Dean's Executive Leadership Series - 2009-2010

Transcript of Q&A with Leslie Margolin, President and General Manager of Anthem Blue Cross in California

Start

Dean Linda Livingstone: I just have one question for Leslie and then I want to open the floor because I know so many of you have questions you would like to ask related to some of the things that Leslie mentioned in her remarks, and probably about other things as well. But the one question I wanted to ask you, you were talking at the end of your remarks about being willing to partner with anybody and work with anybody. So I would just say, you know, when you look across this room, we're just average, everyday citizens and customers of Anthem Blue Cross or other insurers. What can we do as consumers of health care, as average citizens in California and other places to be a part of the solution to help bring this to some kind of resolution that makes sense and actually helps solve the problems?

Leslie Margolin: I think there are a number of things that you can do and you can think about it from a university perspective and you can think of it from just a purely individual perspective. I think each of us could play a role in reframing the debate, and I think that's the single most important thing that we can do. It is—it reminds of sort of look over here, look over here. This is the issue so we don't have to get at the real issues in the health care reform debate, and we need to. So I think talking with friends and family, talking in your communities with legislators, with regulators, not buying into sort of the hype and sort of insisting, insisting of them and insisting of me that we get down to the real discussion and the real solutions. I think that's the most important thing you can do. I also—after my testimony and that was one of the hardest days of my life, and I went to the airport and was sitting there and I was kind of tired as you might imagine. And you know, they had a panel of Anthem consumers who had come up just before me at the hearing hall, and one of the women on that panel who I noted. I recognized her because I saw her with a microphone up to her mouth, and she came up to me in the airport after I spoke and she said, "I'm so sorry what you had to go through. For the first time having heard you speak, for the first time I have faith that we can actually solve the health care crisis." And she said, "The only thing I was disappointed about in your remarks is you didn't ask for consumers' help." And I was struck because I hadn't. I'd talked about everybody else, that I thought of as stakeholders, and I talked about patients, but I hadn't talked about people as consumers of insurance and care. So I've learned an important lesson through her words and I intend to include consumers in helping us think about this. And so in that respect, just as individuals,

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if we ask for help, please come and share your thoughts and your experiences and your advice about the health care system has served or not served you.

Dean Linda Livingstone: Wonderful. Open it to the audience. Who would like to kick us off this evening? Yes, sir?

Audience member 1: Just, I'm a policy holder with Blue Cross Anthem, and I also have cancer, which is kind of—my question is, I was listening to a program yesterday and somebody mentioned in California they have cancer insurance and it's being somehow created—it was created in Sacramento or something like that. But it's the first I've ever heard of it. And they said that nobody likes it because it's too expensive, but I was just thinking to myself, well I've never even been told about it and even the hospital that I go to, they never mentioned it. Nobody's ever mentioned it. Nobody's ever mentioned it to me until I heard this little blurb and I go well, this is interesting. I going to hear from the President of the company, maybe she can—it's kind of a weird place to request it, but I--

Dean Linda Livingstone: No, it's a legitimate question about what are the products that are out there and how do you learn about them in the system. So speak to—he had a particular question about cancer policies that are there, and I actually know we have them at Pepperdine that are available to purchase a supplemental to our insurance. So it's a great question.

Leslie Margolin: It's a great question. I actually don't know the answer, but I have a man on my team who does, who is a graduate of Pepperdine. So you can…

Frank: Sure. Anthem Blue Cross does not offer what they're called, they're critical illness policies. So Anthem Blue Cross doesn't offer them and a lot of the major insurance companies in California and elsewhere don't. Where you find critical illness policies are typically through, and I don't know that they do, but like you're AFLACs and Colonials and TransAmericas. And what they'll do is they'll provide critical illness or accident coverage, and obviously, you know, it's much like life insurance, you're basically paying a premium and there's a risk associated with it that some subset of their population will develop whatever that condition is that they're paying the policy for. And you get a pay out of some sort. But we don't offer that coverage and many of our competitors don't either.

Linda Livingstone: Thanks, Frank, very helpful. Let me go back here, then I'll come back.

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Audience member 2: I know this topic can lead to a long discussion, but I had an interest in what role alternate dispute resolutions such as arbitrations have on tort reform? And what your thoughts were, very generally?

Leslie Margolin: The question was role might alternative dispute resolution have in the world of tort reform. I am such a proponent of alternative dispute resolution in any of its form, be it arbitration, be it mediation, be it just sitting down and engaging in what I would call an intra-space problem solving process. I think it has an enormous role. I think people are afraid of arbitration because they feel that it will narrow their rights, and I think we have to protect against having that happen. But the opportunity to resolve disputes on a more amicable basis, to figure out what went wrong, to make it so that people and organizations aren't afraid to say they're sorry for having made a mistake, I think it's one of the worst problems in the industry. They—in any industry, fear of litigation and fear of kind of the punitive damages that flow from that make it almost impossible for people who are harmed and people who have in one way or another caused harm to sit down and figure out what happened and how can we make sure it never happens again. And that's the debate, that's the inquiry we should be having. So I think there's an enormous role to play. I think you're right, I mean, it is the stuff that books are written, big books and lots of books are written about, but I think it's an important part of the debate.

Dean Linda Livingstone: Question here and then we'll go to Edna.

Audience member 3: I keep hearing that Medicare doesn't pay it's way. How far below. say what you would pay the hospital. is Medicare? Is it 80 percent? Is it--

Leslie Margolin: I think that in virtually any hospital, any medical group, any situation it would be a different number, but the numbers that are most often quoted by hospitals and medical groups are probably in the 20 or 30$ range, that there's that much of a cost shift.

Audience member 4: You talked about doctor's practicing defensive medicine. Do you think the answer to that is a cap on malpractice or do you—what are other ideas about that?

Leslie Margolin: The question was about doctors practicing defensive medicine and what might I think the cap would be—what would the answer be? Would it be a cap on malpractice liability? You know, many states have caps on malpractice liability. There are all different variations on that theme. I actually think the question that was asked a moment ago is probably a bigger part of the solution. It is finding a

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way to have conversation and solution around what are the best courses of treatment, the most successful courses of treatment, the highest value courses of treatment, so that you could—there's a whole body of work, it's called comparative effectiveness where they look at these kinds of issues and try and figure out through medical evidence what are likely to be the most successful solutions. And I think if we could somehow come to some common understanding about that, then people would probably not be as inclined to feel a need to go to what is called defensive medicine, to doing all other kinds of tests and all other kinds of courses of treatment because we would be able to come together in a more rational way to think about sort of generally accepted practices of medicine or successful practices.

Audience member 5: I'm one of the individual policy holders that has had my policy since 1992, because I believed in the insurance system and it was not-for-profit at the time. And as people may well know, the financing for Blue Cross Anthem originated in our policies, people like me. So we are the original policy holders. And so our premiums, 25 percent were taken and used across state lines to violate not for profits, but now we are confined to buy only our health insurance in the State of California. So how can our money go across state lines and purchase that assistance, but yet we can't have a competitive ability to even find a better plan for ourselves. By the way, I believe strongly our health care system is wonderful and I really believe in the insurance system. I don't believe that we should allow our health care to be entrusted to a bureaucratic system. Thank you very much.

Dean Linda Livingstone: Thank you.

Audience member 5: But my question is sincere and then how did Blue Cross and Anthem become the villain to this relative to this, what's going on in Washington?

Leslie Margolin: There are a couple of levels to your question, and I'll answer as best I can and if I miss something, please tell me and I'll get back to it. The issue you raise around premium dollars going across state lines and that was a big part of the debate of the testimony at the Assembly. We are owned by a company that is headquartered in Indiana, WellPoint. Anthem Blue Cross here in California is owned by them, they are our parent company. As in any other industry, subsidiaries of a parent company, dividend dollars back to that company, but dividend to dollars I don’t think of them as just dollars going out of state. What I see is a parent company that provides coverage to 35 million Americans across the country, and that company has to invest in technology, in systems, in processes, in staffing, development, in figuring out what are the break through safety solutions. And if we did that in each state, separately, we would never come up with the kind of solutions that are enabled by our bringing dollars together, trying to figure out solutions. The support that I get to provide coverage and solutions to the part of the business I run is

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four million members in the state, but we have eight million members in the state. I'd never be able to do that on just my piece of your premium here in California. So I think the debate, it's taken on sort of a fever pitch about going over state lines, but I think that the people I work with and live with every day would say that there is great value to us and to our members in that. In terms of how Anthem Blue Cross became the villain in the debate, you know, it was a debate that needed a villain. There had been a sort of a quiet in the storm in the debate and it was looking like health care reform was not going to get legs and was not going to pass. And I think that it was important to resurrect the debate to have someone or something that ignited passions. And I think how it came to be Anthem Blue Cross was that we had poor timing in announcing rate increases.

Audience member 5: Unfortunately though, it looks like it was explicit. It looks like you had a premeditated reason to do it, that you might get a contract down the line from them. That's what it looks like. And people whom I know, they say would you ask that question, because we're concerned. That's what it looked like and we're the Blue Cross people.

Leslie Margolin: Yeah. I'm sorry if it surprises me to hear that. I wouldn't have thought of it. I couldn't have imagined that. And I can only speak from my knowledge and experience and my knowledge and my experience and my wish is that we hadn't. So the idea that we do it deliberately for some reason, it's just the furthest thing from my mind and the mind of anybody that I work with.

Dean Linda Livingstone: Scott, you had your hand up.

Audience member 6: Well, I was just wondering if you had any thought has been given to outcome-based medicine. You know, it seems like I always try and find in situations what motivates somebody and what is the motivation to keep someone alive? Is it the dollars that they earn from it, because maybe that's backwards, maybe they should make more money if they keep them alive, but if they die they don't get as much. I don't know it's kind of absurd but—

Dean Linda Livingstone: But it's Scott. He's an old friend. Scott and I used to work together.

Leslie Margolin: I don't know if you could hear his question? It had to do with whether there was wisdom and reason to think about reimbursement differently and think about reimbursement based on outcomes. Absolutely. Absolutely there is. It's a huge part of what we could tackle and what we need to tackle. What we need to think about reform of reimbursement. And the interesting thing is that medial groups and

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hospitals are ready for it as well. We have a number of efforts underway right now, looking at how you think about episodes of care, how you think about rewarding outcomes. One of the things I didn't mention, but I had in my notes is thinking about just how we structure coverage differently. Wouldn't it be interesting if, and important if we created sort of a basic health insurance policy that rewarded prevention. You think about the crisis in American health care right now. You think about obesity, you think about lifestyle habits and we always, you know, just as a people, we tend to think about what are the sticks that we can employ to stop people from doing things. But what if we created an insurance policy that was—that went across the state that had—that was available to everybody that was affordable, maybe didn't have everybody's favorite mandate in it, but it had 100 percent preventive care and it gave rewards to people for healthy lifestyle, for engaging in diet and exercise and those sorts of things. It's just reframing the question a little bit, but that reframing is so important. Nobody wants to be penalized. Nobody wants that and it causes people to stand up and be angry and resist. But if you reframe it, you get to the same issue, and you get to it in a way that is so positive. So Scott, it's a terrific question and it's—I'd actually love to work with you on it. I—we have so many people who are trying to think this through and I think we could use a few more really good heads on it.

Audience member 6: I have about 100 questions, but I'll pick one. Your programs have improved hospital safety. That seems like something that could be easily scaled across the country. Have you considered that?

Leslie Margolin: I'm sorry, did I interrupt you?

Audience member 6: No.

Leslie Margolin: The question was, our collaborative for patient safety, it's called Patient Safety First, California Partnership for Health. The question was, it seems like it could be scalable or leveragable across the country. Have we thought of that? Absolutely. It is so scalable. What I wanted to do with it, and I partnered with the Hospital Association CEOs up and down the state. What we want to do is launch it across California. We've picked as our initial areas of focus, just three areas. One is eliminating sepsis. The second is eliminating certain, they're called central blood line infections. Infections associated with certain procedures in hospitals. And the third is a slight variation on the theme, and it part—in that we partner with all of the hospitals, but we've also partnered with the March of Dimes, and this one is about providing education and communication to mothers and families and physicians informing about the risks of making voluntary decisions, elective decisions to have early delivery, to induce labor before the full 39 week period of gestation. The risks of that—of those decisions for convenience of the mom or availability

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of the doctor or for comfort, if it's medically necessary to have something like that early, that's perfect, that's fine. But so many people schedule around matters of personal preference or convenience. The dollars at risk of safety of the children and the lifetime of illnesses that result from that decision are—it's extraordinary. We have a bit of a debate in our company about just how much money is at issue over those decisions, but it is many tens of millions of dollars just in our own patient population. So if you take it and scale it across the country, I mean, if you could take just that and marry the March of Dimes and drive that change across the country, it is—we would have such dramatic improvement in health and such dramatic reduction in cost. So I'm all for it. I'll leverage this anywhere that we can. What I want to do is take this pilot in a way that I'm sure we can make it successful, get the kinks out and then replicate it across our organization and share it, I think all the health plans should join in. I don't view this as a proprietary thing. I just think it's a responsibility that we have to improve care.

Dean Linda Livingstone: Two questions here. First and then we'll go to that row.

Audience member 7: Could you go back to preventative care and talk to any initiatives that Anthem Blue Cross currently has? And you also mentioned something about rewards. That was a fantastic idea, but how do you measure it? What are the metrics for that?

Leslie Margolin: You know, I can talk with you about it at a very high level. I think the point I really want to make is everybody is doing work around prevention, having on-site wellness programs, doing work—we work with individual members and we work with employer groups around exercise and fitness programs, around healthy lifestyle choices. We partner—one of the things that Tim Jordan on my team and I have been working on is working with the major athletic teams around California and getting them to come to the schools with us. We work with the Lakers and the Dodgers. We are the primary funders of the Governor's Council on Physical Fitness. So that we can go out to the schools across the state, and we do it ourselves, but they don't want to see a bunch of insurance executives. So we bring people like Lisa Leslie and Leila Ali, people who kids look up to, and we have them come into the schools and talk about fitness, nutrition, teach them ball handling skills. And it's a really fun kind of dynamic thing. The point is it is an area of such great opportunity, and it's about instilling the practices early on in kids' lives so that their practices and habits that they hold for life, I think that's a huge part of it. But it also can come in the form of designing products. It can come in the form of having health care coaches, which we have, people who see an issue or work with a particular population. I think there are any number of ways to get at it. What I believe is necessary is to bring people together who know a lot more about it than I do, clinicians and dieticians and exercise physiologists and figure what would, not just what's the window dressing, not just what's the sizzle part of this, but what's the steak part of it and where do we really

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expect to see results and then drive that. You had a second part to your question and I think I've missed it.

Audience member 7: The metrics, how would you measure if somebody is you know, exercising? I mean, blood work could be misleading sometimes, for example.

Leslie Margolin: Yeah. You know, actually I'm not trying to pass this back to the school, but that's an area where we really could use help thinking about the design of a program would be, what the appropriate metrics—I'm out of my league. I'm a labor lawyer. I haven't a clue. I know you have to measure it. <Laughs> Well, it's true. I know you have to measure it and you have to track it. I was at a meeting, as you might imagine, I've been speaking a lot the last two or three weeks, mostly with our customers and our hospitals and physician partners, but one of the people I spoke with at a seminar a day or two ago talked about, I don't remember the number precisely, and I'm sorry, it was one of the leaders, one of the physician leaders at Kaiser who said with their new electronic medical record system, they can determine obesity among all their members. They know exactly how many members are obese. And the interesting part of it was that he said through the electronic medical records they know that it's 36 percent of their population. Through self reporting it's 26 percent. <Laughs> It struck me so funny and I was thinking, you know, that really gets to you need the appropriate metrics. I'd love—if anybody here wants to help us think about that, we'd love to. So.

Dean Linda Livingstone: It's great. I'm going to take one more audience question, maybe two, because I've got a couple people. In the back row, did you still have a question that you--

Audience member 8: It was about—my question was about electronic medical records and do you think that that would improve patient safety with hospitals? And I know Kaiser implemented that system and it seems to be working from a physician standpoint.

Leslie Margolin: The electronic medical records are an important part of any piece of health-care reform, and it's more the voluntary non-governmental, although there could be a governmental system. You could, I suppose theoretically, figure it out for a nation. But it seems to me that private industry can figure this out. What we have to do is figure it out in ways that our non-proprietary so that a hospital system—we have a couple of pilots going. We have one up in Northern California, one here with Cedars-Sinai in Southern California with our medical records systems. The physician on our team, Dr. Charles Kennedy, is the only health plan representative to President Obama's team looking at this very issue. And what we've learned is that we have a very good system available and what we need to do is make it workable

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for the hospital to have interfaces with all the other health plans, because otherwise they've got to have a HealthNet, A Blue Shield, an Aetna, a Cigna, a whatever. And what they have to have is a system that works for all of us. I'm doing some work right now, in fact we have been leading the work with the Department of Managed Health Care and the Department of Insurance and with the California Health Care Foundation to look at something as simple as a common web portal. I listened to doctors talk to me about what it's like to deal with so many insurance companies, and they describe having to have 20 or 30 different passwords just to get into the system. That ought to be the stuff we compete on. We ought to figure that out, figure it out once for the industry. I mean, we talked earlier about taking cost out of the system and improving efficiency and eliminating abrasion, what a cool way to do it, moving to common credentialing for doctors. We all have our own credentialing forms and processes. We make physicians nuts. And you aren't going to come Anthem Blue Cross because my form is better than the next. You're going to choose us because we have the best network, the highest quality, the best service, best products, best prices, but we compete on stuff that is just silly. And I've put a call out to the entire industry to say, this is the stuff we can fix all by ourselves. We don't have to wait for regulation or legislation.

Dean Linda Livingstone: We'll take one last question.

Audience member 8: You mentioned the difference between Medicare—what Medicare pays and what private insurance pays, and it seems when Medicare wants to reduce costs they just reduce the amount of pay out to the physician and hospitals. Why don't private insurance companies do that as well or take your price down to what Medicare pays? What risk would there be to Anthem by doing that?

Leslie Margolin: Well, I think there's—if you couldn't hear the question was when Medicare can't afford to pay or the costs get to high they just ratchet—this was the question, not my statement. <Laughs> Just for the record. They just ratchet down the reimbursement for physicians and hospitals, and the question was why don't private insurers do that? I think that practice, whether it's done by the government or done by private industry is what's at the heart of the health care crisis. What we do—what we have done for years and years and years is simply shift costs. We move costs around in the system, so if the government ratchets down on what they reimburse doctors and hospitals for, and to the point to that doctors and hospitals say they can't cover their costs, then those costs just pop up somewhere else as an expense. And what's been happening for years is that everybody fixes their little piece of it and then creates a problem somewhere else in the system. And the reason I'm so intent upon the kind of reform that I've described to you tonight is because it takes cost out of the system. It takes it out entirely. It reduces the cost of health care, and so then you can have responsible reimbursement in ways that everybody can make a fair and full living without having to engage in what I think is not the most constructive behavior.

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Dean Linda Livingstone: I know we've got lots of more questions in the audience, but we do need to be good about finishing on time. And it's been a really wonderful conversation. Let me close with this question is, and you've been at Anthem Blue Cross for just a couple of years, but you're obviously in the middle of one of the most interesting times to be in that kind of a role. But you know, at the end of your career, whenever that might be, if you could look back on your time there and say, you know, "The one most significant thing that I helped influence was" what would that be?

Leslie Margolin: It is—it's so clear to me, I've never been more passionate about anything in my life than what we've talked about here tonight. If I could look back at my career and say "Through my seat at Anthem, I was able to bring together the stakeholders across the system of care to solve these critical issues of cost, quality and safety so that in fact we could provide affordable access to care across the state and across the nation." I can't think of anything I'd more proud of.

Dean Linda Livingstone: Wonderful. Well, thank you so much for sharing with us. We really appreciate it.

Leslie Margolin: Thank you very much.

Dean Linda Livingstone: Very good. We have a gift for you and because you love our campus so much, it's actually— includes a picture of our campus.

Leslie Margolin: Oh my. I didn't even tell you.

Dean Linda Livingstone: So when you can't come see us, you can just put on the wall in your office and look at it. So thank you so much for being here.

Leslie Margolin: Thank you so much, what a wonderful gift.

Dean Linda Livingstone: It's been just great.

Leslie Margolin: Thank you all.

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