UPMC LIFE CHANGING MEDICINE

Statement of *W. Thomas McGough, Jr.*
Senior Vice President and Chief Legal Officer, UPMC
Before the Pennsylvania House Committee on Health
December 18, 2013

I am Tom McGough, Senior Vice-President and Chief Legal Officer of UPMC. Thank you for this opportunity to speak to House Bills 1621 and 1622.

I'll begin with the opening paragraph of a statement issued by UPMC's Board of Directors on June 12, 2013:[1]

> ***UPMC's Mission is to serve our communities by providing outstanding patient care and to shape tomorrow's health system through clinical and technological innovation, research, and education.*** *Within the comparatively short life of UPMC, this critical Mission has been advanced with levels of effectiveness and impact that probably are unsurpassed in the history of modern American medicine. Today, UPMC is widely recognized as one of the top academic medical centers in the world. The beneficiaries of UPMC's success include the patients we serve, the communities in which we work and the health of human kind.*

Today, UPMC provides health care to millions of patients annually. In Western Pennsylvania we are the clear provider-of-choice, and draw our patients from all over the world. UPMC currently cares for 40 percent of the patients in our region, and provides nearly 62 percent of the hospital charity care there.[2] In the last fiscal year, UPMC provided $887 million in IRS-defined "Community Benefits," made up of $268 million in charity care and unreimbursed amounts for programs for the poor, $238 million devoted to improving health and quality of life in our region's communities, and $381 million spent on research and education.[3]

To put that total number of $887 million in perspective, it is nearly twice the $470 million budget of the City of Pittsburgh,[4] and roughly three times the total federal, state, and local taxes that UPMC estimates it would pay were it a for-profit company.

Most of the credit for these accomplishments goes to the 60-some thousand people who earn their livings at UPMC. But a significant portion of that credit goes to our Board of Directors, 24 civic leaders[5] who volunteer their time and represent a broad cross-section of the communities and constituencies we serve. Although the Board's membership has changed over time, that body has consistently defined UPMC's mission and provided the strategic vision to fulfill that mission.

That Board also shoulders a fiduciary responsibility to ensure that UPMC's charitable mission is pursued relentlessly and that its charitable assets are guarded zealously. That responsibility has never been taken lightly. If you read none of the other materials we have submitted, I would ask you to read the Background Statement to the Resolution adopted unanimously by the Board on June 12, 2013. It contains a fascinating, and sobering, review of the last 20 tumultuous years of health care in Western Pennsylvania.

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That history reminds us that during those two decades Western Pennsylvania has seen the rise and ultimate failure of two major health systems, AHERF and West Penn Allegheny Health System. The AHERF implosion in particular had seismic effects across the Commonwealth, especially in Philadelphia, and remains the largest bankruptcy in the history of health care.

During that same time period numerous community hospitals failed or have found themselves on the brink of failure. Add to those examples the massive changes and challenges that are now confronting every hospital and every physician across the country and the message to our Board is clear: Providing world-class health care, academic excellence, and economic energy to a region is a complicated and challenging endeavor.

Fifteen years ago the UPMC Board made one of its wisest and most far-sighted decisions: creating the UPMC Health Plan. At the time that insurance arm was formed, numerous critics, including Highmark, publicly stated that UPMC's integrated payor/provider model could not and would not work—that UPMC was destined to be another AHERF. Those critics, especially Highmark, have been proven wrong. As you have heard today, UPMC's integrated model is widely recognized as a highly effective way to deliver medical value, and is now being imitated by organizations across the country, including Highmark.

For 15 years, however, the UPMC Health Plan has been a competitive thorn in Highmark's side, the principal threat to its insurance dominance in Western Pennsylvania. Highmark has responded to that threat aggressively and relentlessly, deploying one strategy after another to drive UPMC out of the health insurance market.[6] So far, none of those strategies has succeeded.

Instead, as Diane Holder has pointed out, the UPMC Health Plan has grown and Western Pennsylvania now has an "ideal" competitive environment for health care.[7] In three short years the region has moved from one of the least competitive markets—with one dominant insurer and one increasingly preferred provider—to one of the most competitive—with Highmark and UPMC each offering narrow network plans featuring their respective health systems and several national insurers competing to offer networks with the best of both systems. It is no wonder that media outlets are reporting on the "price war" for health insurance in Western Pennsylvania.[8]

For the region's hospitals, however, this has been a mixed blessing. When Highmark acquired West Penn Allegheny it touched off what the Pennsylvania Insurance Department has called a "zero sum game" for hospital admissions.[9] To put it bluntly, Western Pennsylvania simply has too many hospital beds, and any gain in admissions at one hospital must come at the expense of other hospitals.

According to plans Highmark filed with the Insurance Department earlier this year, it must increase annual admissions at West Penn Allegheny by more than 41,000 patients if it is going to save that now-struggling system.[10] Note that it must do that whether or not UPMC gives it a contract.[11]

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Highmark has even specified the hospitals from which it intends to take those admissions. Unfortunately, the chart made public by the Insurance Department was and remains redacted as to the number of admissions Highmark plans to steer away from each targeted hospital, but the total of 41,135 is crystal clear:[12]

Table 24
Projected Source of WPAHS Incremental FY17 Admissions

Hospital	Grant Thornton Estimate Admissions	% of Total	Harris Alternative Estimate Admissions	% of Total
Total	*41,135*		*41,135*	
UPMC	[redacted]			
Butler				
St. Clair				
Excela Westmoreland				
HV Sewickley				
Excela Latrobe				
Uniontown				
Washington				
Other				
Undetermined				

As unsettling as this chart is for the region's hospitals, including UPMC, employers and consumers are quickly adapting to this newly competitive environment. As has been widely reported, major employers like Westinghouse, American Eagle Outfitters, Dick's Sporting Goods, PNC, BNY Mellon, Education Management (EDMC), and even the City of Pittsburgh are offering their employees attractive alternatives to Highmark insurance,[13] and while the enrollment data won't be complete until after the first of the year, it appears that employees are taking full advantage of these new options. Meanwhile, UPMC's conversations with employers around the region confirm that virtually all of them will be offering their employees an insurance option that includes in-network access to UPMC by the time the existing contracts between Highmark and UPMC expire at the end of next year.

House Bills 1621/1622

Other witnesses have described or will describe how an integrated model for delivering health care can improve outcomes, both economically and medically. In fact, the nation has now had more than a decade of favorable experiences with hospitals getting involved in the insurance business—Kaiser Permanente, Intermountain Health, UPMC, and Geisinger come to mind. But only when a powerful Pennsylvania insurance company, Highmark, began to get involved in the hospital business did HB 1621/1622 appear. And when they did appear, it turned out that the sponsors saw a problem with, of all things, hospitals getting involved in the insurance business.

Rather than reiterate points made by others about how HB 1621/1622 aren't the right prescription for whatever supposedly ails IDFSs, I'll turn to some other justifications that have been offered for the legislation and point out that it is a bit like snake oil: heavily promoted as a cure for a host of supposed market ailments but in fact curing none of them.

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A. "Access"

In perhaps the most widely disseminated justification for HB 1621/1622, proponents have argued that it would guarantee various forms of access ("affordable" access, "open" access) for various populations (Highmark subscribers, holders of any insurance card, everyone) to UPMC facilities and services.[14] Before examining that argument, it is important to understand what the exact state of "access" to UPMC facilities and services will be when the Highmark contracts expire at the end of 2014. In overview, by January 1, 2015, virtually every insurable resident of Western Pennsylvania will have the option of choosing affordable, full, in-network access to UPMC, and the small faction that can't or don't want to choose in-network access for a particular UPMC facility will have full out-of-network access.

The arithmetic is straightforward: Medicare and Medicaid subscribers, who represent approximately 50 percent of the insurable residents, are already guaranteed in-network access to UPMC after the contracts expire. Add the individual policyholders who will shop on the exchanges and the group plans that now offer or soon will offer insurance alternatives to Highmark, and the number of residents who won't be able to choose in-network access to UPMC will be rapidly receding toward zero. Under the terms of the contract extension brokered by the Governor in 2012, moreover, even those subscribers who choose or are required by their employers to keep Highmark insurance after 2014 will have in-network access to Children's Hospital of Pittsburgh, Western Psychiatric Institute & Clinic, UPMC Northwest, UPMC Bedford Memorial, and any cancer services unique to UPMC. UPMC is also committed to ensuring that Highmark members have in-network access to UPMC Altoona, UPMC Hamot, and UPMC Horizon for all Highmark insurance products. And, of course, Highmark subscribers will have full out-of-network access to all other UPMC facilities and services. As can be seen, everyone in Western Pennsylvania will be able to access UPMC if they choose, with almost all of that access being in-network.

Turn then to the argument that HB 1621/1622 will somehow improve on this situation by guaranteeing "affordable" access to UPMC for Highmark's remaining subscribers. In fact, with or without this legislation, Highmark will never again allow its subscribers to use UPMC affordably.[15] On the contrary, now that it must shift tens of thousands of patients per year from UPMC to West Penn Allegheny or lose its $2+ billion investment, it has no choice but to steer its subscribers away from UPMC by making UPMC too expensive for them to choose. It could do this by network design, by "tiering and steering," or by deploying innumerable other techniques like increased co-pays, deductibles, co-insurance and out-of-pocket maximums. The only certainty is that Highmark will, in fact, render UPMC unaffordable for those who have Highmark insurance.

A variation on this theme is that the bills would somehow guarantee some undefined class of people access to UPMC's "charitable assets." In recent weeks Highmark has been running an increasingly aggressive, even disturbing, series of advertisements attacking UPMC's stewardship of those charitable assets, including its hospitals, and suggesting that HB 1621 and 1622 will impose additional obligations on nonprofit institutions like UPMC.[16] In fact, those bills do not deal with—or even acknowledge—the complex fiduciary responsibilities borne by nonprofit hospitals and instead treat nonprofits identically to for-profits, requiring both to enter into contracts with insurance companies at regulated rates regardless of whether those contracts will preserve or dissipate the provider's assets.

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A final species of the "access" argument attempts to leverage off the plight of a group of subscribers to Highmark's "Community Blue" health plan who found themselves unable to get treatment at UPMC because of Highmark's limitations on that plan. According to several of the bills' promoters, UPMC has denied those patients access to its doctors and facilities, supposedly because they have the "wrong" insurance carrier, "even if they are willing to pay cash."[17] Pointing to this caricature of UPMC's well-publicized decision not to offer non-emergent, out-of-network services to Highmark's Community Blue subscribers because of the unique features of that plan—including its prohibition on "balance billing"—those promoters then state or imply that HB 1621/1622 would somehow force UPMC to treat those subscribers out of network.[18]

In fact, HB 1621/1622 would not change anything about that situation, which hinges on the narrowness of the Community Blue network. Highmark specifically designed that network to exclude certain UPMC hospitals and services so that the plan's subscribers would use West Penn Allegheny or other parts of Highmark's captive health system, Allegheny Health Network. The underlying contracts also placed an additional obstacle in the path of Community Blue subscribers who wanted to use UPMC facilities or services: a prohibition on balance billing.[19]

HB 1621/1622 would alter none of this; those bills leave insurers completely free to exclude providers from their networks as they see fit. Nor do those bills deal at all with services that aren't included in the contracts between the insurer and the provider, i.e., "out of network." So even with HB 1621/1622 Highmark could still structure its contracts and construct its networks any way it pleased, and UPMC could still decide whether and on what terms it would treat non-emergent patients out of network.

There is, however, an important and happy coda to the Community Blue controversy: On December 31, 2014, that plan's prohibition on balance billing will expire, and thereafter its subscribers will have full, out-of-network access to UPMC.

B. Consolidation of Health Care Systems

A different reason offered for enacting HB 1621/1622 is the perceived need to deter a supposed wave of provider consolidations. One of the bills' sponsors asserted at a recent press conference that "dominant providers are buying up community hospitals it seems every week, buying up doctors' offices every week." Another proponent argued in a letter to House members that "Large healthcare systems are consolidating at unprecedented rates . . . buying out countless physicians' offices, satellite hospitals, outpatient care facilities and urgent care centers[,] . . . Acting almost as local healthcare monopolies . . . ."[20] Highmark, meanwhile, asserts through its thinly disguised Coalition for Healthcare Choice that HB 1621 and 1622 "will ensure that any dominant hospital will not be able to demand unreasonable rates from insurers, which raises the overall cost of care."[21]

In fact, HB 1621/1622 say nothing at all about provider consolidation, large healthcare systems, or dominant hospitals. Instead, they impose their onerous regulations, including governmentally set rates, on any hospital—of whatever size—that offers a health insurance program—of whatever size—in competition with established insurers—like, say, Highmark. As Diane Holder and others have pointed out, this transparent attack on a health system's opportunity to offer its services directly to patients is not only a very bad idea, but bad public policy benefitting no one, except, of course, Highmark.

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C. Lowering the Cost of Health Care

According to one of the bills' sponsors, HB 1621/1622 are intended "to bend the curve on cost" in the market for health care. It would supposedly do this by capping the rates paid to hospitals and physicians by health insurers like Highmark at levels far below what those insurers could obtain through arms-length negotiation. Diane Holder and others have explained why this sort of rate regulation has failed everywhere it's been tried. But even if such governmental intrusion into the market actually kept the rates paid to hospitals low, the proposed legislation says nothing at all about how much of those savings the insurer must pass on to the consumer through lower premiums, which would presumably be set at whatever level the insurer thinks the market will bear.

If there is one lesson that Western Pennsylvania has learned over the last decade, however, it is that a dominant insurer like Highmark can force very low rates on doctors and hospitals and then raise premiums to consumers without any real restraint, thereby earning tremendous profits and amassing billions of dollars in reserves. Indeed, in a provision only a dominant insurer could have dreamed up, section 806(j)(2)(iii) of HB 1621 actually prohibits an integrated system from using any operating margin made on the provider side to "subsidize" the premiums charged on the insurance side. Apparently, if the hospital side of the system actually thrives, the organization would actually be forbidden from passing the efficiencies along to consumers.

D. The Law of Unintended Consequences

To the extent that some believe that HB 1621/1622 merit consideration as a lever to force UPMC to give Highmark the long-term contract it so clearly covets, I would suggest consideration of the law of unintended consequences. The Insurance Federation of Pennsylvania pointed out in its presentation that a contract between Highmark and UPMC would combine into a collaborative relationship the region's dominant insurer, its second-most dominant insurer, its dominant provider, and its second-most dominant provider. That combination would control virtually all of health insurance and virtually all of health care in Western Pennsylvania, a result with profound antitrust implications, and would likely do damage to other hospitals and other insurers. As the IFP argues, the region would be far better served by keeping Highmark and UPMC at arm's length than by demanding that they collaborate.[22]

Another unintended consequence of a contract between Highmark and UPMC would be the likely demise of the former West Penn Allegheny Health System. While it was seeking the Insurance Department's approval to acquire that health system, Highmark generated projections showing that, in the event it extended its relationship with UPMC, it could not move enough volume into West Penn Allegheny to turn that system around.[23] That reality explains why the Insurance Department's order approving the acquisition specifically prohibited Highmark from entering into a new contract with UPMC unless it produced:

> *updated information, based on reasonable assumptions and credible projections on the impact of any New UPMC Contract on the financial performance of WPAHS, as well as an independent analysis of an expert on the impact of the New UPMC Contract on both the insurance and provider markets in the region including but not limited to any effects on competition.*[24]

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The introduction and promotion of HB 1621/1622 is merely the latest chapter in a long-running effort by Highmark to lure or force UPMC into a destructive contract, one that would either compel UPMC to exit the insurance market or to surrender the future of its providers to the vagaries of a rate-setting process guaranteed to ruin a world-class academic medical center and the principal engine of Western Pennsylvania's economy.

In its super-heated pursuit of this unwise and unattainable contractual relationship, Highmark has in recent weeks ratcheted its advertising in support of HB 1621/1622 up to new heights. Its television attacks on UPMC have now reached saturation levels in Western Pennsylvania and have ranged in tone from pleading[25] to insulting[26] to vaguely threatening.[27]

Highmark, like UPMC, is a 501(c)(3) public charity operating tax-exempt hospitals that have been built with contributions from the community. Yet it is pouring millions of dollars in charitable assets into this tone-deaf campaign to achieve an unworthy goal.

Regrettably, UPMC has had to waste far too much time and expend far too much money dealing with this political nonsense, resources that could be better spent on providing the highest quality health care to those who need it most.

I want to thank the Committee for this rare opportunity to address HB 1621/1622 in a thorough and temperate fashion and along with Diane Holder would be happy to answer any questions you might have.

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UPMC LIFE CHANGING MEDICINE

References

1 Background Statement and Resolution of June 12, 2013, Tab A.

2 UPMC Community Benefits Report, Fiscal Year 2013, Tab B, p. 9.

3 Id., at 6-7.

4 See "Ravenstahl's proposed budget has not cuts in taxes, services," Pittsburgh Post-Gazette, September 24, 2013 (available at http://www.post-gazette.com/neighborhoods-city/2013/09/24/Ravenstahl-s-proposed-budget-has-no-cuts-in-taxes-services/stories/201309240061).

5 A list of the current Board of Directors is at Tab C.

6 See Amended Complaint, UPMC v. Highmark, Inc., et al., Case No. 2:12-cv-00692-JFC (W.D. Pa), Tab D.

7 See "Where you live determines how much you pay for health insurance," Kaiser Health News, September 29, 2013. http://www.kaiserhealthnews.org/stories/2013/september/30/premium-variation-intrastate-obamacare-marketplaces-exchanges.aspx.

8 Id.; "Aetna wants Highmark to know it's not an interloper," Pittsburgh Post-Gazette, November 24, 2013 (available at http://www.post-gazette.com/business/2013/11/24/Aetna-wants-Highmark-to-know-it-s-not-an-interloper/stories/201311240114);

"Westinghouse drops Highmark; Aetna to handle all health insurance," Pittsburgh Post-Gazette, September 25, 2013 (available at http://www.post-gazette.com/businessnews/2013/09/25/Westinghouse-drops-Highmark-Aetna-to-handle-all-health-insurance/stories/201309250083);

"Highmark-UPMC battle brings competitive pricing to region as new health care law dawns," Pittsburgh Tribune-Review, September 25, 2013;

"Pittsburgh employees to see 2 health suitors," Pittsburgh Post-Gazette, August 29, 2013 (available at http://www.post-gazette.com/businessnews/2013/08/29/Pittsburgh-employees-to-see-2-health-suitors/stories/201308290372);

"Highmark, Aetna, HealthAmerica among health insurers battling for business," Pittsburgh Business Times, September 2, 2011 (available at http://www.bizjournals.com/pittsburgh/print-edition/2011/09/02/highmark-aetna-healthamerica-business.html?ana=e_ph&page=all);

"Insurers see opportunity in UPMC-Highmark split," Pittsburgh Post-Gazette (July 29, 2011)(available at http://www.post-gazette.com/businessnews/2011/07/29/Insurers-see-opportunity-in-UPMC-Highmark-split/stories/201107290144).

9 Economic Analysis of Highmark's Affiliation with WPAHS and Implementation of Integrated Healthcare Delivery System, Compass Lexecon Submission to Pennsylvania Insurance Department dated April 24, 2013 ("Compass Lexecon Report") (PID Docket No. 1401) at 147. The zero-sum game is actually a negative-sum game because, as Highmark itself concedes, hospital admissions are projected to continue to decline, aggravating the already troubling oversupply of hospital beds in the region.

Id. at 136 ("Highmark recognizes that [western Pennsylvania] has a declining population that will result in fewer inpatient discharges"); id. at 158 (Western Pennsylvania "has a declining and aging population and industry participants consider the Pittsburgh area to be over-bedded relative to other areas of the United States"); id. at 117 ("Overall inpatient volumes in the southwestern PA area have been flat or declining.").

10 Compass Lexecon Report at 148.

11 The PID's economist, Compass Lexecon, explained in its Final Report that Highmark's PID submissions reveal that "a continuing Highmark/UPMC contract would not materially affect WPAHS's FY13 through FY17 incremental discharge projections."

Id. WPAHS's discharges under Highmark's Base Case (no UPMC contract) scenario were 89,624 for FY17 with UPMC being the "primary source of WPAHS' incremental discharges."

Id. at 126. Under Highmark's "New UPMC Contract" projections, Highmark assumed that it would secure a new contract from UPMC allowing Highmark to tier and steer patients away from UPMC and into the Allegheny Health Network. Under this scenario, Highmark projected that WPAHS would only have 6,800 fewer incremental discharges in FY17 than under Highmark's Base Case/ No Contract scenario. Id. at 159-60. The 6,800 difference "in discharges derives from eliminating one source of discharges - discharges from enrolled that decide to stay with Highmark who otherwise would have switched to UPMC."

Id. Incremental discharges "through all other sources remain the same as in the case where UPMC is out of network."

Id. at 160. In other words, Highmark's own projections demonstrate that its plan is take most of the 41,135 admissions it needs from UPMC under both the no-contract and new-contract scenarios it submitted to the PID.

12 Id. at 148.

13 "Westinghouse drops Highmark; Aetna to handle all health insurance," Pittsburgh Post-Gazette, September 25, 2013;

"Pittsburgh employees to see 2 health suitors," Pittsburgh Post-Gazette, August 29, 2013;

"Aetna's inroads into the market," Pittsburgh Post-Gazette, March 1, 2012 (available at http://www.post-gazette.com/business/businessnews/2012/03/01/Aetna-s-inroads-into-the-market.html);

"National carriers' membership rates jump as access to UPMC expands," Pittsburgh Tribune-Review, Dec. 18, 2011 (available at http://triblive.com/x/pittsburghtrib/news/s_772588.html#axzz2nHgHGouL).

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14 See Press Release, Rep. Dan B. Frankel (announcing introduction of "legislative package aimed at protecting patient access and choice in the health care marketplace")(available at http://www.pahouse.com/frankel/PAHouseNews.asp?doc=30322);

"Pa house bills aimed at protecting consumer health care access, lawmakers say," Pittsburgh Tribune-Review, Oct. 2, 2013 ("'Hundreds of thousands of people are on the verge of being forced to find a new doctor or hospital because of the logo on their insurance card,' Christiana said.")(available at http://triblive.com/news/adminpage/4807594-74/care-legislation-health#).

15 *See* Compass Lexecon Report at 119 ("the overall success of [Highmark's] proposed IDN rests with the assumption that UPMC and Highmark will not extend their present contract beyond 2014 and UPMC would become a more expensive out-of-network option for Highmark policyholders.")(emphasis added).

16 http://www.youtube.com/watch?v=V_kfTX02yDA); http://www.youtube.com/watch?v=FDOvnqG1Fmg&feature=youtu.be&noredirect=1; http://www.youtube.com/watch?v=V_kfTX02yDA

17 See, e.g., Letter of October 17, 2013, from Michael Brunelle, Executive Director, SEIU PA State Council; see also Letter of November 15, 2013 from T. McGough, Tab E.

18 "Pa house bills aimed at protecting consumer health care access, lawmakers say," Pittsburgh Tribune-Review, Oct. 2, 2013 (available at http://triblive.com/news/adminpage/4807594-74/care-legislation-health#); http://www.youtube.com/watch?v=Kz71HIbfkAU; http://www.pahouse.com/frankel/PAHouseNews.asp?doc=30322;

19 Although UPMC has made repeated requests over the last several months that Highmark waive this prohibition, Highmark refuses. Indeed, Highmark's most recent emphatic "no" to UPMC's request for this simple fix came December 6, 2013.

20 See, e.g., Letter of October 17, 2013, from Michael Brunelle, Executive Director, SEIU PA State Council; see also Letter of November 15, 2013 from T. McGough, Tab E.

21 http://www.coalitionforhealthcarechoice.org/

22 Statement of The Insurance Federation of Pennsylvania to the House Health Committee.

23 *Highmark Inc. v. WPAHS*, No. GD-12-018361 (Allegheny Cty. Ct. Com. Pl.), Hr'g Tr., Nov. 1, 2012 at 641, 658 (Dr. Keith Ghezzi, former Highmark consultant and interim WPAHS CEO, testifying that Highmark had projections before filing its November 2011 Form A with PID that keeping UPMC in its network would "not return [WPAHS] to profitability" or "financial stability");

See also id. Hr'g Tr., Oct. 26, 2012 at 251 (Nanette DeTurk, Chief Financial Officer and Executive Vice President and Treasurer of Highmark, testifying that she knew the Mediated Agreement would result in "fewer patients" and "less money" for WPAHS);

Id. at 317-19 (Dr. Kenneth Melani, former Highmark CEO, testifying that the Mediated Agreement "compromised" WPAHS' ability to compete with UPMC); Id. at 456, 462 and Hr'g Tr., Nov. 1, 2012 at 641, 658; WPAHS Ex. 230 (internal Highmark email dated May 1, 2012 and revealed in November 2012) (executing the Mediated Agreement would make "the turn[-] around of WPAHS much more difficult if not improbable");

Highmark v. WPAHS, WPAHS Ex. 24 (Highmark PID Projections dated July 2012) at 1, 6 (Mediated Agreement would "extend the turnaround time for WPAHS," reduce its revenue by $400 million and net income by $200 million);

Highmark's Addendum No. 1 to Amendment No. 1 to Form A, Aug. 24, 2012 (PID Docket No. 866) at 4 (Mediated Agreement would "negatively impact[]" the "projected volumes at WPAHS").

24 Approving Determination and Order of the Pennsylvania Insurance Department dated April 29, 2013 at 15-16.

25 http://www.youtube.com/watch?v=FDOvnqG1Fmg&feature=youtu.be&noredirect=1

26 http://www.youtube.com/watch?v=ZQ-wM9DNwM4&feature=youtu.be

27 http://www.youtube.com/watch?v=V_kfTX02yDA

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UPMC LIFE CHANGING MEDICINE

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November 15, 2013

Re: House Bills 1621 and 1622

Dear Representative:

Recently you may have received a letter dated October 17 from Michael Brunelle of the SEIU PA State Council in support of House Bills 1621 and 1622. I am writing on behalf of UPMC and the system's 60,000 employees to alert you to serious misrepresentations contained in Mr. Brunelle's letter and to highlight the reasons why this proposed legislation is being opposed not only by the avowed targets of the bills, UPMC and Geisinger Health System, but also by the Insurance Federation of Pennsylvania (IFP), the Hospital and Health System Association of Pennsylvania (HAP), and many other individuals and organizations across the state. The earlier public statements of UPMC, Geisinger, the IFP, and HAP opposing this legislation are enclosed.

Mr. Brunelle leads off his letter by suggesting that the proposed legislation is necessary to combat "large health systems" that are supposedly "consolidating at unprecedented rates." But the legislation has nothing at all to do with consolidation among health systems; it would instead impose its crippling regulations and forced contracting on any hospital—of whatever size—that offers a health insurance program—of whatever size—in competition with established insurers—like, say, Highmark.

That understanding reveals the true purpose of the proposed bills: to undermine UPMC and Geisinger, two Pennsylvania health systems that have achieved national recognition for the excellence of both their clinical arms and their insurance plans but have, in the course of doing that, threatened Highmark's decades-long dominance of the health insurance market.

Mr. Brunelle then writes that UPMC is going to "refuse to treat 3.1 million people with Highmark insurance in 2015—**even if they are willing to pay cash.**" (emphasis in original). That statement is absolutely false. When UPMC's contract with Highmark expires at the end of 2014, **everyone** still subscribing to Highmark insurance will be able to obtain treatment at UPMC. Those insured through government programs like Medicare Advantage, Medicaid or CHIP—more than half of Highmark's current subscribers—will have in-network access to all UPMC facilities and services, as will any Highmark subscriber using Children's Hospital of UPMC, Western Psychiatric Institute and Clinic, UPMC Northwest, UPMC Altoona, UPMC Bedford, and any unique cancer services that UPMC has to offer.

In addition, all other services at UPMC will be available to Highmark subscribers on an out-of-network basis. If the cost of those out-of-network services would be too high for those patients, virtually every one of them now has or will have the opportunity to secure full in-network access to UPMC through one or more of the five health insurance companies now competing with Highmark to serve them.

Note that Highmark's intention, indeed its imperative, is to make UPMC unaffordable to as many patients as possible so that Highmark can redirect them into its struggling subsidiary, Allegheny Health Network. If it secures a new UPMC contract, Highmark will put UPMC's services in its most expensive tier, as it did recently with Geisinger. If it doesn't secure a new UPMC contract, Highmark believes (as it advised the Pennsylvania Insurance Department) that its subscribers will hold onto their Highmark card and flock to AHN to avoid out-of-network charges. Either way, Highmark will never again provide "affordable access" to UPMC because to do so would doom AHN.

Mr. Brunelle also writes that without the legislation current UPMC patients will be "abandoned mid-treatment because they have the wrong insurance card." That is also completely false. Any patients in treatment who might choose to hold onto their Highmark cards after the current contracts expire are ensured appropriate continuity of care by Pennsylvania law and by the contracts themselves.

I would suggest you consider the SEIU's motives in entering this debate on the side of legislation that would damage UPMC, cement Highmark's monopoly over health insurance in Western Pennsylvania, and inevitably drive up the cost of health care to SEIU's membership. As you may know, SEIU has been engaged for nearly two years in an as-yet-unsuccessful campaign to persuade a group of UPMC's employees to name it as their bargaining representative. That effort has in recent months included a well-publicized and well-funded "corporate campaign" to inflict harm on UPMC in any way possible. Part of that campaign has been its suspiciously enthusiastic—and now deceptive—support of Highmark's effort to force a new contract on UPMC.

Please let me know if you have any questions or would like to meet to discuss House Bills 1621 and 1622.

Very truly yours,

W. Thomas McGough, Jr.

Enclosures

UPMC LIFE CHANGING MEDICINE

UPMC OPPOSITION TO FRANKEL AND CHRISTIANA'S GOVERNMENT HEALTH CARE INTERVENTION BILL

October 2, 2013

The legislation's chief sponsor, Rep. Dan Frankel (D-Pittsburgh) has stated that it is designed to "require that all health care systems accept all insurers" and control "consolidation" among hospitals to ensure that they do not obtain undue leverage in their negotiations with health insurers.

But no state has ever enacted radical "any willing insurer" legislation that would require a hospital to give an in-network contract to whatever insurer wants one and on whatever terms the government or some outside party specifies. Such legislation would be regressive and anti-competitive and would create a new state bureaucracy of price controls to "arbitrate" shotgun marriages.

Nor has any state tried to "control" hospital mergers and acquisitions by imposing on the merged entity, after the fact, a punitive and discriminatory level of regulatory requirements.

More importantly, though, the Frankel/Christiana bill doesn't even pretend to do what its sponsors say it's supposed to do. It does not regulate large hospital systems formed by consolidation – Community Health System's recent acquisition of Sharon Regional Health System, for example, is not covered. Nor does it require every hospital to enter into a contract with any willing insurer – instead, it imposes that mandate only on those hospitals that affiliate with an insurance plan.

The bill, in fact, targets only "integrated delivery networks" (IDNs) for its crippling regulation. At present, there are only two established IDNs in Pennsylvania – UPMC and Geisinger Health System – each of which has been nationally recognized for quality and innovation.

Not coincidentally, UPMC and Geisinger are each locked in highly-publicized competitive battles with Highmark, western Pennsylvania's dominant health insurer and the chief supporter of the Frankel/ Christiana bill. Clearly, Frankel and Christiana's only objective is to inflict maximum damage on two highly-esteemed health care organizations that have had the foresight and courage to challenge Highmark's insurance monopoly by bringing competition into the market for health insurance.

Highmark's support for this legislation also displays its lack of interest in creating an IDN with the rapidly failing Allegheny Health Network, despite the promises it made to the Pennsylvania Insurance Department to "save" West Penn Allegheny Health System by integrating it into Highmark's wholly-owned network. The proposed legislation prohibits the very kind of financial integration that drives an IDN toward improvements in the quality and cost of health care.

UPMC LIFE CHANGING MEDICINE

Finally, the proposed legislation would not provide any greater "access" to UPMC than is already, or soon to be, available. When Highmark's commercial contracts with UPMC expire, virtually the entire population of western Pennsylvania will still have the choice of full, affordable, in-network access to UPMC's hospitals and doctors through government programs, the health exchanges, national insurers such as Aetna, Cigna, HealthAmerica and United Healthcare, as well as the UPMC Health Plan. This new-found competition is already transforming western Pennsylvania into one of the most affordable insurance markets in the state.

While insurers and hospitals don't always agree on public policy issues, in this case every hospital and insurance company operating in Pennsylvania, the Insurance Federation of Pennsylvania (IFP), and the Hospital Association of Pennsylvania (HAP) oppose this government intervention.

IFP

We're not surprised, but we are disappointed:

- Highmark is again looking for the government to help it perpetuate its monopoly. That's what this bill is all about – not protecting consumers or giving them good choices and competition for health insurance. It is purely about giving Highmark – and only Highmark – unprecedented advantages in negotiating contracts with providers.

- Highmark is asking state help in two areas that are as unprecedented as they are unwise:

    - It wants the state to help it – the insurer with a monopoly in the western PA insurance market – for help negotiating its provider contracts, help that insurers with much smaller market shares don't get.

    - It wants the state to force a major competitor – UPMC – to collude with it. Consumers benefit when competitors compete, not collude.

- The consumers of western PA are finally seeing real choice and competition in the health insurance market. That should be encouraged. This bill, unfortunately, would be a return to the olden days of an insurance "market" that is controlled by only Highmark.

- Whatever else a monopoly needs, it doesn't need government help to preserve that monopoly. But that is what this bill does.

- Highmark is holding everyone hostage these days – including, based on its recent ads, its own employees, since it is threatening to fire thousands of them unless it gets a new UPMC contract. Meanwhile, it is evading the only question that matters:

    - Highmark, recognizing you don't want this to happen, what are you doing to prepare your policyholders and employees for an end to your contractual relation with UPMC on December 31, 2014.

- Highmark may want to evade that – but the General Assembly and the administration shouldn't. The consumers of western PA deserve and need an answer, not a bill that advantages only one party – Highmark.

HAP

HAP has consistently argued that there is compelling public policy interest for the state to ensure that there is a competitive insurance market to enable broad access to coverage. However, we have always opposed legislation that would result in a regulatory framework that either prevents health care providers from being able to effectively structure contractual relationships with health plans or unduly interferes with insurance market competition.

As a result, we oppose House Bills #### and #### because, in their current form, they go well beyond any compelling interest by state government, they will result in unfair competition, and they will open the door to an even worse competitive insurance market down the road.

Further, with specific regard to HB ####, we oppose utilizing the Health Care Facilities Act--that provides state oversight of the quality of care provided by licensed health care facilities--to impose contracting restrictions on hospitals. We also do not believe the mandatory arbitration process called for by the draft is feasible. Finally, beyond our fundamental opposition to legislation that would force a specific hospital and specific health plan to contract with each other, we do not believe the legislation is fair because it forces only hospitals to abide by the arbitration.

Geisinger

Geisinger Health System strongly opposes the "Any Willing Payer" legislation proposed by Representative Jim Christiana and Representative Dan Frankel. While we appreciate their concerns, this type of legislation is anticompetitive and given its focus on integrated delivery systems, puts organizations like Geisinger at a competitive disadvantage. Selective and exclusive network contracting is a fundamental part of the competitive process which leads to minimizing costs and maximizing consumer welfare. Further, there is nothing in this legislation that addresses one of the core principles of meaningful health care reform- value; paying for quality rather than quantity and tying provider reimbursements to outcomes.

We have serious concerns regarding any willing payer legislation and strongly disagree with governmental intervention that compels two companies to enter into a contractual relationship. Moreover, based on our experience, the fundamental transformation of care delivery and financing that is necessary to drive effective reform of the health care system cannot result from relationships that are forced upon providers and payers. However, we acknowledge and respect the concerns highlighted by this legislation and we look forward to the opportunity to work with the legislature on effective ways to continue improving healthcare in the Commonwealth.

October 17, 2013

RE: Support House Bills 1621 and 1622

Dear Representative:

On behalf of the nearly 80,000 SEIU members in Pennsylvania, I urge you to support House Bills 1621 and 1622. The bipartisan bills would protect the rights of consumers to select their doctor or hospital without large healthcare systems using their market dominance to reducing patients' access to care and raises prices.

How people receive healthcare in Pennsylvania is changing and the state must be prepared to respond. Large healthcare systems are consolidating at unprecedented rates. Already in Pennsylvania, general hospitals and specialty care institutions are buying out countless physicians' offices, satellite hospitals, outpatient care facilities and urgent care centers. In some regions these dominate provides are also selling their own insurance plans making the integrated systems both the payer and provider of care. Acting almost as local healthcare monopolies they can force out competitors and determine how care is provided and the cost.

These anti-competitive practices put millions of Pennsylvanians are at risk of losing access to their doctor. In Western Pennsylvania, UPMC will refuse to treat 3.1 million people with Highmark insurance in 2015 – **even if they are willing to pay cash.** In northeastern Pennsylvania, the Geisinger Health System will not accept a senior's Medicaid Advantage plan from outside companies. Other integrated healthcare systems in the state can be expected to follow this model of price increases and limiting access to care if Legislature does not act.

House Bills 1621 and 1622 provides the needed reforms to protect your constituents and communities. Together the bipartisan bills will restore competition by forcing health systems to focus on providing the best quality healthcare at the highest value rather than trying to control the local healthcare market.

House Bill 1621 and 1622 would:

- **Ensure patients are not denied access to care or abandoned mid-treatment because they have the "wrong" insurance. Nonprofit hospitals would be required to contract with all interested insurers and arbitrators would settle disputes;**
- **Prevent dominant hospital systems or affiliated physician practices from charging unreasonably high prices and driving costs through anti-competitive practices;**
- **Ensure doctors can continue to treat patients in the region if their practice is purchased by a health system and they choose to leave it.**

Finally, nearly 20,000 of our members work in healthcare, including at non-profit hospitals. When a neighbor is injured or a child in sick, they want to help them get better without concern for which insurance card they carry. We believe this bipartisan legislation will ensure these not-for-profit corporations remain open to everyone and serve the public good.

For all of these reasons we urge you to co-sponsor and support House Bills 1621 and 1622.

Sincerely,

Michael Brunelle
Executive Director
SEIU PA State Council

Pittsburgh Post-Gazette
post-gazette.com

Make Pennsylvania's health systems truly compete

Here's a bipartisan proposal to make health care giants such as Highmark and UPMC better serve patients

October 13, 2013 12:00 AM

By State Rep. Dan Frankel and State Rep. Jim Christiana

Nobody needs to make the comparison between Andrew Carnegie's steel empire and UPMC. UPMC has made it itself, by affixing its logo atop the U.S. Steel Tower.

And the points of comparison are many, including size, influence and the way these companies have done business.

Carnegie Steel, which became U.S. Steel, was famous for pioneering vertical integration. It not only owned the facilities to make steel, it also owned iron mines, coal mines and railroads. It owned the basic ingredient, the energy source and the means of transportation. Carnegie Steel controlled the market.

What's developing in the Pittsburgh health care market, ground zero for a broader national trend, is not simply a monopoly of health care services -- though that is occurring. Potentially, it's the creation of a vertical monopoly to rival Carnegie's in the early 1900s. Pittsburgh is like a proverbial canary in one of Carnegie's coal mines.

It's strange for us -- even unsettling -- to think of sick patients as "market share." But whether the average Pennsylvanian considers his knee injury or her daughter's asthma as part of the "patient volume" that contributes to a hospital system's bottom line, hospital executives certainly do.

Large health care systems around the country are consolidating at unprecedented rates to control an ever-larger part of patient services. They own both general hospitals and critical specialized institutions -- such as Children's Hospital of UPMC and UPMC Hillman Cancer Center -- that people seek out in a crisis. But these health systems also

have bought up countless physicians' offices, which are a source of patients, and built or bought satellite hospitals, outpatient facilities and urgent care centers. Meanwhile, health care systems and insurers are consolidating to provide health care services, collect premiums from patients and make insurance payments to their own doctors and hospitals.

Ideally, all of this consolidation would work in patients' favor. Doctors and nurses could coordinate care more effectively and efficiently. Larger networks could stretch dollars further.

But if left unchecked, this kind of consolidation may be great only for hospital executives and bad for the rest of us. That's why we have introduced legislation to get in front of these trends in hopes of redirecting the conversation away from patient volume and back to patient care.

Right now, once a hospital system has captured enough "market share" -- that's you and me and our neighbors when we get sick -- it has enormous leverage over how services are provided, what they cost and how they are paid for.

We've been watching this unfold in Western Pennsylvania for decades. Today we hear about UPMC refusing to accept patients insured through Highmark. But just a few years ago we heard about our major local hospital system refusing to contract with national insurers.

In northeastern Pennsylvania, Geisinger Health System has refused to contract with any outside Medicare Advantage companies, which appears to be driving up health care costs for seniors. That's a problem.

Given its large share of the Pittsburgh health insurance market, Highmark's recent purchase of the Allegheny West Penn Health System could generate the same concerns -- unless we set some rules.

If we want the highest-quality, highest-value health care networks, we need two things: full access and true competition. Our legislation would accomplish this in several ways:

- First, hospital executives would not be able to force providers to refuse to see patients because they have the "wrong" insurance card. There would be no wrong insurance card when it comes to receiving services at nonprofit hospitals built with community dollars.

• Hospitals couldn't stand in the way of "tiered" health plans that pass on savings in the form of lower co-pays and premiums when patients choose low-cost providers.

Right now we're charged the same amount whether we go to a hospital that bills our insurance company $300 or $3,000. A good tiered product could allow us to pay less out of pocket up front if we choose doctors or hospitals that bill our insurance companies less. Insurance companies would pass the savings along to us. If we wanted to go to a higher-cost hospital, we could still do so and pay a little more.

Western Pennsylvanians are not familiar with these tiered plans because we haven't seen many in our region. Expensive hospitals don't like these plans, which force them to compete with high-quality, less expensive hospitals. Western Pennsylvania hospital executives have refused to allow them -- something they've admitted publicly. Our legislation would prevent this.

• Hospital health plans under our legislation would compete for customers on their merits, not on their affiliations. Hospitals couldn't use the profits received from an outside insurance company to subsidize their own health insurance plans.

• Finally, hospital systems couldn't buy doctors' practices and essentially force doctors to sign non-compete clauses that make them leave town to practice medicine if they don't want to work for that system.

Carnegie Steel used its vertical monopoly to make a fortune in the steel industry. But despite the many similarities between today's health care industry and the industrialists of the gilded age, there is one critical difference: These hospitals are supposed to be not-for-profit corporations, and their bottom line is supposed to be the public good.

State Rep. Dan Frankel, D-Squirrel Hill, represents the 23rd Legislative District. State Rep. Jim Christiana, R-Beaver, represents the 15th Legislative District.

First Published October 12, 2013 8:00 PM

http://www.post-gazette.com/Op-Ed/2013/10/13/Make-Pennsylvania-s-health-systems-truly-compete/stories/201310130002

Highmark's 'Community Blue' patients rejected by UPMC

March 5, 2013 5:00 AM
By Bill Toland Pittsburgh Post-Gazette

When Marie Acquafondata retired after 40 years at what is now UPMC Shadyside, she and her husband, John, had to switch health insurance plans. They left her UPMC Health Plan and signed up with Highmark's new Community Blue plan, offered by his employer.

Community Blue is a low-cost "select-network" plan, which means it doesn't include most UPMC doctors and facilities in its directory of preferred, "in-network" physicians. And as the Bloomfield couple -- and hundreds more -- are now finding out, UPMC is scrubbing Community Blue subscribers from its rosters of active patients as UPMC and Highmark fight for local health care supremacy.

The Community Blue insurance plan launched Jan. 1, and those who joined on day one were given two months by UPMC to find new doctors. On Saturday, they were cut loose.

For Mrs. Acquafondata, a breast cancer survivor who worked in histology research, that means she'll be losing nearly all of her doctors -- primary care, endocrinology, oncology and more. The couple were willing to pay out of their own pockets to keep her doctors, said Mr. Acquafondata, a courier for West Penn Allegheny Health System, the would-be acquisition target of Highmark Inc.

"Anything and everything she had was a UPMC physician," Mr. Acquafondata said.

Though paying out-of-pocket may be an option for other would-be UPMC patients, not so for Community Blue customers. And that's a point of contention between the two squabbling Pittsburgh health care giants: UPMC says this is what happens when customers subscribe to a Highmark product that intentionally excludes UPMC; Highmark calls the "firing" of longtime UPMC patients "unacceptable and unethical."

When Mrs. Acquafondata began receiving certified letters from UPMC clinics and physicians last month, telling her that "you will no longer be an active patient," she felt "betrayed and angry ... I don't think that's right," she said.

As a longtime UPMC employee, she has great respect for the system, its physicians and her former colleagues, but she said she blames UPMC, not Highmark, for this lockout.

And because of her long tenure with the health system, she is also familiar with UPMC's "Patient Bill of Rights," particularly item No. 13, which says, in part, that "a patient has the right to medical and nursing services without discrimination based [upon] source of payment."

Cash is usually an accepted form of payment -- but not when it comes to Community Blue customers.

"We have decided that a Community Blue subscriber's willingness to self-pay or ability to self-pay is not one of the approved exceptions" that would allow them access to UPMC's provider network, said UPMC spokesman Paul Wood.

The Acquafondatas had looked into other options before choosing Community Blue, particularly the purchase of extended UPMC Health Plan coverage through COBRA, a federal law that allows retirees, spouses, dependent children and others to continue with their former health plans. But coverage purchased through that program for former employees is far more expensive than what current employees pay. For the Acquafondatas, the UPMC Health Plan coverage would have been five times more expensive than the Community Blue premiums.

"It was a no-brainer," Mr. Acquafondata said. They went with his Highmark plan, made available to him because he is a WPAHS employee; Highmark and West Penn Allegheny employees are, essentially, the canaries in the coal mine during the early, test-drive months of this UPMC-free product.

Alicia Marney of Monroeville likewise was willing to pay out-of-pocket to continue to see her UPMC doctor. She, too, is a breast cancer survivor. Because of the rarity of her form of cancer, she has been treated through a special clinical trial being conducted by Shannon Puhalla, a medical oncologist and hematologist at UPMC Cancer Center at Magee-Womens Hospital of UPMC.

Until this year, that is.

Ms. Marney, a secretary at Forbes Regional Hospital, now has coverage through Community Blue. When she met with Dr. Puhalla last month to discuss her treatment, she was told that she could not return.

Both Ms. Marney and her fiance, Rocco Vitalone, said Dr. Puhalla is a wonderful physician who was apologetic about the marching orders. "This is not my decision," they remember her saying. But that doesn't ease the sting, said Ms. Marney.

"I work in a hospital. I understand billing and insurance," she said. "I have no understanding of why this could not be a self-pay [situation]."

For a routine office checkup, Ms. Marney figures she would have had to pay an extra $70 on top of what she paid with her old coverage, based on her understanding of the cost of her visits to Magee.

Even though Community Blue considers UPMC out of network, because of the special nature of her clinical trial, Ms. Marney had received an "exception letter," sometimes

known as a waiver letter, from Highmark. A waiver allows the patient to seek care out of the provider network, at in-network costs.

But to date, UPMC has declined to continue treatment, she said.

Mr. Wood, the UPMC spokesman, said that there might be case-by-case exceptions to UPMC's policy, including patients receiving "unique treatments."

But he stressed that the blame lies not with UPMC for the lockout, but with Highmark for not adequately communicating to its Community Blue customers that they would lose UPMC access. That's evident, he said, in the phone calls fielded by UPMC customer service reps from Community Blue customers. (In one such call, a woman said "we would have never picked this plan" had she known she would lose her doctors.)

The loss of UPMC access is why so few companies, other than Highmark and WPAHS, have signed on with Community Blue, Mr. Wood said, adding that UPMC had sent out "hundreds" of the notification letters.

"So it's a pretty small number of people that are, unfortunately, being caught in this situation," he said.

One UPMC employee, who did not want to be identified, said: "We all feel horribly about this ... we have been leaned on by UPMC" to refuse treatment for Community Blue members, even those with exception letters. "It's not the [doctors], it's the administrative powers."

Generally, health care providers can treat whomever they wish, and can cut patients loose as well. If a patient has a history of skipping appointments, for example, he or she can be dismissed from a practice.

However, it's common for doctors -- especially primary care physicians -- to see patients who are considered out-of-network.

In those cases, depending on the arrangement with their insurer, patients are usually responsible for a higher co-payment and the remaining balance of the physician-billed charges after the insurer picks up part of the tab. Sometimes, a patient will dispense with insurance altogether and just pay in cash.

In other words, just because a health insurer considers a doctor "out-of-network," and leaves him or her off the insurer's list of preferred providers, doesn't necessarily mean that doctor is off limits. It just means the insurance coverage won't work there.

For Ms. Marney, there's an extra layer of irony at play -- her fiance, Mr. Vitalone, has health insurance through Blue Cross Blue Shield of Illinois. His insurance plan does not include UPMC among its in-network providers, yet he is still able to see the health system's doctors on an out-of-network, extra-cost basis.

That means UPMC doesn't exclude all out-of-network payment arrangements, or even all out-of-network Blue Cross Blue Shield-affiliated patients.

"Bottom line," Mr. Vitalone said in a letter sent to UPMC and the Post-Gazette, "I could not be more disappointed with [UPMC] ... It is disheartening and honestly it feels criminal."

"It's disappointing," Ms. Marney said, "that we, the patients going through a serious illness, have to be part of the so-called war."

Community Blue is the revived version of a popular Highmark insurance product that was eliminated in 2002 when UPMC and Highmark agreed to a 10-year contract allowing the insurer's customers to be treated at UPMC facilities. When the two parties agreed last year to a contract extension running through the end of 2014, part of that agreement allowed Highmark to offer insurance products in which UPMC hospitals were out-of-network.

Under the new Community Blue plan, Children's Hospital of Pittsburgh, UPMC Northwest, UPMC Bedford and Western Psychiatric Institute and Clinic are considered "in-network," and the rest of UPMC's hospitals are out-of-network.

http://ppgmobile.libercus.net/businessnews/2013/03/05/Highmark-s-Community-Blue-patients-rejected-by-UPMC/stories/201303050244

AMENDMENTS TO THE HEALTH CARE FACILITIES ACT ADDRESSING PROVIDER CONSOLIDATION AND MARKET POWER
SECTION BY SECTION SUMMARY

Policy Goals of Legislation:

- Require that a hospital(s) that is part of an integrated delivery network (IDN) enter into a contract with any willing insurer.
- If a mutually agreeable contract cannot be reached, imposes a contract on the parties through mandatory binding arbitration, including the establishment of a default provider agreement until the arbitration process is completed.
- Prohibits a hospital(s) that is part of an IDN from: (1) placing restrictive covenants on their physicians in employment contracts; (2) incorporating contractual provisions that limits or precludes the use of tiered networks by insurers; and (3) using any portion of the reimbursement rate to subsidize a health insurance carrier operating as part of the same IDN.

The following is a high-level summary of the provisions contained in the *amendments to the Health Care Facilities Act.*

- **SECTION 1. DEFINITIONS.**
  - The following new definitions will be added: "Default provider agreement," "Health insurance carrier" and "Integrated delivery network."

- **SECTION 2. LICENSURE.**
  - As a condition to obtain a license, in addition to existing requirements that hospitals must follow, a hospital(s) that is part of an IDN must enter into a contract with any willing health insurance carrier.

  - A hospital(s) that is part of an IDN may not: (1) place restrictive covenants in its employment contracts; (2) use contractual provisions that limit or preclude the use of tiered networks by insurers; (3) use any portion of the reimbursement rate to subsidize a health insurance carrier operating as part of the same IDN; and (4) incorporate a termination provision for reasons other than a willful breach of the contract.

  - Failure of any hospital operating as part of an IDN and a willing health insurance carrier to maintain a mutually agreeable contract will result in the parties entering into a default provider agreement while they submit to mandatory binding arbitration. Likewise, failure of any newly affiliated hospital with an IDN or failure of any hospital operating as part of a newly formed IDN and a willing health insurance carrier to enter into a mutually agreeable contract within 90 days of the affiliation or formation will result in the parties submitting to mandatory binding arbitration to establish a contract.

  - The arbitrator will set all terms of the contract. An arbitrator will be chosen from the American Arbitration Association's national healthcare panel of arbitrators experienced in handling payor-provider disputes. The arbitration will be conducted pursuant to the American Arbitration Association's Healthcare Payor Provider Arbitration Rules, and all costs associated with the process shall be split equally between the parties.

  - Contract terms and conditions will be set as follows:
    - each party will be required to submit best and final contract terms;
    - the arbitrator may request additional documents, data and other information;

- payment terms and all other contractual provisions will be set by the arbitrator; and
- the default provider agreement will remain in effect until the parties complete the arbitration process.

- Payment terms under the default provider agreement will be established according to an amount equal to the greatest of three possible amounts:
  - the amount the insurer negotiated with other in-network hospitals for the same services;
  - the amount calculated by the same method the insurer uses to determine payments for out-of-network services (such as the usual, customary, and reasonable (UCR) charge); or
  - the amount that would be paid under Medicare for the same services.

- Copies of all contracts will be submitted to both the Department of Health and the Insurance Department.

➢ **SECTION 3. ISSUANCE OF LICENSE.**

- In addition to the existing standards, the Department of Health will issue a license to a hospital(s) that is part of an IDN when it is satisfied that the hospital(s) has contracts will all willing insurers, that the hospital(s) does not have restrictive covenants in its employment contracts that restrain any health care practitioner from engaging in their lawful profession, and that the hospital(s) has submitted an attestation statement certifying that no portion of any reimbursement rate with a health insurance carrier is subsidizing the health insurance carrier operating as part of the same IDN.

- Hospitals submitting an attestation statement must keep all applicable documents and information relating to its methodology for developing reimbursement rates for every health insurance carrier so that the Department of Health may readily verify that no portion of any reimbursement rate is subsidizing the health insurance carrier operating as part of the same IDN.

- The Department of Health may conduct surveys, as necessary, of hospitals operating as part of an IDN to determine compliance with these requirements.

- When conducting surveys, the Department of Health may retain attorneys, independent actuaries, independent certified public accountants or other professionals as surveyors. All expenses incurred related to conducting these surveys shall be charged to and paid by the hospital being surveyed.

➢ **SECTION 4. CONFIDENTIALITY.**

- Any documents received by the Department of Health or Insurance Department for the purpose of compliance with this Act shall be confidential and shall not be subject to the Right-to-Know Law.

➢ **SECTION 5. EFFECTIVE DATE.**

- This act shall take effect in 90 days.

THE PATIENT ACCESS AND CONSUMER CHOICE ACT
SECTION BY SECTION SUMMARY

SUMMARY OF POLICY GOALS OF LEGISLATION:

- Require that a hospital-owned physician practice that is part of an integrated delivery network enter into a contract with any willing Health insurance carrier.
- Designate an Established reimbursement rate if a Hospital-owned physician practice that is part of an integrated delivery network refuses to contract with a Health insurance carrier.
- Prohibit a Hospital-owned physician practice that is part of an integrated delivery network from placing restrictive covenants on their physicians in employment contracts.

The following is a high-level summary of the provisions contained in the Patient Access and Consumer Choice Act.

- **SECTION 1. SHORT TITLE.**
  - The Patient Access and Consumer Choice Act
- **SECTION 2. LEGISLATIVE FINDINGS.**
  - To ensure that physician practices operating as part of an integrated delivery network are not permitted to use their market dominance to exert undue pressure on health insurance providers or to restrict a patient's access, mandatory contracting requirements must be imposed requiring that all physician practices operating as part of an integrated delivery network contract with any willing Health insurance provider.
- **SECTION 3. DEFINITIONS.**
  - **Default provider agreement** - An agreement between a Hospital-owned physician practice that is part of an integrated delivery network and a Health insurance carrier to provide Health care services which is imposed upon the parties in the event that they fail to enter into a mutually agreeable Provider contract within the time frames established by this Act.
  - **Hospital-owned physician practice** - A physician practice that provides Health care services or other professional medical services to an individual, that is owned, operated, under joint control or a subsidiary of a hospital.
  - **Integrated delivery network (IDN)** - One or more entities with common ownership, operation, control or which are otherwise affiliated which include (i) one or more hospitals, one or more physician practices, and/or one or more providers offering Health care services and (ii) one or more Health insurance carriers or any other entity offering health insurance, administering health benefits, operating a health maintenance organization (HMO), and/or offering other health care benefits and coverage to employers and/or individuals in the Commonwealth.
  - **Provider contract** - A written agreement between (i) Hospital-owned physician practice that is part of an integrated delivery network or any entity directly or indirectly owned, operated, or controlled by or otherwise affiliated with an integrated delivery network and (ii) any Health insurance carrier (iii) for the payment or reimbursement of Health care services provided to any person by a Hospital-owned physician practice that is part of an integrated delivery network or any other entity directly or indirectly owned, operated or controlled by or otherwise affiliated with the integrated delivery network.

- **SECTION 4. RESPONSIBILITIES.**
  - A Hospital-owned physician practice that is part of an IDN must enter into a Provider contract with any willing Health insurance carrier.
  - A Hospital-owned physician practice that is part of an IDN may not place restrictive covenants in its employment contracts.
  - A Hospital-owned physician practice that is part of an IDN and the Health insurance carrier to must maintain a Provider contract with any willing Insurance Carrier. Failure to do so will result in the parties entering into a Default provider reimbursement agreement for payment terms while all other contractual terms remain unchanged and the parties will be required to enter into immediate binding arbitration.
  - Failure of any newly formed or affiliated Hospital-owned physician practice that is part of an IDN and the Health insurance carrier to enter into a contract within 90 days of the formation/affiliation will result in the parties entering into immediate binding arbitration.
  - The Default provider agreement shall set the Established reimbursement rate which will be the greater of three (3) possible amounts:
    - the amount negotiated with in-network providers for the same services;
    - the amount calculated by the same method the Health insurance carrier generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable (UCR) charge); or
    - the amount that would be paid under Medicare for the same services.
  - An arbitrator shall determine all terms of the new contract.
  - A Provider contract between a Hospital-owned physician practice that is part of an IDN and the Health insurance carrier may only be terminated for willful breach of the terms of the Provider contract by either party.
- **SECTION 5. CONFIDENTIALITY.**
  - Any documents received by the Department of Insurance for the purpose of compliance with this Act shall be confidential and shall not be subject to the Right-to-Know-Law.
- **SECTION 6. ENFORCEMENT.**
  - The Department of Insurance shall ensure compliance with this Act and promulgate such regulations as may be necessary to carry out the provisions of this Act.
- **SECTION 6. PENALTIES AND SANCTIONS.**
  - The department may impose a civil penalty of not more than $25,000 per day, not to exceed $1,000,000 per calendar year, on a hospital-owned physician practice that is part of an IDN for a violation of this Act.
- **SECTION 8. EFFECTIVE DATE.**
  - This Act shall take effect in 90 days.

Memorandum

Posted: July 26, 2013 12:42 PM
To: All House Members
From: Representative Jim Christiana
Subject: Reforms to Address Restricted Heath Care Access

Ever-increasing healthcare spending is impacting local government, businesses, and individual consumers by crowding out the possibility for other spending – on education, businesses expansion, or household budget items. According to some estimates, health care spending will be 20 percent of our gross domestic product by 2020. Hospital spending, a key driver of health care costs, has been growing at nearly 5 percent annually.

Hospital consolidation is one of the major components of this increased spending – experts link consolidation with increased rates and higher health care costs. Nonetheless, with the current changes in the marketplace further hospital consolidation is expected. Pennsylvania must get in front of this trend in order to create a fairer, more transparent healthcare system that encourages hospitals to compete based on value, rather than on market leverage. Patients should reap the benefits of clinical integration – better coordinated care and increased efficiency – but should be protected from the potential for collusion or other anti-competitive behavior leading to higher prices or restricted access.

Components of a fairer, more competitive healthcare marketplace include transparency, payment reform and real competition based on value. In the near future, we will be introducing legislation that begins to tackle some of these issues in order to ensure that consolidation does not result in higher prices and less access for our constituents to the hospital and doctor of their choice.

We propose to begin addressing marketplace fairness issues first by focusing on hospitals operating as part of an integrated delivery network – where a large health system and insurance carrier/health plan operate under the same corporate structure. These institutions deserve special attention, as they function both as providers and payers, and therefore can have an exceptional impact on the marketplace.

Our legislation would amend Chapter 8 (Licensing of Health Care Facilities) in the Health Care Facilities Act by imposing additional requirements on hospitals operating as part of an integrated delivery network.

Specifically, the amendments to the Health Care Facilities Act add the following criteria to obtain a license to operate a hospital in the Commonwealth:

- Require hospitals operating as part of an integrated delivery network to contract with any willing insurer.

- Permit hospitals operating as part of an integrated delivery network to contract for its services at any price or discount that result in adequate reimbursement rates, provided that such rates are based upon sound actuarial data and the open exchange of information.

- Prohibit hospitals operating as part of an integrated delivery network when contracting with insurers from using contractual provisions and engaging in business practices that impede the availability of quality health care at affordable prices and that restrict access to facilities or services.

- If a mutually agreeable contract cannot be reached, a contract will be imposed on the parties through mandatory binding arbitration, and will include a default reimbursement rate established by the same methodology and approach used in the federal Affordable Care Act (ACA) to set a minimum level of compensation to be paid by insurers to non-participating providers for emergency services.

We will also be introducing freestanding legislation, the Assuring Patient Access & Consumer Choice Act (APACCA), which will establish the same contracting requirements on hospital-owned physician practice organizations operating as part of an integrated delivery network.

There are strong consumer protection and public policy reasons for adopting this legislation. These additional regulatory requirements accomplish two important objectives. First, by requiring hospitals and physicians operating as part of an integrated delivery network to contract with all insurers, consumers will not be denied care, or worse abandoned mid-treatment, simply because they hold one type of insurance over another. All consumers should be afforded access to these vital hospital and physician services, regardless of which insurance card they carry.

Second, the legislation will eliminate the ability of any dominant hospital system from demanding unreasonable rates for services from insurers, and in turn raising the overall cost of health care because they are the "must have" system in the area.

Please join me in co-sponsoring this legislation. If you have any questions, please do not hesitate to call my office at (717)-260-6144.

UPMC LIFE CHANGING MEDICINE

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BACKGROUND STATEMENT

June 12, 2013

UPMC's Mission is **to serve our communities by providing outstanding patient care and to shape tomorrow's health system through clinical and technological innovation, research, and education**. Within the comparatively short life of UPMC, this critical Mission has been advanced with levels of effectiveness and impact that probably are unsurpassed in the history of modern American medicine. Today, UPMC is widely recognized as one of the top academic medical centers in the world. The beneficiaries of UPMC's success include the patients we serve, the communities in which we work and the health of human kind. Consider the following:

- The hospitals, physicians and other health care professionals of UPMC now meet the needs of millions of patients annually. By any measure, UPMC has become the clear provider-of-choice for those living in the communities it serves. UPMC also has made Western Pennsylvania a destination-of-choice for patients from other locations around the world who seek medical care for complex conditions.
- In partnership with the University of Pittsburgh, UPMC has pioneered new approaches to transplantation, heart disease, cancer, neurological diseases and injuries, orthopedic conditions, psychiatric disorders and other life-threatening conditions. This unique and critical partnership also has provided education and training for most of the region's physicians, nurses and other healthcare professionals.
- Nearly 60,000 people earn their livelihoods at UPMC, making it Pennsylvania's largest non-governmental employer, and the spending by UPMC and its employees has been a critical factor in restoring and preserving the region's economic health. The system's total economic impact on the region is estimated to be nearly $22 billion annually, making it the principal driver of Western Pennsylvania's new "meds and eds" economy. After the decline of the smokestack industries and the more recent Great Recession, UPMC buoyed the local economy and helped the region to avoid the devastating consequences suffered by other cities.
- In the past fiscal year alone, UPMC also provided more than $622 million in community benefits, including charity care, uncompensated care from government programs for the poor, community health improvement programs and donations, funding for medical research, and education for tomorrow's health care professionals. The vast majority of the care for the region's underserved and economically disadvantaged population is provided by UPMC, while its $100 million commitment to The Pittsburgh Promise stands as an unprecedented example of philanthropic re-investment in the people of the City that has long been its principal home.

The fiduciary responsibility to pursue and protect that Mission is ultimately entrusted to UPMC's Board of Directors, twenty-four unpaid volunteers representing a broad cross-section of the communities and constituencies it serves. Its Board

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has ensured that UPMC provides innovative, high-quality, and cost-effective healthcare to the residents of Western Pennsylvania. It is a Board that also has been consistently attentive to risk – being mindful, in particular, of lessons from the recent history of healthcare in Western Pennsylvania, lessons that are telling but that, at least for some, seem to have been quickly, and perhaps conveniently, forgotten:

- As the original Allegheny General Hospital, a highly respected Pittsburgh institution with a long and proud history, became the Allegheny Health Education and Research Foundation, its operations were jeopardized by a flawed business strategy, poor management decisions, and questionable oversight. The result was the largest bankruptcy in American healthcare history, a series of criminal prosecutions, the loss of tens of millions of Western Pennsylvania dollars and thousands of Western Pennsylvania jobs, and permanent damage to what had been the Allegheny General Hospital.
- When the Board and management of the Western Pennsylvania Hospital assumed the role of "white knight" in saving what was left of the Allegheny General Hospital, their intentions almost certainly were noble. However, an objective look at the financial circumstances of these two institutions strongly suggested that West Penn lacked the strength to assume that responsibility and that the weight of Allegheny General inevitably would quickly pull West Penn, another institution with a long and proud history, into financial jeopardy, which it did.
- Meanwhile Highmark repeatedly tried to support and subsidize the new West Penn Allegheny Health System, over time infusing hundreds of millions of dollars into it. As now is absolutely clear, these subsidies did not rescue West Penn Allegheny from the financial difficulties that were the product of its own management decisions. However, by distorting the competitive environment, those subsidies caused lasting damage to other regional hospitals. St. Francis Hospital, which had been in operation since 1861 and which had particularly distinguished itself as a provider of compassionate psychiatric care and mental health services, did not survive. Mercy Hospital, the city's only remaining Catholic hospital, no longer could sustain itself and asked to become a part of UPMC under an arrangement that helped preserve its distinctive Catholic mission.

Throughout these tumultuous times, though regularly targeted by both Highmark and West Penn Allegheny, UPMC held fast to its mission, which the Board pursued with focus and foresight. A prime example of the Board's stewardship was the creation, fifteen years ago, of the UPMC Health Plan, which over the years has transformed UPMC into an integrated health system. By design, integrated health systems create provider networks that compete on quality, cost and member satisfaction when compared to traditional insurers that instead offer broad networks less attuned to clinical innovation, service, and cost. At its founding, moreover, the UPMC Health Plan emerged as the first real insurance competitor in a market historically dominated by Highmark.

When the UPMC Health Plan was formed, numerous critics, including Highmark, publicly contended that this integrated model could not and would not work—that UPMC was destined to be "another AHERF." But the Board's integrated strategy has been repeatedly confirmed as UPMC has thrived while other respected medical

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institutions in this region have struggled and sometimes failed. Indeed, nationally recognized experts today encourage providers to create financing arms, take on financial risk, and align internal incentives up and down their organizations — actions already taken by UPMC. These experts, supported by the new health reform legislation, now further promote vertical integration and vigorous competition as ways to limit the cost of healthcare and enhance value.

Given these trends, it was perhaps not surprising that two years ago Highmark reversed its longstanding condemnation of UPMC's integrated model and announced its own plan to become an integrated health system by acquiring the financially troubled West Penn Allegheny Health System. Highmark's expressed intention was, and has remained, to resurrect West Penn Allegheny as a competitor to UPMC and to put the full weight of its insurance monopoly behind this new competitor.

UPMC, consistent with its responsibilities to its patients and to the broader community, immediately advised the public of the impending expiration of the contracts allowing Highmark to include UPMC facilities and physicians in its network and specified that a renewal of those contracts would not be possible were Highmark to acquire West Penn Allegheny and reposition itself as a competing provider, both because it would put UPMC at risk and because it would undermine the very competition that should benefit the region, as a driver of even higher levels of quality and of lower cost. Then, as now, UPMC recognized the potential to move Western Pennsylvania from among the least competitive healthcare markets, with a dominant insurer and a dominant provider, to one of the most competitive, with two integrated health systems competing on the basis of quality, service, and cost, and at least three national insurers offering in-network access to both systems.

By mid-2012, with the end of the Highmark/UPMC contracts looming, Highmark and West Penn Allegheny had still not completed their proposed combination. At the Governor's behest, UPMC and Highmark therefore entered into a Mediated Agreement that extended the contracts between them until December 31, 2014, specifically to "provide for sufficient and definite time for patients to make appropriate arrangements for their care and eliminate the need for governmental intervention" when the contracts expired. As one part of that agreement and consistent with its commitments to patients and community, UPMC agreed that after 2014 Highmark subscribers would continue to have in-network access to various unique facilities and services at UPMC, including Children's Hospital, Western Psychiatric Institute and Clinic, certain oncology services not available at West Penn Allegheny, and two facilities that are essentially the sole providers of hospital services in their communities, UPMC Northwest Hospital and UPMC Bedford Memorial Hospital.

The Pennsylvania Insurance Department ultimately approved Highmark's proposal to acquire West Penn Allegheny on April 29, 2013, **an approval built on a Highmark plan that assumed no further contract extension with UPMC**. Highmark and West Penn Allegheny closed their transaction that same day.

As Highmark, UPMC, and the community in general approach this newly competitive market for what is perhaps the most personal, sensitive, and important service of all—health care—no one can afford to ignore demographic or medical reality. Southwestern Pennsylvania, where all of West Penn Allegheny's

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facilities are located, has a significant surplus of hospital beds, the product of a stable or declining population combined with advances in medical care that have reduced the need for acute admissions. As a result, any effort to increase patient admissions at one hospital will succeed only at the expense of other hospitals—a reality the consultants retained by the Pennsylvania Insurance Department described as a "zero sum game."

In the face of that reality, Highmark has put forward a business plan that requires it to increase admissions at West Penn Allegheny's hospitals by 41,000 patients per year. As the St. Francis and Mercy experiences suggest, some of those patients could come from community hospitals. In dealing with that large number, however, Highmark has made no secret of where it intends to get the vast majority of those admissions: UPMC.

As to how it would shift tens of thousands of patients per year from the UPMC doctors and hospitals that have been historically—and overwhelmingly—preferred to West Penn Allegheny's offerings, Highmark has presented two alternative plans. Highmark's "Base Case," as proposed to the Pennsylvania Insurance Department, assumes that it will have no contracts—commercial or Medicare—with UPMC after 2014 and that its subscribers will therefore not have the option of going to UPMC hospitals or physicians in network. According to Highmark, the vast majority of the "contestable volume" of patients in that Base Case will switch to West Penn Allegheny providers rather than change their insurer to keep UPMC in network. Whether or not Highmark's Base Case assumptions are sound can only be determined in the competitive marketplace. However, it is important to note that this Base Case with no UPMC contract was accepted by the Insurance Department—with extensive conditions and monitoring to assure that Highmark meets the expectations it has created. Among those conditions is one requiring Highmark to seek Insurance Department approval before signing any contract that it might offer UPMC, to ensure that, should UPMC ever agree to such a contract, it would not impair the recovery of West Penn Allegheny or otherwise lessen competition among either insurers or providers.

In fact, Highmark's alternative business plan assumes that any new contract with UPMC would, unlike the current contracts, permit Highmark to use economic incentives to "tier and steer" Highmark's subscribers away from UPMC and into the West Penn Allegheny Health System. Highmark has given these contractual provisions the appealing, but misleading, name "consumer choice initiatives," because as Highmark has already demonstrated any "choice" it might provide to its subscribers would be illusory.

In what would amount to a classic bait and switch, Highmark would lure employers and subscribers into new contracts or contract renewals with the illusion of in-network access to UPMC only to use tiers, co-pays, co-insurance, deductibles and the like to steer those subscribers over to West Penn Allegheny. While Highmark has said that it would tier and steer based on differences in "cost and quality," even those pressures would undermine patient choice. Nor could UPMC ever rely on Highmark to gauge "cost and quality" fairly and objectively, particularly where Highmark's announced intention is to drive an additional 41,000 patients every year away from UPMC and into West Penn Allegheny.

Highmark simply has no option but to force its subscribers toward West Penn Allegheny; over the

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last decade, those subscribers have overwhelmingly chosen UPMC when given an unfettered choice. That is why Highmark has outlined only two business plans supporting a rescue of West Penn Allegheny: its base plan in which its subscribers would have no in-network access to UPMC and therefore would have to use West Penn Allegheny, and its alternative plan, where its subscribers would be offered the illusion of access to UPMC only to be steered to West Penn Allegheny.

Clearly UPMC could not responsibly sign contracts giving Highmark the free use of anti-competitive weapons to harm UPMC. The diversion of 41,000 patients per year from UPMC's system would be the equivalent, for example, of closing both UPMC Mercy and UPMC Shadyside, with the attendant loss of approximately 11,000 jobs. Nor could UPMC, as a committed healthcare provider, willingly allow Highmark to discourage patients from using the hospitals and physicians they overwhelmingly prefer. Indeed, Compass-Lexecon, the consultants retained by the Insurance Department, recognized that it would be "unreasonable" to assume that UPMC would enter into the contracts proposed by Highmark.

Were Highmark to divert tens of thousands of patients away from UPMC and into West Penn Allegheny, UPMC would be greatly diminished. It could no longer invest more than $250 million in annual support of cutting edge research, education and training at the University of Pittsburgh. Nor could it make commitments to initiatives like the Pittsburgh Promise, which is investing $100 million of UPMC funds in an unprecedented opportunity for economically challenged families to send their children to college and as an incentive for families to remain in Pittsburgh. It could no longer invest more than $500 million per year in capital projects creating facilities and jobs in Pittsburgh. It could no longer provide care to the vast majority of the underprivileged and underserved. If Highmark wants to inflict that kind of damage on one of the world's best health systems and on the constituents and communities that it serves, it should have to do that by competing, integrated health system to integrated health system, without seeking to create yet another uncompetitive market by handicapping its chief competitor.

UPMC's Board owes a fiduciary obligation to preserve and protect the charitable assets that have been entrusted to it and to ensure that those charitable assets are managed and deployed in pursuit of UPMC's Mission. Highmark's announced plan to steer tens of thousands of admissions away from UPMC's hospitals in Southwestern Pennsylvania poses a direct, substantial threat to UPMC's charitable assets, to its clinical and academic mission, to its role as the economic driver of the region, and to its ability to provide future benefits to the community. Highmark's opportunity to deliver on that devastating plan would be greatly enhanced were it to secure contracts capturing UPMC's hospitals and its physicians within its network after December 31, 2014, particularly if any such contracts allowed Highmark to impede its subscribers' access to UPMC's hospitals and steer them instead into its newly formed health network.

Any concerns, moreover, about continued access to the unique community assets managed by UPMC have already been addressed in the Mediated Agreement, which provides for Highmark subscribers to have in-network access to certain UPMC specialty hospitals, certain unique oncology services, certain "sole-provider" hospitals, certain services at non-UPMC facilities under joint ventures, and certain services provided by UPMC physicians

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at non-UPMC locations or facilities, even after the existing commercial contracts expire on December 31, 2014.

Meanwhile, enhanced competition in both the insurance market and the provider market positions Western Pennsylvania to maintain high quality and affordable healthcare. There will be at least five choices of insurance sponsors available to consumers and businesses, including the UPMC Health Plan, rated as having the highest quality and consumer satisfaction of commercial plans in western Pennsylvania and having at its core UPMC's world class providers. Highmark, meanwhile, will offer plans centered on West Penn Allegheny and designed to entice patients away from UPMC. National insurers, including Aetna, Cigna, and United Healthcare, and others, already are offering and will continue to offer access to both UPMC providers and Highmark providers. Although the Pittsburgh market had long been a competitive outlier without either vibrant national carriers or consumers accustomed to shopping for less costly insurance alternatives, the region's employers and consumers have more recently been the beneficiaries of a price war that will save them tens of millions of dollars on health insurance premiums.

Finally, eighteen months is a reasonable amount of time for Highmark and UPMC to negotiate and implement a transition plan that would allow everyone affected by this development to adapt to and make informed decisions about that transition. Numerous employers are already offering their employees insurance options that will include full, in-network access to UPMC after 2014; others will follow suit once it becomes clear that the current contracts will, in fact, expire. No further time should be wasted, however, in making that expiration clear and in moving forward with the appropriate transition.

UPMC LIFE CHANGING MEDICINE

RESOLUTION

UPMC Board of Directors
June 12, 2013

It is therefore resolved as follows:

- UPMC cannot, in keeping with its central clinical and academic mission, its duty to protect and preserve its charitable assets, and its obligations to the communities it serves, enter into any extension of the existing commercial contracts, or any new commercial contracts, providing Highmark with in-network access to any current UPMC hospitals or physicians in Southwestern Pennsylvania beyond Children's Hospital of Pittsburgh of UPMC, Western Psychiatric Institute and Clinic, UPMC Northwest, UPMC Bedford Memorial and certain other services (including certain unique oncology services) as specified in the Mediated Agreement of July 1, 2012, and therefore will not do so;
- Management shall continue to enter into, or extend, commercially reasonable contracts with health insurers that do not own or control provider services that compete with UPMC's hospitals or physicians; and
- Management shall immediately attempt to engage Highmark in discussions regarding the transition that will take place between the date of this resolution and December 31, 2014, with the purposes of (1) providing all subscribers, patients, physicians, and employers with adequate, timely and accurate information on which to base the choices they will have; (2) ensuring for the smooth and safe transfer of insurance coverage and patient care; and (3) providing for enhanced competition in the market for health insurance and the market for health services.

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