

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

█ PMPM difference applies to a family of four for a 12-month period, which is approximately █. Approximately 78% of Highmark's enrollees are located in the area impacted by the IDN, so that the overall effect of the IDN cost savings on Highmark's premium for these members is approximately \$3,000 █, i.e., the IDN results in a \$3,000 lower premium for a family of four.

According to Dr. Harris's analysis, without the Affiliation, UPMC would face less competition. Other competing hospitals are not sufficient alternatives to the constraint WPAHS would have on UPMC with the Affiliation. Dr. Harris analyzes claims data to show that other insurers are reimbursing UPMC for hospital services at higher rates than Highmark pays.³⁴⁴ Without the transaction, Dr. Harris concludes that Highmark would not receive the lower cost savings and improved quality and would need to pass on its higher cost to its enrollees. UPMC Health Plan would not constrain Highmark from passing these costs on to consumers. UPMC currently operates at high utilization rates and would not have the incentive to hold down insurance premiums. It would raise its rates to the level of other insurers.

I have reviewed the methodology and assumptions used by Highmark in reaching this estimate and conclude that the methodology, assumptions, and results are not unreasonable, although I concur with Dr. Harris that a great deal of uncertainty underpins these estimates. If Highmark's estimates are correct, the consumer welfare effects will be significant. A family of four will face a 10% higher (about \$3,000 for a family of four) health plan premium if the affiliation does not occur. The Affiliation would significantly benefit Highmark's members and likely spur additional price and quality competition from competing insurers.

B. WPAHS'S COMPETITIVE POSITION WITHOUT THE AFFILIATION

1. WPAHS'S TURNAROUND EFFORTS

In 2010, WPAHS implemented its Urban Consolidation Plan ("UCP") with the intent to "stabilize and strengthen the System's financial footing."³⁴⁵ The plan focused on transforming Allegheny General Hospital and West Penn Hospital into one quaternary health care facility

³⁴⁴ Harris Amended Supplement 5 at ¶¶ 17-19.

³⁴⁵ "West Penn Allegheny Health System, Inc., Proposed Turnaround Plan," Alvarez & Marsal, November 4, 2011.

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

located at Allegheny General. The plan also incorporated an expanded regional footprint based on enhanced community hospital programs and a network of ambulatory care centers. By the first quarter of 2011, WPAHS reported that it had closed the emergency department at West Penn Hospital and was transitioning patients to Allegheny General to eliminate redundancy in the city. It constructed and opened two new units at Allegheny General: (1) a step-down unit with 24 private rooms, which freed up beds for ICU, and (2) another 24 private room unit for surgical ICU for cardiovascular, cardiothoracic, and transplantation. WPAHS opened two new outpatient care centers in Vandergrift and Peters Township. It also renovated and expanded the emergency departments at Forbes Regional Medical Center and at Alle-Kiski Medical Center (Allegheny Valley Hospital).³⁴⁶ During this period, the first half of fiscal year 2011, WPAHS reported a net profit of \$2.1 million, but an operating loss of \$26.8 million due to restructuring charges, including severance packages, consulting fees, and integration expenses. The UCP initiative failed, however, because the system had not planned sufficiently to shift patient volumes to Allegheny General from West Penn, and instead, the system lost a significant volume of patients.

WPAHS undertook an internal Collaborative Design Process (“CDP”) to determine steps necessary to turnaround the system after its unsuccessful implementation of its UCP.³⁴⁷ WPAHS is now undergoing an extensive, multi-phase renovation project “designed to facilitate revitalization of the hospital into a full service facility with a core focus on women’s health with supplemental clinical services designed to provide access to a full array of community-based services for the residents of Western Pennsylvania eastern corridor.”³⁴⁸ As part of Phase I, WPAHS re-opened West Penn Hospital’s Emergency Department.³⁴⁹ This has resulted in a [REDACTED] daily emergency admissions rate. In addition, general admissions have increased with new physician recruitment in several specialty areas.

WPAHS also has converted two floors to private rooms, renovated the medical/surgical ICU and

³⁴⁶ “West Penn Allegheny Health System Makes Substantial Restructuring Progress, Post Financial Results for the First Half of Fiscal Year 2011,” WPAHS Press Release, February 25, 2011 at 11.

³⁴⁷ As part of its IDN strategy, Highmark independently engaged Alvarez & Marsal to develop a prototype turnaround plan for WPAHS.

³⁴⁸ Highmark Supplemental Response to PID Information Request 3.8 from the Pennsylvania Insurance Department.

³⁴⁹ WPAHS Response to Supplemental Request 3.8 from the Pennsylvania Insurance Department, WPAHS -008180-8.

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

hospital's labor and delivery suites. WPAHS completed Phase I renovations in March 2012 at a cost of \$17 million, with another \$15 million for equipment.³⁵⁰

Phase 2, which began in March 2012, focuses on revitalizing cardiac services. Renovations include the cardiac catheterization and EP labs, post-op heart ICU, and CCU. WPAHS should complete renovations by [REDACTED] at a cost of \$13 million, with an additional equipment cost of \$15 million. Services will resume in [REDACTED].³⁵¹ Forbes Regional Hospital opened a comprehensive breast care center in August 2012.³⁵²

As part of its revitalization effort, WPAHS continues to recruit specialty physicians, specifically invasive cardiologists, EP cardiologists, pulmonologists, general surgeons, bariatric surgeons, and to affiliate with independent primary care physicians.³⁵³

In its efforts to continue improving its performance, WPAHS has approved numerous performance improvement initiatives expected to have a [REDACTED] million and [REDACTED] million effect on net income in FY13 and FY14, respectively. Projects include GPO cost reductions, moving staff, staff reductions, and consolidation of the One Allegheny Center and data center lease. The remaining performance improvements "projects" arise from the alignment with Highmark, specifically volume growth from Community Blue, Care Alignment, WPAHS physician recruitment, ACA, and Highmark physician recruitment. These account for [REDACTED] million ([REDACTED]) and [REDACTED] million ([REDACTED]), respectively, of the positive net income effect in FY13 and FY14.³⁵⁴

³⁵⁰ WPAHS Supplemental Response to Request 3.8 from the Pennsylvania Insurance Department, WPAHS-008182-83.

³⁵¹ Highmark Supplemental Response to PID Information Request 3.8 from the Pennsylvania Insurance Department.

³⁵² WPAHS Response to Supplemental Request 3.8 from the Pennsylvania Insurance Department, WPAHS-008173-74.

³⁵³ Highmark Supplemental Response to PID Information Request 3.8 from the Pennsylvania Insurance Department.

³⁵⁴ WPAHS also includes two financial adjustments—recouping a shortfall on 4% Highmark rate increase in FY12 and termination of its [REDACTED] contract. WPAHS projects net income performance improvements across the entire WPAHS, including physician organization, SWS-IT, SWS-RC, and individual hospitals to be [REDACTED] million and [REDACTED] million in FY13 and FY14, respectively. See WPAHS Response to Supplemental Request 2.4.2 from the Pennsylvania Insurance Department (WPAHS-008125-33).

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

2. WPAHS'S CURRENT STATUS

For FY12 ending June 30, 2012, WPAHS employed over 600 physicians and had 57,455 discharges.³⁵⁵ Its total net patient service revenues were approximately \$1.475 billion, a decrease of \$29.3 million, or 1.9, percent from FY11. Its operating losses after restructuring totaled \$112.5 million, an increase of 53.8% from FY11. After accounting for \$58.56 million gifts and grants, including forgiveness of \$50 million in loans from Highmark, WPAHS's deficiency of revenues over expenses was \$37.8 million compared with an excess of revenues over expenses of \$—20.4 million in FY11. These FY11 excess revenues would have been losses but for \$50 million in loans forgiven by Highmark. WPAHS attributes these poor financial results to two factors—reduced volumes from closure of services at WPAHS and only marginally increased reimbursement rates for its services.³⁵⁶ In addition, WPAHS's inpatient discharges declined by 6.4% compared with FY11, primarily due to a 29% decline in inpatient discharges at West Penn. WPAHS attributes the majority of its inpatient decrease to closure of West Penn's emergency services and other services.³⁵⁷ West Penn closed its emergency department from December 2010 through February 14, 2012.

WPAHS's total assets were valued at approximately \$1.3 billion and it had approximately \$1.5 billion in total liabilities. WPAHS received \$158 million from Highmark in FY12, \$100 million in loans, another \$50 million as gifts and grants, and \$8 million as an unrestricted payment.³⁵⁸

As of FY12 May YTD, WPAHS continued to incur an operating loss before restructuring expenses, which resulted in net operating losses, although less than originally projected.³⁵⁹ Table 31 presents key operating and financial data for each of the five WPAHS hospitals. Inpatient days for each of the five WPAHS hospitals declined from FY2011, with West Penn and Canonsburg incurring the largest declines. Average length of stay increased slightly at Allegheny General, West Penn and Forbes, but declined at both Allegheny Valley and Canonsburg. All but

³⁵⁵ WPAHS estimated actual discharges for FY12 is as of April 1, 2012, but may be refined at later date.

³⁵⁶ West Penn Allegheny Health System, Annual Report, For the Fiscal Year Ended June 30, 2012, Consolidated Statements of Operations, Unaudited.

³⁵⁷ West Penn Allegheny Health System, Annual Report, For the Fiscal Year Ended June 30, 2012, Consolidated Statements of Operations, Unaudited.

³⁵⁸ West Penn Allegheny Health System, Annual Report, For the Fiscal Year Ended June 30, 2012, Consolidated Statements of Operations, Unaudited.

³⁵⁹ Highmark Supplemental Response to PID Information Request 4.6.9 from the Pennsylvania Insurance Department, "Highmark/WPAHS Joint Committee Meeting, June 26, 2012 at UPE-0013854.

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

West Penn achieved a decline in re-admission rates, often used as a measure of quality improvement. All five WPAHS hospitals incurred not only net income losses, but also net operating losses.

Table 31

WPAHS Key Operating Statistics for FY 2012

	Allegheny General	Change from FY2011	West Penn	Change from FY2011	Forbes Regional	Change from FY2011	Allegheny Valley	Change from FY2011	Canonsburg	Change from FY2011
Volume										
Inpatient days	131,205	-0.6%	41,457	-28.3%	79,014	-1.1%	44,509	-6.5%	15,342	-10.2%
Discharges	23,589	-1.4%	6,757	-29.0%	15,221	-1.5%	8,605	-5.7%	3,263	-5.3%
ALOS										
Average Daily Census										
Adjusted Days										
Adjusted Discharges										
Adjusted Occupied Beds										
Outpatient Registrations										
Observation Cases										
Readmissions										
Acute Volume Occupancy Rate										
Case Mix										
Hospital Case Mix										
Medicare Case Mix										
BC Managed Care Case Mix										
Key Operating Metrics										
Operating Margin	0	-2.9%	0	-54.2%	0	-26.0%	0	-9.1%	0	-65.6%
Net Margin	0	-22.6%	0	-530.4%	0	-59.3%	0	-24.4%	0	-3916.4%
NSPR Per CMI Adjusted Discharge	7,635	3.4%	8,383	9.2%	4,953	-0.3%	4,410	1.2%	4,293	6.0%
Payor Mix--Discharges										
Medicare										
Medicaid										
Managed Care										
Medicare										
Medicaid/Medicaid Applying										
Blue Cross										
Other										
Other										

Source: WPAHS Response to Data Requests and Reconciliation Items 1A, 1B, and 1D. For WPAHS/Grant Thornton Dated August 29, 2012 for Blackstone

Several other metrics above speak to the poor financial performance of both West Penn and Canonsburg Hospital. Although West Penn's hospital case mix, a measure of the medical intensity of patients, is below that of Allegheny General, its average length of stay and NSPR per CMI adjusted discharge is higher at West Penn than at Allegheny General. Both West Penn and Canonsburg had operating margins in the single digits, which results in negative net margins after fixed costs. West Penn's payor mix is different from the other four hospitals. West Penn has a smaller Medicare base of business, but a significantly higher Medicaid inpatient base. In addition, West Penn's Blue Cross business accounts for a greater portion of the hospital's discharges than at the other four hospitals. The higher Medicaid payor mix likely stems from its location in a predominately-lower income area of Pittsburgh.

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

C. FINANCIAL MARKETS ASSESSMENT OF WPAHS'S FINANCIAL CONDITION

On December 29, 2011, KPMG issued an independent auditor's report stating that WPAHS had recurring losses from operations and a net deficit of about \$99 million. In addition, its declining volumes and operations "in a challenging service area that includes significant competition," raised doubts about WPAHS as a going-concern.³⁶⁰

WPAHS has confronted several independent assessments of its financial viability since Fall 2011. Moody's downgraded WPAHS's bond rating to Caa1 from B2 to "reflect the severity of the financial status of the system and our belief that, without the financial support of Highmark (Baa2/stable), the system would have been forced to restructure earlier in the year..."³⁶¹ On November 12, 2012, Moody's downgraded WPAHS's bonds from Caa1 to Ca and re-issued its negative outlook. Moody's reported the downgrade reflected the high likelihood that WPAHS would have to undergo a restructuring or bankruptcy filing. It also noted delays in finalizing the affiliation with Highmark, large operating losses, continuing decline in WPAHS's admissions, and weak cash position.³⁶²

On October 25, 2012, Fitch, another bond rating firm, downgraded WPAHS to CCC from B+ to reflect "the increased possibility of a debt restructuring, coupled with and arising from heightened uncertainty about the progress of WPAHS's affiliation with insurer Highmark, Inc."³⁶³ Fitch noted WPAHS's "extremely poor liquidity, coverage and profitability metrics" and its "precarious financial situation" as additional justification for the downgrade.³⁶⁴ Fitch further downgraded WPAHS's bonds from CCC to C in January 2013.³⁶⁵

³⁶⁰ Independent Auditor's Report on Supplementary Information, KPMG, December 29, 2011, Exhibit 82 submitted in Highmark v. WPAHS et al., Civil Division, No. GD-12-18361.

³⁶¹ Moody's Investor Service, "Moody's Downgrades West Penn Allegheny Health System's (PA) Bond Rating to Caa1 from B2; Outlook Remains Negative," 22 November 2011.

³⁶² "Moody's Cuts WPAHS's Bond Rating," Pittsburgh Business Times, November 13, 2012. <http://www.bizjournals.com/pittsburgh/news/2012/11/13/moodys-cuts-wpahs-bond-rating.html>.

³⁶³ FitchRatings, "Fitch Downgrades West Penn Allegheny Health System (PA) Revs to 'CCC' from 'B+', October 25, 2012, Exhibit 63 submitted in Highmark v. WPAHS et al., Civil Division, No. GD-12-18361.

³⁶⁴ FitchRatings, "Fitch Downgrades West Penn Allegheny Health System (PA) Revs to 'CCC' from 'B+', October 25, 2012, Exhibit 63 submitted in Highmark v. WPAHS et al., Civil Division, No. GD-12-18361.

³⁶⁵ "Agency Downgrades West Penn Allegheny Health System Bond Rating, Pittsburgh Post-Gazette, January 22, 2012." <http://www.post-gazette.com/stories/business/news/agency-downgrades-west-penn-allegheny-health-system-bond-rating-670002/>

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

D. THE PARTIES VIEWS ON THE EFFECT OF THE AFFILIATION NOT OCCURRING

1. HIGHMARK'S POSITION

Highmark and its economist, Dr. Harris, have submitted their analyses of the effects of the WPAHS/Highmark affiliation not occurring. With UPMC remaining in the Highmark network post-2014, Highmark believes that failing to consummate the affiliation with WPAHS would result in "higher costs, reduced access, and greater consolidation of the provider market, as WPAHS likely would be forced to shut down additional services or possibly see a for-profit partner, which would demand higher provider rates to meet required returns on capital."³⁶⁶ Highmark believes these responses would increase volume at UPMC, which would strengthen UPMC further and increase UPMC's rates.³⁶⁷ Highmark further believes that if it is unable to implement its IDN strategy with WPAHS as a key component, "the market will be dominated by one provider system [UPMC] and ultimately costs, and premiums, will increase."³⁶⁸

Highmark estimated the comparative financial consequences for Highmark, UPE, and Highmark's policyholders and subscribers under a No Affiliation Scenario.³⁶⁹ This relies on certain highly stylized assumptions. First, Highmark assumes that WPAHS would continue its financial deterioration with limited options for survival. A for-profit entity would acquire WPAHS and would eliminate service lines and facilities. This would attract more patients to UPMC facilities. A new Highmark contract with the for-profit entity would result in a [REDACTED] increase in rates for Highmark's commercially insured business, effective July 1, 2013. Second, Highmark assumes that its next contract with UPMC would result in a [REDACTED] increase in rates, effective January 1, 2015. Third, without WPAHS at the core of UPE's IDN strategy, its provider network costs would be higher and it will lose its competitive advantage in the marketplace. This would result in a loss of policyholders and subscribers to other competing insurers. Fourth, Highmark would shift investment in its IDN away from WPAHS to other

³⁶⁶ "Supplemented Overview of Highmark's Strategic Vision," Addendum No. 5 to Amendment No. 2 to Form A, Tab E at 15.

³⁶⁷ "Supplemented Overview of Highmark's Strategic Vision," Addendum No. 5 to Amendment No. 2 to Form A, Tab E at 15.

³⁶⁸ "Supplemented Overview of Highmark's Strategic Vision," Addendum No. 5 to Amendment No. 2 to Form A, Tab E at 19. See also pp. 26-28 where Highmark discusses its views that it is the best partner for WPAHS and that the affiliation is in the best interest of the community.

³⁶⁹ Amendment No. 1 to Confidential Supplement (Volume II) Submitted with Form A, Tab 8 at 9-13.

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

community hospitals.

Based on these assumptions, Highmark projects that UPE's pre-tax income will be approximately \$480 million lower than in its updated affiliation scenario in the period 2012-2016. It projects 800,000 fewer policyholders/subscribers under this scenario by 2016 because Highmark would lose its lower cost advantage relative to its competitors. For policyholders/subscribers, Highmark projects the average annual cost of healthcare for a family of four in WPA would increase by almost \$3,000, or █████, by 2016 compared with the updated affiliation scenario.³⁷⁰

Dr. Harris examined the likely effects on health plan premiums of a No Affiliation Scenario. He acknowledges that it is impossible to predict what would happen to all factors affecting premiums if the proposed affiliation does not occur. Dr. Harris does not provide an independent assessment of the effect of no affiliation on Highmark's premiums; rather, he relies solely on Highmark's estimation. Without the Affiliation, Dr. Harris concludes that the quality of care improvements and cost savings expected from the IDN would not occur because of the absence of the necessary investments and alignment of incentives to make those benefits happen.³⁷¹ He does, however, address Highmark's assumption that the reimbursement rate increases from UPMC and WPAHS, combined with the absence of IDN benefits, would result in higher premiums, approximately \$3,000 per year for a family of four by 2015, and these higher premiums would be passed on to its health plan enrollees. Dr. Harris concludes that other major health insurers are paying substantially higher reimbursement rates to UPMC than Highmark pays under its current contract, which enables Highmark to pass these additional costs on to insurance consumers.³⁷²

With higher provider costs due to contracting with UPMC and with an assumed for-profit owner of WPAHS, Highmark will need to recoup these higher costs either by passing these costs on to subscribers, taking a reduced margin, or a combination of the two. According to Dr. Harris, Highmark's ability to pass these costs on to subscribers depends on whether UPMC also chose to raise its premiums to levels comparable to Highmark and other insurers. This would depend on

³⁷⁰ "Supplemented Overview of Highmark's Strategic Vision," Addendum No. 5 to Amendment No. 2 to Form A, Tab E at 19.

³⁷¹ Harris Amended Supplement 4 at ¶ 35.

³⁷² Dr. Harris bases his analysis on a review of 36 outpatient claims, not inpatient claims, for Aetna, Cigna, HealthAmerica, and UnitedHealthcare. See Harris Amended Supplement 5 at ¶¶ 14-15.

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

whether UPMC's hospitals have high capacity utilization and would expect to maintain these high utilization rates after its premium increase. Dr. Harris finds that UPMC has higher occupancy rates than the statewide average occupancy rate. UPMC would face less competition if the affiliation does not occur, thus resulting in conditions likely to maintain its occupancy rates at relatively high levels. Although left unstated, it appears Dr. Harris is concluding that UPMC, Highmark, and other competing health care insurers would all raise their premiums if the affiliation does not occur, thus making access to healthcare in WPA even costlier than it is today.

Hammond Hanlon Camp LLC ("H2C") prepared an analysis of WPAHS showing that a number of factors adversely affect WPAHS's financial valuation, including WPAHS's distressed credit profile, the size and scale of WPAHS's operations, and market conditions in WPA. It also concluded that WPAHS's bondholders would receive [REDACTED] in a consensual plan and likely less than [REDACTED] in a Chapter 11 filing.³⁷³

All of these independent analyses of WPAHS's financial situation support the view that WPAHS is financially unstable and is highly dependent on this Affiliation to restore its financial stability.

2. WPAHS'S POSITION

WPAHS provided little information on the likely effects if the PID did not approve the affiliation, indicating that it had not conducted such an analysis.³⁷⁴ WPAHS stated that it would likely need to seek an alternative capital partner, although whether an interested partner would emerge is uncertain.³⁷⁵ WPAHS also indicated that it is also uncertain how an alternative partner would approach contract negotiations with Highmark. In addition, WPAHS's Interim President and CEO stated in testimony that the WPAHS Board of Directors and executive staff concluded that an affiliation with private investors or for-profit healthcare providers would not preserve the charitable mission of WPAHS, which was a key consideration in choosing to align with Highmark.³⁷⁶

³⁷³ "Highmark Inc., WPAHS Restructuring Plan Prepared by H2C, September 27, 2012, Exhibit 70 submitted in Highmark v. WPAHS et al., Civil Division, No. GD-12-18361 at 9.

³⁷⁴ WPAHS Response to POD Information Request 4.3.20 from the Pennsylvania Insurance Department.

³⁷⁵ WPAHS Response to Request 4.3.4.2 from the Pennsylvania Insurance Department.

³⁷⁶ HMK-WP0006758-9, Testimony to Pennsylvania Insurance Commissioner by Keith Ghezzi, MD, Interim President and CEO, WPAHS, April 17, 2012.

[REDACTED]

378

E. POTENTIAL LOSS OF WPAHS AS A COMPETITIVE CONSTRAINT ON UPMC

Both Dr. Harris and I recognize that UPMC and WPAHS hold unique positions in WPA in that these two hospital systems are primary competitors, and in some cases, the only providers of highly complex tertiary and quaternary hospital services in WPA. One of the competitive effects and public interest issues in this matter is the importance of WPAHS as a competitive alternative to UPMC. That is, whether a more vigorous and financially healthy WPAHS competitive alternative would discipline UPMC and serve as a strong alternative for insurers and consumers. For this reason, I examined the extent to which WPAHS and UPMC are next best substitutes for the purpose of determining the degree to which WPAHS acts as a competitive constraint to UPMC. In the next section, I review one of the series of analyses that Dr. Harris conducted and provided, which was an assessment of service offerings at each hospital by major service line.

Dr. Harris used an extension of the discharge share analysis, which considered shares at the service-line level, as evidence that WPAHS is likely the closest competitor to UPMC for acute-care patients residing in WPAHS's 90% draw area for several service lines and for many DRGs.³⁷⁹ I agree with Dr. Harris's conclusion that UPMC is the primary provider of a large number of tertiary and quaternary, as well as of many services regarded as primary and

³⁷⁷ WPAHS Confidential Discussion Materials for the BOD, June 23, 2011, WPAHS-003950.

³⁷⁸ WPAHS Response to Request 4.6.9 from the Pennsylvania Insurance Department, "Executive Committee of the Board of Directors Update," April 6, 2011, WPAHS-003158-60).

³⁷⁹ Harris Supplement 1 at ¶ 7. This analysis classified each patient in the database into one of the 30 service lines. The Indiana Department of Health assigned service lines based on DRGs.

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

secondary, with shares in excess of 75 percent in several major service lines. WPAHS competes directly with UPMC in most major categories of inpatient services. For some services, consumers have few alternatives outside of those two systems. The economic discussion of WPAHS' role as a competitive constraint to UPMC provides context for what likely could happen to healthcare costs if WPAHS is a weakened (or non-existent) competitor.

While community hospitals in the area have available bed capacity and the ability to compete in many acute care inpatient services, only the UPMC system and WPAHS provide the full range of acute-care services in the area and have demonstrated capability in treating the most severe cases. The following provides some specific examples:

- In **Neurosurgery and Surgical Tracheostomy**, UPMC's share exceeds 60% in both service lines and WPAHS is the only other competitor serving a substantial number of these commercial patients, with 28.0 percent share in neurosurgery and 21.3 percent share in surgical tracheostomy.³⁸⁰ There are a total of 1,413 commercially insured neurosurgery patients and 464 commercially insured surgical tracheostomy patients in the 90-percent area.
- Similarly, UPMC's share of **Oncology/Hematology** is 58.2 percent with WPAHS is next largest supplier at 17.9 percent.³⁸¹ There are 4,125 commercially insured patients in this service line in the 90-percent area.
- UPMC and WPAHS combine to serve most of the commercial HIV population, accounting for 80.0 percent of patients.³⁸² There are 35 commercially insured patients in these service lines in the 90-percent area.

Within WPAHS's 90-percent discharge area, as shown in Harris Table 1A, UPMC has the largest share, followed by WPAHS.³⁸³

³⁸⁰ Harris Supplement 1 at ¶ 5.

³⁸¹ Harris Supplement 1 at ¶ 5.

³⁸² Harris Supplement 1 at ¶ 5

³⁸³ Tables 1A, 1B, and 2 of the Harris Supplement 1 present detailed shares and discharges in all 30 service lines. Appendix III 3a, 3b and 3c and Table 1A contain a copy of these tables for convenience.

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

Table 1A
Shares by Service Line
West Penn Allegheny Health System 90% Service Area
Acute Care, Commercial Payors

Service Line Number	Service Line Description	UPMC Health System	West Penn Allegheny Health System	St. Clair Memorial Hospital	Heritage Valley System ¹	Excelsa Health System ²	Jefferson Regional Medical Center	Washington Hospital	Butler Memorial Hospital	Other Hospitals In Highmark's WPA Service Area ³
26	Surgical Tracheostomy	66.8%	21.3%	1.5%	2.2%	1.3%	2.8%	1.1%	0.2%	2.8%
21	Psychiatry	66.7%	8.3%	8.3%	0.0%	8.3%	0.0%	8.3%	0.0%	0.0%
14	Neurosurgery	65.0%	28.0%	1.3%	1.2%	0.4%	0.3%	0.7%	0.3%	2.9%
17	Oncology/Hematology	58.2%	17.9%	5.5%	3.7%	3.3%	2.2%	1.7%	1.4%	6.2%
25	Spine	58.2%	16.1%	3.3%	8.9%	2.6%	1.7%	3.8%	1.2%	4.2%
27	Thoracic Surgery	54.3%	17.2%	7.1%	5.8%	2.9%	3.3%	2.3%	1.5%	5.6%
30	Other	53.7%	17.1%	6.0%	3.6%	4.2%	3.2%	1.7%	1.8%	8.5%
7	General Surgery	51.4%	14.9%	5.6%	7.3%	4.5%	4.0%	2.0%	1.6%	8.8%
6	General Medicine	50.6%	15.4%	6.1%	4.2%	4.4%	2.6%	4.3%	1.7%	10.7%
13	Neurology	49.5%	19.5%	6.3%	2.9%	3.4%	3.1%	3.2%	2.3%	9.8%
16	Obstetrics	49.3%	17.3%	6.7%	6.9%	5.8%	0.0%	2.5%	2.2%	9.4%
20	Other Orthopaedics	49.3%	18.0%	8.5%	4.2%	2.7%	3.6%	2.7%	1.4%	9.8%
19	Other OB	48.6%	20.1%	4.5%	3.3%	6.1%	0.0%	2.6%	1.9%	13.0%
9	HIV	48.6%	31.4%	2.9%	5.7%	0.0%	8.6%	0.0%	0.0%	2.9%
24	Rheumatology	46.3%	19.0%	5.2%	5.2%	4.8%	3.0%	3.9%	2.6%	10.0%
12	Nephrology	45.3%	14.0%	8.8%	3.9%	4.7%	4.5%	3.6%	1.9%	13.2%
28	Urology	44.3%	15.6%	5.4%	5.0%	5.5%	5.9%	1.9%	2.5%	14.1%
4	Endocrinology	43.1%	13.7%	9.2%	4.1%	5.8%	4.8%	3.7%	1.8%	13.9%
10	Major Joint Procedure	43.0%	14.3%	9.7%	7.8%	3.7%	4.9%	1.6%	2.8%	12.1%
8	Gynecology	43.0%	15.7%	4.3%	8.1%	6.3%	0.6%	3.0%	3.4%	15.7%
18	Open Heart	42.9%	16.8%	8.4%	5.5%	4.5%	8.1%	5.3%	5.5%	3.0%
3	Dermatology	42.0%	12.9%	8.3%	5.2%	6.6%	6.1%	3.3%	1.9%	13.7%
5	Gastroenterology	41.6%	16.0%	8.1%	5.0%	6.3%	5.1%	3.4%	1.9%	12.6%
22	Pulmonary	38.6%	13.1%	9.9%	5.6%	5.6%	5.9%	4.3%	2.1%	15.0%
29	Vascular Surgery	37.7%	14.1%	9.1%	10.5%	6.8%	6.3%	3.8%	4.0%	7.8%
2	Cardiology	35.2%	14.4%	10.0%	6.0%	6.7%	6.1%	5.3%	2.7%	13.5%
1	Cardiac Caths	34.0%	12.4%	8.1%	7.5%	7.8%	6.0%	7.5%	5.1%	11.6%
Total Hospital Share		46.6%	16.0%	7.2%	5.8%	5.0%	3.6%	3.1%	2.1%	10.6%

Source: Pennsylvania hospital inpatient migration data reported to the Pennsylvania Health Care Cost Containment Council (PHCC), purchased through DataBay Resources. Data reflect discharges from April 2010 through March 2011. Service Line Definitions come from the Indiana State Dept of Health at www.in.gov/indh/reports/hosp_disch_data/2007/mis-drs.xls

Notes:

- [1] The Heritage Valley System consists of Heritage Valley Beaver and Sewickley Valley Hospital.
- [2] The Excelsa Health System includes Excelsa Westmoreland Regional Hospital, Excelsa Latrobe Area Hospital, and Excelsa Frick Hospital.
- [3] Highmark's WPA service area includes the following 29 counties: Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Centre, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Huntingdon, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, Warren, Washington, and Westmoreland

Additionally, Dr. Harris analyzed the services provided by area hospitals at the DRG level and reached similar conclusions. He finds that WPAHS provided 713 of the 722 acute-care DRGs where the UPMC system had discharges over the twelve-month period of his data. The remaining nine DRGs had few discharges at UPMC hospitals, 69 in that time period.³⁸⁴ The next closest hospital system, in terms of DRG coverage, is Heritage Valley, which however, did not provide 105 of the DRGs treated by the UPMC system. These 105 DRGs represent substantial patient volumes at the UPMC system. UPMC hospitals discharged 4,059 inpatients in these 105 DRGs in the twelve months of data used.³⁸⁵ There were 106 DRGs, accounting for 4,820 patients, in which the UPMC system had discharges, but not the Excelsa system hospitals. For St. Clair, there were 131 DRGs (accounting for 6,553 UPMC system discharges) not served; for

³⁸⁴ Harris Supplement 1 at ¶ 6.

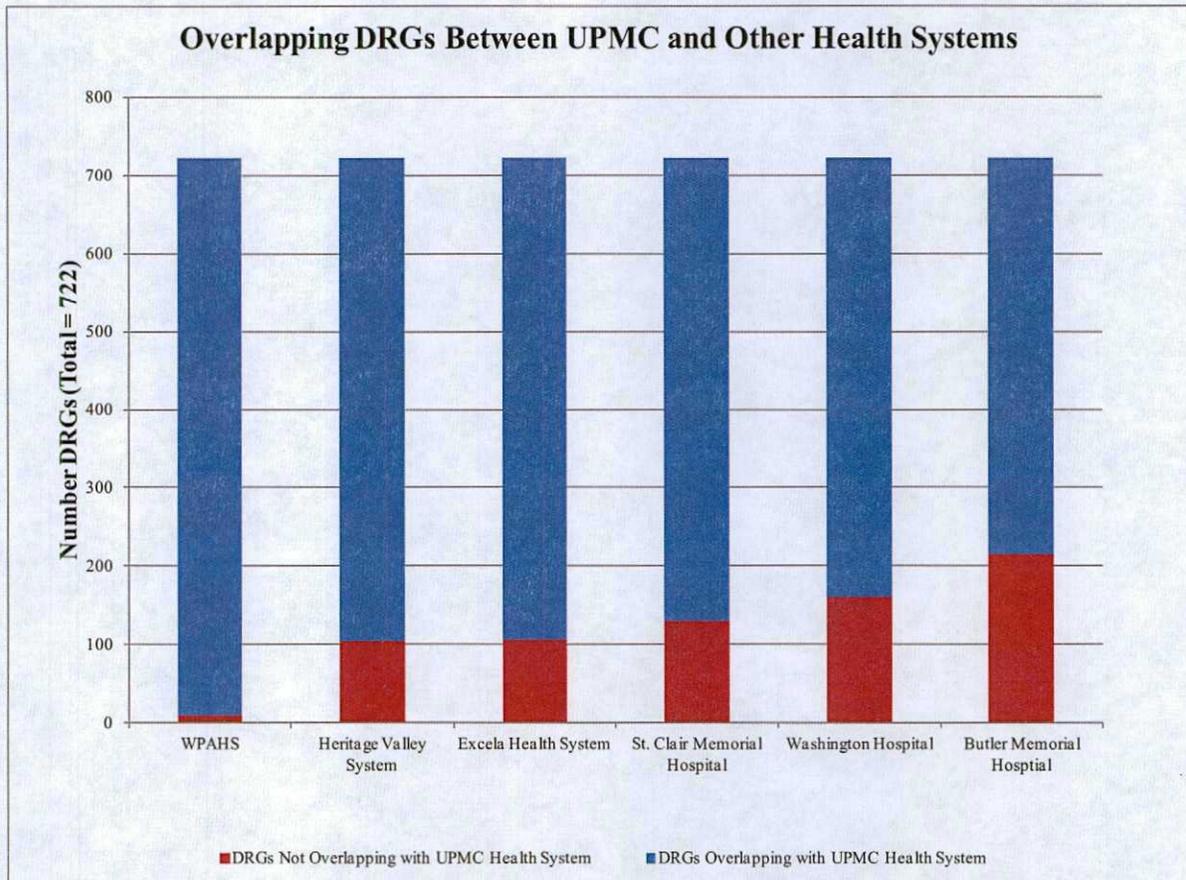
³⁸⁵ Harris Supplement 1 at ¶ 6.

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

Washington Hospital, 161 DRGs (accounting for 8,172 UPMC system discharges); and for Butler Memorial Hospital, 215 DRGs (accounting for 9,432 UPMC system discharges).³⁸⁶

Figure 2 presents a graphical representation of the UPMC DRGs served at area hospitals and systems.

Figure 2



Dr. Harris reports that no other hospital or system in this area provides the breadth of service line or DRG coverage provided by WPAHS and UPMC.³⁸⁷ This suggests that UPMC and WPAHS are closest competitors and that others may be more distant. Dr. Harris concludes that “if the proposed change of control does not occur, WPAHS may become further weakened or exit the market,” and that “if either were to occur, the analyses reported in Tables 1A, 1B, and 2 [of

³⁸⁶ Harris Supplement 1, Table 2.

³⁸⁷ Harris Supplement 1 at ¶ 6-7.

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

Harris Amended Supplement 1] *suggest that the UPMC system will face considerable less competition in several service lines than if the proposed change does occur.*³⁸⁸ [emphasis added]. The end result, according to Dr. Harris, would be that “[t]his reduced competition likely would result in higher prices or reduced quality for these hospital services.”³⁸⁹ [emphasis added].

I conducted additional research to confirm Dr. Harris’s analysis and determine whether the findings were consistent when looking at commercial patients and at patients with more or less severe illnesses. To do this, I used the same discharge database and service line classifications as Dr. Harris. Using those sources, I summed discharges by hospital and service line to determine which hospitals offered which services, as Dr. Harris had done. To simplify the output, I restricted the set of hospitals reported in the analysis to those located in the six counties around Pittsburgh.³⁹⁰ This allows for a focus on the importance of WPAHS, the UPMC system, and other hospitals most geographically proximate to WPAHS. The analysis used data for all payors and separately for commercial patients. It also examined both patients whose DRGs had weights less than 2.5 (classified as “low weight”) and those whose DRGs had weights of 2.5 or greater (classified as “high weight”).³⁹¹

Across all payors and patients, UPMC and WPAHS have a combined share of at least 75 percent of patient discharges in six out of the 30 total service lines, as shown in Table 32. Those service lines include Spine, Neurosurgery, Neonatology, Other OB, Surgical Tracheostomy, and HIV. These represent some of the more severe or complex cases. Analysis also shows that only selected hospitals within the WPAHS and UPMC systems currently provide these services as measured by discharges. In these services, the larger hospitals in downtown Pittsburgh generally appear to be the closest substitutes. For many of the services, these hospitals are Allegheny General for WPAHS and Presbyterian Shadyside for UPMC.

³⁸⁸ Harris Supplement 1 at ¶ 7.

³⁸⁹ Harris Supplement 1 at ¶ 7.

³⁹⁰ I have also reviewed the analysis of service lines presented in H₂C, “Report to the Board of Directors Regarding Affiliation with West Penn Allegheny Health System, February 5, 2013, and conclude it is consistent with the analyses I present here.

³⁹¹ Each DRG has a unique case weight, which is an indication of case severity. Weights are computed by CMS based on the relative costs of treating patients in each DRG.

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

Table 32

Summary of Service Lines for Hospitals in Pittsburgh and Surrounding Counties

Service Line	All Payor Discharges				High Weight (≥ 2.5) Discharges				Low Weight (< 2.5) Discharges			
	All Area	UPMC System	WPAHS System	Other Area	All Area	UPMC System	WPAHS System	Other Area	All Area	UPMC System	WPAHS System	Other Area
Neurosurgery	4,852	65.6%	28.6%	5.8%	2,012	70.3%	26.8%	2.9%	2,840	62.2%	29.9%	7.9%
Surgical Tracheostom	1,963	64.1%	21.3%	14.6%	1,933	63.8%	21.6%	14.6%	30	83.3%	6.7%	10.0%
HIV	191	57.6%	26.2%	16.2%	65	53.8%	32.3%	13.8%	126	59.5%	23.0%	17.5%
Neonatology	3,835	59.7%	19.9%	20.4%	1,893	65.5%	24.0%	10.5%	1,942	54.2%	15.8%	30.0%
Other OB	1,898	55.6%	18.7%	25.7%	-	-	-	-	1,898	55.6%	18.7%	25.7%
Spine	10,074	59.8%	16.4%	23.7%	3,949	65.7%	13.1%	21.2%	6,125	56.1%	18.5%	25.4%
Oncology/Hematology	14,202	52.8%	16.9%	30.2%	1,207	64.0%	22.5%	13.5%	12,995	51.8%	16.4%	31.8%
Neurology	17,167	45.0%	20.5%	34.5%	188	59.0%	26.6%	14.4%	16,979	44.8%	20.5%	34.7%
Urology	6,017	43.6%	16.7%	39.7%	935	54.2%	22.1%	23.6%	5,082	41.7%	15.7%	42.6%
Other	8,773	53.2%	17.2%	29.6%	2,472	53.5%	20.5%	26.0%	6,301	53.1%	15.9%	31.0%

Includes all discharges at hospitals located in Allegheny, Armstrong, Beaver, Butler, Washington, and Westmoreland counties. Service lines where hospitals outside of the UPMC and WPAHS systems account for less than 25% of discharges are outlined.

Additionally, for women’s services and childbirth, West Penn is a key facility for WPAHS and UPMC serves these patients at Magee Women’s. This high overlap is more apparent when considering higher-acuity patients. The following sets out each of the key service lines:

- **Spine: (10,074 patients at area hospitals)** Combined, the WPAHS and UPMC systems have a 76.3 share of discharges. The UPMC system has a 59.8 percent share, with the majority of these procedures performed at Presbyterian Shadyside and Passavant. WPAHS has a 16.4 percent share, with most of these procedures performed at Allegheny General.
- **Neurosurgery: (4,852 patients at area hospitals)** The WPAHS and UPMC systems combine for a 94.2 percent share of neurosurgery discharges. The UPMC system has a 65.6 percent share, with about two thirds of these procedures performed at Presbyterian Shadyside. WPAHS has a 28.6 percent share, with most of its procedures performed at Allegheny General.
- **Neonatology: (3,835 patients at area hospitals)** In total, the WPAHS and UPMC systems have a 79.6 percent share of discharges. The UPMC system has a 59.7 percent share, with the majority of these procedures performed at Magee Women’s Hospital. WPAHS has a 19.9 percent share; most of these patients received care at West Penn Hospital.
- **Other OB: (1,898 patients at area hospitals)** The WPAHS and UPMC systems have a

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

74.3 percent share of the other OB discharges. The UPMC system has a 55.6 percent share, again with the majority performed at Magee Women's Hospital. WPAHS has an 18.7 percent share, with the majority performed at West Penn Hospital.

- **Surgical Tracheostomy: (1,963 patients at area hospitals)** UPMC has a 64.1 percent share, mostly at Presbyterian Shadyside. WPAHS has a 21.3 percent share, mostly at Allegheny General.
- **HIV: (191 patients at area hospitals)** UPMC has a 57.6 percent share, with the majority of the procedures performed at Presbyterian Shadyside. WPAHS has a 26.2 percent share, with its procedures performed at multiple hospitals.
- UPMC and WPAHS have at least a combined 60 percent share of patient discharges (but less than 75 percent) in 12 other service lines in the Pittsburgh MSA; these are set out below with number of patients shown:
 - Other (70.4 percent; 8,773 total patients)
 - Oncology/Hematology (69.7 percent; 14,202 total patients)
 - Thoracic Surgery (69.3 percent; 3,147 total patients)
 - Obstetrics (65.3 percent; 23,136 total patients)
 - General Surgery (65.6 percent; 26,584 total patients)
 - Neurology (65.5 percent; 17,167 total patients)
 - Normal Newborn (63.8 percent; 20,470 total patients)
 - Rehabilitation (64.5 percent; 7,559 total patients)
 - Other Orthopedics (63.7 percent; 17,503 total patients)
 - Urology (60.3 percent; 6,017 total patients)
 - General Medicine (60.5 percent; 16,255 total patients)
 - Open Heart (62.0 percent; 4,119 total patients).

1. HIGHMARK'S INSURED PATIENTS

In 2011, [REDACTED] of the [REDACTED] Highmark patients ([REDACTED]) treated at WPAHS hospitals were in service lines where the UPMC system and WPAHS had a combined share of more than 60

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

percent.³⁹² Approximately [redacted] [substantial portion] of the Highmark-insured patients treated at WPAHS facilities would have few alternatives other than UPMC if WPAHS were significantly weakened or forced to exit. This service line analysis also suggests that it may be more difficult for insurers, including Highmark, to shift patients from UPMC to hospitals other than WPAHS for many services.³⁹³

F. COMPETITIVE EFFECTS OF A NO HIGHMARK/WPAHS AFFILIATION ON THE HOSPITAL MARKET

WPAHS is an especially important competitive constraint on UPMC. Both offer a wide range of services in multiple facilities. Moreover, they have a number of service lines where they are especially close competitors, including six clinical areas—Spine, Neurosurgery, Neonatology, Other OB, Surgical Tracheostomy, and HIV—UPMC and WPAHS have a combined share of at least 75% of patient discharges. Further weakening or loss of WPAHS, including for these critical services, would lessen a competitive constraint on UPMC and would likely affect UPMC's ability to exercise market power.

Absent the Affiliation, WPAHS would need to acquire capital in order to support its continuing operations, through either a consolidator hospital system, strategic buyer, or private investor. I have not seen any economic evidence indicating that a for-profit hospital system is the only likely alternative for WPAHS. Even if this were the likely alternative source for capital, I am not aware of any economic studies showing that for-profit hospital ownership necessarily results in higher reimbursement rates than those set by not-for-profit hospitals such that WPAHS's rates would increase by identity of ownership.³⁹⁴

If WPAHS's current financial difficulties do not allow it to realign and improve services, its current situation likely will lead to potentially higher costs and less efficiency in future. With WPAHS's current financial situation, WPAHS has limited ability to compete effectively with

³⁹² Includes commercially insured and Medicare Advantage patients.

³⁹³ Additional detail is provided in the tables in Appendix III.

³⁹⁴ Lynk found that not-for-profits priced lower in concentrated markets. See Lynk, William, "Nonprofit Hospital Mergers and the Exercise of Market Power," *Journal of Law and Economics*, (1995), 38: 437-461). Subsequent studies, however, found no connection. See Simpson, John and Shin, Richard, "Do Nonprofit Hospitals Exercise Market Power?" *International Journal of the Economics of Business*, 1998, 5(2): 141-157 and Dranove, David and Ludwick, Richard. "Competition and Pricing by Nonprofit Hospitals: A Reassessment of Lynk's Analysis." *Journal of Health Economics*, (1999), 18: 87-98.

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

and discipline UPMC. If its financial and operating condition does not change for the better soon, WPAHS may have to substantially cut services, close facilities or reduce staffing, including eliminating investments in new services, and as a consequence, physicians would likely accelerate their referrals to other, stronger hospitals and away from WPAHS, thus increasing insurers and consumers dependence on UPMC for healthcare. With Aetna, Cigna, and UnitedHealthcare having reached in-network agreements with UPMC, insurers are already shifting some volumes to UPMC.

Absent this affiliation and WPAHS's compromised ability to constrain UPMC, it is likely that UPMC has the incentive and ability to raise reimbursements to insurers materially above current levels. To some extent, WPAHS constrains UPMC's current rates. WPAHS also influences UPMC's expansion strategies, as evidenced by the recent opening of UPMC East virtually across the street from WPAHS's Forbes Regional Medical Center. Without a stronger WPAHS, there are reduced significant competitive constraints on UPMC's ability to raise its rates to other insurers and shift substantially larger numbers of enrollees to its own plan, with lower reimbursement rates. Thus, a stronger WPAHS would act to constrain insurance premiums in WPA.

WPAHS competes not only with UPMC but also with other community-based hospitals in WPA. Excess hospital bed capacity and duplication of services increases the cost of healthcare in the community. The relatively low occupancy rates and excess bed capacity suggest that the community would benefit from a reduction in hospital bed capacity. This would strengthen the financial and operating viability of the community's remaining hospital assets. Eliminating excess hospital capacity is difficult to accomplish since each player believes it is the "other guy's" capacity that is excess. Mergers and acquisitions of hospitals in the same community are a means of rationalizing capacity as part of an effort to achieve efficiencies and synergies. If the PID approves this Affiliation, it will be important to allow Highmark the flexibility to rationalize these hospital assets as part of its IDN strategy. This would increase the likelihood that Highmark achieves projected cost savings and these savings flow back to the community in the form of lower costs, greater access to the right level of care, and higher quality of healthcare delivery in WPA.

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

VII. POSSIBLE REMEDIES TO ADDRESS POTENTIAL COMPETITIVE EFFECTS AND PUBLIC BENEFITS POST-AFFILIATION

In developing my expert opinion on the proposed Affiliation, the PID asked me to assess specific potential conditions, including those set forth in the public record on the proposed Affiliation, and to address the circumstances under which conditions could achieve the goals of protecting competition while permitting the benefits and efficiencies of the transaction. As a context for that review, I examined economic literature and enforcement policy statements on remedies, and particularly examined remedies employed in vertical mergers by antitrust authorities and the rationale for them. This review showed more varied remedies applied in vertical mergers than applied in horizontal mergers, and these vertical remedies tend to include both conduct and structural remedies. Conduct remedies used in vertical mergers include information firewalls and provisions requiring non-discriminatory behavior and structural remedies include targeted divestitures to limit the extent of vertical integration.³⁹⁵

Several interested parties have presented views to the PID that the transaction poses substantial risks of anticompetitive effects and have suggested conditions to limit the ability of Highmark/WPAHS to engage in anticompetitive conduct post-transaction, such as charging supra-competitive prices for, or limiting substantially access to WPAHS's services. The concerns primarily relate to terms and conditions of access to WPAHS facilities and the resulting effects on competition in the insurance sector; the conditions proposed primarily involve pricing, access, and contract provisions, but also relate to contracting between UPMC and Highmark.³⁹⁶ I have reviewed these comments and have considered them in my analysis as asked by the PID.

³⁹⁵ Feinstein, Deborah, "Editor's Note: Are the Vertical Merger Guidelines Ripe for Revision?" *Antitrust*, (Summer 2010) at 7.

³⁹⁶ I excerpt here a number of the conditions that have been proposed in comments filed by insurers or representatives of the insurance industry, and include the response to these by UPE: Comments of Timothy Guarneschelli, Vice President and Secretary Health America, dated May 24 2012, In re the Acquisition of Control of or Merger with Domestic Insurers by UPE, a Pennsylvania nonprofit Corporation. (Proposed terms and conditions: No termination of existing provider contracts, and agreement to negotiate in good faith with health plans and physicians. Rates should be market based and no subsidizing of Highmark Health plan by WPAHS or MFN. A ban on conditioning access to hospital or physician services on taking any other service. A ban on refusals to deal in any specialist services – price decided by a panel of independent community leaders/ completely independent board for WPAHS. Must show savings to the community); Comments of Patrick Gillespie, Director of State Government Affairs, Cigna dated June 1, 2012 (Approval should be conditioned on the termination of in network contracts between Highmark and UPMC on January 1, 2015, and a prohibition of any MFN provision in the

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

In my review of economic literature, consent decrees, and commentary, I note that conduct remedies, in particular, can be potentially effective for addressing competition concerns raised by vertical mergers. The most common forms of conduct remedies are firewalls, non-discrimination and anti-retaliation provisions, and prohibitions on certain contracting practices.³⁹⁷

A guiding principle from this review about effective merger remedies is (a) their close relationship to the competitive issue of concern, and (b) crafting of provisions that limit significant competition-reducing activity without disrupting the accomplishment of the benefits of the transaction. Moreover, remedies are more efficient if self-enforcing and limited. To assist in the review of proposed conditions for the PID, I assume here that the potential competitive concerns for consideration are:

- the (potential) access of Highmark (WPAHS) to competitively sensitive information of its insurer (hospital) rivals and involvement in decision-making concerning supply or customer relationships with rivals; and
- risks of *anticompetitive* changes in the terms and conditions of contracting between insurer and hospital rivals and the merged entity.

In addition, as detailed in the preceding sections, the proposed Affiliation and IDN could potentially yield substantial benefits to the community, including re-invigorated competition of WPAHS with UPMC and the prospect of efficiencies, cost savings, and quality improvements.

agreement between the two); Comments of Samuel Marshall, President & CEO of the Insurance Federation of Pennsylvania, dated June 1, 2012 (Highmark and/or UPE must allow West Penn to remain open to other insurers and The Department should establish an ongoing review process to make sure this is being fulfilled. Highmark must accept only reasonable rates from West Penn, not artificially reduced rates designed to attract patients to this hospital. All terms and conditions between Highmark and West Penn should extend to all other providers, practices, and facilities Highmark purchases. Department should have prior approval of any future investments in West Penn. Approval should be conditioned on an ending of Highmark's contracts with UPMC as of January 1, 2014. Recommends conditions proposed by HealthAmerica.); Response by UPE to Comments of Timothy Guarneschelli, dated May 24, 2012, Comments of Patrick Gillespie, dated June 1, 2012, and Comments of Samuel Marshall, dated June 1, 2012; (UPE believes the conditions proposed by these members of the insurance industry are inappropriate. Eliminating in-network access to UPMC for Highmark policyholders would disrupt continuity of care and unduly restrict provider choice. The current Highmark-UPMC agreements do not contain MFN provisions. WPAHS hospitals will contract with all insurance carriers who are interested).

³⁹⁷ See Antitrust Division Policy Guide to Merger Remedies, US Department of Justice, Antitrust Division, June 2011 at 12, 13. Also see Ramirez, Edith, "FTC Behavior Remedies," ABA Antitrust Fall Forum, November 17, 2011 at 6 ("Behavioral remedies almost exclusively used in vertical mergers; ...Structural remedies may be used for a vertical merger, but behavioral remedies are often effective; Concerns are not loss of a competitor, but change in competitive incentives and increased ability to exploit market power").

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

There is, however, considerable uncertainty associated with the timing and likelihood of the accomplishment of these benefits, and their impact is dependent on several factors, such as success in shifting volumes to WPAHS or alternatively achieving substantial cost reductions through other means. In addition to reviewing proposed conditions or remedies to mitigate competitive issues, the PID asked me to identify specific approaches that would provide transparency for the public (and the PID) on the accomplishment, or lack thereof, of identified benefits resulting from the Affiliation, including metrics or reports that Highmark could provide to the PID, either to affirm the achievement of specific targets or to identify when Highmark must undertake additional actions when specific targets are not met. To assess this and determine whether there were practical and implementable alternatives, I reviewed metrics and reporting requirements that have been employed by other agencies with regard to hospital, insurer or other transactions, and assessed these in the context of this transaction.

For convenience of exposition, I organize the following discussion by type of condition, with a brief introduction as to the rationale for the condition in vertical mergers, generally, and then its relevance and potential applicability for this transaction. I have attempted to identify approaches that reduce substantially the relevant risks in ways that are self-enforcing and rely on competitive forces to achieve results to assist the PID in consideration of the conditions. I note at the outset that I reviewed and considered concerns expressed by market participants in their public comments and from interviews, and conditions proposed, including in public comments. I have taken care, however, to differentiate between targeted remedies that protect the competitive process and competition from ones that impose artificial limitations on competitors in ways that could adversely affect the ability of competitors to respond to consumer demands or to marketplace changes.

A. FIREWALL CONDITIONS

Firewalls are a class of provisions that govern both the dissemination or sharing of competitively sensitive information between and among the formerly independent operations of the new vertical entity and the personnel from each such entity that can be involved in decision-making and engaged with its rivals (who are suppliers or customers) at the other entity post-transaction. A vertical transaction may raise the concern that a dominant firm which acquires one of a

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

relatively few downstream (or upstream) competitors could obtain or share information on the terms and conditions of rival contracts and thereby potentially reduce substantially competitive innovation or pricing between the now merged firm and its rivals at one or both levels. In this section, I set out the relevant issues for consideration of firewall conditions in the context of the proposed Affiliation and Transaction; and illustrate the potential concerns raised, the specific conditions, and linkages between them for use in evaluation of these conditions by the PID.

Insurer competition in WPA involves a complex array of factors, including negotiated rates with several hospitals and providers, network configurations and product design with new incentives for consumers or employers, and pricing of products. Providers may gain knowledge of these competitively sensitive plans and rates as part of the negotiation of managed care agreements and supporting arrangements. The underlying concept for firewalls in this proposed Affiliation would be to restrict Highmark's knowledge of and ability to influence WPAHS's (or JRMC) negotiations with rival insurers, and conversely, WPAHS's influence on Highmark's negotiations with rival hospitals. Such firewalls would mitigate competitive concerns arising from Highmark's ownership of a major provider of hospital services to competing healthcare insurance rivals. Likewise, firewalls could also be constructed that would prohibit WPAHS's access to reimbursement contract rates and terms between Highmark and other hospital service providers.

Remedies used in several vertical merger cases have included firewall provisions and these provisions are among the most common types implemented.³⁹⁸ Firewalls to prevent the

³⁹⁸ See for example: Ramirez, Edith, "FTC Behavior Remedies," ABA Antitrust Fall Forum, November 17, 2011 at 8. An example of imposing firewalls in a vertical transaction is PepsiCo's acquisition of two of its largest bottler-distributors and subsequent exclusive license from the Dr Pepper Snapple Group (DPSG) to bottle, distribute and sell certain carbonated soft drink brands of DPSG in specific territories. The FTC expressed concern that as a consequence of its acquisition of the two large bottlers, PepsiCo would gain access to DPSG's "commercially sensitive confidential marketing and brand plans. Without adequate safeguards, PepsiCo could misuse that information, leading to anticompetitive conduct that would make DPSG a less effective competitor or would facilitate coordination in the industry." In order to address this concern, the consent agreement allows only PepsiCo employees who perform carbonated soft drink "bottler functions" access to the DPSG commercially sensitive information and prohibits PepsiCo employees involved in "concentrate-related functions" from seeing that information (see Analysis of Agreement Containing Consent Order to Aid Public Comment, In the Matter of PepsiCo, Inc., FTC File No. 091-0133, February 26, 2010 at 1.). An example of an organizational firewall in a horizontal matter in hospital services was in Evanston's acquisition of Northwestern and Garland Park. In that matter as an alternative to divestiture, the FTC required each of the hospital systems to have separate

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

dissemination of competitively sensitive business information are common among vertically integrated firms, particularly integrated hospitals and insurance entities. Examples of competitively sensitive information among providers and insurers may include:

- Present and future reimbursement rates by payor
- Payor-provider reimbursement contracts
- Terms and conditions included in agreements or contracts between payors and providers including discounts in reimbursements in agreements
- Reimbursement methodologies including provisions relating to performance, pay for performance, pay for value, consumer choice initiatives (e.g., tiering of providers), and
- Specific cost and member information, and revenue or discharge information specific to the payor.

From a competitive perspective, the following principles guide an effective firewall among vertically integrated hospitals and insurers with regard to personnel and decision-making:

- Separate managed care contracting information and activity of the hospital and of the insurer segments, including the personnel who engage in decision-making and contracting with suppliers (customers),
- Firewall mechanisms that prevent sharing of competitively sensitive information among persons at the hospital and insurer entities, with clear definition of what constitutes competitively sensitive information, and
- Clear confidentiality policies, procedures and protocols that describe the specific persons and positions that can have access to competitively sensitive information with clear policies and procedures for monitoring or auditing compliance with established firewalls, reporting of violations, and remedial actions taken in the event of a violation of the firewall.

Concerns raised in this instance suggest that protection of highly confidential and competitively sensitive business information is among the most significant concerns, particularly in light of changes in response to healthcare reform, the development of new products and exchanges, and the recent dynamic changes in WPA with rival insurers gaining access to UPMC. Firewalls targeted at protecting specific competitive information that is fundamental to negotiations and product development between supplier and purchaser protect information from dissemination to the merged entity's rival operations appear to have no significant offsetting costs if well crafted. Moreover, consent decrees with firewall provisions are not unusual and suggest that vertically

teams for negotiating hospital rates with healthcare insurers. See *In Re Evanston*, FTC File No. 9315 (2007).

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

integrated firms can develop and implement appropriate safeguards to protect competitively sensitive materials. In the present matter, it is also imperative from a competitive perspective to establish firewalls that prevent persons with influence over managed care contracts and related reimbursements on the health plan side from obtaining information on managed contracts and related reimbursements on the provider side.

B. RESTRICTIONS ON CONTRACTING PRACTICES

A fundamental aspect of competition in healthcare is the contract negotiated between hospital and insurer, and ultimately between insurer and consumers/employers. Competition results in a highly differentiated set of contracts and terms, with price and non-price terms (duration, escalators, scope of services, quality and value metrics) varying widely even for a given payor or a given hospital. Thus, competitive markets may see either greater uniformity for a given payor or provider (e.g., for transactional costs and enforcement purposes) or substantially varying terms; there may be greater or less commonality across a marketplace. Thus, economic assessment of proposed conditions regarding contract terms should consider these competitive outcomes and focus more narrowly the review of proposed conditions to provisions – especially those not currently in use – that if imposed could artificially limit the ability of rivals to discipline pricing or to pressure the merged entity to accomplish benefits for consumers, without offsetting benefits:

“Restrictive or exclusive contracts can be competitively neutral, procompetitive, or anticompetitive, depending on a number of factors. In some situations a merged entity might use restrictive or exclusive contracting anticompetitively to block competitors’ access to a vital input. Or, a merged entity might enter into short-term contracts with key customers that include automatic renewal provisions to foreclose or slow entry. In these types of situations, it may be appropriate to impose limits on the merged entity’s ability to enter into restrictive or exclusive contracts. Prohibitions on restrictive contracting may be particularly appropriate in vertical mergers in which the merged entity will control an input that its competitors must access to remain viable.”³⁹⁹

There have been a number of conditions recommended by commentators with regard to contracting between Highmark and hospitals, and between WPAHS and rival insurers. There are

³⁹⁹ U.S. Department of Justice, Antitrust Division “Antitrust Division Policy Guide to Merger Remedies;” Department of Justice, 2011 at p. 17, and *United States v. Chancellor Media Corp.*, 1999-1, *United States v. AlliedSignal, Inc.*, 2000-2, and *United States v. Aetna, Inc.*, 1999-2.

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

some specific provisions that are more readily enforceable and could provide protection of competition without significant cost. There are others, however, that appear to pose more substantial costs and uncertain benefits. I address each proposed condition related to contracting below:

- *Prohibition on anti-consumer choice initiative (e.g., anti-tiering/anti-steering) language:* Development of limited and tiered networks is still at a nascent stage in WPA and limited by current contracting provisions at UPMC with insurers. Highmark has been able to negotiate an exception in its current UPMC contract and can offer Community Blue as a narrow network product. Exclusion of provisions in any future Highmark or WPAHS/JRMC/SVHS contract with any provider or insurer that would prohibit either party to the contract from offering, for example, a tiered network product as a condition for the contract would enable, but not require, market participants independently to negotiate mutually beneficial contracts for rival products of this type. In my view, consumer choice and other member cost-sharing initiatives, e.g., tiered network products, are procompetitive and consistent with healthcare reform efforts to incentivize consumers to consider the costs of healthcare in choosing providers with the objective of lowering overall healthcare expenditures.⁴⁰⁰
- *Prohibition on MFNs in contracts between UPE hospitals/providers and insurers and in Highmark contracts with hospitals/providers:* I understand that Highmark does not currently use MFNs, and has been subject to a prohibition on the use of MFNs in its contracts with providers.⁴⁰¹ The requirement to continue not to use MFNs would appear to impose few costs and could be extended to contracts with UPE hospitals and insurer contracts. Continued prohibition on MFNs and extension to these would enable rival insurers to attempt to negotiate prices and terms independently with UPE hospitals/providers. In my view, such prohibition on MFNs achieves many of the goals sought by insurer and hospital commentators to address their competitive concerns without the regulation, costs and possible inefficiencies associated with more invasive relief.
- *Prohibition including provisions prohibiting of contracting with rivals:* UPE hospital/providers should be able to negotiate at arms-length with rivals if they choose to do so.
- *Limitations on contract lengths beyond customary and usual duration:* Contracts that substantially exceed normal and customary lengths (usually 2-5 years) have the potential to limit the ability of rival hospitals/insurers to respond to changes in the market place

⁴⁰⁰ I note that Highmark's IDN cost savings estimates are predicated on assumptions that Highmark is fully able to use tiered and limited networks, is not constrained in its ability to use mechanisms for "steering" patients, and that it is able to accomplish considerable shifts of volumes from UPMC to WPAHS. These suggest that Highmark has assumed that it can negotiate a mutually beneficial contract with UPMC after 2014 at reimbursement rates consistent with encouraging UPMC to reach a contract for in-network services that do not include terms that limit these initiatives.

⁴⁰¹ In Re Application of Medical Services Association of Pennsylvania d/b/a Pennsylvania Blue Shield and Veritas Inc., et al, Decision and Order, Docket No. MS96-04-09S, November 27, 1996, at 49.

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

and may inhibit competitive change; moreover, there does not appear to be any pro-competitive or business justification for substantially longer contracts that have been raised in the record here.⁴⁰²

- *Prohibition on exclusivity requirements between Highmark and UPE Hospitals/providers or between Highmark and third party providers:* Currently, there do not appear to be exclusive contracts in force between Highmark and providers or WPAHS and insurers.⁴⁰³ The proposed transaction does not appear to require exclusivity for its success. As such, it would appear that prohibitions on exclusive contracting could protect the ability of rivals to compete for business and contracts without imposing costs or limitations on the ability of WPAHS or Highmark to achieve relevant goals if the PID were to determine that it would be necessary to include this prohibition.
- *Requirements to contract or contract on identical terms:* While some have suggested that UPE hospitals/providers and Highmark should be required to contract with all entities (e.g., any willing provider provisions), there are potentially high costs that recommend against this approach, especially in an area where there is substantial excess capacity and efforts are underway to have narrower or tiered networks to accomplish greater volumes

⁴⁰² Length of contract was a consideration in the DOJ evaluation of competition in WPA. “The signs of increased competition are appearing just as an existing long-term contract between Highmark and UPMC comes up for renewal. *Long-term contracts between dominant hospitals and insurers can dull their incentives to compete, leading to higher prices and fewer services. If a dominant hospital is guaranteed a predictable revenue stream for many years from a dominant insurer, then the hospital may be less likely to promote the growth of new insurers by offering them competitive rates. Similarly, if a dominant health insurer is guaranteed rates from a dominant hospital for an extended period, then the insurer may be less likely to promote competition in the hospital market by investing in more affordable hospitals.* Not all contracts between dominant hospitals and insurers are anticompetitive. Contracts with shorter terms can provide significant benefits to consumers by providing consumers with more options, while at the same time encouraging dominant hospitals to promote competition among health insurers, and encouraging dominant health insurers to promote competition among hospitals. The foreseeable expiration of the contracts increases the need for both the dominant hospital and the insurer to have alternatives to their dominant counterparts. *In the circumstances here, it appears that the long-term contract between Highmark and UPMC did diminish the incentives of each to compete and expand competition in these highly concentrated health insurance and hospital markets.*” [emphasis added]. Statement of The Department of Justice's Antitrust Division on Its Decision to Close Its Investigation of Highmark's Affiliation Agreement With West Penn Allegheny Health System http://www.justice.gov/atr/public/press_releases/2012/282076.htm April 10, 2012.

⁴⁰³ I note that there are examples of exclusive contracting in healthcare; for example, it is relatively common for hospitals to have some exclusive contracts with specialized providers such as anesthesiologists or ER physicians, and that these contracts periodically are put out for bid. I note that in the requirements for contracting practices set forth in the North Carolina COPA for Mission Hospital discussed below, these contracts were exempted from the no-exclusivity remedy. In addition, as discussed above, there are circumstances in which providers and insurers are able to negotiate substantially better terms in exchange for the commitments such as those involved in exclusive arrangements.

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

at lower cost providers.⁴⁰⁴ Some aspects of non-discrimination provisions are equivalent to this requirement; others are more similar to the points above.⁴⁰⁵

- *Express conditions on pricing and non-price terms: remedies addressing price or rate of price change are among the most complex and controversial of the proposed conditions by commenters on the Affiliation and Transaction:* In my view, the more limited and targeted conditions addressed above with regard to firewalls and specific provisions on contracting are sufficient to protect competition without requiring further conditions. Specifically, some commenters seek to have Highmark's prices be at parity with those of other rivals. This has the potential to distort competition rather than enhance it if forced on the marketplace because competitive marketplaces have an array of price points and do not necessarily gravitate to parity. A concern about anticompetitive price increases at WPAHS initiated by Highmark, which has been raised by commenters, however, could reinforce the importance for consideration by the PID of strong firewalls and separation of decision-makers to provide as much opportunity as possible for rivals to negotiate competitively beneficial contracts.
- *Limitations on new contracts with UPMC: several commenters recommended that the PID preclude Highmark from renewing its contract with UPMC in the future:* The stated rationales were the financial ramifications of continued inclusion of UPMC in-network on WPAHS volumes and the stability and success of the IDN and Affiliation, and the ability of Highmark to continue to have lower prices and cost structure at both UPMC and WPAHS relative to rivals. Having assessed all of the factors, I draw the conclusion as an economist that it is better to permit Highmark to attempt to respond to market demand, which appears to include consumer demand for a Highmark-UPMC product and to develop strategies for successful re-vitalization of WPAHS, than to artificially restrict Highmark's options, and to rely on competition from rivals, protected if necessary by specific conditions, to discipline Highmark's conduct.⁴⁰⁶ I also note that the current UPMC contract appears to bring Highmark's rates up substantially from the prior contract. In addition, Highmark's incentives and those of consumers align if Highmark can achieve lower costs at WPAHS and pass those benefits along to consumers.

C. DYNAMIC OVERSIGHT AND REPORTING

⁴⁰⁴ See Klick, Jonathan and Wright, Joshua D., "The Effect of Any Willing Provider and Freedom of Choice Laws on Health Care Expenditures," (2012). Scholarship at Penn Law. Paper 449.

⁴⁰⁵ "Non-discrimination provisions incorporate the concepts of equal access, equal efforts, and equal terms. If, for example, an upstream monopolist proposes to merge with one of several downstream firms competing in the same relevant market, this may raise competitive concerns that the upstream firm will favor the acquired downstream firm by offering less attractive terms, imposing restrictions on access to inputs, or refusing to deal with, the acquired firm's competitors. In certain circumstances, imposing non-discrimination clauses requiring the upstream firm to offer the same terms to all downstream competitors can promote competition." See Antitrust Division Policy Guide to Merger Remedies, US Department of Justice, Antitrust Division, June 2011 at 14-15.

⁴⁰⁶ In other sections of this Report, I address the alignment of Highmark and WPAHS incentives to develop a successful IDN and the benefits that could accrue to competition and policy holders, as well as contingency plans proposed by Highmark and other approaches to evaluating the success of the proposed Affiliation.

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

The proposed Affiliation and Transaction is complex, with investments and results occurring over time. As noted in Sections in this Report, there are many uncertainties and specific circumstances required for the IDN and the Affiliation to yield benefits, including the financial stabilization and re-invigoration of WPAHS. Some of these are time dependent and potentially require implementing contingency plans if specific targets do not materialize. Moreover, the accomplishment of goals and public benefits may not be readily transparent to the public. The PID asked me to consider if there is an approach the PID could take to obtain either verification or reporting from Highmark on its accomplishment of specific objectives or adherence to conditions, or that would provide notification of certain triggering events (e.g., additional transactions, or performance standard).

I have conducted a review of consent decrees, including those involving healthcare, to address these questions. There are several examples in consent decrees where monitoring or enforcement provisions were required with regard to future transactions or merger compliance. To allay certain competitive effects in particular cases, the DOJ Antitrust Division has required a merged firm to make certain information available to a regulatory authority that otherwise would not be required. Under such transparency provisions, this information enables the regulatory authority to monitor the firm closely for any evidence of anticompetitive practices and to assess whether the benefits of the transaction continue to exceed any potential harm to consumers.⁴⁰⁷

Two examples at the state level involving hospital transactions provide examples of reporting requirements and specific metrics, with examples of annual reports filed subject to the agreements between the parties. The two examples are from Massachusetts and North Carolina, with the former involving an acquisition of several hospitals in Massachusetts and the latter involving a merger of two hospitals in the same market.⁴⁰⁸

⁴⁰⁷ United States v. MCI Communications Corp., 1994-2 (“For example, a telecommunications firm may be required to inform a regulatory agency of the prices the firm is charging customers for telecommunications equipment, even though the regulatory agency may not have the authority to regulate those prices.”).

⁴⁰⁸ In the Caritas Christi transaction in Massachusetts, the parties entered into an Assessment and Monitoring Agreement with the State whereby the Attorney General reserved the right to monitor the new entity for five years following approval of the merger. The agreement provided that the Attorney General would monitor the impact of the transaction, the cost of healthcare (price, total medical expense, etc.), changes in treatment and referral patterns, and other aspects of the transaction. The parties agreed to provide information required by the Attorney General at their own cost and expense. See Statement of the Attorney General as to the Caritas Christi transaction, (October 6, 2010) at Assessment and Monitoring

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

In connection with its review, the AGO executed an Assessment and Monitoring Agreement whereby, for the five-year period following Steward's acquisition of Caritas's assets, the AGO would monitor (1) Steward's compliance with certain provisions of the Asset Purchase Agreement between Caritas and Steward relating to the public interest and (2) the "impact of the Transaction on the provision of health care services to the Communities" served by Steward.⁴⁰⁹

To assist the PID in its consideration of conditions, I summarize briefly here some of the reporting requirements and approaches that were used in these two matters. I include these not to suggest that the specific terms and conditions or scope of reports imposed in these two cases apply here, but to show the operational approach and the types of reporting and metrics used. The metrics and reports required and implemented suggests that certain metrics and financial measures are more conducive to self-reporting on a consistent basis than other metrics (such as relative price comparisons), which appear more difficult to develop and track. On balance, the review suggests that basic financial metrics and specific targets or goals that can be mutually defined or have already been defined by the agency or the merged entity for reporting purposes, are the most straightforward to develop and track as targets or thresholds for further action.. Finally, several consent decrees include reporting requirements that involve notification of any proposed new transaction.

Among the relevant reporting or metrics requirements in Caritas were:

Agreement. In late 1995, the merger of the only two acute-care hospitals in Asheville, North Carolina into Mission Hospital raised the concern about potential anticompetitive effects of the transaction. The State entered into a Certificate of Public Advantage ("COPA") agreement with the hospitals as a condition for allowing the merger to go forward. The parties were required to file specific reports every two years with the Department of Health and Human Services and the Attorney General; these were to provide information specified in the Agreement; certification that the transactions' benefits outweighed disadvantages of the merger, and specific financial information. See http://www.ncga.state.nc.us/EnactedLegislation/Statutes/pdf/ByArticle/Chapter_131E/Article_9A.pdf. Both of these involved extensive reports and evaluation, as well as more targeted and specific metrics or verification provided by the parties.

⁴⁰⁹ The latter is broader than a reporting requirement as discussed below. In September 2011, the AGO executed two substantively identical Assessment and Monitoring Agreements in connection with its review of Steward's proposed acquisition of Morton Hospital and Quincy Medical Center, thereby bringing those transactions within the scope of its monitoring responsibilities, e.g., Att'y Gen. of the Comm. of Mass., Morton Hosp. & Med. Ctr., Inc. et al. & Steward Health Care Sys. LLC, Assessment & Monitoring Agreement (Sept. 30, 2011), available at <http://www.mass.gov/ago/docs/nonprofit/morton/complaint-exhibit-l.pdf>.

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

- *Requirement to develop and post metrics on charitable care and community benefits:* This was accomplished by using an existing report filed by other entities.⁴¹⁰
- *Annual monitoring report which includes three specific areas, annual reports, a baseline, and efforts to track certain metrics over time:*⁴¹¹ The areas for which reporting and analysis were required were specific to this particular transaction and include metrics (e.g., financial) as well as much more comprehensive data gathering and evaluation of other information, including examination of:
 - **Medical System Organization.** We examine how Steward is organized and how its medical system has changed over time, including changes to the system's delivery of acute care, sub-acute care, and physician services.
 - **Market Position.** We examine Steward's competitive position within the markets it serves, and the impact of its activities, and those of its competitors, on these markets. This includes monitoring Steward's market share in its communities and referral patterns for its patients by provider type and service line; measuring Steward's cost and efficiency compared to its competitors; and evaluating the impact of Steward's competitive efforts on other providers and the markets it serves.
 - **Financial Performance.** We examine the financial results of Steward's business operations. This includes measuring changes in Steward's financial condition over time and the impact of specific business initiatives on Steward's financial state.⁴¹²

The State of North Carolina has used a related process for ex-post monitoring of a merger between two hospitals that occurred in the mid-1990s.⁴¹³ Among the relevant provisions are

⁴¹⁰ Steward agreed in each transaction to comply with the AGO's Community Benefits Guidelines and to report on community benefits and charity care under those Guidelines. Information on the community benefits and charity care levels at each Steward hospital is available on the AGO's website. The obligation imposed on Caritas/Steward was compliance with reports filed annually by non-profit hospitals in Massachusetts. See

http://www.cbsys.ago.state.ma.us/cbpublic/public/hccdownloadreportdatanew.aspx?report_year=2011 for a description of the categories of information required in filings with regard to benefits.

⁴¹¹ "This Impact Monitoring Report has five parts. Part I reviews the origins of the AGO's monitoring commitment and describes the monitoring approach reflected in this Report, including data relied upon and limitations of that data. Part II summarizes the AGO's findings from its first year of monitoring. Part III reviews Caritas's performance prior to Steward's acquisition to establish a baseline for assessing Steward's impact post-acquisition. Part IV reports on Steward's first year of operations, reviewing the same performance metrics examined in Part III for Caritas. Based on the results of the AGO's first year of monitoring, Part V identifies metrics to watch in future years of monitoring." at 1.

⁴¹² These three categories involved a wide range of analyses and metrics. "Key metrics to monitor include changes in patient volume by major service category; changes in payer mix, including whether Steward successfully grows volume from payers featuring its limited network product, and any changes in the mix of higher margin versus lower margin payers; and trends in financial results. Additional metrics under DPH's oversight include the clinical quality and patient satisfaction performance of the system's providers." Interim Report at 56.

⁴¹³ Mission Health System, Inc. Agreed Upon Procedures Report For Year Ending September 30, 2011. First reports are at <http://www.ncdhhs.gov/dhsr/pdf/copamission2011.pdf>

PRELIMINARY--SUBJECT TO PUBLIC REVIEW

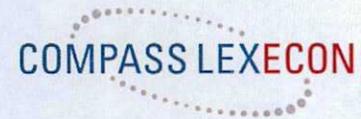
annual reports on financial performance with specific metrics, and specific review and validation that contract terms were in compliance:

- Reporting requirements with regard to contracts included a review process whereby auditors determine that the Hospital has not entered into agreements that
 - “contains a provision that prohibits the Hospital from entering into a provider contract for any services it offers with any other health plan;”
 - for physicians that ” contain an exclusive provision that requires the physician or group of physicians to render services only at Mission Hospitals, or which requires only one physician or group of physicians to provide particular services at Mission Hospitals;” or
 - Hospital contracts that “contain a most favored nation provision that guarantees either party that it will receive the benefit of any better price, term, or condition that the other party to the contract allows to a third person for the same service.”
- Review of specific financial metrics in baseline case and for comparison with peers.⁴¹⁴

Margaret E. Guerin-Calvert
Senior Consultant
Compass Lexecon
April __, 2013

APPENDIX I

TAB A



COMPASS LEXECON
1101 K Street, NW
Washington, DC 20005

p: (202) 589-3451 | f: (202) 589-3480
www.compasslexecon.com

MARGARET E. GUERIN-CALVERT
Email: mguer-in-calvert@compasslexecon.com

EDUCATION

- 1976 A.B., Economics, Brown University
- 1979 M.P.A., (Masters in Public Affairs), Woodrow Wilson School of Public and International Affairs, Princeton University

PROFESSIONAL EXPERIENCE

- 2012-present Senior Consultant, Compass Lexecon
- 2012-present President, Center for Healthcare Economics and Policy and Senior Managing Director, FTI Consulting, Inc.
- 2008-2012 Vice Chairman, Compass Lexecon and Senior Managing Director, FTI Consulting, Inc
- 2003-2008 President, Competition Policy Associates (Compass) (As of January 2006, Senior Managing Director, FTI Consulting Inc.)
- 1994-2003 Principal, Economists Incorporated
- 1990-1994 Assistant Chief, Economic Regulatory Section, Economic Analysis Group, Antitrust Division, U.S. Department of Justice
- 1987-1990 Senior Economist, Economists Incorporated
- 1986-1987 Director of Analytical Resources Unit, Economic Analysis Group, Antitrust Division
- 1985-1986 Economist, Economic Analysis Group, Antitrust Division, U.S. Department of Justice

- 1982-1985 Economist, Financial Structure Section, Division of Research and Statistics,
Board of Governors of the Federal Reserve System
- 1979-1982 Economist, Economic Policy Office, Antitrust Division, U.S. Department of
Justice
- 1976-1977 Research Associate, Energy Economics Group, Arthur D. Little, Inc.

TEACHING EXPERIENCE

- 1984 Adjunct Lecturer, Institute of Policy Sciences, Duke University
- 1984-1989 Executive Education for Top State Managers, conducted by The Institute of
Policy Sciences, Duke University
- 1983 Lecturer, Board of Governors of the Federal Reserve System and American
Institute of Banking
- 1979 Teaching Assistant, Princeton University

TESTIMONY

Investigation into the Competitive Marketing of Air Transportation, CAB

Arbitration Between First Texas Savings Association and Financial Interchange Network

In Re "Apollo" Air Passenger Computer Reservation System (CRS) MDL DKT. No. 760 M-21-49-MP

U.S. v. Ivaco, Inc.; Cannon, Inc.; and Jackson Jordan, Inc.

Consent Order Proceeding before the Competition Tribunal, Canada Between The Director of Investigation and Research and Air Canada, Air Canada Services, Inc., PWA Corporation, Canadian Airlines International, and the Gemini Group Automated Distribution Systems Inc.

In the Matter of an Application by the Director of Investigation and Research under Section 79 of the Competition Act and in the Matter of certain practices by the D & B Companies of Canada Ltd. (Respondent), before the Competition Tribunal

Beville v. Curry, et al.; Comanche County District Court, Case No. CJ-95-115

U.S. v. Northshore Health System, et al.

Testimony before Committee on Banking and Financial Services, U.S. House of Representatives (April 29, 1998)