
# Testimony before the Senate Banking and Insurance Committee

Public hearing to review the dispute between University of Pittsburgh Medical Center (UPMC) & Highmark

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University of Pittsburgh
William Pitt Union Lower Lounge
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Good morning Chairman White and members present. I would like to thank the Senate Banking and Insurance Committee for hosting this important public hearing and extending an invitation to all senators located in the region that are impacted by this issue. It is my hope, as I am sure it is yours, that this hearing as well as future hearings scheduled on this topic will serve to educate both elected officials and the public on the facts of the contract dispute between Highmark and UPMC.

It is not my role as a regulator to speculate; therefore my comments will focus on the Insurance Department's involvement in the disagreement between Highmark and UPMC to date and what authority we currently have in the review of a contractual dispute such as this.

Since the Insurance Department's core function is to protect consumers, we have maintained ongoing communication with both Highmark and UPMC, encouraging them to come to a resolution for some time. While we generally do not comment on pending regulatory matters, I can say that we have met with both parties a number of times. We have urged them to stop the negative attacks that have resulted in nothing more than heightening fear and confusion for consumers.

Since the contract dispute began garnering public interest, the Insurance Department's Bureau of Consumer Services has logged approximately fifty formal complaints or inquiries on the topic and has informally received many more expressions of concerns from consumers and businesses, so it is evident uncertainty and distress exists with the public in this region. Rhetoric used by both of these key community players has been alarming and its disruptive effect needs to stop. Both Governor Corbett and I are concerned about this matter and are actively monitoring its impact upon consumers.

Let me address some basic points about the contract dispute:

- First, it should be noted that the current contract does not expire until June 30, 2012. Following that, there is an additional year of run-off when Highmark customers will still be able to access at least UPMC hospitals. We have asked UPMC for clarification about continued access to UPMC physicians during the one year run-off. We have also asked if UPMC intends to treat CHIP enrollees receiving care through Highmark as commercial members, therefore making them ineligible for in-network coverage.

- Second, the current contract does not involve all of UPMC. Certain UPMC hospitals are under separate contracts which expire after 2012. These hospitals include Hamot Medical Center, Children's Hospital, and Mercy Hospital.

- Third, we understand from both Highmark and UPMC that any contract termination, should one occur, will not impact Medicare beneficiaries who are in Highmark's Medicare Advantage Plan. Nor will it impact Medicaid beneficiaries.

- Lastly, in the event of any termination, Highmark subscribers who are either in a UPMC hospital or undergoing treatment through a UPMC physician at the time will continue to be able to access that care until they are discharged or their treatment is completed.

Given that there is almost a year before the current contract expires, both parties are aware the Insurance Department expects them to use this time constructively. In addition, they must provide accurate, non-inflammatory information to the public throughout this period. While the Insurance Department does not have binding authority to force the execution of an agreement, we will continue to talk with both of them and stress that a reaching a resolution prior to the contract ending is preferred. Above all, we have asked both companies to act in a way that keeps the best interests of Western Pennsylvania consumers in mind.

It is our hope that this dispute will be resolved prior to June 30, 2012. However, we realize the importance of communicating what consumer safeguards can be triggered in the event an agreement is not reached by this date. Should this occur, certain information must be filed with the Insurance Department and a full regulatory review process will follow. The Department is committed to keeping consumers informed of developments throughout such a review.

The Insurance Department's statutory authority in contract issues such as this is contained in Act 94 of 1975 ("Act 94"). Act 94 governs the maintenance of contractual relations between hospital plan corporations ("Blue plans") and hospitals. Act 94 was enacted to stabilize the relationship between the Blue plan and the hospital and to see that services are available to subscribers and will continue to be available to subscribers who pay premiums. In fact, Act 94 was enacted following the highly disruptive impact of the expiration of a contract between a Blue Plan and a group of associated Philadelphia hospitals.

Act 94 requires that a party provide the Department "90 days advance written notice" of the end of a contract. Generally, these termination notices are for negotiation purposes only. The parties tend to reach an agreement on new contract terms without the contracts expiring or terminating, or the parties agree to a contract extension prior to the deadline.

If the termination involves a contract with hospitals having more than 5 percent of the beds in the area served by a Blue Plan, the Department has the authority to step in and "suspend" the termination of the contract after the 90 day notice period expires. In the past, the Department

has forwarded letters to the parties indicating that if a contract is not in place by 11:59 p.m. on the last day of the contract, the terminations will be suspended pursuant to Act 94.
The termination is suspended for a period not to exceed six months, pending completion of an investigation by the Department.

The Department also uses this to trigger a "cooling off" period between the companies while also beginning the process to re-engage, sort through, and resolve their issues. During this time we would act as a facilitator and conduct public hearings for the purpose of investigating the reasons for the termination. Notice of any public hearing would be published in the Pennsylvania Bulletin. At least fifteen days notice will be given.

Based on the record made during the hearings, the Department will make specific findings about the facts of the dispute. We would either approve termination of the contract or recommend terms for continuation of the contract that would be in the best public interest.

In making our determination, we would consider: (1) whether the continuation of the contracts is in the public interest; (2) the rights of a hospital to be paid its costs for hospitalization services; and (3) the needs of subscribers for efficient, reliable hospitalization at a reasonable cost.

If the Department recommends that the contract should continue, the Blue Plan and the hospitals will renew their negotiations to determine whether a new agreement can be reached based on the terms the Department recommends. Pending those negotiations, the termination of the hospital contracts will be suspended for another period not to exceed 90 days from the date of the decision of the Department.

Based on the current statute, if the parties cannot agree on a new contract within the additional 90 day period, they will inform the Department. At that point, we would approve termination of the contract which would then expire after 30 days. We would prescribe the form and extent of notice which the Blue Plan will use to advise its subscribers. This notice would also highlight that hospitalization in the hospitals involved is not covered by a contract between the hospital plan corporation and such hospitals.

I do want to be clear that since its enactment in 1975, the Department has only invoked Act 94 twice. I would also note that the Department has been aware of many highly adversarial contract renegotiations and has heard before that a termination was inevitable. However, in all but two of those cases the parties reached an agreement of some type. In 2008, the Department suspended the termination of the contract between Conemaugh Health System

and Highmark. The parties reached a mutual agreement before a hearing was scheduled. Before that, the Department invoked Act 94 in 1996 in a matter involving Capital Blue Cross and St. Joseph Medical Center/Community General Hospital. Even in the two cases where Act 94 was triggered, the parties ultimately came to an agreement before a public hearing required by Act 94 was held.

If you take the information I have provided and apply it specifically to the Highmark/UPMC dispute, you can pull together an estimated timeline of anticipated events. For example, if the Department would need to intervene, it would do so on June 30, 2012. The contract termination would be suspended for a period not to exceed six months, which would be no later than December 30, 2012. Further periods of negotiation under Act 94 would extend any termination until at least the end of April in 2013.

Again, I would note that we understand the current UPMC/Highmark contracts contain a one year run-off, so a Highmark subscriber will continue to be able to access these hospitals through June 30, 2013.

While this timeline may be helpful to anticipate what to expect in a worst case scenario, I want to again reiterate that the Insurance Department strongly encourages and prefers Highmark and UPMC to resolve the dispute before arriving at this juncture. Nonetheless, while we will continue to hope for the best, we will also start planning for the worst. The Department played an active role in the separation of Highmark and Capital BlueCross in 2001 that led to minimal consumer disruption in Central Pennsylvania. The dispute between Highmark and UPMC has the potential to be far more disruptive to consumers even with Department involvement. Accordingly, if the parties cannot reach agreement on a full contract renewal, at the very least we would urge UPMC and Highmark to consider an extended transition period that allows for more than one year of planning and adjustment for consumers, businesses, and medical providers in this area.

One important item to mention is that should the end result be the expiration of a contractual relationship between Highmark and UPMC, it is the Department of Health that would then monitor and oversee any impact on network adequacy.

The proposed acquisition of West Penn Allegheny Health System by Highmark often becomes enmeshed in the Highmark/UPMC dispute. However, from a regulator's standpoint, the review process between Highmark and West Penn and Highmark and UPMC are distinct. It is our understanding that we will receive a filing from Highmark sometime this month. It will likely be a transactional filing. The standards for reviewing such transactions do contemplate consumer

comments and input, including public hearings organized by the Department. We will update both the community and the legislature on any developments pertaining to this proposal, so keep an eye out. But as of this date no filing has been submitted to us for review, so we cannot formally comment any further.

I would like to end by reinforcing that the Insurance Department is committed to working with both Highmark and UPMC to reach a resolution that is in the best interest of consumers. While rhetoric has heightened fears in the region, it is important for you as an elected official to provide clarity for your constituents. Should they need assistance, please direct them to our consumer services office. We are enhancing our health insurance information area and will shortly have a unit dedicated solely to health questions. Our toll-free hotline is 877-881-6388. Additionally, we are in the process of creating a page on our website devoted to clarifying the contract dispute which will include a copy of my remarks from today and consumer FAQs, so please visit <www.insurance.pa.gov> for more information moving forward.

Equally as important is encouraging your constituents – key influencers in the dispute – to convey their concerns directly to both Highmark and UPMC. It is the consumer's voice that should be heard loudest by both parties.

At this time I would be happy to take any questions from the members present.