TESTIMONY

Enabling Health Care Quality, Safety and Affordability

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Oversight and Investigations Subcommittee
of the Committee on Energy and Commerce

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WELLPOINT®

INTRODUCTION

Thank you, Chairman Waxman and members of the Subcommittee for inviting me to testify today. I am Angela Braly, President and CEO of WellPoint, Inc., and I appreciate the opportunity to appear before you to provide information related to the Anthem Blue Cross March 1st individual market rate increases for members in California and to explain the increases being reported in the media. There seems to be a lot of confusion about the issue, and it is a real case-in-point on why we need sustainable health care reform that will specifically address the growth in the underlying cost of health care services and that takes into account the need for insurance market regulatory changes to be actuarially sound.

WellPoint provides health benefits to nearly 34 million members across the country, representing nearly one in every nine Americans. Our subsidiary companies serve these individuals in the United States through programs and services including medical insurance benefits; life and disability insurance benefits; pharmacy benefits, dental, vision, and behavioral health benefit services; long-term care insurance; and flexible spending accounts. We also serve another 24.5 million Medicare beneficiaries in 25 states as a Medicare administrative contractor through our National Government Services subsidiary.

We care deeply about our California customers and the communities we serve as well as all the people we serve across America. And we share the concern raised by this Subcommittee and appreciate the opportunity to explain why rates—which reflect known and anticipated medical costs—are increasing substantially for certain individual members. In addition to being California's largest individual health insurer, we are the largest Medi-Cal provider (California's MediCaid program), and a HIPAA insurer of last resort (for those individuals exhausting COBRA coverage and who do not qualify to be underwritten in the individual market.) We work diligently to improve the health and wellness of all Californians. In fact, our participation in the state's public programs serving low-income and high-risk Californians is substantially larger than other insurers operating in California, including the two largest not-for-profit health plans.

We take our commitment to advancing quality very seriously, and we continue to implement a variety of initiatives to help achieve these goals. For example, Anthem Blue Cross recently led a patient safety collaborative in California, working directly with providers across multiple geographies to partner with the state's three regional hospital associations to employ systematic and sustainable efforts to improve patient safety. These include sharing data, resources, and proven, successful safety practices to reduce the incidence of pre-term births, and to reduce the incidence of sepsis and other hospital acquired infections (ventilator associated pneumonia, central line blood stream infections and catheter associated urinary tract infections). We are aggressively taking these actions because focusing on the quality and cost of care is the only path to creating a sustainable health care system.

We have also improved our administrative efficiencies to reduce overall administrative costs and improve health care quality. For example, we led the industry in the establishment of the

Committee on Operating Rules for Information Exchange (CORE) which has brought together more than 115 health industry stakeholders – health plans, providers, vendors, the Centers for Medicare & Medicaid Services, associations and others – to help streamline administrative transactions to reduce the amount of time providers spend on those transactions allowing them to focus on patients. We continuously work to become more efficient and effective as an organization and in our interactions with other parts of the health care system. We continue to make improvements to ensure that our members receive the most reasonably priced products that we can provide while continuing to focus on initiatives to increase the quality of care and in turn the health of our members.

The past few weeks have seen a great deal of attention directed at the recent rate increase that Anthem Blue Cross announced for the California individual market. While the March 1st rate increases are significant for certain individuals, it is important to note that the rate increases:

- Relate only to the individual market;
- Reflect estimated medical trend that is rising due to increases in medical costs and adverse selection, as explained further below;
- Reflect that Anthem Blue Cross provides coverage in the California HIPAA and MRMIP programs for which rate increases are restricted and whose losses are borne by the individual market;
- Even if the rate increases were to have gone into effect on March 1st, the individual business in California was estimated to generate an after-tax operating margin of 1.5%;
- Even after our proposed rate increases, our products remain competitively priced in the market;
- An independent actuarial firm reviewed our March 1st rate filing (rates were filed with the California Department of Insurance in November 2009), concluding that the March 1 rate increase was actuarially sound and the company's methodology was reasonable. Anthem Blue Cross has nonetheless agreed to defer implementation for two months to allow further review.

These rate increases related to the individual insurance market where individuals purchase coverage directly (not through their employer). This portion of our California membership represents approximately 10 percent of our more than our approximately eight million members in California.

As you know, we exist in a competitive marketplace where many individual purchasers are free to choose from among a number of carriers. For example, a search for coverage in Los Angeles from an online broker would yield over 100 coverage options from 7 large insurers. The rate increases are not the result of a lack of competition, but rather the underlying cost trends.

Raising our premiums was not something we wanted to do – but we believe this was the most prudent choice given the rising cost of care and the problems caused by many younger and healthier policyholders dropping or reducing their coverage during tough economic times. By law, premiums must be reasonable in relationship to benefits provided which means they need to reflect the known and anticipated costs they will cover. All health insurers are in the same position, and even with this increase our company's premiums remain quite competitive. While we believe that an increase in our rates is unfortunate, it is necessary and we welcome the opportunity to explain why rates are going up in a challenging economy.

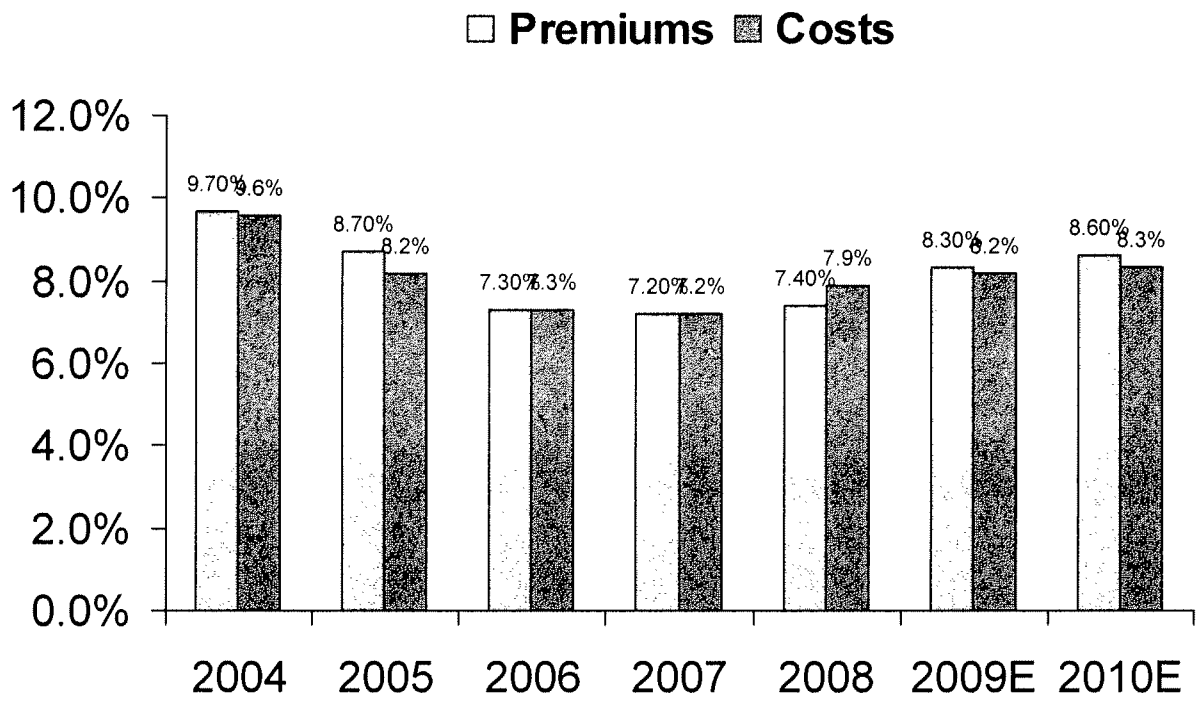
We would also like to emphasize that we are cooperating with a California Department of Insurance review of our March 1st rates. An independent actuarial firm concluded that our rates are actuarially sound and necessary, reflecting the expected medical costs associated with the membership in these plans. Nonetheless, we have agreed to postpone the March 1st increases for two months to allow for additional review.

OVERVIEW

Briefly I would like to discuss the causes for the March 1st rate increase in the California individual market, and will provide more detail later in my testimony. Generally speaking, the cost increase can be broken into two parts: (1) general medical inflation, and (2) a significant change in the risk pool, also called "adverse selection".

- **Higher medical costs as reflected by general medical inflation:** The increases in premium costs are driven by prices charged by clinicians, hospitals, medical device manufacturers, pharmaceutical companies and other suppliers in health care that are accelerating much faster than general inflation as well as increases in consumer utilization. Provider prices increase because of provider rate increases, new technology, and by cost-shifting to the private sector because Medicare and Medicaid do not fully cover provider costs. In effect, the private sector – including our members—are subsidizing the public sector. Experts have found that commercially insured families pay almost $1800 more each year for their coverage as a result of this cost shift[1]. Higher patient utilization is primarily driven by a shift in the demographics of this country, which has an aging population and rising incidence of chronic disease which can be lifestyle related, plus the increasing use of high-cost diagnostic testing by providers.

[1] Milliman, http://www.milliman.com/expertise/healthcare/publications/rr/pdfs/hospital-physician-cost-shift-RR12-01-08.pdf



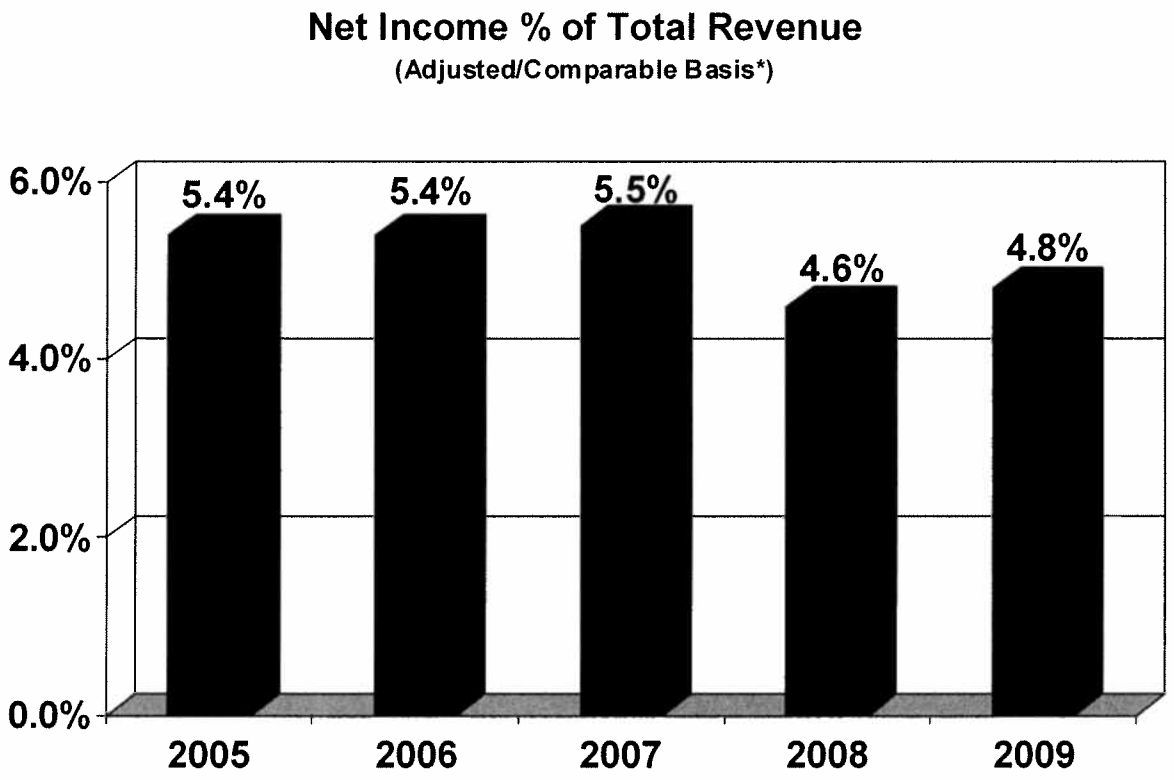
Source: Millman, CMS, Company documents, Barclays Capital Managed Care 2010 Industry Outlook Report

- **Adverse Selection:** In a difficult economy, younger, healthier policyholders who lose their jobs and income often sacrifice their health coverage. This means there are fewer policyholders among whom to spread risk and those remaining have higher health care costs. The result is higher premiums for those left in the pool.

These are the drivers behind our claims trend, and when we evaluated our claims trend for our individual market products in order to set our 2010 rates, we determined that a rate increase averaging approximately 25% (excluding aging) was necessary to cover cost trends and adverse selection and was projected to result in an after tax operating margin of 1.5%.

Much has been made of the profit WellPoint, the parent company of Anthem Blue Cross, earned in the last quarter of 2009. However, it is important to review our profits on an adjusted basis as explained below.

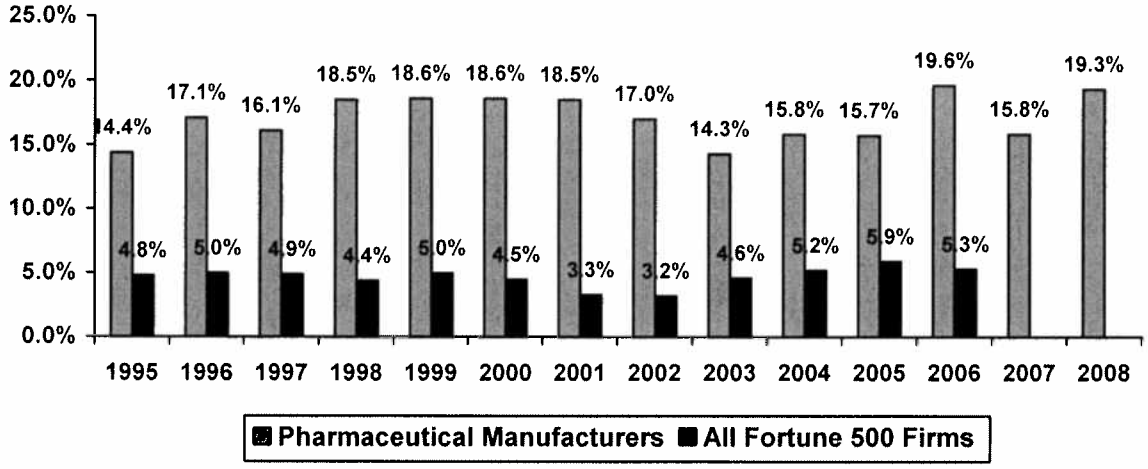
Here are a couple salient details to put our fourth quarter results in perspective. We sold our Pharmacy Benefit Management unit to Express Scripts, so excluding that one-time gain to earnings, our real fourth quarter earnings were approximately $380 million after tax. When our annual income is fully adjusted the percentage of net income to total revenue has remained generally consistent from year to year as shown below.



* Adjusted to remove the after-tax impact of realized gains (losses) on investments and other significant non-recurring items. 2009 specifically excludes the one-time gain related to the sale of our Pharmacy Benefit Management companies. For comparison purposes, 2005 includes the reclassified financial results of WellChoice which was acquired on December 28, 2005.

These earnings are in line with other health insurers given our size as the largest insurer in the United States by membership, providing coverage to tens of millions of Americans. Significantly, our net margin in the fourth quarter on a fully-adjusted basis was 3.5%, again completely in-line with our competitors and well below the margins of many other companies in the health care industry including pharmaceutical companies, medical device companies and others.

Profitability of Pharmaceutical Manufacturers, 1995-2008



Note: Percent is the median percent net profit after taxes as a percent of firm revenues for all firms in the industry. 2007 and 2008 data not available from Kaiser. According to Fortune Magazine, the median percent net profit after tax for all Fortune 500 companies in 2007 and 2008 was 5.7% and 3.7%, respectively.

Source: Kaiser Family Foundation and Sonderegger Research Center, Prescription Drug Trends: A Chartbook Update, November 2001, Exhibit 4.11 at http://www.kff.org/insurance/3161-index.cfm, updated with data from *Fortune*, Fortune 500 Industry Rankings: April 14, 2003, Vol. 147, No. 7, p. F-26; April 5, 2004, Vol. 149, No.7, p. F-26; April 18, 2005, Vol. 151, No. 8, p. F-28; April 17, 2006, Vol. 153, No. 7, p. F-26; April 30, 2007, Vol. 155, No. 8, p. F-32; 2007 and http://money.cnn.com/magazines/fortune/; Kaiser Family Foundation, Kaiser Fast Facts, Profitability of Pharmaceutical Manufacturers, 1995-2008. September 16, 2009. http://facts.kff.org/chart.aspx?ch=218

Putting this in perspective, if we returned our entire fully adjusted fourth quarter after-tax operating profit back to our members, it would be $5.13 per member month or about $60 per year.

Here are a few additional facts to add some context to the current discussion:

- The Anthem Blue Cross profit margin in California is in-line with and below that of many of our competitors;
- Both for-profit and not-for-profit health plans must generate revenue in excess of costs to ensure they are able to not only pay claims, but also to maintain their solvency and operate their business;
- In California Anthem Blue Cross insures more high-cost, low-income individuals than any of our competitors, including the two largest not-for-profit health plans;
- Despite how our rate increase was reported in the media, we still have many affordable and competitive options available in the individual insurance market. Since this is a competitive market, many purchasers often shop around for the best value;

- The average March 1st rate increase is approximately 25% before factoring in attained (actual) age, not the 39% reported;
- The March 1st rate increase will apply only to a person who chooses not to change his or her product. Switching to a less-costly product is an option we offer members and which many choose to do. We offer ten products in the individual market in California—with nearly sixty different benefit and premium levels—that provide consumers numerous options for affordable coverage.

DETAILED DISCUSSION OF CALIFORNIA INDIVIDUAL RATE INCREASE

It is important to note that the proposed March 1st rate increase that is being reported in the media relates only to the individual insurance market where individuals purchase coverage directly (not through their employer), which represents approximately 10 percent of our approximately eight million members in California. Furthermore, the figure of 39 percent being reported by the media represents the largest rate increases and includes the impact of aging and was experienced by only a portion of our members. Specifically, the rate changes range from a 20.4 percent *decrease* to a 34.9 percent increase excluding the impact of age-category changes. Additionally, the rate notices reflect the March 1st rate increase for an individual who does not choose to change his or her product to diminish the impact of premium increases, which is an option we offer to members and which many individuals choose to do.

Clearly, we understand that rate increases create a challenge for many of our members. However, it is important to know that many of our members often have a choice of coverage. We help our members understand their options by making available health plan advisors who work with the member to help ensure they understand their coverage options. Further, our products remain very competitively priced when compared with the dozens of other plans competing in the California individual market, including our two largest not-for-profit competitors. Even after these March 1st rate changes, a 40-year old woman in Los Angeles can obtain coverage with a $1,500 deductible for as low as $156 per month.

We would also like to emphasize that we have cooperated and are continuing to cooperate with the California Department of Insurance's review of our rates. As part of our review process, an independent actuarial firm concluded that our rates are actuarially sound and necessary, reflecting the expected medical costs associated with the membership in these plans, and that they satisfy or exceed the medical loss ratio required by California law.

Recently, Anthem Blue Cross agreed to a request by the California Department of Insurance to postpone the March 1st rate adjustment for individual members in California by two months to allow the Department additional time for review. To avoid confusion for our members, we decided to implement the delay for all Anthem Blue Cross individual members regulated at either the California Department of Insurance or the Department of Managed Health Care.

Anthem Blue Cross filed these rates with the appropriate regulators in November of 2009. They are actuarially sound and in full compliance with all requirements in the law. We welcome the scrutiny, and are confident that our rates reflect known and anticipated medical costs and are established consistent with sound actuarial principles and state law.

Our decision to agree to postpone the rate increase does not change the underlying facts. All health plans are in the same situation in trying to deal with the steadily increasing medical costs in the delivery system, which are not sustainable. We are also experiencing a higher proportion of healthy individuals choosing not to enroll, leaving an insured pool that utilizes significantly more health care services. We need to refocus the health care reform debate toward steps that will improve quality and control the underlying medical costs, which is driving the high cost of coverage.

We understand the impact any rate adjustment has on our members and their ability to continue to have health insurance. We are committed to improving quality and reducing costs in the health care system and improving the lives of the Californians we serve and the health of communities all across the state which can reduce their premium rates. Our members will be receiving a letter shortly that describes these rate changes in detail and whom to contact for additional information about their coverage options.

Rate increases reflect the increasing underlying medical costs in the delivery system which are unsustainable. We hope to continue to work with you and others to help mitigate the factors driving these large rate increases, as described below.

WHY INDIVIDUAL MARKET RATES ARE INCREASING FASTER THAN MEDICAL INFLATION

Health insurance rates increase year-over-year to reflect general medical inflation and other factors. Medical costs increase each year primarily due to (1) prices charged by clinicians, hospitals, medical device manufacturers, pharmaceutical companies and other suppliers of health care accelerating much faster than general inflation, and (2) increases in consumer utilization. Provider price increases above general inflation are driven largely by increased provider cost-shifting to private health insurers due to Medicare and Medicaid not fully covering provider costs, provider consolidation, and higher-priced technologies. Increases in consumer utilization of health services are primarily driven by a shift in the demographics of this country, which has an aging population and rising incidence of chronic disease (some related to lifestyle), plus the increasing use of high-cost diagnostic testing by providers. [2]

For 2010, we expect hospital inpatient and outpatient costs in California to grow by over 10 percent, driven primarily by hospital reimbursement rates. Additionally, we expect

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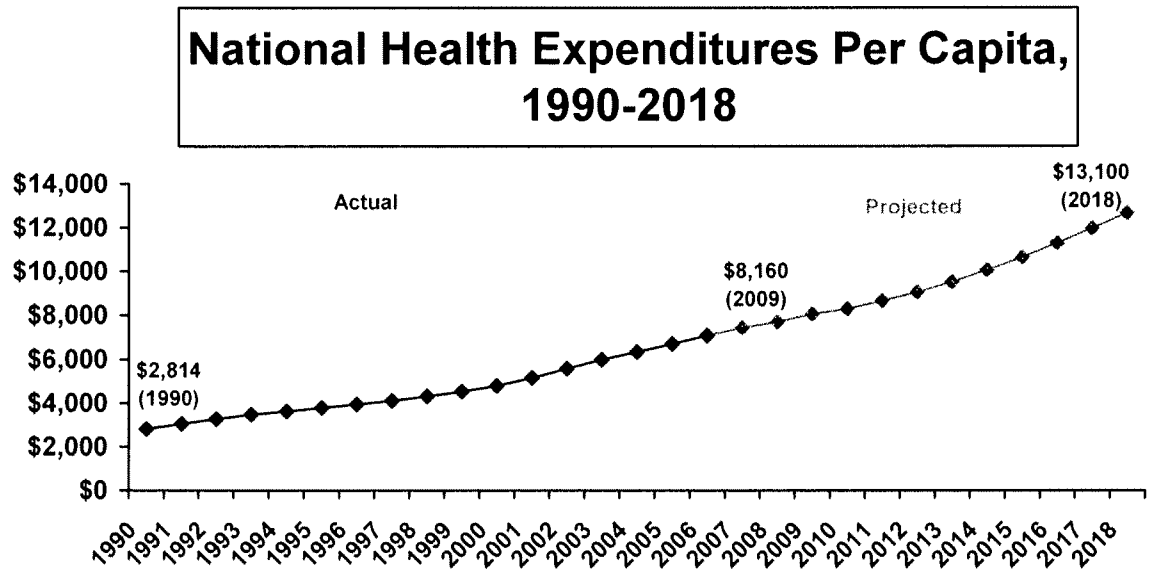
[2] Drivers for rising health care costs are detailed in the 2008 PricewaterhouseCoopers report *The Factors Fueling Rising Health Care Costs 2008.*

pharmacy costs in California to grow by over 13 percent. These cost increases that continuously drive premium increases are unsustainable and must be addressed.



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (Historical data from NHE summary including share of GDP, CY 1960-2007, file nhegdp07.zip; Projected data from NHE Projections 2008-2018, Forecast summary and selected tables, file proj2008.pdf); Kaiser Family Foundation, Kaiser Fast Facts, National Health Expenditures per Capita, 1990-2018. March 19, 2009. http://facts.kff.org/chart.aspx?ch=860.

Other factors result in California rate increases in the individual health insurance market being higher than general medical inflation, including:

- **Less healthy risk pool in a challenging economy.** One dynamic in this challenging economy is that individuals are far more likely to keep their coverage if they are less healthy and require ongoing medical services, and a higher proportion of individuals who do not need services disenroll or choose not to enroll. The result is an insured pool that utilizes significantly more services per individual than under better economic times. This in turn leads to higher costs in the pool and to rate increases higher than general medical inflation. For example, if an insurance pool consists of 100 individuals that incur aggregate medical costs of $10,000 per month, the cost per individual is $100 per month. However, if 10 individuals leave the pool who incur little or no costs because of the challenging economic times, the $10,000 now must be spread over 90 individuals. The per-individual cost is now $111 per month, an increase of 11 percent. This means a health insurer must increase rates 11 percent in order to cover the increase in costs per individual and this is before reflecting general medical inflation. While this dynamic always exists, in a challenging economy it becomes more prevalent as individuals who are paying for coverage without a government or employer subsidy must choose to continue coverage or use the money for other necessities.

- **Individuals moving to lower-cost options in a challenging economy.** Another dynamic in our current challenging economy is that a higher proportion of healthy individuals move to lower-cost coverage, such as coverage with a higher deductible, than in more robust economic times. Our experience also shows that new, healthy enrollees are more likely to enroll in similar high-deductible plans. For example, in 2009, affordability concerns led a high proportion of Anthem Blue Cross individual members to switch from higher-cost products to lower cost-products, resulting in an average 2009 premium increase after product migration of just 2 percent, considerably lower than the average rate increase of 13.8 percent initially reported in 2009. Meanwhile in 2009, the average claims per member increased by 8 percent, dramatically more than our premium increase of 2 percent. The fact that the weak economy caused more people to move to lower-cost options in 2009 contributed to the fact that the Anthem Blue Cross individual business in California as a whole operated at an approximately $10 million loss during 2009.

- **Individuals aging into a higher age category.** The reported March 1st rate increases include demographic changes, such as individuals aging into higher age segments. Since rates increase by age, a renewing customer will often face higher rates. These age rate increases occur before reflecting general medical inflation and reflect higher medical utilization associated with aging.

- **"Deductible leveraging."** Benefit costs for members are typically divided between the premium paid by a member and the member cost sharing (e.g., deductibles and co-payments). When a member does not change plans, deductibles and co-payments, which are a set cost such as a 20 dollar copayment to see a primary care physician and therefore typically remain unchanged at renewal. Because of this, the deductible and co-payments do not increase and are not connected to necessary increases related to medical inflation. Because higher costs due to the increases related to medical inflation must be offset in some way, there is a "leveraging" effect and the medical cost increases disproportionately increase the premium component of benefit costs (as opposed to the member cost-sharing share of benefit costs, which is fixed). This results in premiums for fixed deductible products increasing faster than general medical inflation.

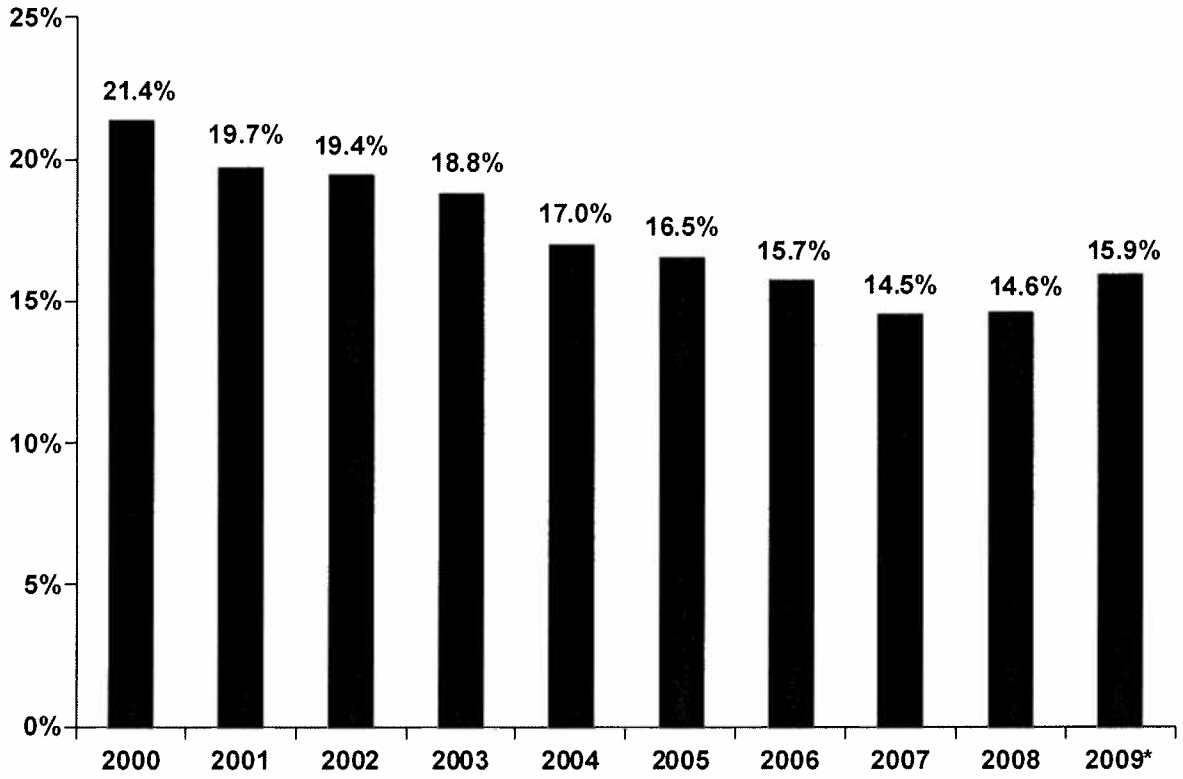
- **Higher Baseline Costs.** In addition, we experienced higher than anticipated unit medical costs and utilization in 2009. Our Anthem Blue Cross individual market rates for 2009 were insufficient to reflect these costs. While we are not pricing to recover 2009 losses, the March 1st individual market rates must reflect these higher baseline costs

All of these rating dynamics are part of necessary, actuarially-sound rating practices and each of these factors contributed to the March 1st individual market rate increases in California in addition to general medical inflation. Other individual market health insurers are facing the same dynamics and are being forced to take similar actions.

MISLEADING ACCUSATIONS OF HEALTH INSURER PROFITS

During the past year I have been listening to the health care reform debate and the accusations that have been made of health insurers, specifically those related to health insurer profits. I was very disappointed to see the health reform debate change from one of possible change and productive results to an attack on the health insurance industry, specifically pointing to our profits and citing this as the primary reason for premium increases, which is very misleading.

WellPoint Selling, General and Administrative Expense Ratio Trend



* Includes 30 bps for the 4Q09 severance charge relating to the sale of certain portions of the company's business and other improvements and productivity.

As noted before, our profit margins as a company have declined over the past five years, our administrative cost ratio has declined, and yet premiums have increased, reflecting higher prices of hospitals, drug companies, and other providers. Additionally, aside from attacks on the entire health insurance industry, the debate has seemed determined to create a divide between for-profit and not-for-profit companies in the healthcare system. As I have already mentioned, in California the Anthem Blue Cross profit margin is in-line with, and below some of our not-for-profit and for-profit competitors and are significantly below other providers, both for-profit and not-for-profit, in health care delivery.

It is also important to note that according to *Fortune 500* magazine, the 2008 profits as a percentage of revenue for health care, insurance and managed care were 2.2 percent. This is significantly lower than other sectors of the health care industry.

Profit as Percent of Revenues Source: *Fortune* List of Profit by Industry, May 4, 2009 - Select Industries http://money.cnn.com/magazines/fortune/fortune500/2009/performers/industries/profits/	
Industry	**2008 Profits as Percent of Revenues**
Food and Drug Stores	1.5%
Health Care - Insurance and Managed Care	**2.2%**
Medical Facilities	2.4%
Health Care - Pharmacy and Other Services	3.0%
Specialty Retailers	3.2%
Insurance - Property & Casualty	3.3%
Commercial Banks	5.2%
Food Services	7.1%
Utilities - Gas and Electric	8.7%
Oil and Gas Equipment, Services	10.2%
Financial Data Services	11.7%
Medical Products and Equipment	16.3%
Pharmaceuticals	19.3%
Internet Services and Retailing	19.4%
Network and Other Communication Equipment	20.4%

Studies continue to demonstrate that health insurer net (after-tax) profits are a very small percentage of a member's premium. While there are a variety of ways to estimate health insurer net profit as a percentage of premium, regardless of the year, company, or aggregation of the data we have found that net profits fall between a -3.5 percent (loss) and 6 percent (gain), with most falling in the 2 to 5 percent range. To be more specific, the PricewaterhouseCoopers studies concluded that the insurance industry's profit margin is 3 percent. This is consistent with an America's Health Insurance Plans (AHIP) estimate that publicly-traded health insurers averaged a 2.4 percent net profit margin over the last 5 years.

When discussing profits, any comparison of absolute amounts will be misleading. For example, if companies merge, acquire other companies, or sell one of their assets, it stands to reason that its total profits will be significantly affected by that event. For example, WellPoint's fourth quarter 2009 net income was significantly higher due to the gain on the sale of its pharmacy benefit management subsidiary. After adjusting for this sale, WellPoint's fourth quarter 2009 adjusted net income was significantly less.

POLICY CHANGES TO MITIGATE VOLATILE INDIVIDUAL MARKET RATE INCREASES

Several factors contribute to the volatility in the individual health insurance market, including the fact that the individual market is the "market of last resort" for individuals who do not have

access to the employer market or government-subsidized public programs, and participation in the individual market is voluntary (i.e., individuals can forgo coverage). The market exhibits a high "churn" rate, with the average individual or family participating in the market for only about three years on average. This means that while overall enrollment may remain relatively constant, with 1/3 of the risk pool leaving each year, the overall risk of the members can increase quickly. This can lead to wide swings in rates—even if the dynamics seem to shift only slightly.

California's individual health insurance market is particularly challenging. In contrast to most states that use high risk pools and broad-based funding sources to subsidize HIPAA guaranteed issue products (for those individuals exhausting COBRA coverage and who do not qualify to be underwritten in the individual market), California requires us to absorb the very high costs associated with these individuals without additional funding support. In 2009, Anthem Blue Cross alone experienced an approximate $58 million operating loss on these HIPAA purchasers who exist in the guaranteed issue product environment in California. Additionally, as a result of being the only PPO and the only statewide option in the state's high risk pool (MRMIP), in 2009 Anthem Blue Cross experienced an additional operating loss of more than $10 million in the MRMIP "graduate" program.[3]

In November 2008, our industry came forward with an interdependent framework of policy proposals that would help control costs and improve health insurance markets for consumers. Included in this framework was an effective, enforceable, personal coverage requirement that would expand and stabilize the individual health insurance market, even when combined with requirements on insurers to accept all applicants with no pre-existing condition exclusions and limit rate variation between higher risk and lower risk individuals. In the proposal, we emphasized that the entire framework rested on a meaningful and effective personal coverage requirement that ensured that virtually everyone would have health coverage. As shown in some of the examples above, even if a small fraction of healthy individuals choose to forgo coverage, it can lead to substantial rate increases and an environment where individuals purchase coverage only when services are needed. Ultimately, an effective personal coverage requirement must (1) be deployed with sufficient subsidies to ensure no one is exempted, (2) include sufficient "checkpoints" to make sure everyone is enrolled for coverage, and (3) contain sufficient penalties to ensure healthy individuals enroll in coverage rather than pay the penalty.

Unfortunately, the proposed personal coverage requirements in the health care reform legislation passed by both houses of Congress failed all three requirements by (1) exempting tens of millions of Americans from the requirement, (2) using the tax filing process as the only checkpoint which misses tens of millions of Americans who do not file taxes, and (3) including penalties that are a small fraction of the cost of coverage. Under this framework, it is only logical that many individuals—primarily those who are healthy—would have not been

[3] For a period of time until 2008, members in California's high risk pool (MRMIP) were limited to being MRMIP members for three years. After three years, individual market carriers were required to accept these members on a guaranteed issue basis.

effectively included by the mandate or would have made the logical choice to pay the penalty unless they needed health care services. The result will be a national health insurance market that is similar to New York, where the average individual market premium is over twice the average individual premium in California.[4] And this is a finding borne out by analyses completed by our senior actuaries. In fact, these analyses showed that the legislation considered by Congress would increase California individual market premiums for the young and healthy by as much as 106 percent (before premium subsidies for certain eligible individuals).[5] The personal coverage requirement must be substantially improved for reform to be successful.

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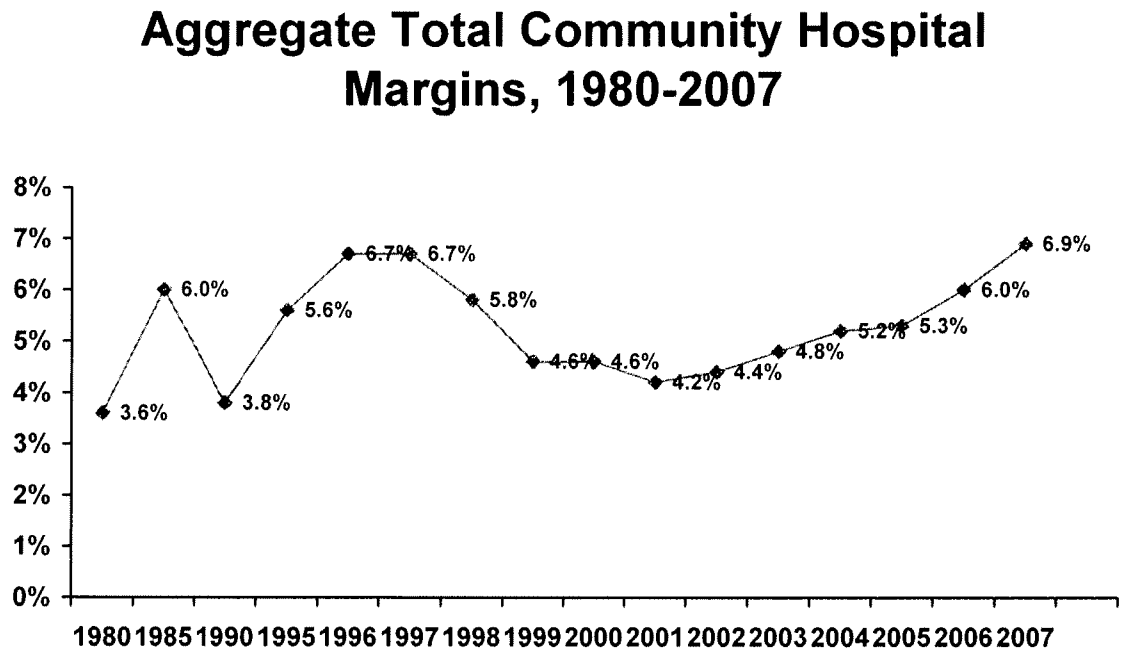
[4] AHIP Individual Market Survey. October 2009. http://www.ahipresearch.org/pdfs/2009IndividualMarketSurveyFinalReport.pdf

[5] WellPoint premium impact analysis: http://www.wellpoint.com/newsroom/stats_facts.asp

CONCLUSION

In closing, I want to assure the Subcommittee that WellPoint supports responsible, sustainable health care reform that will specifically address the growth in the underlying cost of health care services and also take into account that insurance market regulation must be actuarially sound. Reform must go beyond the insurance marketplace to address system-wide challenges and associated costs. Changing how we finance health care without changing how we deliver health care is simply not sustainable.

Additionally, we firmly believe that the primary focus of responsible health care reform must be improving quality and controlling the underlying medical costs, which is what is driving the high cost of coverage. On a national scope we continue to see hospital margins rise which impacts our underlying medical costs.



Note: Total Community Hospital Margin calculated as the difference between total net revenue and total expenses, divided by total net revenue.

Source: American Hospital Association and Avalere Health, Avalere Health analysis of 2007 American Hospital Association Annual Survey data, for community hospitals, *Trendwatch Chartbook 2009, Trends Affecting Hospitals and Health Systems*, Table 4.1, p. A-32, at http://www.aha.org/aha/trendwatch/chartbook/2009/appendbe4.pdf; Kaiser Family Foundation, Kaiser Fast Facts, Aggregate Total Community Hospital Margins, 1980-2007. September 16, 2009. http://facts.kff.org/chart.aspx?ch=159.

We believe that the government must take action in this area to facilitate higher levels of quality and efficiency. We believe that an essential ingredient for practical and sustainable health care reform is improving health care quality, which in turn can help manage costs. There are many opportunities to improve health care in this country, as we are far from having a system that provides the right care at the right place at the right time. Building on the following

principles, WellPoint has identified solutions that will help deliver better health care while helping to reduce costs:

- Promote evidence-based medicine, with focus on outcomes;
- Align payment incentives for improved health outcomes;
- Focus on prevention and managing of chronic illness;
- Provide transparency on medical errors and reform medical malpractice laws;
- Promote safety and efficiency through the adoption of health information technology.

Health plans have provided significant ideas for reform, some of which are incorporated in the legislation being considered in the House and Senate. Unfortunately, neither of the bills currently being considered by Congress will stem health care cost growth and the resulting insurance premium increases, rather higher premium increases are expected to result. We look forward to continuing to play a constructive role by providing members of this Subcommittee and your fellow legislators with assessments of how proposals for reform would impact your constituents. We have decades of real-world experience with different reforms in various local markets that we are sharing with Congress and the Administration, so that our policymakers can make decisions using the best available evidence of what works best.

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

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

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

Thank you for this opportunity to explain the factors behind our March 1st rate increases in California's individual health insurance market and my views on the need for meaningful and sustainable health care reform.

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