BlueCross BlueShield
of Illinois, New Mexico, Oklahoma & Texas

Statement of Colleen Reitan, Executive Vice President & Chief Operating Officer
Health Care Service Corporation, d/b/a/ Blue Cross and Blue Shield of Illinois, New Mexico, Oklahoma and Texas
Hearing *"Between You and Your Doctor: The Bureaucracy of Private Health Insurance"*
United States House of Representatives, Domestic Policy Subcommittee of the Oversight & Government Reform Committee
2:00 p.m. Thursday, September 17, 2009
2154 Rayburn House Office Building

Introduction

Good afternoon Mr. Chairman and members of the Subcommittee. I am Colleen Reitan, Executive Vice President and Chief Operating Officer of Health Care Service Corporation ("HCSC"), a Mutual Legal Reserve Company which does business as Blue Cross Blue Shield of Illinois, Blue Cross Blue Shield of New Mexico, Blue Cross Blue Shield of Oklahoma and Blue Cross Blue Shield of Texas.

One of the areas within my responsibilities is management of our Subscriber Services Division, which is responsible for processing member health care claims and inquiries. I am also responsible for our Information Technology, Finance and Actuarial functions.

Prior to joining HCSC in 2008, I was President and Chief Operation Officer of Blue Cross and Blue Shield of Minnesota, that state's largest health insurer. I have more than 20 years experience in the Blue Cross Blue Shield system and am the co-creator of the Minnesota Health Information Exchange, a national model for sharing electronic information. I have a Master's degree in Health Care Administration from the University of Minnesota.

HCSC's mission is to "promote the health and wellness of our members and communities through accessible, cost effective quality health care." As the largest customer-owned health insurance company in the nation, we have a workforce of more than 16,000 employees serving

12.3 million members through our Blue Cross Blue Shield Plans in four states. Unlike a stockholder-owned company, the individuals and employers who are served by HCSC are also its owners, which, first and foremost, drive HCSC to structure its business practices to promote their health and wellness. To that end, we offer a full range of products that maximize access to needed care while making products as affordable as possible. We use our earnings to improve our administrative capabilities and other programs where they can further benefit our members and the physicians who serve them, and also to fund the reserves health insurers are required to hold.

We certainly recognize, and share, the public's concern with the current health care system. Fundamentally, we believe in the strength and value of the health care system as it exists. But we also know that every system must be on a path of continued improvement. We believe health insurers are uniquely positioned to help foster and inform the design and implementation of necessary improvements to the healthcare system. HCSC welcomes the opportunity to serve in this role.

To that end, HCSC has been an active advocate for health care reform, supporting:

(1) The proposition that health insurance companies be required to offer coverage to all applicants, coupled with a personal responsibility requirement to obtain and maintain health coverage;

(2) Subsidies for those Americans who cannot afford health care;

(3) Health and wellness initiatives that focus on prevention; and

(4) Initiatives that promote effective care, treatment, research and information technologies that improve quality and provide value for each health care dollar.

The issue of medical policy being explored by the Subcommittee today is a critical factor in any sustainable health care reform solution. We applaud Congress for including $1.1 billion for comparative effectiveness research in the *American Recovery and Reinvestment Act.* On behalf of HCSC, and its members, I thank the Subcommittee for the opportunity to discuss this important issue. I also thank the Subcommittee for its recognition and respect for the limitations under the Health Insurance Portability & Accountability Act and other patient privacy laws and regulations that govern my testimony.

HCSC's Approach to Medical Policy

HCSC's approach to medical policy is fully aligned with its member-focused structure and related philosophy of engaging with the providers who serve our members. HCSC medical policies are written statements that include benefit coverage positions for new or existing technology, products, devices, procedures and medications. By providing benefit coverage positions for specific treatments, medical policies help to ensure access to safe and effective care. All HCSC plans provide open access to the public to HCSC medical policies through their websites.

The development and maintenance of our medical policy involves a process that is built upon the bedrock of evidence-based medicine. This is consistent with the principles of comparative effectiveness research, which focuses on identifying care that is most likely to improve condition-specific health outcomes. To accomplish this, information from a variety of sources, including, but not limited to, the Agency for Health Care Research and Quality ("AHRQ"), the Blue Cross and Blue Shield Technical Evaluation Center, peer-reviewed medical

literature, statements from professional organizations, and recommendations from the practice community are all considered in the development of our medical policy coverage positions. The process is iterative. Findings and new data arising from unique claims and third-party review of cases brought to our attention through our appeals processes are used to further enhance the medical policy.

HCSC medical policies are routinely reviewed on a periodic basis. When a new or recently revised medical policy may limit the scope of coverage, HCSC provides at least a 90-day notice of this planned change on our websites. If during that period, new information is obtained that may impact this coverage position, HCSC will review it and, if appropriate, reassess its position.

The following are some examples of how HCSC has incorporated our evidence-based approach to medical policy into two key tenets that underpin our administrative activities: Access and Quality.

Access

Our medical policy positions seek to ensure that benefits are available for high quality care for our members in an efficient and consistent manner. A clear medical policy enables our claims payment system to be structured in a manner that allows the vast majority of the claims we receive to be efficiently processed without manual review.

One of HCSC's four Guiding Principles is our belief "that the interests of our members are of primary importance to [HCSC]. The members provide the reasons for our existence and the rationale for the resources with which we operate." Our corporate claims administration policy reflects that principle by striving to promptly and correctly process claims.

Claims payments, first and foremost, must be consistent with contractual benefits, corporate benefits policy and procedures, and any applicable state regulations. Our policy also provides, however, that, where there is latitude in interpreting how these authorities apply, we will "favor a benefit interpretation ***for the member*** that is as liberal as is administratively practical and financially prudent." This member-focused operating philosophy aligns naturally with our member-owned business structure.

Our philosophy is embraced by our employees. For example, we receive around 570,000 claims per day and approximately 97% of process-ready claims are paid within 14 days of processing. Both our claims item accuracy and financial accuracy are at approximately 99%. As demonstrated in a recent customer survey, 93% of our group business customers surveyed rated their overall customer experience "Excellent" or "Good."

HCSC's efforts to ensure that our benefit coverage positions are responsive at the level of the individual member also entail the efforts of medical professionals in each of our four plans. HCSC employs locally licensed physicians, pharmacists and nurses located in each of the states in which we operate. This means that local physicians can pick up the phone and speak with a local HCSC medical director. This process frequently serves to allow communication about previous interventions and possible changes to standard therapies. It further enables HCSC to glean important information about potential changes in standards of care. Lastly, this form of communication can also assist in ensuring that the practitioner is aware of the member's appeal rights. Information generated throughout this process is used to further hone our efforts to improve access to quality and affordable care.

Finally, we remain accessible to members in situations where members may question or disagree with a claims determination. In 2009, over 92% of member inquiries in our group business were resolved by our claims professionals on the first contact. If a claims issue remains unresolved, we have robust appeals processes which are governed by plan contracts and state insurance and labor regulations.

Quality

Another of our Guiding Principles is our belief that "we, as representatives of our members, have an obligation to provide leadership in the health care field." As such, we continually seek new ways with which to collaborate with our broad network of health care providers for the benefit of our members. For instance, we have taken a leadership role in publicly reporting on the performance of our providers, which has positively impacted both provider performance and the outcomes for our members. We also use data analytics to identify potential gaps in evidence based preventive care and chronic care management and use this information to inform members and providers about opportunities to improve the quality of care.

We have invested in technology that facilitates enhanced data sharing with physicians to improve both clinical decision making and operational efficiencies. HCSC recognizes the important role electronic medical records must play in any health care solution. We are dedicated to the continued development of tools to provide actionable information to our network physicians as well as the acceptance of electronic information from network practitioners.

As we explore long-term solutions, our benefit plans are increasingly designed around proven preventive care services. These are in accordance with nationally recognized clinical

guidelines. Prevention and wellness are critical factors in decreasing the rate of preventable chronic diseases such as Type 2 diabetes, high blood pressure, cardiovascular disease and some forms of cancer. In tandem with evidence-based medical policy, the design of benefits that encourage and engage members in preventive care can help to control health care costs and improve quality.

Rescission[1]

Rescission is an unfortunate, but necessary, part of fraud prevention. HCSC regrets any situation that requires us to rescind coverage for any of our members. Given the gravity of these situations, HCSC only rescinds insurance coverage when it is clear, after a thorough review and appeals process, that the applicant intended to deceive by either failing to disclose or misrepresenting relevant and material medical information. It is our goal in applying this strict standard to limit the numbers of rescissions, while at the same time ensuring that we identify and prevent insurance fraud. Both the Administration and Congress recognize that fraud places significant cost burdens on the healthcare system and, in turn, on other insured citizens.

When we learn that a misrepresentation may have been made on an insurance application, we assess the facts and circumstances carefully and with the degree of rigor and sensitivity they deserve. We have a multifaceted review process, which includes a thorough review of the facts that were not disclosed on an insurance application, review by an internal committee and an appeal process for the applicant.

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[1] The Subcommittee's August 26, 2009 invitation requested information on policy rescissions by insurers. As a point of clarification, the issue of policy rescission (i.e., revocation of insurance coverage) is a separate and distinct contractual issue that is not encompassed or impacted by HCSC's medical policy previously described.

We are also committed to "reforming" policies, rather than fully rescinding them, which means in many cases we are able to work to exclude coverage for the medical condition(s) related to the misrepresentation(s), rather than revoking an entire policy. In addition, over the past year we have committed to making our review even more robust, by adopting a plan which we are working to have implemented by early 2010 to require independent third-party review of all rescission recommendations. As a result of our processes, rescissions are not a frequent occurrence for HCSC.

Conclusion

HCSC is committed to working with the Administration and Congress to achieve comprehensive health care reform to expand access and improve the quality of care for all Americans. I thank you on behalf of HCSC for the opportunity to be part of this important discussion on that goal.