

Press Conference Materials



Excerpts from  
Pennsylvania Insurance  
Department  
Expert Reports

The Blackstone Group  
and LECG LLC

Pennsylvania Insurance Department



## **Excerpts from Blackstone Reports**

**January 22, 2009**

These excerpts should be read in conjunction with both Blackstone's Report on the Proposed Consolidation of Highmark Inc. and Independence Blue Cross dated September 2, 2008 and Blackstone's Supplemental Report on the Proposed Consolidation of Highmark Inc. and Independence Blue Cross dated January 20, 2009 (collectively, the "Reports"). These Reports have been prepared and are being filed on the public record to assist the Pennsylvania Insurance Department ("PID") in its consideration of the Form A Applications of Highmark Inc. and Independence Blue Cross (the "Applicants") dated April 27, 2007, as amended.

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**I. Response to Comments Received from Highmark and IBC on  
Blackstone's Report Dated September 2, 2008**

**Response to Comments Received from  
Highmark and IBC on Blackstone's  
Report Dated September 2, 2008**

**Blackstone Report References and Blackstone Comment**

**Source Reference Blackstone Comment**

Highmark and IBC

"If data from 2006 is included with the data examined by Blackstone, the data shows that Pennsylvania's physician growth rate has recently accelerated and is now ranked number one or two (versus neighboring states and the United States as a whole) as opposed to being ranked 5 to 7 in Blackstone's analysis, which is based on older data." pp.8-9

Response to Blackstone's Report on  
the Proposed Consolidation of  
Highmark Inc. and Independence Blue  
Cross

Blackstone has updated the analysis on physician fight on p.125 of its September 2, 2008 report for the recently released 2006 data. That analysis is included in Section I of the Blackstone Supplementary Report.

"Further, the Companies believe that concerns regarding the new company's "leverage" vis-à-vis physicians and hospitals is misplaced in that: there is virtually no overlap in the location of group customers, which undermines any suggestion of an ability to obtain additional leverage post-consolidation; the new company will remain highly motivated by its customers and its competitors to create the broadest and deepest hospital and physician networks it can to meet customer expectations." p.9

While the Applicants maintain that there is "virtually no overlap in the location of group customers," Blackstone believes this concern is valid even if geographic overlap applies to only a small amount of providers. To the extent that a provider was contracting with Highmark and IBC on different terms prior to the Consolidation, it is possible that the provider will now contract with Newco on one set of terms, potentially negatively affecting provider reimbursement.

"Blackstone claims that the consolidation may increase Newco's negotiating leverage with providers, which would provide it with a reimbursement cost advantage versus new entrants. As explained in response to Concern #2, the consolidation will not increase Newco's negotiating leverage with providers." p.10

See prior comment.

"Newco will not have a scale-based cost advantage relative to three health insurers already present in Pennsylvania with large overall enrollments (UnitedHealth, Aetna, Cigna) nor to other potential entrants with comparable or larger national enrollments, such as Kaiser Permanente and Humana Inc. Indeed, it is the realization of scale-based economies that will enable Newco to compete more effectively against these larger, national insurers. Further, this type of scale-based cost advantage is typically viewed as being a benefit to customers who can potentially receive lower prices as a result of the consolidation and its concomitant efficiencies." p.11

The barriers to entry exacerbated by Newco's increased scale-based cost advantage are applicable to potential entrants of any size. There are only seven insurers nationwide with overall enrollment levels larger than or comparable to Newco's that may feasibly rival Newco's scale-based cost advantage. However, the Consolidation's creation of a much larger entity may preclude many other smaller potential entrants. Moreover, while a scale-based cost advantage may benefit customers in the short run in the form of lower prices, the long-term impact of higher barriers to entry and subsequently lower competition may lead to higher prices in the long-run.

**Response to Comments Received from  
Highmark and IBC on Blackstone's  
Report Dated September 2, 2008**

**Blackstone Report References and Blackstone Comment**

Source	Reference	Blackstone Comment
Highmark and IBC	<p>"There is virtually no overlap in the Companies' broker-based business. Therefore, Newco will neither control a larger percentage of broker volume in any relevant market, nor gain more leverage over brokers, meaning the consolidation will not create a higher barrier to entry with respect to broker relationships." p.11</p> <p>"Blackstone notes a concern raised by objectors that the consolidation will increase Newco's combined reserves which objectors argue may allow a combined company to sustain price competition more aggressively against entrants or support Newco's expansion into other products or geographies. This argument requires that Newco's reserves be in some sense excessive, beyond what it would require to conduct its regular business absent entry competitors." p.11</p> <p>"Blackstone posits that Newco could potentially adopt IBC's policy of not disclosing certain experience data, which would make it more difficult for entrants to price the risk of and win new business. First, Blackstone's stated concern is based upon a mistaken premise – that IBC discloses less experience data to its customers as a matter of business policy. This is not correct. IBC's claims experience data disclosures are driven by three factors: the needs of its customers (not competitors); the capabilities of its systems; and the regulatory environment in which it operates (e.g., HIPAA constraints)." p.12</p>	<p>Blackstone believes this concern is valid for any broker that may service both Highmark and IBC customers. While the Applicants maintain that Newco will not control more volume in any relevant geographic market, the concern applies to a broker's overall volume regardless of geographic market.</p> <p>The ability to sustain price competition does not necessarily require an excessive level of reserves. As the Applicants note, Newco's risk-based capital may fall into the "sufficient" category, leaving Newco with some flexibility to sustain price competition. Furthermore, the Consolidation may now make it potentially easier for Newco to sustain price competition in certain geographic areas, such as Philadelphia, where Newco's financial profile will be stronger than that of IBC historically.</p> <p>Based upon interviews with interested parties, Blackstone understood that IBC does not disclose experience data as a matter of policy. If IBC is willing to disclose experience data if and when requested by its customers, then this barrier to entry would not be impacted by the proposed Consolidation.</p>

**II. Pro Forma Direct Premiums and Market Share Estimates**

**Pro Forma Direct Premiums and Market Share Estimates**

**Overall Rankings by Market Share by State**

**Ranking by Market Share in One State**

*(\$ in millions)*

Rank	State	Insurer	Direct Premiums	Market Share
1	North Dakota	Noridian Mutual	\$791	69.6%
2	Alaska	Premiera Blue Cross	382	61.3%
3	Alabama	BCBS of Alabama	3,499	57.2%
4	Iowa	Wellmark	2,428	53.7%
5	Hawaii	Hawaii Medical	1,639	51.4%
6	Maine	WellPoint	1,064	51.0%
7	Idaho	Blue Cross of Idaho	975	48.2%
8	New Hampshire	WellPoint	905	46.7%
9	Montana	BCBS of Montana	506	45.4%
10	Michigan	BCBS of Michigan	8,413	43.8%

**Memo:**

45	Pennsylvania	IBC	\$9,186	27.1%
49	Pennsylvania	Highmark	8,253	24.3%
5	Pennsylvania	Newco	\$17,439	51.4%

Source: NAIC 2007 Market Share Reports for Accident and Health Insurers. Note that a single insurer or single state may appear in these rankings more than once. For example, Pennsylvania will appear in the rankings for each insurer that operates in the state. Further, a single insurer may appear multiple times if they have significant direct premiums or market share in more than one state. For example, WellPoint appears twice in the top ten ranking by market share in one state as a result of its presence in both Maine and New Hampshire.

**Pro Forma Direct Premiums and Market Share Estimates**

**Overall Rankings by Direct Premiums by State**

**Ranking by Direct Premiums in One State**

*(\$ in millions)*

Rank	State	Insurer	Direct Premiums	Market Share
1	California	Kaiser Foundation	\$35,100	36.8%
2	California	WellPoint	15,313	15.9%
3	California	UnitedHealth	10,132	10.5%
4	New York	UnitedHealth	9,569	20.7%
5	Pennsylvania	IBC	9,186	27.1%
6	Michigan	BCBS of Michigan	8,413	43.8%
7	California	Blue Shield of California	8,289	8.6%
8	New York	WellPoint	8,268	17.9%
9	Pennsylvania	Hightmark	8,253	24.3%
10	California	Health Net of California	7,766	8.1%

**Memo:**

2	Pennsylvania	Newco	\$17,439	51.4%
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Source: NAIC 2007 Market Share Reports for Accident and Health Insurers. Note that a single insurer or single state may appear in these rankings more than once. For example, Pennsylvania will appear in the rankings for each insurer that operates in the state. Further, a single insurer may appear multiple times if they have significant direct premiums or market share in more than one state. For example, WellPoint appears twice in the top ten ranking by direct premiums in one state as a result of its presence in both California and New York.

**Pro Forma Direct Premiums and Market Share Estimates**

**“Blue” Market Share in Top 10 States by Population**

**“Blue” Market Share in Top 10 States by Population**

*(\$ in millions)*

Population Rank <sup>(1)</sup>	Top Ten States by Population	Total “Blue” Market Share <sup>(2)</sup>	Market Share of Top 3 Non-“Blue” Competitors <sup>(2)</sup>	Market Share of Top Non-“Blue” National Competitors <sup>(3)</sup>
1	California	24.6%	55.5%	51.4%
2	Texas	17.8%	34.9%	37.5%
3	New York	33.6%	30.3%	26.8%
4	Florida	22.0%	40.9%	43.2%
5	Illinois	47.9%	19.9%	20.7%
6	Pennsylvania	58.8%	17.9%	10.9%
7	Ohio	25.9%	31.0%	24.9%
8	Michigan	43.8%	21.9%	8.9%
9	Georgia	31.0%	24.7%	18.4%
10	North Carolina	41.3%	25.7%	27.8%
		<b>Maximum</b>	<b>55.5%</b>	<b>51.4%</b>
		<b>Mean</b>	<b>30.3%</b>	<b>27.0%</b>
		<b>Median</b>	<b>28.0%</b>	<b>25.9%</b>
		<b>Minimum</b>	<b>17.9%</b>	<b>8.9%</b>

Note: “Blue” indicates a Blue Cross or Blue Shield licensee.

(1) Based on 2007 estimates of the United States Census Bureau.

(2) Based on the NAIC 2007 Market Share Reports for Accident and Health Insurers.

(3) Includes Aetna, Cigna, Humana, Kaiser Permanente, and UnitedHealth.

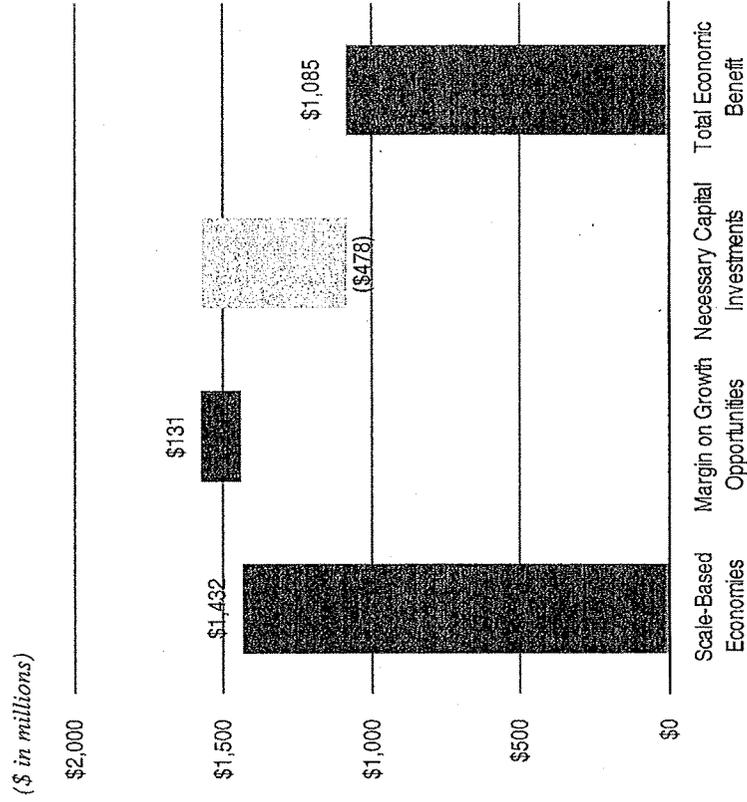
### **III. Synergies and Public Benefits**

## Synergies and Public Benefits

### Synergies Overview Summary

Based on the Applicants' most recent estimates, the proposed Consolidation is expected to yield over \$1 billion in scale-based economies and new growth opportunities. Blackstone believes that these total synergy estimates are reasonable based on its review of the work performed by Highmark, IBC, and Booz & Co.

- ▶ Scale-based economies
  - Information technology
  - Pharmaceutical
  - Back office
  - Corporate functions
  - Procurement and facilities
  - Middle office
  - Front office
  - Unbranded subsidiaries
  - Seniors business
- ▶ New growth opportunities
  - PBM expansion
  - Unbranded subsidiaries
  - National accounts
  - Ancillary products



## Synergies and Public Benefits

### Synergies Overview Projected Synergies by Year

Shown below is the expected timing of when Newco will realize synergies from the proposed Consolidation. Due in part to the significant capital investments expected in the early years following the proposed Consolidation, the \$892 million net present value ("NPV") of these synergies is \$193 million less than the nominal value of \$1.085 billion.

(\$ in millions)

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total
Scale-based economies	\$52	\$133	\$201	\$327	\$346	\$374	\$1,432
New growth opportunities	1	4	10	23	40	53	131
Necessary capital investments	(204)	(156)	(75)	(39)	(2)	(2)	(478)
<b>Total synergies</b>	<b>(\$151)</b>	<b>(\$20)</b>	<b>\$135</b>	<b>\$311</b>	<b>\$384</b>	<b>\$426</b>	<b>\$1,085</b>
<b>NPV of sources<sup>(1)</sup></b>	<b>(\$152)</b>	<b>(\$19)</b>	<b>\$125</b>	<b>\$273</b>	<b>\$323</b>	<b>\$342</b>	<b>\$892</b>

(1) Assumes a weighted average cost of capital ("WACC") of 7.75%, which is the WACC of both Highmark and IBC, based on the similar risk profile of synergy realization relative to the free cash flow generation of the combined companies. Future years are adjusted from the baseline number by a 3% rate of inflation, which is the benchmark inflation rate based upon adjusted 10-year Treasury Inflation Protected Securities ("TIPS") as of August 2008. Assumes a transaction close date of January 1, 2009.

## Synergies and Public Benefits

## Summary of Merger-Specific Synergies

Of the projected synergies from the proposed Consolidation, Blackstone estimates that between \$719 million and \$1.085 billion are merger-specific and cannot feasibly be achieved in any other way. The net present value of these merger-specific synergies is estimated by Blackstone at between \$589 million and \$892 million.

(\$ in millions)

Synergy	Admitted Synergies in:						Total Merger-Specific Synergies	
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Over 6 Years	
Information Technology								\$345
Pharmaceutical								200
Back Office								109
Corporate Functions								86
Procurement and Facilities								91
Middle Office								59
Front Office								53
Unbranded Subsidiaries								36
Seniors Business								25
<b>Total scale-based economies</b>	\$40	\$97	\$133	\$144	\$201	\$229	\$327	\$239
								\$346
								\$255
								\$374
								\$1,004
								\$1,432
PBM Expansion								\$38
Unbranded Subsidiaries								18
National Accounts								7
Ancillary Products								2
<b>Total margin on growth opportunities</b>	\$1	\$2	\$4	\$5	\$10	\$12	\$23	\$20
								\$40
								\$27
								\$53
								\$282
								\$386
<b>Gross merger-specific synergies</b>	\$40	\$98	\$136	\$149	\$210	\$240	\$350	\$259
								\$386
								\$282
								\$427
								\$1,069
								\$1,562
<b>Necessary capital investments<sup>(1)</sup></b>	(158)	(204)	(113)	(156)	(75)	(25)	(39)	(2)
								(1)
								(2)
								(350)
<b>Total merger-specific sources of synergies</b>	(\$118)	(\$151)	(\$15)	(\$20)	\$88	\$135	\$216	\$257
								\$384
								\$281
								\$426
								\$719
								\$1,085
<b>NPV of merger-specific synergies<sup>(2)</sup></b>	(\$118)	(\$152)	(\$14)	(\$19)	\$90	\$125	\$190	\$216
								\$323
								\$226
								\$342
								\$589
								\$892

(1) Capital investments for the low end of each range are adjusted pro rata for the percentage of synergies admitted out of the total potential synergies per sub-category.  
(2) Assumes a weighted average cost of capital ("WACC") of 7.75%, which is the WACC of both Highmark and IBC, based on the similar risk profile of synergy realization relative to the free cash flow generation of the combined companies. Future years are adjusted from the baseline number by a 3% rate of inflation, which is the benchmark inflation rate based upon adjusted 10-year Treasury Inflation Protected Securities ("TIPS") as of August 2008. Assumes a transaction close date of January 1, 2009.

## Synergies and Public Benefits

### Public Benefits Overview Projected Public Benefits by Year

Newco expects to give over \$1 billion in synergies realized in the proposed Consolidation back to either its policyholders or the Commonwealth of Pennsylvania. Shown below is the expected timing of when Newco expects to provide these benefits to its policyholders and the Commonwealth. The \$1.106 billion NPV of these "uses" is \$215 million greater than the NPV of the sources of synergies from the proposed Consolidation, indicating that the Applicants are promising more benefits on an NPV basis than they are expected to realize in synergies in the proposed Consolidation.

(\$ in millions)

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total
Hold administrative fees flat <sup>(1)</sup>	\$0	\$27	\$67	\$67	\$67	\$67	\$295
Pass on pharmacy cost savings	10	25	45	80	80	80	320
Eliminate Blue Card between Highmark and IBC	6	6	6	6	6	6	36
Support programs for the uninsured	50	50	50	50	50	50	300
Invest in quality improvement programs <sup>(2)</sup>	50	50	0	0	0	0	100
<b>Total Public Benefits excl. CHR</b>	<b>\$116</b>	<b>\$158</b>	<b>\$168</b>	<b>\$203</b>	<b>\$203</b>	<b>\$203</b>	<b>\$1,051</b>
<b>NPV of Public Benefits excl. CHR<sup>(3)</sup></b>	<b>\$112</b>	<b>\$141</b>	<b>\$139</b>	<b>\$156</b>	<b>\$145</b>	<b>\$135</b>	<b>\$829</b>
Community Health Reinvestment <sup>(4)</sup>	0	0	120	120	120	0	360
<b>Total Public Benefits incl. CHR</b>	<b>\$116</b>	<b>\$158</b>	<b>\$288</b>	<b>\$323</b>	<b>\$323</b>	<b>\$203</b>	<b>\$1,411</b>
<b>NPV of Public Benefits incl. CHR<sup>(3)</sup></b>	<b>\$112</b>	<b>\$141</b>	<b>\$239</b>	<b>\$249</b>	<b>\$231</b>	<b>\$135</b>	<b>\$1,106</b>

Note: Blackstone notes that the analysis Blackstone has done is only for the purpose of analyzing the present value of the commitment by the Applicants to extend their CHR agreement. The issue of whether to credit that value as among the public benefits that would arise because of the proposed transaction is beyond the scope of this report. The initial decision by the Applicants to enter into the existing CHR agreement was made before the proposed transaction was even thought of, so it is not immediately apparent why simply extending it, or perhaps extending it on terms less financially generous, is a consequence of underwriting the proposed transaction. Making that judgment would involve an assessment of the reasons why the CHR agreement was made when it was and the likelihood that those same reasons or others, not including the carrying out of the proposed transaction, would lead to a similar decision in the future anyway. That analysis is beyond the scope of this report.

<sup>(1)</sup> Blackstone is still reviewing the details of this calculation based on recently received information.

<sup>(2)</sup> The precise timing of Newco's investments in quality improvement programs is still subject to change.

<sup>(3)</sup> Assumes a discount rate of 7.75%, which is equal to the discount rate that was used to derive the present value of the "sources" of synergies.

<sup>(4)</sup> Includes only the Commonwealth directed component of the CHR commitment. Amounts would be subject to change based on actual premiums realized in those years.

**Synergies and Public Benefits**

**Selected Potential Reasons to Discount Value of Public Benefits**

There are several reasons why the potential value of public benefits, as proposed by the Applicants, may need to be discounted. Some of these reasons pertain to the difficulty in being able to audit the public benefits going forward.

Potential Reason to Discount Value	Hold Administrative Fees Flat	Pass on Pharmacy Cost Savings	Eliminate Blue Card Between Highmark and IBC	Support Programs for the Uninsured	Invest in Quality Improvement Programs	Community Health Reinvestment
▶ Exact level of policyholder savings or public benefit will be difficult to quantify given that one must make assumptions about what would have happened in the absence of the Consolidation	✓	✓	✓	✓	✓	✓
▶ Potentially onerous for the PID to adequately monitor and audit the realization of the public benefit	✓	✓	✓	✓	✓	
▶ Some portion of this public benefit would accrue to policyholders outside of Pennsylvania	✓	✓	✓			
▶ Even if the PID is capable of monitoring public benefits during the first six years, there is the potential for Newco to reduce the value of these public benefits after year 6 absent PID monitoring in perpetuity	✓	✓	✓			
▶ Without knowing specifics of the investments, it is difficult to be certain that money invested will truly benefit policyholders and/or the public				✓	✓	
▶ To the extent that Highmark's future standalone RBC ratio would have exceeded 750%, Highmark would have been obligated to submit a plan to the PID illustrating how it would reduce its surplus level; this may have benefited policyholders or the public in the absence of the proposed Consolidation	✓			✓	✓	✓

## LECG Report Excerpts for PID

### I. Impact of Health Insurance Monopsony on Health Care Customers and Providers

*(pp. 27-29 of LECG Supplemental Report)*

As stated in the initial LECG report, the Applicants' arguments are based on the following chain of reasoning: "(1) the Blue-on-Blue competition in central Pennsylvania has led to less leverage with health care providers and higher provider costs; (2) increased provider costs have in turn driven up medical costs in central Pennsylvania; and (3) these increased medical costs have been passed on to consumers and have resulted in higher premiums."<sup>1</sup> More generally, the Applicants' argument is that the monopsony power over providers that existed in central Pennsylvania prior to Highmark's entry was actually good for consumers because it resulted in lower premiums (due to lower provider costs) and that the entry of Highmark was actually bad for consumers because it resulted in higher premiums (due to higher provider costs).

While this type of argument may have some intuitive appeal, it is based on a rather straightforward economic fallacy that has been addressed thoroughly in the economic and healthcare literature related to the economic concept of monopsony. As described in the initial LECG report, economic theory shows that a monopsony buyer purchases fewer inputs at below competitive rates compared to a competitive buyer. However, consumers do not typically benefit from the monopsonist's lower input prices. Instead, the lower output resulting from lower provider prices forced by the monopsonist typically lead to higher (not lower) prices to consumers when the monopsonist has market power downstream in the ultimate market for its goods and services (i.e., the monopsonist also has monopoly power). Monopsonist/monopolist firms in effect use the lower prices they negotiate to increase their profit margin, rather than pass on the lower provider rates because of a lack of downstream competition. Accordingly, the lower rates from providers that result from market power over those providers are generally not expected to be passed on to consumers in the form of lower premiums where the health insurer has market power in the downstream market. Overall, not only does the existence of monopsony in health insurance create the risk that health care customers will pay higher nominal premiums, but that they will likely also suffer from a reduction in the quantity and quality of provider care.<sup>2</sup>

When applied to health insurance, this means that lower rates from providers that result from market power over those providers are generally not expected to be passed on to consumers in the form of lower premiums, particularly in situations where the health

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<sup>1</sup> LECG Report, pg. 106.

<sup>2</sup> In addition to the various references to monopsony literature at pages 84-85 of the LECG report, we add an additional cite that puts forth a rather easy to understand description of monopsony in a health care setting: "Monopsony as an Agency and Regulatory Problem in Health Care," by Peter J. Hammer and William M. Sage, *Antitrust Law Journal*, Volume 71, Issue 3, 2004, pp. 949-988.

insurer has market power in the downstream market.<sup>3</sup> Economic theory generally predicts that health insurance customers will be harmed by a health insurer with market power over providers in the form of higher quality-adjusted premium levels to health care consumers. In simple terms, this translates into a lower quantity and/or quality of health insurance per premium dollar spent.<sup>4</sup> Overall, not only does the existence of monopsony in health insurance create the risk that health care customers will pay higher nominal premiums but that they will also suffer from a reduction in the quantity and quality of provider care.

The Applicants attempt to somehow rebut the fundamental economic insight that monopsony harms consumers by arguing that the actual experience of Blue-on-Blue competition in central Pennsylvania shows otherwise. The Applicants' primary evidence in this regard involves its comparison of premium levels in central versus western Pennsylvania in 2006 and 2007 that attempts to adjust for benefit design and certain demographic factors. In its initial report, LECG put forth five separate reasons that the data does not ultimately support the Applicants' contention that Blue-on-Blue competition in central Pennsylvania has harmed consumers.<sup>5</sup> In its response to LECG's critique of the data, the Applicants' offer a rebuttal of but one of these five reasons and simply assert that if premiums could be adjusted for quality and regional morbidity rates, the results would be even stronger. Even if this were the case (which the Applicants have yet to demonstrate) the Applicants have failed to address LECG's other concerns regarding the data comparison.

In addition, the Applicants mischaracterize LECG's evaluation of evidence in this area, claiming that LECG "...resorts to anecdotal statements of consumer sentiment."<sup>6</sup> In its report, LECG stated there is "...a great deal of evidence to suggest that competition between Highmark and CBC has benefited health care customers in central Pennsylvania."<sup>7</sup> In support of this conclusion, LECG not only cited to the "strong sentiment" of consumers in the area but also to: (1) various Highmark business documents, which we believe acknowledge the benefit of the Blue-on-Blue competition to both the competitive process and to consumers; (2) basic economic theory; and (3) Highmark's own profitability data.<sup>8</sup>

*(pp. 30-31 of LECG Supplemental Report)*

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<sup>3</sup> In our initial report, we also discussed arguments made by some economists that the creation of monopsony in health care does not lead to a reduction in the quantity supplied of health care provider services (see p. 84 of the LECG report). However, we also discuss various criticisms of this model.

<sup>4</sup> A reduction in the quantity of health insurance can take many forms including a reduction in the number of insured, a reduction in coverage for existing insured, etc. A reduction in the quality of health insurance can take many forms including a reduction in the availability of providers, a reduction in the quality of providers, a reduction in consumer service, etc.

<sup>5</sup> LECG Report, pgs. 107-108.

<sup>6</sup> Highmark and IBC Response, pg. 12.

<sup>7</sup> LECG Report, pg. 105.

<sup>8</sup> See LECG Report, pgs. 105-109.

By contrast to the situation in central Pennsylvania, a number of commentators expressed concerns regarding the negative impact from the market dominance of Highmark and IBC in the western and southeastern parts of the Commonwealth. This included concerns raised by numerous providers that the monopsony-type leverage of Highmark and IBC had serious negative impacts not only for providers but for the Commonwealth. Examples include the following:

- In his written comments to the Pennsylvania Senate Banking and Insurance Committee on October 7, 2008, Dr. Peter Lund of the Pennsylvania Medical Society stated that "...Pennsylvania is losing direct patient care physicians" and that the consolidation will exacerbate physician exit through a continuation of "monopsonistic contracting and reimbursement practices in those Pennsylvania markets where there is already substantial market power of Highmark or IBC."<sup>9</sup>
- At the Philadelphia hearings regarding the proposed consolidation, Dr. Ruth Holland, who is President of the Chester County Medical Society, stated that "the climate for physicians in Pennsylvania is unhealthy" and that medical students in Pennsylvania are leaving the state to practice medicine in "more hospitable, doctor-friendly states."<sup>10</sup>
- In written testimony at the Philadelphia public hearings regarding the consolidation, Bob Orzechowski expressed concerns regarding the leverage of dominant health insurers over his 9 provider private hematology and medical oncology practice in Berks County, Pennsylvania. Mr. Orzechowski stated that reimbursement for his practice has diminished as competition among health insurers has diminished and that his practice has "...not raised our prices in years for almost all of our services."<sup>11</sup>

## **II. The Potential for Highmark to Enter Southeastern Pennsylvania**

*(pp. 10-12 of Initial LECG Report)*

Another part of the economic analysis of potential competition is evaluating the likelihood that Highmark would expand into the 5-county Philadelphia area absent the consolidation, given the recent expiration of Highmark's and IBC's agreement that Highmark would not sell Blue-branded commercial products in Philadelphia. Highmark officials claim they would never expand into the Philadelphia area with commercial

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<sup>9</sup> See Lund, Peter S., *Mixing Blues*, Presented to the Pennsylvania State Senate Banking and Insurance Committee, October 7, 2008, pg. 1.

<sup>10</sup> See Testimony of Dr. Ruth Holland, July 16, 2008, pgs. 139-140.

<sup>11</sup> See Orzechowski, Bob, *Public Testimony Regarding the Proposed IBC - Highmark Merger*, July 15, 2008, pgs. 1-2.

managed care products after leaving the area in 1996. They present a number of arguments to support their position. These include:

- Highmark's earlier presence in Philadelphia was unprofitable and Highmark's Blue Shield competition in the Harrisburg area with Capital's Blue Cross mark has been unprofitable, so they would not expand into the Philadelphia area as an independent competitor;
- Entry into southeastern Pennsylvania would be more difficult than Highmark's entry into central Pennsylvania;
- Highmark's competition with CBC in central Pennsylvania has not benefited consumers and has created substantial confusion about the Blue marks;
- Entry by Highmark into southeastern Pennsylvania would potentially put at risk the revenues and profits associated with various Highmark products that IBC sells as a Highmark agent in the 5-county area; and
- Highmark has stated that it simply has no plans to expand into the Philadelphia area in competition with IBC if not for the consolidation.

However, there are reasons to believe Highmark would enter the Philadelphia area if not for the proposed consolidation, or that the threat of its entry may currently impose some competitive discipline in that area already. These reasons include:

- Highmark recently entered into a joint operating agreement with Blue Cross of Northeastern Pennsylvania that gives Highmark a partnership interest in selling Preferred Provider Organization ("PPO"), Health Maintenance Organization ("HMO") and other health insurance products in northeastern Pennsylvania;
- Although Highmark may not yet be profitable in its competition with CBC, it did choose to compete Blue-on-Blue in the Harrisburg area, and shows no sign of leaving;
- Highmark did compete in Philadelphia at one time, but signed a 10 year agreement not to sell Blue-branded commercial products in Philadelphia when it sold that business to IBC in 1996. When that agreement ended last year, Highmark was contractually able to enter Philadelphia with its Blue Shield mark. Instead, Highmark and IBC apparently replaced the agreement with the proposed consolidation, eliminating the possibility of Highmark entering the Philadelphia area as an independent competitor if the filing is approved;
- Highmark has a physician provider network in Philadelphia for its indemnity products, so it would only have to reach an agreement with a sufficient

number of hospital providers to offer a competitive provider base in Philadelphia;

- Highmark’s state-wide Blue Shield license gives it a strategic advantage over the regional Blue Cross providers in the state, including IBC, since Highmark can enter into the Blue Cross regions (e.g., Philadelphia) without risking a retaliatory entry by the Blue Cross provider in Highmark’s current regions of operation (i.e., IBC cannot enter with Blue-branded products into western Pennsylvania);
- *\*\*Redacted\*\**;
- Pro forma calculations of Highmark entry into Philadelphia absent the proposed consolidation suggest such entry would be profitable under certain circumstances;
- Highmark officials appear to have previously stated that they did not intend to expand their service area beyond Pittsburgh, although the company in fact has subsequently expanded well beyond Pittsburgh; and
- Highmark has stated that it is committed to providing state-wide coverage, which would presumably include Philadelphia with or without the proposed consolidation.

The Pro Forma model we use to estimate the financial impact on Highmark of entering the Philadelphia region is intended to assist in understanding the likelihood that Highmark would enter and compete against IBC if not for the consolidation,. Under one version of the Pro Forma model, we assume that Highmark must offer substantial and long term customer discounts of 7.5 percent below current market levels in the first year of entry, 5.0 percent in the second year and 2.5 percent in the third and subsequent years. This version of the model generates a -\$184 million net present value from Highmark’s entry, suggesting Highmark would not be likely to enter. The second version of the Pro Forma model more reasonably assumes price discounts of 5.0 percent in the first year, 2.5 percent in the second year and 1 percent in the third and subsequent years. This version of the model generates a net present value from Highmark’s entry of +\$288 million, and suggests that Highmark would be likely to enter the Philadelphia area if not for the consolidation.

The results of these models are sensitive to certain financial assumptions beyond these alternative levels of discounting discussed above. Key variables that drive the ultimate result include: (1) the size of the initial investment; (2) the level of customer discounts and provider premiums necessary to “buy” into the market; (3) the level of the long-term customer discounts and provider premiums due to increased competition; and (4) the variable operating cost ratio.

Highmark's previous experience in entering central Pennsylvania demonstrates the financial challenges involved in entering a market as a second Blue competitor. Highmark has experienced an estimated \$132 million in operating losses since entering the central region in 2002. Highmark's operating losses in central Pennsylvania are the result of a number of factors including: (1) initial significant losses Highmark experienced in "buying" into the market; (2) low long-term operating profits due to intense competition, particularly with CBC; and (3) relatively high operating expense ratios, also partially resulting from the competition with CBC. Whether Highmark would have a more financially attractive entry experience in southeastern Pennsylvania in part depends on the degree to which Highmark has learned from some of its mistakes in the central Pennsylvania area (e.g., early underwriting miscues) and also the willingness of providers to give Highmark competitive reimbursement rates (perhaps to encourage competition and due to its successful track record of quickly gaining volume in central Pennsylvania).

Another potential financial challenge faced by Highmark derives from the relatively low operating margins for IBC in southeastern Pennsylvania. IBC currently has recently had operating margins under 3 percent in southeastern Pennsylvania which could give Highmark a relatively narrow margin for error in order to achieve profitable entry. However, some of IBC's reported operating costs are fixed and Highmark would not have to incur some of these costs in entering the market. Highmark would also gain from any scale advantages from entry, since it would expand its membership base. In addition, IBC's low operating margins could also reflect some degree of inefficiency in IBC's operations. Overall, Highmark could view entry into southeastern Pennsylvania as an opportunity to compete against a relatively vulnerable Blue insurer.

### **III. The Economic Impact of Blue-on-Blue Competition in Central Pennsylvania**

*(p. 104 of Initial LECG Report)*

Data and other evidence from Highmark's competition with CBC in the Harrisburg area suggest that competition in this area has benefited both health care consumers and providers. The market participants that we have interviewed, including health care customers, providers and competitors, overwhelmingly supported the viewpoint that competition between Highmark and CBC has provided significant benefits to both customers and providers.

*(p. 106 of Initial LECG Report)*

**\*\*Redacted\*\***. It is economically sensible that the existence of "Blue to Blue" competition diminishes the price premium associated with the Blue brand and enables customers to leverage the Blue insurers against one another in order to gain a favorable price. At the same time, this can also limit the ability of the Blue brands to differentiate their offering at least in the short-run, leading to intense price competition. While such a

market dynamic may frustrate the competing Blue plans, this kind of price pressure may be welcome by health care customers, as is the case with the central Pennsylvania customers that we have interviewed in our investigation.

An additional issue *\*\*Redacted\*\** is that of customer confusion. Highmark has argued that the competition in central Pennsylvania has actually harmed health care customers in that area, leading to customer confusion and higher premiums.<sup>12</sup> *\*\*Redacted\*\**, we have not heard such a complaint by any customers either in the context of our interviews or in the public hearings and whatever confusion may have initially existed appears to be diminishing. Indeed, *\*\*Redacted\*\** Highmark plans to differentiate its product offering from that of CBC – a strategy similar to that undertaken by companies facing Blue-on-Blue competition in other states (e.g., California-based insurers WellPoint and Blue Shield of California offering competing Blue plans).

*(pp. 28-30 of LECG Supplemental Report)*

The Applicants attempt to somehow rebut the fundamental economic insight that monopsony harms consumers by arguing that the actual experience of Blue-on-Blue competition in central Pennsylvania shows otherwise. The Applicants' primary evidence in this regard involves its comparison of premium levels in central versus western Pennsylvania in 2006 and 2007 that attempts to adjust for benefit design and certain demographic factors. In its initial report, LECG put forth five separate reasons that the data does not ultimately support the Applicants' contention that Blue-on-Blue competition in central Pennsylvania has harmed consumers.<sup>13</sup> In its response to LECG's critique of the data, the Applicants' offer a rebuttal of but one of these five reasons and simply assert that if premiums could be adjusted for quality and regional morbidity rates, the results would be even stronger. Even if this were the case (which the Applicants have yet to demonstrate) the Applicants have failed to address LECG's other concerns regarding the data comparison.

In addition, the Applicants mischaracterize LECG's evaluation of evidence in this area, claiming that LECG "...resorts to anecdotal statements of consumer sentiment."<sup>14</sup> In its report, LECG stated there is "...a great deal of evidence to suggest that competition between Highmark and CBC has benefited health care customers in central Pennsylvania."<sup>15</sup> In support of this conclusion, LECG not only cited to the "strong sentiment" of consumers in the area but also to: (1) various Highmark business documents, which we believe acknowledge the benefit of the Blue-on-Blue competition to both the competitive process and to consumers; 2) basic economic theory; and (3) Highmark's own profitability data.<sup>16</sup>

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<sup>12</sup> See testimony of Dr. Kenneth R. Melani of Highmark at the PID Public Hearings in Philadelphia, July 15, 2008, (p. 69 of transcript).

<sup>13</sup> LECG Report, pgs. 107-108.

<sup>14</sup> Highmark and IBC Response, pg. 12.

<sup>15</sup> LECG Report, pg. 105.

<sup>16</sup> See LECG Report, pgs. 105-109.

In addition, a number of public commentators have put forth the opinion that competition in central Pennsylvania has benefited providers and consumers. This includes the following:

- CBC's economic expert, Dr. Monica Noether, has opined that Highmark's entry into central Pennsylvania "...forced Capital to become more innovative in developing new products, enhancing existing products and improving customer service."<sup>17</sup> Dr. Noether provided a number of examples of improvements at CBC since competition began with Highmark including new Stop Loss, Medicare and PPO products, increased flexibility in its HMO products and development of an electronic prescribing system (that has helped to reduce prescribing errors).<sup>18</sup>
- In his written testimony dated July 10, 2008, Richard J. Gilfillan, M.D., President and CEO of Geisinger Health Plan, stated that its service areas in northeastern and central Pennsylvania are "very competitive" and include a large number of successful health insurers.<sup>19</sup> According to Gilfillan, the presence of competitive marketplace with many strong health insurers enables smaller health insurers like Geisinger to obtain relatively "similar medical cost structures."<sup>20</sup> In addition, it means that brokers are less influenced by "any one incumbent carrier's market share" and "are open to offering their customers multiple products."<sup>21</sup> Dr. Gilfillan contrasts this situation with that which exists in southeastern Pennsylvania, where IBC's practice of forcing down the rates it pays providers has created "an effective barrier to entry for new carriers for at least 10 years."<sup>22</sup>
- In his comment on September 25, 2008, Gary Morel, President of Morel & Associates, stated that "[t]estimony shed light on the fact that the Central Region of Pennsylvania has a more robust health insurance market with the mainly competitive presence of Capital Blue Cross and Highmark. Not only do consumers have more options, but the hospital community has increased leverage to sustain operating margins well in excess of the balance of the state."<sup>23</sup>
- In her testimony before the Senate Banking & Insurance Committee on October 7, 2008 Paula Bussard, Senior Vice President of Policy and

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<sup>17</sup> See comments of Dr. Noether, October 14, 2008, pg. 60.

<sup>18</sup> See comments of Dr. Noether, October 14, 2008, pg. 60.

<sup>19</sup> See Gilfillan, Richard J., *Pennsylvania Insurance Department Hearings Regarding: Highmark/IBC Consolidation*, July 10, 2008, pg. 3. (Hereafter Testimony by Richard J. Gilfillan).

<sup>20</sup> See Testimony by Richard J. Gilfillan, M.D., July 10, 2008, pgs. 3-4.

<sup>21</sup> See Testimony by Richard J. Gilfillan, M.D., July 10, 2008, pg. 4.

<sup>22</sup> See Testimony by Richard J. Gilfillan, M.D., July 10, 2008, pgs. 4-5.

<sup>23</sup> See Morel, Gary L., *Re: Form A filing for Highmark and Independence Blue Cross*, September 25, 2008, pg. 2.

Regulatory Services for the Hospital & Healthsystem Association of Pennsylvania, stated that “experience has shown that in the regions of the state – the south central and Lehigh Valley areas – that have more robust health insurer competition (multiple Blue and commercial health insurer plans), there has been a more stable hospital financial picture over time.”<sup>24</sup>

- In his presentation, entitled “The Color of Blue”, on July 10, 2008 to the Pennsylvania Insurance Department, Peter Lund, President of the Pennsylvania Medical Society, stated that “We have seen first hand that employers, individuals, physicians, and hospitals benefit from the healthy competition between Highmark Blue Shield and Capital Blue Cross in Central Pennsylvania and the Lehigh Valley.”<sup>25</sup>
- In his comments made on October 14, 2008, David Balto, Attorney at Law, stated that “The evidence provided by numerous parties in this investigation has clearly demonstrated that the impact of Highmark’s entry has lead to greater competition between insurance companies, ultimately benefiting employers, healthcare providers and consumers.”<sup>26</sup>

LECG is unaware of any public comments, testimony or other evidence relating to this proposed consolidation in which a market participant other than the Applicants has supported the contention that competition in central Pennsylvania has been bad for health insurance consumers in that area.

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<sup>24</sup> See Bussard, Paula A., *Statement of The Hospital & Healthsystem Association of Pennsylvania before the Senate Banking & Insurance Committee*, October 7, 2008, pg. 3.

<sup>25</sup> See Lund, Peter S., *The Color of Blue*, Presented to the Pennsylvania Insurance Department, July 10, 2008, pg. 3.

<sup>26</sup> See comments of David A. Balto, October 14, 2008, pg. 2.