TESTIMONY BEFORE THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

Public Hearing on the Contract Termination Between

Highmark and the University of Pittsburgh Medical Center

Presented By:

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Secretary

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Good Morning. My name is Eli Avila, and I am the Secretary of the Pennsylvania Department of Health. I am joined today by Michael Wolf, Executive Deputy Secretary and Acting Deputy Secretary for Quality Assurance, as well as Bill Wiegmann, from the Bureau of Managed Care.

I want to thank Chairmen Vance and Kitchen and the Senate Public Health and Welfare Committee for the invitation to explain the role of the Department of Health regarding the contract impasse between UPMC Health System and Highmark.

The mission of the Pennsylvania Department of Health is not only to promote healthy lifestyles and prevent injury and disease, but also to protect public health by ensuring the safe delivery of quality health care for all Commonwealth citizens.

Over the next few minutes, I will explain the Department's role in protecting the health of the citizens affected by the Highmark and UPMC impasse; but, before I do, I'd like the opportunity to highlight several key points:

- Like the Insurance Department, the Department of Health believes the two parties should continue to negotiate and reach a settlement equitable to both parties;
- The Department has certain targeted oversight authority and, as the public health agency, we are deeply concerned about how this dispute could impact the access to specialty care in the region such as Hillman Cancer Center, Magee-Women's Hospital of UPMC and Western Psychiatric Institute and Clinic of UPMC; and
- Third, I want to stress that we understand and have prioritized this as an unprecedented and critical matter. Although the Bureau reviews 20 or so of these potential "health plan – hospital terminations" each year, none are of the magnitude presented by the loss of the UPMC Health System facilities and physicians from the Highmark network. Therefore, we will be vigilant about serving our mission. We have already begun conducting meetings with concerned organizations to gather stakeholder input.
- Finally, I would like to clarify how the Department of Health considers the UPMC Heath System in the current situation. UPMC consists of 14 acute care

hospitals, a number of specialty facilities, and nearly 3,000 physicians that comprise a significant proportion of Highmark's network in western Pennsylvania. It is this system of providers that is involved in the current contract impasse. In 2002, Highmark entered into an agreement separately with each hospital of the 14 hospitals that make up UPMC as a provider. Those UPMC hospitals that are contracted to and credentialed by Highmark make up part of Highmark's network that it offers as part of its insurance products. Also supporting these insurance products are the UPMC physicians. We are seeking clarification from Highmark on these physician contracts and their expiration or termination dates.

In the current state of affairs, the DOH's Bureau of Managed Care has regulatory authority over Highmark's HMO and PPO lines of business and network access. The DOH can require Highmark to take corrective action if problems with network access arise.

The UPMC Health Plan is a separate entity which consists of commercial HMO, HealthChoices, CHIP, Medicare and PPO lines of business. The UPMC Health Plan is NOT involved in the impasse with Highmark.

Then there is the UPMC Health System which is a vertically integrated health delivery system operating as a non-profit entity. The DOH does regulate some aspects of the UPMC Health System through the Healthcare Facilities Act. However, the DOH does not have regulatory responsibility for non-profit entities, nor does it get involved with questions of monopolies or restraint of trade, nor does it review or approve the business transactions of for profit, or not-for-profit entities, which includes the UPMC Health System.

The Department of Health has three defined areas of regulatory oversight in a situation like the one we are discussing today:

- Monitoring health plans for network adequacy;
- Ensuring continuity of care; and

- Monitoring PPO network adequacy.

Please allow me to explain all three roles.

Network Adequacy: Under Article 21 of the Insurance Company Law of 1921, relating to Quality Health Care Accountability and Protection, which is commonly known as Act 68 and its managed care regulations, the Department of Health is responsible for monitoring managed care plans for network adequacy. This includes a review of the network when the plan first becomes certified to operate and then when it adds counties to its approved service area. The Department also reviews the sufficiency of a plan's provider networks when it loses an acute care hospital or a large provider group.

Recent press coverage estimated that more than 3 million individuals insured by Highmark could be affected by the potential loss of the UPMC facilities and physicians from Highmark's network. However, it is important to note that the Department's oversight of Highmark affects only a portion of these individuals. Under Act 68 and the HMO Act, the Department monitors Highmark's HMO, Keystone Health Plan West, and reviews network adequacy for CHIP beneficiaries in conjunction with the Insurance Department. Under the PPO Act and regulations, the Department is tasked with reviewing network access for PPO enrollment. However, the Department of Health does not have the ability to review the networks for other Highmark lines of business: companies that self-insure with Highmark, those covered under the Federal Health Benefit Plans, or those insured under Highmark's traditional indemnity business.

Under the managed care regulations, a managed care plan must notify the Department of the loss or potential loss of an acute care hospital, or a provider group with 2,000 or more assigned enrollees. When a managed care plan notifies the Department of Health of the potential loss of an acute care hospital or large provider group, the Department requires the plan to submit an impact analysis. The plan must identify what hospitals are lost, along with any special service units such as NICU, burn, transplant, or cancer units. It then must identify what

facilities remain in the network, and how far these facilities are from the facilities that will no longer be in the network. The Department needs to know this because, under the managed care regulations, a plan is required to provide members with access to covered services within certain parameters.

The plan must also explain how it will provide the special services that are to be impacted by the loss, although the regulations allow for some flexibility in this area. For infrequently utilized health care services, such as transplants or burn care, a plan may provide access to non-participating health care providers or contract with health care providers outside of the approved service area.

In addition, the plan must provide the number of primary care physicians (or PCPs) and specialists that will no longer be available due to the termination. This includes the number of members associated with every PCP and specialist who will no longer be in the network as of the effective date of the termination and the number of specialists and PCPs remaining in the network who can provide services for the PCPs and specialists that were lost. This is intended to demonstrate that there is sufficient capacity of these physicians to absorb the number of members being displaced.

Right now, the status of Highmark's future network is still very fluid. Ideally, the Department would like to see a resolution between Highmark and UPMC where the two parties would continue to work together. If it is ultimately determined that such a resolution is not possible, then the Department will need a full information set including clarification from Highmark when the facility contracts end and when the physician contracts end.

For most of these network adequacy questions, it is too early in the process to do any kind of analysis. It is unclear at this point if the proposed Highmark and the West Penn – Allegheny Health System agreement will reach fruition and, if they do, what will be included in the arrangement. Furthermore, discussions continue regarding Children's Hospital of Pittsburgh and whether or not it will leave the network at the same time as other UMPC hospitals. The same is the case for the UPMC Mercy campus and the Hamot Medical Center in Erie. It is not clear whether

the physician contracts will terminate as of June 30, 2012 similar all hospital contracts will terminate as of the same date or August 31, 2012. There may also be an option for the hospitals to continue for an additional year in the network before those contracts terminate.

If, for example, the termination date for either the hospitals or physicians (or both) is June 30, 2012, then by no later than January 31, 2012, Highmark will need to provide the Department with a detailed impact analysis of the loss of the UPMC hospitals and physicians. Highmark will need to identify the facilities that will be lost, including special service units such as NICU, burn, transplant, cancer, etc. Highmark will then be required to identify the remaining hospitals in its network, explain how lost campuses and special services will be and are being replaced, then provide information regarding the number of miles these facilities are located from those that will be dropped from the network. The Department will use this information to ensure that regulatory requirements for access are being met.

Finally, due to the magnitude of potential impact from this dispute, this will be a very complex review. For this reason, the Department, working in conjunction with the Insurance Department, will also be asking Highmark for a staffing plan so that we know that the company has sufficient trained staff available to answer all the questions that are going to be raised by members.

Continuity of Care: Under the law, when a managed care plan terminates a hospital or large provider group, the plan is required to offer members continuity of care in treatment for up to 60 days, and pregnant women must be offered continuity of care through delivery and the post partum period.

While the Department understands that this is not a contract termination on Highmark's part, given the large amount of disruption that will occur with this transition, the Department of Health will ask that Highmark provide continuity of care as outlined in the law. We believe continuity of care is vital in order to provide minimum protection to members, especially for people who will need to find a new provider, as well as women who are pregnant and near their delivery date, or who have just delivered.

Although we will make this request of Highmark, we will within our mission to ensure adequate access to care – also be asking UPMC to not take unfair advantage of this situation. We ask that they continue to provide services to these individuals under the same terms and conditions currently in place with Highmark.

PPO Network Adequacy: Although the PPO Act and regulations allow for a network review of non-gatekeeper PPOs (which are PPOs where you don't have to go to a PCP to get referred for specialty services), the Department's authority is less clear with regard to managed care plans. However, over the past several years, as enrollment in PPO plans has increased, the Department of Health has moved closer to the Act 68 network requirements as a guide to network adequacy for non-gatekeeper PPOs.

In addition, for several years the Department has taken the position that a PPO cannot have an out-of-network penalty for a covered service for which there is no available participating provider. So, in the case of Highmark, if the loss of UPMC Health System severely reduced the size of a PPO network so that beneficiaries were forced to use a non-participating provider because no in-network provider were available, the Department would consider a prohibition on greater out-of-pocket cost than they would have incurred if they went to a participating provider.

Conclusion: In conclusion, the Department of Health has great concern for the disruption that could occur to a vast number of individuals in western Pennsylvania if Highmark and UPMC terminate their contract. The Department stands ready to act with the Insurance Department within its scope of authority to minimize the amount of disruption. The Department will continue to be involved, per its mission, to guide the overall process as it relates to protecting public health and assuring access to care and will exert its oversight over the lines of business it is empowered to regulate under the laws relating to managed care plans. We are still hopeful that the two parties will reach an agreement. However, if an agreement cannot be reached, we will work with UPMC to ensure minimal interruption to provided services and are prepared to require from Highmark a rigorous impact analysis demonstrating the effects of the loss of UPMC from its network, and the capacity of

its remaining or revised network to provide services to the citizens of western Pennsylvania.

Thank you again for the opportunity to speak with you today. That concludes my testimony, and we will be happy to take any questions.