**UPMC AND HIGHMARK CONSENT DECREE: AN ANALYSIS OF THE PITTSBURGH MARKET AND IMPLICATIONS FOR MEMBERS**

by

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University of Pittsburgh, 2018

**ABSTRACT**

The Western Pennsylvania commercial health insurance market is heavily dominated by a select few insurers, including the University of Pittsburgh Medical Center (UPMC) Health Plan and Highmark, Inc. Because of their size and influence, these two multi-billion-dollar organizations are competitors, but from different perspectives. UPMC evolved from being a health care delivery system to an integrated payer-provider, while Highmark began as a Blue Cross Blue Shield health insurer and acquired Allegheny Health Network.

In the process of entering new markets, each respective system encroached on the core services of the other organization, disrupting the normal trends of health insurance member enrollment and patient delivery for the Pittsburgh region. This dynamic shift caused failed negotiations for renewal of contracts between the two integrated delivery finance systems, and the establishment of a legal document to determine when Highmark members were eligible to be seen at UPMC facilities.

In order to protect members during the contractual dissolution of the two enterprises, certain provisions were enacted for each entity to follow. Known as the UPMC Highmark Consent Decree, this document provides temporary protections for vulnerable populations but expires in 2019. This analysis will discuss the implications for members in the Western Pennsylvania region, the benefits and disadvantages of the decree itself, and a projection for the health care market in Pittsburgh after the contract ends. The importance of public health in this analysis focuses on what the positive and negative implications are for health care insureds in the Western Pennsylvania region. The paper defines what was successful in this process and what could have been improved in order to achieve the optimal result for consumers, providers, and payers in the region. Additionally, this case study will be compared to the national market trends in health care mergers and acquisitions as well as the effects of these trends on market competitiveness and consumer behaviors.

TABLE OF CONTENTS

[preface x](#_Toc529442464)

[1.0 introduction 1](#_Toc529442465)

[2.0 Background 3](#_Toc529442466)

[2.1 Pennsylvania insurance market 6](#_Toc529442467)

[2.2 highmark origins 8](#_Toc529442468)

[2.3 Payer to provider 9](#_Toc529442469)

[2.4 UPMC Origins 10](#_Toc529442470)

[2.5 UPMC Health Plan Initiative 11](#_Toc529442471)

[3.0 market conditions 14](#_Toc529442472)

[3.1 input from chief legal counsel 16](#_Toc529442473)

[4.0 upmc highmark Consent decree 19](#_Toc529442474)

[4.1 joint Clinical review process 22](#_Toc529442475)

[4.2 Implications for members 25](#_Toc529442476)

[5.0 Discussion 28](#_Toc529442477)

[5.1 Consumer Perspective 28](#_Toc529442478)

[5.2 Payer perspective 32](#_Toc529442479)

[5.3 State perspective 36](#_Toc529442480)

[5.4 Attorney General perspective 37](#_Toc529442481)

[5.5 successes and failures 37](#_Toc529442482)

[5.6 Case Study 39](#_Toc529442483)

[6.0 Conclusion 41](#_Toc529442484)

[Bibliography 43](#_Toc529442485)

List of tables

[Table 1. Insurer-Level ACA Enrollment, 29-County WPA (2014-2015) 11](#_Toc529442486)

[Table 2. Pennsylvania Healthcare Insured Members by Insurer (2013-2016). 12](#_Toc529442487)

[Table 3. NCQA Ratings 30](#_Toc529442488)

[Table 4. Insurer-Level Medicare Advantage Enrollment as of June 2012 and March 2017, 29-County WPA 35](#_Toc529442489)

List of figures

[Figure 1. Health Insurance Coverage of the Total Population in Pennsylvania, 2014 7](#_Toc529442490)

[Figure 2. Insurer-Level ACA Enrollment, 29-County WPA (2014- 2015) 12](#_Toc529442491)

[Figure 3. Consumer Survey Response: Interest in Using Performance Scorecards, 2015 29](#_Toc529442492)

# preface

I would like to acknowledge my essay advisor, Professor Driessen, and my readers, Dr. Terry and Dr. James, who consistently guided me throughout this process and provided relevant feedback. I greatly appreciate their efforts and time dedication to this portion of my graduate experience.

I am thankful to the Department of Health Policy and Management that has given me so many opportunities to discover my interests in health policy and public health, as well as the ability to learn interdisciplinary skills and apply them in a practical sense. The continuous support and dedication of our faculty, staff, and colleagues has been boundless, and I am privileged to be a part of this distinguished program and its alumni.

# introduction

The Pennsylvania health care market is dominated by a few major entities. Highmark Blue Cross Blue Shield (BCBS) is a large health insurer with over 5 million members, and the University of Pittsburgh Medical Center (UPMC) is a large provider system with over 35 hospitals. In 2017, UPMC had over 310,000 inpatient admissions, 840,000 emergency visits, and 700,000 home care visits (UPMC, 2018). The enormous amount of care being delivered to populations in the Western Pennsylvania Area (WPA) region is contingent upon existing contracts between health insurers and provider systems. Recently, Highmark acquired a provider network called Allegheny Health Network (AHN) and UPMC expanded to offer insurance options. These business decisions led to failed contract negotiations between Highmark and UPMC in 2012 and resulted in changing health insurance and delivery options for consumers. When these contract agreements came to an end, a consent decree was established between the two entities to ensure member protection and transition options for the future. Yet, there is still speculation about what will occur and how it will impact health insurance members when this consent decree expires in June of 2019.

This essay will begin by discussing the history of health insurance in the United States (US) and how it historically relates to hospital and health care delivery services. It will then expand upon the current state of health insurance and delivery in the Pennsylvania market. In further detail, the essay will focus on a recent disruption in the Western Pennsylvania health insurance marketplace, instigated by the competitive interests of two large health care enterprises, UPMC and Highmark. These enterprises entered into a legal consent decree as a requirement by the Pennsylvania State Department of Health (DOH) and the Pennsylvania Insurance Department (PID). The purpose and timeline of this decree and the criteria established for insurance member protection will be analyzed throughout the essay. An analysis from the consumer, payer-provider, and state perspective will be provided. Finally, the case study of these two systems will be compared to a similar scenario in the Northeast US.

# Background

In the early 1900s, US common law established workplace safety requirements and employer liability for any injuries caused by negligence in the work facility. Between 1910 and 1915, 32 states formally enacted workers’ compensation insurance laws. As a result of these early laws, employers were able to purchase insurance plans to retain legal defenses without bearing the full cost of negligence cases. Legal defenses included the ability for an employer to claim that their worker assumed his or her own risk upon signing the employment contract, that the injury occurred due to negligence by the employee rather than the employer, or that the employee was at least partially at fault for the injury. Without this insurance coverage, employers were liable to incur the full cost of medical claims for an injured worker at their facility.

Originally, physicians and organized medicine groups supported the workers’ compensation model as it promised payment by the employer fund. Over time, however, employers began to partner with certain physicians to provide care, which in turn caused a “reduction in the demand for [local physician] services” for those without employer partnerships (Morrisey, 2013). These interests were all considered when the call for compulsory health insurance plans began in the pre-World War I era. Employers did not support compulsory health insurance legislation because it did not have any offsetting reduction in costs like workers’ compensation did. Groups such as the American Medical Association (AMA) ultimately opposed this legislation as well due to fear that health insurance would disrupt the doctor-patient relationship, evidenced by the workers’ compensation fund examples. As a Brooklyn physician at a compulsory health insurance symposium in 1919 stated,

Compulsory health insurance is … Un-American, unsafe, uneconomic, unscientific, unfair, unscrupulous legislation supported by paid professional philanthropists, busybody social workers, misguided clergymen, and hysterical women (Morrisey, 2013 p. 3)

Despite the strong opposition to compulsory health insurance, the idea of sickness funds prevailed. It is estimated that approximately 1,300 sickness funds existed in the late 1890s, prior to workers’ compensation insurance. These were typically supported by fraternal organizations, unions, or employers, with the purpose of supporting a sick member at up to 60% of his wages during an illness or injury using the larger pool of money. Members contributed about 1% of their weekly wages to finance the sickness fund. Essentially, this was a precursor to private health insurance that workers and employers alike found to be satisfactory.

Private health insurance in the US began during the Great Depression era of the early 1930s. As economic downturn swept the nation, hospitals saw decreased occupancy rates and drops in the average receipt dollar amount per patient. This financial crisis was also marked by a 400% increase in charity care, which is free care delivered by hospitals to patients in need. Given the circumstances, hospitals recognized a need to increase occupancy and care delivery by offsetting cost. Baylor University Hospital developed a model that enrolled 1,250 public school teachers into a plan where 21 days of hospital care was promised in return for 50 cents a month. Similarly, a model in Sacramento, California, promised to cover services at any hospital in the community. This ideology expanded throughout the 1930s and 1940s, and the American Hospital Association (AHA) began to approve hospital service plans through the Blue Cross Commission in 1946. The plans had to be designed to improve public welfare, cover hospital charges only, allow the insured to have a free choice of physicians, and be non-competitive with other Blue Cross approved plans in order to be approved. This set the stage for exclusive regional Blue Cross health insurance plans.

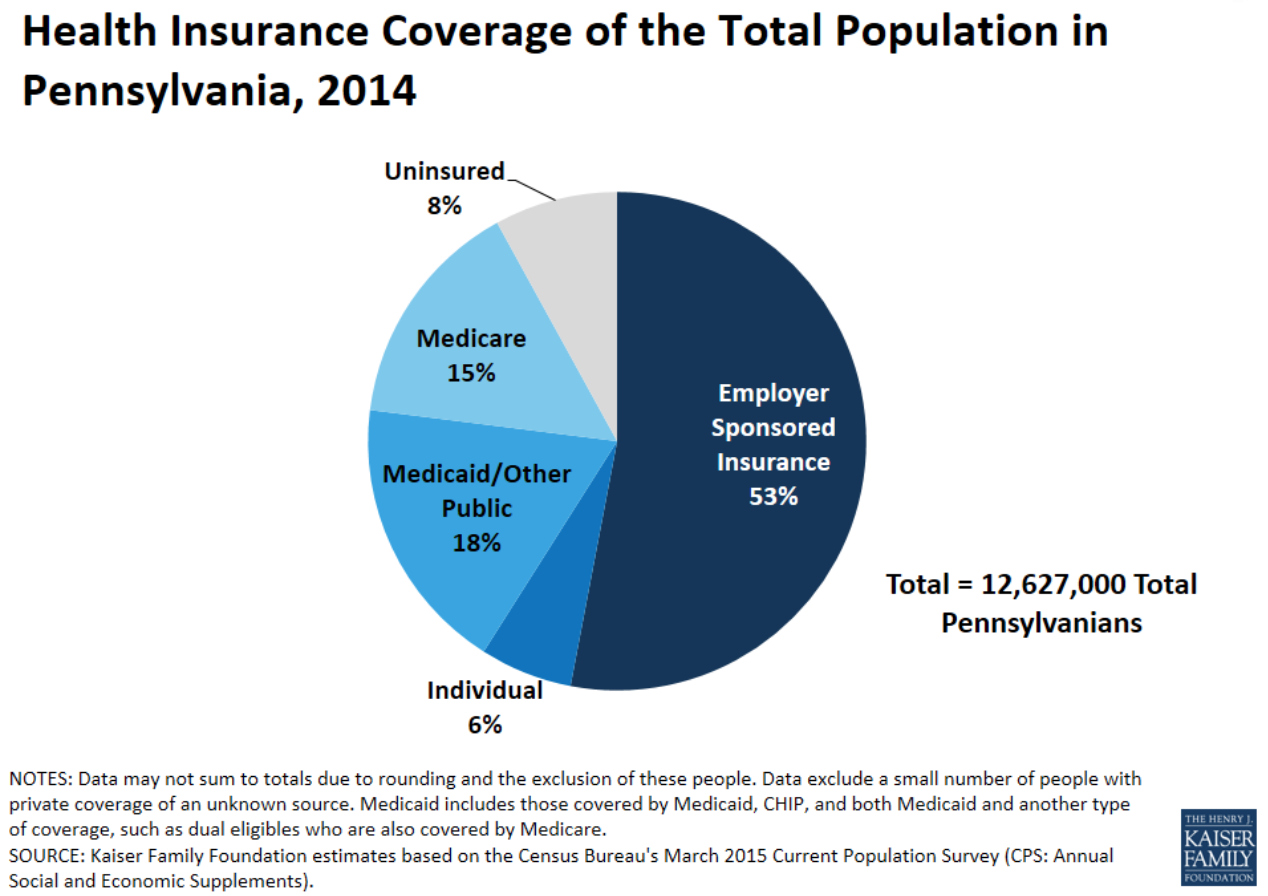
Simultaneously, the California Physician’s service, established in 1939, was creating a medical service plan. This plan required two criteria, free choice of physician and indemnity – the idea that the plan would pay a certain dollar amount on behalf of the patient to the physician for a medical event. This Blue Shield plan followed the same approval model of the Blue Cross Commission. Operating separately for decades, the two plans formally merged in 1977 to form the Blue Cross Blue Shield Association (BCBSA).

The rise of commercial insurance plans began to rival the BCBSA during the 1970s. Commercial insurance plans of the 1930s were initially designed to provide hospitalization and surgical coverage. Over the decades, these plans began to gain competitive advantage due to their rapid growth. World War II brought with it a high demand for war material production and wage freezes imposed by the federal government on many employers. A need for employers to incentivize their workers by other means developed – namely, employer-sponsored health insurance. Commercial insurers gained large portions of market share during the 1950s, rivaling the BCBS plans. Rather than focusing on community rating, where all insured individuals are part of one large risk pool, commercial insurers began to use experience rating. This would allow a less risky group of individuals to be collectively part of a risk pool. For example, a group of teachers might be required to pay lower monthly premiums than miners due to the less dangerous nature of their work. Over time, the relative risk of experience rated plans continued to attract less risky individuals, making the insured and the insurer better off when it came to cost burden. In turn, this removed low-risk individuals from the BCBS plan risk pools, causing cost increases for these plans and their members. As a result, the BCBS plans had to move to experience rating to remain competitive with commercial insurers.

Another transition in the US insurance market has been the shift from traditional indemnity insurance plans towards managed care organizations (MCOs). MCOs have gained momentum since the 1990s, and many BCBS plans have adopted this technique. MCOs aim to effectively balance the cost burden of their insured population through managed care or population health techniques, while selectively contracting with certain providers as in-network. This structure was developed in response to the rising cost of health care, to increase competition with other insurers, and in response to federally mandated prospective payment systems. Medicare and Medicaid reimbursements to hospitals were changed by Congress in the 1980s, so hospitals were paid a fixed amount based on the diagnosis codes of admitted patients. By effectively managing the cost of care for patients with chronic, costly conditions, MCOs can maintain financial well-being. This model also incentivizes providers by reimbursement focused on value rather than quantity; preventive health techniques and quality metrics are used to reduce readmission rates or hospital acquired infections. This translates to a safer, more enjoyable experience for the patient and increased quality across the continuum of care. Today, the competitive strategy between BCBS plans and the private, commercial insurers continues to evolve.

## Pennsylvania insurance market

To understand recent trends in the WPA health insurance market, it is important to first understand the state health insurance market and its trends, which are heavily dominated by a few health insurers who have a strong presence in the WPA region. Pennsylvania is the fifth largest health insurance market in the United States, and the 14th largest insurance market in the world, when comparing premium volumes (Pennsylvania Insurance Department, 2017). With approximately 12.5 million residents, 92% of Pennsylvanians were insured as of 2014 (Kaiser Family Foundation, 2018). Of the insured population, almost six in 10 Pennsylvanians had private health insurance, with the large majority of these covered by employer-based insurance. About 15% of Pennsylvanians were enrolled in Medicare as of 2014, with 39% of these beneficiaries participating in a privately administered Medicare Advantage plan. Figure 1 illustrates the health insurance coverage make-up for Pennsylvania, according to Kaiser Family Foundation.



*Source: (Pennsylvania Insurance Department, July 2017)*

Figure 1. Health Insurance Coverage of the Total Population in Pennsylvania, 2014

The uninsured rate in Pennsylvania, which was approximately 5% as of 2016, is comparable to the national average for other states; the trend in the insured rate since implementation of the Affordable Care Act has roughly halved from approximately 10%. As of 2014, Pennsylvania individual, small group, and large group insurance markets were dominated by a few major insurers (Pennsylvania Insurance Department, 2017). In 2015, roughly 648,000 enrollees participated in the individual market of Pennsylvania; the market share of the top three insurers for the individual market was Highmark, with 45%; Independence Health Group, with 23%; and UPMC Health System Group, with 9% (Pennsylvania Insurance Department, 2017). For the small group market, Independence Health Group controlled 23% of the market share; Highmark, 18%; and Aetna, 17%. For the large group market, Highmark Group controls 32% of the market share; Independence Health Group controls 23%; and Aetna Group controls 12% (Pennsylvania Insurance Department, 2017). It is important to note that compared to other states, the health insurance market in Pennsylvania is less competitive due to the market share held by these select few insurers(Pennsylvania Insurance Department, 2017).

## highmark origins

With origins from the Great Depression, Blue Cross and Blue Shield health insurance plans were instituted to help citizens pay for costly health care services and hospitalizations. The Pennsylvania Medical Society supported the development of Blue Cross and Blue Shield (BCBS) as separately operating plans in the state of Pennsylvania (PA) until 1996, when the Blue Shield and Blue Cross plans of PA consolidated to form Highmark. These two Blue plans were structured as non-profits that operated in a traditional business sense; rather than answering to a group of shareholders, profit margins were reinvested in business endeavors or used to offset the cost of care for individuals with greater health risks, as a means of balancing the low and high-risk individuals who comprised the risk pool. Between Highmark and three other affiliated Blue plans in Pennsylvania, complete coverage options were made available to Pennsylvania residents by December of 1996, making it the largest health insurance provider in the state with 4.7 million members. After 12 years of affiliation with the Mountain State BCBS, the name “West Virginia Highmark” was adopted; Highmark Delaware came into effect in 2012. In 2015, Blue Cross of Northeastern Pennsylvania (BCNEPA) officially merged with Highmark BCBS (Highmark Corporate Profile – link 5).

## Payer to provider

The West Penn Allegheny Health System (WPAHS) was purchased by Highmark in 2013 as a strategic acquisition to begin competing with the University of Pittsburgh Medical Center (UPMC). After years of uncertain financial status, WPAHS had raised doubts about its ability to survive (Evans, 2013). With the purchase of WPAHS, the hospital delivery system in the contract was renamed Allegheny Health Network (AHN). Highmark and AHN became one of the largest integrated payer-provider networks in the Unites States once the merger was finalized. The enterprise formed a vertical alignment with Highmark, the insurance provider, serving as the parent company; AHN would be an affiliate delivery system, coupled with the newly purchased Jefferson Regional Medical Center.

The Pennsylvania Insurance Department (PID) paid careful attention to the purchase of the WPAHS; it maintained the ability to regulate financial decisions of Highmark, which had originally proposed $400 million in financial aid to WPAHS; this became $1 billion before the end of the negotiating period (Kaiser Family Foundation, 2018). It also established that a firewall must be put into place between Highmark and AHN; this would prevent rate information from being exchanged between the parent and affiliate, and avoid the disclosure of competitor pricing or product information to AHN. Other conditions in the contract included that Highmark cannot extend provider contracts with its own hospitals and physicians longer than five years. This move into the provider space marked the dissolution of a relationship between Highmark and UPMC; although it created competition in the market, UPMC noted during this time that it would not look to extend contracts with Highmark in the future.

## UPMC Origins

Founded as Presbyterian Hospital of Pittsburgh, what is now known as the University of Pittsburgh Medical Center was legally incorporated in 1895; the University of Pittsburgh was considering building a medical center and convinced Presbyterian to move to Oakland on the promise of a tract of land. In 1949, a three-tiered mission was embarked upon as a collaboration between the University of Pittsburgh and Presbyterian Hospital, the goals being patient care, education, and research. In 1986, three university-affiliated hospitals entered a shared management agreement, forming a precursor to the modern-day health system. This system continued to merge with community and specialty hospitals. In 1997, UPMC launched its health insurance product under the Insurance Services Division as a means of complementing its provider network. Today, it has evolved to become a $14 billion integrated global health enterprise, with assets as of 06/30/2017 at $12.9 billion, and annual revenue of $14.3 billion (Twedt, 2014). Though its newest addition, the UPMC health plan, is relatively new to the Western Pennsylvania market, UPMC has seen a 17.5% increase in year-to-year revenue as of 2016 and continues to optimize its solid financial status by investing billions in new infrastructure and innovative technology.

## UPMC Health Plan Initiative

In 1997, UPMC Health Plan was established. It offered employer and group insurance as well as individual products. Though it remained relatively uncompetitive financially for the first few years, a large uptick in membership in the 2010s brought this health plan to the forefront of the health insurance market. This time period was marked by UPMC Health Plan advertising their competitive, low cost premiums for members in the Pittsburgh region, a feature which continues to attract members currently. During 2014, enrollment was not impacted heavily by UPMC entering the market, but 2015 saw a dynamic shift in enrollment. UPMC took nearly 29% of the ACA enrollment across 29 counties from 2014-2015 (Pennsylvania Insurance Department, 2017). Although Highmark maintained approximately 83,000 members in the ACA market for this same geographic region, its percent of the market share dropped from roughly 93 percent to 63 percent for the same time period (see Table 1).

Table 1. Insurer-Level ACA Enrollment, 29-County WPA (2014-2015)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Enrolled** |  | **Enrolled** |  |
| Insurer | 2014 | 2014 | 2015 | 2015 |
| **Total** | **88,381** | **100.0%** | **133,427** | **100.0%** |
| Highmark | 82,609 | 93.5% | 83,441 | 62.5% |
| UPMC | 2,483 | 2.8% | 42,391 | 31.8% |
| United | 0 | 0.0% | 4,227 | 3.2% |
| Geisinger | 2,144 | 2.4% | 1,996 | 1.5% |
| HealthAmerica | 1,145 | 1.3% | 1,239 | 0.9% |
| Other | 0 | 0.0% | 107 | 0.1% |
| Capital BlueCross | 0 | 0.0% | 26 | 0.0% |

In ACA enrollment, UPMC gained nearly 29% in the same category for 2014-2015 (see Figure 2 below).

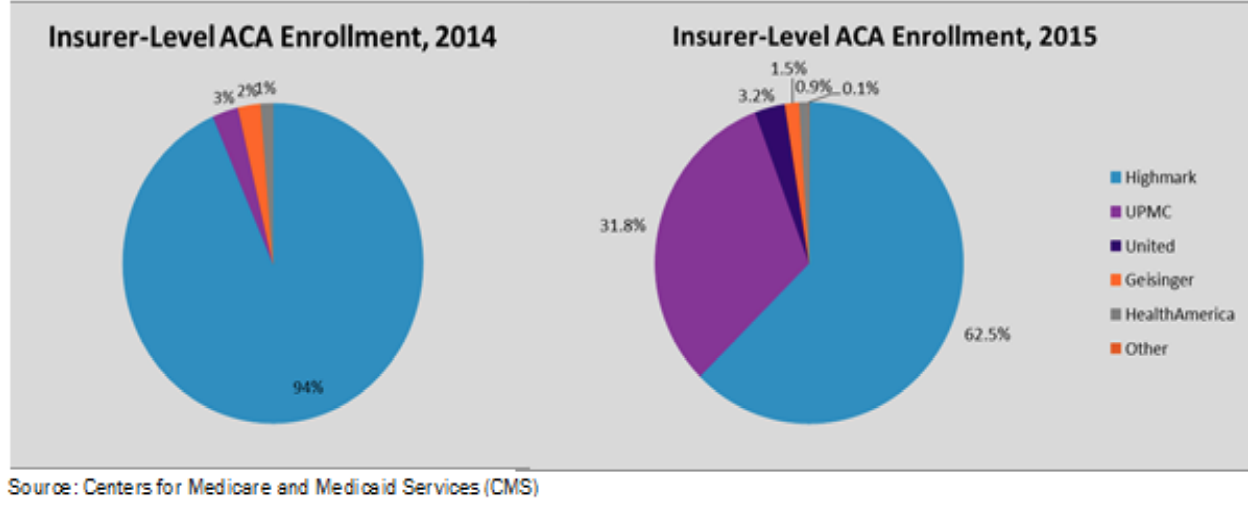
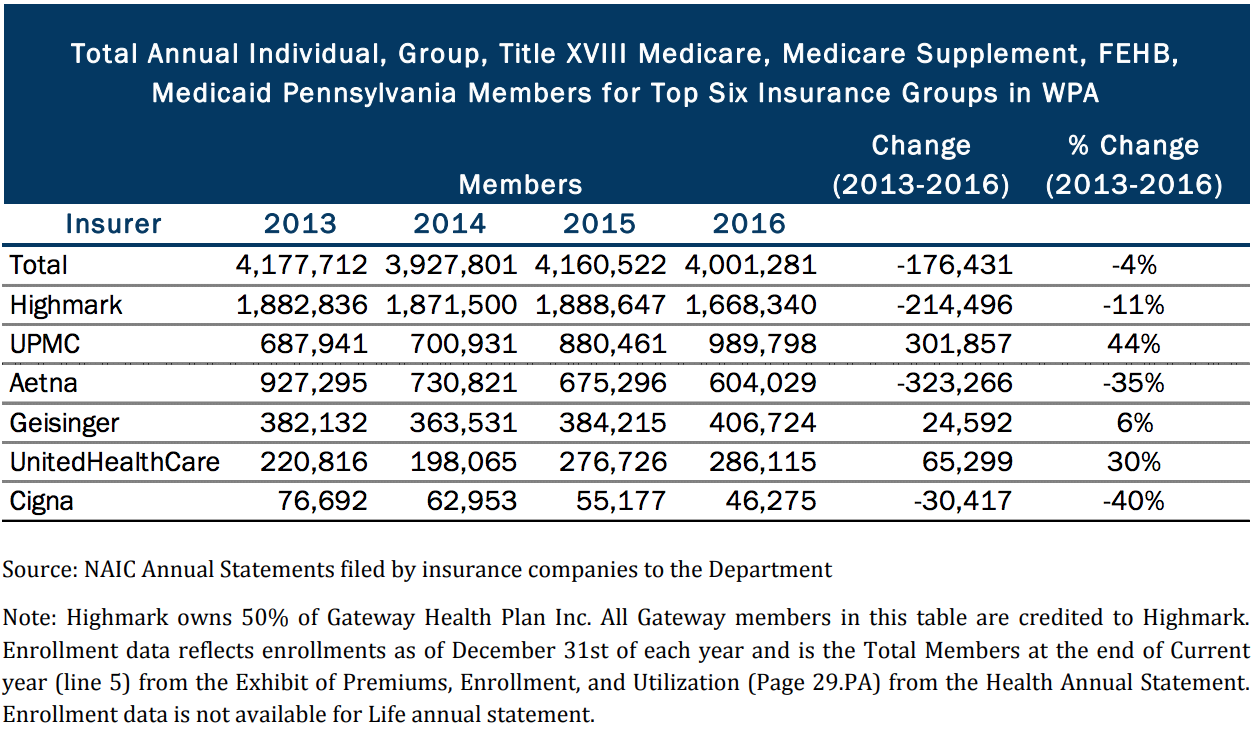


Figure 2. Insurer-Level ACA Enrollment, 29-County WPA (2014- 2015)

Additionally, among all insurers in Western Pennsylvania Area (WPA) region, UPMC Health Plan had a marked 44% increase in the percent change of overall enrollment from 2013-2016. Highmark experienced a negative 11% change in WPA enrollment for the same time period (see Table 2 below).

Table 2. Pennsylvania Healthcare Insured Members by Insurer (2013-2016).

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Total Annual Individual, Group, Title XVIII Medicare, Medicare Supplement, FEHB, Medicaid Pennsylvania Members for Top Six Insurance Groups in WPA** | | | | | | |
|  | **Members** | | | | **Change (2013-2016)** | **% Change (2013-2016)** |
| **Insurer** | **2013** | **2014** | **2015** | **2016** |  |  |
| Total | 4,177,712 | 3,927,801 | 4,160,522 | 4,001,281 | -176,431 | -4% |
| Highmark | 1,882,836 | 1,871,500 | 1,888,647 | 1,668,340 | -214,496 | -11% |
| UPMC | 687,941 | 700,931 | 880,461 | 989,798 | 301,857 | 44% |
| Aetna | 927,295 | 730,821 | 675,296 | 604,029 | -323,266 | -35% |
| Geisinger | 382,132 | 363,531 | 384,215 | 406,724 | 24,592 | 6% |
| UnitedHealthCare | 220,816 | 198,065 | 276,726 | 286,115 | 65,299 | 30% |
| Cigna | 76,692 | 62,953 | 55,177 | 46,275 | -30,417 | -40% |



As the UPMC Health Plan continues to evolve, many of the favorable conditions under which Highmark initially operated have been disrupted by this new competitor. It would be reasonable to assume a continued positive trend in UPMC Health Plan enrollment for the coming periods.

# market conditions

When the vertical integration of Highmark and AHN occurred, the PID recognized that this changing dynamic in the market could cause potential adverse effects for members. Because the purchase of AHN would likely solidify competitor status with the UPMC health plan and delivery system, any renegotiation of contracts was anticipated to result in narrower networks for Highmark and UPMC insurance enrollees. This would leave patients with less physician choice and reduced access to care. For example, a UPMC Health Plan enrollee might no longer be able to receive treatment from a primary care physician (PCP) who is affiliated with AHN unless they pay an out-of-network (OON) rate. If this PCP happens to be the only provider within a reasonable distance, that patient might be forced to travel much further distances to receive the same type of health care services at an in-network rate.

To reduce the likelihood of these events, the PID issued a regulatory outline meant as policyholder and public interest protection in 2013 (2017). This document set forth compliance criteria for both Highmark and UPMC in order to protect consumers and to maintain financial viability moving forward. Given the rapidly deteriorating relationship between the two entities, it became clear that any negotiations of contracts for the coming year would be limited in nature if not completely dissolved. As anticipated, 2013 renegotiations were extremely restricted and essentially resulted in a separation plan for both enterprises. PID stated, “In an effort to provide clarity and certainty for consumers, Highmark and UPMC have each entered into a consent decree with the Office of the Attorney General (OAG), the Insurance Department (PID) and the Department of Health (DOH)”(1).

The PID included the following conditions as part of the 2013 ordered to protect consumers in the health insurance market of Western Pennsylvania:

(1) prohibition of limitations on the use of consumer choice and other member cost‐sharing initiatives, such as tiered network products, (2) monitoring and reporting of the effect of the affiliation transactions and IDN strategy on community hospital discharges, (3) various actions to be undertaken by Highmark to identify opportunities to deliver more cost‐effective healthcare and a robust and vibrant network with meaningful choice, (4) transitioning of care for Highmark subscribers as UPMC moved to out‐ of‐network status in health plans offered by Highmark, and (5) financial investment in “community health reinvestment” activities (p. 3)

The PID felt that it was necessary to intervene in this affair for multiple reasons. First and foremost, the formal purchase and consolidation of AHN by Highmark posed the risk of reduced market competition in WPA. With less competition, insurance rates are likely to increase, which is one of the fundamental concerns for member protection. Moreover, protecting consumer choice was a critical component of the 2013 PID order. Limiting the power of Highmark to restrict consumer choice ensured that members had reasonable flexibility in their health care service accommodations.

Second, Highmark was expected to financially improve the well-being of AHN to ensure viability of the delivery system. Because there was uncertainty about the financial status of AHN at the time of its acquisition, Highmark had to agree to a WPAHS corrective action plan. This plan included the need for improved infrastructure, operations, efficiency, and revenue generating opportunities. From a broad perspective, these provisions were important to continue supporting the volume of patient health care delivery in the WPA region and to ensure that essential health care services were available to vulnerable populations of individuals enrolled as Highmark insurance members.

Lastly, the 2013 PID order called for a transition plan to be established between Highmark and UPMC. Since Highmark was the largest insurer in the region at this time and UPMC the largest provider, it was critical to ensure that Highmark members would be able to access services elsewhere. For this reason, the PID order required network adequacy, in-network access to UPMC specialty hospitals that are exceptions for Highmark members, and quality continuation of care for Highmark members who were already receiving services with UPMC practitioners or transitioning to AHN practitioners. Vulnerable populations of members, including Medicaid, CHIP, and Medicare Advantage (MA) enrollees also had to be guaranteed in-network access.

## input from chief legal counsel

As mentioned previously, the integration of Highmark and AHN served as the formal adoption of a health care delivery system, encroaching on the market territory of the UPMC delivery system. UPMC refused to negotiate a Highmark contract that would extend beyond December 31, 2014, without significant rate increases due to this encroachment on its service territory. This contract would alter the ability of Highmark members to receive health care services at any UPMC facility, which would have significant implications for consumers in the region; essentially, the largest health insurer in Western PA and the largest provider of hospital, outpatient, and physician services had come to a standoff.

Because of this, the PID stated that Highmark must either reach a reasonable contract with UPMC by summer of 2014, or else initiate a formal transition plan to include network adequacy requirements; in-network options for hospital and physician services in the UPMC network that could not be accessed elsewhere in the Pittsburgh region; continuity of care for individuals receiving ongoing care from any physician within the UPMC network, at an in-network rate; and lastly, in-network access extended to vulnerable member populations (Pennsylvania Insurance Department, 2017). The provisions laid out in this transition plan are approved by the PID, and for this reason the PID reserves the right to extend particular provisions for up to five years past the date of expiration for the contract, December 31, 2018.

Beginning in 2010, UPMC and Highmark entered preliminary discussions about rate negotiations. UPMC argued for an increased rate of reimbursement for services provided for Highmark members, as well as hospital tiering – a strategy used by health insurers to rank hospitals according to the cost of service they provide - and urgent care differentiation from services delivered in inpatient or outpatient settings. At this point in the conversation, there was no plan to end contract negotiations. Meanwhile, The Allegheny Health, Education, and Research Foundation (AHERF) was financially unsustainable and failing. There was some discussion of hospital mergers, but no precise plan for merger or acquisition was developed for Highmark and UPMC. Public knowledge of the Highmark and Allegheny Health Network (AHN) merger occurred in late 2010 to 2011, with the formation of AHN officially taking place in 2013. The established contract required that 180 days of notice be given for any changes to membership plans and had a built in one-year extension period. This allowed the newly merged Highmark-AHN network to establish rate negotiations and also served as the beginning of the period when Highmark-AHN became a competitor to UPMC in the provider market.

Pennsylvania negotiations continued in 2011 and 2012, which resulted in dispute resolution through the governor’s office. In 2014, Highmark agreed to pay reimbursements at a substantially increased rate, and officially morphed into an integrated delivery finance system as Highmark-AHN. As mentioned previously, the Commonwealth of Pennsylvania and PID wanted to ensure that no harm came to members during the transition period while Highmark was acquiring AHN. These rate changes may have reflected the minimum financially sustainable threshold at which the integrated system could operate. Given the unstable financial status of AHN at its time of purchase, many changes occurred to mitigate the potential adverse effects of financial risk for the enterprise or lack of health care access for patients in this market segment.

The year 2014 also marked the beginning of significant advertising campaigns and commercials by Highmark and UPMC that sought to undermine one another. At the same time, state investigation of the non-profit status of UPMC began. The structure of UPMC as a lateral organization had to be investigated to ensure that non-profit status was met by charitable donations and other financially required criteria. In April of 2013, the WPAHS merger occurred. The consent decree, which was established in 2014, is meant as a formal communication plan that laid out the specifics about in and out of network status for Highmark and UPMC Health Plan members, provider services, and service delivery locations. During a conversation with a leader of Highmark Health, Anne Shearon, a chief legal counsel vice president of Highmark, pointed out that “even a well-written document will have shortfallings” (A. Shearon, personal communication, July 27, 2017).

# upmc highmark Consent decree

The consent decree is a five-year, state-brokered legal document that was enacted on June 27, 2014, and applies to all Highmark and UPMC members, including Medicare Advantage patients. In its original form, the consent decree stated that the resolution including all provisions discussed previously would extend through June of 2019. But Highmark argues that because Medicare is a federal program that operates on a calendar year basis with its provider contracts, this would leave Medicare Advantage (MA) beneficiaries with a lack of options for the remainder of 2019. Security Blue and Freedom Blue MA plans will no longer provide in-network access to Highmark members seeking care at UPMC facilities or with its affiliated physician practices once the decree draws to an end.

As of November 2017, over 26,000 pending cases had been brought forth by UPMC as discrepancies. UPMC claimed that these complex cases either did not meet criteria for out-of-network (OON) in their network, or were continuity of care (COC) cases, meaning the patient should be able to continue receiving treatment at UPMC at an in-network rate. These cases accumulated due to the high volume of UPMC and Highmark disputes (T. Fitzpatrick, personal communication, Nov 7, 2017). Certain provisions within the decree serve as protections for the consumers and providers who have no direct involvement with the failed negotiations between Highmark and UPMC. For instance, community hospitals have been a major concern, as many have affiliations with either UPMC or Highmark. However, it would be detrimental to the consumer and the community hospital if services were suspended or priced at an OON rate when that hospital is the sole provider for a given community, or provides procedures that may not be offered elsewhere in the region. Due to their specific network contracting, many physicians who are associated with one of the two entities would be penalized unfairly by the in or out of network provision as well.

Another major concern involves emergency services as they relate to Highmark members who might be visiting a UPMC facility under urgent conditions. It would be unrealistic to expect that a Highmark member experiencing a heart attack could not be taken to a UPMC hospital if it is the closest facility that can provide the appropriate medical attention. Given this scenario, the consent decree deemed that UPMC must adhere to “good faith” negotiations with Highmark on “in-network rates and patient transfer protocols for emergency and trauma services for hospital, physician, and appropriate continuity of care services at all UPMC and Allegheny Health Network hospitals by July 15, 2014” (UPMC Consent Decree, 2014). It is estimated that $700 million in claim expenditures would have been diverted from Highmark if UPMC no longer accepted Highmark members in an emergency situation. This may seem like a relative benefit for Highmark with expense avoidance as a health plan; however, it would also have negative implications for the financial status of AHN as a provider (T. Fitzpatrick, personal communication, Nov 7, 2017). With this in mind, a sustainable, enterprise-level decision had to be made regarding access to care and quality delivery.

Additionally, member protections were put in place for vulnerable populations, which are defined as eligible or enrolled consumers age 65 or older with Medicare or Medicare Advantage and also those covered by federal benefit programs such as Medicaid, CHIP, and Medigap health plans. This provision set forth that under the current circumstances, including rates and program structure, UPMC would agree to cover vulnerable populations as mentioned above at an in-network rate. This ensured that downstream market implications such as disruption of long-term clinical care relationships would not negatively impact the consumer base. Because UPMC was accustomed to treating a large portion of patients in the Greater Pittsburgh Area, this provision guaranteed treatment for vulnerable members who may not be able to receive health care services elsewhere. A large part of this consideration stemmed from the infrastructure capabilities that UPMC had in contrast to AHN at the time. Although AHN hospitals had existed in the community for quite some time, there would be serious capacity issues if all Highmark members were swiftly transitioning to care delivery at one of the six flagship AHN hospitals within the Pittsburgh region.

To put this in perspective, only an estimated 15% of Highmark members continued to use UPMC facilities as of December 2017, a population of nearly 750,000 members (Gough, 2017). Collectively, the roughly 2,000 hospital beds would not be enough to sustain this portion of care to all Highmark members in the Pittsburgh region (T. Fitzpatrick, personal communication, Nov 7, 2017). Quality of care would likely suffer due to this capacity issue, and patient wait times for specialist or follow-up appointments would increase. Not only would this be a major concern for patient safety and quality of care but missing these metrics might result in non-compliance with hospital regulators. Overall, this outcome was avoided through exceptions set forth in the consent decree which, on a larger scale, evenly distributed the membership of each entity across the Pittsburgh payer and provider market.

Historically, many members within the Highmark network have been satisfied with the size of the provider network and the competitive pricing, both elements that will be compromised by the ending of the consent decree. It is likely that the growing membership of UPMC will create a healthy competition between the insurers who control large parts of the market in Western Pennsylvania. Ironically, much of the competitive pricing that Highmark has previously been able to offer its enrollees was due in part to the favorable 10-year contract with the UPMC provider network. Moving forward, it is unlikely that Highmark will benefit from this restricted provider and hospital network without major operational and infrastructure changes to the AHN system.

## joint Clinical review process

Inevitably, there are complex patient cases that require additional review by clinical staff in order to make a determination for in- or out-of-network purposes according to the UPMC-Highmark Consent Decree. This process has proven to be time consuming and inefficient for both of the health care organizations involved. The review process itself takes place on a daily basis; both UPMC and Highmark representatives must participate, Monday through Friday. Referred to as the Joint Clinical Review (JCR), this panel consists of physician assistants, physician reviewers, and nurse managers from both Highmark and UPMC. The majority of these clinicians have full-time responsibilities relating to the review process; for instance, the nurse managers must summarize and prepare each case determination upon completion of review. First, there is a determination made about whether the case should be presented to the JCR committee, a decision made by UPMC based on how ambiguous the case criteria appear. The decision-making process regarding the specifics of the case is outlined in criteria a through e below.

1. Continuity of care – this clause establishes that a member who is receiving treatment from a physician at one organization can continue to receive that treatment at an in-network rate, as long as the member is deemed to have a chronic or persistent condition.
2. Chronic, persistent condition – for example, a patient who is seeing a UPMC physician for continuing evaluation of a liver cirrhosis, and potential liver transplant. A Highmark member, in this case, is eligible to continue seeing their physician so long as they have been seeing them since initiating treatment for that specific condition. If in-network Highmark physicians are available to treat this condition type, the individual is referred to a Highmark customer service representative to make them aware of the potential for treatment within the AHN system.
3. If a member seeing a gynecologist for a preventive wellness check-up, including a pap smear and normal pelvic exam, for example, is treated by a UPMC physician for an irregular pap smear, this would not be considered in-network. Any referral to a specialist would be deemed to fall outside of the consent decree criteria, as the patient could have been referred to an in-network specialist.
4. Routine and preventive are not considered to be chronic conditions – example listed above.
5. No new doctors – if a UPMC physician in a certain practice group retires, for instance, and refers their group of patients to another physician within this practice, any further services provided will be deemed OON for Highmark and in-network for UPMC as this referral should have been handed off to an AHN physician.

If no decision can be reached through this clinical review process, the case is sent to the State Department of Health; the organization that is deemed to be inconsistent with the consent decree legal basis is charged $300 per case for review costs and for the inability to reach an accurate decision. This penalty is put in place to protect tax payer dollars, as a large volume of cases are sent to the DOH because of disagreement and ambiguity.

Highmark practitioners are obligated to complete this process because UPMC chooses which patient cases will be adjudicated. This process has created an enormous work volume for the nurse managers, who often cannot complete their clinical summaries within the 40-hour work week, and therefore take cases home in the evenings and on the weekend to continue meeting their requirements. Additionally, these cases are complex in nature and usually ambiguous in terms of their criteria for meeting the continuity of care, vulnerable populations, or other exclusion clauses set forth in the consent decree.

Because of this, physician assistants must prepare the cases for the physician reviewer each day. Often, they will spend hours summarizing the critical information from patients with several comorbidities and costly hospital stays, with the final decision coming down to a set of arbitrary criteria laid out in the Consent Decree. For example, a UPMC physician might argue that a single episode of care for a patient preventive health screening qualifies as a continuity of care case according to the decree. They might state that the patient had been seen at this practice previously and therefore was continuing to receive care for an existing condition. It falls upon the physician assistants at the opposing organization to research the patient record, determining whether this episode of care is related to any others. This exchange might take several rebuttals before a decision is made. Finally, physician reviewers who have a majority of their work responsibilities outside of the JCR panel feel burdened with the daily review process.

Although physician reviewers alternate days, it is important to establish interrater reliability among the reviewers; this is difficult when the cases reviewed are not specific to one type of specialist. For example, many cases that are reviewed in JCR relate to continuity of care issues for women undergoing normal preventive health screening procedures during annual obstetric or gynecological (OB-GYN) exams, but with abnormal results. If a patient in this situation were seeing a UPMC gynecologist for her initial treatment, but received abnormal testing results and was then referred to a specialist for follow-up care, it might be debated whether the referral should be issued to a UPMC or AHN physician.

Often, these scenarios require dialogue about the specifics of where the patient is located, what services are available to them within a reasonable distance, and consideration of the condition risk before a final decision can be made. In cases where both physicians fail to come to an agreement, the case must be sent to the Department of Health for final adjudication of in- or out-of-network status with UPMC as the primary entity; that is, Highmark would have to pay an in-network rate losing up to 15% difference in the total payment amount - to the UPMC provider if they lose a case. This can become extremely costly over the course of hundreds of cases, not to mention that the complexity of these cases usually mean that the episodes of care are unusually high in cost. As a penalty for failing to reach agreement, the DOH issues a $300 penalty per case to the organization that loses the adjudication. Not only is this process time consuming, but it has created employee frustration and burnout for both UPMC and Highmark with the ever-growing demands of their positions; it has also become an unsustainable financial situation for both entities involved.

## Implications for members

As the UPMC-Highmark Consent Decree draws closer to its end, disputes over the final contractual obligations for each enterprise remain. As mentioned previously, the official document, validated by the Pennsylvania Insurance Department, states that the formal consent decree criteria will apply until June 30, 2019. However, according to a January 2018 press release from the Pennsylvania Office of the Attorney General (AG), the Commonwealth Court determined that UPMC would be ordered to comply with providing in-network care to over 140,000 MA members until December 30, 2019. There was no indication of extension for commercial insurance or individual market enrollees. After this date, UPMC facilities will no longer be obligated to accept Highmark insurance members at an in-network rate, with the exceptions of emergency department services; continuity of care determinations; oncology services; and other specialty services that are exclusively available through UPMC facilities, such as Western Psychiatric Institute and Clinic or UPMC Children’s Hospital. However, even these exception services draw to an end; Highmark members receiving treatment at UPMC cancer programs affiliated with a community hospital will have in-network access until 2021; UPMC specific cancer programs will extend in-network rates until 2024; and UPMC Children’s Hospital will extend until 2022 (Pittsburgh Post-Gazette, 2018).

Unless UPMC and Highmark are able to renegotiate an agreement that is reasonable for both systems, it is likely that members will have to establish loyalty to one system or the other moving forward. There has been some media coverage that has indicated this possibility, but it is yet to be seen. The positive implications for members might include more streamlined health insurance and electronic health record information; treatment issued by clinicians who have ready access to the patient health information and can therefore provide higher quality care; and consistency in fulfillment of consumer expectations for both health insurance benefits and health provider delivery. Some negative implications of this issue might include reduced flexibility in options for seeking health care; increased travel time for patients to in-network facilities; and difficulty for vulnerable populations seeking care after the provisions of the decree end. It is hard to project exactly how consumers will act in this scenario, but it is clear that the ending of this decree between the two organizations will change consumer experience, for better or worse, abruptly.

Highmark has appointed a UPMC transition leader through the newly formed customer alignment department. This department was established in August of 2017 to assist in the final two years of dissolution between the contracts, and to promote member outreach and retention. Customer alignment will seek to enhance payer-patient and provider-patient relationships through internal marketing campaigns, community outreach, and innovative member benefit programs. Additionally, Highmark customer alignment will facilitate greater patient awareness through case and disease management outreach. Patients who have chronic conditions and utilize services frequently will be contacted regularly to communicate the changes that are occurring with the ending of the consent decree.

From an internal perspective, Highmark wants to retain the Medicare and Medicaid enrollees it originally had, while also striving for a marketable benefit package for its commercial line of business. This is likely the case for UPMC as well. Many advertisements released in the fall months of 2017 were tailored towards Medicare enrollees, as there is a very short window in which beneficiaries can choose their plan for the year. This member enrollment period is highly influenced by reputation and experience with the organization. Since Medicare enrollees have recently experienced relatively similar benefits and out of pocket (OOP) costs between the two organizations’ plans, they are inclined to enroll with whichever company they feel most comfortable with.

# Discussion

In order to analyze the effect of the consent decree on the Pittsburgh market, it is important to consider each stakeholder perspective. Although the process has not been perfect, certain provisions set forth in the consent decree were relatively successful in assuring member protection, consumer choice, and financial sustainability. This section will discuss the takeaways as they relate to each perspective.

## Consumer Perspective

From a consumer perspective, there are many differing beliefs about the Highmark UPMC contractual dissolution. As a 2015 Deloitte health consumer survey found, “gaps between what individuals are interested in doing and what they have experienced suggest many people want to become empowered consumers, but have not yet made the move” (p. 1). Often, health care consumers who are infrequent users – essentially the stable, healthy patients – do not have as much at stake. It is probable that most of these health care consumers do not know much about the Highmark UPMC consent decree whatsoever. But in an emergency situation or when continuing care for a chronic condition becomes a necessity, these consumers may change their perspectives. As Deloitte mentioned in the 2015 publication, the leading indicators for transforming into engaged health care consumers include poor health status, higher income, and being young. This portion of the insured population would likely become the most knowledgeable consumers about consent decree implications if the situation warranted it.

Moreover, Deloitte (2015) discovered that consumers are much more engaged in tapping online resources for health care reporting and quality metrics than in previous years. From 2013 to 2015, consumers who reported monitoring of personal health and wellness using technology increased from 17% to 28%. One quarter of respondents also reported comparing different doctors and hospital performance scorecards online before choosing a provider or facility (see Figure 3).

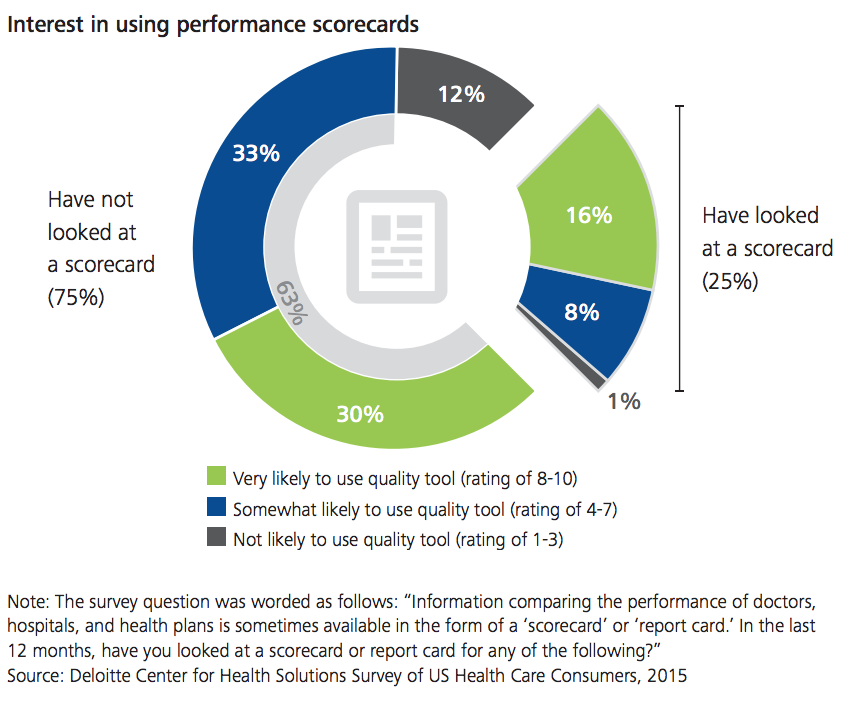
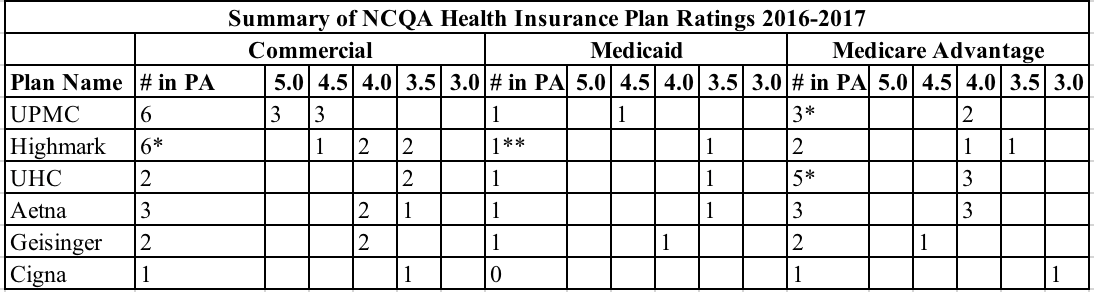


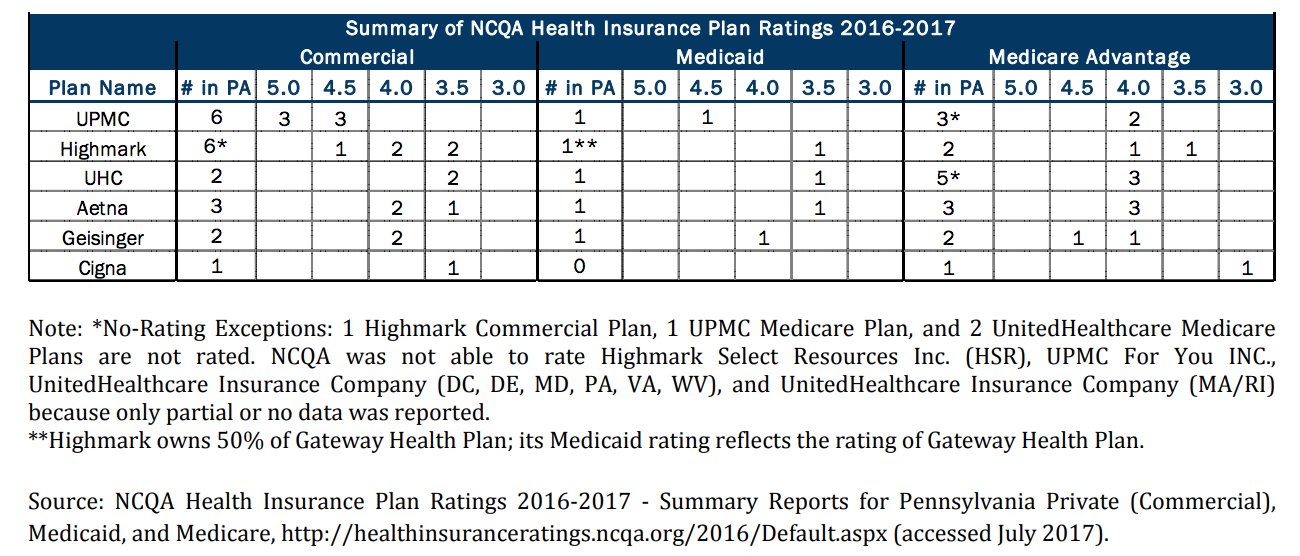
Figure 3. Consumer Survey Response: Interest in Using Performance Scorecards, 2015

These findings imply that current consumers are more empowered in their health care choices than previously. It could be argued that this increases consumer understanding of the importance of quality, safe outcomes and the facilities that deliver them. With this in mind, it is not a stretch to speculate that patients will be willing to do their homework when it comes to researching quality outcomes for AHN versus UPMC providers as well as comprehensive benefit offerings from Highmark versus UPMC Health Plan. Although existing patient-provider relationships will have some bearing on this decision-making process, a rational consumer would look for the most quality outcomes for a relatively reasonable price.

At the health plan level, national quality rating groups such as the National Committee for Quality Assurance (NCQA) post annual ratings publicly. When faced with the brand name decision of choosing Highmark or UPMC Health Plan insurance, consumers in the WPA market might look to ratings for decision support (see Table 3 below). Among commercial, Medicaid, and Medicare Advantage (MA) health insurance plans, UPMC was ranked higher overall than Highmark in health plan quality ratings.

Table 3. NCQA Ratings





Additionally, Deloitte reports in a 2014 study that there is greater public access to information about quality and safety ratings for hospitals. Sources include the federally administered ‘Medicare Advantage Five-Star quality rating system’ for comparison of MA plans, ‘Hospital Compare,’ healthgrades.com, as well as a multitude of websites and technology applications (“Quest for Value in Health Care”). Clearly, consumer decision making will be influenced by the increased uptake of these information sources.

Narrow networks are another decision point that influences health care consumers. Even if consumers have a comprehensive benefit package through Highmark or UPMC Health Plan, the number of primary care physicians or specialists who are in the network for that benefit package might influence consumer decision. Cost and flexibility in provider choice are two elements which vary between benefit packages. If a consumer is more interested in saving money than having flexibility in their provider choice, they might opt for a narrow network plan. Over the past few years, Highmark has been recognized for having a comprehensive selection of these plans, while UPMC offers more broad coverage plans generally speaking. Highmark insurance enrollees might be willing to stay with Highmark instead of switching to UPMC Health Plan if these narrow network products are tailored to their specific needs.

Additionally, both the Highmark-AHN enterprise and UPMC Health Plan and providers have embarked on aggressive marketing campaigns aimed at the consumer base. UPMC Health Plan advertisements have focused on its strategic rise as a leading insurer in the WPA region, as well as the high ranks received on the NCQA quality ratings, as discussed previously. Highmark has focused its consumer advertisements on the Center for Medicare and Medicaid Services (CMS) quality ratings, depicted in Table 3. Many television commercials have focused on the patient-provider relationship at AHN, emphasizing anecdotes about satisfactory patient experiences and the option to schedule same-day appointments. Despite all of these claimed accolades and consumer-focused campaigns, it is difficult to draw a one-to-one comparison between the two health plans due to their structural differences.   
 Altogether, consumer perception of the UPMC Highmark Consent Decree is ambiguous. Unless a consumer is actively engaged in their health care process, they may not know much about the consent decree process at all. Those individuals receiving long-term care or managing chronic conditions are probably more likely to be active decision makers. Both Highmark and AHN have aggressively campaigned their personalized stories about satisfied patients, while UPMC Health Plan and the provider network have focused on quality ratings and innovative medicine in their advertising. Consumers will likely be influenced by a combination of their existing relationships with providers, their health literacy and knowledge of quality or safety ratings, and the offering of health insurance products tailored to their preferences for cost, quality, and access options.

## Payer perspective

The UPMC Highmark Consent Decree was issued due to a conflict that two large systems could not negotiate. So, what perspective does each payer system have post-consent decree, and how have the two entities fared in terms of insurance enrollment?

Clearly, both Highmark and UPMC have aimed to improve their image among consumers by improving the quality of their health insurance plan offerings and the delivery of health care services in provider facilities. To do this successfully, each respective payer wants to offer the lowest possible per member per month (PMPM) cost, while maintaining quality and accessibility for its insured populations. At the same time, these plans take part in name branding techniques such as the aggressive consumer advertising campaign and community giving for highly visible public affairs.

As mentioned in the consumer perspective section, narrow network products are one way for a health plan to be competitive. These products reduce costs for consumers by offering a benefit package that has less flexibility in provider and hospital in-network choices. A significantly larger proportion of Highmark members have enrolled in narrow network products since the 2013 PID order. Highmark plans to offer higher quality, lower cost products through these narrow network plans; by leveraging AHN providers who score above average in terms of quality ratings and below average on cost of care, these narrow network products may be a way to enhance member retention. According to the 2017 publication on the effects of the 2013 PID order, Highmark has been a leader in offering a selection of narrow network products to its enrollees (“Assessment of Healthcare Competition in WPA”).

At the same time, UPMC has focused on offering three individual and family plans in WPA that are broader in nature, as well as five employer group plans in which benefits are based upon residence of the employer. The UPMC Health Plan argues that due to its vertical integration, it is incentivized to keep premiums low while efficiently providing high quality care. This results in a high membership retention rate, reported as 90% across its insurance products as of 2017 (“Assessment of Healthcare Competition in WPA”).

The integration of Highmark and AHN follows a slightly different philosophy due to the nature of its data on insureds and the firewall policy that exists between the two organizations. First, Highmark has the benefit of an enormous amount of information that is captured due to its Managed Care Organization (MCO) structure. Experience as a payer gives Highmark an advantage, as the health plan already has the infrastructure and processes in place to efficiently capture patient information. Moving into the provider space, Highmark has the opportunity to identify care delivery areas that require improvement more easily than UPMC might with a limited amount of managed care data. Operating many insurance products that refer patients to in-network AHN facilities incentivizes Highmark to maintain a strong reputation for both their insurance and delivery services.

Furthermore, both Highmark and UPMC have opportunities to advance population health and value-based care initiatives due to their unique position. By leveraging the enormous data sets now available, both entities can identify which member populations require the most attention. Through case and disease management programs and wellness coach outreach, integrated systems are able to focus on the continuum of care for patients. Though the newly formed Highmark integrated delivery finance system continues to experience growing pains, it has employed innovative techniques to enhance patient experience during each interaction with the insurance plan and provider.

Moreover, other payers have found opportunities among the uncertainty in the WPA region. National carriers such as Aetna, Cigna, and United Healthcare have achieved hospital penetration rates of 100% due to inclusive contracts with both AHN and UPMC delivery systems (pg. 18). These carriers have started to offer narrow network products in order to remain competitive with the low rates offered by competitors.

Since the issuance of the consent decree, UPMC and other payers have had success in capturing Medicare Advantage (MA) market share. As mentioned in the consent decree, protections for vulnerable populations were a main concern of the transition plan, MA members being one of these groups. In WPA the 2012-2017 period resulted in decreased traditional Medicare enrollment, while MA membership rates increased significantly (Table 4). As noted in Table 4, Highmark lost over 19% of MA membership during the five-year period, while UPMC Health Plan gained nearly 50% in its MA membership. Other competitors in the region also experienced positive trends in MA membership. While these data do not indicate a negative effect on MA members, they do suggest that Highmark has experienced drastic changes in its membership composition over the past few years. Trends in rates of change indicate that MA memberships are actually doing relatively well; they are able to access and make essential changes to their insurance plans in order to reap the most benefit for services covered.

Table 4. Insurer-Level Medicare Advantage Enrollment as of June 2012 and March 2017, 29-County WPA

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Insurer | **Enrolled 2012** | **Enrolled 2013** | **Enrolled 2014** | **Enrolled 2015** | **Enrolled 2016** | **Enrolled 2017** | **% Change (2012-2017)** |
| **Total** | **443,338** | **458,852** | **468,237** | **478,363** | **487,476** | **500,060** | 12.8% |
| Highmark | 246,603 | 239,447 | 235,981 | 212,432 | 214,295 | 198,732 | -19.4% |
| UPMC | 109,425 | 121,563 | 124,142 | 143,624 | 155,248 | 163,647 | 49.6% |
| Aetna/HealthAmerica | 51,518 | 61,159 | 81,413 | 93,987 | 85,803 | 94,585 | 83.6% |
| United | 14,737 | 14,622 | 3,416 | 4,448 | 8,398 | 16,448 | 11.6% |
| Geisinger | 6,315 | 7,204 | 8,363 | 8,372 | 8,131 | 9,083 | 43.8% |
| Other Insurers | 14,740 | 14,857 | 14,922 | 15,500 | 15,601 | 17,565 | 19.2% |

Additionally, Medicaid members were considered to be a vulnerable population as defined by the consent decree provisions. Since the 2013 PID order, Gateway Medicaid members, a Highmark subsidiary for this line of business, have continued to utilize the UPMC ‘exception’ hospitals at about the same rate as previously. This indicates that the trends in Medicaid member services have not undergone significant changes post consent decree.

## State perspective

Despite many of the shortfallings of the Highmark UPMC Consent Decree, the PID assessment of competition post 2013 order has shown some promise in its results. If nothing else, the decree has mobilized innovative strategies among Highmark and UPMC and in some cases, entire departments that did not exist previous to the conflict. For example, Highmark has increasingly used innovative techniques to address the siloes that exist across the enterprise. Recently, a quality, safety, and value committee has been developed to focus on strategic alignment of quality across Highmark, AHN, and Gateway. Strategies like this have a sense of urgency due to UPMC essentially having the upper hand in health plan quality ratings and provider market branding. Overall, this process has instigated a fierce competition between the two systems, which should result in provide lower premium rates and increased quality of care for consumers.

In January of 2018, Governor Wolfe announced a “landmark agreement” between Highmark and UPMC, which expanded upon the previously established services that will be made available as in-network to both Highmark and UPMC enrollees. These facilities include the UPMC Center for Assistive Technology, UPMC Center for Excellence for Treatment of Cystic Fibrosis, and certain highly specialized transplant services. Additionally, UPMC affiliated hospitals in the central and eastern regions of Pennsylvania will provide in-network services to Highmark members because they are the only hospitals able to deliver specialized care in the regions. For the remaining Highmark consumers in the WPA region who do not require UPMC specific care, the ending of the decree will signify the official choice between insurance and delivery. Governor Wolfe expressed approval of the actions taken by both Highmark and UPMC to protect vulnerable members despite their disagreements.

## Attorney General perspective

In 2015, the Pennsylvania AG, Kathleen Kane, announced that she would plan “to file a motion “to enforce the consent decree between UPMC and Highmark after weeks of discussion between state and federal officials resulted in no agreement in the latest dispute between the two health care giants” (Pittsburgh Post-Gazette). Based on this statement, it was not clear what the AG felt was being violated by either health care entity, just that there was a plan to present her concerns to the Commonwealth Court.

In a statement released in 2018, Highmark indicated that it had appeared in Commonwealth Court with the AG to uphold the promises of the consent decree and protect vulnerable member populations, requiring UPMC to comply. The results of this case, which was brought by AG Josh Shapiro, ordered that UPMC would have to continue to provide in-network care to about 140,000 Medicare Advantage members in WPA through the end of 2019. Shortly thereafter, a statement issued by the Office of the AG praised the court ruling. This essentially means that member protection will have a guaranteed extension through December 30, 2019, despite the original text of the consent decree stating an expiration as of June 30, 2019. It remains to be seen what will occur beyond this date, and how those implications will directly impact health insurance members.

## successes and failures

Overall, the conditions of the UPMC Highmark Consent decree were set forth to “mitigate potential adverse competitive effects on competition and on rivals contracting with Highmark domestic insurers and/or AHN” and to “maximize market-based access opportunities of unrelated providers and community hospitals to the IDN and insurers to AHN healthcare providers” (Pennsylvania Insurance Department, 2017). The mechanisms put in place to ensure member protection and competition in the marketplace were designed in response to the Highmark–AHN merger, including a Firewall Policy for protection of competitively sensitive information shared between the payer and provider entities; prohibition of exclusive contracting; limitations on the duration of reimbursement contracts over five years in length; and prohibition on most favored nations arrangements, for purposes of fair contracting with different affiliate providers.

The Firewall Policy was successful in establishing a team of officers within the Highmark–AHN network to provide clarity on information that can and cannot be shared. This provision of the decree was critical for equity among the many affiliated providers for the network. It has worked reasonably well, including the executive leadership who are involved; often, executives who must be present for meetings that involve sensitive information are able to recuse themselves or ask a delegate to attend on their behalf.

One largely unanticipated result of the UPMC Highmark Consent Decree involves the administrative burden placed upon the Department of Health (DOH). Without realizing the number of disputed case quantities, criteria set forth in the decree set the stage for an overwhelming volume to be adjudicated through the JCR. The result of this process was an enormous amount of cases with ambiguous clinical criteria which were sent to DOH for final determination. After months of accumulating, the DOH stated in 2017 that they would not continue to use taxpayer money to resolve the issues of two health enterprises. Although the resolution of this statement cannot be disclosed publicly, both entities were made aware of their scored “wins and losses” for ambiguous cases to date as a means of dissuading further DOH review. In retrospect, it would have been more efficient for the PID to include specific criteria about what would happen in the event of an ambiguous clinical case. This would have prevented the bottleneck of JCR cases and alleviated the administrative burden on both health plans.

## Case Study

Despite the unique nature of the UPMC-Highmark consent decree, other disagreements leading to mergers and acquisitions in health care have changed markets across the US. For example, an early 2000s rivalry between Partners Healthcare in Massachusetts and multiple health plans – Tufts Associated Health Plan, Harvard Pilgrim, and Blue Cross of Massachusetts – led to a similar change in the state insurance market. Rate negotiation between Partners Healthcare, a large delivery system in the state, and these health plans was unsuccessful. This was largely due to the 1997 Balanced Budget Act, a federal policy which was designed to reduce Medicare spending at the federal level, but resulted in reimbursement cuts from health insurers to providers, thereby influencing the amount of reimbursement that Partners Healthcare received.

After nearly entering a consent decree, Partners Healthcare was able to successfully achieve a 6% rate increase from Tufts and Blue Cross of Massachusetts. However, Harvard Pilgrim did not agree to negotiate, and Partners was still losing money three years after this dispute. In the end, Harvard Pilgrim resorted to selling hospitals from their integrated system to Partners Healthcare instead of agreeing to an increased reimbursement rate. This changed the landscape of the local market, and similarly to the current consent decree situation in Pittsburgh, was a convoluted process. It is hard to draw conclusions about what precisely occurred to member populations through resources available on this case study. However, the acquired system did remain and continues to evolve today (Partners Healthcare, 2008).

# Conclusion

In conclusion, the UPMC Highmark Consent Decree has certainly changed the dynamics of the Pennsylvania health insurance and delivery markets. With increased competition, both Highmark and UPMC have strived to make gains in their respective areas of opportunity. For Highmark, this has involved enhancing the brand name of AHN and focusing on cohesive integration for the payer and provider networks, a transition that has continued to pose challenges. Despite this, Highmark has an opportunity to strive for innovation and aligned quality across the patient continuum of care, improving the well-being of patients. This opportunity did not necessarily exist prior to integration with a delivery system. Having the large data capabilities as a payer coupled with the provider expertise offered by AHN promotes quality in all interactions with the health system for the patient.

Additionally, UPMC has made impressive gains in the insurance market for WPA region, striving to market their employer and individual health plans. With their internationally recognized brand name for health care delivery already confirmed, UPMC will likely benefit the most from continuing to capture insurance enrollees. This will allow UPMC to compete with other national insurance carriers and reap the benefits of integrated data systems between payer and provider. Not only will this benefit the enterprise, but it will promote increased quality of care for members who will have seamless health profiles throughout the UPMC insurance and delivery system. As a result, enhancing quality of care will be more possible than before the health plan development.

As with many of these evolving health care markets, the dynamic will continue to change and may promote healthy competition in the market, benefiting members as long as two large health entities exist. At the same time, the examples portrayed in this discussion have reflected consolidating systems, which could result in health care monopolies once a large competitor fails in the marketplace. This process could cause confusion for members about where to receive services and how long they have to do so with one health care provider or the other. Altogether, the consent decree serves as a temporary protection for members but leaves one wondering whether this will truly be sustainable for both entities and beneficial for health care recipients in the long run.

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