

Angela F. Braly
Chair, President and Chief Executive Officer
WellPoint, Inc.
Afternoon Keynote Address
“Leading Change: Making Health Care Reform Work for Consumers”
[Harvard Business School 8th Annual Healthcare Conference](#)
January 29, 2011
Boston, Mass.

Ms. Braly was introduced by Regina Herzlinger, the Nancy R. McPherson Professor of Business Administration at the Harvard Business School, and author of Who Killed Health Care? and Consumer-Driven Health Care: Implications for Providers, Payers, and Policymakers.

Thank you, Reggie for that great introduction. I do remember meeting Reggie about 10 years ago when I was running Blue Cross Blue Shield of Missouri and hearing all about this great new idea of consumer-directed health care. I’m so delighted to be here and to have a conversation with you, particularly given that you are the “godmother of consumer-directed health care.” I really think your work and influence are going to have an even bigger impact as we go forward, because with the advent of health care reform, I think we’re going to see more true consumers come to the marketplace.

As the author of many important health books, Reggie knows that Mark Twain said, “Be careful about reading health books. You may die of a misprint.” But that’s not my Mark Twain quote for today. He also said, “Let’s make a special effort to stop communicating with each other, so we can have some conversation.” I think that applies to what has happened with the health care reform debate. We’ve had rhetoric; we’ve had sound bites, so now it’s time to have a discussion, to have an explanation, and to have understanding. So what I’d like to do today is have a conversation.

First, I’m going to share with you a couple of the questions that we’ve been hearing lately from our customers. Then, I’d like to talk to you about some of the challenges that still exist in health care and will exist for some time and need to be addressed. And then finally, for the students in the audience, I’ll challenge you to think about your role and being part of the solution in the coming years.

Leading the Coming Change

WellPoint serves more Americans than any other health benefits company – about one in nine Americans is a member of one of our health plans. I’ve been talking to a lot of our customers over the last weeks and months, and the questions they have asked us – from the largest customers that we have to the individual member – is, “What’s happening next in health care reform?” and “What’s going to happen to me?”

The answer in large part is that health care reform is still a work in progress and many of their questions cannot yet be answered fully. Clarity is going to gradually emerge through 2014 and even beyond. But what we do know is that all of the participants in the health care system – the regulators, the hospitals, the doctors, the drug companies, the device manufacturers, the insurers, but most importantly, all of us as patients who are members – are going to be impacted.

Employers are asking themselves the tough question about whether or not they're going to stay in the business of providing health benefits. And individuals are asking the question about whether they can afford it, in any event. At WellPoint, we serve most of our customers as Anthem Blue Cross or Anthem Blue Cross Blue Shield, so you can find us at anthem.com. We're also Empire Blue Cross Blue Shield in New York. We are not the Blue Cross and Blue Shield plan of Massachusetts, which Deb Devaux from the Massachusetts plan will talk about later today.

The rest of the country is looking at Massachusetts to try to understand what the impact of the change in health care reform has been here and how that might apply across the country. We are the Blue Cross or Blue Cross Blue Shield plan in 14 states and our customers are very uncertain and they want more clarity. So our responsibility – our opportunity – is to provide them with the answers that they need and to lead the change. We acknowledge that the law of the land is health care reform, and we are committed to making it work for our customers.

Before I get into health care reform, I think we all have to acknowledge that the changes in the economy have had a significant impact on health care. High unemployment rates, which many of us expect will continue, have affected how Americans do and will access health care in the future. The percentage of Americans with employer-sponsored insurance is at its lowest rate since 1987, and by no coincidence, the percentage of government-sponsored insurance benefits are at their highest rate since that same year. So knowing these are current challenges – and there's going to be a lot of additional changes coming in health care both now and throughout 2014 and beyond – it's our job to provide more clarity.

So what I encourage you to do is go to one of our websites – it's called makinghealthcarereformwork.com on the Web, on Twitter and on Facebook, or to our blog, healthychat.com. You'll get additional information about health care reform as it evolves, and you can have a conversation with us.

Health Care Reform and the Coverage Challenge

You all probably know many of the aspects of health care reform; I'll cover just a few. And most of them relate to insurance market reform. The question being addressed is coverage: how we're going to get it and how it's going to work.

Health insurers have been required since late last year to provide coverage to dependents up to age 26. Some of you on your parents' policies might have benefited from that.

There are no longer lifetime maximum limits on policies. Effective January 1, 2011, for their fully insured members, health insurers must meet what's called a minimum medical loss ratio or "MLR." That means at least 80 to 85 percent of premiums paid must go to medical care, depending on the kind of product you have. MLRs mean that our industry, including the amount of administrative cost and profit that we can have, are now regulated. If we charge too much for a premium, then we have to write a rebate check to the customer beginning in mid-2012.

We also know that in 2014, there are a number of significant changes that would go into effect. One is that there will be a mandate for individuals to be required to buy a health insurance policy, and we as insurers will be required to accept all applicants, whether or not they might have a pre-existing health condition – what we call "guarantee issue."

There's going to be a penalty on individuals. There will also be a penalty on employers per employee, and the new, state-run health exchanges will come online, which will create a new marketplace. You have one here in Massachusetts, and the theory is that it would be a broad marketplace for individuals, and then eventually small businesses, to buy a set of standard health insurance benefits. Now, the standard – what those benefits will look like – will depend upon a package of essential benefits that have not yet been defined. And, we know that the federal government will offer subsidies for those buying standard products from the exchange.

Health Care Reform's Unresolved Challenge -- Affordability

All of these reforms deal with coverage, and everyone will want to know how to navigate these issues. But there's one challenge that we haven't discussed and it's just beginning to be discussed here in Massachusetts as the price of reform comes in higher than expected and premiums continue to rise at unsustainable rates. That challenge, of course, is *affordability*. You can look at affordability in a couple of ways: It starts with unit costs – the cost of the service provided. Then, there is the number of units of service provided, or utilization. But with health insurance, another factor that's incredibly important is who is in or out of the pool. We call that "selection," and all of those factors go into whether or not a product is affordable, and there's been a lot of rhetoric about it, but I think it's time to have a conversation about costs, and that conversation is long overdue.

Slide 1: Premiums Compared to Inflation

Last year, total health expenditures in the U.S. reached \$2.5 trillion, or \$8,086 per American. That's an overwhelming amount of money for working men and women. And let's look at the trend in premium increases over the last nine years. The top line is premium growth. The bottom line is the growth of inflation. And as you can see, premiums have risen four times faster than inflation. So what's causing this? I'm going to talk about the drivers, but let me address our role in this picture. Over this period of time, health insurance industry margins have gone up and they've gone down and they've gone up and they've gone down, but essentially, they have averaged about 6 percent over the same period. So we know that we're paying more in premiums. So who's paying for it?

Slide 2: Employee Share of Premiums

We all know that employers still pay a significant share of the premiums, but it's not just the employers and the payers whose costs have gone up. Your cost and my cost as an employee – as a consumer – is also rising faster than inflation. And, employees are also paying a larger share of the premium. Employers are contributing 20 percent more than they were only five years ago, but employee contributions have increased at a rate that's more than double that of the employers.

Slide 3: Increased Deductibles

Consumers also are bearing more of their risk for medical costs. Over the last decade, the average PPO deductible has more than tripled. Of course, this increases your overall out-of-pocket costs just like increasing premiums.

Slide 4: Increase in Prescription Copays

And it's the same story with copays for prescriptions. Depending on the tier, we've seen an overall increase in drug copays by almost 40 to 90 percent over the past decade.

What all of this adds up to is that our traditional methods of keeping costs down have not worked, and the employer, the employee, the individual and government are paying for it. So I think affordability is our biggest challenge in health care, and it's only getting bigger.

Addressing the Affordability Challenge

So, how do we start addressing rising costs in new ways that might work? Well, one of the best ways is to help people start making health care choices like health care consumers, but that's easier said than done in this current system. No one knows what the costs are, and when we see them, we really don't know how they make sense. Everyone hears about variation in health care costs, but how does it really play out?

Slide 5: Care Comparison: Cost of Colonoscopy with Biopsy

Would it surprise you to hear that the price for the very same colonoscopy with biopsy is \$7,186 at one California hospital and \$4,391 at another hospital in California? It's \$3,146 at a Connecticut hospital; \$5,589 at a hospital in New Hampshire; and in my hometown of Indianapolis, at a hospital there, the cost bottoms-out at \$2,352. And if you think costs are generally more expensive on the coasts, think again. A colonoscopy with biopsy at a hospital in Milwaukee, Wisconsin, is \$8,778.

We do want our members to act like consumers, so in order to make the system be one where there's true consumer choice, especially if people ultimately pay for these costs through their premiums, their deductibles and their coinsurance, they need to know about

these huge disparities in costs. So how can we help them make the right decisions? We need to provide them with the right information. We need to provide them with the tools that give them transparency about these costs.

Slide 6: Care Comparison: Quality Measures

We have an online tool for our members on anthem.com called Anthem Care Comparison, and this example shows you how it works. It covers 59 common procedures. In this example, it's for a coronary artery bypass graft, and you can evaluate not only what the costs are among your local hospitals, but you could also click on tabs to see how many times a procedure has been performed in a given facility, what their safety record is, what their complication and mortality rates are, and what their patient satisfaction measures are. And the great news is that this tool has been adopted by the Blue Cross and Blue Shield system nationwide, and will soon be available to 100 million members, including here in Massachusetts.

We're also partnering with the ZAGAT Survey, so when you visit a doctor, you can share what your experience has been with our other members, just like you would a restaurant or a hotel. So Care Comparison is a great tool; ZAGAT is a great tool, but is it enough? Is this transparency enough to empower the consumer to make the right decision about health care? I would say the cost issue is bigger, and we need more than one approach. We need to be asking the question about what is the value of a given medical service, and why are there so many differences in cost across the country?

Reggie will tell you that it's because there is not true consumerism in health care, and I agree. Better information is very helpful, but it's not enough. As good as our Care Comparison tool is, it's just not enough. So what's the next step?

Slide 7: Value-Based Purchasing Design

One of the answers is an innovation we call Value-Based Benefit Design. In California, we're working with CalPERS, the California Public Employees' Retirement System, to drive more affordable reimbursements for hip and knee replacements. When we looked at the data in California, the cost of an inpatient hospital stay associated with hip and knee replacement ranged from \$15,000 to \$110,000 with no meaningful difference in quality. So CalPERS and our California plan teamed up with all this data and with other partners of CalPERS and set a threshold of reimbursement of no greater than \$30,000. CalPERS members can have the surgery wherever they'd like, but their reimbursement will not exceed \$30,000, leaving the member to make up the difference. This puts both choice and responsibility in the hands of consumers. And with CalPERS' more than 1.6 million public employees, they can really have an impact.

Slide 8: CalPERS Initiative Participating Facilities

There are also a lot of participating hospitals in this program, including some of the most reputable hospitals in California. So what happens if your hospital is not on the list? You pay more. So we know that this will drive health care value for our members.

We also have another example: our Smart Shoppers program in New Hampshire. When a physician recommends a service or a test, such as carpal tunnel surgery, a colonoscopy or a CT scan, the patient is provided with cost and quality information for that area's care providers for the procedure requested. If the member chooses a more cost-effective provider, they will qualify for an incentive ranging from \$50 to \$100. Sometimes that can be a lot relative to the service at hand. This saves cost and rewards the member for making the value-driven decision, and it's a step in the right direction to making the member more of a consumer in health care.

Slide 9: California Hospital Revenue

But, this effort is just a part of what we need to do to redefine the conversation, and one of the areas where I think we need to redefine the conversation is around cost-shifting. In California alone, hospital revenue from commercial health plans rose by 159 percent between 2000 and 2009. That's more than twice the rate of increase for Medicare and more than eight times the rate of increase for Medi-Cal, the state's Medicaid managed-care program. Now, this cost-shifting was due frankly to a couple of factors: First, the willingness of our industry and employers – our customers – and what was then a positive, roaring economy where the customer wanted choice. They were rejecting some of the restraints that they had in the prior HMO gatekeeper model. Second, the power of consolidating systems to demand this higher payment from the commercial market or leave a gaping hole in the network was very influential in cost-shifting.

Well, I would say in this economy, this issue is coming to a tipping point. We can't just keep pushing around costs. There is no more "give" in the system. Arguably, those costs will turn into subsidies, so we are just filling that same balloon with more air. We can't keep pushing on the balloon or it will pop. We need a conversation about where the costs are in the system and what provides the most or the least value. We have to change the way we pay for health care.

At WellPoint, we're gladly changing the way we pay to reward quality. Our nationwide quality improvement program paid over \$100 million last year for higher quality, better safety and better outcomes. Accountable care organizations, or ACOs – and many are starting across the country – hold some promise for containing costs, provided they are, in fact, accountable. And we're also paying for improved coordination of care. In Colorado, for example, we have one of the nation's leading and most advanced patient-centered medical home projects, and just in the first year of the program, we've seen improvement in all of the diabetes management measures. We've seen a 14 percent decrease in emergency room utilization and a 3 percent increase in preventative services.

In fact, this program is being independently evaluated by your colleagues across town at the Harvard School of Public Health.

And finally, let me say that an unhealthy population is an unaffordable population. We have to deliver value to consumers by actively and passionately advocating for healthy living. We all know that small personal changes in our diet, exercise and prevention can have a positive impact not only on our health, but also on those around you. We call it “Our Health Connects Us,” and you all have a “Health Footprint.”

We’ve partnered with Bob Harper, who is one of the trainers on *The Biggest Loser*. I’m told people at Harvard don’t watch a lot of TV, but *The Biggest Loser* is a TV show, where these trainers are really helping very obese people get healthy, and we partnered with Bob and have developed a Health Footprint that you can calculate. So if you go to anthem.com and look for the Anthem Difference, there is a calculator that you can tell what your Health Footprint is, or you can follow [mytrainerbob](https://twitter.com/mytrainerbob) on Twitter. But what you are doing with your health is influencing others.

Leadership Required From All

So the next few years are certainly going to provide many challenges around health care and many challenges for American businesses. As I said earlier, we can’t just stand by and wait for these changes to the system to just happen. We have to ask the right questions; we have to answer the tough ones; we have to do the hard work to find the answers and solutions. The pressures are on the system, and I think these pressures are leading to a result that is just unsustainable. So with a challenge like this, we also have incredible opportunities.

Slide 10: Projected National Health Expenditures

The projected rise in health care spending creates both a challenge and an opportunity – an opportunity for those who can most effectively optimize the affordability, or bend this trend curve, and to improve the quality of health care for consumers. We believe we have to lead. We must work with patients, with doctors, hospitals, drug and device companies, health insurers and employers, and we have to work together to find these answers and to find the solutions to a health care system that works.

And it especially applies to the students in this room. We need you – a new generation of business and health care leaders – to help find the answers to make health care more affordable. You need to be entrepreneurial and passionate about finding these solutions. We are at WellPoint, and I can’t think of a more exciting time to be in our industry.

Slide 11: WellPoint’s Mission

I’d like to close with my own passion – my purpose as a CEO – and that’s our mission *to improve the lives of the people we serve and the health of our communities*. Our mission isn’t just rhetoric. We have a conversation about it every day, and we’ve even tied a

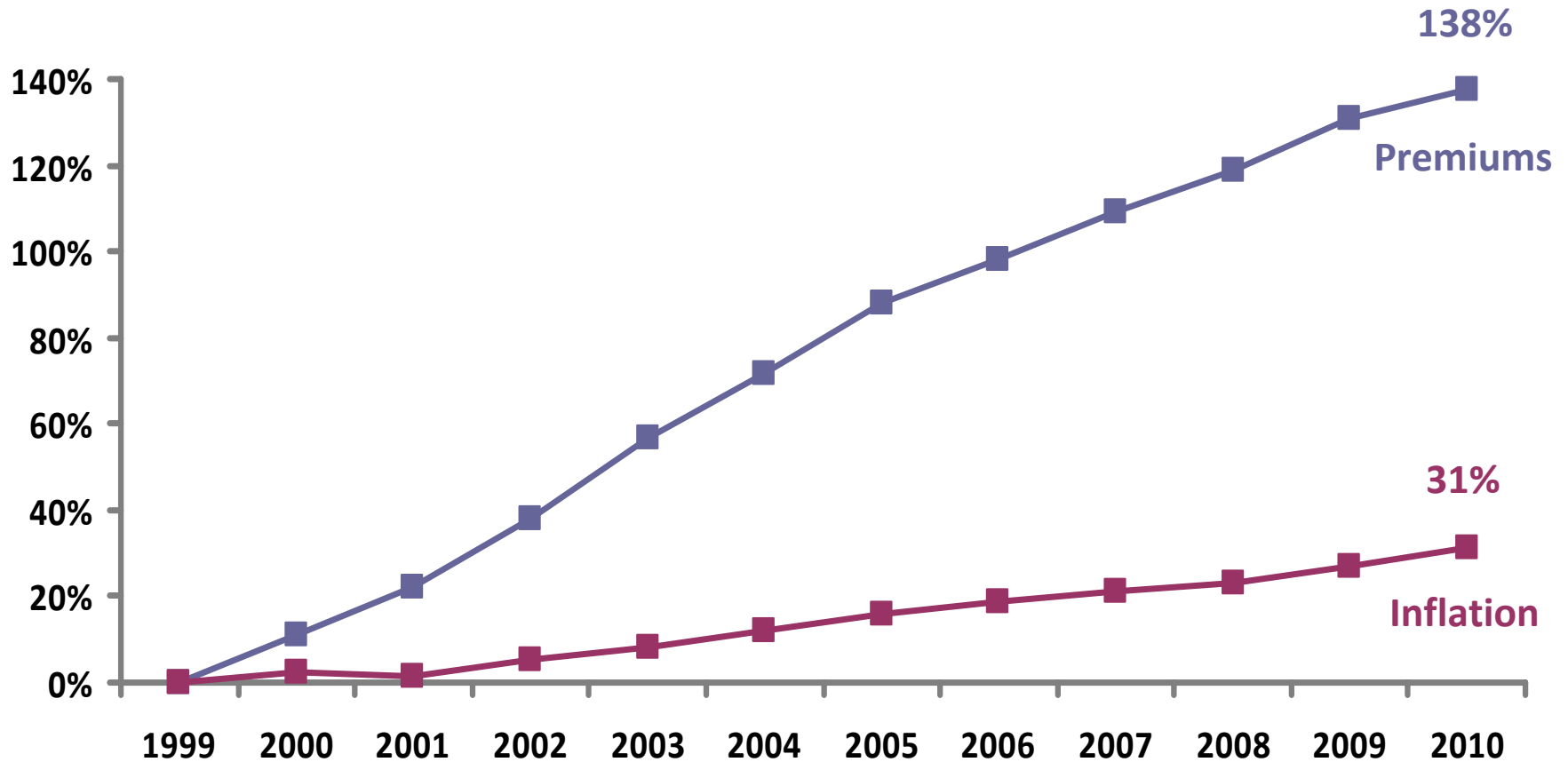
percentage of our bonuses to it. We created our Member Health Index, which tracks when we're making a difference in the most important metric of all – our members' health. Our index tracks 40 different health measures across our more than 33 million members. I'm proud to say that we've moved the needle every year since its inception. Behind this data are 400,000 additional members screened for colorectal cancer, 220,000 members who have had their cholesterol checked, and nearly half of all of our high-risk members who have connected with one of our 3,000 nurses and clinical professionals to help manage their care.

I'm energized by this because I wake up every morning knowing that our 38,000 associates are making a difference in people's lives, and I hope that you'll join us in making a health care system that works for all Americans.

Thank you.

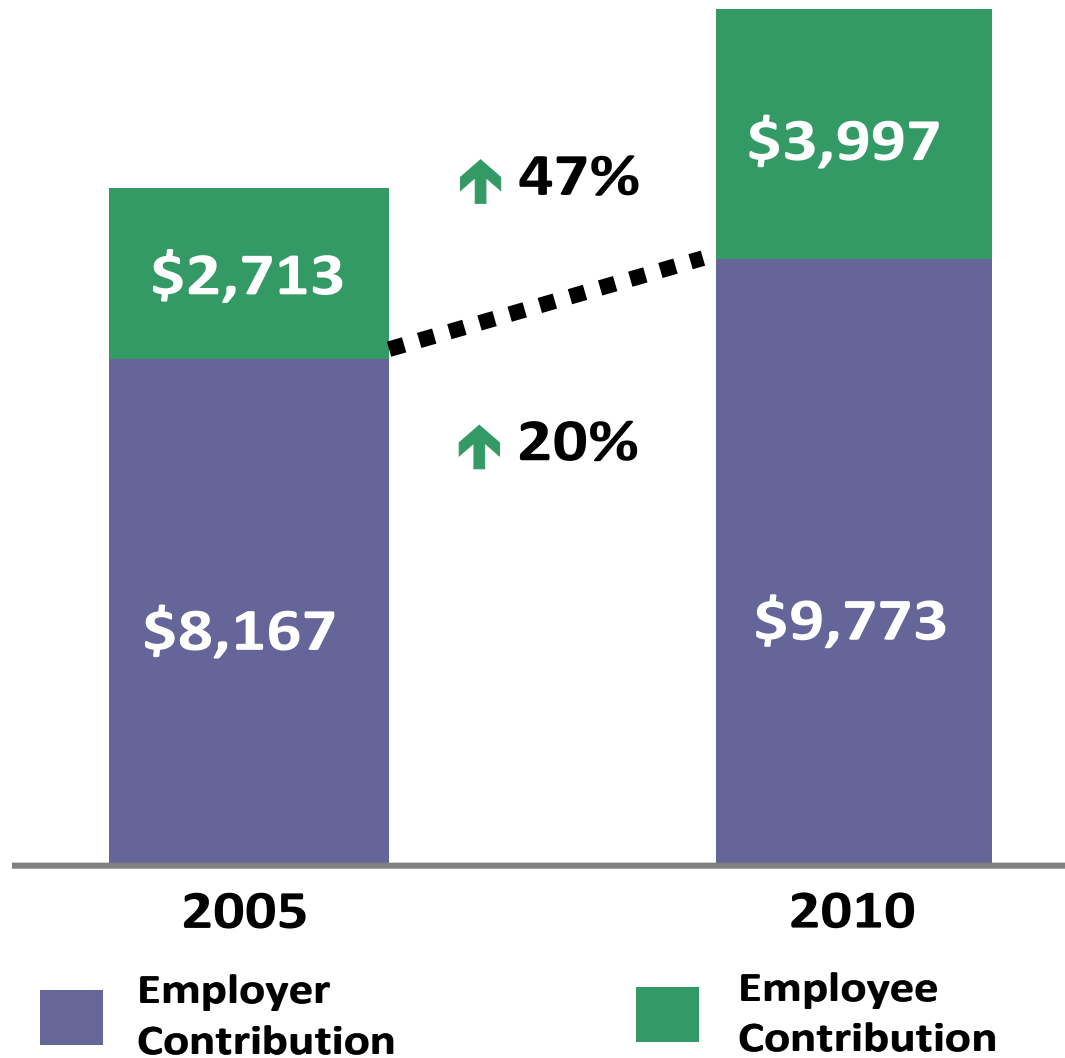
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Cumulative Premium Increase Compared to Inflation 1999-2010



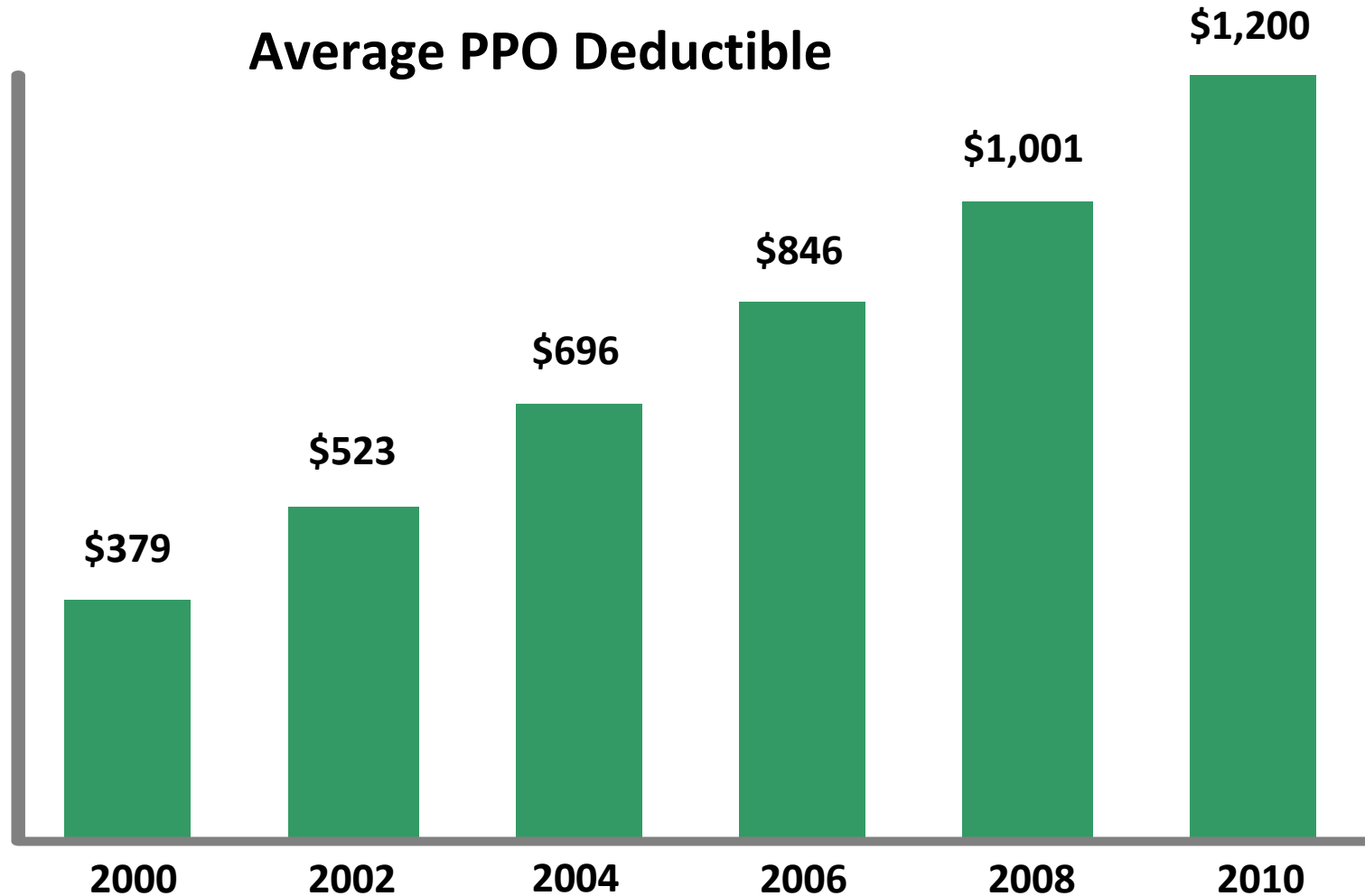
← Average aggregate industry margin ≈ 6% →

Increased Employee Share of Premiums: 2005-2010

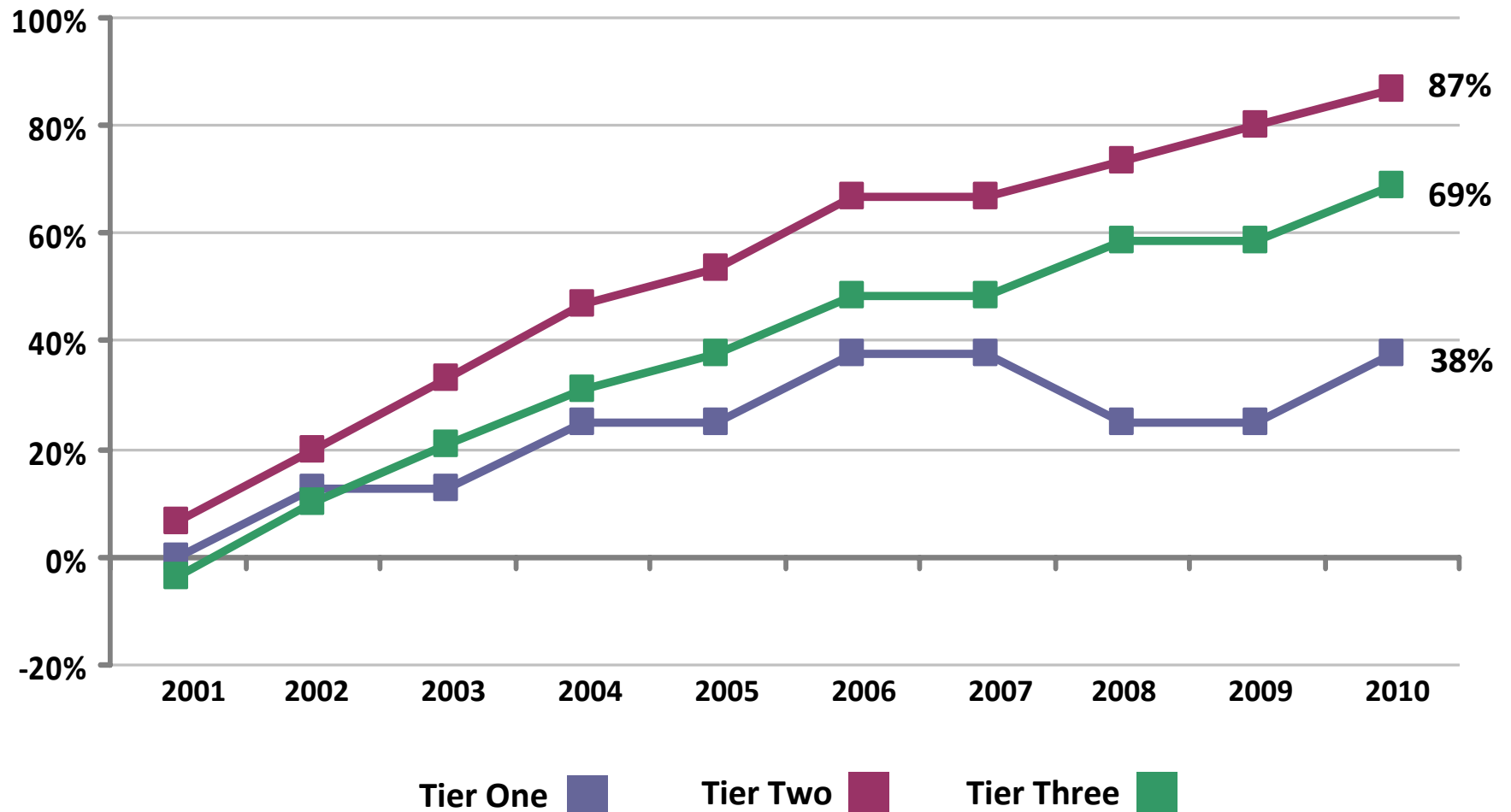


Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2010

Increased Deductibles: Average PPO Deductible 2000-2010

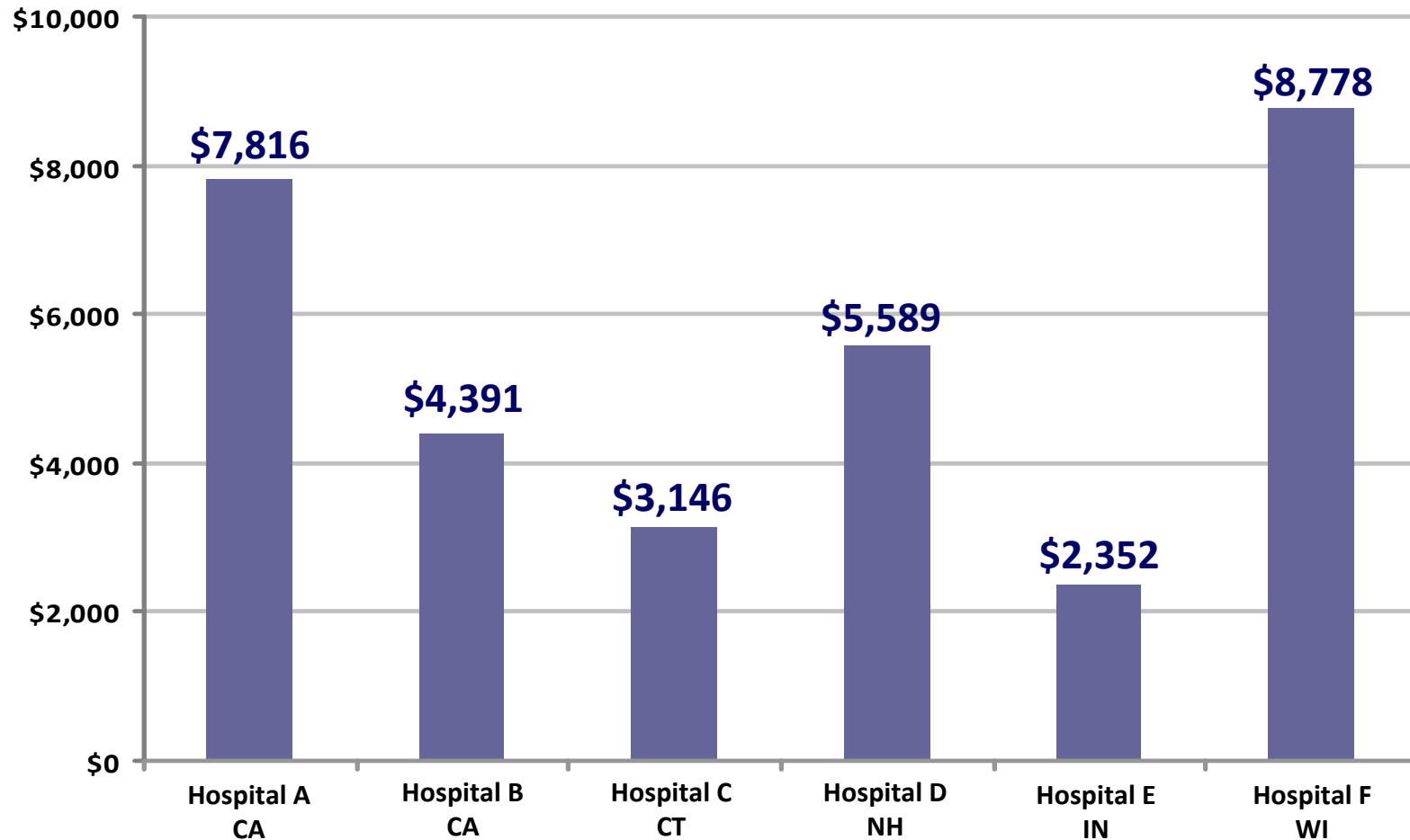


Percent Increase in Prescription Copays: By Formulary Tier 2001-2010



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2010

Care Comparison: Comparative Cost of Colonoscopy with Biopsy



Source: Anthem Care Comparison



















































Care Comparison: Consumer Cost and Quality Tool

Report on Coronary Bypass Surgery

This report compares hospitals within 250 miles of Alexandria, VA for **Coronary Bypass Surgery**, and is based on your selections and rankings. This is just one of several sources you should consult to select a hospital; always consult your physician about what decision is right for you.

- Summary
- Patients
- Mortality
- Complications
- Length of Stay
- Cost
- Safety
- Patient Experience

[Related Reports](#)

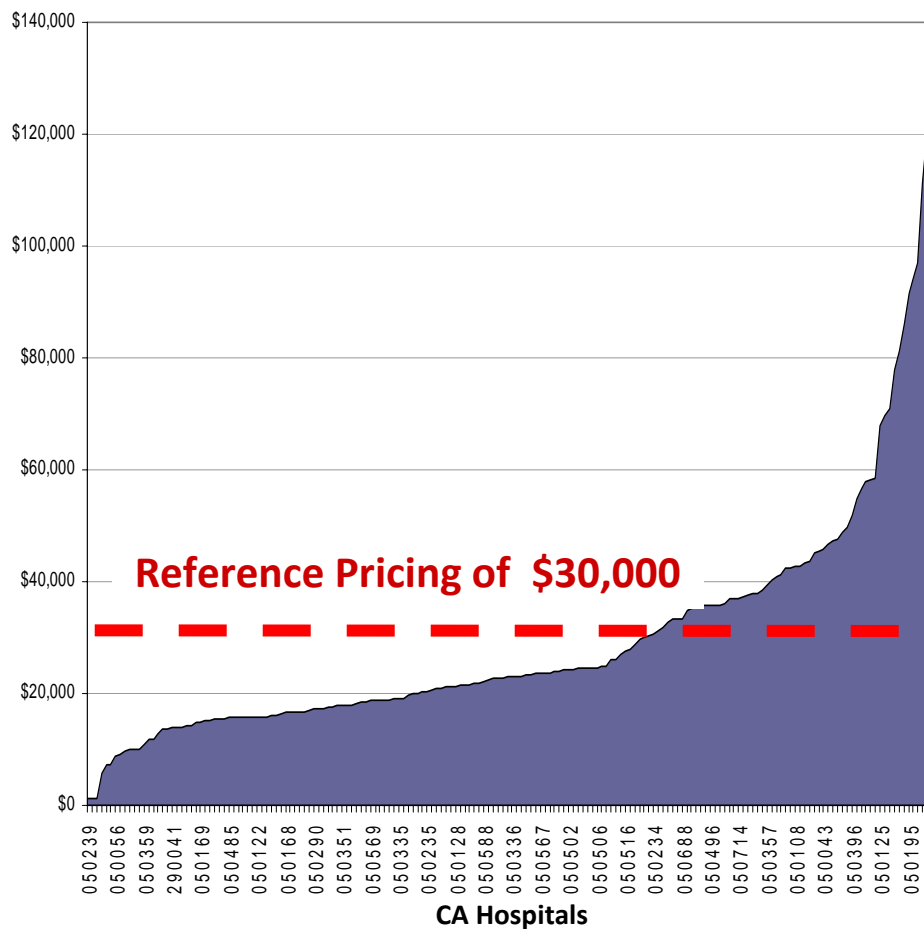
Overall	Name	Patients/yr	Mortality	Complications	LOS
	University of Maryland Medical System				
	Sinai Hospital				
	Union Memorial Hospital				
	Washington Adventist Hospital				
	Johns Hopkins Hospital				
	Suburban Hospital				
	Prince George's Hospital Center				
	Alexandria Hospital				
	Virginia Hospital Center Arlington				
	Inova Fairfax Hospital				

Source: Internal data

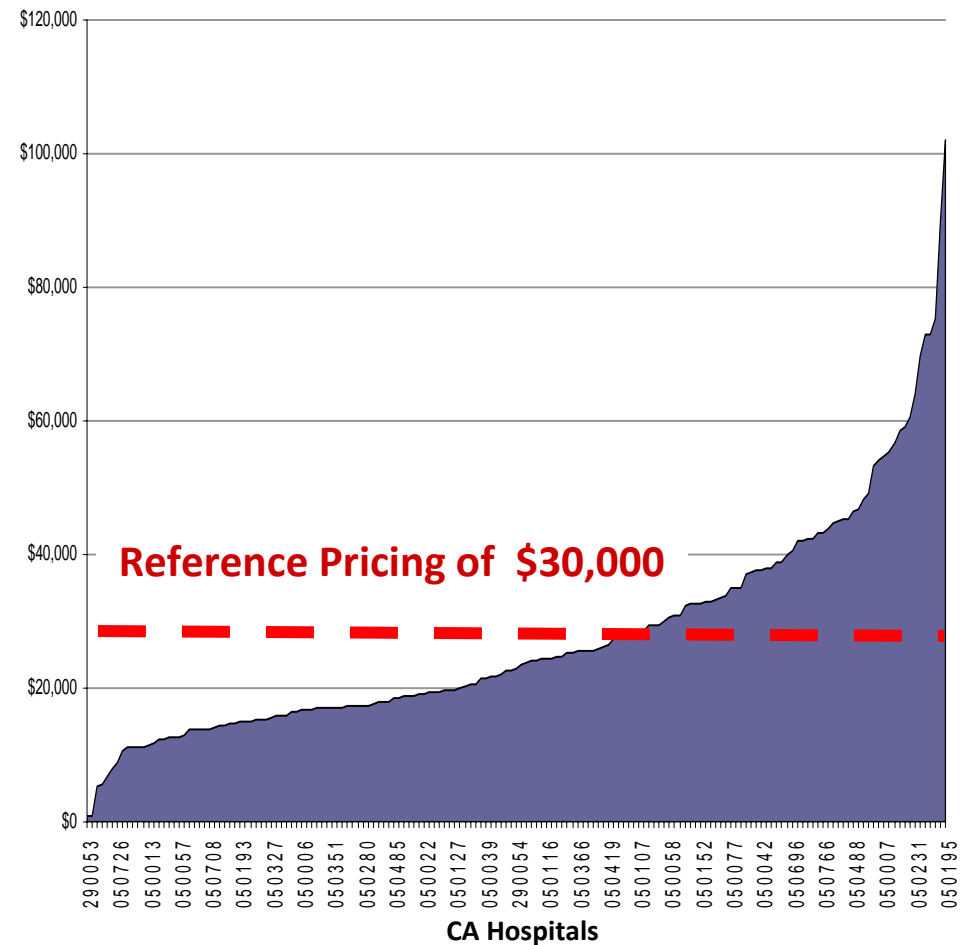


CalPERS-Anthem Value Based Purchasing Design: Knee/Hip Replacement

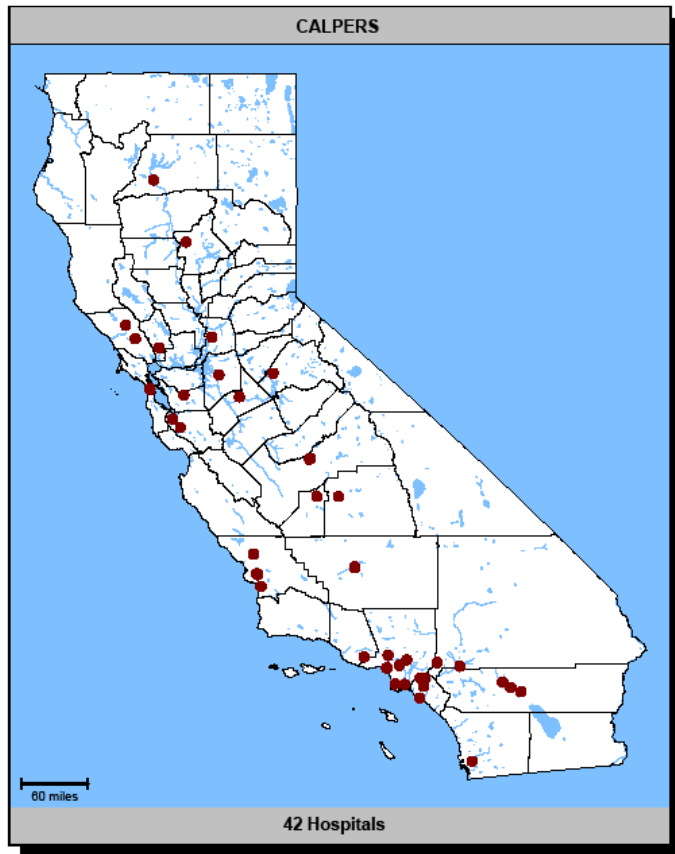
Average Cost for Total Hip by Facility



Average Cost for Total Knee by Facility



CalPERS-Anthem Value Based Purchasing Design: Participating Facilities 2011



Alvarado Hospital

Arroyo Grande Community Hospital

Bakersfield Memorial Hospital

Cedars-Sinai

Dameron Hospital

Desert Regional Medical Center

Eisenhower Medical Center

El Camino Hospital

Enloe Medical Center

French Hospital Medical Center

Fresno Surgical Center

Good Samaritan Hospital

Hanford Community Medical Center

Healdsburg District Hospital

Hoag Memorial Hospital Presbyterian

Huntington Memorial Hospital

John F. Kennedy Memorial Hospital

Kaweah Delta Medical Center

Loma Linda University

Long Beach Memorial Medical Center

Mercy Medical Center-Redding

Methodist Hospital of Sacramento

Placentia Linda Hospital

Queen of the Valley Medical Center

San Antonio Community Hospital

San Joaquin Community Hospital

Santa Monica UCLA Medical

Santa Rosa Memorial Hospital

Sierra Vista Regional Medical Center

Sonora Regional Medical Center

St Agnes Medical Center

Stanford University Hospital

St Jude Medical Center

St. John's Hospital and Health Center

St. Joseph Hospital-Orange

St. Mary's Medical Center

St. Vincent Medical Center

Stanislaus Surgery Center

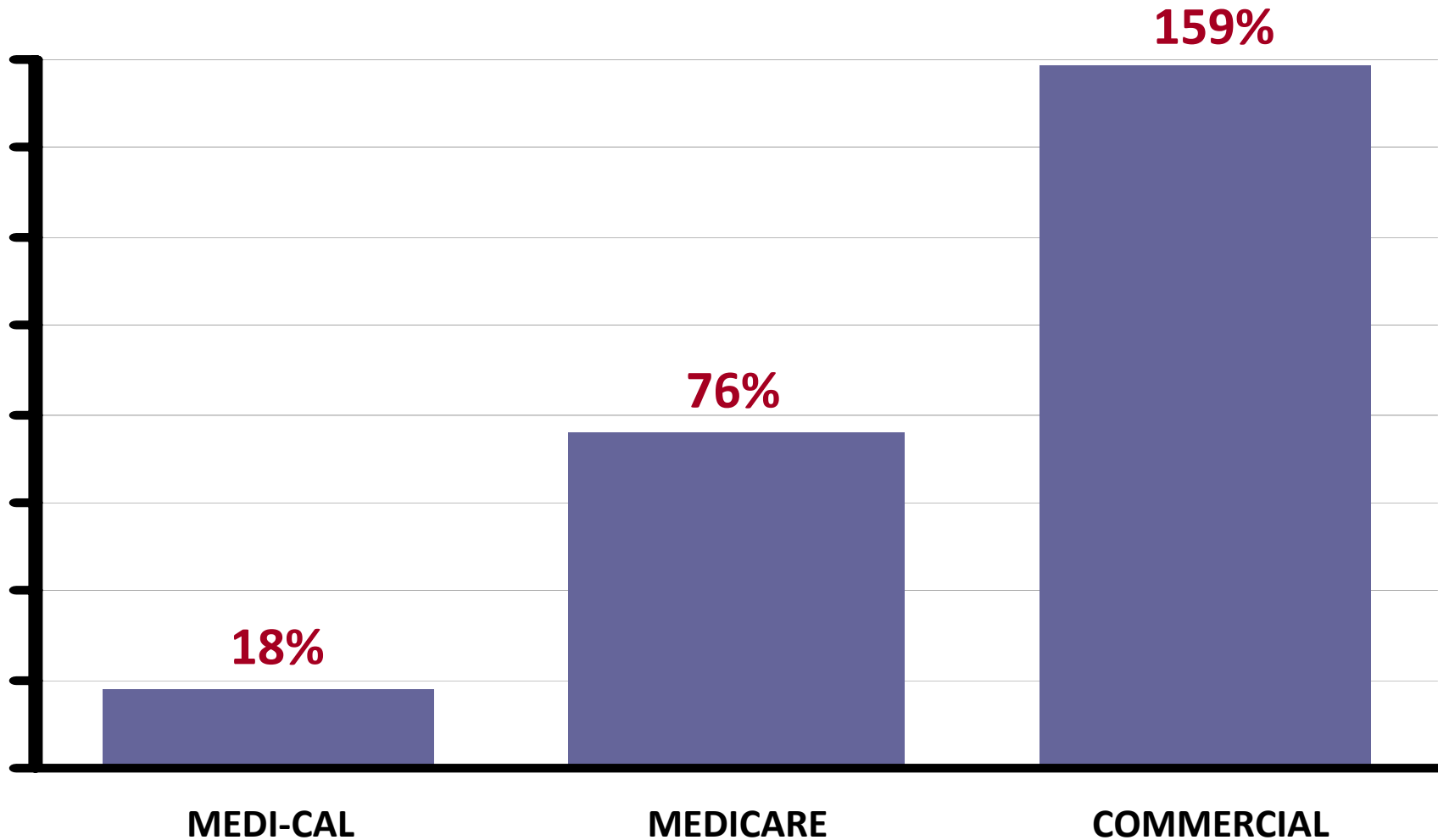
Thousand Oaks Surgical Hospital

Torrance Memorial Medical Center

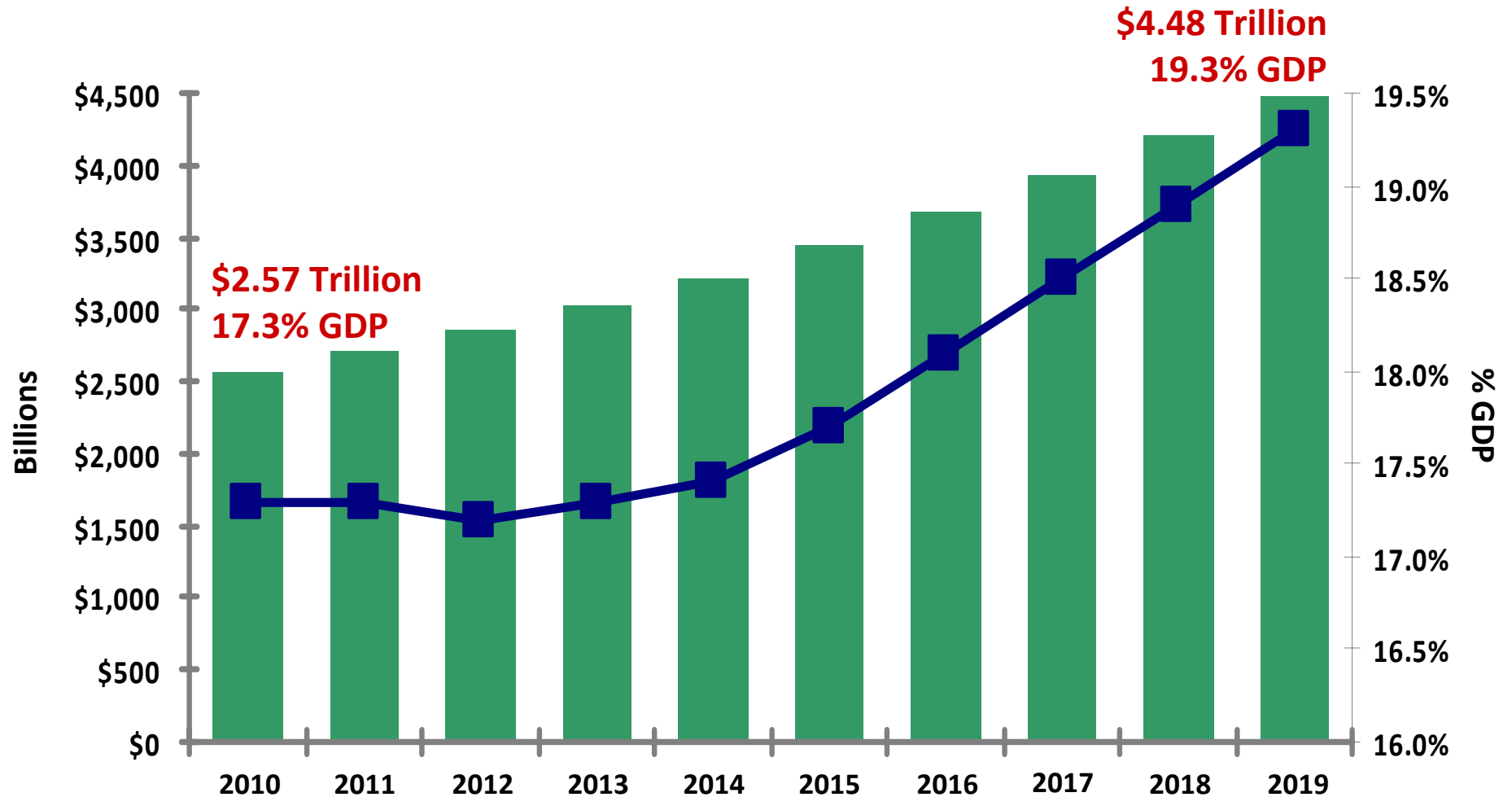
Twin Cities Community Hospital

UCSF Medical Center

California Hospital Revenue 2000-2009: Absolute Growth in Net Inpatient Revenue per Day

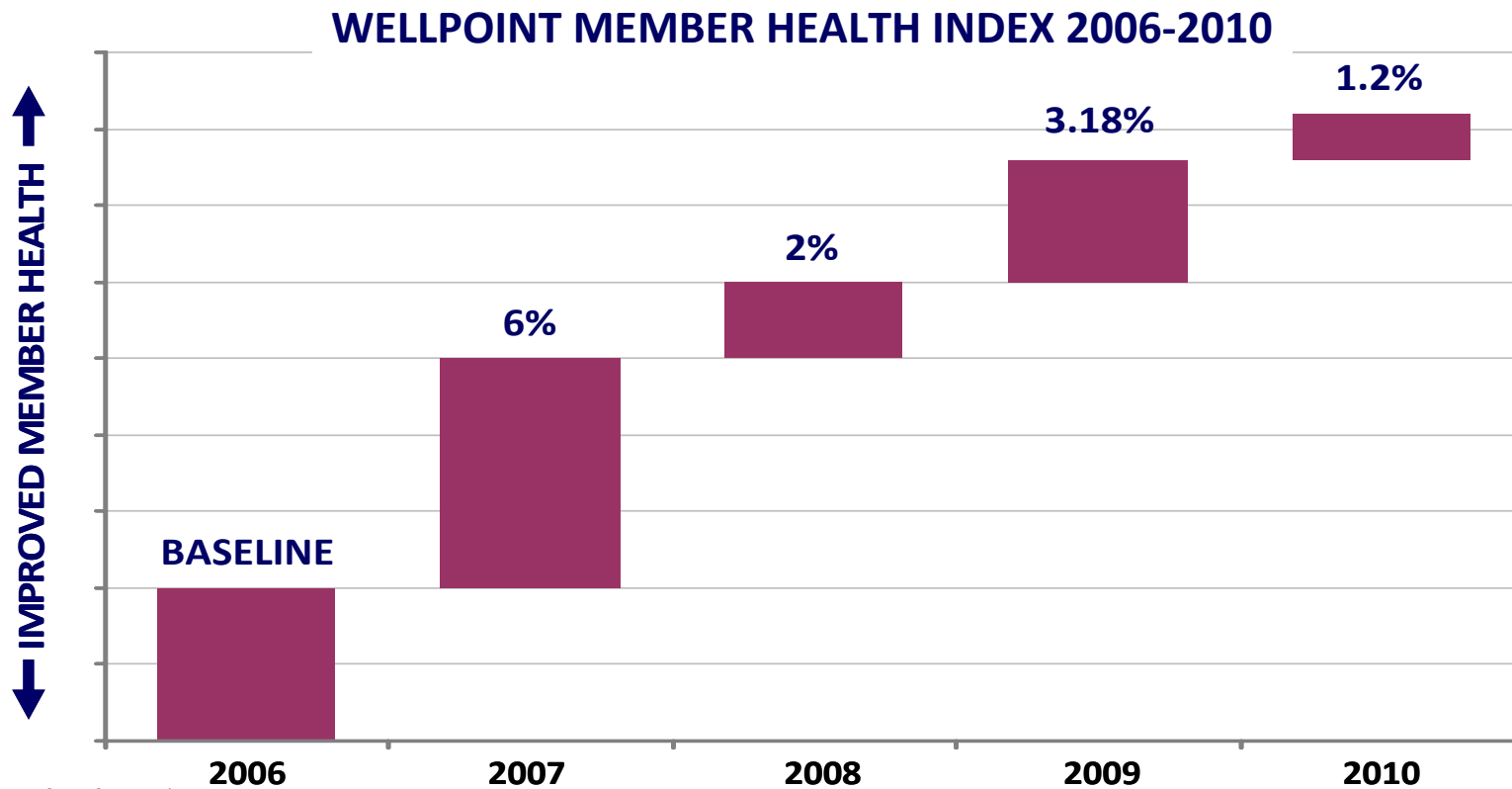


Projected National Health Expenditures: In Billions and as Percent of GDP



2008 version of the National Health Expenditures (NHE) released in January 2010

Improve the lives of the people we serve and the health of our communities



Source: Anthem Care Comparison