CONSENT DECREEING ADULTS?

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When giants battle, sometimes we mere mortals get trampled. The Consent Decree, the state imposed temporary treaty between Highmark and UPMC, expires as of June 2019. What this means for all practical purposes is that after June, UPMC facilities – with very few exceptions – no longer are in-network for Highmark insurance customers and vice versa. This is a big deal right now. Many seniors have entered open enrollment for Medicare Advantage plans (the private plans that manage many senior's Medicare benefits). If they want managed Medicare, they will have to decide soon which carrier will do the managing. In many cases this means that their choice of insurer may limit their choice of providers. This is a pretty big change for many people who have grown accustomed to being able to see any provider. This is going to mean that for some folks, choosing the plan with the best benefits or price will mean having to stop seeing their usual doctors, or stop going to facilities to which they have grown accustomed.

Let's separate fact from fiction and review some of the impacts to the region and to all employers.

What's Happening

As of July 1, 2019, Highmark members will no longer be considered in-network at most UPMC hospitals and facilities. What this means is that the negotiated rates that Highmark had with UPMC (often 60-85 percent lower that UPMCs actual "sticker" price) will no longer apply. Members will have to pay full charge, if UPMC accepts them as patients, which they are not required to do except in emergencies. Highmark had argued in the courts that the UPMC hospitals should not be considered "truly" out of network as applied to its Medicare Advantage members until 12/31/2019 because Medicare Advantage is a yearly program and members should not be put in a scenario where some hospitals are in for the first half of the year but not the last half.

While courts had initially supported this argument, Highmark lost on appeal by UPMC. UPMC made the case that Medicare Advantage customers should make their choices based on the providers in network for the whole year, and if UPMC was going to be out of network as of 6/30/2019, then that should be a factor in their choice of Medicare Advantage plans. After some back and forth, the Pennsylvania Supreme Court ruled in favor of UPMC stating that the contract ends at the end of 2018 with six months of runout until 6/30/2019.

The choice for many Medicare Advantage enrollees is, "do I keep my insurance coverage and the benefits I am accustomed to or do I keep my doctor?" As the area's largest insurer, Highmark wants people to stick with their carrier, arguing that the new burgeoning Allegheny Health Network is up to the challenge. UPMC on the other hand, as the area's leading health system, wants you to choose your doctor and hospital over the insurer. In a fairly unorthodox move, UPMC announced that Highmark Medicare members who want to use UPMC providers will not only have to pay full charge (a significant mark-up), they would also have to pay "up front." There will be no payment plan options for them. This "cash on the barrel" approach is not typical. It underscores how much UPMC wants to make clear to those choosing Medicare plans the downsides of choosing a plan without UPMC in-network. Through this business decision, UPMC brings home the stark reality of the effect that its split with Highmark will have on the residents of Western Pennsylvania.

Regional and Employer Impact

There aren't a lot of good publicly available data sources that provide quantitative modeling of patient willingness to trade-off insurers vs. providers as it relates to cost (premium vs. copays and deductible). However, you can be certain that over the past few years both Highmark and UPMC have spent a lot of time and effort to try to model patient choice and behaviors so that they can predict how access to providers will affect the way seniors choose their Medicare Advantage plans.

It is worth noting that Highmark wanted to keep UPMC in network for Medicare Advantage in 2019. It is also worth noting that UPMC wanted to make it clear--flamboyantly and painfully clear in fact--that UPMC would not be in network. Clearly, both Giants know that patients are more likely to be loyal to providers than to their insurers. In fact UPMC's "cash on the barrel," unwilling-to-entertain payment-plans policy is meant to underscore the lack of access and create further impetus to move away from Highmark. It is not clear for example that they would apply this kind of draconian restriction on uninsured patients. This policy seems aimed squarely to weaken Highmark, its biggest rival. UPMC has taken pains to point out that other national carriers will continue to access UPMC.

Many seniors face uncomfortable choices this fall as they consider their Medicare Advantage carriers for next year. They can stick with their carrier at the cost of their provider or vice versa. For some individuals, this will indeed be a major adjustment and crisis. In some cases they may see a PCP from one system and a specialist from another making the choice that much harder. One can conjure a mental image of a 94-year-old widow who may now find herself unable to stick with the carrier she is comfortable with because the doctor she has been with for decades is no longer in network. This is not a happy image.

Change is inevitable. Inevitable also is that there will be some who are seriously hurt by that change. This region's health care market is evolving and changing. It is important for everyone in the region, not just the Medicare population, to begin to accept the consequences of the change and begin to decide what they will do.

In some respect, many of us in the region were probably hoping that Mom and Dad would get back together. The expiration of the consent decree and the challenges facing seniors in the market are the equivalent of the moving trucks coming in to take away half the furniture. No one likes moving, no one likes disruptive change when it is foisted upon them. But, as the Greek philosopher Heraclitus once said, "the only constant is change."

The question we should all be asking ourselves now is "what's next?" and "how can we make these changes work for us?" To be sure, there are some risks. There is a chance that as the

systems become more and more separate, the result will be an overinvestment in certain specialties creating redundancy because the separate systems can't share resources. Someone ends up paying the excess cost and it is usually the patients and the businesses of the region. On the flip side, studies have shown the benefits of having care under integrated delivery and financing system (IDFS). There can be better coordination of care in an IDFS and often a better patient experience. Kaiser has used this model for decades and shown that it can result in cost savings, high quality, and high satisfaction.

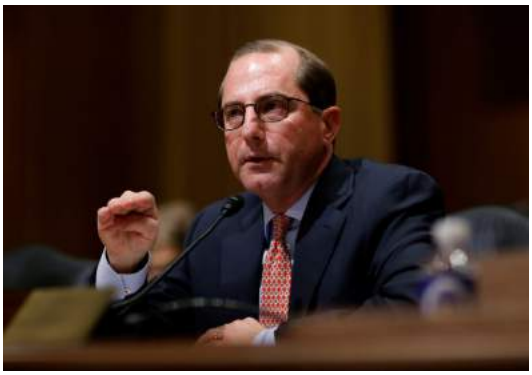
From an employer perspective, limiting access can be a challenge. Whereas individuals can make choices for themselves in Medicare Advantage, employers must find solutions that are flexible and meet many disparate needs. When employees have to deal with difficulty in accessibility and availability due to restrictions on networks, it can add to the overall economic and lifestyle burden on the employee. This is particularly true if employees must go to other cities for subspecialty care needed for particular services.

Employers have a few options. First they can hedge their bets by offering a national carrier option for employees or retirees. This provides access to both systems. Another more complex strategy is to pool buying power with other employers and consider attempts at a directly contracted network. The directly contracted network could be an adjunct to the existing network from your carrier, or it could be a full replacement. By having additional options available, employers can strengthen their position in the market and may have the opportunity to come up with some creative cost and quality programs that meet employee needs. This will take effort and planning, but other large employers around the country are looking at these types of models. It can and is happening.

Conclusion

U.S. Health and Human Services Secretary Alex Azar has stated that Western Pennsylvania is on his radar and they are looking at the consequences of the ruling for all patients. He is looking within the Medicare rules to make sure they are properly applied. Time will tell if they will act and how they may act. In the meantime, do what you can to educate your employees on what is happening and talk to your broker or consultant about what you can do to mitigate the confusion.

As always, PBGH and Tonic Advisors will continue to keep you informed as the issue unfolds.



Health and Human Services Secretary
Alex Azar