



**BlueCross BlueShield
Association**

An Association of Independent
Blue Cross and Blue Shield Plans

Testimony

Before the

**Committee on Health, Education, Labor, and Pensions
House of Representatives**

on

Implementing Best Patient Care Practices

Presented by:

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INTRODUCTION

Madame Chairwoman and other distinguished members of the Committee, my name is Dr. Donald Fischer, Senior Vice President and Chief Medical Officer of Highmark Blue Cross and Blue Shield of Pennsylvania. I am honored to have the opportunity to testify before you today on behalf of the Blue Cross Blue Shield Association on best practices to promote quality health care. BCBSA is a national federation of 39 independent, community-based, and locally-operated Blue Cross and Blue Shield (BCBS) companies that collectively provide health care coverage to 102 million individuals – one in three Americans.

At Highmark, I have responsibility for overseeing the management of our clinical and non-clinical professionals who develop and deliver a comprehensive range of programs, including case management, pharmacy management, condition management, and wellness and prevention. BCBSA and Highmark strongly believe that all Americans should have health care coverage, and that the care delivered should be of high quality. There is ample evidence to demonstrate that there remains a quality chasm in health care in this country; despite the highest per capita spending in the world, we do not receive the value that we should for our expenditures. It is estimated that as much as 30 percent of all health care spending is wasted, going toward ineffective, redundant or inappropriate health care. It is our firm belief that improving quality of care will result in significant cost efficiencies.

Highmark's efforts to improve the quality of care – and ultimately have an impact on costs – are built around trying to reduce the unwarranted variation in medical practice that cannot be explained by patient demographics or severity of illness. The variation can be due to the underuse of tests and treatment known to be effective, the overuse of tests and treatments that may not have significant clinical value, and the misuse of tests and treatments that contribute to medical errors. These are the significant factors that are preventing us from assuring patient safety. Our mutual goal with providers is to assure that the right care is provided to the right patient at the right time.

Most physicians and hospital staffs are well trained and well intentioned, but need to spend more time focusing on improving the processes by which care is delivered, and using systems to support decision making that adheres to the scientific evidence that is available. This requires training in process improvement techniques, and a realignment of financial incentives. Our current system includes misaligned incentives that drive increased health care costs, without regard to quality of care or outcomes. I am often asked why I left academic medicine, where I truly found great satisfaction in helping children with congenital heart disease and their families.

My rationale is that I felt I could do much more to advance health in this country by having an opportunity to focus on championing patient safety and quality improvement for large populations of patients. My role at Highmark allows me to do that, and I believe we have demonstrated repeatedly that we bring value to our members and the caregivers in our network through our quality improvement programs.

BCBSA also believes that we must change processes and incentives in our current health care system to advance the best possible care, not just drive the use of more services. We believe that by helping providers implement best patient care practices, we can deliver better value and efficiency to members, ensuring access to affordable and high quality health coverage.

In my remarks today, I would like to focus on what Highmark is doing to improve quality and affordability by facilitating the adoption of best patient care practices for hospitals, primary care physicians, and members. Our main strategy with providers is to continue to raise the bar on quality through the use of pay-for-performance (P4P) programs that begin to align incentives through a program known as QualityBLUE. We also have pioneered an incentive program for members known as Lifestyle Returns, aimed at increasing adherence to preventive guidelines. These programs aim at aligning the incentives among the employer, the member, the physician, the hospital and the health plan. My testimony will emphasize four major lessons learned from these programs that are advancing best patient care practices:

- **Focus on measuring quality indicators that have been identified by national quality improvement organizations as areas of opportunity.**
- **Tie significant financial incentives to improvements in these quality measures.**
- **Facilitate the improvement by providing practice coaching and guidance to support the hospitals and physicians who are our partners in improving quality.**
- **Provide education, motivational coaching and incentives to members to improve adherence to the evidenced based guidelines for prevention and chronic care.**

Our approach to implementing best patient care practices has yielded significant, measurable outcomes – not only saving dollars, but also saving lives. As I share these results with you, please keep in mind that Highmark has many other programs to improve quality, such as worksite wellness programs performed in conjunction with our employer accounts. In addition, we regularly work with other BCBS Plans and the Association to continue to raise the bar on quality. As Highmark’s Chief Medical Officer, I meet quarterly with the other Blue Plan CMOs to spread best patient care practices. I also help my Plan take full advantage of Association-wide initiatives such as Blue Distinction, a program to identify the best hospitals and healthcare

facilities for cardiac care, bariatric surgery, transplantation, and the treatment of complex and rare cancers.

IMPROVING QUALITY AND PATIENT SAFETY IN THE HOSPITAL SETTING

I would now like to discuss examples of how Highmark has applied these guiding principles into practice to address important clinical issues. When Highmark launched QualityBLUE, we decided to focus on evidence-based measures of clinical quality that are in accordance with nationally recognized guidelines, and to utilize measures that will drive the greatest proportional improvements in quality. We also sought input from the primary care physician community and our network hospitals to ensure that the measures were valid and actionable.

Our QualityBLUE program for hospitals focuses on the following major areas, with each hospital being mandated to participate in the first two, and electing to focus on two additional initiatives among the others:

- Reduction of Methicillin Resistant *Staphylococcus aureus* infections (MRSA)
- Reduction of Central Line Associated Bloodstream Infections (CLAB)
- Medical Technology Implementation
- Reduction in Surgical Infections, using the Surgical Care Improvement Project (SCIP)
- Reduction of Deep Vein Thrombosis through use of SCIP venous thromboembolism project
- Adoption of the American Heart Association's Get With The Guidelines (GWTG) programs for cardiac disease and stroke
- Reduction of *Clostridium difficile* (CDAD) infections
- Reduction of Catheter-Associated Urinary Tract Infections

In addition, all hospitals are scored on their performance on the Centers for Medicare and Medicaid Services' Hospital Compare Process of Care Measure Set.

I would like to give examples of improvements related to the first two areas, because they represent among the greatest health threats to hospitalized patients.

Central Line Associated Bloodstream Infections (CLAB)

A central line is an invasive catheter device inserted in a patient and used to monitor hemodynamic status, provide nourishment, and administer medication. These types of devices place a patient at an increased risk for a bloodstream infection. Bacteria introduced through these lines can lead to life-threatening infections. Unfortunately, these catheter-related bloodstream

infections are common, costly and potentially lethal. Each year in the United States, central venous catheters may cause an estimated 80,000 catheter-related bloodstream infections and, as a result, up to 28,000 deaths among patients in intensive care units. In 2007, the Centers for Disease Control National Healthcare Safety Network published a national average of 2.7 infections per 1,000 line days for intensive care unit patients. By comparison, the **average hospital-wide rate for hospitals in QualityBLUE for 2008 was only 1.0 infections per 1,000 line days.**

To attain this result, we coordinate with QualityBLUE hospital participants to implement procedures to reduce central line associated bloodstream infections hospital-wide, working toward a goal of zero. This includes following evidence-based practices for insertion, maintenance, and use of central lines. Removing central lines, when no longer necessary, has also shown to be an evidence-based practice to reduce CLAB infections. For this program year, we instructed hospitals to implement procedures to assess daily the necessity of continued line use and, when appropriate, to remove the line.

When comparing the baseline data (FY 2007) to FY 2008, many hospitals improved their CLAB rate from baseline: 23 hospitals reported a rate of less than 1.0 CLAB per 1,000 Central Line days, with four of 23 hospitals even reporting **zero** CLAB. The average reported CLAB rate for all hospitals at FY 2007 baseline was 1.15 and for FY 2008 was 1.02.

While there were still 341 CLAB infections at QualityBLUE hospitals in the past year, had CLAB infections occurred at the national average rate, there would have been a potential of 907 infections at these hospitals. At an estimated cost of \$38,703 per case, that represents a potential savings to the health care system of more than \$ 21.9 million compared to the cost had the network performed at the national average. More importantly, there was a reduction in mortality and morbidity compared to the national norm, with “mortality savings” estimated to be in the range of 68-142 lives saved.

MRSA

MRSA first emerged as a pathogen causing healthcare-associated infections (HAI) in hospitals throughout the United States in the late 1970s. Since that time, MRSA has spread to hospitals throughout the country and has become the most common pathogen causing HAI in healthcare facilities in the United States and throughout the world. In 2004, MRSA accounted for up to 60% of the Staphylococcus aureus infections acquired in the intensive care units (ICU) of healthcare facilities that reported data through the National Nosocomial Infections Surveillance (NNIS) system.

Studies estimate the attributable medical costs associated with MRSA infections in U.S. hospitals average \$35,367 per case. Additionally the Centers for Disease Control and Prevention (CDC) reported that approximately 120,000 persons were hospitalized in the year 2000 with an MRSA

infection estimating an annual total cost of \$3.2 billion to \$4.2 billion for hospitals nationwide. For these reasons, and for the safety and welfare of our members, prevention and reduction of MRSA is an issue that we could not ignore.

A key component of the QualityBLUE MRSA indicator is to develop a system to identify the prevalence of MRSA entering the hospital from the community. By identifying patients as carriers of MRSA, upon admission, a previously unknown “reservoir” of MRSA is determined. Infection control procedures can be implemented for these patients that help prevent the transmission of MRSA from this patient population to other hospital patients. With fewer new patients becoming colonized with MRSA, future MRSA infection development is avoided.

Thus, to prevent and reduce the number of MRSA infections, QualityBLUE hospital participants implement active surveillance testing on their three highest risk units, and then take steps to minimize the likelihood of transmission of the MRSA to other patients. They screen hospital admissions to determine if a patient is a carrier of MRSA; when a carrier is identified, the hospital implements barrier precautions to reduce the likelihood of spreading the infection, uses dedicated equipment, adheres to strict hand hygiene practices, and requires staff to wear personal protective equipment at all times around the patient.

The QualityBLUE program measures the rates at which hospitals screen patients for MRSA on admission, and again at discharge, as well as determining the rates of transmission within the hospital setting. We require hospitals to monitor active surveillance testing compliance and set a goal of 90% compliance with obtaining cultures on patients admitted to one of the three units and at the time of transfer from the unit or discharge from the hospital.

For 1st quarter FY 2008, the admission and discharge compliance with obtaining surveillance cultures for all QualityBLUE hospital participants was 92.0% and 81.5% respectively. By the end of the 3rd quarter of the program year, admission culture compliance improved by 4.5% over Qtr 1 (to 96.2% compliance) and discharge culture compliance increased by 11.8% over Qtr 1 (to 91.1% compliance). MRSA transmission rates ranged from 0.8 to 3.7 infections per 1000 patient days, reflecting persistent unwarranted variation in practice among the participating facilities. That being said, it is only through measurement and awareness that these facilities can address the problem that was previously unquantified and unmanaged.

INCREASING THE QUALITY IN PRIMARY CARE PRACTICES

Our QualityBLUE program for primary care physicians (family practice, internal medicine, pediatrics) focuses on the following six areas of quality improvement:

1. Clinical Quality Indicators (focusing on eliminating underutilization of these evidenced base guidelines)
 - Appropriate use of Acute Pharyngitis Testing

- Appropriate Asthma Medications
 - Persistence of Beta Blocker Treatment
 - Breast Cancer Screening
 - Cervical Cancer Screening
 - Cholesterol Management for patients with Coronary Artery Disease
 - Comprehensive Diabetes Care
 - Adolescent Well-Care Visits
 - Varicella Vaccination Status
 - Well Child Visits for the First 15 Months
 - Mumps-Measles-Rubella Vaccination Status
 - Congestive Heart Failure Annual Care
 - Well Child Visits - 3 to 6 Years
2. Increasing appropriate Generic Drug utilization
 3. Improving Accessibility for members, providing evening and weekend hours for visits
 4. Participating in a “Best Practice” process improvement project
 5. Adopting Electronic Prescribing tools
 6. Adopting Electronic Health Records

All six measures drive overall improved quality care for our members, as well as encourage increased levels of care coordination. Care coordination at the primary care level is a critical component of improving outcomes for patients with chronic conditions, and we continue to seek strategies and practices to increase its practice.

As examples of success, the following are illustrative of the impact of the program during 2008.

Adoption of Electronic Health Records (EHR) and Electronic Prescribing tools

The implementation rate for EHR in 2008 increased by 50%, while the rate of use of electronic prescribing increased 52%, with 586 practices (40% of the total QualityBLUE practices) now using these electronic tools.

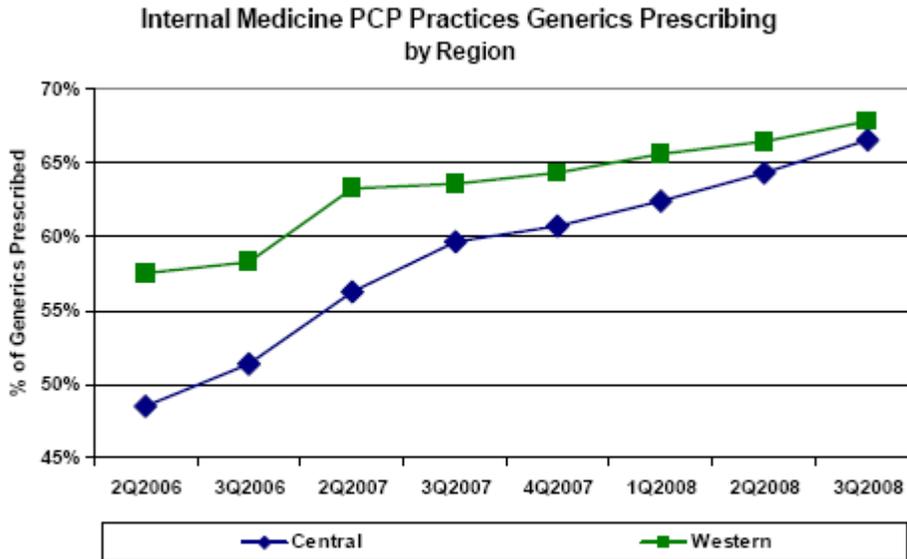
Generic Drugs

In early 2004, we implemented the Generic/Brand Prescribing indicator in the western region QualityBLUE physician program. In April 2006, the QualityBLUE physician program was implemented in the central region with the inclusion of the Generic and Brand drug measure.

Evidence of the impact pay-for-performance programs have on advancing practice change can be seen in the rapid growth in the Highmark central region’s use of generic drugs. The central region incorporated the Generic/Brand indicator in the second quarter of 2006. At that time, there

was nearly a 10% difference in generic prescribing rates for internists between the two regions. As of 3rd Quarter 2008, both regions essentially shared the same Internal Medicine network percentage of 68% (western) and 67% (central). This is a significant accomplishment for both western and central networks but most importantly demonstrates the rapid 40% increase in central region performance once physicians in that region had an incentive for generic prescribing (see Figure 1 below).

Figure 1.



During 2008, the generic prescribing rate for Highmark’s book of business increased by 3.8%, resulting in cost savings for our accounts of approximately \$137 million, and direct savings to our members of over \$24 million. These savings are also associated with increased adherence of our members to their medication regimens, a clear quality benefit related to the increased affordability of generic medications.

2007 survey data showed a 4% increase across all Blue plans in generic fill rates due to system-wide implementation of such strategies. That increase translates into an estimated \$3.3 billion in health care cost savings in 2007 due to increased generic drug use. A recently-released CMS report supports these findings, noting that reduced growth in the United States in 2007 of retail prescription drug spending (only 4.9 percent, as compared to 8.6 percent growth in 2006) was due in large part to sustained growth in the generic dispensing rate.

ALIGNING FINANCIAL INCENTIVES TO QUALITY IMPROVEMENTS

Our QualityBLUE programs for both hospitals and physicians have achieved clear successes in raising the bar on quality. One key driver behind this success has been a thoughtful restructuring of our reimbursement system to reward best practices that achieve good outcomes.

Hospitals

Hospitals in the Highmark network are offered an opportunity to participate in QualityBLUE via their contract negotiation. The QualityBLUE Hospital program provides program participants a negotiated program reimbursement based on the attainment of identified performance objectives and targets throughout a contract year. The hospital places at risk a portion of their negotiated reimbursement based on the achievement of agreed upon clinical quality improvements targets, approximating from one to three percent of total hospital reimbursement. The earned reimbursement is paid to the hospital either via a lump sum payment at the conclusion of the program year or the reimbursement is integrated into the hospitals rates for the subsequent year (earn in one year, paid in the next). In the fiscal year 2008 QualityBLUE program, Highmark paid more than \$42 million in earned performance-based reimbursement. In this setting, quality departments of these hospitals are no longer simply tolerated as a requirement of JCAHO, but they become revenue centers bringing real value to their patients and to the hospitals' bottom lines.

Physicians

Physicians participating in QualityBLUE receive quality scores based on the measures described earlier, up to a maximum of 115.

Quality Measure	Description	Possible Quality Score
Clinical Quality	Expected Quality Guidelines	65
Generic/Brand Rx	Prescribing Patterns	20
Member Access	Weekly office traditional and non-traditional hours	5
Best Practice	Clinical Practice Improvement Activity	15
Electronic Health Record	Uses evidence of implementation progress	5
Electronic Prescribing	Uses evidence of purchase and functionality	5
Total		115

Physicians are scored on a quarterly basis, and receive incentive payments for each evaluation and management claim filed during the subsequent quarter, based on their total score. Those who score less than 65 points do not receive incentive payments. Those scoring between 65 and 89 receive \$3 per filed claim; between 90 to 100 receive \$6 per filed claim; and more than 100 points receive \$9 per filed claim. These incentive payments are highly significant, comprising up to 15 percent of a practice's total reimbursement. Our experience is that only incentive opportunities of this magnitude have the potential to motivate changes in practice. In 2008, 60 percent of the 1,297 physician practices participating in QualityBLUE earned bonuses. A total of \$14 million was paid in incentive payments to primary care physicians in FY2008.

PROVIDING COACHING AND GUIDANCE

Significant incentives are necessary to raise performance on key measures, but they are not sufficient without additional coaching and management support. That is why Highmark feels it is paramount to cultivate on-going relationships with its provider community by providing information and establishing forums to obtain feedback and share best practices, through newsletters, Lunch and Learns, and Best Practice Forums, and through the dedication of consultative resources that provide on-site program guidance.

Hospitals

To support QualityBLUE hospital partners throughout the performance year, Highmark has developed engagement strategies designed to provide quality of care information to healthcare staff, facilitate inter-facility communication, provide consultative support and encourage implementation of best practices. We have formed Highmark QualityBLUE teams of professionals that include medical technology experts, Registered Nurses, Certified Infection Control Professional, Speech Pathologists, Registered Health Information Administrators, and Certified Professional Healthcare Quality experts, including Medical Directors.

The teams have established and led the following types of activities:

Partners in Quality Newsletter: The Highmark QualityBLUE team developed the Partners in Quality Newsletter, a quarterly publication, as a tool to communicate with QualityBLUE hospital partners regarding program highlights. Topics of interest related to the program, as well as interviews with physician champions, submission of articles by QualityBLUE hospital participants and information on upcoming "important dates" related to the QualityBLUE program are included.

Best Practice Forum: Annually, Highmark hosts the QualityBLUE program "Best Practice Forum" inviting QualityBLUE participants to share their positive clinical improvements identified through participation in the program. The day-long event includes poster presentations, clinical break-out sessions, nationally renowned speakers, and presentations by clinicians

recognized as experts in a wide range of clinical topics. In November of 2008, more than 250 hospital staff attended this event.

Program Orientation and Ongoing Clinical Consulting: Highmark QualityBLUE staff members are available to answer questions regarding the program throughout the year. As new hospitals consider entering the program, QualityBLUE staff members meet with healthcare facilities and discuss the QualityBLUE program with the hospital Quality teams. For new participants, orientation to the program is conducted early in the program year and prior to the mid-year evaluation. The QualityBLUE team provides consultative support throughout the program year. Currently, the hospitals are visited as part of the program requirements at mid-year and year-end to facilitate quality improvement activities and to assess alignment to the current QualityBLUE program year.

Physician Support

To support physicians in their quality improvement efforts, Highmark formed the Medical Management Consultant (MMC) Team over 10 years ago. The team is comprised of 15 staff members, one Medical Director, and two Clinical Pharmacy Consultants. This experienced and dedicated staff provides consultative quality improvement support, education and training to more than 3,221 physicians. They have developed long term relationships with these physician groups, and have become trusted partners in bringing value to the delivery of healthcare in their practices.

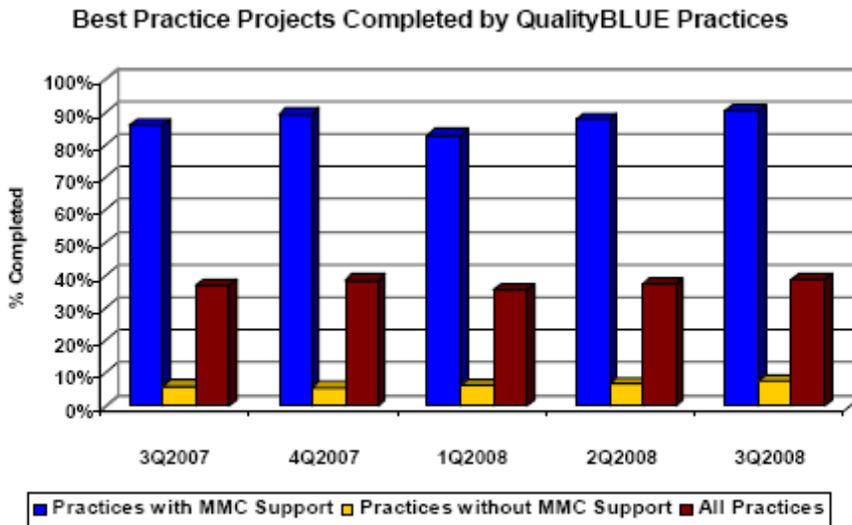
Specifically, MMC teams help physician practices by:

- Assessing where the practice's current performance is against quality performance criteria – the Quality Improvement Roadmap to Success
- Evaluating the practice office operations to determine process improvement opportunities.
- Meeting with the physicians and staff to provide feedback and recommend a course of action to improve clinical quality and office operations
- Collaborating with the physicians and staff to create a work plan that defines the problem; establishes baseline measures; specifies action steps; designates responsible team members; establishes a timeline for expected outcomes; and incorporates a control mechanism to ensure the operations don't falter.
- Scheduling meetings to monitor and report on the practice's performance against their clinical quality and process improvement activities, helping to assure they succeed in their efforts and maximize their incentive opportunity.

We have demonstrated that practices which have the benefits of a Medical Management Consultant are more successful with every aspect of the QualityBLUE program. It is quite

evident in Figure 2 that the practices with this resource were far more successful in implementing Best Practice projects leading to measurable quality improvement in their offices.

Figure 2.



ENGAGING MEMBERS IN QUALITY IMPROVEMENT

In addition to health plans, hospitals and physicians, our members play an important role in helping to improve quality and manage costs. For many years, the challenge for health plans has been to consistently engage consumers in wellness and healthy lifestyle improvement programs. Our experience, using our own employee workforce as a testing ground, shows that financial incentives make a big difference.

Since 2005, Highmark has encouraged our employees to participate in a program known as Lifestyle Returns, designed to improve adherence to preventive care guidelines, and encouraging use of personalized online programs that focus on weight management, stress reduction, smoking cessation and healthy eating habits. Employees receive financial incentives if they set and meet targeted health goals. Prior to 2005, a maximum of 9% of Highmark employees obtained a preventive health exam during the year. During 2008, over 60% of employees obtained all preventive exams and screenings recommended for their age and gender. We have also provided on-site fitness facilities and have encouraged employees and their managers to encourage regular use of these resources. In addition, all employees are able to access health coaches for management of chronic conditions, targeted health conditions, and wellness training.

The results show that health promotion and wellness programs are cost-effective. Our study showed that employee participation in the program produced an estimated savings of \$1.65 in avoided health care expenses for every dollar spent on the comprehensive employee wellness program, including the payment for the employee incentive. The study’s findings were published

in the February 2008 Journal of Occupational and Environmental Medicine. Equally important, empowering individuals to lead healthier lifestyles has an immeasurable positive impact – higher quality of life, increased productivity, reduced time off work, and stronger communities of healthier people.

We are now spreading these member programs to our Plan accounts, and seeing similar health and productivity gains.

FOSTERING QUALITY IMPROVEMENT ON A NATIONAL SCALE

As I mentioned at the beginning of my testimony, Highmark has implemented a number of other important strategies, some unique to Highmark, some established by the Blue Cross and Blue Shield Association. To give you an idea of other approaches to implementing best patient care practices, I would like to focus on one Highmark initiative and one Association initiative. BCBSA has designated nearly 800 Blue Distinction Centers (BDC) across 43 states. This national program designates facilities that have demonstrated expertise in delivering quality healthcare in the challenging specialty areas of Transplantation, Bariatric Surgery, Cardiac Care, and Complex and Rare Cancers. To receive this designation, facilities within participating Blue Plans service areas must meet stringent quality criteria, as established by experts in the specialty field. To meet these BCBSA requirements, the Centers must demonstrate better outcomes and consistency of care, which provide greater value for Blue Plan members. Facilities that have the BDC designation are subject to periodic evaluations as criteria continue to evolve. At this time Highmark's 49-county service area has facilities with Bariatric Surgery, Cardiac Care and Complex and Rare Cancer designations.

Cardiac Care

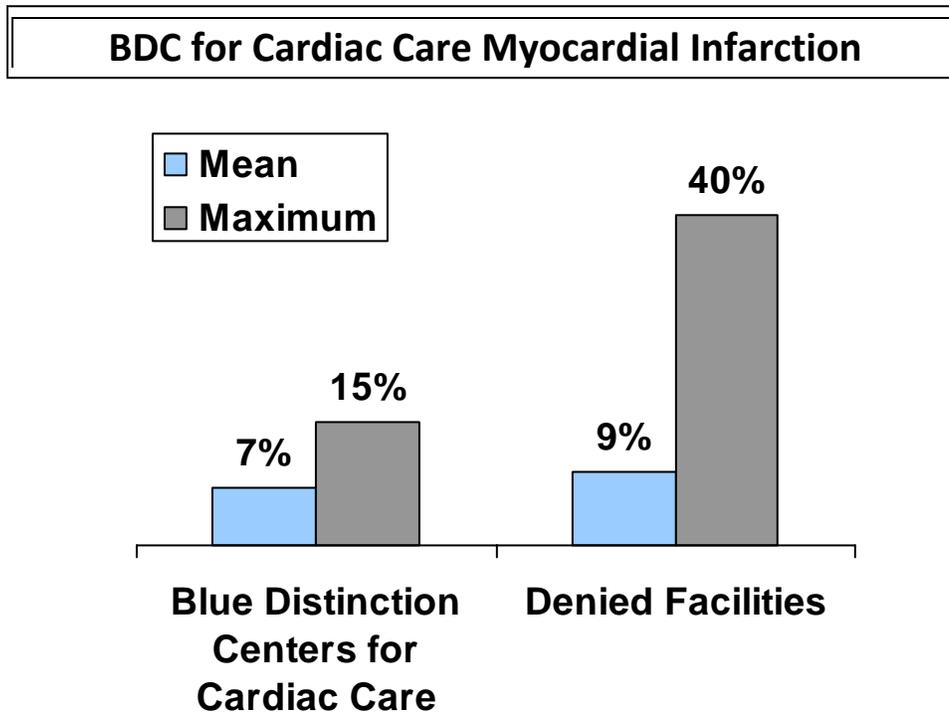
The early results for the Cardiac Care BDCs are especially encouraging. Currently there are more than 410 Blue Distinction Centers for Cardiac Care across the country, including those in Highmark's network. The stringent clinical criteria that facilities met were developed in collaboration with the American College of Cardiology (ACC), the Society of Thoracic Surgeons (STS), and with the input from a panel of leading clinicians.

For example, a study by HealthCore, Inc., found that readmission rates for certain procedures performed at Blue Distinction Centers for Cardiac Care[®] were lower than at other hospitals. The study found:

- 26 percent lower readmission rates for bypass surgery and 37 percent lower for outpatient angioplasty, based on 30-day cardiac-related readmission rates.
- 21 percent lower readmission rates for bypass surgery and 32 percent lower for outpatient angioplasty based on 90-day cardiac-related readmission rates.
- Lower costs, five percent less for bypass procedures and 12 percent less for outpatient angioplasty, with a 90-day episode of care.

Similarly, there is a significant difference in the inpatient mortality of patients admitted to BDC facilities as opposed to those facilities that were denied the designation. Figure 3 demonstrates the difference in mean and maximum mortality levels between these two groups, findings which further support the value of the program.

Figure 3. Inpatient Mortality Rates for Myocardial Infarction at Blue Distinction Centers for Cardiac Care compared to Facilities denied the designation.



And in a striking confirmation that improved quality leads to better affordability, allowed charges for CABGs were \$45,215 in BDCs, \$2,260 less than in non-BDC hospitals. Keep in mind that economic criteria were not used to designate facilities as BDCs – it just turned out that facilities that offered better care were associated with better clinical outcomes and generated more affordable care, an important insight for national policy. Quality pays.

CONCLUSION

The best care is that which assures that the right care is provided to the right patient in the right setting at the right time. Providers should be rewarded for delivering high quality healthcare with financial incentives to have full information about their patient at the point of care, coordinate their care with other caregivers, and use a systems approach to adhere to evidence based guidelines to assure appropriateness. This is especially true for the increasing number of individuals with chronic conditions. Properly aligned incentives can reinforce the adoption of

evidence-based practice standards and are a necessity to providing transparent quality information for consumers to make informed choices about their care. Raising the bar on quality – which will lead towards elimination of wasteful spending – will result in better outcomes and more prudent use of valuable resources.

As leaders in the health care community for over 80 years, BCBSA and the entire Blues system looks forward to working with the new Administration, Congress, and all stakeholders to enact healthcare reforms that improve the quality of care delivered to all Americans.