Pennsylvania House of Representatives

Insurance Committee

"Implementation of Federal Health-Care Reform"

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**Testimony of Diane P. Holder**

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Good morning Mr. Chairman and members of the House Insurance Committee. My name is Diane Holder and I am an Executive Vice President of UPMC and President of the UPMC's Insurance Services Division which includes the "UPMC Health Plan".

I would like to first thank the Committee for asking UPMC Health Plan to testify regarding how Pennsylvania can best implement healthcare reform in concert with the Federal reform legislation. As the new Federal law unfolds, we look forward to working closely with members of the House and Senate as well as various federal and state agencies to help improve the access to healthcare for those who do not have coverage. Additionally, we believe there are unique roles for Integrated Delivery Systems, such as UPMC, to help improve the quality and affordability of healthcare for all Pennsylvanians.

By way of background, The UPMC Health Plan is owned by the University of Pittsburgh Medical Center. The UPMC is well known as one of the leading clinical health systems in the country. In fact, just last week, US News and World Report announced their annual Honor Roll and only 14 providers in the country out of nearly 5,000 were recognized for this distinction. I am proud that UPMC was one of them.

However, in addition to the longstanding mission of clinical care and research excellence, UPMC made a decision in the mid 1990s to expand its mission to further serve the community through the creation of a family of health plans. We did this primarily because we believed there was a better way to finance care and to improve access to care than through the traditional insurance models. We also believed it was important for the citizens of Western Pennsylvania to have insurance options.

I personally created for UPMC one of our Insurance Companies, Community Care Behavioral Health Organization. I was at that time the CEO of Western Psychiatric Institute and Clinic. We created this new health insurance company to try to avoid in Pittsburgh some of the serious problems that occurred in Philadelphia in the early days of Medicaid managed care. Unfortunately, in those early years, a large percentage of the dollars in Philadelphia that should have been used to care for people with severe conditions, such as schizophrenia or autism, were not used to care for these patients and instead found their way into administrative costs and profits. We created an alternative to the traditional insurance companies and today Community Care is fortunate to serve over 500,000 Pennsylvania Medicaid recipients across the Commonwealth.

Our mission is to help create effective systems of care and put the dollars into care for children and adults who need mental health and drug and alcohol services. One of my proudest days occurred when I learned that Community Care won the Moffit Ethics Award from the American Society of Community Psychiatrists. Parenthetically, I had heard second hand that there was an argument at their board meeting because there were board members who did not believe you could give a "managed care" company an "ethics" award. We have also been recognized by consumer and family organizations including the Alliance for the Mentally Ill and the National Alliance for Autism Research.

The UPMC Insurance Services Division has since grown to six insurance-regulated entities and covers over one million members under Medicare Advantage, Medicaid, Children's Insurance Program, commercial insurance and Medicaid behavioral health programs through Community Care. Our commercial business serves over 6,000

employers in 30 counties in Western Pennsylvania while our Medicaid plan operates in Western PA as well as South Central PA. We have been one of the fastest growing Medicaid plans in the state for the past several years. In fact, in Allegheny County, the majority of new enrollees in Medicaid choose the UPMC for You over the other choices. We are also ranked the highest quality Medicaid plan of the seven in Pennsylvania.

Additionally, we serve one of the nation's largest Special Needs Plans in the country. This is a population of people who receive both Medicare and Medicaid benefits. Approximately half of this group receives their medical benefits because they are permanently disabled including serious and debilitating medical conditions such as multiple sclerosis, severe epilepsy or traumatic brain disorder. Unfortunately, this program may be in jeopardy in the coming year because the Medicare Advantage payment reductions may make Special Needs Plans financially difficult to support. This population is amongst the most vulnerable with tremendous medical burden and a great need for care coordination and support. Pennsylvania has a disproportionately high percentage of people enrolled in Medicare Advantage plans including Special Needs Plans. In western Pennsylvania there are many counties where over 50% of Medicare eligible people have enrolled in Medicare Advantage plans. The national average is 20%. This means that as the reductions occur in Medicare Advantage, a disproportionate number of people in western Pennsylvania will experience a negative financial impact. Healthcare Reform has many positive aspects but there may be unintended consequences. I would ask your assistance to raise these issues with federal legislators and CMS due to the significant impact most notably in western Pennsylvania.

I describe all of this because as Pennsylvania and the nation enter a new era of healthcare reform, I believe it is also vitally important to discuss progress that has been made and programs and methods that have worked and not throw the proverbial "baby out with the bath". Pennsylvania has been more proactive than most states regarding Children's Health Insurance, Medicaid and Medicaid Behavioral Health. We need to consider all the citizens of Pennsylvania and to think through carefully the safety net type of coverage programs that we have today as well as where we have gaps. The planning must take into account those who get their coverage through their employers, through government programs, though their own personal means as well as those who have no ability to get coverage at all.

Today, there are three areas that I want to touch on which I believe are critical to building a sustainable model for healthcare reform:

1. Access to coverage and the role of Exchanges;
2. Cost and the role of new payment and financing models; and
3. Consumer engagement

Access to Coverage:

Pennsylvania has recently appointed the Health Care Reform Implementation Advisory Committee and UPMC is pleased to serve on that Committee. Given that Pennsylvania may be able to draw down federal dollars as early as this fall to assist in planning an Insurance Exchange, the effort is necessary now.

There are many critical decisions to be made in order that an Exchange plan can be in place to meet the Federal guideline which states that the

Commonwealth must codify governance in State law and establish an Exchange Board by January 1, 2013. There are many questions that we have regarding the Governance and rules that will guide a Pennsylvania exchange. For example, the State may choose to align with other States; it may choose to have one Exchange for individuals and another for small group purchasers; it may choose to have a State agency run the Exchange or a private entity; it must determine how to certify that "qualified health benefits plans" are consistent with Federal guidelines; it must decide to allow or not allow Exchange plans to be offered within and outside the Exchange; it must develop coverage guidelines and basic benefit plans; etc. The list of required decisions is extensive and the decisions require significant thought.

One of the most critical decisions is how to set up an Exchange that minimizes the risk for adverse selection against the Exchange and adverse selection for plans within the Exchange. Adverse selection may occur when a population differentially selects, is steered toward or is selected though a specific design and there is inadequate financial support for the population that is insured. It is not uncommon in many insured populations that 1% of the population can account for 20-30% of the dollars expended.

We have experienced at various times in our insurance history the impact of adverse selection. For example in the early years of our Medicaid plan operation, there was no risk adjustment for severity of illness in the capitation. Therefore, if you were a health plan that had a network that included a regional transplant center versus a plan which offered a network that did not have a local transplant center, you could find yourself with a disproportionate number of members who selected your plan because they were in need of a transplant. In our case, we

had approximately 20 percent of the region's population in our plan and roughly 60 percent of the transplants in that region. This and other risk selection issues resulted in a tremendous imbalance amongst the three Medicaid plans in the region with ours struggling and a third earning disproportionately high profits. Once the Medicaid program allowed the dollars to follow the member by the creation of a high risk pool that would be distributed proportionately to the plan based on the illness severity of the members and the medical costs they incurred, there was an ability to sustain three choices of Medicaid plans for our region.

Adverse selection, risk adjustment and network designs along with benefit plans and the actuarial soundness of rates will be vital to the long term survival of functional Exchanges. Additionally, there will need to be appropriate mandates for purchasing insurance coverage or there will not be adequate dollars to cover the entire population. We also believe that it is very important that Exchanges allow offerings from regional health plans versus only those that can offer a statewide network or national coverage. Many of the highest quality health plans in the country are regional health plans and we believe that consumer choice should include these types of plans.

The second significant issue for healthcare reform is how to decrease the costs of healthcare in order to create an affordable sustainable system. Most of the Federal legislation is focused on enhancing coverage for currently uninsured individuals but unless we find a method to arrest the cost drivers of healthcare trends, there is no way to sustain the coverage of those who are currently insured let alone expand access.

The new federal reform has identified Accountable Care Organizations (ACOs) as one of the new types of demonstration programs that will be funded. ACOs are organized systems of care that can take some type of risk for a population and have the infrastructure to provide the appropriate medical care for a set dollar amount. These will begin as Medicare demonstration projects but have the potential to expand. One of the key reasons that ACOs are believed to offer hope to reduce the trend of increasing medical costs is that the incentives between the payer of care and the provider of care would be aligned. Currently across the U.S., we have a payment system that rewards the volume of services provided versus the quality or the outcome of services provided.

One of the reasons systems such as UPMC, Kaiser, Geisinger, Group Health Cooperative and many other integrated health care systems are gaining national attention and being discussed as potential models of care is that they have payer arms supporting their provider system. And collaboration between the payer and provider functions of the organization serve to align incentives to improve quality and cost. For many years, these systems have had capitated populations and have been responsible for managing a defined dollar amount for that population and have been measured on their quality and cost outcomes.

At UPMC we have seen significant improvement for our members. For example, the UPMC for You Medicaid program has demonstrated excellent quality outcomes and has contained medical trends. Last year the trend was lower by approximately half of the Pennsylvania state average and performed even better against the national Medicaid trend. It is also a plan that demonstrates better clinical quality

outcomes for rates of prenatal care, well child visits, chronic disease management and many other critical clinical metrics, ranking 7th in the nation in quality outcomes and as I mentioned earlier, 1st in Pennsylvania.

Additionally, for our Medicare members we have seen readmission rates drop significantly compared to Medicare Fee for Service and we have also been able to offer a zero premium price for the older adults whose fixed incomes make premium increases very difficult. For our Commercial and Medicare members we have worked with the physicians in our network and by placing Health Plan nurses into primary care offices and providing team support to the doctors and the patients as well as sharing clinical and utilization data, we have seen much better care coordination and improved medication adherence. 75% of all medical expenditures are related to chronic diseases and by focusing on helping our members who have these conditions and coordinating the resources of both our doctors and our Health Plan we have seen excellent results, improving both cost and quality outcomes. Physicians receive enhanced fees to coordinate care and increasingly there is opportunity to move to bundled payments and additional risk relationships to reward quality, effectiveness and efficiency.

The third issue that supports sustainable healthcare reform is an activated, informed consumer. Unfortunately, we have a culture in this country that has led to a significant number of inactive, overweight adults and children. Kenneth Thorpe, PhD, a health economist at Emory University, has studied the data related to the escalating health costs in this country[1]. He examined the past twenty years of cost increases and

[1] Thorpe, K., "The Rise In Health Care Spending And What To Do About It", Health Affairs, November/December 2005.

he found this: There is a greater prevalence of disease; there is greater treated prevalence of disease (that is we now treat people at lower clinical thresholds than in the past); and there is greater technology innovation (stents, neonatal interventions, etc.). He also notes that if the population had the same average weight today as it did in 1985 we would have ten percent less cost per person for health care.

Obesity is a leading driver of the development and exacerbation of chronic illnesses such as diabetes. Unfortunately we have a diabetes epidemic in this country and one in three babies born in the year 2000 is expected to develop diabetes in their lifetime[2]. The number one cause of blindness and amputation is diabetes and 25% of the Medicare budget is diabetes related.

We must align healthcare delivery and healthcare payment to address the need for prevention, early intervention, care coordination and patient education and self management if we are going to improve the health of the American population and make a dent in the costs associated with healthcare. Also, we need to evaluate which treatments work effectively for which populations. Dr. Arthur Levine, the Dean of the University of Pittsburgh School of Medicine, has recently been appointed to chair the Systematic Review Working Group on Comparative Effectiveness Research and Clinical Practice, National Center for Biotechnology Information, the National Library of Medicine, National Institutes of Health. This group will help determine how funding should be used for comparative treatments so we understand better what works and what doesn't. Understanding clinical effectiveness is a critical component of the new Healthcare Reform

[2] (1990 – 1998) Implementing the Chronic Care Model in a Health System: Impacting Diabetes, Linda Siminerio, RN, PhD, Diabetes Institute, University of Pittsburgh

agenda. As we meet here today on the University of Pittsburgh's campus and down the street from UPMC's flagship hospital, it is a good reminder that science must play an important role in what guides our decisions for care. It is important to understand not just what is less expensive but rather what is most effective from a quality and cost perspective for which patients under which conditions.

There are, of course, a myriad of other important issues we need to address such as: care at the end of life and the relative lack of supportive and palliative services; we need to address the health literacy of the population which contributes to poor health outcomes; we need to address the motivational issues for people to address health behaviors; we need to reduce waste and medical errors; we need to reduce the practice of defensive medicine and address torte reform. And at a broader level, we need to evaluate health related public policies such as why most schools no longer have daily physical education or healthy cafeterias. Medical care does not equate to good health but access to high quality medical care is critical to good health. We believe Integrated Delivery Systems will play an increasingly important role in achieving the goals of healthcare reform here in Pennsylvania and for the nation at large.