



HIMSS MN Health IT Institute
University of Minnesota
Carlson School of Management
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Wells Fargo & Company

Who is Paula Roe and why is she here?

1. I represent a payer....a BIG payer
2. I've been doing this (purchasing health care) for some time in this market, as well as nationally, so I have a perspective as well as opinions that I am pleased to share with all of you...and interested in your feedback as well.
3. And my CEO, Dick Kovacevich, was on the national Health Information Technology Leadership Panel led by David Brailer M.D., Ph.D. along with 9 other CEOs of major US companies.

A little about Wells Fargo...

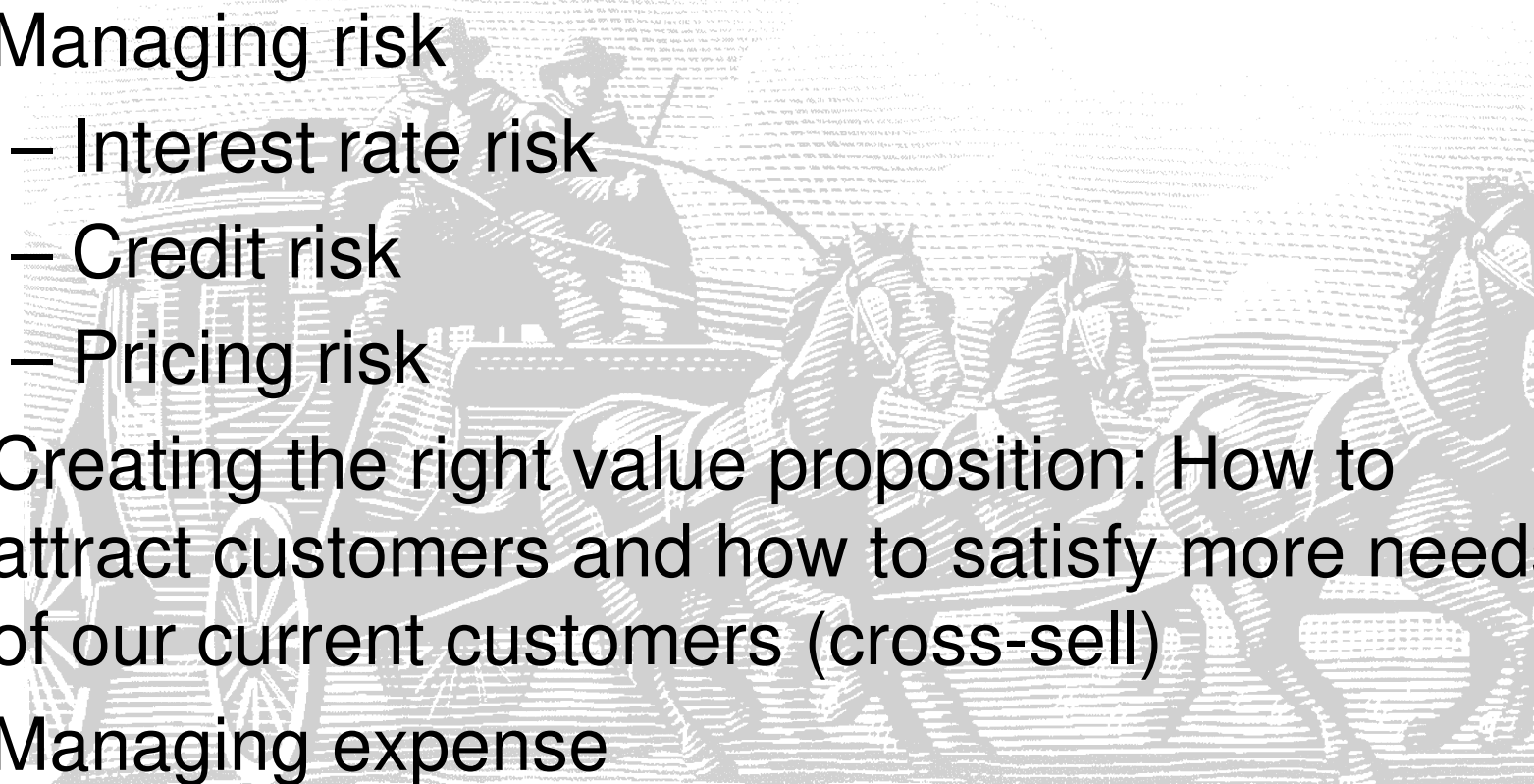
We are a diversified financial services company providing banking, insurance, investments, mortgages and loans to individuals, families and companies with the aim of helping our customers achieve financial success

- 155,000 employees in all 50 states and Canada and Caribbean (among America's 40 largest private employers)
- 23 million customers
- 17th on list of Fortune 500

A little *more* about Wells Fargo...

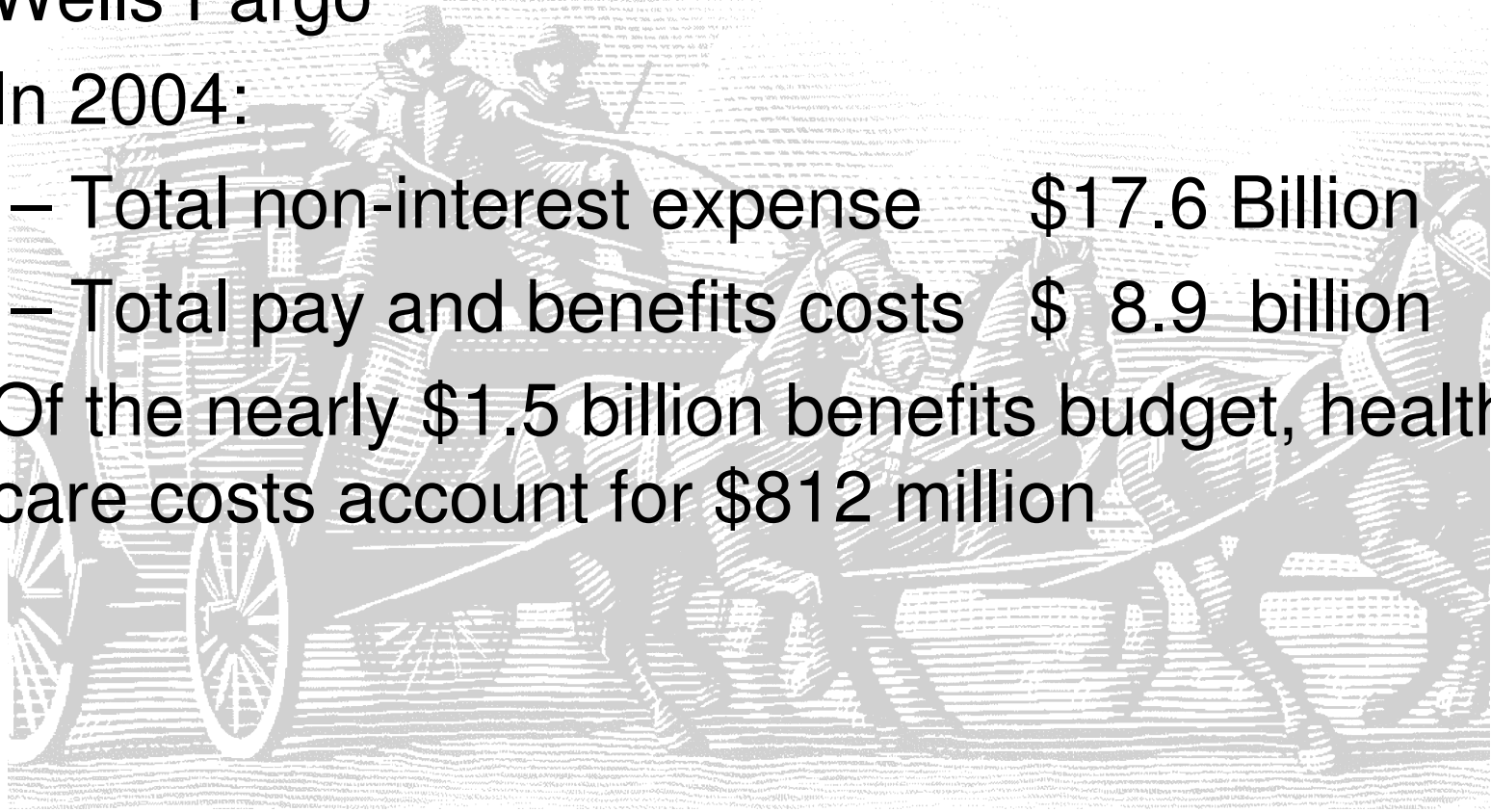
- #1 retail mortgage originator in US
- #1 internet bank
- 4th largest ATM network
- Only Aaa rated bank (highest possible credit rating) in the US
- #6 among the country's "100 Best Corporate Citizens" by *Business Ethics* magazine for commitment to community, diversity and human rights
- #9 among America's largest corporate contributors—\$93 million to 15,000 non-profits in 2004

What are our business challenges?

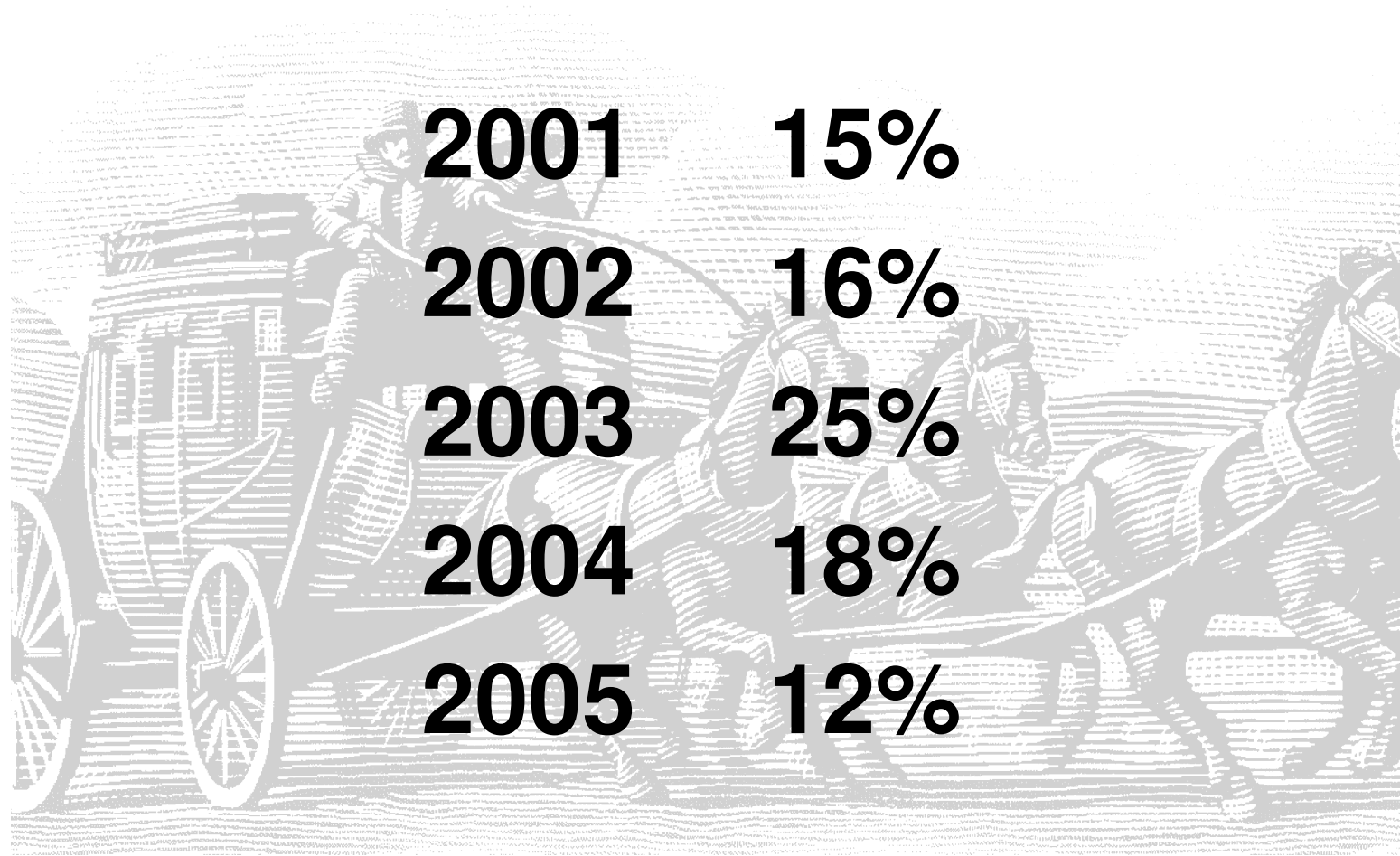
- Compliance and regulations
 - Managing risk
 - Interest rate risk
 - Credit risk
 - Pricing risk
 - Creating the right value proposition: How to attract customers and how to satisfy more needs of our current customers (cross-sell)
 - Managing expense
- 

A little about expense...

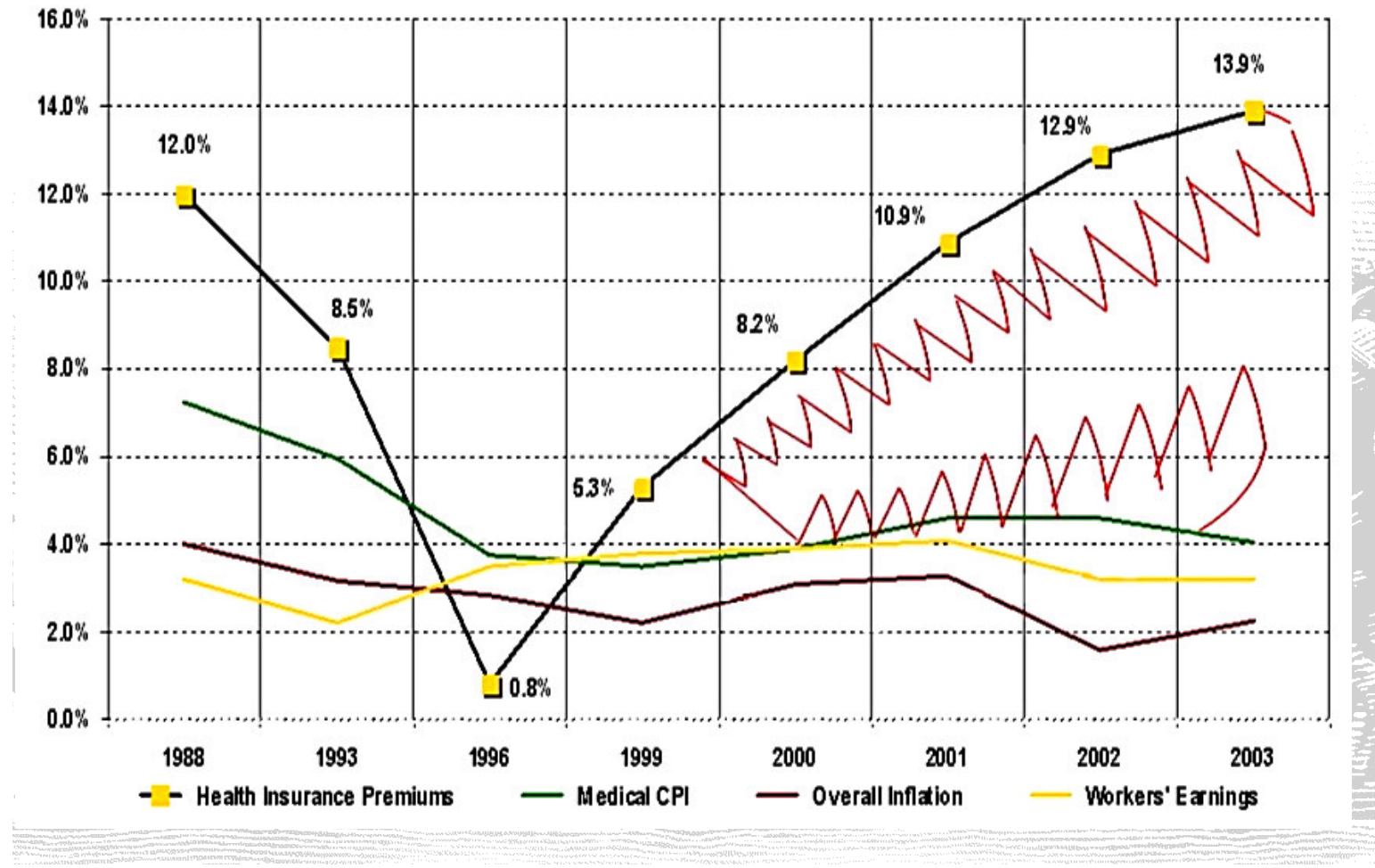
- Human resource expense is the “big gorilla” at Wells Fargo
- In 2004:
 - Total non-interest expense \$17.6 Billion
 - Total pay and benefits costs \$ 8.9 billion
- Of the nearly \$1.5 billion benefits budget, health care costs account for \$812 million



History of recent health care premium increases at Wells Fargo



We all know that America has a problem!



What have we done at Wells Fargo?

1. Offer managed care across all geographies
2. Introduced wellness initiatives
 - WebMD with Health Risk Assessment
 - Health Fairs
 - Smoker/Non-Smoker rates
3. Participate PBGH, WBGH, BHCAG etc
4. Work with Congress (HSA legislation etc)
5. Reduced the Wells Fargo Pension Plan formula (future accruals) and reallocated funding to increase health premium subsidies (robbed Peter to pay Paul)

Current Assessment

- Clearly what we have done so far is not enough... “finger in the dyke” against forces such as:
 - Demographics i.e. aging population
 - Population health status i.e. obesity epidemic
 - Cultural forces (violence, diverse needs etc)
 - Exploding device and pharmaceutical technologies
 - Rampant waste and inefficiency in the “system”

Health Care News—One Day—One Newspaper

Body electric

Implantable devices that emit small bursts of electricity soon could be used to treat depression, obesity and a host of other medical conditions.

Wide waistline can thin the wallet

Metabolic syndrome patients account for \$4 of every \$10 spent on prescription drugs.

not come into wide use until the last decade. The first international symposium on the syndrome was and roughly one in eight childr have metabolic syndrome, w overeating and inactivity bei

Big leap in breast cancer therapy

New drug results called amazing.

By Josephine Marcotty
Star Tribune Staff Writer

Numbers bring special comfort to Cynthia Toms, 43, who is a breast cancer patient and an accountant.

Blue Cross tiers include doctors

Plan will affect decisions on patient care

that also meet the insurer's quality guidelines. Patients pay a higher co-insurance if and Children's Hospital of Minnesota.

More News...

Medica news release May 11, 2005

Patient Choice Plan Gives Consumers Control Over Healthcare Decisions Through Information on Quality and Cost

MMA news release May 12, 2005

The MMA told Blue Cross that there is a need for more transparency, more information about the criteria used to make hospital tiering decisions.

Star Tribune May 13, 2005

Blue Cross and Blue Shield of Minnesota has reversed its decision to place physicians in price tiers as part of a controversial new insurance product after cries of outrage from doctors. The equally controversial plan to tier hospitals remains.

Minnesota Medical Association

Health Care Reform Task Force Recommendations

- Increase emphasis on prevention and health maintenance by strengthening public health policies and systems.
- **Educate consumers and assist them in playing a more central role in decision making and participating in care management.**
- Assist physicians and other providers in delivering **evidence-based care.**
- Build the **information infrastructure** to allow collection, reporting, and dissemination of the information needed to measure and improve quality and equip patients to make cost and quality choices (this should connect clinical with claims data for all clinics, hospitals, doctors, and insurers).
- Develop **payment systems** to support quality practice
- Leverage existing quality improvement work
- Make behavioral health care a part of basic medical benefits.
- Support efforts to improve care delivery and payment for patients with chronic and complex conditions
- **Reduce administrative complexity and cost.**
- Support the establishment of a medical home for every Minnesotan through changes in administrative and payment policies.

Wells Fargo's philosophy and vision

At Wells Fargo we believe that health coverage is an integral part of our employment offering to ensure our team members' financial success and an important part of our strategy to promote a productive and engaged work force.

This demands both sustainable health care cost trend and high quality health care for our employees.

Wells Fargo's vision for the future (cont.)

WF vision for our employees

- Information to be a good consumer (cost and quality)
- “Skin in the game” (know and care what services cost)
- Affordable health care and health insurance i.e. improvement in trend of future premium increases
- Incentives to get right treatment and get back to work
- Better quality of life

WF vision for providers

- Shared understanding and pressure from their patients who have a stake in costs and outcome
- Incentives to provide evidence-based medicine
- Rewards for better performing providers
- Better outcomes and greater efficiency

What does this mean?

- We are contemplating going “back to the future”
 - Back to deductibles and coinsurance (no more office visit/Rx copays)
 - With new tools to support employee health care consumerism
 - Access to quality and cost data
 - Wellness prompts
 - With incentives to spend wisely including a company-funded HSA (balance carried over year to year)

Critical Success Factors

Presumes **significant improvement** in the “system-ness” of health care

Definition of system: *“A group of interacting, interrelated, or interdependent elements or parts that function together as a unified whole to accomplish a goal”*

Another definition of “system”

“An assembly of computer hardware and software configured for the purpose of classifying, sorting, calculating, computing, summarizing, transmitting and receiving, storing, and retrieving data with a minimum of human intervention”

Critical Success Factors cont.

System-ness compels investments in health information technologies:

- Electronic medical records (EMR)
 - Electronic clinical decision support tools
 - Electronic claims payment processing
- which together will streamline and modernize health care delivery and improve quality and patient safety

Critical Success Factors cont.

Patient consumerism demands transparency

- information on costs in advance of incurring charges
 - Provider fees
 - Prescription medications (generic alternatives etc)
 - Diagnostic, lab, radiology fees
 - Medical devices
 - Hospital charges
- Information on quality in advance of selecting provider
 - Error incidence
 - Patient outcomes, number of procedures performed

Data must be **available** (online), **comparable**, **transparent**

Critical Success Factors cont.

In addition to providers, consumers ought to have easy access to their medical records:

- Record of basic health status and changes i.e. weight, BMI, BP, cholesterol levels, immunizations etc.
- Copies of mammogram, MRI, PSA reports, etc.
- Health history (prior surgeries, family health risks)
- Medications (allergies, tolerance etc)

This will save time, avoid duplication of services, avoid complications and adverse reactions and increase patient knowledge and responsibility

Who will pay for health information technology?

- HIT will pay for itself (many times over) over the long run by reducing waste.
- Still—who makes the initial investment?
 - Providers
 - Health plans?
 - Government?
 - Payers?
- Most likely, cost will be shared by all of the above.
- Government's role should be to set interoperable standards for HIT and lead the way with Medicare/Medicaid populations.

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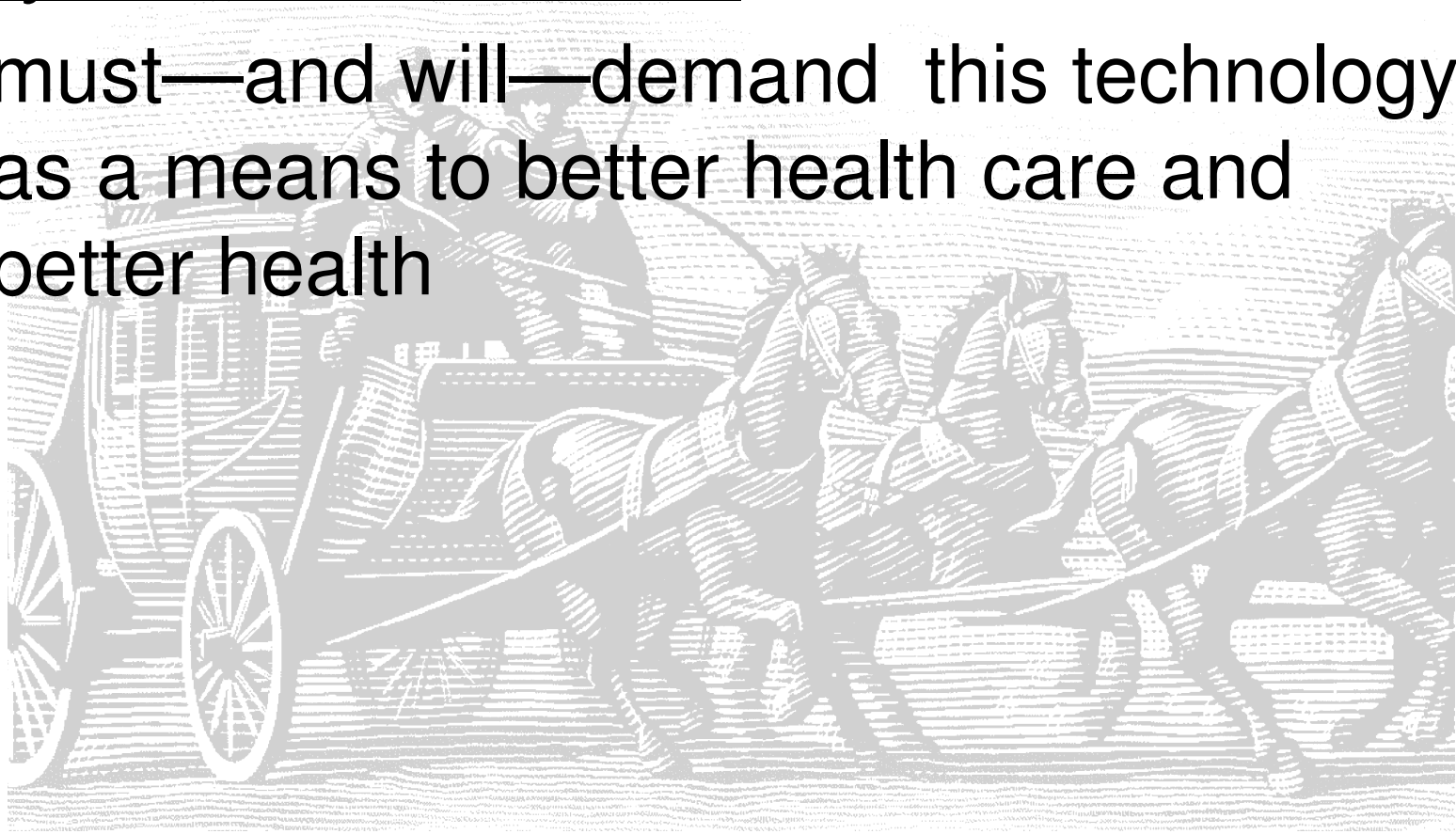
Providers

- *may* lack enthusiasm because, for the most part, they are paid on a fee for service basis and this will eliminate services or substitute lower cost services for higher cost.
- Yet providers who demonstrate high value/high quality will see more demand for their services.
- should see reduced admin and clerical costs and faster bill payment.

Conclusions

Payers and consumers

- must—and will—demand this technology as a means to better health care and better health



Conclusions

Adoption of HIT combined with changing our health benefits design to incent, engage and empower the consumer towards rational purchasing is our best hope of addressing the inefficiency, waste and runaway costs in our health care system and, presumably, preferable to the alternatives such as further growth in our uninsured population, single payer system, or rationing care.