TESTIMONY

# Enabling Health Care Quality, Safety and Affordability

Brian Sassi
Executive Vice President and Chief Executive Officer, Consumer Business Unit
WellPoint, Inc.

Testimony presented before the Domestic Policy Subcommittee of the Committee for Oversight and Government Reform

September 17, 2009

WELLPOINT

## INTRODUCTION

Thank you, Chairman Kucinich and members of the subcommittee for inviting me to testify today. I am Brian Sassi, president and CEO of the Consumer Business Unit for WellPoint, Inc., and it is an honor to appear before you to discuss how WellPoint is advancing health care quality and safety in the United States. WellPoint provides health benefits to nearly 35 million members across the country, representing nearly one in every nine Americans. Our subsidiary companies serve an additional 30 million individuals in the United States through programs and services including life and disability insurance benefits; pharmacy benefit management; dental, vision, and behavioral health benefit services; long-term care insurance; and flexible spending accounts. We also serve 22 million Medicare beneficiaries in 26 states as a Medicare administrative contractor through our National Government Services subsidiary.

We recognize that with the largest membership of any private insurer, we have the ability to change health care for the better. We also recognize that, with this ability, we have a responsibility to our members and to all Americans to advance health care quality, safety, and affordability, and to invest in innovative solutions to address the persistent health problems our country faces today and anticipate the challenges of the future. As a family of primarily Blue Cross or Blue Cross Blue Shield plans, WellPoint has decades of experience in our local markets and communities from California to Maine. We believe this blend of national scope and local depth is a unique and powerful combination that contributes greatly to our ability to improve the quality and value of our members' health coverage.

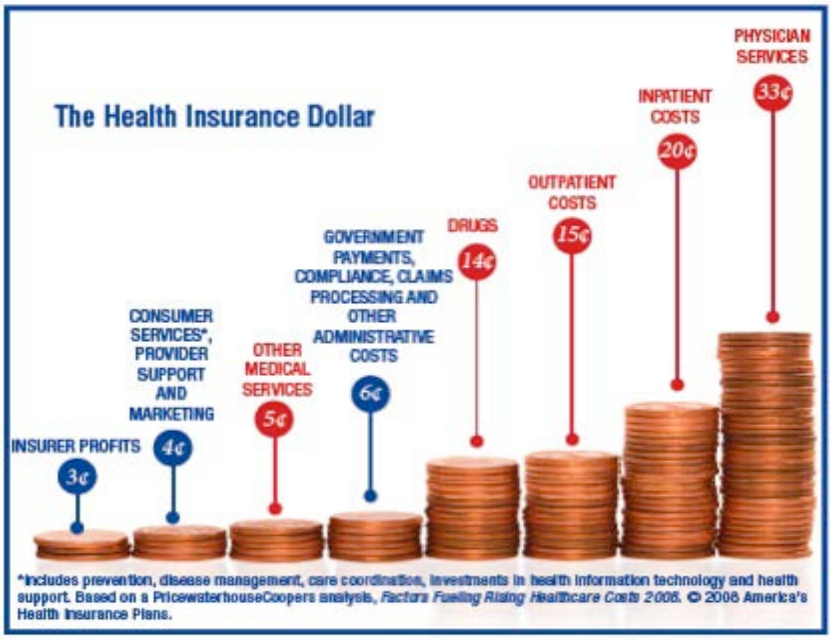
I look forward to discussing how WellPoint helps create the best health care value for our customers. The renewed debate over health care reform has provided us today with an opportunity to discuss how managed care has evolved over the past decade. At WellPoint, we are proud of how we develop medical policy to try to help physicians keep current on what works in health care. We are proud of how our nurses and other health professionals support our members to ensure their care is safe, necessary, and timely. And looking to the future, we continue to explore new payment models that reward value over volume and that stress safety, efficiency, and patient satisfaction.

### Where Premium Dollars Go

The operating expenses of health plans have received much attention over the past several months. To help inform the debate, America's Health Insurance Plans (AHIP) commissioned PricewaterhouseCoopers (PwC) to conduct an analysis last year, breaking down how a dollar of health insurance premiums is spent. PwC's study shows that 87 cents of every premium dollar is paid out to cover the costs of health care services and products.

Of the remaining 13 cents of the premium dollar:

- 6 cents go toward taxes, other government payments, claims processing and other administrative costs;
- 4 cents go to consumer services (including prevention, disease management, care coordination, and investments in health information technology and health support), provider support and marketing; and
- 3 cents go to profits.




## How We Develop Medical Policy

At WellPoint, our technology assessment and clinical reviews are the foundation for clinical decision making and address all medical procedures, devices, genetic testing, and specialty pharmaceuticals. Our medical policy development process involves input from premier academic institutions, expert physician representation from 33 medical specialty societies, and consideration of the standards of care in our communities. We follow guidelines set forth in federal publications such as "The Guide to Clinical Preventive Services," as published by HHS and the Agency for Healthcare Research and Quality; the Advisory Committee on Immunization Practices (ACIP) and those established by groups such as the American Heart Association, the National Comprehensive Cancer Network; and the American College of Cardiology. The Medical Policy and Technology Assessment Committee and its subcommittees in behavioral health and hematology and oncology meet at least quarterly, and more often as necessary, to review emerging clinical research that is published or presented at national meetings. Our medical policy decisions are extensively researched, and vetted externally to ensure the most comprehensive and clinically informed policies possible.

Our medical policies are available online to all network physicians. The policies include background and coding guidelines, as well extensive discussion on the rationale upon which they are based. The policies contain detailed references to the peer-reviewed journals and other authoritative publications used in making the medical policy determination, as well as a complete chronological revision history, so that physicians may view the progression of how and why the policy became what it is today.

**How We Process Claims**

Last year, WellPoint received 380 million claims and processed 97 percent of them within 30 days. We do not "defer" the remaining 3 percent of those claims, but sometimes we "pend" claims as we await additional information from the provider or patient or as we determine whether our coverage determination is consistent with the member's policy. Once we receive the necessary information, the claim will either be approved or denied – again, consistent with the member's policy.

Earlier this month, a nurses' organization in California issued a report suggesting that managed-care companies in California, such as our Anthem Blue Cross subsidiary, rejected more than 20 percent of the claims we received in the first half of 2009. However, the data that organization relied upon for its report came from a regulatory filing that requires a count of all claims that may not initially be paid by a health plan for *any* reason. Some common examples of these claims are:

- claims for people who are not our members;
- claims within the member's policy deductible;
- claims that have already been paid by other health plans;
- claims not paid because the same claim was submitted multiple times; and
- claims returned to a provider because necessary information was missing or incorrect.

Once we received the necessary information to resolve the claims in question, our Anthem Blue Cross subsidiary in California ultimately denied less than 3 percent of the claims received during the first half of 2009. To provide further context, we denied less than than one-half of one percent (<0.5%) of the total number of claims received on the basis that our medical personnel determined the services were not medically necessary for the member.

**How Our Operating Expenses Improve the Quality, Safety and Efficiency of Care**

We believe that an essential ingredient for practical and sustainable health care reform is improving health care quality, which in turn can help manage costs. There are many opportunities to improve health care in this country, as we are far from having a system that provides the right care at the right place at the right time. Building on the following four principles, WellPoint has identified solutions that will help deliver better health care while helping to reduce costs:

- Promote evidence-based medicine and determine real-world outcomes
- Align payment incentives for improved health outcomes
- Focus on prevention and managing of chronic illness
- Promote safety and efficiency through the adoption of health information technology

I'd like to offer examples of how we follow through on each of these principles:

- ***Promote Evidence Based Medicine & Determine Real-World Outcomes***

  At WellPoint, we believe it is important that we continuously monitor and evaluate the effectiveness of treatments, procedures, therapies and pharmaceuticals to identify, minimize, and/or eliminate quality gaps. WellPoint's clinical research subsidiary, HealthCore, Inc., performs clinical outcomes and comparative effectiveness research to determine what works in health care and advance high-quality, cost-effective care. HealthCore studies use clinical, laboratory, and drug information to determine how therapies, treatments, and pharmaceuticals work in the real world, outside of the compliance-guaranteed clinical trial environment.

  For instance, nine of ten Americans experience back pain at least once in their lifetime, and $90 billion is spent nationally on back pain treatment annually. Additionally, low back pain is the number-one cause of lost productivity among our employer groups. Although clinical studies have shown that most back pain resolves within six weeks without invasive treatment, our analysis revealed more than 20 percent of those studied underwent unnecessary imaging tests and nearly 1,000 of our members underwent inappropriate and expensive back surgery less than six weeks after diagnosis. We recognize some back pain sufferers may indeed require imaging or surgery, and as a result, we implemented a program to educate members and physicians on clinically comparable and appropriate alternative treatment options, including pharmaceutical pain management, physical therapy, or rest during the first six weeks of experiencing back pain.

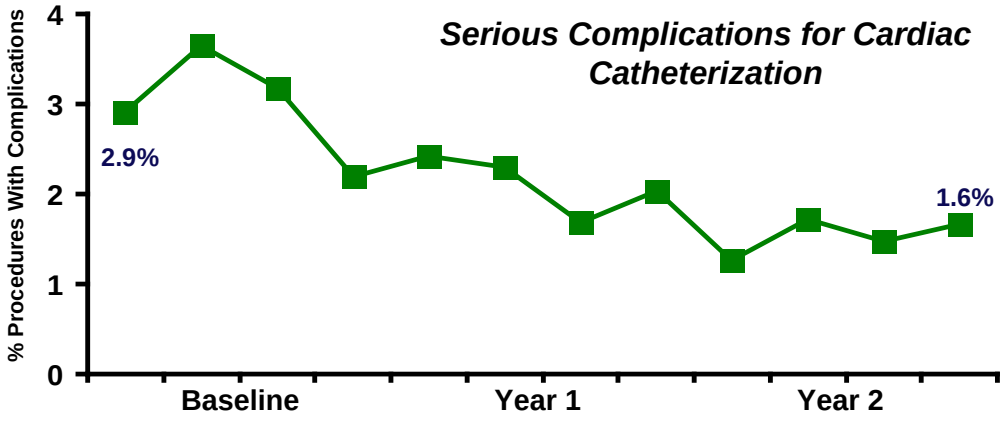
- ***Align Payment Incentives for Improved Health Outcomes***

  The current health care system is designed to reward quantity over quality, and volume over value. Although we know some care is unnecessary and potentially harmful, we also recognize that sometimes, the "right care" is more care or different care. We have implemented clinical programs to enable better-informed physician-patient decision-making that reflects evidence-based medicine and the unique health and financial characteristics of each member treated.

  For example, we work hand-in-hand with medical specialty societies to develop consistent, meaningful performance metrics and reward physicians and hospitals for improved patient outcomes, compliance with recommended care guidelines, use of health information technology, and patient satisfaction. These incentives represent true, tangible health improvement results, as demonstrated by a five percent improvement over the national average for door-to-balloon time for heart attacks[1] and

[1] Internal analysis; validated by actuary. Note: Hospital performance payment program as applied to American College of Cardiology National Cardiovascular Data Registry (NCDR)® outcomes

a reduction in serious complications for cardiac catheterizations in our Virginia hospital quality program.[2]




- ***Focus on Prevention and Managing Chronic Illness***

Chronic illness, such as diabetes, asthma, and heart disease is our country's number one public health issue, affecting nearly half of all Americans. Staggering cost estimates of the hundreds of billions of dollars associated with chronic illness do not even include the indirect costs due to lost productivity in American industry.

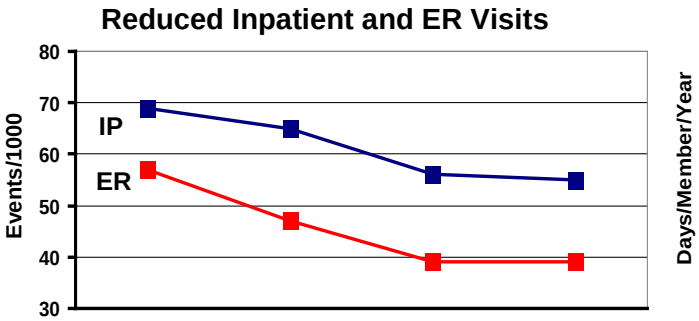
Yet, we also know, through research by RAND and others, that existing, proven, and established guidelines are only followed 55 percent of the time[3]. Recent studies of our most vulnerable populations suggest that 35 percent of recommended screenings and preventive care are not delivered to our elderly Medicare and Medicaid population,[4] and only 41 percent of recommended preventive care is delivered to children. [5] Variation even exists among our country's leading academic institutions, where Wennberg demonstrated a 300 percent variation in hospital days and use of clinical procedures during the last six months of life. [6] Finally, we know that there is often no correlation between cost and quality and that actually an inverse relationship may exist,

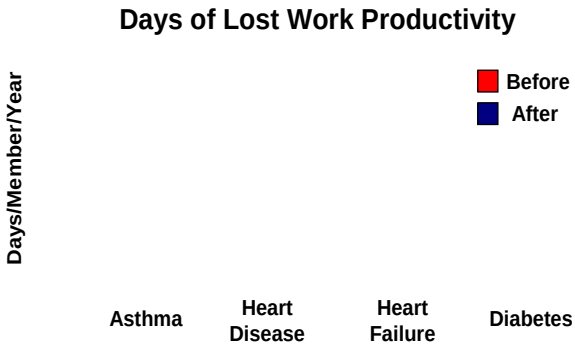
[2] See Note 12 above
[3] McGlynn, E.A, S.M. Asch, J. Adams et. al. 2003. *The Quality of Health Care Delivered to Adults in the United States*. NEJM 348 (26): 2635-45
[4] Zingmond, D. S.; Wilber, K.H.; MacLean, C.H.; Wenger, N.S. 2007 *Measuring the Quality of Care Provided to Community Dwelling Vulnerable Elders Dually Enrolled in Medicare and Medicaid. Medical Care*. 45(10):931-938, October 2007;
[5] Yu, S.M., Bellamy, H.A, Kogan, M.D., Dunbar J.L., Schwalberg, R.H., Schuster, M.A. 2002. *Factors that Influence Receipt of Recommended Pediatric health and Dental Care*, Pediatrics Vol. 110 (6) December 2002, pp. e73; Mangione-Smith R, DeCristofaro AH, Setodji CM, Keesey J, Klein DJ, Adams JL, Schuster MA, McGlynn EA. *The Quality of Ambulatory Care Delivered to Children in the United States* The New England Journal of Medicine, Vol. 26, No. 5, Sept 2007, pp. 644-649
[6] John E Wennberg, Elliott S Fisher, Thérèse A Stukel, Jonathan S Skinner, Sandra M Sharp, and Kristen K Bronner; *Use of hospitals, physician visits, and hospice care during last six months of life among cohorts loyal to highly respected hospitals in the United States* BMJ 2004 328: 607; *See also*; Dartmouth Atlas

such as where the most expensive care for Medicare beneficiaries is also of the poorest quality.

At WellPoint, we know that one percent of our membership drives 25 percent of our medical costs, and five percent of our membership drives 50 percent of costs. The majority of these members are the severely chronically ill, typically those with multiple chronic conditions. Our goal is to help these members manage their conditions and prevent their illnesses from progressing to a more advanced stage.

WellPoint's 4,000 nurses, dieticians, social workers, pharmacists, exercise physiologists and respiratory therapists speak with thousands of members each day encouraging them to learn about their conditions and how they can manage them. We help members schedule necessary follow-up and specialist care, remind them to pick up important prescriptions, and serve as a real-life resource when they have questions or concerns 24 hours a day, 7 days a week.




This direct person-to-person contact has demonstrated an increase in preventive screening, improved compliance with evidence-based care and improved health outcomes for our members. For example, these programs demonstrated a 20 percent decrease in chronic condition-specific inpatient admissions and a 32 percent decrease in condition-specific emergency room visits. Additionally, employers saw a 25 percent to 50 percent reduction in days of lost work productivity[7].

- ***Promote Safety and Efficiency Through The Adoption of Health Information Technology***

Health information technology is the future of the health care system and WellPoint's administrative costs are invested in programs that create system-wide efficiency, as well as improved national public health safety, monitoring, coordination, and response.

[7] Internal analysis; validated by actuary. This example is a Health Management Corporation analysis of WLP contract accounts that would contain the average employee make-up for an employer group.

The Institute of Medicine Report "To Err is Human" estimated that at least 44,000 Americans die every year in hospitals as a result of medical errors.[8] For Medicare alone, $8.6 billion dollars can be attributed to patient safety events.[9] Adverse drugs events lead to more than 7,000 deaths, 1.5 million injuries, and 700,000 emergency room visits annually, translating to loss of life, decreased quality of life, and $77 billion in avoidable health care costs.[10] Patients who had potentially preventable adverse medical events were twice as likely to die during a readmission within 30 days following discharge and 32 percent more likely to be discharged to a long-term care facility.[11]

To respond to public demand for increased safety, WellPoint has developed the Healthcare Safety Sentinel System℠ to monitor more effectively and rapidly the safety of pharmaceuticals and other medical therapies. WellPoint's Healthcare Safety Sentinel System℠ was developed in close collaboration with leading government and academic institutions, including the FDA, and faculty from key academic institutions, including Harvard University, the University of North Carolina, and the University of Pennsylvania. The Safety Sentinel System, which will ultimately be able to monitor safety risks associated with drugs and other clinical care decisions in real-time, will also assist physicians and other health care professionals to make more informed decisions about how to treat their patients.

The Healthcare Safety Sentinel System℠ is already operational and performing work for the CDC on biologic, vaccine and human tissue product safety. It has also been selected as one of four potential technologies to serve as the foundation for the FDA Sentinel Initiative, the nation's drug safety surveillance system. The Healthcare Safety Sentinel System℠ will make it possible to examine whether particular combinations of treatments could cause serious medical problems, especially in patients with certain diseases. This critical information will allow health care decision-makers including federal agencies, physicians, consumers and manufacturers to move far more quickly than in the past in addressing potential drug risks.

## CONCLUSION

In closing, I want to assure the Subcommittee that WellPoint supports responsible health care reform, but reform must go beyond the insurance marketplace to address system-wide challenges and associated costs. Changing how we finance health care without changing how we deliver health care would be incomplete reform, at best.

[8] Institute of Medicine; Too Err Is Human: Building a Safer Health System (http://www.iom.edu/Object.File/Master/4/117/ToErr-8pager.pdf)

[9] The Fourth Annual HealthGrades Patient Safety in American Hospitals Study (2007)

[10] See Classen DC, Pestotnik SL, Evans RS, et al. Adverse drug events in hospitalized patients. JAMA 1997;277(4):301-6.

[11] Adverse Patient Safety Events: Costs of Readmissions and Patient Outcomes Following Discharge. Bernard D, Encinosa W; AcademyHealth. Meeting (2004 : San Diego, Calif.). Abstract AcademyHealth Meet. 2004; 21: abstract no. 1908

Health plans have provided significant ideas for reform, many of which are incorporated in the legislation being considered in the House and Senate. We look forward to continuing to play a constructive role by providing members of this subcommittee and your fellow legislators with assessments of how proposals for reform would impact your constituents. We have decades of real-world experience with different reforms in various local markets that we are sharing with Congress and the Administration, so that our policymakers can make decisions the same way we make medical policy – using the best available evidence on what works best.

But as the health reform debate continues, our main focus will remain on improving the lives of the people we serve and the health of our communities. We do this every day by:

- providing clear, actionable, evidence-based messages to our members and their physicians, and by connecting our health care system through health information technology;
- encouraging an informed physician-patient dialogue regarding the risks and benefits of available treatment options and what is best for each patient;
- deploying thousands of nurses, physicians, and other health professionals to support and empower members in their own care; and
- promoting innovation through an unbiased, transparent scientific analysis of clinical research and real-world outcomes.

I appreciate the opportunity to testify before you today and to respond to your questions.