

Testimony of

Ronald A. Williams

Chairman and Chief Executive Officer, Aetna Inc.

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“Addressing Insurance Reform”

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[Written submission]

Good morning Chairman Kennedy, Ranking Member Enzi and members of the Committee. Thank you for the opportunity to be here today. I am Ronald A. Williams, Chairman and Chief Executive Officer of Aetna Inc., one of the nation's leading diversified health care benefits companies. I appreciate the opportunity to share my views with this committee and to continue working with you to transform our health care system, which we can all agree is in urgent need of reform. I believe our health care system must provide affordable, high quality coverage for all Americans.

My company is committed to taking part in the development of meaningful, broad-based solutions, and I am convinced that we can help move reform forward. Our views are shaped by our experience with the 36.5 million unique individuals to whom we provide products and services in all 50 states; the 894,000 health care professionals with whom we interact daily; and the thousands of employers for whom we devise benefits solutions regularly and the 50 states and multiple federal entities that regulate our products.

Our industry, my company and the expectations of the people who are our customers and members have changed a good deal over the past several years. Insurance is not just about paying claims anymore. Increasingly, our stakeholders expect us to be their partner, to add value and to innovate. Employers want affordable, high-quality products and services to enhance the health and productivity of their employees. Doctors and hospitals want to give their patients access to medical innovations and new technologies, with fewer administrative barriers. Our members want access to our network of health care professionals, tools to make informed decisions, transparency of price and quality data, and access to the expertise of nurses and trained professionals on issues ranging from chronic disease care to wellness and prevention.

At Aetna, our business model has changed significantly over time as we work to meet these new expectations. We have been at the forefront of bringing the information age to health care. That is why we have spent more than \$1.8 billion on technology and innovation since 2005. Our innovations mean that we no longer simply process and pay claims; now we have sophisticated systems that scan hundreds of millions of interactions between our members and their doctors, hospitals and pharmacies to alert them and their physicians to sometimes dangerous interactions caused by errors or omissions.

Our workforce has changed also. Today, nearly 40 percent of our workforce are clinical professionals or work in information technology. The focus of all our employees is to improve health and ensure our consumers get the best, most appropriate treatment possible, including wellness and preventive care and managing their complex diseases. If you are an Aetna member, you can reach a health care professional at any time of the day or evening who can respond to your health care needs.

As the health care system hurtles toward \$4.3 trillion in annual spending by 2017, we have an opportunity and an obligation to achieve meaningful reform and improvement. Our experience and perspective tell us that we are a nation and culture unique from the rest of the globe, and we require a uniquely American solution that will enable the health care system to meet the nation's expectations for health care quality, access and affordability.

To transform our current healthcare system into what it should be, we need to work collaboratively to address the key roadblocks that stand in our way and build a sensible path to reform:

- **It is essential that we realize real reform while preserving and building on the employer-based health care model that works for most Americans.** We should avoid systemic disruption to the 177 million Americans who have employer-sponsored coverage, and instead build upon the strengths and innovations of private health coverage for the good of other populations. Together, employers and insurers are driving innovations that are helping many Americans better maintain their health, take advantage of helpful health care technology and access safe, quality health care.
- **We need to accelerate our efforts to harness the power of health information technology (HIT), which is so critical to addressing cost and quality issues.** Congress made a significant investment in HIT in the American Recovery and Reinvestment Act, but the United States still lags behind other countries in the use of electronic medical records (EMRs). If 90 percent of all providers in the United States were using EMRs, we could see savings of about \$77 billion within 15 years¹. With the advent of sophisticated clinical decision support capabilities, those savings, coupled with lives saved, could exceed current expectations. At Aetna, we have made significant investments in health information technology, and we are not finished. Our investments are designed to help patients and doctors take action on their health conditions and help patients get the standard of care they expect and require.
- **We need to confront the challenges associated with the rising cost of health care.** Costs will rise from \$8,000 per person this year to more than \$13,000 per person in the next decade. There is an important, but often overlooked connection between health care costs and the premiums people pay for health insurance coverage. Health insurance premiums reflect the underlying cost of health care. So unless we, as a nation, are successful in “bending” the cost curve, we will see premiums continue to rise at a pace far faster than either wage growth or inflation – which puts health insurance out of the financial reach of a growing number of U.S. residents. If we do not address the issue of costs, reforms made today to improve access will not be sustainable. We all have a significant role to play in this complex problem. This includes our industry, which is committed to achieving new levels of simplification and reduced administrative costs.

A Solid Foundation for Reform

Many are questioning whether we can achieve meaningful health care reform. I believe the answer is that we can reform our system and simultaneously achieve the dual goals of improving access and making healthcare more affordable. All of the players in health care – health insurers, hospitals, physicians, employers, pharmaceutical companies, consumers, legislators and regulators – will need to focus on achieving both of these goals together.

¹ Modern Healthcare, “By the Numbers,” 2006-2007 Edition, December 17, 2006, p 66.

As you consider how to structure reform, I urge you to build upon the current employer-based system that today covers 177 million people – 60 percent of the American population. When given the choice, 82 percent of workers who are eligible for employer-offered coverage participate in their employers' health plans.²

Leveraging the strengths of the employer-based system would enable people to keep the health coverage they have if they are satisfied. It would also continue the innovation that has resulted from employers and health plans working together over decades to improve quality and value. We recognize that maintaining the basic structure of health care coverage through the employer-based system is not enough. Our customers are demanding that we make sound health care investments that positively impact their physical and financial health. We have responded to this imperative by:

- Developing products and services that improve the quality of health care and help control rising benefits costs;
- Providing members with access to convenient tools and easy-to-understand information that can help them make better-informed decisions about their health and financial wellbeing;
- Introducing new levels of transparency to the health care system; and
- Pioneering new ways to focus on wellness and prevention programs.

We recognize that maintaining the current structure is not enough. Reform efforts need to focus on access and affordability of insurance for the 45 million uninsured Americans and those seeking coverage in the individual and small group markets. A growing number of people, nearly 18 million under age 65, are accessing insurance through the individual market. In addition, coverage is often expensive and unstable for the millions accessing coverage through the small group market.

Critical Components of Reform

Getting all Americans covered

Covering all Americans is imperative for fixing our nation's health care system. An enforceable individual coverage requirement, combined with subsidies and other changes to make coverage affordable, is the best way to ensure that all Americans have continuous access to insurance coverage and high-quality health care. Since 2005, we at Aetna have been speaking out in support of an individual coverage requirement, as we believe it is the critical step for achieving universal coverage.

One of the great, and often painful, challenges in our system is that too many individuals often have difficulty accessing coverage in the individual market. Insurers have relied on tools like medical underwriting and preexisting condition exclusions to maintain the solvency of the current system, which lacks universal participation. Insurance works best when everyone

² Pickreign, Jeremy et al. "Employer Health Benefits 2008 Annual Survey," Kaiser Family Foundation and Health Research and Education Trust, September 2008.

participates in the system continuously, whether they are healthy or sick. Today's individual market system does not reflect these principles and insurers face adverse selection, wherein people enter the insurance marketplace when they need coverage and healthcare services.

An enforceable individual coverage requirement solves this problem better than any other proposed policy, because it allows us to bring everybody – both healthy and unhealthy – into the insurance pool. By using an individual coverage requirement to address the challenge of adverse selection, we can transform our system into one where private insurance is provided on a guaranteed issue basis with no preexisting condition exclusions and a rating system that does not include health status. We support allowing insurers to provide discounts on premiums for those who engage in healthy behaviors to help increase incentives for good health. These reforms would allow all Americans access to coverage and would help people keep their health coverage as they go through life transitions, allowing true portability.

An individual coverage requirement must, of course, be coupled with sliding scale subsidies to ensure that income is not a barrier for any individual's fulfillment of this requirement. In addition, we must offer tax credits for small businesses to encourage them to offer (and subsidize) employee coverage. We must create a rational regulatory structure that is conducive to creating affordable coverage options. I would encourage greater uniformity of state laws and regulations and the development of a new federal charter. Insurers with a multi-state presence face costly administrative burden to comply with divergent state laws and regulations, and these higher administrative costs are passed onto the market at large through higher insurance premiums. A national entity would need to determine a standard benefit package and determine what types of actuarially equivalent plans could be offered. Under a national framework, plans could cross state boundaries and be offered through national, state or regional insurance exchanges that create new pooling mechanisms.

We believe an individual coverage requirement, subsidies and insurance market reforms create the best framework for addressing our country's access challenge. Others believe a new public plan is the silver bullet for the uninsured. I would submit that, for a number of reasons, a public plan is not the best way to fix our system.

First and foremost, insurers bring innovation, value and choices that allow individuals to choose a tailored approach to their individual needs that a one-size-fits-all public plan just could not achieve. With our unique capabilities in the realm of encouraging wellness and prevention, providing care coordination and chronic disease management, and empowering consumers and providers with health information technology, we can offer health care that responds to the specific needs of individuals. Health care is one area in which we must leverage the agility of the private sector to provide continued innovation and customization of health care plans.

Beyond recognizing the added value that private insurers can provide, we must also be aware of the challenges a new public plan would impose on the rest of the system. A public plan would most likely employ the payment rates used in Medicare, which are far lower than the rates paid by private payers. In fact, the average family of four with private insurance spends an additional \$1,788 on health care each year because of Medicare and Medicaid underpayments to providers. On an aggregate level, commercial payers incur approximately \$89 billion more in costs than

they would if public and private payers all paid equivalent rates.³ Expanding the use of low public payment rates would mean expanded cost-shifting for our health care system.

There is no doubt that getting all Americans into the health care system is of the utmost importance. The best solution for our country will not be to shift us over to a system for which the public sector gradually takes more and more responsibility and competes with the private market, but rather to engage in a public-private partnership that allows each sector to focus on what it does best. Aetna is fully committed to active participation in this partnership to create a better system in which no one is left out.

Bringing affordable coverage into reach

If we want to ensure that all Americans have access to high-quality, affordable health coverage, we must both slow the growth of health care costs and get greater value out of our health care spending.

The cost of health care in the United States is growing at an unsustainable rate. National health spending will reach \$2.5 trillion in 2009 and by 2018, it is expected to reach \$4.4 trillion and comprise just over one-fifth (20.3 percent) of Gross Domestic Product (GDP). This year, we can expect the top three cost drivers – hospitals, physicians and prescription drugs – to comprise 73 percent of health care spending.⁴

If we fail to effectively address our nation's health care cost problem, which is ultimately driven by the increasing illness burden borne by our population, we will find that access expansions will be unsustainable. A case in point is Massachusetts, where the absence of payment reform and more effective utilization threatens to undermine the ultimate success of truly commendable access reforms. Investments in health information technology and tackling payment reform are both necessary to slow the cost growth and improve quality.

HIT can live up to expectations: The use of health information technology will not only be a powerful tool to bend the cost curve, but will also help address our country's pervasive quality issues. The United States continues to lag behind its peers globally in embracing HIT solutions necessary to yield cost reductions and quality gains. Compared to other developed nations the United States trails in its overall use of electronic medical records (EMR), with an adoption rate of only 28 percent.⁵ A *New England Journal of Medicine* survey suggests that 83 percent of US doctors have still not adopted EMR technology.⁶ Consequently, Aetna continues to strongly support the President's initiatives to accelerate HIT adoption and commends the Congress' recent work to invest up to \$22 billion to promote the use of electronic health records that have clinical decision support capacity as recommended by the Institute of Medicine.

³ Milliman, *Hospital & Physician Cost Shift*, December 2008; figures reflect 2006 and 2007 data.

⁴ Centers for Medicare and Medicaid Services, "National Health Expenditures Projections: 2008 – 2018."

⁵ The Commonwealth Fund, "2006 International Health Policy Survey of Primary Care Physicians in Seven Countries," November 1-2, 2006.

⁶ The New England Journal of Medicine, "National Survey on Physician Adoption of Electronic Health Records," July 2008.

Over the past four years, Aetna has invested more than \$1.8 billion in deploying health IT solutions that improve both the quality and cost-efficiency of the care that is delivered to our members. In making these investments, Aetna recognized from the outset that beyond its other claims and care management technologies, robust clinical decision support capabilities are essential to yielding the desired quality and cost returns necessary to produce a return on HIT investment. This was a key reason for Aetna's 2005 acquisition of Active Health Management and its innovative Care Engine® technology.

This unique technology provides a truly integrated solution for providers to extend clinical decision support beyond the electronic records platforms that may be contained in a physician's office or hospital. Care Engine® scans millions of lines of pharmacy, lab, diagnostic, claims and other clinical data and matches them up to the latest available medical literature. It can scan disease management members' data for opportunities to improve care through enhanced diagnostic and therapeutic precision, and then notify physicians and patients with actionable information that can lead to improved outcomes at the point of care. Among the providers and plan sponsors now utilizing Care Engine®, it has demonstrated that the technology's use can generate a meaningful return on investment by measurably improving quality outcomes (e.g., 19 percent reductions in overall hospitalizations)⁷ while producing overall cost savings (e.g., eight-fold ROI or 6 percent reduction in average charges)⁸.

As we look ahead to ensure the public also receives a strong ROI for this new national HIT investment, it will be important for the Secretary and the Office of the National Coordinator within the Department of Health and Human Services to reinforce expectations in regulation and other guidance that: 1) providers meet measurable targets focused on quality outcomes in their use of publicly financed health information technology; and 2) that these technologies measure up to standards that ensure their capability to assist providers with clinical decision support that integrates pertinent data from all of the critical points within the health care system.

Addressing health care costs and quality: a critical foundation

On an annual basis, the United States spends \$650 billion more on health care than peer OECD countries, even after adjusting for wealth.⁹ The vast majority (\$436 billion) of this "excess" spending results from outpatient care. There are other factors that contribute to the "excess," including technological innovation, high levels of utilization, misaligned incentives for providers, lack of transparency and consumerism, higher prices and population health challenges.

We need to tread carefully when it comes to some of these cost factors, as we do not want to stifle the innovation that drives improvements in our ability to improve and save lives. We can, however, work to ensure that technology is used appropriately to improve the standard of care

⁷ The American Journal of Managed Care, "Using a Claims Data-Based Sentinel System to Improve Compliance With Clinical Guidelines: Results of a Randomized Prospective Study," 2005;11:93-102

⁸ The Journal of Health Economics, "Information Technology and Medical Missteps: Evidence From a Randomized Trial," 2008; 585-60.

⁹ McKinsey Global Institute, "Accounting for the cost of US health care: A new look at why Americans spend more," December 2008.

and drive better patient outcomes. We can also realign incentives in our system to ensure that quality and value serve as the primary motivators for choosing specific treatments.

The American health care system is wrought with inefficiencies, wasteful duplicative spending and poor performance. Understandably, there is a strong concern that our inputs in health spending are not yielding high enough quality output in care and outcomes, and the impact of these quality disparities is brought to bear in very real terms. In fact, between 35,000 and 75,000 avoidable deaths and \$2.7 billion to \$3.7 billion per year in avoidable medical costs can be attributed to unexplained variations in care,¹⁰ underscoring the need for widespread dissemination of evidence-based medicine and standards. The guidelines must ultimately be applied at the individual member level to mitigate variation and wasteful spending.

Payment reform will also be a critical tool to improve quality and bending the cost curve:

The traditional fee-for-service (FFS) payment structure often rewards physicians and hospitals for the volume of services they deliver rather than the value or quality of care they provide. Aetna supports transforming the payment system into one that aligns provider reimbursement incentives with the pursuit of high-quality outcomes for patients. We need a payment system that works for the patient, bringing them value – high quality at the right cost.

Reform needs to focus on promoting patient-centered care that integrates the multiple aspects of the health care delivery system and shifts the model from episodic, acute care to comprehensive, evidence-based care. Yet equally important is that any attempts to enact comprehensive payment reform include the input and support of the multiple stakeholders that make up the system, including providers, patients, employers and health plans. The managed care backlash of the 1990s taught us the valuable lesson that in order for payment reform to succeed, providers need to participate in the agenda-setting and metric-development process and patients need to know their interests are being served.

We believe engaging consumers in their own health care is also of critical importance in achieving greater value within our health care system. As the leader in consumer-directed health plans (CDHPs), we continue to help plan sponsors with empowering their employees to make informed decisions about their medical care. In fact, the average large employer saved more than \$7 million per 10,000 members over the course of five years when an Aetna Health Reimbursement Arrangement (HRA) or Health Savings Account (HSA) was offered as a plan option. We also found that Aetna customers with CDHPs were much more likely to use online consumer tools and information – a leading indicator of employee engagement. They were also more likely to use preventive services than those enrolled in traditional health plans.

Congress has taken some important steps forward: I applaud the Members of this Committee, the Senate and the House for their success in passing several key reforms that will start to slow the growth of our nation's health care costs while improving healthcare quality. The inclusion in the American Recovery and Reinvestment Act of 2009 of \$1.1 billion in funding for comparative effectiveness research will help ensure that we invest in treatments that truly offer added benefit to the right patients. The commitment of \$22 billion to investments in health information technology infrastructure and Medicare and Medicaid incentives for providers

¹⁰ National Committee for Quality Assurance, "The State of Health Care Quality," 2007.

to electronically exchange patient health information will not only help to advance quality of care, but will help us to achieve long-term savings.

Conclusion

I believe that President Obama and this Congress have charted a course of change, and I want to make clear that we too are committed to expanding access, controlling costs and improving the quality and value of care people receive. I hope this Committee and the nation as a whole will view Aetna and our industry peers as partners in advancing these shared goals. Our experience and effectiveness in developing and using technology to drive quality improvements, for example, can inform the larger discourse about health information technology and comparative effectiveness. We will support those efforts aimed at addressing access and affordability as well as the quality and value of health care in America. Over the past several years, Aetna has tried to lead by harnessing innovation and utilizing technology to serve people, and by stepping out front on issues that we believe can truly make a difference to our country.

The health care system needs fundamental reform, and that will require determination and collaboration across the healthcare system that is unprecedented. We are ready and willing to work with you – because we know that success will be rooted in public/private cooperation – to create and implement practical solutions that drive systemic change.

Working together, I believe that the path forward is achievable and that we will be able to bring a new approach to health care that efficiently and safely gets people to their desired destination – optimal health.

Thank you.