



**BlueCross BlueShield
Association**

An Association of Independent
Blue Cross and Blue Shield Plans

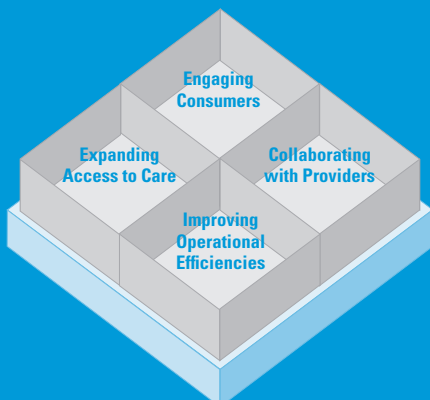
Keynote Remarks: BluePrint for the Future

Scott P. Serota

*President and Chief Executive Officer
Blue Cross and Blue Shield Association*

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Management Association
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Knowledge-Driven Solutions

Scott P. Serota, president and chief executive officer of the Blue Cross and Blue Shield Association, was the keynote speaker February 26, 2006, at the Annual Spring Summit of the Healthcare Financial Management Association (HFMA) meeting in San Antonio, Texas. In his remarks, Serota laid out a blueprint for a better healthcare future and called on HFMA members and other key healthcare stakeholders to collaborate in bringing about meaningful and constructive change on behalf of healthcare consumers across the country.

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Architects of Change

Thank you for the invitation to be here. This is a unique opportunity to speak with you about our Blue Cross and Blue Shield vision for consumer-directed health plans, the future of healthcare and how the healthcare system will be structured. As you listen to this presentation, please think about how we can partner to succeed, because it's clear to me and it's clear to the Blues that it is going to take a collective effort to keep healthcare private, affordable and accessible. No one side can do this by themselves. This can't be a payer-dominated approach, a government-dominated approach or a provider-dominated approach. We have to work together. So I'm speaking to you today, from that perspective: How can we partner? How can we work together to accomplish our objectives and keep our healthcare system private? From the Blues' perspective, keeping the healthcare system private is a paramount objective for us. We think that a public healthcare system will not serve the needs of our constituents as well as we can do it in the private market.

Let's take a minute and talk about the Blues. You notice the title of the presentation is "BluePrint" – we have this propensity to use blue in just about everything we do! We are very proud of our brand and its 76-year history. We were the first in healthcare financing, starting in Dallas - at least that's where Blue Cross began. Blue Shield started in the Pacific Northwest. By virtually any measure, we're the number one brand in healthcare. In fact, when you survey consumers, typically they put us in a class by ourselves. We like the fact that they view us as a breed apart.

We have 94 million subscribers throughout the country – 1 out of every 3 Americans carries a Blue Cross and Blue Shield card. It is remarkable testimony to perseverance, to quality service, to focus on the customer, and we're very proud of that. Our networks cover America coast-to-coast, with no gaps in coverage. We have a Blue Cross and Blue Shield plan in every square inch of the United States. We contract with 90 percent of America's hospitals and 80 percent of America's physicians. We also have hospital contracts in 200 foreign countries, a well developed expatriate program, and frequently are asked to evaluate international opportunities.

Dramatic change in healthcare

What I'd like to do now is share with you a vision of where healthcare may be going, and point out some opportunities we can do together. Healthcare is facing very dramatic challenges and will continue to face those challenges on into the future.

We have a healthcare system that accounts for \$1.9 trillion, 16 percent of the GDP. Now, I always say to folks, I don't know that's a bad thing. I mean what's more important than health? If we're spending 16 percent, 17 percent, 18 percent of our GDP on healthcare, I don't know that that's a bad thing. But we're not getting the most for our money. We need to look at it in terms of improving value in healthcare, not reducing costs. We have to be very clear as we deliver our message collectively, both from the provider side and the payer side: Costs are not going to go down in the foreseeable future. We've got breakthrough technologies, an aging population and increasing utilization. All the factors point to healthcare costs going up. What we have to do is ensure that the value that consumers receive for those costs goes up. That's a challenge that we as an industry can take on and we should take on.

We have an 8 percent overall increase in costs vs. a 3 percent increase in the CPI. Hospital costs are up almost 9 percent, physician costs are up more than 9 percent, prescription drug costs are up more than 8 percent. Again, I'm not passing judgment. I'm just commenting on the numbers. The sad truth as we get to that value equation, though, is that we spend more than twice as much on healthcare as the closest country to us. Thirty-five other countries, by some measure, deliver better quality healthcare. I say by some measure because I also note that when affluent people in other countries are really sick, they're getting on an airplane and coming here. If you're really sick, this is where you want to be. I believe the quality of our healthcare system is without peer in the world, but we're not very good at measuring it. We're not very good at transparency, and we're not very good at prevention. We're much better at dealing with high-visibility, episodic issues.

Twenty-three countries enjoy a longer life span and 41 countries have lower infant mortality rates, so this gets back to that challenge that I put forth earlier: we need to improve the value of our healthcare system. We need to ensure that for every dollar spent, we optimize the value people receive. Our number one goal is to keep quality healthcare affordable to all.

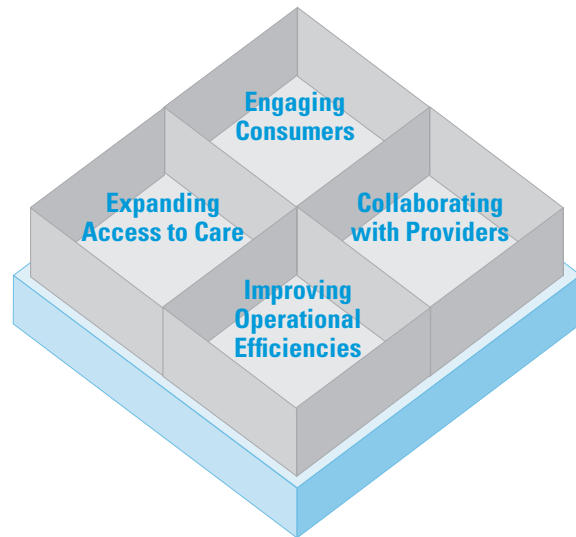
Future healthcare system

Let's focus on a myth. We all talk about a healthcare system. Let's be honest—we don't have a healthcare system. We have the world's largest cottage industry. We have independent physicians working in their offices, doing their own thing. We have hospitals, some in partnership, but mostly independent, doing their thing. We have payers doing their thing. Government has its agenda. We do not have an integrated vision. We do not have a master plan, if you will, for healthcare delivery in America. Given that we don't have a system, we need to create one. My vision is of a system that centers on the consumer. I'm a former hospital administrator and it's hard for me to say that. We should really be saying patient. But what we're trying to do is to convert healthcare into a more retail-type economy, where patients are consumers. We are trying to get them to behave in that kind of a fashion, as opposed to the more passive patient role that has evolved over time. We're trying to get them to be more advocates.

We need to evolve into a fully integrated system. We need to link our technologies together. We need to link our visions together. We need to have a shared objective of optimizing quality at affordable rates. We all have to buy into that at some point. We can't wait for the government to lead because they won't. Something else will always become a higher priority, something more immediate, something more short-term. We have to do it. We in the private sector have to find the areas where we can collaborate – find those opportunities, where we have mutual interest and move forward. We need to empower the consumer to serve at the center of that equation and gear all of our activities and results toward the consumer.

*The healthcare system
of the future must be
consumer-centric*

BluePrint for the Future



Knowledge-Driven Solutions

*BluePrint Vision:
Making knowledge
work for more
affordable healthcare
in communities
nationwide*

My BluePrint fits naturally with my vision: making knowledge work for more affordable healthcare in communities nationwide. The Blues are a community-based organization. Yes, we're big at 94 million members. We serve every market. We operate healthcare the way it ought to be – at least from my perspective – on a local basis. I don't sit in Chicago with our staff making national policy to tell all the Blue Plans this is the way we have to do it. Blue Plans do what they think is right in their local markets, working with their local providers. It's different in New York than it is in California than it is in Nebraska. It's different the way they operate because the delivery systems are different and the needs of consumers are different and the needs of the physicians are different.

We have a unified voice in Washington on a number of matters, but we operate our healthcare plans the way they ought to be, in the local markets and in the communities. Our BluePrint is realistic. It's practical and it's doable. There are critical components of a visionary system for healthcare. We need to improve quality, affordability and access. And it is clear we will be successful only if all participants in the system collaborate: providers, employers, payers, government and consumers. We all have to sit at the table and decide how we can make the healthcare system work for each of us. We have to build the system based on knowledge. We have to make our system more accessible, more affordable and we have to make information more transparent and accessible to folks as we move forward.

Key assumptions

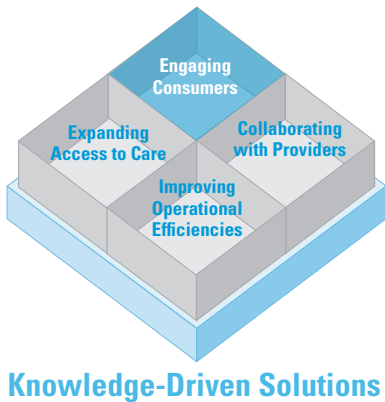
Our program is predicated on several key assumptions. Accountability is first and foremost. Each of the stakeholders has to assume accountability for what they do. They have to be willing to step up and say, “I’m responsible.” That means we – as consumers – stepping up and saying we’re responsible for the healthcare we consume. We’re responsible for the behaviors that we choose. We ought to be responsible for the cost and the consequences of those behaviors. That’s a leap. That’s consumerism reaching into healthcare.

We have created a system where some individual consumers are smokers and some are overweight. Yet, people with bad health habits pay the same as the healthy. In fact, the healthy subsidize them. There’s no accountability there for behavior. There are no economic consequences. There are efficient hospitals and inefficient hospitals, with no economic consequences for those inefficiencies. The more you do, the more you get paid with no measure of quality and no reimbursement based on quality. Accountability has been very diffuse. Part of the issue is if you can’t measure it, if you don’t know what you’re trying to accomplish, how can you be sure that you’re adding value and producing good results?

As payers, we take in premiums and we pay claims. When costs go up we blame you and you blame us – and we all blame the doctors. We just point the finger around and none of us steps up and says fix it. We’ve got to do it.

We have to have interoperability and transparency. We have to be able to communicate. We have to use the same terminology. We have to use the same systems in some form or fashion so we can all communicate and all share our data on a real time, 24/7, basis. People want what they want and when they want it – and that is now. And they want information. We have to make information accessible to them – and make sure people at least have the tools they need to make knowledge-based decisions. What they choose is a separate issue, but we need to make sure they’re at least empowered with good information. That’s obviously a huge issue – not only getting information out, but also improving the literacy level of people so they can understand and process the information.

We have lots of challenges to make this work but, we need to do it. Let’s dig a little deeper into the components.



Engaging Consumers

To me, the most important group – and the group that has been most left out, if you will, of healthcare planning – is the consumer. They are the single-most important stakeholder group.

We’ve done a lot of survey work to find out if individuals really want this power and we’ve learned 90 percent of consumers want to partner with their doctors in their healthcare decisions. They want to be more involved, both for themselves and for their families. That’s based on a Rand study. There’s obviously a risk. When I’ve spoken to groups of physicians, they say patients are “Web-infected”. When they show up they’ve been on the Internet and they know exactly what’s wrong when they walk in because they’ve diagnosed themselves. They know exactly what treatments are required. All the doctor has to do is sign the form and out the door they go.

We’ve got to get beyond that. We have to get good information and good knowledge in their hands. We need to make sure there are credible sources of information, because they do act on what they learn. I go on the Web frequently, but I certainly don’t take everything I read there as gospel. But 60 percent of the folks go online and they act based on what they’ve read on the Internet, so we need to make sure there are good credible sources of information. The Rand study told us that better information leads to more informed decisions and genuinely impacts behavior. When you give consumers good information about healthcare and they act on it, the outcomes are better and they’re more satisfied. It sounds intuitive, and the survey proves that point.

We need better decision-making tools. They can range from the Internet to nurse lines to health coaches to a whole host of things, but consumers need better tools. There was a study done in Oregon on health literacy. In general, literacy is a problem, but health literacy is an even bigger problem. The more information you put out the more potential exists for even wider gaps between socio-economic status and access to healthcare, because of literacy and understanding the information that’s presented. There are gaps that we have to overcome with regard to literacy if we’re going to make this vision a reality, but it’s one that we need to take on.

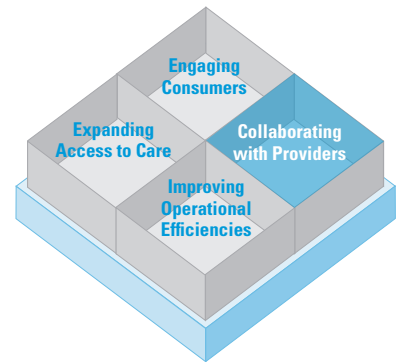
Consumer engagement and empowerment also are needed to ensure the success of consumer-directed plans, of HSAs, and we really need to focus on that. I believe it’s a huge opportunity, not just for the Blues, but for each of you. Providing information, in a way that people can understand is a great way to capture a patient population and get them committed to your organization and to your brand, your institution. It is a business opportunity that shouldn’t be neglected and that you could certainly do in collaboration with your local Blue Cross and Blue Shield plan. It would serve our collective interests to do that. I think it is a great opportunity and one we shouldn’t miss as we move forward.

Collaborating with Providers

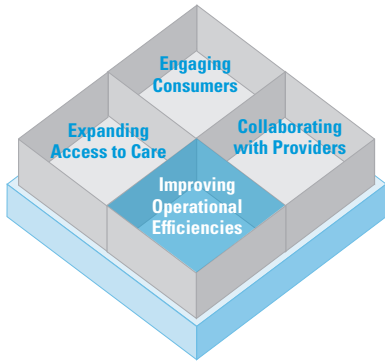
We in the Blues need to collaborate with providers as well. Collaborating with you is essential for us to be successful in the marketplace. We can't do it alone. We don't see the patients. By the time we're talking to patients, they're usually aggravated. It means a claim wasn't paid, a service was denied or they're not happy with an outcome. They don't call us to say, gee, we're really glad you paid that claim. If we do our job right, they'll never know. It will just be done. You, however, get to see, you get to touch and you get the privilege of talking to the consumer. We need you to be successful. We're working with physicians, hospitals, organized medicine to develop evidence-based measures. Our approach, which I'll talk more about later, is not to create new measures or our own unique set of criteria, but rather to capitalize on the evidence-based medicine that is already in existence today, to institutionalize the best practices that folks already know about, and to build those into reimbursement systems and structures to provide better outcomes.

We work with providers extensively to evaluate the efficiency and efficacy of new technologies. We focus on expensive and redundant technologies. We have a very well developed Technology Evaluation Center, which has been operating for more than 20 years. It looks at new technology with an independent panel of physicians and other experts to evaluate whether a technology is adding value. We look at it both from a clinical and an economic standpoint to say, "Is this better than what exists today?" We do this in collaboration – and we make recommendations to Blue Plans who make the final decisions as to whether something should be covered. It is a role that we have played at the Association for a long time and one which has become the gold standard, if you will, of technology evaluation.

Our goal is to help improve quality and to consistently deliver improved quality. Pockets of outstanding quality are a start, but certainly not an end point. We need to ensure that best practices permeate the delivery system. Again, another need for collaboration, another need for interconnectivity, and interoperability, so we can communicate rapidly what's working and share great outcomes. Providers are critical in that role today and will be even more critical as we move forward.



Knowledge-Driven Solutions



Knowledge-Driven Solutions

Improving Operational Efficiency

Operational efficiency and operational excellence are another critical piece of our BluePrint. A startling statistic: in healthcare, with all of our investment and hi-tech delivery, we only spend an average of \$5,000 per employee on information technology. That's about the same level as the mining industry and education. The average across all industries is about \$7,000. Now, again, that's increasing cost, administrative cost, which everybody attacks, but if we're going to succeed and accomplish this BluePrint, we need to ramp up our investments in information technology. Obviously, we need to do this to maximize our returns, but we also need to invest appropriately in information technology so that we can communicate and do our job more efficiently and more effectively.

Again, some facts. There is about \$150 billion of administrative waste annually in the healthcare system. Duplicate billings and a whole host of things would fall in that category. Another \$500 billion in redundant, unnecessary care, according to the Institute of Medicine. In an audience like this it's an especially difficult message that there's \$300 billion of unnecessary or inefficient care because that's topline revenue to you. If we take \$300 billion out, somehow you've got to replace that or reduce expenses accordingly. But there is \$300 billion minimally of unnecessary or duplicative care that needs to be addressed.

Fraud accounts for another \$80 billion a year. Fraud should be a simple one. We should all jump on fraud. Nobody gets rich on fraud but the bad guys. You all know about the "rent-a-patient" scam that occurred in California. We found another one in Florida where they were advertising for free vacations. Just call this number, go down to a beach in Florida, and we get billed for alcohol and drug treatment while you're on the beach sipping margaritas or piña colodas or your drug of choice. We're getting billed for that as alcohol and drug rehab. As good as we get at catching them, there are people who come up with new scams over and over again. We need collaboration to stop these things. We need eyes and ears in the marketplace to ferret it out. As I said, that's \$80 billion that only the bad guys are benefiting from. There are things we can do if we collaborate to reduce this cost so we have those dollars to invest in things which are critical – to improve efficiency and effectiveness, improve quality, improve knowledge and information, and keep quality healthcare affordable.

Expanding Access to Care

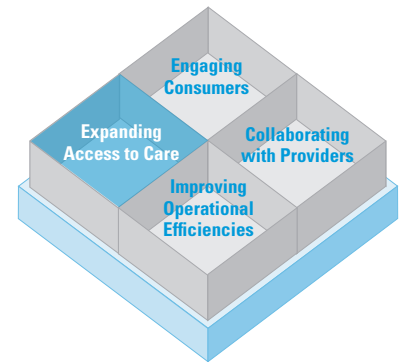
Access to care is another critical piece of this puzzle. Uninsured individuals and their families are much more apt to be hospitalized for avoidable conditions. Again, no great surprise, but if people are uninsured, they have a tendency to defer care. If they defer care, they end up in the hospital for things which could have been treated on an ambulatory basis if they'd gone earlier. They're more apt to forego preventive care. Fewer than one in four uninsured adults with chronic conditions visited a health professional last year. These are the people who genuinely need care, need to see their providers frequently. Fewer than one in four actually consulted a provider, even though they have a chronic health condition and could benefit from that.

The uninsured obviously lead to higher costs. They show up in your institutions and there's nobody to pay. You treat them. Bad debt has been a real problem in the healthcare system for as long as I can remember. This presents a huge problem and obviously it leads to cost-shifting. We all pay more when somebody can't pay, because your costs are your costs. It's a zero-sum game. We have to do something. We have about 45 million uninsured in America. I say "about" because 1) it's hard to tell, and 2) it depends on how you ask the question what response you're going to get as to how many uninsured there really are. It's important to note that there is not a one-size-fits-all vision of that 45 million people. A large percentage, maybe 10 million people, actually are covered by existing government programs. They are Medicaid or they have CHIP coverage but they don't know it. When they're surveyed they say they're uncovered. They don't consider that health insurance. We don't need new programs for them. We need better communication, and we need to encourage people to enroll and take advantage of the programs that exist.

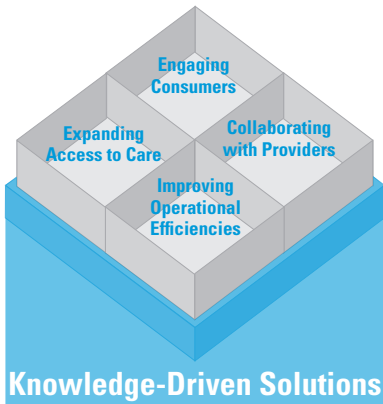
The fastest growing segment of uninsured—about 20 percent—have household incomes of \$50,000 or more a year. The fastest growing segment has a household income of more than \$75,000 a year. These are individuals, in my mind, who choose to be self-insured. They look at the cost of healthcare, they look at the cost of their health insurance, they look at their family budget and say I'm not getting sick this year. While they could purchase health insurance, they choose not to. Those are the very people, typically, we want in the healthcare system because they don't use care. We need those people to help subsidize the sick folks. They're like my 23-year-old son who, if he had to buy his own health insurance, would say, "car or health insurance? Easy choice. I'll take the car and count on Dad." You've got a lot of folks like that out there that need to buy coverage. We need to get those people in the system.

Then you have a large number – the real problem – of more than 20 million or so people who are hard-working, many working for small businesses where the company doesn't offer health insurance, either because they don't understand that they could afford it but they choose not to, or they're afraid if they offer it nobody will buy it. They believe if their people couldn't pay their own share of it, it could be a morale dis-incentive. We need programs for those folks. We need tax credits. We need something that incents these people, these businesses and individuals, to purchase healthcare coverage. There is a segment of the population that needs a government intervention and we need to work on that.

We support comprehensive solutions for the uninsured. It's not a one-size-fits-all solution, but we do need solutions. We think that consumer-directed plans and HSAs are an important piece of that solution, particularly for the \$50,000-\$75,000 per-year household, where you can create a product that's affordable. You can create a product that people might buy, particularly when you do it with a tax-incented savings component – a product that actually encourages people to buy coverage, which would be a good thing.



Knowledge-Driven Solutions



Knowledge-Driven Solutions

The foundation of this BluePrint, the underpinning of everything we do in the healthcare system, is knowledge. There's an unbelievable amount of healthcare information across all of our groups. If we could somehow collectively access, harness and package that information and make it available to consumers as they are making choices, what a powerful force we would have in the healthcare marketplace. We have claims information on 94 million people covered by the Blues. We have longitudinal information on these folks. Frankly – a little bit of bragging—once they get our card, they don't want to give it up. We have people – lots of them – who have been with us their whole lives. We insure almost 5 million people in the federal government. We have a retention rate among those employees of 99 percent. We have a wealth of data that we could share. You have a wealth of information in your institutions. We have to figure out a way to harness the power of that information and make it available.

We need instant patient information. How many of you hear the complaint all the time, "I've got to fill out the clipboard. I show up, I've got to write my name down. When I go to the next department I've got to do it again." We ought to be able to fix that. We've got to move it to the next step and get an electronic record available. Providers ought to be able to know what's happening to patients wherever they are, and that information should follow patients.

Employers are demanding actionable account analysis. They are asking: What about my employees? Tell me what I can do as an employer to improve the health status of my employees. They want action. We ought to be able to develop data that's specific for employers about what's happening to their people. Obviously HIPPA-protected and secure, but we need to be able to do that so employers can be proactive. After all, they're paying the bill. We need to be able to help them do a better job of managing healthcare.

The researchers would love getting their hands on this kind of data. Imagine what reports might come if a group of researchers got hold of all this data, and what good might come out of that. The government could use this data to help shape health policy. Consumers could get decision-support tools. As providers, you could get better information to do your own facility planning and analyzing what services are being used and where they're being used. The power of data is incredible, if we could harness it, if we were willing to share it, if we didn't have such proprietary feelings about our own data and our information. Again, let's keep focusing on collaboration. Sharing information is a fundamental foundation.

BluePrint in Action

As I look out, I see a tremendous convergence occurring between the financial services organizations and health insurers. You may have read that the Blues have decided to open a bank. We're going to have a Blue Cross and Blue Shield Health Bank. We're beginning the process of approvals for an industrial bank in Salt Lake City. Not a bricks and mortar bank, not a bank that you can get loans or mortgages from, but a bank that's designed for healthcare, to partner with individuals and HSAs.

We're doing it for a number of reasons, not the least of which is to make your experience better. If people show up with \$3,000, \$5,000 deductibles, you're back in the collection business. We want to be in a position, as partners with you, to help you through that process by providing a card that we manage on a debit or credit basis that will allow you to ensure payment. We'll access the right accounts and we'll pay what we owe and we'll make sure they pay what they owe. We'll get into that side of the business on your behalf. That's our real thrust into this business. We want to maintain intimacy with our customers. We don't want to lose them, and we don't want somebody else stepping in disenfranchising us from our customers. We want to improve your experience, both you and individual physicians. We're really focused on that. We're excited about it and it will be, I think, a tremendous benefit, both to you and us.

Right now, there are about 3 million HSA accounts. Some estimates say this will grow up to about 25 million by 2010. We project 10 percent to 15 percent of our population will move into an HSA account over the next five years. They'll create a lot of assets – a lot of dollars that people will want to invest. Investment firms will want those dollars to invest. Right now, 25 percent of firms with greater than 500 employees plan to offer a consumer-directed health plan next year. Fifty percent with 5,000 or more will offer one next year. I think there are important ramifications for you and hospital financial management in regard to collections as you move into this. If you're not anticipating a large influx of people with high-deductible plans, it needs to be on your planning horizon, because it's coming. What's unclear at the moment – in light of the President's support for HSAs – is whether those numbers are understated.

We've done some early research into people who have HSAs. Understand, we've really only been looking at them a year because they're relatively new, but there is evidence they do impact behavior. HSA users are more engaged. They act on information that is provided to them. After all, it's their money and they want to know where it's being spent. We all get questions like, "Why can I find out more about a television set than I can about a surgeon?" People want to know and they're going to demand information. They're going to ask hard questions. They're going to ask them at the institution and at the doctor's office, and they may be uncomfortable questions. We need to be prepared for that.

Among HSAs, so far there's (1) lower overall utilization than the general population, (2) slightly higher utilization of generics, (3) fewer emergency room visits, and (4) preventive care, interestingly enough, tracks with the general population. In short: some of the things we anticipated would happen are, in fact, happening. I think they will happen more and more as people have their own dollars at risk.

I will also tell you that a large number of people who enroll in HSAs view them as tax shelters, not healthcare accounts. They're going to put money in there and never spend it. They're going to write checks themselves to pay for their healthcare, and they're going to let this money accrue on a tax-deferred basis as an alternate form of savings. It's okay with me however they do it, as long as they make good decisions about healthcare. We're tracking this and doing continuous research because we want to be certain that a bad impact doesn't occur – that people don't seek care because they have to pay for it. That's obviously a fear.

Now some would argue that this is just a sophisticated game of cost-shifting to the employee – saying to the employee, you've got to be accountable for your actions and accountable for your behaviors, and here's a piece of economic accountability.

Achieving Transparency

Transparency is a critical feature of the healthcare system of the future. You heard the President, in his State of the Union address, talk about transparency. Comprehensive information, including pricing and key quality measures, that consumers can use to make informed healthcare decisions for themselves and for their families – that's how we define transparency. People need to know what it costs and what the success rate is when they're going to purchase something. We have to figure out a way to make it available, in a form or fashion that's understandable and realistic. You and I both know it's not so easy to say this is what an appendectomy is going to cost, or this is what a delivery will cost, because everybody's different. You need different mixes of tests and you don't cookie-cutter medicine. But it's up to us as the professionals and the experts in the field to figure out a way to give that information to consumers so they can make good

choices. We've been having the debate about making quality information available for at least 20 years. The arguments, about my patients are sicker or I get a different population, or it's hard to measure follow-up care. You know what? It doesn't matter. We have to make the information available. If we don't figure out a way to do it, CMS is going to do it. They're going to take the data and put it out there and people are going to draw conclusions any way they want. We're much better served if we step up as experts in the field and figure out a way to get this information out there for people so they can use it. Public provider performance measures need to be out there. We have to include pricing. We have to provide it uniformly across all stakeholders. This is not proprietary and this needs to be available.

We also have to provide tools and resources so people can understand and interpret the information that we're giving them. That's almost as important, or more important, than giving them the information, to help them understand what it means. We have to have open access to data for consumers, and we have to engage them as patients rather than just treat them. It's got to be active not passive. They have to play an important role and participate in healthcare decisions that are being made for them and with them, and they have to play a bigger role in financing it.

I think transparency is a cornerstone and it may be the biggest hurdle that we face getting our information out there. We've tried it in a number of ways. We've had some Blue Plans – and I'm sure this has happened to some of you and was uncomfortable – publish hospital directories with dollar signs next to them like restaurant guides: whether they were expensive, more expensive, cost-efficient. Do you know what the response to that was? We had hospitals calling us, saying how do we get more dollar signs? We don't want to be the low one – we want to be the high one! It's the truth. We took the dollar signs out. It obviously wasn't the way to do it.

We have to figure out mechanisms that are going to work. Trial and error experimentation maybe, but we've got to figure out something that will work. I can tell you that our customers are demanding it, and the powerful voice of business when they weigh in on this issue will be a challenge. I don't know if you have read some of the media coverage – about reports that General Motors is not in the automotive business anymore, but rather in the health benefit business and they sell cars to finance it. When businesses start weighing in on these kinds of issues, you're going to see change and you're going to see change rapidly. So, again, we need to get ahead of that curve.

Consumer transparency: Comprehensive information available to consumers which they can use to make informed healthcare decisions for themselves and their families.

Enhancing Transparency

We need to use existing measures and not reinvent the wheel. There are many measures out there. Let's use existing, accepted measures. Let's promote behavior change and consistent results, elevate the performance of providers, help consumers improve their healthcare and manage their costs. We have a hospital measures program that's in pilot. I'm sure you read about some of the difficulties we had when we partnered with the Joint Commission on Hospital Accreditation to get data. We just want the data. We just want to partner and provide good information. We just want to make it work.

We are working with physicians to have physician measures as well, important measures related to safety. We're working with Don Berwick's 100,000 Lives Campaign. Blue Cross and Blue Shield of North Carolina invested \$5 million in this program, and every hospital in Massachusetts is also a participant in these programs working with Blue Cross and Blue Shield of Massachusetts. We are working very hard to try and find good measures. As I said, we're experimenting at the local level to try to figure out ways to make it work. If you haven't already, I encourage you to reach out to your local Blue Plan and find a way to make this work. Collectively, we will like it a lot better if we create it.

Supporting Health IT

Health IT is a tremendous enabler for achieving our BlueVision. Turning data into information and information into actionable knowledge is the critical component. That's what we're looking for – getting the information into people's hands so they can do something with it. The benefits are obvious: improved quality and improved collaboration. Patients – again, based on research done by Rand – patients get the recommended evidence-based treatment about 55 percent of the time. We need to do better than that. If these are the recommendations of the professional societies and the experts in the field, patients ought to be getting it more often. We need to improve on that. We don't need to beat the IOM report to death, but 195,000 deaths annually in institutions—we need to fix that. We need to do better.

We need seamless information flow across all stakeholders. I know I sound like a broken record on that issue, but I am a member of the AHIC (American Health Information Community) group appointed by HHS Secretary Michael Leavitt. I am the payer representative of this group. We are working on interoperability – mechanisms by which we can share information across all stakeholders. We have breakthrough initiatives in several categories: Bio-surveillance, consumer empowerment, chronic care, and electronic health records. Our goal is develop interoperable standards with clear and realistic goals and ensure a wise use of resources. Every vendor in the world is approaching the AHIC group with their solution. We're glad for that, frankly, because there's some real great innovation there, but we don't want this to be a vendor-driven system. This needs to be a healthcare-driven system. We as providers and payers need to step up, decide and define the business terms, and then ask vendors to help us – we do not want vendors to define the system.

Again, my request to you is to get involved, through your professional organizations, through HFMA, through your own institutions. Be involved and help AHIC set realistic goals. Help us when you're asked to comment on goals. Provide us feedback because otherwise we can't design a system that we can participate in and that you can all make work. Participate and help us be successful as we move forward.

Making PHRs and EHRs Reality

PHRs (Personal Health Records) and EHRs (Electronic Health Records) and whatever the next generation is are the new buzz words. Everybody thinks they need to have one and need to create one. They are important tools and for purposes of this discussion I'm defining a PHR as a tool that's owned by the consumer, a personal health record that would include personal family history, treatments that you want to disclose, health risk assessments and a host of things. I think it's important and people are going to want it. Hurricane Katrina showed the importance of having something like that, but it's not the panacea it's being painted to be. I don't know about you, but when I go to the doctor and he says how much do you weigh, and I say, "oh, about 160 lbs," he says, baloney, get on the scale. He's not taking my information and saying that's right. He's going to want to verify. So I think personal health records can help, but they're not the total end point. They can help with the clipboard kind of information and all those kinds of things.

When we get to clinical information, that really needs to be a tool that's owned by the providers and that information actually comes from the medical record. Obviously HIPPA-protected and released by the patient – that all goes without saying. But we really need to develop a tool that has a quality focus, has a verifiable patient history, has lab and Rx physician notes, and triggers when patients don't follow their care. For example, if a prescription is written and never filled, the physician would get notification. A truly interactive electronic health record would be a wonderful outcome for the healthcare delivery system. – Not a proprietary tool. Would I love to see everyone with a Blue-branded electronic healthcare record? Sure I would, but realistically it has to be all payers. Everybody has to have a piece of this. It has to work across the system. That to me is a critical goal that we need to work on.

There are lots of experiments. I observed one in Tennessee recently – a pilot with the Medicaid population there and it was very impressive. There are others in other markets. Blue Plans in Nebraska and Massachusetts and a host of other places are piloting things to try and make them work on an all-payer basis.

Again, I urge you to participate. Make sure your voice is heard. Make sure the information you want in that record is there and make sure it's accessible and usable for you as you try to do your jobs.

Summary

I believe the BluePrint I've described to you – making knowledge work to keep healthcare affordable – is doable. I think that there can be a better future, a private healthcare system as opposed to a cottage industry. I truly believe we can make that happen. We can do it with engaged and informed consumers, with doctors and hospitals delivering better quality based on evidence-based practices shared across the system. We are all striving to improve quality, efficiency and affordability. We need a collective vision, where the government is encouraging the system to remain private, developing realistic incentives to make it work, and providing adequate reimbursement for the services that we provide and not forcing us to deal with unfunded mandates. We need to support transparency, to provide data, including pricing information, to patients. We need to do this on a voluntary basis or else the government may come down with price controls in the future, and that's an end result none of us want.

In healthcare, no idea ever goes away, it just gets recycled. Consider whether we might see a rebirth of capitation at some point in the future. It won't be called capitation. I assure you it will be called something else, but the principles will be the same. If you're not modeling or trying to figure out how you'll operate under that kind of environment, you should be, because it might come back. Don't walk away thinking the Blues are planning to get back into that business. We're not, but I think as you talk about pay-for-performance and as you talk about care on a more holistic basis, inevitably the conversation will move in that direction.

We have to reconcile keeping healthcare affordable with the rising costs that you all face every day – with staff shortages, with patient demands and the need for more reimbursement. We have to figure out mechanisms to deal with that.

I'd ask you to embrace pay-for-performance. It's in every other industry and it ought to be in ours. The best providers ought to be paid for their commitment and delivery of quality, and everybody ought to know it.

Collaborate, communicate and innovate. Work with your partners, work with your local Blue Plan to figure out creative solutions. The future system, in my opinion, must focus on the consumer. We can create that system or we can watch it be created. I encourage you to be an active participant in making it happen.

Thank you for the opportunity. I have enjoyed being with you.

Scott P. Serota has served as president and chief executive officer of the Blue Cross and Blue Shield Association since 2000. He is a founding member of the National Business Group on Health's Institute on Healthcare Costs and Solutions and a board member of the Council for Affordable Quality Healthcare (CAQH). He also is a member of the American Health Information Community (AHIC) working with the department of Health and Human Services to advance health information technology, including electronic health records. President George Bush appointed Serota to serve on the Policy Committee of the White House Conference on Aging. He also serves on the board of the National Center for Healthcare Leadership, HRET (Health Research and Educational Trust), Accrediting Commission on Education for Health Services Administration and is a member of the American College of Healthcare Executives.



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