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BERKELEY RESEARCH GROUP, LLC

BEFORE THE PENNSYLVANIA HOUSE HEALTH COMMITTEE

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Thank you for this opportunity to speak to you today. My name is Henry Miller. I am Director, Health Analytics of Berkeley Research Group, LLC. I have worked as a consultant to UPMC Health Plan for the past five years and previously worked as a consultant to Highmark Blue Cross Blue Shield, Blue Cross of Northeastern Pennsylvania and the Commonwealth's Department of Public Welfare. My remarks today focus on the nature and importance of Integrated Delivery Networks and the potential impact of House Bills 1621 and 1622 on the costs and quality of healthcare in Pennsylvania.

I have conducted research and consulted on healthcare issues for more than 40 years. During that time, I observed changes brought about by passage of Medicare and Medicaid, development of managed care and other events that have shaped the U.S. healthcare system. I am actively involved in analyzing the impact of the Affordable Care Act which is rapidly changing the way in which healthcare is financed and delivered.

I have a few key points relating to Integrated Delivery Networks and House Bills 1621 and 1622 that I would like to share with you.

First, consolidation of hospital systems, a long-standing trend, is accelerating now that the Patient Protection and Affordable Care Act is being implemented. In the ten years prior to the passage of the Act, approximately 500 hospitals were acquired or merged with larger hospital systems. In the first three years following the Act's passage, more than 300 hospitals were acquired or merged. In a survey conducted in 2012, only 13 percent of executives at independent hospitals reported that they were not considering a merger or acquisition. Lower margins on patients funded by Medicare and Medicaid and increasing competition for more profitable services from specialty providers are driving the need for consolidation.

The Affordable Care Act is also changing health insurers' environment. The Act requires insurers to spend 80 percent of individuals' premiums and 85 percent of groups' premiums on medical care and

related activities. Just as in the case of hospitals, competition among insurers is up and profits are down. As a result, health insurers are also looking for consolidation opportunities.

Healthcare delivery and finance have typically been separate activities in the U.S., but as health insurers look for new profit opportunities and hospital systems grow larger, the two activities are converging. It's more than Highmark purchasing providers to establish its own network. Kaiser, of course has been both a provider and an insurer since the end of World War II. More recently, United and CIGNA purchased physician practices and physician management companies; Humana purchased a national network of urgent care centers; and WellPoint purchased a network of 26 primary care clinics in California.

At the same time, hospital systems have started their own health insurance operations. We're familiar with UPMC Health Plan and Geisinger Health Plan in Pennsylvania, but there are many others as well. Johns Hopkins Health System in Baltimore owns and operates the Johns Hopkins Health Plan; Intermountain Healthcare in Salt Lake City owns and operates SelectHealth; Sharp Healthcare, San Diego's largest hospital system, has operated its health insurance subsidiary for several years. This year, a survey by the Advisory Board, a national research organization that focuses on hospitals, found that 18 percent of hospital systems already operate their own health insurance company and another 28 percent intend to launch one in coming years.

Integrated Delivery Networks are becoming a key element of American healthcare. More importantly, they offer opportunities for improving healthcare value. Value – better quality at lower prices – is enhanced by competition. Unlike independent hospitals and insurers, Integrated Delivery Networks are judged by **both** the quality of care provided to patients and the cost of coverage purchased by consumers. Their ability to enhance healthcare value at a rate greater than competitors is the primary determinant of their success.

House Bills 1621 and 1622 will constrain Integrated Delivery Networks and limit opportunities to enhance healthcare value rather than promote it. For example, the Bills place responsibility for healthcare pricing in the hands of insurers. If a health care system and an insurer cannot reach agreement, it prescribes choices for an arbitrator to consider. The arbitrator's choices are not choices at all. The first choice – the rate paid by the insurer for similar services to hospitals in its network – would

allow an insurer to negotiate low rates with a handful of hospitals that may be struggling for patient volume and then force other hospitals to accept those rates.

The second choice – the rate paid by the insurer based on its formula for out of network payment – leaves the determination of the rate entirely to the insurer. There is no standard approach for out of network payment to hospitals. If the insurer establishes a formula that pays rates below hospitals' costs, the Bill could require the hospital to accept the rate.

The third choice is the Medicare rate – but nationally, two-thirds of hospitals are paid less than their costs by Medicare. Medicare's overall rate of payment covers only 90 percent of hospital costs for Medicare patients. Medicare payment rates are ultimately set by Congress where the concern is the impact of rates on the Federal budget, not the ability of hospitals to provide quality care.

House Bill 1621 would allow insurers to pay hospitals at rates below their costs, which could initially force hospitals to cut costs at the expense of improving quality and value. Failure to impose cost cutting measures would ultimately result in hospital bankruptcies like the bankruptcy of Allegheny Health Education and Research Foundation (AHERF) that rocked the Commonwealth's healthcare system 15 years ago.

Healthcare innovation is critical to improving healthcare value. Today, innovations in medicine and the delivery of care extend life, improve the quality of patients' lives and improve the ways in which care is delivered. Providers, not health insurers, foster these innovations, but they require financial resources. The proposed legislation gives control over financial resources to health insurers by allowing them to set prices for care. Their desire to compete with other health insurers on the basis of lower premiums will ultimately limit resources available for innovation and will assure Pennsylvanians that their local healthcare system will lag behind states where innovation is encouraged.

House Bill 1621 does not recognize the complexity of insurer/provider contracts. Insurer/provider contracts are complex and include far more than the rates for care. Contracts identify how claims will be submitted to insurers, how medical necessity will be determined, how services provided to patients will be reviewed and many other aspects of the insurer/provider relationship. Moreover, methods of paying for hospital services are complex. Per case payments that may be based on alternative

definitions of cases, per diem payments, percentage of charge payments and bundled payment rates are available to pay for inpatient care. Per visit payment (which also can be based on alternative definitions), fee schedules and percentage of charge payments are available for outpatient services. Because there are so many different ways to address the many aspects of hospital contracts and because both sides will know that arbitration is automatically available, few contracts will be accepted prior to arbitration. Arbitration will be complex and time-consuming and will require arbitrators with unusually extensive knowledge of the insurer/provider contract environment.

There is an ongoing need to improve value in our healthcare system. House Bills 1621 and 1622 purport to add value by regulating the insurer/provider relationship and forcing providers to contract with insurers at rates determined by the insurer. Past efforts to regulate hospital rates have failed. Between 1970 and 1995, 12 states either seriously considered or implemented hospital rate regulation. Eleven of those states abandoned the approach in favor of a competitive system. Only one state (Maryland) retained hospital rate regulation but it has now decided to replace its prior approach with innovations focused on population-based health rather than hospital rate controls. There is no evidence that hospital rate regulation, whether administered by government or by insurers, can improve the value of healthcare.

In fact, research shows that competition, rather than regulation, reduces costs and improves quality. The development of two strong Integrated Delivery Networks in Western Pennsylvania (UPMC and Highmark/West Penn Allegheny) provides an outstanding opportunity to take advantage of the benefits of competition. House Bill 1621 seeks to constrain these systems because they also operate as insurers, but it is because they operate as both insurers and providers that they can compete to provide lower premiums and higher quality care to employers and other purchasers of health coverage.

Healthcare value can and should be improved, but House Bills 1621 and 1622 will make sure that the status quo of higher than necessary health services utilization and the need to improve quality of care will continue. Worse, it will mean that Pennsylvania will lose the opportunity to gain from the improvements in value brought about by competition that the rest of the U.S. will experience in coming years. Pennsylvania can lead the nation in the development of competitive strategies that improve healthcare value. House bills 1621 and 1622 would instead force Pennsylvania to lag behind the rest of the U.S.

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Henry Miller is Director, Health Analytics of the Berkeley Research Group. He has 40 years of experience as a healthcare consultant and researcher specializing in health care finance, public policy and regulatory analysis and strategic planning. In addition, he has provided expert testimony to the U.S. Congress, several state legislatures, in Federal, State and local courts and in arbitration proceedings.

Dr. Miller has directed several public policy and regulatory analysis projects. He served as the economic advisor to the Alaska Department of Insurance in its review of the application by Premera Blue Cross to convert to for-profit status. He also worked with another large Blue Cross and Blue Shield plan to support its efforts to convert to for-profit status. He directed key elements of the work conducted by the Governor's Commission for Rationalizing Healthcare in New Jersey. He assisted several Primary Care Trusts and Strategic Health Authorities in the U.K. as they addressed changes in National Health Service requirements.

Dr. Miller has worked on health insurer/provider contracting issues for more than thirty years. He was a member of the Medicare oversight committee for the effort to develop the practice expense component of the RBRVS physician fee schedule. He assisted CMS on several projects related to the development of the Medicare Hospital Outpatient Prospective Payment System and directed a project to assess opportunities to improve the Medicare Inpatient Prospective Payment System (IPPS) based on DRGs. He has designed hospital, physician and pharmaceutical payment systems for seven Medicaid programs and more than thirty Blue Cross and Blue Shield plans and other health plans. This work has included both in network and out of network payment. In addition, Dr. Miller has worked with more than 50 health plans, including some of the largest plans in the U.S., Blue Cross and Blue Shield plans and regional health plans on varied aspects of their operations, including evaluation of premium rate setting strategies, organizational structure, community relations, provider payment systems, operating systems and strategic planning.

Dr. Miller has directed evaluations of several programs for the Department of Health and Human Services, including programs managed by the Office of Women's Health, the Health Resources and Services Administration (HRSA), the National Center for Health Statistics, the Agency for Healthcare Research and Quality (AHRQ) and the National Institutes of Health. Much of this work focused on delivery and financing alternatives for improving access to care to vulnerable populations. He directed a project that investigated innovative approaches to care management initiated by Federally Qualified Health Centers. He directed studies of research on access to care for disadvantaged, minority and disabled populations for AHRQ. In other work, he developed a strategic plan for a managed care plan for the uninsured and low income populations in Hillsborough County, Florida and designed an innovative delivery system for low income populations in Rochester, New York. His work for HRSA includes evaluations of health care for the homeless programs as well as several federally funded women's and maternal and child health programs.

Dr. Miller received his doctorate in Economics and Accounting from the University of Illinois.