Testimony Prepared for Presentation to the

Health and Human Services Committee

Presented by

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Thank you Chairperson. My name is William George and I am President and Chief Executive Officer of Health Partners, Inc. I wish to thank you and the Health and Human Services Committee for providing this forum to articulate our position regarding some of the proposals presented by the Department of Public Welfare (DPW).

Health Partners is a 24-year old, non-profit, hospital-owned Southeastern Pennsylvania plan covering almost 140,000 Medicaid members. Until recently, we also covered 23,000 Medicare Advantage beneficiaries. Health Partners is the second largest HealthChoices plan in the Philadelphia area. Our plan is headquartered in Center City, Philadelphia, and employs over 450 local residents, many of whom are former welfare recipients.

Health Partners' Background

Health Partners was founded 24 years ago by four Philadelphia hospitals who conceived the idea of a prepaid health plan emphasizing primary and preventive care for Medical Assistance recipients.

- The founding hospitals were Episcopal Hospital, the Medical College of Pennsylvania, Temple University Hospital and St. Christopher's Hospital for Children. Health Partners did **NOT** begin as a commercial plan that adapted to a culturally diverse, medically complex population. Rather, our focus has always been on the unique requirements of disadvantaged communities.

- In 1996, Health Partners was one of 17 HMOs selected from 372 plans nationally for the new Medicare Choices demonstration project, and in 2007 we became a Medicare Advantage program with newly-established Part D prescription drug coverage. Senior Partners continued to grow until August of 2007 when our Board of Directors sold the successful line of business to Bravo Health, Inc.
- We hold an "Excellent" accreditation status from the National Committee for Quality Assurance (NCQA) and have received numerous awards and recognitions, most recently for our anti-violence efforts, such as the Human Rights Award from the Philadelphia Commission of Human Relations. We are also the recipients of a "Diversity in the Workplace" Award from the Greater Valley Forge Human Resources Association.
- Most importantly, we are very proud that Health Partners has consistently been the top managed care plan in member satisfaction. For three of the last four years, we've ranked #1 in the Commonwealth for Overall Satisfaction with Plan by members, based on the annual CAHPS survey. In the Delaware Valley, we've been ranked #1 among plans for the past four years.
- Member satisfaction has not come at the cost of providing efficient and effective care. As shown in a 2005 Lewin Group evaluation, Health Partners and the other Managed Care Organizations (MCOs) saved the Commonwealth $2.7 ***billion*** over five years, providing immense value in terms of cost savings, improved health outcomes and improved access for our State's most vulnerable citizens.

As you can see, we have worked very hard over many years, with extensive collaboration and expertise, to be a recognized success for the Commonwealth.

Pharmaceutical Carve Out

We have been successful in our efforts by fully integrating all aspects of health care under our control. Before we make any corrections to plans, we assess the effect that correction may cause on patient care and costs.

For a number of years, both the medical and the insurance industry, as well as consumer-focused trends have all pointed to the value of a fully-integrated, holistic approach to providing comprehensive, coordinated care, as does the Governor's new Prescription for Pennsylvania. The proposal to carve out pharmaceutical services would take our local efforts in the opposite direction, destabilizing the gains made and further innovations under development.

We deeply oppose the pharmacy carve-out. We have significant and compelling constituent-related and financial concerns and arguments for our opposition. Here are the following reasons:

- **Expertise:** If you have ever watched a cooking show, the expert chef can always whip up three fantastic looking and tasting meals in less than 30 minutes. They're prepared with all the appropriate tools, time-tested recipes, pre-measured and in some cases, pre-cooked ingredients, selected after much trial and error. They make it look like a "piece of cake" to replicate. Try that at home in 30 minutes! You're likely to end up four hours later with the kitchen looking like a war zone

and a few disaster dishes to serve. Try doing it seven days a week and you will be the one needing medication.

The managed care organizations are like your TV chefs. We make pharmacy management look simple. We make it seamless for our members, our pharmacists, our providers, the advocates and the State. But behind that seamless system, are people, strategies, study, sensitivity and years of development. It is anything but easy. And remember, this system that we've developed is culturally sensitive, multi-language based, and understands the myriad health care disparities that represent the communities we serve.

- **Costs**: DPW has claimed substantial savings will be realized from a potential carve-out. However, **Rebates** are one of the primary sources of the savings. To obtain the rebate, the State will have to have an enormous use of name brand drugs. At Health Partners, in early 2007, we were successful in converting 72% of our prescriptions to generic dispensing, saving millions of dollars. We expect to improve by 75% by the end of 2008 and our goal is 79% in 2009. Add that savings to those from the other MCOs, and that number in savings is significant. The State analysis looked at 2005 data when plans were 62-63% generic, so the dominator has dropped significantly. Given this scenario, the State will have to REGROUP in terms of their REBATE assumptions. It will have to move some portion of members back to higher cost brand drugs to obtain these rebates. Has the State completed a comprehensive cost-benefit analysis for this? Remember, generics cost on average $15 and name brand drugs average $150 per script. The

money is in driving the generic percentage up – not in maximizing rebates on $150 prescriptions for name brand drugs!

Representatives from DPW announced at a meeting last week with the Delaware Valley Healthcare Council that the Department has just recently reconsidered their earlier position on injectables and infusion drugs, so these high cost drugs would **remain** with the MCOs. If that's the case, then what happens to the assumed savings from the carve-out?

- **Cash Flow**: Rebates, in particular, are challenging to manage: you need the expertise to identify, collect, and follow-up. Rebates also come six to eight months AFTER the upfront costs are incurred, creating cash flow problems. One of the benefits of down-loading this risk is that the MCOs cannot come knocking on the legislative door each month due to cash shortages or payment delays from the pharmaceutical companies.
- **Future Innovations Risk**: New, potentially life-saving and controversial biological products are continually introduced into the market. These products are often immediately needed; sometimes they require more study, particularly in light of local provider preferences and adaptation. Early acceptance of a particularly high-cost product could wipe out all projected savings that the State says it will have, which is a risk the MCOs now assume on the State's behalf.
- **Unintended Cost Consequences:** If a new drug is not adopted, members could end up continuing to use more expensive drugs or less effective drugs resulting in higher medical costs.

- **Access:** The MCOs offer members our services 24 hours a day, seven days a week. At Health Partners, we take 8,000 calls a month from members, providers and pharmacies regarding pharmacy benefits. When a member is discharged from a hospital ER in the middle of the night with a prescription and goes to the 24-hour CVS at Hunting Park Avenue and is told they aren't listed as a Health Partners member, that CVS pharmacist will call our on-call pharmacist, who sees to it that our member goes home with a sufficient supply of that drug to treat his/her urgent medical need. Who is going to do that at the State level for the 900,000 members from the seven health plans? What will be the cost of this service to the State?
- **Call Volume:** As with any health care service, there are inevitably going to be lots of calls from members and providers, in addition to the 8,000 pharmacy calls a month. At Health Partners, we conservatively field over 400,000 calls annually from both members and providers. We have invested in people and phone systems who can handle this volume of calls effectively and efficiently. At Health Partners, like the other plans, we have nine pharmacists, 90 nurses and social workers, three physicians and 50 member services representatives to provide the on-going management of our members. These clinicians make informed decisions on a member's care, using the member's clinical and medication history. Who is going to handle this component for the 900,000 members from the seven health plans? How will the State make informed decisions without the member's clinical and medical history? And, what will be the cost of this to the State?

- **Non-Compliance:** When members don't get the service they need, some complain, some give up. If members give up on drug therapies because they're the wrong products, or they couldn't get the prescriptions filled, or it's just too complicated to figure out, who will incur the cost of that non-compliance? If pharmacy is carved out, it will be the MCOs -- a very unhealthy disconnect. The incentive to solve the problem belongs with the party empowered to solve the problem.
- **Transition Challenge**: Converting 900,000 Pennsylvania Medicaid members from seven MCOs to one State pharmacy plan is even more of a challenge than we all faced in January of 2006 when hundreds of thousands of Medicaid members also enrolled in Medicare were transitioned out of HealthChoices' drug coverage and into Part D. Headlines reported on elderly and disabled beneficiaries unable to obtain their needed medications because of identification, authorization and formulary confusion. Lawmakers were flooded with calls and our own staff worked all New Year's weekend and overtime the following weeks to help manage the crisis for members, many of whom weren't even our members any longer. In some cases, wait times were extensive, benefits could not be confirmed and local pharmacies experienced significant cash flow challenges.

  Another example of the transition challenges is just the time it takes to successfully move members from one system to another. Health Partners took seven months to transition 23,000 Medicare members to Bravo Health by August 1, 2007, and we are still dealing with remaining transition issues. DPW is talking

about transitioning 900,000 members in even less time. That's close to 40 times the amount of members that we transitioned. . . .How will this be done?

- **Exchanges of pharmacy information from DPW to the MCOs:** The Department has indicated that they will give pharmacy utilization data to the MCOs every ten days. Right now we get that information real time and we have no confidence, given the limited resources of DPW, that they will be able to make good on their promise. It took DPW months to get maternity billing to work and months to get the high-cost risk pool to work. We are still waiting for on-line clinical histories of our new members. This was promised in 2007. DPW just doesn't have the manpower and resources. Without timely information, our pharmacy based disease management programs will be flying blind.
- **New identification cards** will be needed for 900,000 members. With 30 percent wrong addresses in the State system, that's some 300,000 members with no card on Day One to help them fill their prescriptions. Remember, these are Pennsylvania's most fragile members – they're diabetics, asthmatics and people living with serious conditions like heart disease, cancer, behavioral health issues and HIV/AIDS. At Health Partners, we have 8,200 diabetics, 11,000 asthmatics, 2,000 members with HIV/AIDS, 4,500 pregnant moms, and 24,100 members being treated for behavioral health issues. Multiply our numbers by seven, and you get an idea of how many people will suffer the most and be on the phone to YOU pleading for their lives.
- **Formulary confusion:** Right now, each plan has its own formulary and process, designed to meet both the plan's objectives and the local needs of members and

pharmacies. They know how to work with the plans in their area. For example, over 60,000 of the 900,000 members affected by this change are diabetics. The HealthChoices plans offer a broad choice of diabetic products on their formularies to meet the needs of its members. The State proposal will limit members' choice. For example, the State will only offer Lilly insulin on its formulary. How will those members who do not use a Lilly product for diabetes become informed of this? With 30% wrong addresses in the State system, that's some 20,000 diabetics who will not know on Day One of this transition whether their diabetic products will be offered. Will a statewide system meet local needs and have the appropriate stakeholders been involved in the design?

- **Choice:** Health care in this country has been based on a system of choice. Employers generally offer their employees choices to meet their individual needs. Medicare offers choices. CHIP and Adult Basic offer choices. Just as in the commercial world, we do not confine those covered under these government programs to one provider. Why would we go in the opposite direction when it comes to pharmaceuticals, which are such an integral component of today's health care treatments? MCOs currently have a broader selection of medications available in selected therapeutic categories than the Access and Access Plus plans. If one plan does not meet a particular member's needs, that member has the opportunity to change plans to obtain the coverage that meets their needs. The one plan fits all strategy eliminates that choice. This will create a barrier to patient-centered care and could drive costs up because members with barriers are much more likely to be non-compliant.

- **Continuity of Care**: Separating pharmaceutical care coordination from medical care coordination makes no sense. If the state chooses to implement a temporary period of approving all pharmaceuticals to assure continuity of care at the onset of such a new program, they could experience cost increases in the first month that eliminate all or a substantial portion of the projected savings.
- **Special Needs**: The lives of our members are complicated and as a result, our special needs unit works constantly to help them navigate through personal challenges to increase their compliance with good health care. Obtaining needed medication is a frequent issue. A good example is a pregnant mother who needs certain drugs to help her carry her baby to term. If there are problems, the mother may give up and produce a premature baby that spends 15 or more days in the NICU. The result is a higher Medicaid cost to the MCO that could have been avoided with better care coordination.
- **Provider Compliance**: We have a coordinated effort between our pharmacists and our provider relations efforts to gain their support in achieving proper drug compliance. For example, we are now working on a special Hepatitis C project. While studying provider behavior, we found that we had one specialist with only 50 percent member compliance with Hepatitis C drug regimens while one of our PCPs has 80 percent compliance. Compliance prevents a potential liver transplant and the thousands of dollars in associated costs. We've worked with that specialist on an individual basis, and are also developing best practice guidelines. Our pharmacists will then be conducting individual outreach to assure increased rates of compliance with all of our physicians treating these targeted patients.

Without timely data, this compliance management won't happen and costs will increase.

In summary, we believe that segregating pharmaceutical care from medical care is the wrong direction for the Commonwealth. It is not true reform. It is a regressive action that will drive up both short term and long term medical costs. It is not in keeping with the laudable goals of Prescription for Pennsylvania. If we are truly seeking affordability, accessibility and quality for all Pennsylvanians, then the pharmacy carve-out is not an option. When you consider all that has been presented today, consider the proposed pharmacy carve-out savings of $9 million to really add up to a huge deficit for the State's most vulnerable – Your constituents. Please say no to the Pharmacy carve-out. Thank you.