Under the act, children can remain on their parents' employer health insurance plan until age 26. Also, health plans cannot deny coverage to children under the age of 20 because of a pre-existing condition.



**Employers that don't provide coverage, provide coverage that is too expensive, or have employees who opt out of coverage and buy through the exchanges face financial penalties.**

## IMPLICATIONS FOR HEALTH SCIENCES COMPANIES: ASSESSING THE IMPACT ON THE FRONT LINES

**As purveyors of health-related services and products, health plans, health care providers and life sciences companies will experience health care reform differently:**

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### Health plan impacts

This sector is probably affected most dramatically and must grapple with major issues immediately. Approximately a dozen provisions in the PPACA require action by insurance companies within six months after passage of the act. Changes to be made effective for plan years beginning September 23, 2010 include removing lifetime limits from insurance policies, expanding coverage to dependents up to age 26, and covering preventive benefits without cost sharing. Another noteworthy change for health plans involves administrative standardization, which will require insurers to work with hospitals toward simplifying basic transactions. Together with medical benefit expense floors and new reporting, standardization compels significant investments in automation of core administration activities.

Insurers will need to act fastest, with only limited help from near-term, clarifying regulations. They need to understand the act's effects – not only the list of immediate to-dos but also its broader, longer-term implications. How will the provisions impact their book of business, both in terms of membership and finances? Who will their customers really be in the future? What are the opportunities and risks going forward?

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### Health care provider impacts

While insurers face hard and fast change, health care providers are afforded a more gradual immersion. Changes will happen more on a year-over-year basis, with a number of trial-and-error provisions playing out.

Among immediate priorities facing providers is dealing with significant near-term impacts related to Medicare, including Medicare rate adjustments and establishment of pilot projects to test new payment methodologies. In addition, linkage of Medicare hospital payments to outcomes will elevate the importance of capturing sound data that substantiates treatment quality. Expanding coverage rolls may contribute to hospital volumes and revenues. However, cuts in Medicare payment levels, reduced government funding of indigent care, and increased commercial plan price pressure will lower per-patient revenues, driving smaller and underperforming providers to consider finding partners. Delivery system reforms, such as bundled payments in which hospitals and the attending physicians receive a set dollar amount from the government for the array of services provided a patient before, during and after hospitalization, will require stronger and more diverse relationships between hospitals and physicians.

Provider organizations should assess whether they have optimal relationships with other providers and are creatively managing the health of the populations they serve. Considerations include types of care to offer, where and when to provide it, and effectiveness of IT strategies and preparedness for ICD-10. In addition, nearly \$300 million in new funding for enforcement and program integrity activities provided by the PPACA and the ARRA will compel organizations to assess their ability to prevent, detect and correct potential compliance issues (see “Addressing fraud, waste and abuse” on page 137).

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### **Life sciences company impacts**

Health care reform’s impact on life sciences companies has received less public attention to date than on insurers and providers. However, changes for pharmaceutical companies and medical device makers are significant.

Life sciences companies will see both positive and negative margin impacts. Drug usage should increase with the increased number of insured Americans, increased Medicaid drug rebates, and closing of Medicare Part D’s “donut hole” in prescription drug coverage for seniors. However, a new excise tax will lower margins on some medical devices, and growing use of generic drugs will continue challenging pharmaceutical companies to generate return on capital investments.

The expanded use of comparative effectiveness studies may significantly change how life sciences companies conduct research and development and help guide investment decisions. Life sciences companies will also need to decide which markets are most promising. For example, should they focus on a changing U.S. market or shift attention to other countries?

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### **Suggestions for health care-related companies**

Health plans, providers and life sciences companies should consider a three-pronged response to health care reform:

- Develop rapid responses to the most time-sensitive statutory and business implications. Though major elements of the bill are effective in 2014, no health care organization can afford to delay preparedness.
- Understand the act’s longer-term strategic implications. Pay special attention to how the alignment of cost reductions with improved outcomes and safety could require innovative models of collaboration between payers, providers and life sciences organizations.
- Begin a deliberate process to assess and diagnose organizational strengths and weaknesses resulting from real and potential long-term reform.

We believe taking a structured, disciplined approach to reform requirements, necessary responses and likely organizational impacts can help companies address these three priorities more effectively.

Reporting requirements in the PPACA require changes in benefit administration systems. Employers will be required to submit a filing to the Internal Revenue Service certifying whether full-time employees have coverage, whether they have single or family coverage, how much it costs, and the design of the health care plan. Employers also must calculate on a standardized basis the value of health care benefits they provide to individual employees. They will be required to communicate the value of those benefits through a line item on each employee's W-2.

### *Steps employers can take now*

As noted, most provisions of the PPACA don't go into effect until 2014. However, with insurance reforms effective for plan years starting in September 2010 and an urgent need to inform employees of upcoming changes, employers should take steps now to comply.

They should proceed cautiously, though, especially considering the grandfather provisions. A misstep could mean losing grandfather status and becoming subject to additional requirements. For example, employers that completely revise their employee health care offerings in 2011 or later will lose protections that grandfather status may bring. And, pending regulatory guidance, material modifications to a plan's value or cost to employees may also trigger unintended consequences. Hopefully, material modification guidance will be forthcoming during 2010.

Employers should consider a three-phase approach in addressing health care reform: First, consider adjusting plan designs to meet the immediate requirements of the act, while maintaining grandfather status. The goal is to make needed design and contribution changes without unintended consequences created by loss of grandfather status.

Second, analyze what plan changes will be needed for 2014 when health exchanges and individual coverage mandates go into effect. It will be critical by then to understand what actions employees are likely to take in terms of staying in or opting out of employer-provided coverage. Think of how employees will react to the individual mandate – will they be more or less likely to opt for employer coverage? Also compare coverage costs through an exchange to employer plan costs.

Finally, take a strategic view of health care reform that seeks to balance the PPACA's requirements, health care costs and the business's commitment to providing employee coverage. This strategic analysis needs to be performed in the context of a potentially changed competitive landscape. First, to what degree does health care reform modify how employers within an industry or sector deal with their rewards responsibilities. Second, will health care reform require rethinking workforce composition within selected sectors?

## ADDRESSING FRAUD, WASTE AND ABUSE

**Fraud, waste and abuse are staggering problems in the health care industry, accounting for perhaps hundreds of billions of dollars in losses annually.<sup>9</sup> According to the Internal Revenue Service, estimates of the amount of fraud range from three to 10 percent of national health care expenditures.<sup>10</sup>**

Government efforts to address the situation are intensifying. An additional \$350 million, 10-year investment in fraud surveillance was added in the final revisions to the PPACA.<sup>11</sup>

The ARRA includes funding to strengthen antifraud oversight and investigations through several avenues. Concurrent with passage of the ARRA, the Fraud Enforcement and Recovery Act of 2009 (FERA) was enacted, extending federal fraud laws that previously only addressed government procurement and expanding the scope of the False Claims Act (FCA), which imposes liability on businesses for making false statements or claims for government reimbursement.<sup>12</sup>

Provisions in the PPACA addressing fraud, waste and abuse include increased penalties for submitting false claims, enhanced provider screening and oversight, Medicare and Medicaid requirements to establish compliance programs, and use of tax data to identify fraudulent providers.

One area of enforcement focus could be the fraud potential resulting from the addition of 32 million people to insurance rolls. Law enforcement officials are also expected to pay close attention to hot fraud markets, such as Florida,<sup>13</sup> as well as the nature and evolution of physician-hospital relationships as concepts such as bundled payments gain traction.

Businesses should consider taking several steps in an effort to reduce their exposure and liability related to fraud, waste and abuse, including:

- Take a close look at new fraud-prevention measures included in the PPACA, ARRA and FERA. Understand specific areas the government is targeting, why such areas are being targeted, and new requirements the provisions mandate.
- Anticipate compliance requirements relating to employee health benefits and potential government enforcement actions.
- Establish effective compliance programs and internal controls, beginning with a strong tone of compliance at the top that is actualized through resource commitment.
- Conduct a thorough risk assessment to map exposure in the context of applicable laws and regulations and identify gaps that might expose the company to enforcement activities.
- Expand the scope of existing fraud prevention programs and controls to include new health care-related risks. Assess and refine program components, including comprehensive personnel training; communication protocols; channels for employees to safely report violations, such as whistleblower hotlines; periodic reviews and audits; and penalties for noncompliance.
- Consider additional investment in technology to analyze transactions and detect anomalies.

A prompt and appropriate response is needed when a problem or violation is detected. Effective preparation includes identifying investigative and response resources before a crisis and creating and documenting fraud and abuse protocols.

### A TIME FOR DECISIVE AND INFORMED LEADERSHIP

**H**ealth care reform has monumental implications for businesses in America. Changes will occur over time, and specifics of many of those changes are largely unknown today.

The many uncertainties surrounding health care reform should motivate boards of directors and senior executives to engage as never before in understanding the health care landscape and taking decisive action to shape their companies' strategies going forward. Simply put, corporate leaders can no longer place total responsibility for health care on their human resources departments. Instead, they should address it as diligently as any other aspect of the business, applying similar levels of rigor to planning, risk management, compliance and measurement associated with their organization's health benefits.

Also, a heightened commitment doesn't end at the gates of the corporate campus. Businesses now have a bigger ownership stake in health care than ever. We believe they can help shape the future of health care reform by:

- Developing effective practices in benefits design and sharing them with other employers.
- Working collaboratively with other businesses in their community to shape the local health care delivery system, holding providers and each other accountable for health care quality, safety and cost containment.
- Taking an active part in shaping national and state health care policy through involvement with trade associations.

Finally, health care reform is likely to be a catalyst for innovations in health care services and delivery. What has historically been an insular and rigid system is now even riper for innovation. New players and new service delivery models are expected to emerge to help employers overcome traditional barriers to cost control, efficiency and improving workforce health and quality of life.

By acting both methodically and quickly to comply with near-term reform requirements, while simultaneously laying the groundwork for future decisions, executives can better prepare their organizations for the continuing evolution of the nation's new health care order.

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