Testimony of

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Introduction

Chairman Rangel, Ranking Member Camp and members of the Committee. I am Ronald A. Williams, Chairman and CEO of Aetna. Thank you for the opportunity to speak here today as we approach a critical juncture in the national health care reform discussion. Let me start by emphasizing that we share a common goal. We want to get everyone covered with adequate health insurance, improve the quality of health outcomes, and get better value for each dollar spent on care – with the goal of reducing cost and improving affordability for the American people.

Your effort moves us closer to those goals, and I applaud the committee for trying to offer solutions that address the issues of cost, quality and access. Your plan would maintain the overall strength of the employer-based system, allow people to keep what they have, and provide solutions to improve the individual and small group market. While we may not agree on all the specific details of your overall plan, our intent is the same.

For example, I called for reforms that would guarantee that health insurance companies have to issue health insurance regardless of health status and limit medical underwriting. We can make these reforms if we also have in place an individual coverage requirement, just like Massachusetts, so that insurance is not just about getting it when you are on the way to the hospital.

Facts about the Health Insurance Industry

To fully appreciate that we have common interests, it is important to understand the goals and values of insurers today. Unfortunately, many people have made assumptions about our sector that may have been true 20 years ago but are not based in marketplace realities today.

We are not, in fact, one of the key drivers of health care costs. U.S. health care spending topped $2.4 trillion in 2007, while the combined profits of the top ten health insurers were approximately $8.3 billion. It is important to understand that insurance premiums are directly tied to the cost of underlying services in health care, including doctor, hospital and other provider costs. In 2007, the cost of health care services grew at an annual rate of 6.4%, resulting in overall premium increases, on average, of 6.1%.

Aetna today processes 206,000 calls a day and well over 50 million a year – over 45.5 million calls were answered in an average of 19.3 seconds and 94 percent were resolved the first time; we processed 407 million medical, dental and pharmacy claims in 2008. Of these, only 0.3%, or 1.2 million, were not processed correctly. Getting all this right takes long-term investment, staying current and

complying with the changing regulations from more than 50 jurisdictions and a commitment to constant improvement that can be implemented carefully.

But it would be a mistake to see our business model as a simple claims-paying operation. In fact, the competitive nature of our business requires us to generate strong value on behalf of the members that we cover. We have become leading innovators in chronic disease management, wellness and prevention, performance-driven payment models, quality management, and end-of-life care.

We also have been leading the health information technology (HIT) movement to give consumers and their doctors tools that empower them to make better decisions about their care pathway – using their personal health information in real time. Since 2005, we've invested more than $1.8 billion in HIT, and we're seeing real value for that investment.

Notably, our unique clinical-decision support technology, CareEngine®, provided through ActiveHealth Management, has been used to analyze more than 18 million complete patient records against current standards of care to identify gaps in care and to alert physicians with "care considerations" that they can act on. These clinical alerts have been reviewed by specialists at Harvard, and as a result we are able to say that Harvard approves of the language and how these clinical tools have been built. We have also submitted many of these measures that are used to support the clinicians to the National Quality Forum, and 33 are being reviewed for endorsement. We feel that we are raising the bar in the measurement of quality by our ability to collect diverse data and integrate it into useful decision support for clinicians.

CareEngine was tested in a randomized clinical trial, with the results published in 2005 and again in 2008. The use of the technology and the subsequent physician actions prompted by these care alerts produced a reduction in patient hospitalizations of 8% and a savings in charges of more than $8 per member, per month (PMPM). In a 2008 follow-up study[1], the tool's impact was further validated by findings that showed the use of advanced clinical-decision support with care alerts reduced overall charges by 6%, with charge savings in excess of $21 PMPM.

We are an essential element of health care today, helping employers and consumers get better care. Much of the innovation in our health care system is fueled by private insurers working alongside employers to ensure the health and wellbeing of employees. In fact, many of the payment and quality reforms currently proposed for the Medicare program were actually created, tested and proven by employers and insurers working hand in hand in the private sector.

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[1] The Journal of Health Economics, "Information Technology and Medical Missteps: Evidence From a Randomized Trial," 2008; 585–60.

Our ability, however, to innovate and deliver diverse product offerings across the country is very much affected by our complex regulatory environment. We are one of the most heavily regulated industries in the nation. We are regulated uniquely by 50 states and by multiple jurisdictions within each state; we are regulated by cities, in some cases, and several Federal agencies. Each regulatory body takes a different approach to how it handles regulation of the health insurance market and enforcement of the rules. These regulations today could fill a small town library.

The unintended consequences of these regulations are that each has a different effect on cost to the consumer and our ability to provide innovative product offerings. It is one of the reasons we see individual health insurance in New Jersey that is about 300% more expensive than similar plans offered in neighboring Pennsylvania. Bringing a more common approach to regulating the market – if it is with an eye on simplification – could make the market more responsive and increase consumer access to more cost-effective products. If we are going to set national rules, they need to pre-empt other statutes that try to accomplish similar outcomes.

We are also committed to continually reducing the administrative costs, and have made a pledge to the President to simplify our interactions with doctors, hospitals and other providers to produce savings and, more importantly, to streamline our system so that uniformity throughout reduces costs, improves interaction times, and addresses the key "friction points" that the medical community has asked us to address. The industry has committed to the following administrative simplification reforms:

- Automate and standardize the electronic processes used by health plans to do business with providers including: claims submissions, eligibility verification, claims status, payment and remittance.
- Eliminate the variation in how our industry implements administrative standards through the designation of an organization to develop uniform rules that would be incorporated in future versions of IT standards enabling providers to access consistent insurance information.
- Implement uniform standards for health plans' personal health records (PHRs) to ensure that patients and their providers have accurate, real-time information available 24 hours a day regardless of location. PHRs will help reduce duplicate tests, ensure up-to-date medication history, and facilitate better quality care by physicians.
- Adopt uniform quality performance measures that are actionable for physicians, hospitals, and other clinicians and issue consumer-friendly reports that assist patients in making more informed decisions.
- Propose that an independent third-party entity is created to: coordinate the collection of information on provider licensure, board certification, and adverse actions; and facilitate credentialing by hospitals and health plans across all private plans and public programs.

- Propose that a multi-stakeholder national task force is created to develop a process similar to the National Correct Coding Initiative (NCCI) to address correct coding for all populations and health care services covered by public programs and private insurers.

The differences between Medicare and private plan administrative costs are often referenced, despite the significant differences in the target populations and services provided. Even so, when compared on a per-member, per-month basis, administrative costs are nearly the same for Medicare and private plans.

Cost and Quality

Underlying medical trend is rising about 12-15% per year due to the cost and utilization of medical services. Recently, *The New Yorker* magazine, in a story by Atul Gawande, highlighted a worrisome problem in this country that some are now calling the "McAllen, Texas Problem." McAllen has one of the highest Medicare expenditures per capita in the country, yet its population is no sicker than most other places. But because it has high provider capacity, this capacity drives up volume and cost. A lesson for our country – we need to align incentives with quality outcomes, not volume.

The problems we face in health care can be solved. In fact, the industry came close in the 1990s, when the medical cost trend dipped from 8.1% in 1992 to (-1.1%) in 1995. Back then, you had a medical home called a primary care physician whom you needed to consult before you could see a specialist; you had limited choice of doctors and hospitals from a closed network, a network that agreed to tighter payment rates for services; and payments to providers were bundled for highly intensive procedures and allowed providers to keep some of the savings. Ultimately, that model did not work as consumers wanted more choice and more control over their options, and providers wanted more control over the options they could offer. We don't advocate it now. We may have achieved many of the right results but in the wrong way.

Consumers' expectations remain essentially the same today as they were in the '90s. Today most experts agree that 30% of health care is unnecessary, and yet the majority of Americans believe they don't get the tests and treatment they need. Fifty-five percent of Americans say insurers should pay for what a doctor recommends, even if a treatment has not been proven more effective than a cheaper one. If our collective goal is to achieve affordable coverage for all Americans, it is essential that we address these issues and make delivery system reform happen.

A lot of exceptional work is being done to examine the issue of paying for quality vs. volume. In cooperation with providers and employers across the country, we continue to experiment with aligning quality incentives and payments to providers when they follow the medically recommended care pathways, as determined by

the various medical professions. As a result, we have seen improving averages in breast cancer and colorectal screening, improving back surgery outcomes while reducing the use of imaging, improved use of antibiotic management leading to fewer readmissions (in one network alone readmissions went down 19% over a 60-day period), and we have seen similar results in diabetes management, oncology and cardiac care. When we focus on the patient in a holistic manner, we get better quality outcomes for patients and overall reduced costs. These are programs that have been done in cooperation with groups such as the Leapfrog Group and our own Bridges to Excellence program. These programs have reduced cost while improving quality. When people get the right care at the right time, the whole health system benefits, and we achieve value-based health care for all.

Making insurance affordable will require us to bend the health care cost curve; all of us have a role in this effort. But we must start with a major reform of the payment system, as this is the underlying cause of the over expenditure we live with today.

Prevention and Wellness

Health care reform needs to include strong prevention and wellness initiatives; it is the most important investment we can make in our future. Today, our health care delivery system is largely oriented toward the treatment of disease, rather than focusing on preventable health conditions. Refocusing our system to prevent disease and promote wellness can lead to better health for all Americans and positively impact costs system-wide.

More than half of Americans are living with at least one chronic disease. Nearly one in five four year-olds is obese, with significant disparities in prevalence among different racial and ethnic groups. The United States spent $217.6 billion on direct costs in treating non-institutionalized Americans for chronic disease in 2003, while experiencing an added $905 billion in losses associated with indirect costs.

We must refocus the health care system on getting and keeping people healthy throughout their lives. I believe a number of strategies are critical to refocusing our system on wellness and prevention, including:

- Using consumer engagement and targeted incentives to encourage sustained healthy behavior and change unhealthy behaviors;
- Developing an integrated, holistic approach to care management to allow for early intervention and education; and
- Promoting coverage policies and initiatives that encourage the use of high-value health care and address the needs of specific population segments.

Our own experience, as both an employer and as a leading national health insurer, tells us how effective this approach can be. Our *Wellness Works* employee programs are engaging employees, helping them get healthier and contributing to lower medical costs. The *Get Active Aetna* program, for example, is a 16-week fitness action campaign through which 55 percent of employees logged 970,000 exercise hours in 2008 – walking a total of 3,397,524 miles, the equivalent of walking 136 times around the earth.

Aetna Health Connections Disease Management helps people with chronic conditions get the treatment and preventive care they need by taking a wider view of an individual's health, rather than focusing solely on a single disease. Aetna's nurses and clinicians help members understand and follow their doctor's treatment plan and better manage ongoing conditions with the goal of helping members achieve their optimal level of health. Employers who invest in this program have seen a 2 to 1 return on their investment. Moreover, through disease management programs, we have seen reductions in emergency room visits and inpatient admissions, including a 7 percent reduction in ER visits for asthma, a 13 percent reduction in inpatient admissions for coronary artery disease and an 18 percent reduction in inpatient admissions for strokes.

Importantly, the employer-based system provides a critical venue for implementation of wellness and prevention programs, as insurers can help employers target interventions to the specific needs of their employees and their families. Congress should consider providing tax incentives to employers for offering evidence-based wellness programs, while also considering vehicles for pre-tax purchase of wellness-promoting activities. Grants for community-based wellness and fitness programs should also be considered, and wellness and prevention initiatives should be implemented in public programs.

Insurance Markets

Keeping what you have: We need to make the health insurance market work for everyone, and I believe we can. But as the President has stated: "if you like what you have you should be able to keep it." Choice is always at the center of what Americans want to maintain. Whatever we do, we need to ensure we do not implement reforms that adversely affect the ability of the insurance market to offer choice. In a *New York Times* poll reported in Sunday's newspaper, 77% of Americans, an overwhelming majority, said they are happy with the coverage they have. Your bill recognizes that people want the ability to keep what they have, but if the rules are too sweeping or strict and the regulatory structure too complex and constraining, you will limit choice and destabilize existing markets. If strict rules tilt the playing field too much in favor of exchanges, consumers will slide out of their plans into these exchanges and face higher premiums that they will not find acceptable. Tax credits and/or subsidies should be offered inside and outside the proposed exchanges. If we fail to do this, it will destabilize risk pools causing an additional rise in premiums.

Large Employers (50+)

Today, more than 177 million Americans get their insurance through the employer-based system, and the large majority of the 50+ market is self-insured. Employers expect great value for their spend in health care; they want wellness and prevention for their employees, chronic disease management, quality outcomes, and they want measurable results for each of these areas. This is not a system that should be changed, and by an overwhelming majority most employers don't want to see this market touched by reform.

- More than 95% of employers polled in a recent survey overwhelmingly want to continue to provide their employees this type of coverage.
- It is the employers' long-term commitment to their employees' health that has driven much of the innovation we have today in terms of services that help improve and sustain employee health.

But, outside this market, insurance does not work well for everyone, and we need to reform these markets if we are gong to achieve full access for all. We do need specific reforms for the individual market and those parts of the small group market that are not working. We also need to remember that 18 million people are insured in the individual market, 30 million in the 2- 9 market, and about 38 million in the 10-50 small group market. We should not expose these policyholders to disruptions that include higher rates. Where the market is not adequate we recommend the following:

Specific solutions for the individual and under-10 small group markets

The committee's reforms would make important progress in addressing the lack of coverage in this market. Only about 35% of the people in this market have access to insurance because of affordability concerns or pre-existing conditions. By reforming the individual market, which should also include small businesses with fewer than 10 employees, we can tailor insurance market solutions to effectively address the needs of the uninsured without disrupting or even unraveling the entire insurance market.

We can cover the uninsured if we:

- Guarantee issue of insurance and align it with a strong individual coverage requirement.
- Subsidize those that truly need help and possibly those at high risk
- Provide affordable coverage options, which improve choice and reduce complexity.
- Provide modified community rating for age, geographic location and family size, but toss out health status and gender.
- Design benefit options that meet specific needs of consumers. Most consumers, when using their own money, pick a benefit design that is similar to the Massachusetts Bronze plan. The premium for this plan is about 55% lower than the premium for FEHBP's Blue Cross Blue Shield standard plan.

We think it makes sense for these plans to be offered via an exchange and believe it should be national or statewide, run by the State Insurance Commissioner. If the federal government decides to set the rules for the exchange, they should preempt state rules. Exchanges should be operated under a consistent set of federal rules.

Setting rating bands is all about which part of our population subsidizes which other part. In making policy decisions, we need to be mindful of how reforms may impact different segments of the population. While the very purpose of an insurance pool is to spread risk, how much should a 23-year-old with a lower than average income pay to lower the rate for a 60-year-old with a higher than average income? It's only when we truly reduce the cost of health care that we will be able to provide affordable coverage. The National Association of Insurance Commissioners should be asked to provide recommendations on rate bands; once set, they should be reviewed periodically to ensure rate bands are not unfairly and adversely affecting different segments of the population. These bands should offer a cap but should not be so tight as to make insurance unaffordable for too many Americans.

Small Group 10 to 50

For small businesses with between 10 and 50 employees, 85% of whom offer their employees (about 38 million people) health insurance, we need a package of solutions that makes the current market work better. I believe the intent of the Small Business Health Options Program (SHOP) act is the right approach, as it provides a package of solutions intended to address the major issues for these small businesses – rate volatility and affordability of coverage. We support:

- Allowing groups to keep what they have
- Individuals entering the exchange if their employer doesn't offer coverage
- Rating rules that are consistent nationally (and consistent in and outside the exchange) – rating rules should not be set in statute
- Overall age band of 5:1
- Subsidies for the costs of high-risk individuals

I would call on the committee to leave some details to regulation, understanding that making our new model work will require time and experience. This would allow greater flexibility in meeting different consumer needs and expectations. Examples on this point include benefit package design, where we need not legislate in a "one size fits all" manner. Rate banding is another example; while moving to a national standard is advisable, we need to allow for flexibility in designing rate bands that are based on actuarial modeling and reflect our collective intent to expand access and increase affordability. This may take some experience with a new system to get right.

For group markets over 50, we do not see a need to change this market, given that it is almost fully covered. Any changes to this market could adversely affect reform overall.

The Public Plan

I've been asked whether we could compete with a public plan. All things being equal, I would say, yes, we can provide better value, quicker innovation and do a better job in areas such as wellness, prevention, and chronic disease management.

However, everything I have read so far says that a public plan would pay providers Medicare rates or something close to them and would control the delivery of care itself. The government would be, in other words, setting prices for services and paying below what providers consider to be market rates. There is no competition in this scenario. And, the government is missing the point – it is not how much we pay that is the problem, it is what we pay for that caused high-volume consumption of health care services. If everyone is paid at the same rate, how does that spur competition?

It would be extremely difficult for the government to be both a player and a referee. I cannot support this kind of public plan and see it as a danger to the stability of community and rural hospitals and to health care overall. It would lead to continuing to reward episodic care, as opposed to care management. It will be costly to implement, taking dollars away from an already burdened health care system. And, it could be a plan of last resort, creating a new problem for us to manage.

Conclusion

In closing, I want to be clear that we seem to have many more areas of agreement than we do areas in dispute. By making insurance coverage a matter of personal responsibility, you are laying the groundwork needed to help resolve the problem of access for so many of the nation's uninsured. And, this requirement would serve as a key building block for other important reforms, such as guaranteed issue regardless of the consumer's health status and pre-existing conditions.

I also hope you will take away from this discussion how vital the private sector is to innovation. Whether we're talking about health care product designs, quality measures or payment system reforms, the private sector has worked with employers and consumers to find new ways of delivering innovation and value to an ever-changing marketplace. With changes in the regulatory system, that value can be compounded many times over. We are an integral part of the health care system that will continue to deliver real value and new ideas if allowed to participate on a level playing field.

That is why a public plan option makes such little sense for health care consumers going forward. If we get everyone in the system and implement needed reforms across the individual and small group markets, it serves little purpose to weaken the ability of private insurance to deliver the level of service and value that so many Americans are happy with today.

Thank you for the chance to offer our perspectives and recommendations. We look forward to working with you to pass meaningful reform that addresses affordability, access and quality. I'm confident that, together, we can arrive at a solution that America can afford, and we can get it done this year.