Competitive Assessment of the Western Pennsylvania Insurance and Healthcare Markets

Prepared for

Pennsylvania Insurance Department

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* Report reissued to correct citation and an expired source link per Letter to Kathryn Speaks dated January 29, 2024.

EXECUTIVE SUMMARY

PURPOSE OF THIS REPORT[1]

This 2022 competitive assessment ("Report") of healthcare insurance and healthcare delivery services in Western Pennsylvania ("WPA") updates and identifies specific changes to the structure and dynamics of competition since 2017 and evaluates the extent to which the 2013 Order,[2] including Conditions imposed originally and as amended (the "Conditions"), waivers granted, continued to achieve their purpose of preserving or enhancing the competitive dynamics in the WPA for both healthcare insurance and healthcare delivery services since 2017. The study also evaluates whether it is likely that the continued presence or absence of each of the specific Conditions remains necessary to ensure adequate protections for competition and the public interest going forward. This assessment is intended to inform the Department as to the competitive and economic merits of continuing the scope of the 2013 Order's Conditions or assessing whether modifications to the 2013 Order are warranted.

SUMMARY OF CONCLUSIONS IN OUR 2017 REPORT

In 2017, we prepared a similar assessment for the Pennsylvania Insurance Department ("PID" or "Department"). In that assessment, we updated and examined developments and trends in the WPA healthcare insurance markets and healthcare delivery markets. At that time, we found that neither the 2013 Order and Conditions nor the affiliation of Highmark Inc. ("Highmark") with West Penn Allegheny Health System, Inc. ("WPAHS") and the other affiliated health systems had an adverse effect on access to healthcare insurance or healthcare delivery services, the quality of care available to consumers, or the value consumers obtain from purchasing healthcare insurance or receiving healthcare services.

SUMMARY OF CONCLUSIONS OF THIS REPORT

Our overall conclusions in this Report are consistent with the 2017 findings as they relate to the competitive dynamics in the WPA. Our assessment finds no indication that the 2013 Order has

[1] Susan Henley Manning, PhD and Margaret E. Guerin-Calvert are the principal authors of this report conducted under an ongoing Compass Lexecon engagement with support for analysis from Sabiha Quddus and Moises Marin of the Center of Healthcare Economics and Policy, a business unit of the Economics Practice at FTI Consulting, Inc. specializing in healthcare economics and applied microeconomics. This analysis reflects the opinions and assessments of the authors, not of Compass Lexecon or FTI Consulting as a firm, nor does it necessarily reflect views of other professionals at Compass Lexecon, FTI Consulting or other organizations with which the authors are or have been affiliated.

[2] Pennsylvania Insurance Department Order No. ID-RC-13-06, as amended (the "2013 Order"). Any capitalized terms not defined in this report shall have the meaning ascribed to them in Appendix 1 (Definitions) to the 2013 Order.

had an adverse effect on healthcare insurance, healthcare delivery, or the quality of care and variety of plans available to Highmark members or other consumers in WPA.

Our findings from this 2022 assessment are as follows:

- ***Three important conditions of competition have occurred since 2017***. Since 2017, these three major developments have occurred that potentially affected the healthcare insurance and healthcare provider competitive landscape in WPA:

  (1) *The COVID-19 Pandemic ("Pandemic").* The Pandemic appears to have had a positive, although likely short-term positive, economic impact on health insurers, but an adverse impact on healthcare providers.

  (2) *The 2019 ten-year insurer/provider contract between Highmark and the University of Pittsburgh Medical Center ("UPMC").* The 2019 provider/insurer contract between Highmark and UPMC appears to have resulted in some Highmark members choosing UPMC hospital facilities over other facilities in some areas, but it is too early to draw conclusions about its longer-term impact on consumer hospital facility choice.

  (3) *The Blue Cross Blue Shield Association ("BCBSA") settlement that opens up competition among BCBSA licensees.* The BCBSA settlement does not appear to have had a competitive impact, thus far, in WPA based on the data available and analyzed.

- **Competition within the WPA healthcare insurance marketplace has strengthened since 2017.** This report finds: (1) UPMC health plan is now a formidable competitor of Highmark although the two competitors tend to focus on different health plan products; (2) both Highmark and UPMC are expanding their geographic reach further across the Commonwealth; (3) there remains a national insurer presence (e.g., UnitedHealthcare, Aetna, and Cigna) in the Commonwealth and in WPA; and (4) although Highmark has lost significant membership, Highmark is re-gaining membership as it continues to develop new and innovative network products to use in competing for members.

- **Healthcare delivery services competition in WPA remains strong as compared with the level of competition before the 2013 Order**. Allegheny Health Network ("AHN")[3] provides a viable competitive alternative to UPMC for Highmark members and other WPA patients. AHN's operations are unprofitable with net operating losses incurred in 2020 through first half of 2022. AHN receives regular infusions of funds from Highmark. In addition, our analysis finds that Highmark member discharges at community hospitals as well as some AHN

[3] AHN is the parent organization of a western Pennsylvania-based healthcare system of eight acute care hospitals, including WPAHS and certain other affiliated providers, which constitute AHN's integrated delivery and financing system ("IDN") with Highmark Health.

hospitals have shifted to UPMC facilities after Highmark's most recent contract with UPMC in 2019. In this Report, our reference to, and discussion of, the AHN's facilities, hospitals or AHN's operations are intended to refer to the applicable hospitals and other providers affiliated with AHN, including WPAHS and other affiliated entities.

- **The competitive and public interest Conditions appear to continue to achieve their purposes while not placing Highmark at a competitive disadvantage**. The Conditions appear to continue to achieve their purpose of preserving or enhancing competitive dynamics in the WPA for both healthcare insurance and healthcare delivery services. These Conditions do not exhibit any material impact that would suggest that these Conditions have placed Highmark or AHN at a competitive disadvantage in the period from 2017 to the present, or hampered Highmark's and AHN's ability to respond to material changes in the conditions of competition, i.e., the Pandemic, and the Highmark and UPMC insurer/provider contract. The ability of Highmark to request waivers to these Conditions provides a safeguard for Highmark to respond to changing competitive conditions, and Highmark has made waiver requests and such waiver requests been granted by the Department.

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I. BACKGROUND

On April 29, 2013, the Pennsylvania Insurance Department issued the 2013 Order authorizing the change of control of Highmark Inc. subject to certain conditions. The change of control transaction included the affiliation of Highmark with WPAHS. A stated purpose of the affiliation was to implement its IDN of which a principal component was the affiliation of Highmark with WPAHS and the affiliations with Jefferson Regional Medical Center (now Jefferson Hospital) and Saint Vincent Health System/Saint Vincent Health Center (now Saint Vincent Hospital), all of which are now part of AHN. An additional purpose was to strengthen the new IDN both financially and in delivering quality of care. In the 2013 Order approving the transaction, the Department determined that the imposition of specific conditions as part of the Order was necessary to preserve and promote competition and consumer welfare in the Commonwealth of Pennsylvania, and to ensure that the change of control would not violate Section 1402 of the Insurance Holding Companies Act.

The 2013 Order imposed Conditions on Highmark that were intended to mitigate the risk that the vertical nature of the transaction would adversely affect competition for healthcare insurance and healthcare delivery services in WPA, considering, among other things, the current market conditions, and prior history of contracting in the marketplace. In addition, the Department included in the 2013 Order certain public interest and policyholder protection conditions for the benefit of consumers and policyholders. These Conditions included, among others:

CONDITION	COMPETITIVE PURPOSE
COMPETITIVE CONDITIONS	
Prohibition on exclusive contracting (Conditions 1 & 2)	Increases access for consumers and promotes competition
Provider/Insurer contract length limitation (5 years) (Condition 3)	Designed to keep contract terms and conditions up to date with market conditions and allow switching
Prohibition on most favored nation contracts or arrangements (Conditions 5 & 6)	Provides for robust competition in negotiating contracts
Firewall to protect competitively sensitive information ("CSI") (Conditions 7, 8, & 9)	Prevents Highmark from access to other insurers' CSI and AHN from access to other providers' CSI
PUBLIC INTEREST CONDITIONS	
Consumer choice initiatives –anti-steering and anti-tiering prohibitions (Condition 20)	Prevents Highmark from favoring through use of anticompetitive provisions for one hospital/system over another competing hospital
Affiliation and IDN impact on community hospitals (Condition 21)	Monitor the impact of the Highmark/AHN IDN on the viability of competing and independent community hospitals
Community health reinvestment (Condition 23)	Incentivizes Highmark to invest in community health to ensure viability and competition

While certain Conditions of the 2013 Order expired on December 31, 2018, the Conditions listed above do not expire.

In 2017, the Department requested that Compass Lexecon assess the changes in the WPA healthcare insurance and healthcare delivery services markets that occurred since issuing the 2013 Order. The 2017 study concluded that neither the 2013 Order nor the affiliation had an adverse effect on access to healthcare insurance or healthcare delivery services, the quality of care available to consumers, or the value to consumers purchasing healthcare insurance or receiving healthcare services. The Department has asked Compass Lexecon to update the 2017 study based on recent developments that have occurred in WPA.

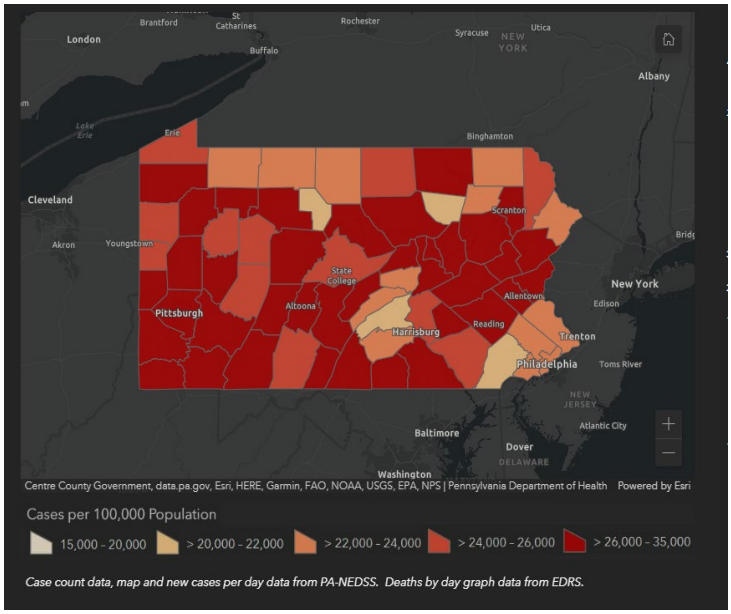
A. Major Competitive Developments Since 2017

Since 2017, the competitive dynamics in WPA have continued to evolve in both healthcare insurance and healthcare delivery services. Three major developments have occurred that have the potential to affect the health insurer and provider competitive landscape in WPA: (1) the Pandemic, (2) the 2019 ten-year insurer/provider contract between Highmark and UPMC, and (3) the BCBSA settlement that opens up competition among BCBSA licensees.

1. The Pandemic

The World Health Organization declared COVID-19 a global pandemic on March 11, 2020. The first confirmed case in Pennsylvania occurred on March 6, 2020, and the first COVID-related confirmed death occurred on March 18, 2020.[4] The incidence of COVID-19 in WPA was similar to most of the state, particularly those counties in central Pennsylvania.

In addition to the toll on individuals and families, the Pandemic has taken a great toll on providers, especially hospitals which have experienced rapid and sustained patient volume losses, large margin shortfalls, and other challenges which continue today. Early in the Pandemic, hospitals were prohibited from performing scheduled or non-emergency procedures to allow sufficient capacity to deal with the Pandemic. A phased approach over several months enabled hospitals to restore scheduled and non-emergency

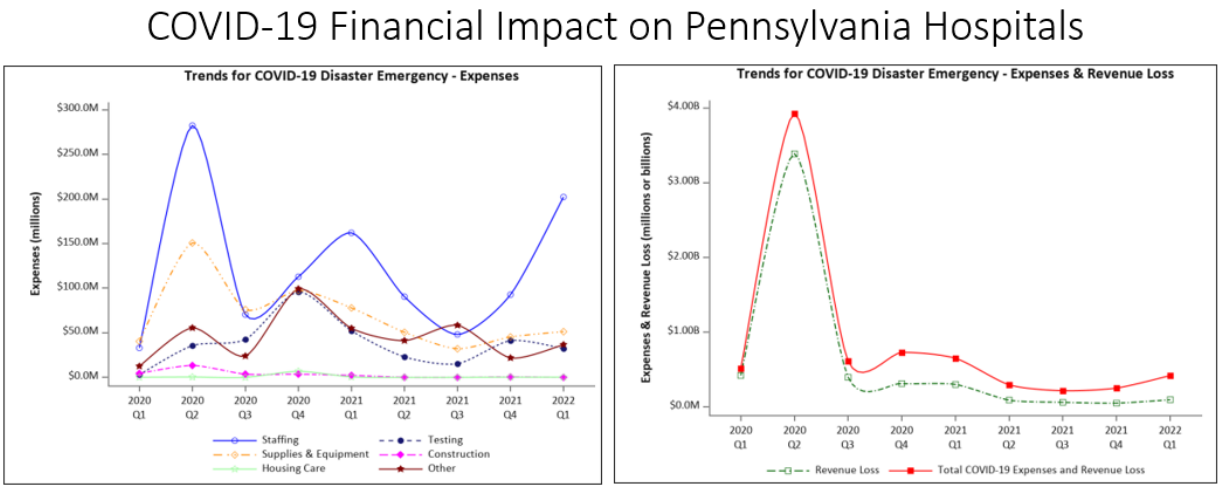


[4] COVID-19 Dashboard. Pennsylvania Data, Pennsylvania Department of Health. Accessed December 11, 2020. https://www.health.pa.gov/topics/disease/coronavirus/Pages/Cases.aspx.

procedures but almost all hospitals reported much lower activity levels during the remainder of 2020 and into 2021.

Nonetheless, from March 2020 through March 2022, Pennsylvania hospitals incurred Pandemic-related revenue losses and additional expenses of $7.6 billion, of which over 75% occurred in 2021.

Figure 1: COVID-19 Financial Impact on Pennsylvania Hospitals



Source: COVID-19 Disaster Emergency Report, PHC4, "A Pennsylvania report on the effect of the COVID-19 disaster emergency on hospitals and health care facilities in the Commonwealth", July 2022.

To stem the financial impact of these changes on providers, the Federal government passed financial measures to assist providers in providing care, particularly to the uninsured and underinsured. Providers in Pennsylvania received assistance through these programs, including (1) 16,204 providers received a total of $6.55B in Provider Relief Fund Payments;[5] (2) uninsured treatment, testing, and vaccine payments totaled $254.27M on 2,895 provider claims;[6] (3) COVID-19 awards ($5B total for 2,240 awards,[7] (4) Rural Health Clinic (RHC) Testing and

[5] HHS Provider Relief Fund: U.S. Map of Provider Relief Fun Payments. Date accessed: 12/1/2022. https://taggs.hhs.gov/Coronavirus/Providers. These awards included payments through the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020; the Families First Coronavirus Response Act; the Coronavirus Aid, Relief, and Economic Security (CARES) Act; the Paycheck Protection Program and Health Care Enhancement Act (PPPHCEA); the Coronavirus Response and Relief Supplemental Appropriations Act (CRRSA - Division M, Title III), 2021; and the American Rescue Plan Act of 2021.

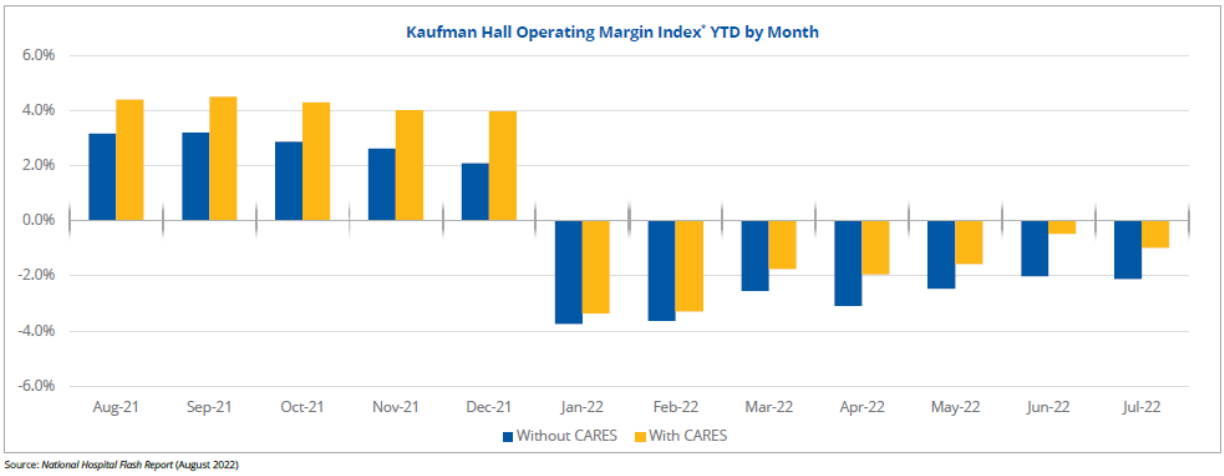
[6] Testing, Treatment, and Vaccine Administration for the Uninsured: U.S. Map of Treatment & Testing of the Uninsured. Date Accessed: 12/1/2022. https://taggs.hhs.gov/Coronavirus/Uninsured. This fund covered reimbursements directly to eligible health care entities for claims attributed to testing, treatment, and/or vaccine administration for the uninsured.

[7] HHS COVID-19 Awards: U.S. Map of COVID-19 Awards. Date Accessed: 12/1/2022. https://taggs.hhs.gov/Coronavirus.

Mitigation[8] (amount not available); and (5) Coverage Assistance Fund Payments ($504.6K).[9] Other programs designed to assist providers in managing Pandemic responses included the COVID-19 ACCELERATED AND ADVANCE PAYMENT (CAAP) REPAYMENT & RECOVERY, which accelerated or advanced payments to providers and suppliers stemming from the Pandemic and the American Rescue Plan Act, which contained a number of provisions designed to increase coverage, expand benefits, and adjust federal financing for state Medicaid programs.[10]

We do not have data on the offsetting impact of these programs on Pennsylvania hospitals, particularly those in the WPA. However, initial funding through the CARES (Coronavirus Aid, Relief, and Economic Security) Act protected hospital profitability. Once federal funding was cut back, hospitals have borne the cost burden of delivering care. In 2022, hospital margins nationally plummeted and continue to be significantly below 2021 margins. Our review of individual hospital margins in WPA is consistent with those nationally and in the Northeast/Mid-Atlantic areas as they experience these adverse continuing financial impacts from the Pandemic.

Figure 2: Kaufman Hall Hospital Operating Margin Index, YTD by Month



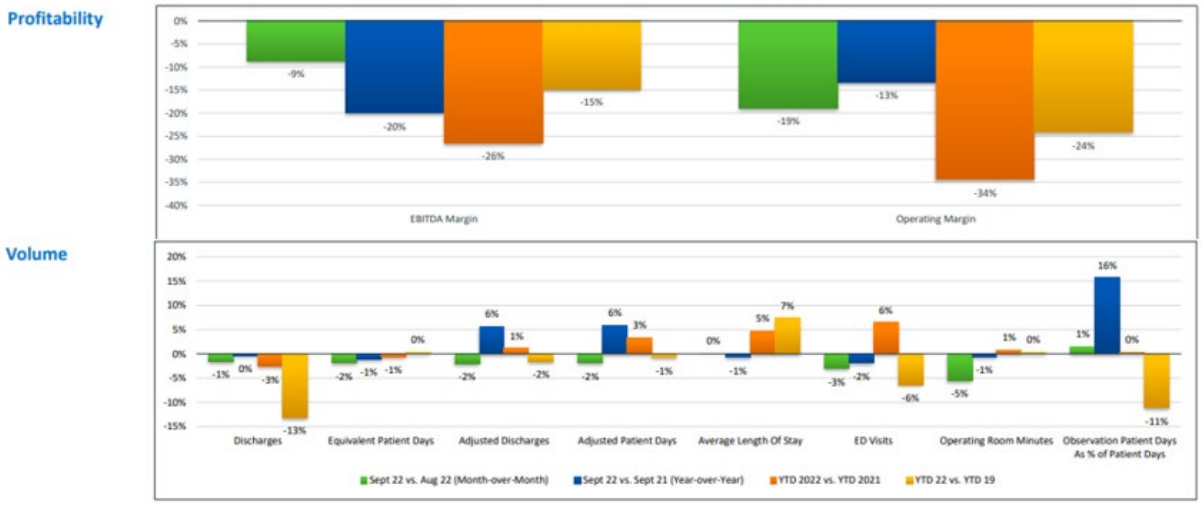
Source: *National Hospital Flash Report* (August 2022)

[8] Rural Health Clinic (RHC)Testing & Mitigation: U.S. Map of RHC Testing & Mitigation Payments. Date accessed: 12/1/2022. https://taggs.hhs.gov/Coronavirus/RuralHealthClinics. This funding covered access to care for rural residents.

[9] HHS Coverage Assistance Fund: U.S. Map of Coverage Assistance & Attested. Date accessed: 12/1/2022. https://taggs.hhs.gov/Coronavirus/CoverageAssistanceFund. This fund covers the costs of administering COVID-19 vaccines to underinsured patients.

[10] For example, the law provided additional temporary fiscal incentives to adopt Medicaid expansion for the 12 states (along with Missouri and Oklahoma) that had not done so. In addition, coverage for post-partum women covered under Medicaid is extended from 60 days to a full year. The Act also contained several Medicaid financing funds and payments, and federal matching funds.

Figure 3: Northeast and Mid-Atlantic Hospital Profitability and Volume Trends



Source: Kaufman Hall, National Hospital Flash Report, October 2022.

2. Highmark's and UPMC's Insurer/Provider Reimbursement Contract

Highmark's 2002 insurer/provider contract with UPMC expired on December 1, 2014. The Commonwealth attempted to restore Highmark member access to UPMC facilities and physicians because UPMC was viewed by members as a "must have" provider for certain products and services, such as cancer services and its Children's Hospital.

On June 24, 2019, the Pennsylvania Attorney General announced that he had brokered a 10-year contract offering full in-network access to Highmark members to certain UPMC facilities and physician services in Pittsburgh and Erie, PA. Beginning July 1, 2019, all Highmark members in broad access networks (such as PPO Blue, Blue Card, Freedom Blue, and Security Blue) have had full in-network access to all UPMC facilities and doctors.[11] Members in high-performing or tiered products, such as Community Blue Flex or Connect Blue, have not had the same full access, but certain services or facilities, such as exception hospitals and some community oncology services,

[11] Broad networks typically include most, if not all, of an area's healthcare providers (hospitals, outpatient facilities, physicians, specialists). Narrow networks typically include a limited number of providers in an area. In a broader network, the provider must compete with other providers in the same broad network which reduces the likelihood that any network member will choose any one provider. In a broad network, a provider typically is less willing to accept a discounted rate since members will have a significant choice among providers and providers will have less opportunity to draw patients. Similarly, with narrow networks, the provider is competing against fewer other providers within the network for patients, so the likelihood that the provider will get more of the network's members is greater. The provider typically is willing to take a greater discount on its reimbursement rates because of the prospect of obtaining additional business. For this reason, narrow networks are considered an effective means of reducing healthcare costs through reduced premiums or out-of-pocket costs, albeit with less consumer choice at the point of care.

are in-network for these high performance or tiered products, as well. The agreement required the PID to provide a Condition 3 waiver to Highmark which enabled the 10-year contract term, and a limited waiver to Conditions 5 and 6 allowing Highmark to preferentially place UPMC hospitals and physicians on its most favorable in-network tier.

With the 2019 10-year UPMC/Highmark negotiated insurer/provider contract, the competitive dynamics within WPA are expected to change. More Highmark members now have access to UPMC facilities and AHN must compete even more vigorously for patients in the Pittsburgh and Erie areas. Additionally, UPMC's health plan has steadily been gaining members in WPA and is a more formidable rival to Highmark's health plans. This competitive dynamic may change as Highmark members can access UPMC providers without being a member of UPMC's health plans.

With two large and more symmetrical vertically-integrated healthcare delivery and financing networks competing against one another in WPA, competition can take one of two forms—intense competition or tacit collusion, or more specifically, diminished competition as rivals may tend to accommodate rather than react to competitor's actions to raise price or reduce the quantity or quality of products and services. We examine the impact of these changed dynamics to determine whether Highmark member lives, and WPA consumers generally, continue to benefit from competition between Highmark, UPMC, and other fringe insurers and providers in the WPA insurer and provider marketplaces.

3. BCBSA Antitrust Settlement

In 2012, employers and individual policyholders filed an antitrust lawsuit against BCBSA entities alleging that these firms conspired to allocate insurance markets across the country in violation of Sherman Antitrust Act § 1. The class action lawsuit claimed that the alleged market allocation scheme allowed the insurers to avoid competing against one another and drive-up premiums and costs to members. There was an April 2018 judicial decision to try the matter under a "per se" violation rather than under a "rule of reason" standard. The higher per se standard does not allow the balancing of pro-competitive justifications for the practice, and settlement talks ensued. On August 9, 2022, the Judge approved the final settlement (the "BCBSA Settlement").

Of relevance to this report, the BCBSA Settlement requires BCBSA to eliminate two restrictive rules for its Blue licensees.[12] First, it eliminates the rule restricting the amount of business from non-Blue brands for insurers that hold a Blue license. Specifically, the rule had required that at least two-thirds of national net revenues from health plans and related services had to emanate from Blue-branded products. The elimination of this requirement would enable a Blue licensee

[12] See, Final Order and Judgment Granting Approval of Subscriber Class Action Settlement and Appointing Settlement Administrator for specific relief and terms of the Settlement Agreement, including that it does not represent admission of antitrust violation, etc.; located at https://www.bcbssettlement.com.

to expand its non-Blue branded plans to other markets without restriction on the amount of revenues that may be generated. For example, this would enable Capital Blue Cross, Independence Blue Cross, or others to offer non-Blue branded products in Highmark's WPA and Northeast PA market areas, or alternatively, for Highmark to offer non-Blue branded products in other BCBSA licensee markets.

These changes have the potential to increase competition and choice for individuals and employers in WPA and more broadly. Second, the BCBSA maintained a rule that limited Blue licensees from competing with each other for large national employers that have employees in regions covered by different Blue insurers. The rule specified that large employers must work with the Blue insurer that offers coverage where the employer's headquarters is located. The rule change in the Settlement enables BCBSA licensees to compete with each other for large national contracts. This could potentially increase competition within WPA and provide national employers greater choice and ability to compare prices across competing Blue licensees.

II. HEALTHCARE INSURANCE MARKETS IN WPA

As a baseline for this assessment, at the time of the 2013 affiliation of Highmark with WPAHS, Highmark held a substantial share of healthcare insurance products and services in WPA. Highmark's share of relevant markets ranged from approximately 55-75%, depending on the specific insurance type. Defining the market as all commercial insurance products in the 29-county WPA, Highmark's share was approximately 60%. Rival commercial insurers' shares estimated in the same geography were generally low (often less than 5%) with the larger insurers –UPMC, HealthAmerica, and Aetna – having shares of less than 10% each. The commercial insurer HHI (Herfindahl Hirschman Index) exceeded 3,700, which is considered a highly concentrated market with the presumption that Highmark's significant share provided it with market power. We concluded that the significant market position of Highmark had provided it with the ability to negotiate substantially different terms with UPMC Health System and with other providers than its rivals, implying that Highmark's size, reputation, and/or other qualities were important competitive dimensions in contracting and that other insurers were weaker on these dimensions. We concluded that rival insurers functioned as more of a competitive fringe.

A. Changes in the provision of healthcare insurance within Pennsylvania and WPA since 2017

Since 2017, the competitive dynamics in Pennsylvania and WPA have continued to change in the healthcare insurance markets. UPMC's Health Plan has grown significantly by focusing on health plans that reach the Medicaid, Medicare, and ACA (Affordable Care Act) communities, and by expanding its commercial health plans. Other national insurers, such as UnitedHealthcare and Aetna, have remained competitors and have slightly increased their share of the market since

2017. In addition, potential new competition from other BCBSA insurers may provide additional insurance choices in the near future as a result of the BCBSA Settlement.

According to National Association of Insurance Commissioners ("NAIC") data filed with the Department, the total Pennsylvania membership across all offered insurance products (i.e., Individual, Group, Title XVIII Medicare, Medicare Supplement, FEHB, Medicaid, and Other Members) increased by 7% between 2013 and 2016. Since 2017, the total healthcare insurance enrollment continued to increase by 12%, from 8.3 million insured in 2017 to 9.4 million insured in 2021. Table 1 presents the annual percentage of healthcare members by type of insurance in Pennsylvania as reported to the Department. These data show a significance increase in Medicaid (33%) and Medicare (20%).

Table 1: Pennsylvania Healthcare Insurance Members

Total Annual Individual, Group, Title XVIII Medicare, Medicare Supplement, FEHB, Medicaid, Other Members by Group Type in PA								
	Share					Change (2017-2021)	% Change (2017-2021)	% Change (2013-2016)
Insurer	2017	2018	2019	2020	2021			
Total Members	**100%**	**100%**	**100%**	**100%**	**100%**	**1,032,207**	**12%**	**7%**
Medicaid	42%	42%	43%	48%	50%	1,156,379	33%	35%
Group	19%	18%	18%	15%	14%	-281,643	-18%	-34%
Other	12%	13%	12%	12%	11%	42,564	4%	28%
Title XVIII Medicare	12%	12%	12%	12%	12%	195,134	20%	12%
Individual	8%	7%	7%	6%	6%	-85,833	-13%	47%
FEHB	5%	5%	5%	4%	4%	-9,975	-2%	-9%
Medicare Supplement	2%	2%	2%	2%	2%	15,581	8%	-20%

Source: NAIC Annual Statements filed by insurance companies to the Department.
Note: Enrollment data reflects enrollments as of December 31st of each year and is the Total Members at the end of Current year (line 5) from the Exhibit of Premiums, Enrollment, and Utilization (Page 29.PA) from the Health Annual Statement. Enrollment data is not available for Life annual statement.[13]

Medicaid

Medicaid expansion has played a key role in reducing the uninsured rate in Pennsylvania since 2015. In particular, Medicaid members have increased substantially, from a 43% share in 2019 to a 48-50% share in 2020-2021 (Table 1). During the Pandemic, Medicaid coverage due to expanded eligibility guidelines under the ACA, ensured that people who lost their jobs still had health coverage. In March 2020, the Families First Coronavirus Response Act provided states with

[13] Glossary of Insurance Terms. Date accessed 12/1/2022. http://www.naic.org/consumer_glossary.htm#O. Other includes "accident and health coverages not otherwise properly classified as Group Accident and Health or Credit Accident and Health (e.g., collectively renewable and individual non-cancellable, guaranteed renewable, non-renewable for stated reasons only, etc.). Includes all Medicare Part D Prescription Drug Coverage, whether sold on a stand-alone basis or through a Medicare Advantage product and whether sold directly to an individual or through a group.

additional Medicaid funding under the condition that no one would be disenrolled from Medicaid during the Pandemic. Since these states have not been conducting periodic eligibility redeterminations during this time, Medicaid enrollment increased significantly since 2020 in both Pennsylvania and nationally.[14] There were over 4.5 million enrolled in Medicaid in 2020 and over 4.6 million enrollees in 2021.

Comparatively, commercial group and individual insurance declined by 18% and 13% respectively, likely due to job losses (loss of employer plans) during the Pandemic, and hence a shift to government coverage. Group insurance also declined by 34% pre-Pandemic, between 2013 and 2016. More details on individual and group insurance in Table 5.

ACA Exchanges

Overall, the ACA insurance exchange membership in WPA has declined since 2017. As reported in Table 2, total enrollment in the 29-county WPA decreased from more than 118,000 members in 2017 to about 101,000 members in 2020. In 2014, Highmark's share of ACA enrollment in WPA was 94% and UPMC's share was 3%. Despite revising its ACA exchange offerings in 2015, Highmark incurred significant financial losses. Highmark's share fell to 62.5% in 2015, while maintaining almost the same number of enrollees, whereas UPMC shares increased due to new enrollees. The 2017 to 2020 Centers for Medicare and Medicaid Services ("CMS") data show that UPMC became the largest insurer on the ACA exchange marketplace as Highmark pulled further out of the exchanges. UPMC remained the largest insurer with over 85% share in 2020 even as Highmark somewhat increased its share. The number and share of ACA enrollees decreased slightly for UPMC from 2017 to 2020, while Highmark share increased by four percentage points during this time.

Table 2: Insurer-Level ACA Enrollment, 29-County WPA (2017-2020)

Insurer-Level ACA Enrollment, 29 County WPA (2017-2020)								
Insurer	Enrolled 2017	Share 2017	Enrolled 2018	Share 2018	Enrolled 2019	Share 2019	Enrolled 2020	Share 2020
All WPA	**118,703**	**100.0%**	**112,126**	**100.0%**	**103,626**	**100.0%**	**101,039**	**100.0%**
UPMC	107,224	90.3%	107,159	95.6%	97,491	94.1%	86,098	85.2%
Highmark	10,744	9.1%	4,317	3.9%	4,521	4.4%	13,270	13.1%
Capital Blue Cross	187	0.2%	102	0.1%	833	0.8%	841	0.8%
Geisinger	548	0.5%	548	0.5%	781	0.8%	830	0.8%

Source: CMS.

Highmark also self-reported having just a 5% ACA share in WPA in 2019 (consistent with CMS data in Table 3), after pulling out of its ACA plans in over a dozen counties in 2016. However, more recently, Highmark has expanded outreach for its ACA-backed insurance plans, which

[14] Pennsylvania and the ACA's Medical expansion. Date accessed: 12/1/2022. https://www.healthinsurance.org/medicaid/pennsylvania/.

includes a new narrow-network plan now open to Westmoreland County residents, as AHN builds out more medical facilities there.[15] According to Highmark officials, Highmark is expected to get a large number of new enrollees in the ACA market, estimating approximately 20% share of the region's ACA individual market by 2022.[16]

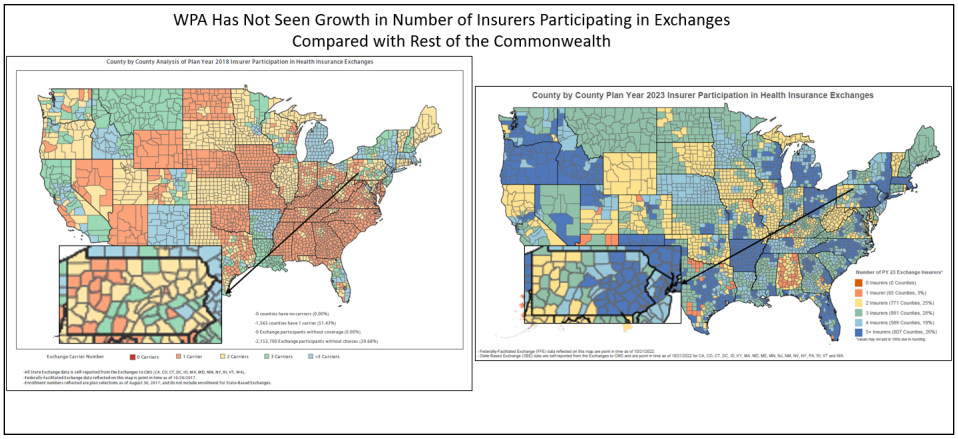
Table 3: Self-Reported ACA Enrollment Estimates, PA, 2017-2021

Self-reported ACA Enrollment Estimates, PA, 2017-2021					
	2017	2018	2019	2020	2021
Highmark	142,895	131,552	147,942	93,173	116,798
UPMC	287,107	243,117	258,287	249,454	231,611

Source: Highmark and UPMC filings with the Department.

Despite the substantial size and share of UPMC and the renewed interest by Highmark, WPA has not experienced a growth in the number of insurers competing on the exchange as in other areas of Pennsylvania.

Figure 4: County by County Insurer Participation in Health Insurance Exchanges, 2018 and 2023



Source : CMS (https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2017-10-20-Issuer-County-Map.pdf; https://www/cms.gov/files/document/py2023-county-coverage-map.pdf.

[15] Information on ACA enrollment filings by Highmark and UPMC provided by the report numbers much greater than those reported by CMS (Table 2 vs. Table 3). We are unable to resolve this discrepancy without discussions with Highmark and UPMC.

[16] "More Americans expected to enroll in Affordable Care Act health plans as costs drop, benefits increase." Date accessed: 12/1/2022. https://triblive.com/local/regional/more-americans-expected-to-enroll-in-affordable-care-act-health-plans-as-costs-drop-benefits-increase/.

Medicare Advantage

The total Medicare Advantage enrollment in the 29-county WPA increased by 15% since 2017. Highmark had declining Medicare Advantage (Medicare Advantage or "MA") enrollment in WPA over time while UPMC, Aetna, and United enrollment increased. Highmark had the highest total MA enrollment until 2018, but its members have decreased by 23% between 2017 and 2021, from 197,469 to 151,641 respectively (Table 4).

Table 4: Insurer-Level Medicare Advantage Enrollment*, 29-County WPA (2017 - 2021)

Insurer-Level Medicare Advantage Enrollment* as of June 2017 through June 2021 (29 County WPA)						
Insurer	Enrolled 2017	Enrolled 2018	Enrolled 2019	Enrolled 2020	Enrolled 2021	% Change (2017-2021)
Total	**500,741**	**514,923**	**529,404**	**551,982**	**575,044**	**15%**
UPMC	164,720	175,810	187,345	186,377	192,016	17%
Highmark	197,469	188,668	157,782	156,332	151,641	-23%
Aetna	94,458	99,452	120,922	140,244	149,275	58%
United	17,368	23,235	32,708	34,279	41,825	141%
Humana	7,776	7,909	9,825	13,106	16,798	116%
Other Insurers	18,950	19,849	20,822	21,644	23,489	24%

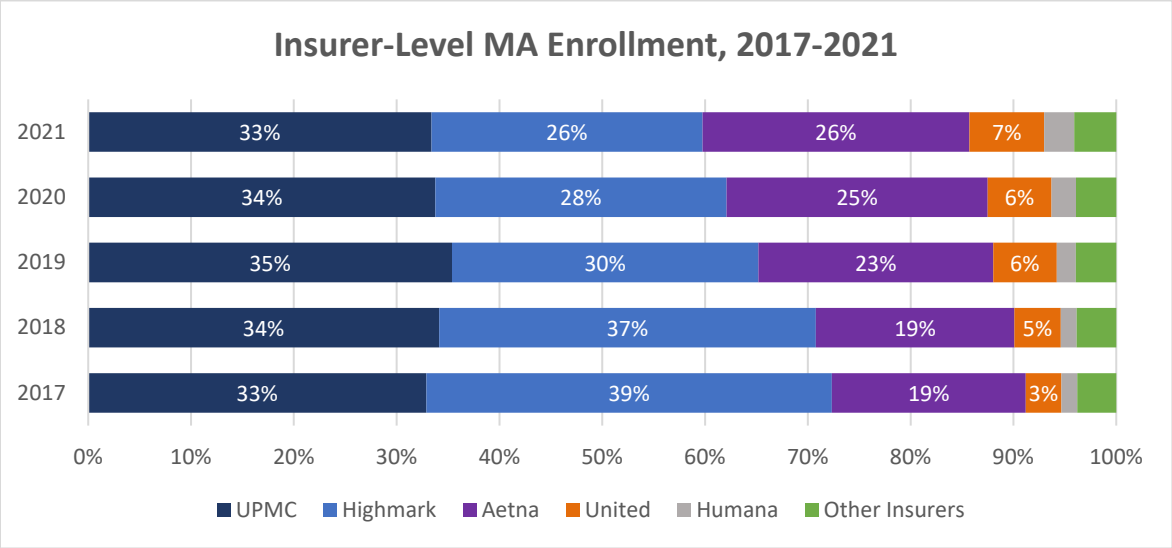
Source: CMS.
Notes: *Enrollment figures report the number of beneficiaries enrolled by contract in the country. To comply with HIPAA privacy rules, CMS sets enrollment numbers to zero for plans with 10 or less enrollees.
Aetna acquired Coventry Health Care, Inc., owner of HealthAmerica on May 7, 2013. CVS-Aetna announced their proposed merger on Dec. 3, 2017.

UPMC has the highest MA plan enrollment in WPA in 2021, as shown in Figure 5. Other insurers, such as United and Aetna, have expanded their MA enrollment substantially. Aetna is now third largest. This is a potential benefit of imposing the competition conditions under the 2013 Order, and the former elimination of the UPMC-Highmark 10-year contract that opened up more competition from these third parties. However, Highmark's new 10-year contract with UPMC became effective on July 1, 2019, allowing seniors enrolled in Highmark MA plans to have in-network access to UPMC hospitals and doctors. The 2020 and 2021 shares reported below likely capture some first and second-year impact of this agreement. Despite this agreement, Highmark's share of MA enrollees in WPA has declined in 2020 and 2021. An analysis of Large Blues plans found that the Blues' two largest MA plans, of which Highmark is one (the other being BCBS of Michigan) had share declines between 2020 to 2021, while small Blues plans gained shares both nationally and in the states in which these plans compete.[17] Highmark is still below

[17] As Medicare Advantage Enrollment Booms, Healthcare Entities Need to Plan Around Key Trends: 2021 Medicare Advantage Competitive Enrollment Report. Date accessed: 12/1/2022. https://www.chartis.com/insights/medicare-advantage-enrollment-booms-healthcare-entities-need-plan-around-key-trends.

its 2018 enrollment counts (consistent with findings in Table 4), although its shares have recently started to grow.[18] Highmark's acquisition of the remaining 50% of Gateway Health in August 2021, which offers Medicaid and Medicare Advantage products across the Commonwealth, is part of its plans to improve care delivery and may increase MA enrollment going forward. Gateway Health (Highmark Wholecare) generated approximately $96M in operating profits as of June 2022, due to beneficial developments and enrollment trends.[19]

Figure 5: Insurer-Level Medicare Advantage Enrollment in WPA, 2017-2021



Source: CMS.
Notes: Aetna acquired Coventry Health Care, Inc., owner of HealthAmerica on May 7, 2013. CVS-Aetna announced their proposed merger on Dec. 3, 2017.

Commercial Insurance

The total Commercial insurance members in Pennsylvania–for the top six insurance groups in WPA–declined by 17% between 2017 and 2021 (Table 5). Even prior to this period, these commercial plans experienced a 26% decline from 2013 through 2016, primarily due to a reduction in commercial Group membership (Table 1). Highmark has the highest commercial enrollment in PA. Although Highmark's enrollment declined in 2018 and 2019, there was a gain in membership in 2020 and 2021 since the 2019 Highmark/UPMC contract. UPMC shows an opposite trend, membership increased in 2018 and 2019 but declined 2020 onwards. Geisinger and Aetna had significant declines in commercial members during this period, 37% and 72% respectively.

[18] Ibid.
[19] 1H'22 Financial Results: Highmark Health, Highmark Inc., & Allegheny Health Network. October 2022.

Table 5: Commercial Insurance Members in Pennsylvania by Insurer

Total Annual Individual and Group Members by Key Insurance Groups in PA for Top Six Insurance Groups in WPA								
	Members					Change (2017-2021)	% Change (2017-2021)	% Change (2013-2016)
Insurer	2017	2018	2019	2020	2021			
Total	**1,361,504**	**1,312,830**	**1,255,410**	**1,184,705**	**1,130,562**	**-230,942**	**-17%**	**-26%**
Highmark	576,386	552,455	537,331	541,411	543,369	-33,017	-6%	-26%
UPMC	457,426	466,231	475,749	450,497	422,050	-35,376	-8%	40%
Geisinger	149,011	153,340	135,424	103,536	94,340	-54,671	-37%	-27%
Aetna	142,084	104,536	66,587	51,217	39,481	-102,603	-72%	-61%
UnitedHealthCare	36,597	36,268	40,319	38,044	31,322	-5,275	-14%	54%
Cigna	0	0	0	0	0	0	0%	0%

Source: NAIC Annual Statements filed by insurance companies with the Department

Note: Enrollment data reflects enrollments as of December 31st of each year and is the Total Members at the end of Current year (line 5) from the Exhibit of Premiums, Enrollment, and Utilization (Page 29.PA) from the Health Annual Statement.

Aetna acquired Coventry Health Care, Inc., owner of HealthAmerica on May 7, 2013. CVS-Aetna announced their proposed merger on Dec. 3, 2017.

Overall Healthcare Insurance Competition

Table 6 reports the overall change in healthcare plan members from 2017 to 2021 across Pennsylvania for the top six insurers operating in WPA.[20] Total members for these insurers have collectively increased by 11% since 2017. While Highmark had the largest share of members between 2013 and 2016, its membership declined substantially during this period. Highmark's total membership declined by 11% between 2013-2016 and by 5% from 2017-2021. However, since the Highmark-UPMC 2019 contract, Highmark has been gaining members in 2020 and 2021. Simultaneously, UPMC and UnitedHealthcare have had the largest increase in total enrollment since 2017 at 22% and 35% respectively. UPMC's membership gains are likely due to significant expansion of its hospital base and health plans across the state.[21] Other insurers, such as Aetna and Cigna, have also expanded membership.

[20] These member counts do not include behavioral, vision, dental or other plan members. We are unable to determine if reported members include members reported in more than one plan.

[21] UPMC Financial Results and Systems Highlights Calendar Year 2021. February 28, 2022. UPMC claims to be the largest insurer in WPA with 4 million members—due to having the highest market share in Individual, Medicare, Medicaid, Behavioral Health, Children's Health, and Community care insurance products.

Table 6: Pennsylvania Healthcare Insured Members by Insurer

Total Annual Individual, Group, Title XVIII Medicare, Medicare Supplement, FEHB, Medicaid Members by Key Insurance Groups in PA for Top Six Insurance Groups in WPA								
	Members					Change (2017-2021)	% Change (2017-2021)	% Change (2013-2016)
Insurer	2017	2018	2019	2020	2021			
Total	**4,614,863**	**4,562,195**	**4,516,905**	**4,882,709**	**5,112,557**	**497,694**	**11%**	**0%**
UPMC	1,828,605	1,860,394	1,899,112	2,128,498	2,227,481	398,876	22%	39%
Highmark	1,528,825	1,476,388	1,406,415	1,437,360	1,453,576	-75,249	-5%	-11%
Aetna	504,236	465,536	449,513	520,297	589,285	85,049	17%	-35%
Geisinger	430,640	433,423	411,620	399,885	412,684	-17,956	-4%	6%
UnitedHealthCare	281,380	284,400	304,258	347,246	379,671	98,291	35%	30%
Cigna	41,177	42,054	45,987	49,423	49,860	8,683	21%	-40%

Source: NAIC Annual Statements filed by insurance companies to the Department
Note: Enrollment data reflects enrollments as of December 31st of each year and is the Total Members at the end of Current year (line 5) from the Exhibit of Premiums, Enrollment, and Utilization (Page 29) from the Health Annual Statement. Enrollment data is not available for Life annual statement.
Aetna acquired Coventry Health Care, Inc., owner of HealthAmerica on May 7, 2013. CVS-Aetna announced their proposed merger on Dec. 3, 2017.

Table 7 details the Pennsylvania health insurer market concentration by metropolitan statistical area (MSA) as of January 1, 2021. Overall, concentration (measured using HHI[22]) has been increasing in this market, with a few exceptions. Highmark is the largest insurer across the Commonwealth for commercial and exchange products combined.[23] The WPA MSAs (highlighted in grey) indicate that the WPA market is highly concentrated. As a highly concentrated market, it is in consumers' interests to ensure that market leaders, such as Highmark, cannot engage in contracting practices that would diminish the market's contestability or competitiveness. Although the WPA market remains highly concentrated, competition among healthcare providers remains strong, as compared with competitive conditions before the 2013 Order. Our assessment indicates that vertically integrated healthcare systems can operate competitively, particularly in circumstances where competitive conditions are imposed that assist in mitigating some of the potential harm from vertically aligned buyers and customers that compete with other rivals. The competitive conditions contained in the 2013 Order work to help ensure that end goal for consumers in WPA.

[22] Herfindahl-Hirschman Index (HHI) exceeding 2,500 is considered to be a highly concentrated market. HHI calculated as the sum of the squared shares for each firm within a defined market.
[23] Products include commercial Individual, Group, Federal Employee Health Benefit Plan, Consumer Driven Health Plan (CDHP), State/Local Employee Plan, Blue Card HOME, Student Health, EPO, and public heath exchange lives.

Table 7: PA Health Insurer Market Concentration by Metropolitan Statistical Area, 2021

MSA	States	HHI Concentration	Largest Insurer	Share	Second Largest	Share
Pennsylvania		1,737	Highmark	29	CVS Health	19
Allentown-Bethlehem-Easton	PA-NJ	1,759	Highmark	27	Capital BC	21
Altoona	PA	2,403	Highmark	31	UPMC	28
Bloomsburg-Berwick	PA	4,083	Geisinger	60	Highmark	17
Chambersburg-Waynesboro	PA	2,872	Highmark	45	Capital BC	25
East Stroudsburg	PA	2,900	Highmark	47	CVS Health	17
Erie	PA	3,442	Highmark	50	UPMC	28
Gettysburg	PA	2,395	Highmark	38	Capital BC	25
Harrisburg-Carlisle	PA	2,686	Highmark	43	Capital BC	21
Johnstown	PA	3,252	Highmark	47	UPMC	29
Lancaster	PA	2,949	Highmark	45	Capital BC	27
Lebanon	PA	3,460	Highmark	53	Capital BC	21
Philadelphia-Camden-Wilmington	PA-NJ-DE-MD	2,314	Independence Hlth Grp	36	CVS Health	26
Pittsburgh	PA	3,060	Highmark	41	UPMC	35
Reading	PA	2,184	Capital BC	29	Highmark	29
Scranton—Wilkes-Barre	PA	3,604	Highmark	53	Geisinger	26
State College	PA	2,521	CVS Health	35	Capital BC	30
Williamsport	PA	2,603	Highmark	40	Geisinger	23
York-Hanover	PA	2,352	Highmark	37	Capital BC	25

WPA MSAs highlighted in grey; green represents increase from previous year; red represents decrease from previous year; yellow no change
Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2021 Combined PPO+HMO+POS+EXCH (Total) product markets
Source: American Medical Association, 'Competition in Health Insurance, A Comprehensive study of U.S. markets, 2022 Update'

B. Expansion of narrow network products

One of the objectives of the Conditions in the 2013 Order was to ensure that consumer choice would not be restricted among healthcare plans as well as providers. Narrow networks are health plans that have a lower premium and out-of-pocket costs, but as a trade-off, the choice of health care providers for members is limited. While narrow networks impose greater restrictions on consumers' choice of providers, they can enhance competition among providers and curb providers' negotiating leverage in competitive markets, as hospitals are competing with other providers to be designated in-network and gain patient volume.[24] The use of narrow networks in healthcare plans is a cost containment strategy that can be beneficial as care delivery increasingly shifts to value-based payment models. At the time of the 2013 Order, only Highmark offered a narrow network health plan option. Today, both Highmark and UPMC offer an array of narrow network plans.

Highmark offers a selection of narrow network insurance products in WPA focused on providing consumers a lower cost option for healthcare insurance in exchange for limiting in-network access to some hospitals. Highmark has successfully incentivized its members to shift to narrow networks over time and away from more inclusive, higher cost broader networks. About 45% of

[24] Narrow network plans can also encourage consumers to make choices among hospitals for specific services, or choices among plan types (e.g., narrow versus broader). Tiered-networks are a variation on narrow networks, offering greater choice, but different out-of-pocket costs for choice of hospitals on different tiers. S. Delbanco, R. Berenson, and D. Upadhy, "Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care", Urban Institute Research Report, April 2016. Date accessed: 12/1/2022.
https://www.urban.org/sites/default/files/2016/05/03/04_narrow_networks.pdf.

Highmark plan members were in a narrow network plan in 2016 compared with 5% at the time of the 2013 Order.[25]

Highmark's portfolio of network offerings includes family network plans and employer group plans for small and large businesses in Pennsylvania. For employers, Highmark offers two narrow network plans for small businesses (Performance Blue and Together Blue EPO) and two narrow network plans for large businesses (Performance Blue and Performance Flex Blue). The individual network offerings include:

- Family Network Plan - Highmark offers an insurer market for families. Health coverage and network offerings and benefits are dependent on family size/dependents and location in WPA. Information on specific plans, or descriptions of general plans offered are not available.[26]
- Employers - Highmark offers plans for small and medium/large businesses within Pennsylvania. Options for employers are dependent on coverage and employee size.
    - Small Businesses, with 1-50 employees, have four health plan options to choose from[27]
        - PPO- Plan with largest selection of providers. Members participating in BlueCard have coverage across the country.
        - Performance Blue- High performance network plan with high-quality providers and low cost.
        - Together Blue EPO- Lowest cost ACA plan with benefits including zero out-of-pocket costs for preventive screening, wellness exams, immunizations, vaccinations, and contraceptives. Only offered in Allegheny, Mercer, Westmoreland, Washington, and Erie counties.
        - Balanced funding- Self-insured plan that combines claims cost, administration fees, and stop loss insurance benefits into a single fixed monthly payment.
    - Medium and large sized businesses, with 51+ employees, also have four plans to choose from[28]
        - PPO Blue – Plan with the broadest access to doctors and hospitals.

[25] Results are provided from the 2017 Compass Lexecon report, based on Highmark enrollment data. Narrow network products are identified as 'Community Blue' and 'Connect Blue.' Full-risk products are identified as direct pay, regional risk, regional semi-risk, and national plans. These shares are based on full-risk products.
[26] Individual and Family Plans. Date accessed: 12/1/2022. https://www.highmark.com/plans/individual-families.html.
[27] Small Group Health Plans. Date accessed: 12/1/2022. https://www.highmark.com/employer/solutions/small-business/wpa/medical-plans.
[28] Large Group Health Plans. Date accessed: 12/1/2022. https://www.highmark.com/employer/solutions/large-business/wpa/medical-plans.

- Performance Blue- This plan offers higher-quality care and lower costs than the traditional PPO plans. No referrals are needed for a specialist and preventative care is 100% covered.
- EPO Blue Easy- No deductibles and no coinsurance for a broad network of doctors and hospitals, only co-pays required.[29]
- Performance Flex Blue- Lower costs options over traditional PPO offering coverage across Pennsylvania. Two-tiered network option is available: Enhanced value and Standard value. Enhanced value coverage could lead to more out-of-pocket savings. Also, preventative care is 100% covered.

Highmark has recently developed new network products that deliver high quality of care and lower costs, giving consumers greater choice. Highmark has launched two new networks in Pennsylvania to help employers in WPA offer employees access to care at the lowest cost. These networks, Performance Blue and Performance Flex Blue, which Highmark describes as "high-performing" networks[30] are designed to deliver quality care at lower costs through strong relationships with local providers in WPA, such as Allegheny Health Network, Conemaugh Health System, Excela Health System, Washington Health System, St Clair Memorial Hospital, and Penn Highlands Healthcare, which are participating in Highmark's value-based care initiatives.[31]

UPMC offers a broad range of network plans for families. For individual and family plans, UPMC offers four plans, three of which are narrow networks—UPMC Partner, UPMC Select, and UPMC Standard. Members may choose from UPMC providers and some specific non-UPMC providers. These plans are restricted to residents in certain WPA counties.

- Individual and family plans:[32]
  - UPMC Partner Network (EPO)- UPMC's most affordable network option available to residents located in the following WPA counties: Allegheny, Bedford, Blair, Erie,

[29] Highmark describes the EPO Blue Easy product as a broad network, but we note that the product has more limited network arrangements than Highmark's traditional products.
[30] Highmark launches new high performing networks in western Pennsylvania. Date accessed: 12/1/2022. https://www.highmark.com/newsroom/press-releases/highmark-launches-new-high-performing-networks-wpa.html. "Performance Flex Blue will offer PPO and PPO Qualified High Deductible plans, as well as an EPO and EPO Qualified High Deductible plans as a tiered benefit design. It is available for self-insured and fully insured large employer groups beginning Jan. 1, 2021. Performance Blue will also offer PPO, PPO Qualified High Deductible plans, EPO and EPO Qualified High Deductible plans for self- and fully insured large employer groups, but with a more select network of doctors and hospitals." Blue High Performance Network. Date accessed: 12/1/2022.
[31] Highmark also announced that it will be participating in Blue High Performance Network (Blue HPN), a new national network built on doctors and hospitals focused on enhancing quality while reducing costs. See ibid.
[32] Health Insurance: Coverage for individuals and families. Date accessed: 12/1/2022. https://www.upmchealthplan.com/individuals/learn/plans-and-services/health-insurance.aspx.

Lawrence, Mercer, Somerset, and Venango. This network includes all UPMC providers and some non-UPMC providers.

- UPMC Select Network (EPO)- This plan includes all UPMC providers and a select group of non-UPMC providers, available to residents located in the following WPA counties: Allegheny, Beaver, Butler, Fayette, Washington, and Westmoreland.
- UPMC Standard Network (HMO)- This plan offers higher quality providers within the UPMC network including all UPMC doctors, a select group of non-UPMC doctors, and most community hospitals. PCP (Primary Care Provider) referral is needed for a specialist. This plan is available to Crawford and Clearfield County residents only.
- UPMC Premier Network (PPO)- UPMC's broadest network with access to all UPMC providers and facilities and many independent providers and facilities. Although it is the highest priced, this plan allows patients to use in-network and out-of-network providers and is the most flexible in terms of cost sharing. All WPA counties, except Crawford and Clearfield, are covered under this plan.

UPMC also offers a wide variety of employer group plans for small, medium, and large-size businesses. UPMC's provider network includes more than 140 hospitals in PA, OH, WV, and MD, with national network coverage under Cigna PPO. Similar to its individual and family plans, some of these plans, such as UPMC MyCare *Advantage* restrict membership to residents or employers in certain counties. Nine different medical plans are available, dependent on company size.

- Employer Group Plans[33]
  - UPMC Small Business *Advantage*- Full in-network plan for companies <51 employees.
  - UPMC Business *Advantage*- Full in-network plan for employers with 51+ employees.
  - UPMC Inside *Advantage*- Plan with 51+ employee requirement with EPO and PPO options. Tiered benefit plan that provides low out-of-pocket costs at UPMC Level 1 and Level 2 facilities.
  - UPMC MyCare *Advantage*- Tiered benefit design focused on patient-centered care available to groups with 51+ employees. EPO and PPO options available to employers in the following WPA counties: Allegheny, Beaver, Bedford, Blair, Butler, Erie, Fayette, Lawrence, Mercer, Somerset, Venango, Washington, and Westmoreland.
  - UPMC Consumer *Advantage*- Plan which qualifies members for a health savings account. Available with Premium or Partner Network.
  - UPMC *HealthyU*- Plan has a built-in incentivized wellness program that rewards members for healthy choices. Available as a PPO or an EPO plan. Includes employers with as few as two employees.
  - UPMC Self Assure Level Funding- Self-funded ASO (Administrative Services Only) plan for

[33] Medical Plan Options. Date accessed: 12/1/2022. https://www.upmchealthplan.com/employers/plans-and-services/medical-plans/.

companies with 25+ employees.

- UPMC Total *Advantage* – Available to groups with 51 or more employees across UPMC Health Plan's Pennsylvania service area. Offers access to a broad network across PA with one plan.
- UPMC Virtual Care - Innovative health care plan that offers choice and cost savings to groups with 2-50 employees. Offered through UPMC Partner Network.

Due to insufficient information publicly available on these health plans, it is not feasible to do a one-to-one comparison of the rates for UPMC and Highmark health plans. According to NAIC annual filings data, Highmark had a 55% share of commercial group membership in Pennsylvania among the top six insurers in 2021,[34] with a 98% commercial membership retention in 2022.[35]

In WPA, the broadest networks include both Highmark and UPMC. Hospital penetration rates for national carriers (Aetna, Cigna, and UnitedHealthcare) are 100% due to the inclusion of both AHN and UPMC facilities in their networks.[36] However, some national carriers are beginning to offer narrow networks within the Commonwealth as well. For example, Aetna currently has seven narrow networks in Pennsylvania; three (WPHO Narrow Network Commercial, Butler Narrow Network, and Penn Highlands Narrow Network Commercial) are in WPA.[37] National carriers may be shifting to narrow networks to better compete with AHN and UPMC in WPA.

The enrollment counts reported for Highmark and UPMC are insurer-based estimates for Pennsylvania from NAIC annual statements filed with the Department. Official data for insurance membership in WPA is not publicly available.

C. Changes in WPA healthcare insurance competition since 2017

UPMC health plan is now a formidable competitor of Highmark. At the time of the 2013 Order, Highmark was leading the healthcare insurance market in WPA with approximately 60% share, and other insurers included UPMC, Aetna, UnitedHealthcare, Cigna, HealthAmerica, and Geisinger.[38] Since 2013, UPMC has grown significantly as a competitor to Highmark in the WPA insurance market, with an estimated commercial share of 8% in 2013 which increased to 25% share in 2021.[39] Additionally, UPMC claims to be the largest medical insurer in WPA with 4.1 million members in 2021, driven largely due to growth in government insurance market

[34] Highmark, UPMC, Aetna, Geisinger, UnitedHealthcare, Cigna.
[35] Highmark Health Mid-Year 2022 Financials. August 30, 2022.
[36] "Highmark Health Response to June 5, 2017 Inquiry #1 from Compass Lexecon."
[37] "Highmark Health Response to June 5, 2017 Inquiry #1 from Compass Lexecon."
[38] Economic Analysis of Highmark's Affiliation with WPAHS and Implementation of an Integrated Healthcare Delivery System, Submission to Pennsylvania Insurance Department, Margaret E. Guerin-Calvert, April 24, 2013 (hereafter "Compass Lexecon 2013 Expert Report").
[39] The market is defined as all commercial insurance products in the 29-county WPA. UPMC, "Financial Results and System Highlights Calendar Year 2021," February 28, 2022.

segments. Despite recent challenges due to the continued effects of the Pandemic and cost pressures faced by AHN, the Highmark-AHN integrated health delivery and financing system business model has continued to be financially beneficial to Highmark on a consolidated basis since 2013, with profits at Highmark offsetting losses at AHN.[40]

Highmark Inc. Insurance Plan Membership

The termination of Highmark's contract with UPMC, at the time of the 2013 Order, significantly narrowed Highmark's network offerings. Consumers who wanted to access all of UPMC's healthcare system had to purchase insurance from an insurer other than Highmark. Simultaneously, consumers who wanted access to UPMC health plans did not have access to AHN, which was affiliated with Highmark. Consumers who preferred access to both UPMC and AHN had to enroll with national carriers who offered broad network offerings. Highmark has recently developed new network products that deliver high quality of care and lower costs – including narrow networks such as Performance Blue and Performance Flex Blue.[41]

With the Highmark/UPMC 10-year contract, UPMC providers in WPA became participating providers in Highmark's designated commercial and Medicare Advantage products.[42] Highmark's view has been that this contract, in combination with Consumer Choice Initiatives (discussed in Section IV.A), will increase Highmark's members' access to affordable, high-quality, and cost-effective care in WPA from providers of their choice.[43] Specifically, Highmark's view is that this contract is intended to offer Highmark members broad access to UPMC, AHN, and independent community hospitals and providers, while also offering narrow network products that include access to AHN, independent community hospitals, and UPMC Exception Hospitals.[44] Additionally, this new contract addresses emergency care costs at all UMPC hospitals.

[40] 1H'22 Financial Results Highmark Health, Highmark Inc., & Allegheny Health Network. October 2022.
[41] Highmark launches new high performing networks in western Pennsylvania. Date accessed: 12/1/2022. https://www.highmark.com/newsroom/press-releases/highmark-launches-new-high-performing-networks-wpa.html."Highmark has also announced that it will be participating in a new national network of higher quality providers who deliver better and more affordable care called Blue High Performance Network (Blue HPN). Starting Jan. 1, 2021, more than 185 million Americans in more than 55 major markets will have access to Blue HPN across the country."
[42] Letter from Jack Stover to Deputy Commissioner Joseph DiMemmo. July 3, 2019.
[43] Letter from Jack Stover to Deputy Commissioner Joseph DiMemmo. September 20, 2019.
[44] Exception Hospitals and Providers include: UPMC's Bedford, UPMC Northwest, UPMC Altoona, WPIC (UPMC Western Psychiatric Hospital), UPMC Physicians and Ancillary Providers, and UPMC Children's Hospital.

Highmark estimates insuring 2.4 million members in WPA.[45,46] Moreover, Highmark acquired the remaining 50% of Gateway Health (now Highmark Wholecare) in August 2021, which offers Medicaid and Medicare Advantage plans across Pennsylvania, to improve care delivery to its members.[47] Despite its insurer/provider contract with UPMC, Highmark's share of MA enrollees has declined in 2020 and 2021 (Table 4).

Highmark's position is that it has benefited from its recent affiliation with HealthNow, a New York based healthcare insurance carrier, in March 2021.[48] HealthNow–re-branded as Highmark Blue Cross Blue Shield of Western New York and Highmark Blue Cross Blue Shield of Northeastern New York— solidified the Highmark brand in the state of New York and, according to Highmark, offers improved growth opportunities, synergies, and new product offerings.[49] Other collaborations outside of WPA include:

- Highmark's partnerships with Bayhealth, Christiana Care, Geisinger, Lehigh Valley Health Network, Penn State Health, and WellSpan Health aim to make health care more affordable outside WPA in Pennsylvania and Delaware.
- AHN's Community-Based Care Partnerships with Providers:
    - $1 billion joint investment collaboration with Penn State Health in Central PA to create new healthcare access points, including new local hospitals and clinics, integrating >100 community physicians; invested $25 million in Penn State Health Cancer Institute; developed lower cost solutions to assist Penn State Health
    - Working with WellSpan Health in Central PA to improve care, engage physicians, lower costs
    - Collaboration with Lehigh Valley Health Network to launch insurance plan to improve health outcomes and lower costs
    - Clinical joint venture with Geisinger to invest >$100 million to improve access to care in northcentral PA.

Highmark's 2021 financials show that Highmark generated substantial operating profits in its healthcare insurance operations, although some of the returns were partially offset by the monetary transfers by Highmark to AHN to cover AHN's operating losses. Specifically, Highmark's

[45] Highmark Corporate Snapshot, 2019. Date accessed: 12/1/2022. https://www.highmark.com/newsroom/corporate-snapshot.
[46] Highmark's core health plan membership has increased across its entire service area (PA, DE, WV, NY) with approximately 6.8 million Highmark members as of January 2022, with total commercial retention rates at 98%, up from 93% in 2020 despite COVID-19 impact on employment. Highmark Health Year-End 2020 and 2021 Financials.
[47] 1H'2022 Financial Results: Highmark Health, Highmark Inc., & Allegheny Health Network. October 2022.
[48] Ibid.
[49] Ibid, Highmark Health Year-End 2021 Financials, March 22, 2022.

total 2021 operating profits were approximately $301 million –a 71% decrease from 2020 when the Pandemic caused a large decrease in utilization.[50] The 2020 operating profits were higher in comparison to 2021 due to risk corridor payments from CMS –in October 2020, Highmark received $571 million in reassurance payments from CMS for risk corridor losses between 2014 and 2016 as required by the ACA and U.S. Supreme Court ruling in May 2020. Overall, Highmark's balance sheet continues to improve with ~$12.5 billion in cash and investments and ~$10.4 billion in total net assets.

Table 8 reports the annual revenues, operating income, and total net assets for Highmark insurance services between 2018 and 2021. Following the decline in revenues in 2019 and 2020, Highmark revenues grew in 2021. Operating income varies substantially year to year. The operating margin is highest in 2020 due to the risk corridor payments from CMS but becomes negative in 2021. Highmark's healthcare insurance services balance sheet improved with an increasing growth in total net assets.

Table 8: Highmark Insurance Services Financials Summary, 2018-2021

Highmark Insurance Services (million $), 2018-2021				
	2018	2019	2020	2021
Revenue	$ 16,885	$ 15,999	$ 15,644	$ 19,136
Growth	2.5%	-5.2%	-2.2%	22.3%
Operating Income	$ 487	$ 87	$ 667	$ 73
Margin	2.9%	0.5%	4.3%	-4.7%
Adj. Operating EBITDA	$ 667	$ 292	$ 783	$ 222
Margin	4.0%	1.8%	5.0%	0.3%
Excess of Revenue Over Expense before Tax	$ 1,223	$ 1,683	$ 2,169	$ 3,103
Margin	7.2%	10.5%	13.9%	16.2%
Total Net Assets	$ 11,640	$ 13,139	$ 15,407	$ 18,176
Growth	0.9%	12.9%	17.3%	18.0%

Source: Highmark Health Audited 2021 Financial Statements, April 2022

Note: "Insurance Services" includes Highmark Inc., Highmark Health, HMHS and HM Health Holding Co.
Revenue excludes Net Investment Income (Including Realized Gains on Investments) of $206M, $609M, $545M, and $564M from 2018 to 2021, respectively.
Adjusted Operating EBITDA calculated by adding Depreciation & Amortization and Goodwill & Intangible Impairment to Operating Income.
Excess of Revenues over Expenses before Tax includes Operating Income, Net Investment Income (Including Realized Gains on Investments), Interest Expense, Equity Gains on Subsidiaries, Other. Components of Net Periodic Benefit Cost, and Net Assets Acquired through Affiliation

[50] 1H'2022 Financial Results: Highmark Health, Highmark Inc., & Allegheny Health Network. October 2022. "Operating profits before intercompany eliminations for HealthPlan (major medical), Dental, HMIG (medical stop loss), Highmark Health Solutions, and Highmark Wholecare (formerly known as Gateway Health, prior to full acquisition in August) operations were ~**$590M** (down~**56%**YoY)".

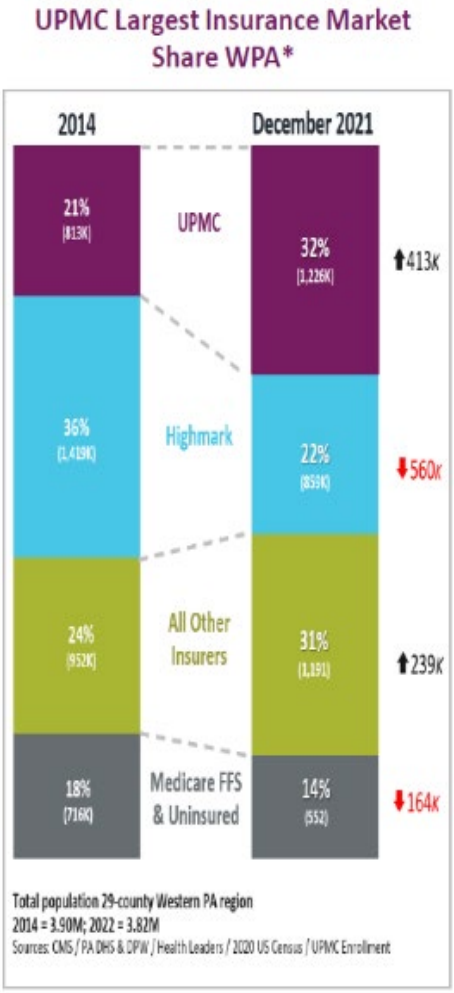
UPMC Health Plan Membership

UPMC claims to be the largest medical insurer in WPA with 4.4 million members as of September 30, 2022, driven largely due to growth in Medicaid and its Behavioral Health products. According to UPMC 2021 financial reports, UPMC has the highest market share in Individual (80%), Medicare (32%), Medicaid (60%), Children's Health (50%), and Community Care insurance products (34%-50%).[51] Medicare is relatively evenly split between Aetna, Highmark, and UPMC. However, Highmark still leads in Commercial Group insurance membership in WPA and PA (40% and 34% respectively).

UPMC Health Plan Membership

As of	September 30, 2022	September 30, 2021
Commercial Health	**589,176**	658,562
Medicare	**200,496**	200,738
Medical Assistance	**720,799**	557,427
Sub-Total Physical Health Products	**1,510,471**	1,416,727
Community HealthChoices	**138,395**	132,677
Behavioral Health	**1,473,874**	1,236,523
Sub-Total Health Products	**3,122,740**	2,785,927
Workpartners	**788,787**	734,647
Ancillary Products	**470,030**	475,067
Third-Party Administration	**13,637**	68,751
Total Membership	**4,395,194**	4,064,392

Source: UPMC Q3 2022 Financials



Source: UPMC Q4 2021 Financial Results

Table 9 reports the annual revenues, operating income, and operating earnings before interest, taxes, depreciation, and amortization (EBITDA) for UPMC insurance services between 2018 and 2021. Revenues grew steadily in this period and operating income/adjusted operating EBIDTA was positive all four years. For the nine months ending September 30, 2022, UPMC's operating income from its insurance business increased to $400M compared with $156M in the same period of 2021. Although expenses increased, revenues increased by more leaving UPMC with 3.9% operating margin compared with only 1.6% during the same period in 2021. UPMC's medical expense ratio as of September 2022 is higher than it was pre-Pandemic, but it has declined since peaking in March 2022 after increasing steadily since March 2021.[52]

[51] UPMC, "Financial Results and System Highlights Calendar Year 2021," February 28, 2022.
[52] UPMC Q3 Financials as of September 20, 2022.

Table 9: UPMC Insurance Services Financials Summary, 2018-2021

UPMC Insurance Services (million $), 2018-2021				
	2018	2019	2020	2021
Revenue	$ 9,005	$ 10,523	$ 12,288	$ 12,987
Growth	17.1%	16.9%	16.8%	5.7%
Operating Income	$ 140	$ 13	$ 418	$ 185
Margin	1.6%	0.1%	3.4%	1.4%
Adj. Operating EBITDA	$ 169	$ 28	$ 433	$ 196
Margin	1.9%	0.3%	3.5%	1.5%

Source: Highmark Health Audited 2021 Financial Statements, April 2022

Notes: 2019 and 2018 figures may not tie to figures originally reported due to reclassifications and adoption of Accounting Standards Update ("ASU") 2017-07.
In 2019, ~$212M of expenditures related to academic and research support provided to the University were reclassified to a separate line item in the were Consolidated Statements of Operations and Changes in Net Assets.In 2018, some net assets with donor restrictions reclassified to net assets without donor restrictions. 2020 Operating Income included ~$380M of grants from the CARES Act; (1) Reported on a consolidated basis only; (2) Includes Gain (Loss) from Investing and Financing Activities of ($367M), $374M, $232M, and $810M from 2018 to 2021, respectively.

Other Competitors

In addition to UPMC, there is an increased presence of national insurers in Pennsylvania and WPA marketplace. UnitedHealthcare, Aetna, and Cigna have continued to increase membership since 2013 and post-2017, potentially due to the competitive conditions imposed under the 2013 Order, and the former elimination of the UPMC-Highmark 10-year contract that opened up more competition from these third parties. This implies that the vertical transaction with the Conditions had no adverse effect on the ability of other insurers to compete in the market, but these conditions may be partly responsible for Highmark's declining share. Although both UPMC and Highmark have increased their variety of product offerings since 2017, potential increased competition from other BCBSA insurers may provide additional insurance choices for plan enrollees in the near future, opening up more direct competition among BCBSA members.

III. HEALTHCARE DELIVERY MARKETS

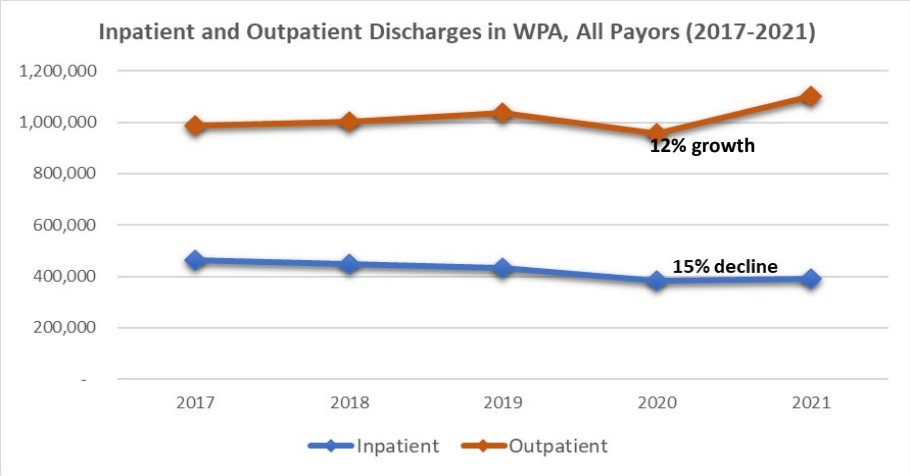
As a baseline for this assessment, at the time of the 2013 affiliation of Highmark with WPAHS, UPMC was the predominant hospital system with over 45% share of inpatient discharges and continues to be vertically integrated into insurance and physician services. Financial difficulties over a prolonged period had weakened WPAHS as a competitor, affecting its investments in facilities and resources, and its perceived quality of service. Insurers, including Highmark and other competitors viewed a stronger WPAHS as the primary future constraint on UPMC and would provide needed bargaining power in contracting with UPMC. We determined that Highmark's affiliation with WPAHS, including the substantial investment and capital Highmark intended to convey to the health system, would change the competitive dynamics and provide WPA consumers a viable competitive alternative to UPMC.

A. Changes in the relevant markets for healthcare services in WPA since 2017

1. General trends 2017-2022

Since 2017, overall inpatient discharges in WPA have declined significantly. The number of hospital inpatient discharges declined from 461,977 in 2017 to 392,044 in 2021, a decline of 15% or 4.0% on average per year (Figure 6). From 2012 to 2016 the decline was 2.2% or 0.6% on average per year. Outpatient discharges in WPA increased from 984,910 in 2017 to 1,102,820 in 2021, a 12% growth or a 2.9% CAGR (Compound Annual Growth Rate). The growth in outpatient discharges was the highest between 2020 and 2021 at 15%, likely due to the surge in telehealth use which accelerated the move to outpatient care. Commercially insured patient discharges followed a similar trend between 2017 and 2021, with a 14% decline in commercial inpatient and a 5% increase in commercial outpatient discharges.

Figure 6: Inpatient and Outpatient Discharges in 29 County WPA, All Payors, 2017-2021



Source: Pennsylvania Health Care Cost Containment Council (PHC4) Discharge data

Figure 6 shows inpatient discharges were declining between 2017 and 2019 before the Pandemic which caused a further sharper decline in 2020. Inpatient discharges increased slightly in 2021 but remained below the pre-Pandemic trend. Similarly, outpatient discharges were increasing slightly between 2017 and 2019, declined sharply in 2020 due to the Pandemic, but increased even more sharply in 2021, thus returning the upward momentum back to pre-Pandemic trend levels.

These trends follow the general nationwide shift away from inpatient care to outpatient settings. A 2022 American Hospital Association report using 2019 data showed a narrowing gap between

inpatient and outpatient revenue as more patients choose to seek care in outpatient settings.[53] Some of the factors driving this shift in care include more innovations in medical technology requiring less invasive procedures which can take place in an outpatient setting, and a growth in ambulatory surgery centers ("ASCs"). This shift is expected to accelerate by 2023 as CMS expands on ASCs' capabilities and allows more inpatient-only procedures (such as certain orthopaedic and cardiac procedures) to be done in hospital-based outpatient departments or ambulatory surgery centers.

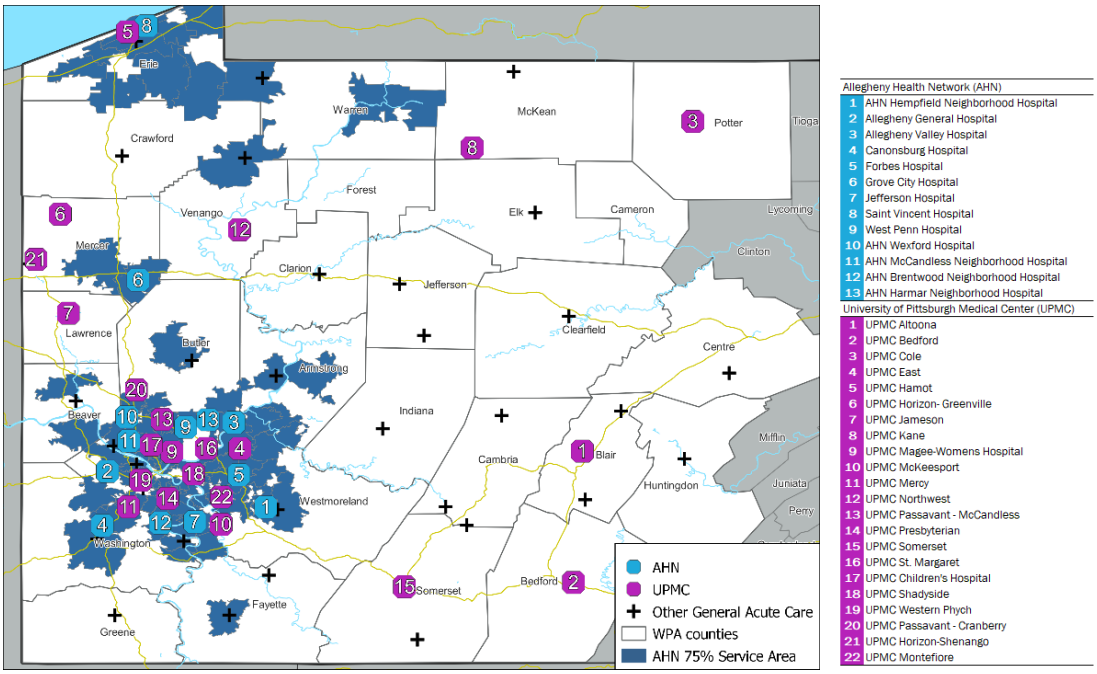
2. Impact of the 2013 Order

The 2013 Order has maintained competition in WPA, resulting in AHN as a viable competitor in comparison to the financially troubled WPAHS that existed prior to its affiliation with Highmark. Since 2017, the competitive dynamics in WPA continued to evolve in the healthcare delivery market, with UPMC and AHN competing against one another to attract patients. Both AHN and UPMC have built out their networks with new hospitals and outpatient facilities, acquired hospitals, and expanded reach across the Commonwealth. During this period, rural and community hospitals in the area have continued to face financial challenges as admissions fall. To maintain their viability, a significant number of these hospitals have merged with other hospitals or have been acquired by UPMC and others.

The report's market share analysis aims to assess whether AHN is a viable and sustainable competitor against UPMC. We measure the competitiveness of these two systems by looking at their presence in AHN's 75% service area. UPMC possesses a significant presence within AHN's service area due to the geographic overlap of the two systems. Figure 7 shows AHN's 75% service area, defined as the zip codes from which 75% of AHN hospital discharges originate.

[53] As above, this is based on 2019 data, which would not have been influenced by COVID-19. In our view, this is more relevant than data that was generated during the pandemic. See American Hospital Association. "Trendwatch Chartbook 2021: Trends Affecting Hospitals and Health Systems." Chart 4.2: Distribution of Inpatient vs. Outpatient Revenues in Community Hospitals, 1995-2020. https://www.aha.org/system/files/media/file/2022/11/2021-Trendwatch-Chartbook-PDF.pdf. American Hospital Association. Additional future trends in outpatient care and shifts are noted in L. Gillespie, "Forecast: Care is moving out of hospitals over next decade", Modern Healthcare, June 4, 2021. Date accessed: 12/1/2022. https://www.modernhealthcare.com/hospital-systems/forecast-care-moving-out-hospitals-over-next-decade, and Sg2, "2021 Impact of Change® Forecast Highlights: COVID-19 Recovery and Impact on Future Utilization." (June 2, 2021). https://newsroom.vizientinc.com/content/1221/files/Documents/2021_PR_ImpactOfChange.pdf.

Figure 7: AHN Hospital Network 75% Service Area



For all payor discharges, UPMC's share of discharges was 45.8% in 2017 and increased to 48.1% in 2021, although total volume of UPMC discharges declined during this period (Table 10). AHN's share was 27% in 2017, increased to 27.3% in 2018 and 2019 prior to the Pandemic, then declined to 26.8% in 2020 and 2021. Excluding community hospitals acquired by UPMC or AHN, all other community hospital inpatient discharges in this area collectively declined from 27.2% in 2017 to 25.1% in 2021.

Table 10: Discharge Shares in AHN's 75% Service Area – All Services, All Payors, 2017-2021

Discharge Share in AHN's 75% Service Area- All Services, All Payors, 2017-2021										
Hospital	Discharge 2017	Share 2017	Discharge 2018	Share 2018	Discharge 2019	Share 2019	Discharge 2020	Share 2020	Discharge 2021	Share 2021
Total	**223,193**	**100.0%**	**217,488**	**100.0%**	**208,659**	**100.0%**	**186,080**	**100.0%**	**191,089**	**100.0%**
UPMC	102,178	45.8%	101,680	46.8%	97,734	46.8%	89,445	48.1%	91,869	48.1%
UPMC Presbyterian Shadyside	27,101	12.1%	27,042	12.4%	25,117	12.0%	22,562	12.1%	22,846	12.0%
UPMC Magee-Womens Hospital	13,972	6.3%	13,602	6.3%	14,976	7.2%	14,500	7.8%	15,292	8.0%
UPMC Hamot	13,819	6.2%	13,430	6.2%	13,470	6.5%	12,810	6.9%	13,352	7.0%
UPMC Mercy	11,096	5.0%	11,158	5.1%	9,783	4.7%	8,968	4.8%	9,030	4.7%
UPMC Passavant	10,644	4.8%	10,515	4.8%	10,124	4.9%	8,911	4.8%	8,567	4.5%
UPMC Children's Hospital of Pittsburgh	5,993	2.7%	6,604	3.0%	6,694	3.2%	5,591	3.0%	6,705	3.5%
UPMC East	6,725	3.0%	6,927	3.2%	6,680	3.2%	6,222	3.3%	6,245	3.3%
UPMC St. Margaret	7,138	3.2%	6,841	3.1%	6,142	2.9%	5,691	3.1%	5,594	2.9%
UPMC McKeesport	4,719	2.1%	4,529	2.1%	3,804	1.8%	3,269	1.8%	3,080	1.6%
UPMC Horizon	434	0.2%	393	0.2%	305	0.1%	282	0.2%	348	0.2%
Select Specialty Hospital - Pittsburgh/UPMC	156	0.1%	165	0.1%	183	0.1%	185	0.1%	339	0.2%
UPMC Northwest	198	0.1%	227	0.1%	206	0.1%	211	0.1%	192	0.1%
UPMC Jameson	98	0.0%	139	0.1%	148	0.1%	152	0.1%	162	0.1%
UPMC Altoona	38	0.0%	46	0.0%	48	0.0%	45	0.0%	55	0.0%
UPMC Other	47	0.0%	62	0.0%	54	0.0%	46	0.0%	62	0.0%
AHN	60,296	27.0%	59,281	27.3%	56,896	27.3%	49,844	26.8%	51,288	26.8%
Allegheny General Hospital	14,332	6.4%	13,858	6.4%	13,786	6.6%	12,515	6.7%	12,585	6.6%
Jefferson Hospital	11,123	5.0%	10,899	5.0%	9,989	4.8%	8,789	4.7%	8,989	4.7%
West Penn Hospital	9,187	4.1%	9,933	4.6%	9,781	4.7%	8,754	4.7%	8,743	4.6%
Forbes Hospital	10,595	4.7%	10,525	4.8%	9,642	4.6%	8,207	4.4%	8,323	4.4%
Saint Vincent Hospital	9,110	4.1%	8,667	4.0%	9,074	4.3%	7,539	4.1%	8,140	4.3%
Allegheny Valley Hospital	3,614	1.6%	3,363	1.5%	2,951	1.4%	2,430	1.3%	2,358	1.2%
Canonsburg Hospital	1,551	0.7%	1,304	0.6%	1,100	0.5%	957	0.5%	1,075	0.6%
AHN Hempfield Neighborhood Hospital	-	0.0%	-	0.0%	-	0.0%	133	0.1%	576	0.3%
Grove City Hospital	784	0.4%	732	0.3%	573	0.3%	520	0.3%	499	0.3%
Heritage Valley	11,499	5.2%	10,701	4.9%	9,770	4.7%	8,391	4.5%	8,200	4.3%
Heritage Valley Beaver	4,117	1.8%	3,819	1.8%	3,841	1.8%	3,440	1.8%	3,525	1.8%
Heritage Valley Sewickley	4,695	2.1%	4,491	2.1%	4,010	1.9%	3,592	1.9%	3,265	1.7%
Heritage Valley Kennedy	2,617	1.2%	2,294	1.1%	1,844	0.9%	1,274	0.7%	1,318	0.7%
Curahealth Heritage Valley	70	0.0%	97	0.0%	75	0.0%	85	0.0%	92	0.0%
Excela	9,123	4.1%	9,016	4.1%	8,988	4.3%	7,785	4.2%	7,750	4.1%
Excela Health Westmoreland Hospital	7,913	3.5%	7,925	3.6%	7,944	3.8%	6,836	3.7%	6,758	3.5%
Excela Health Latrobe Hospital	1,028	0.5%	948	0.4%	925	0.4%	836	0.4%	851	0.4%
Excela Health Frick Hospital	182	0.1%	143	0.1%	119	0.1%	113	0.1%	141	0.1%
Washington Health System	5,872	2.6%	5,392	2.5%	4,943	2.4%	4,656	2.5%	4,669	2.4%
Penn Highlands	3,328	1.5%	2,904	1.3%	2,535	1.2%	2,367	1.3%	2,459	1.3%
LECOM	1,553	0.7%	1,503	0.7%	1,419	0.7%	945	0.5%	897	0.5%
Meadville Medical Center	824	0.4%	686	0.3%	636	0.3%	484	0.3%	664	0.3%
DHL	50	0.0%	27	0.0%	37	0.0%	39	0.0%	50	0.0%
Other	28,470	12.8%	26,298	12.1%	25,701	12.3%	22,124	11.9%	23,243	12.2%

Source: PHC4 Discharge Data.
Note: Excludes MDCs 19 and 20 and DRGS 795, 945, and 946. Limited to patients residing in (zip codes) AHN's 75% Service Area within the 29 County WPA.

Similarly, inpatient discharges for commercial payors followed the same trend (Table 11). UPMC discharge shares increased from 45.3% in 2017 to 51.3% in 2021. AHN shares declined from 29.7% to 27.5% during this period. Community hospitals, excluding those acquired by UPMC or AHN, faced a more pronounced decrease in this area, a decline from 25.0% in 2017 to 21.3% in 2021.

Table 11: Discharge Shares in AHN's 75% Service Area – All Services, Commercial Payors, 2017-2021

Discharge Share in AHN's 75% Service Area- All Services, Commercial Payors, 2017-2021										
Hospital	Discharge 2017	Share 2017	Discharge 2018	Share 2018	Discharge 2019	Share 2019	Discharge 2020	Share 2020	Discharge 2021	Share 2021
Total	**62,479**	**100.0%**	**61,414**	**100.0%**	**59,365**	**100.0%**	**53,292**	**100.0%**	**54,149**	**100.0%**
UPMC	28,324	45.3%	29,135	47.4%	28,941	48.8%	27,296	51.2%	27,756	51.3%
UPMC Magee-Womens Hospital	6,087	9.7%	6,248	10.2%	7,628	12.8%	7,628	14.3%	8,180	15.1%
UPMC Presbyterian Shadyside	6,495	10.4%	6,639	10.8%	6,163	10.4%	5,819	10.9%	5,588	10.3%
UPMC Hamot	4,258	6.8%	4,120	6.7%	3,917	6.6%	3,778	7.1%	3,836	7.1%
UPMC Children's Hospital of Pittsburgh	2,490	4.0%	2,949	4.8%	3,028	5.1%	2,596	4.9%	3,058	5.6%
UPMC Passavant	2,405	3.8%	2,490	4.1%	2,540	4.3%	2,348	4.4%	2,147	4.0%
UPMC Mercy	3,002	4.8%	3,100	5.0%	2,321	3.9%	1,890	3.5%	1,855	3.4%
UPMC East	1,278	2.0%	1,348	2.2%	1,356	2.3%	1,328	2.5%	1,270	2.3%
UPMC St. Margaret	1,330	2.1%	1,286	2.1%	1,190	2.0%	1,174	2.2%	1,083	2.0%
UPMC McKeesport	716	1.1%	655	1.1%	537	0.9%	476	0.9%	406	0.7%
UPMC Horizon	133	0.2%	136	0.2%	86	0.1%	101	0.2%	136	0.3%
UPMC Northwest	53	0.1%	70	0.1%	65	0.1%	65	0.1%	72	0.1%
Select Specialty Hospital - Pittsburgh/UPMC	37	0.1%	30	0.0%	39	0.1%	28	0.1%	64	0.1%
UPMC Jameson	18	0.0%	33	0.1%	43	0.1%	45	0.1%	34	0.1%
UPMC Altoona	12	0.0%	16	0.0%	11	0.0%	10	0.0%	11	0.0%
UPMC Other	10	0.0%	15	0.0%	17	0.0%	10	0.0%	16	0.0%
AHN	18,528	29.7%	18,054	29.4%	17,304	29.1%	14,734	27.6%	14,879	27.5%
West Penn Hospital	4,831	7.7%	5,134	8.4%	5,153	8.7%	4,551	8.5%	4,507	8.3%
Allegheny General Hospital	4,399	7.0%	4,187	6.8%	3,902	6.6%	3,382	6.3%	3,348	6.2%
Jefferson Hospital	2,882	4.6%	2,859	4.7%	2,626	4.4%	2,273	4.3%	2,326	4.3%
Forbes Hospital	3,163	5.1%	3,047	5.0%	2,764	4.7%	2,289	4.3%	2,243	4.1%
Saint Vincent Hospital	2,176	3.5%	1,808	2.9%	2,075	3.5%	1,548	2.9%	1,735	3.2%
Allegheny Valley Hospital	529	0.8%	546	0.9%	409	0.7%	374	0.7%	324	0.6%
Canonsburg Hospital	267	0.4%	215	0.4%	173	0.3%	165	0.3%	189	0.3%
AHN Hempfield Neighborhood Hospital	-	0.0%	-	0.0%	-	0.0%	25	0.0%	124	0.2%
Grove City Hospital	281	0.4%	258	0.4%	202	0.3%	127	0.2%	83	0.2%
Heritage Valley	2,741	4.4%	2,539	4.1%	2,275	3.8%	1,977	3.7%	1,696	3.1%
Heritage Valley Sewickley	1,455	2.3%	1,419	2.3%	1,228	2.1%	1,099	2.1%	773	1.4%
Heritage Valley Beaver	860	1.4%	765	1.2%	769	1.3%	678	1.3%	729	1.3%
Heritage Valley Kennedy	424	0.7%	349	0.6%	276	0.5%	195	0.4%	181	0.3%
Curahealth Heritage Valley	2	0.0%	6	0.0%	2	0.0%	5	0.0%	13	0.0%
Excela	1,993	3.2%	1,964	3.2%	1,931	3.3%	1,697	3.2%	1,834	3.4%
Excela Health Westmoreland Hospital	1,796	2.9%	1,789	2.9%	1,763	3.0%	1,544	2.9%	1,670	3.1%
Excela Health Latrobe Hospital	175	0.3%	165	0.3%	155	0.3%	146	0.3%	149	0.3%
Excela Health Frick Hospital	22	0.0%	10	0.0%	13	0.0%	7	0.0%	15	0.0%
Washington Health System	1,091	1.7%	978	1.6%	887	1.5%	854	1.6%	891	1.6%
The Washington Hospital	1,087	1.7%	976	1.6%	887	1.5%	852	1.6%	891	1.6%
Washington Health System Greene	4	0.0%	2	0.0%	-	0.0%	2	0.0%	-	0.0%
Penn Highlands	723	1.2%	631	1.0%	389	0.7%	262	0.5%	288	0.5%
LECOM	235	0.4%	256	0.4%	220	0.4%	198	0.4%	218	0.4%
Meadville Medical Center	288	0.5%	248	0.4%	201	0.3%	93	0.2%	134	0.2%
DHL	14	0.0%	12	0.0%	19	0.0%	19	0.0%	25	0.0%
Other	8,542	13.7%	7,597	12.4%	7,198	12.1%	6,162	11.6%	6,428	11.9%

Source: PHC4 Discharge Data.
Note: Excludes MDCs 19 and 20 and DRGS 795, 945, and 946. Limited to patients residing in (zip codes) AHN's 75% Service Area within the 29 County WPA.

While commercial inpatient discharges declined since 2017, publicly insured inpatient discharges stayed relatively consistent or slightly increased for UPMC and AHN (Table 12). This indicates that the overall decline in discharges for these systems in the WPA was largely driven by the decline in commercial inpatient discharges.

Table 12: Discharge Share in AHN's 75% Service Area- All Services, Government Payors, 2017-2021

Discharge Share in AHN's 75% Service Area- All Services, Government Payors, 2017-2021										
Hospital	Discharge 2017	Share 2017	Discharge 2018	Share 2018	Discharge 2019	Share 2019	Discharge 2020	Share 2020	Discharge 2021	Share 2021
Medicare Total	**115,441**	**100.0%**	**112,997**	**100.0%**	**108,371**	**100.0%**	**93,781**	**100.0%**	**95,924**	**100.0%**
UPMC	46,978	40.7%	47,328	41.9%	45,074	41.6%	39,474	42.1%	40,301	42.0%
AHN	32,979	28.6%	32,465	28.7%	31,277	28.9%	26,675	28.4%	27,747	28.9%
Community Hospitals	35,484	30.7%	33,204	29.4%	32,020	29.5%	27,632	29.5%	27,876	29.1%
Medicare Advantage Total	**65,537**	**100.0%**	**65,740**	**100.0%**	**62,445**	**100.0%**	**55,405**	**100.0%**	**58,412**	**100.0%**
UPMC	26,126	39.9%	27,446	41.7%	25,772	41.3%	23,207	41.9%	24,300	41.6%
AHN	19,540	29.8%	19,504	29.7%	18,814	30.1%	16,267	29.4%	17,248	29.5%
Community Hospitals	19,871	30.3%	18,790	28.6%	17,859	28.6%	15,931	28.8%	16,864	28.9%
Medicaid Total	**36,329**	**100.0%**	**35,359**	**100.0%**	**34,335**	**100.0%**	**32,213**	**100.0%**	**33,345**	**100.0%**
UPMC	21,481	59.1%	21,015	59.4%	20,941	61.0%	19,610	60.9%	20,460	61.4%
AHN	7,451	20.5%	7,576	21.4%	7,202	21.0%	7,084	22.0%	7,125	21.4%
Community Hospitals	7,397	20.4%	6,768	19.1%	6,192	18.0%	5,519	17.1%	5,760	17.3%

Source: PHC4 Discharge Data.
Note: Excludes MDCs 19 and 20 and DRGS 795, 945, and 946. Limited to patients residing in (zip codes) AHN's 75% Service Area within the 29 County WPA.

Table 13 provides a more comprehensive overview of the growth/decline in inpatient discharge shares in the Greater Pittsburgh Area, by service offerings. Overall, there was a 15% decrease in the total volume of inpatient discharges since 2017. This decline is consistent across a majority of the Major Diagnostic Categories (MDCs), except for respiratory services (MDC 4), newborn services (MDC 15), and trauma services (MDC 24). Total UPMC shares increased by 1.8 percentage points during this time, while total AHN shares remained relatively constant, and other hospitals' shares decreased by 2 percentage points. However, these changes vary substantially at the service level. Between 2017 and 2021, despite overall volume declines, UPMC gained shares for most of the service lines. AHN and community hospitals lost shares to UPMC. AHN gained relative shares from UPMC for a few services such as respiratory services (MDC 4), burns (MDC 22), and factors influencing health status (MDC 23). Both AHN and UPMC gained significant shares for female reproductive, pregnancy, and newborn services (MDC 13,14,15). AHN West Penn continued to have high volumes in female reproductive and newborn services during this time and was named highest-rated hospital for OB-GYN care by U.S. News & World Report.[54] UPMC Magee-Women's Hospital, known for its reputation for most complex OB care,[55] also experienced large share gains for reproductive, pregnancy, and newborn services.

[54] Highmark Health Mid-Year 2022 Financials, August 30, 2022. #1 in Pittsburgh, #2 in PA, #31 in US.
[55] Financial Results and Systems Highlights First Six Months. August 23,2022.

Table 13: Share of Inpatient Discharges by MDC, Greater Pittsburgh Area, 2017-2021

Discharges Share by MDC and Hospital, 2017-2021, Greater Pittsburgh Area													
MDC	MDC Description	Total Volume 2017	AHN (Total) Share 2017	UPMC (Total) Share 2017	Other (Total) Shares 2017	Total Volume 2021	AHN (Total) Share 2021	UPMC (Total) Share 2021	Other (Total) Shares 2021	% Change Total Volume 2017-2021	AHN % Point Change (2017-2021)	UPMC % Point Change (2017-2021)	Other % Point Change (2017-2021)
	Total	**274,619**	**23%**	**42%**	**35%**	**233,044**	**23%**	**44%**	**33%**	**-15.1%**	**0.2%**	**1.8%**	**-2.0%**
1	Nervous System	23,031	26%	45%	30%	19,394	25%	48%	26%	-15.8%	-0.5%	3.8%	-3.3%
2	Eye	432	18%	68%	14%	293	17%	72%	11%	**-32.2%**	-1.6%	4.4%	-2.9%
3	Ear, Nose, Mouth, And Throat	2,893	21%	56%	22%	1,821	19%	65%	17%	**-37.1%**	-2.5%	8.3%	-5.7%
4	Respiratory System	32,595	21%	38%	41%	34,200	22%	37%	41%	4.9%	1.1%	-1.0%	-0.1%
5	Circulatory System	42,385	23%	37%	40%	34,698	23%	37%	40%	-18.1%	-0.1%	0.3%	-0.2%
6	Digestive System	25,989	22%	43%	35%	20,535	21%	45%	34%	**-21.0%**	-1.4%	2.1%	-0.7%
7	Hepatobiliary System and Pancreas	8,825	22%	45%	33%	7,458	23%	45%	32%	-15.5%	1.0%	-0.3%	-0.7%
8	Musculoskeletal System and Connective Tissue	36,861	22%	42%	35%	26,048	19%	46%	34%	**-29.3%**	-3.0%	3.8%	-0.8%
9	Skin, Subcutaneous Tissue, and Breast	8,030	22%	41%	37%	4,401	21%	46%	33%	**-45.2%**	-1.4%	5.1%	-3.7%
10	Endocrine, Nutritional, and Metabolic System	10,266	21%	44%	35%	10,121	20%	45%	35%	-1.4%	-1.5%	0.8%	0.7%
11	Kidney and Urinary Tract	14,974	21%	42%	38%	12,204	19%	42%	40%	-18.5%	-1.9%	0.4%	1.6%
12	Male Reproductive System	1,060	21%	43%	36%	779	12%	54%	34%	**-26.5%**	-8.9%	10.4%	-1.5%
13	Female Reproductive System	1,913	29%	40%	31%	1,311	38%	46%	16%	**-31.5%**	8.7%	6.1%	-14.8%
14	Pregnancy, Childbirth, and Puerperium	23,788	27%	44%	29%	21,758	31%	48%	21%	-8.5%	3.8%	3.7%	-7.5%
15	Newborn and Other Neonates	8,351	21%	53%	27%	9,473	27%	55%	18%	13.4%	6.0%	2.6%	-8.6%
16	Blood and Blood Forming Organs and Immunological Disorder	4,265	21%	49%	30%	3,231	19%	49%	32%	**-24.2%**	-2.1%	-0.1%	2.2%
17	Myeloproliferative Diseases and Disorders	2,888	23%	67%	11%	2,529	25%	66%	9%	-12.4%	2.9%	-0.9%	-2.0%
18	Infectious and Parasitic Diseases and Disorders	16,697	19%	34%	47%	14,768	22%	36%	42%	-11.6%	2.8%	2.3%	-5.1%
21	Injuries, Poison, and Toxic Effect of Drugs	4,527	21%	53%	26%	3,483	20%	57%	23%	**-23.1%**	-1.2%	4.4%	-3.2%
22	Burns	241	29%	67%	5%	180	43%	56%	2%	**-25.3%**	14.1%	-11.2%	-2.9%
23	Factors Influencing Health Status	3,696	21%	44%	35%	2,966	22%	42%	36%	-19.8%	1.0%	-2.6%	1.6%
24	Multiple Significant Trauma	720	44%	49%	6%	850	39%	55%	5%	18.1%	-4.9%	6.0%	-1.1%
25	Human Immunodeficiency Virus (HIV) Infection	133	33%	50%	17%	93	25%	60%	15%	**-30.1%**	-8.4%	10.6%	-2.2%

Source: PHC4 Discharge Data.

Notes:

Greater Pittsburgh Area includes Allegheny, Armstrong, Beaver, Butler, Fayette, Washington, and Westmoreland counties.

Totals include diagnoses that could not be classified to an MDC.

Red shading in the "% Change Total Volume 2017-2021" column indicates % changes of less than or greater than 20%.

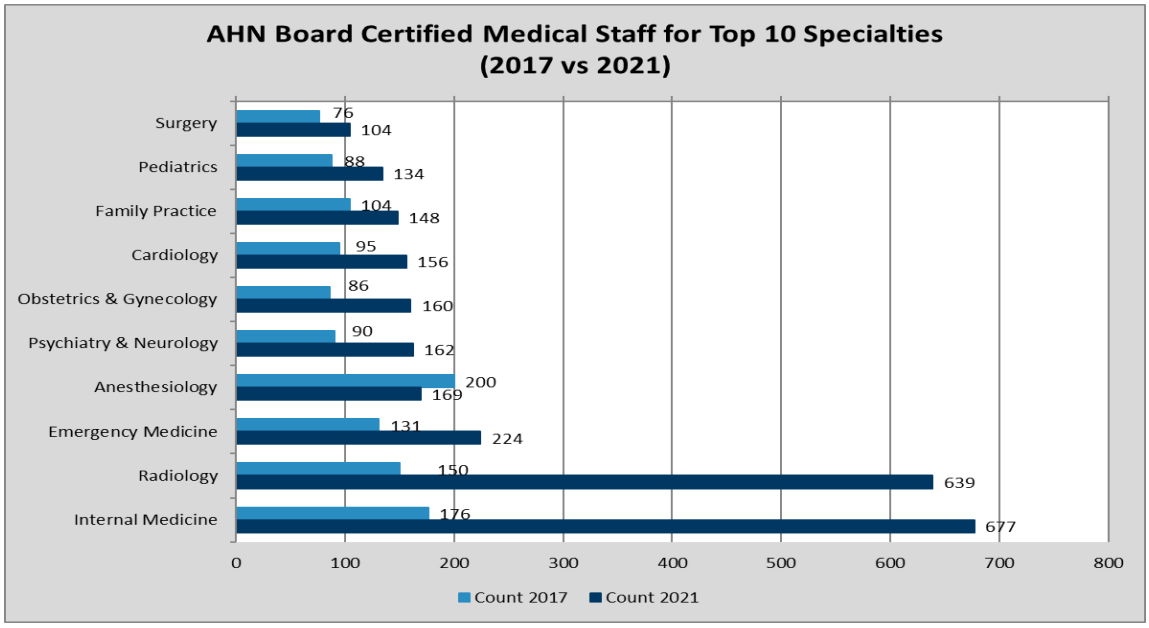
Green/Red shading in the AHN, UPMC, and Other Hospitals % point change columns indicate % point increases/decreases of 1% or more.

UPMC Western Psychiatric Hospital and Select Specialty UPMC are included in the 'UPMC (Total)'

B. Provision of physician services in WPA since 2017

As part of Highmark's initiative to implement an integrated delivery network to better serve residents and enhance AHN's ability to compete more effectively in the WPA market, Highmark added board certified medical staff to its physician network to manage care and meet the demand for general and more specialized healthcare services more effectively. Figure 8 shows the growth in AHN's board certified active medical staff for key specialties. Apart from anaesthesiology, AHN has significantly expanded its network of medical practitioners, including emergency medicine, internal medicine, radiology, OB/GYNs, and cardiology.

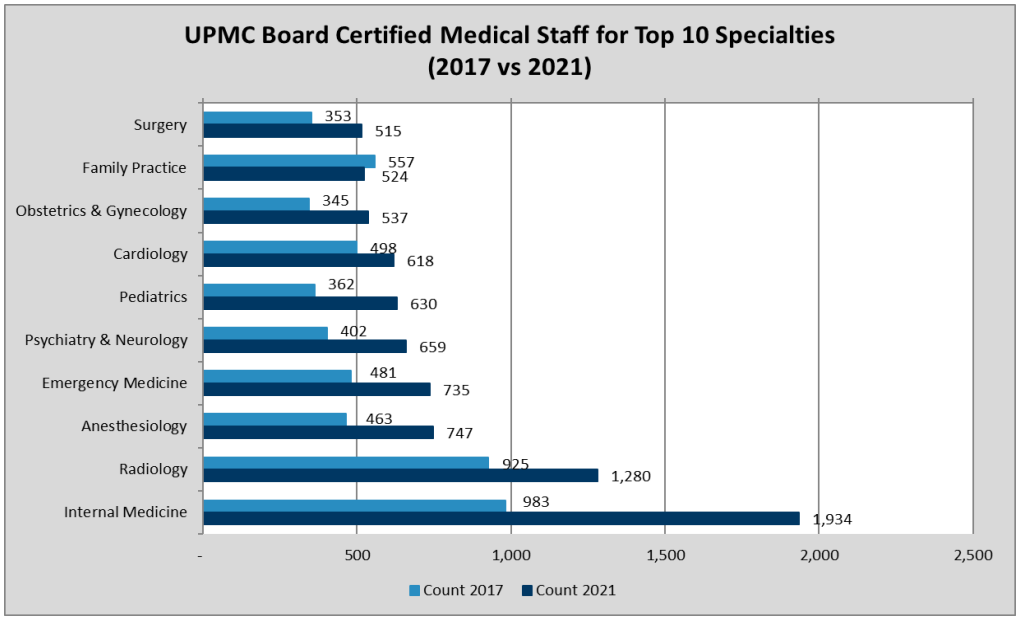
Figure 8: AHN Board Certified Medical Staff for Top 10 Specialties (2017 vs. 2021)



Source: "Active Medical Staff with Clinical Privileges" PA.gov (https://www.health.pa.gov/topics/HealthStatistics/HealthFacilities/HospitalReports/)
Note: AHN Hempfield, Brentwood, and Harmar Neighborhood hospitals are not reported in PA.gov medical staff reports.
It is possible for medical staff to have clinical privileges in more than one specialty. Therefore, totals may be higher than actual number of active medical staff.

Similarly, UPMC remains a leading integrated provider-insurer and continued to support its workforce during this time. UPMC also expanded its medical staff network since 2017, with the largest growth in internal medicine, pediatricians, anesthesiology, and psychiatry and neurology (Figure 9).

Figure 9: UPMC Board Certified Medical Staff for Top 10 Specialties (2017 vs. 2021)



Source: "Active Medical Staff with Clinical Privileges" PA.gov
(https://www.health.pa.gov/topics/HealthStatistics/HealthFacilities/HospitalReports/)
Note: UPMC Western Psych and UPMC Montefiore are not reported in PA.gov medical staff reports. UPMC Children's data is not reported for 2017.
It is possible for medical staff to have clinical privileges in more than one specialty. Therefore, totals may be higher than actual number of active medical.

C. Entry, expansion, and capacity for healthcare services in WPA due to structural changes from a merger or affiliation

Capacity and Utilization for Healthcare Services in WPA

Overall, the utilization for healthcare services (admissions, patient care days, and total length of stay) declined between 2017 and 2021 in WPA (Table 14 and Table 15). Some of this decline may be explained by the shift of care from the inpatient hospital setting to hospital-based and non-hospital-based outpatient settings. Moreover, the financial challenges faced by hospitals as admissions fell since 2017, as well as the added impact of the Pandemic resulted in a number of community hospitals merging with or being acquired by other hospitals. For instance, Heritage Valley acquired Ohio Valley Hospital in 2019, a 124-bed not-for-profit hospital, renamed Heritage Valley Kennedy. Uniontown Hospital joined the WVU Health System in 2020. Penn Highlands acquired J.C. Blair Memorial Hospital (renamed as Penn Highlands Huntingdon) in 2019 and Penn Highlands Tyrone in 2020. More recently, Highlands Hospital joined Penn Highlands Healthcare in 2021, as the eighth hospital in Penn Highlands Healthcare System. Butler and Excela health systems announced their merger in 2022 and completed the transaction in 2023. Structural changes associated with AHN and UPMC hospitals are discussed in the following section.

Total licensed beds in the WPA declined by 165, while staffed beds also decreased by 854.[56] AHN added 229 licenced beds from 2017 to 2021, but also decreased their staffed beds by 231. UPMC, Excela, Duke LifePoint, Heritage Valley, Penn Highlands, and LECOM had increases in the number of licensed beds, whereas Washington Health, Meadville Medical Center, and Steward Health Care had decreases in licensed beds. Excela, Duke LifePoint, Penn Highlands, Meadville Medical Center, and LECOM had increases in total staffed beds, whereas UPMC, Heritage Valley, Washington Health, and Upper Allegheny Health had decreases in beds staffed.

Practitioners generally consider an occupancy rate in the range of 80-85% to be full capacity. Hospitals must maintain some flexibility in capacity to meet unexpected peaks in demand. The overall occupancy rate for WPA was 60.5% in 2017 and increased to 62.5% in 2020, still indicating excess bed capacity to meet demand. UPMC maintained a healthy 74%-77% occupancy rate during the period. AHN's occupancy rate increased by 4.8 percentage points as the additional beds met demands. Excela Health and Washington Health System had occupancy rates close to the WPA average in 2017 (60s to mid-60s). All hospitals except AHN and UPMC had occupancy rates below the WPA average in 2021. Although many hospital systems removed or repurposed general acute care beds during this period, similar to the 2012 to 2015 period, the WPA still remains an over-bedded healthcare market for inpatient services since 2017.

Table 14: 2017 Hospital Capacity and Utilization, 29 County WPA[57]

2017 Hospital Capacity and Utilization (29 County WPA) Sorted by Licensed Beds								
System	Hospital Count	Licensed Beds	Staffed Beds	Admissions	Total Length of Stay	Patient Care Days	Bed Days Available	Occupancy Rate
Total	**61**	**12,078**	**10,833**	**474,289**	**2,385,395**	**2,384,734**	**3,943,092**	**60.5%**
UPMC	13	4,478	3,785	179,047	1,026,209	1,022,984	1,380,715	74.1%
AHN	7	2,214	2,110	87,452	441,298	445,401	770,150	57.8%
Excela	3	576	425	23,944	100,132	100,413	155,125	64.7%
Duke LifePoint Healthcare	4	563	539	20,545	99,449	95,235	195,285	48.8%
Heritage Valley	2	461	461	20,388	86,930	86,930	168,265	51.7%
Penn Highlands	4	339	331	13,794	63,165	62,008	126,387	49.1%
Washington Health System	2	309	255	13,485	54,910	56,511	93,120	60.7%
Meadville Medial Center	2	242	199	8,960	43,121	43,199	74,590	57.9%
Steward Health Care System	1	220	183	7,354	34,503	34,568	66,795	51.8%
LECOM	2	164	164	4,787	30,134	29,893	59,860	49.9%
Upper Allegheny Health System	1	107	87	2,910	14,472	14,912	31,755	47.0%
Other	20	2,405	2,294	91,623	391,072	392,680	821,045	47.8%

Source: Pennsylvania Department of Health Hospital Reports 2017
Note: Occupancy rates were calculated using Patient Care Days divided by Bed Days Available.
UPMC Cole and Somerset were not part of the UPMC system in 2017.

[56] Licensed beds are the total number of beds approved by a hospital's licensing agency. Staffed beds are those licensed beds that are "set up and staffed" so that patient care may be provided in those beds. Often, a hospital has more licensed beds than are actually staffed due to demand considerations or reduced financial ability to staff all licensed beds.

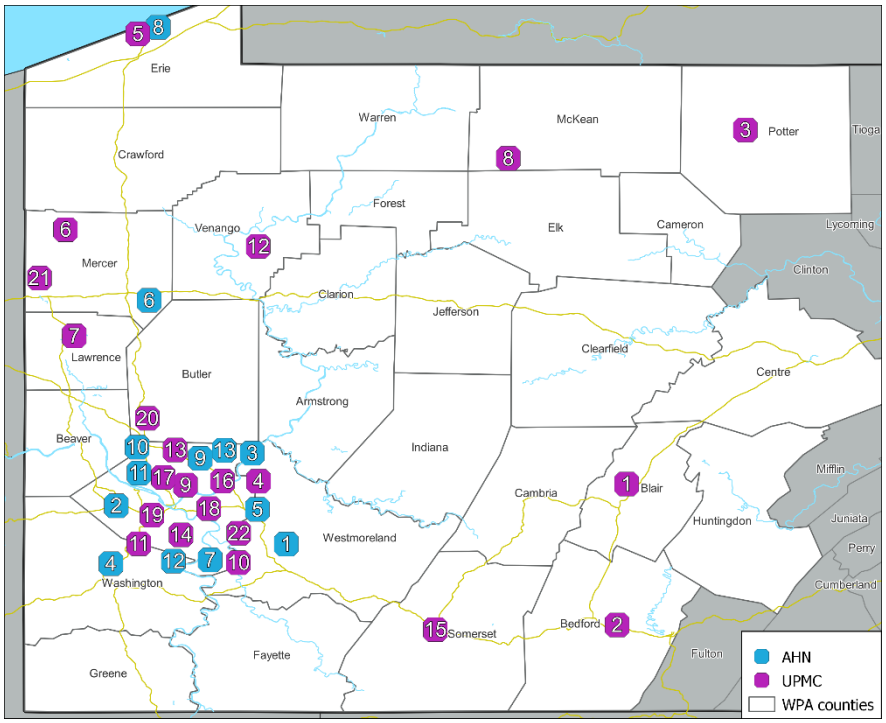
[57] Note the admissions data listed in this figure are sourced from the Pennsylvania Department of Health Hospital Reports and may differ slightly from the data provided by Highmark.

Table 15: 2021 Hospital Capacity and Utilization, 29 County WPA[58]

2021 Hospital Capacity and Utilization (29 County WPA) Sorted by Licensed Beds								
System	Hospital Count	Licensed Beds	Staffed Beds	Admissions	Total Length of Stay	Patient Care Days	Bed Days Available	Occupancy Rate
Total	**61**	**11,913**	**9,979**	**389,760**	**2,300,173**	**2,282,192**	**3,680,236**	**62.5%**
UPMC	15	4,481	3,732	156,101	1,046,722	1,040,408	1,357,644	77.1%
AHN	10	2,443	1,879	75,159	431,872	436,301	690,427	62.6%
Excela	3	578	469	21,257	99,607	98,164	171,185	58.2%
Duke LifePoint Healthcare	4	599	573	16,743	88,479	88,542	209,145	42.3%
Heritage Valley	3	565	402	17,519	86,386	86,386	146,730	58.9%
Penn Highlands	7	683	613	19,504	114,435	113,713	224,148	51.1%
Washington Health System	2	301	216	9,559	42,705	35,653	78,687	54.3%
Meadville Medial Center	2	225	225	6,828	39,278	38,081	82,125	47.8%
Steward Health Care System	1	163	163	6,376	35,175	31,730	59,495	59.1%
LECOM	2	191	191	4,246	30,563	29,448	69,715	43.8%
Upper Allegheny Health System	1	107	29	1,428	10,018	10,018	39,055	25.7%
Other	11	1,577	1,487	55,040	274,933	273,748	551,880	49.8%

Source: Pennsylvania Department of Health Hospital Reports Data 2021
Note: The hospital list is restricted to general acute care hospitals.
Penn Highlands Clearfield and Ellwood City Medical Center were not present in the 2021 Pennsylvania Department of Health Hospital Reports (Closed in 2020).
New AHN hospitals included in 2021 Pennsylvania Department of Health Hospital Reports include AHN Westmoreland and AHN Wexford.
Occupancy rates were calculated using Total Length of Stay divided by Bed Days Available.

Figure 10: Overlap of AHN and UPMC Hospitals



Allegheny Health Network (AHN)	
1	AHN Hempfield Neighborhood Hospital
2	Allegheny General Hospital
3	Allegheny Valley Hospital
4	Canonsburg Hospital
5	Forbes Hospital
6	Grove City Hospital
7	Jefferson Hospital
8	Saint Vincent Hospital
9	West Penn Hospital
10	AHN Wexford Hospital
11	AHN McCandless Neighborhood Hospital
12	AHN Brentwood Neighborhood Hospital
13	AHN Harmar Neighborhood Hospital

University of Pittsburgh Medical Center (UPMC)	
1	UPMC Altoona
2	UPMC Bedford
3	UPMC Cole
4	UPMC East
5	UPMC Hamot
6	UPMC Horizon- Greenville
7	UPMC Jameson
8	UPMC Kane
9	UPMC Magee-Womens Hospital
10	UPMC McKeesport
11	UPMC Mercy
12	UPMC Northwest
13	UPMC Passavant - McCandless
14	UPMC Presbyterian
15	UPMC Somerset
16	UPMC St. Margaret
17	UPMC Children's Hospital
18	UPMC Shadyside
19	UPMC Western Phych
20	UPMC Passavant - Cranberry
21	UPMC Horizon-Shenango
22	UPMC Montefiore

[58] Note the admissions data listed in this figure are sourced from the Pennsylvania Department of Health Hospital Reports and may differ slightly from the data provided by Highmark.

As reported by the Pennsylvania Department of Health Hospital Reports, the occupancy rates for UPMC and AHN systems increased by 3.0 and 4.7 percentage points, respectively between 2017 and 2021. Although AHN and UPMC had steady increases overall, occupancies for individual hospitals differ substantially (Table 16). AHN's flagship hospital, Allegheny General Hospital's occupancy rate was around 66% over this period, indicating that it is operating below the full capacity threshold (80-85%). AHN West Penn Hospital's occupancy rate was over 90% in 2021, indicating full, or even over, capacity. The occupancy rates at AHN's other hospitals mostly increased or stayed constant between 2017 and 2021, except for Forbes Hospital (-2.2 percentage points). Grove City Medical Center, which was recently acquired by AHN in 2019, had an occupancy rate of 28.3% in 2021, a 7.9 percentage point increase since the acquisition.

Within the UPMC system, the majority of the hospitals, including UPMC's flagship hospital show healthy occupancy rates in the 70s or above. Distant UPMC hospitals such as Cole, Horizon, Kane, and Bedford have the lowest occupancy rates.

Table 16: 2017 and 2021 Hospital Capacity and Utilization for AHN and UPMC, WPA

Facility	County	Licensed Beds 2017	Admissions 2017	Patient Care Days 2017	Occupancy Rate 2017	Licensed Beds 2021	Admissions 2021	Patient Care Days 2021	Occupancy Rate 2021	Occupancy Rate Change 17/21
AHN		**2,214**	**87,452**	**445,401**	**57.8%**	**2,443**	**75,159**	**436,301**	**62.6%**	**4.7%**
AHN HEMPFIELD NEIGHBORHOOD HOSPITAL	Westmoreland	-	-	-	0.0%	40	749	2,707	37.1%	0.0%
ALLEGHENY GENERAL HOSPITAL	Allegheny	576	24,562	130,123	65.9%	524	20,279	123,412	66.0%	0.1%
AHN WEXFORD HOSPITAL	Allegheny	-	-	-	0.0%	160	898	3,163	12.2%	0.0%
ALLEGHENY VALLEY HOSPITAL	Allegheny	190	5,461	26,414	59.8%	188	3,614	23,477	86.3%	26.5%
CANONSBURG HOSPITAL	Washington	104	2,205	9,489	25.0%	104	1,619	10,547	45.2%	20.2%
FORBES HOSPITAL	Allegheny	315	13,966	76,497	66.5%	315	11,244	70,107	64.3%	-2.2%
GROVE CITY MEDICAL CENTER	Mercer	89	1,454	5,067	20.4%	67	1,039	3,749	28.3%	7.9%
JEFFERSON HOSPITAL	Allegheny	341	14,341	68,763	55.2%	341	11,879	62,334	66.4%	11.2%
SAINT VINCENT HOSPITAL	Erie	371	13,785	64,510	47.6%	348	12,002	64,531	49.3%	1.7%
WEST PENN HOSPITAL	Allegheny	317	13,132	69,605	60.2%	356	11,836	72,274	90.6%	30.4%
UPMC		**4,478**	**179,047**	**1,022,984**	**74.1%**	**4,481**	**156,101**	**1,040,408**	**77.1%**	**3.0%**
UPMC ALTOONA	Blair	368	20,113	87,719	69.5%	398	17,086	94,621	75.6%	6.1%
UPMC BEDFORD	Bedford	40	1,713	4,914	47.1%	40	1,273	5,092	58.7%	11.6%
UPMC COLE	Potter	59	1,864	7,458	55.6%	49	1,348	5,357	56.2%	0.6%
UPMC EAST	Allegheny	155	8,166	40,618	71.8%	155	7,490	47,759	84.3%	12.5%
UPMC HAMOT	Erie	423	20,197	92,355	78.0%	458	19,210	106,779	79.6%	1.6%
UPMC HORIZON	Mercer	158	5,384	21,453	51.1%	116	4,249	11,228	52.3%	1.2%
UPMC JAMESON	Lawrence	192	5,109	24,196	65.0%	146	4,782	25,153	76.2%	11.2%
UPMC KANE	McKean	31	528	2,038	18.0%	31	311	1,331	26.0%	8.0%
UPMC MCKEESPORT	Allegheny	219	7,292	45,677	68.0%	204	5,423	41,012	75.0%	7.0%
UPMC MERCY	Allegheny	495	18,881	121,730	73.8%	435	14,911	114,954	78.9%	5.1%
UPMC NORTHWEST	Venango	158	5,522	27,640	47.9%	167	6,111	28,944	64.1%	16.2%
UPMC PASSAVANT HOSPITAL	Allegheny	423	15,893	79,805	74.3%	423	14,049	83,473	74.8%	0.5%
UPMC SHADYSIDE	Allegheny	1,566	59,026	418,995	82.9%	1,511	48,462	411,026	80.8%	-2.1%
UPMC SOMERSET	Somerset	111	2,660	12,480	34.9%	98	2,671	14,651	71.7%	36.8%
UPMC ST MARGARET	Allegheny	250	11,223	55,844	73.6%	250	8,725	49,028	73.7%	0.1%

Hospitals with < 50% occupancy rate
Hospitals with >80% occupancy rate

Source: Pennsylvania Department of Health Hospital Reports 2017 and 2021
Note: Total 2017 UPMC figures do not include UPMC Cole or UPMC Somerset (acquisitions took place post-2017).
Total 2017 AHN figures do not include Grove City (acquisition took place post-2017).
2017 occupancy rates were calculated using Patient Care Days divided by Bed Days Available.
2021 occupancy rate were calculated using Total Length of Stay divided by Bed Days Available.
AHN Health Network and UPMC Health System Developments

Since the 2013 Order, AHN and its affiliates have improved its service offerings to be a more effective competitor to UPMC and other providers in the WPA. AHN continues to be a strong competitor of UPMC and has continued to expand care delivery and outreach in the area post-2017. UPMC has also been investing significant resources to expand its presence in Pennsylvania. Since 2017, AHN and UPMC both increased their footprint in the WPA area. UPMC had three acquisitions in WPA since 2017: Somerset Hospital, located in Somerset, Pennsylvania, in February 2019; Cole Memorial hospital which partnered with UPMC Susquehanna and merged with the UPMC system in March 2018; and Kane in April 2017.[59] In 2019, AHN acquired Grove City Medical Center to improve facilities and services in Grove City and Mercer County. AHN also opened a new neighborhood hospital in 2019, AHN Hempfield Neighborhood Hospital, and three additional neighborhood sites in 2020, McCandless Neighborhood Hospital, Brentwood Neighborhood Hospital, and Harmar Neighborhood Hospital. Additionally, in September 2021, AHN opened a new hospital, AHN Wexford Hospital, an all-private 160-bed hospital located in Wexford, which brought a new state-of-the-art labor and delivery unit to Pittsburgh North Hills for the first time in decades.[60]

AHN's most recent care delivery expansions include:

- North Fayette Township AHN Health & Wellness Pavilion includes AGN Center for Reproductive Medicine, behavioral health, primary care, and diagnostic imaging
- New Outpatient facility in Uniontown, Fayette County
- Announced plans for AHN Seneca Valley Outpatient Center which opened on August 8th, 2022
- $11 million expansion of Richard G. Laube Cancer Center at Armstrong County Memorial Hospital
- Montour Health + Sports Medicine Center to open 2022 (still under construction)
- $14 million facility at AHN to house Melanoma and Skin Center at West Penn Hospital opens in early 2022
- St. Vincent Hospital opened a new outpatient behavioral health practice on August 8th, 2022

[59] Other UPMC acquisitions outside of the 29-county WPA post-2017 are as follows: September 2017, Pinnacle Health, a seven-hospital system in South Central Pennsylvania, merged with UPMC and concurrently merged with Hanover Hospital; Lockhaven acquired and merged into UPMC Susquehanna in October 2017; February 3, 2020, Western Maryland Health System became the first Maryland hospital to join the UPMC system.

[60] Highmark Health Year-End 2021 Financials, March 22, 2022.

- AHN West Penn named top maternity hospital by U.S. News & World Report (#1 in Pittsburgh, #2 in PA, #31 in U.S.)
- AHN Gamma pod breast cancer innovation launched

UPMC Health System's most recent expansion of care delivery in WPA and the whole of Pennsylvania include:

- Pittsburgh and Southwest PA
    - Broke ground on new vision and rehabilitation tower at UPMC Mercy
    - UPMC Memorial—opened August 2019 with 35% more space than former facility in York PA; expanded specialty services; adjacent OP center
    - $1 billion investment in Life Sciences
    - UMPC Presbyterian broke ground on a $1.5 billion expansion in June 2022 and is expected to be completed by spring 2023
- Central PA
    - UPMC West Shore—expanding hospital with additional patient floors, emergency department with behavioral health, new operating rooms, additional ICU beds, in Cumberland County
    - UPMC Children's Hospital of Pittsburgh extending services in central PA with behavioral health program, care coordination, expectant parent education, lactation consulting
    - UPMC Outpatient Center in Hershey, in central PA set to open in November 2022
    - 44,000-square-foot UPMC Outpatient Center- 2020 Technology Parkway recently opened in September 2022
- Northwestern PA and Southwest NY
    - Constructing UPMC Hamot's new Patient Tower, seven-story patient tower will include more intensive care unit beds and an expanded imaging unit
    - Expanding Magee-Women's Research Institute to Erie, creating new biomedical commercialization and translational research lab at Penn State's Behrend's Knowledge Park. First expansion outside of Pittsburgh
    - Opened new Women's and Maternity Care Center and Adolescent and Adult Mental Health IP units at UPMC Chautauqua
- Altoona, Bedford, Somerset
    - UPMC Somerset—investing $45 million over 10 years to enhance services and upgrade facilities, including establishing specialty consultation program, adding primary care center, and recruiting/retaining medical staff
    - UPMC Hillman Cancer Center reopened from a $15 million renovation in September 2022

  - UPMC Western Behavioral Health at Twin Lakes $16 million expansion to increase beds by 60% by 2023

- Northcentral PA
  - Broke ground in 2019 on new $13 million UPMC Hillman Cancer Center in Williamsport
  - Kidney evaluation clinic in Williamsport to support transplants in Pittsburgh

AHN and UPMC Financial Trends

AHN has experienced a growth in revenues over time. AHN revenues increased by 6.9% in 2018 and 8.7% in 2019. Although revenues had a slower growth in 2020 (only 2.1%), there was a sharp increase of 10.3% in 2021 (Table 17). Despite the growth in revenues, AHN's operating expenses increased substantially during the Pandemic. These cost pressures were common across the sector nationally,[61] likely due to the continued effects of COVID-19, along with labor and supply conditions resulting in cost growth in employment, staffing, and other operating expenses in excess of revenue growth. As a result, AHN's operating losses were $118 million by 2021, substantially below operating income levels achieved prior to the Pandemic.

Table 17: AHN Key Financial Statistics

AHN Financial Statistics, 2017-2021 (Dollars in Millions)					
	2017	2018	2019	2020	2021
Revenue	$ 3,071	$ 3,285	$ 3,571	$ 3,645	$ 4,020
Growth	*N/A*	*6.9%*	*8.7%*	*2.1%*	*10.3%*
Operating Income	$ 30	$ 39	$ 23	$ (171)	$ (118)
Adjusted Operating EBITDA	$ 172	$ 183	$ 182	$ 11	$ 85
Excess of Revenue over Expenses before Tax	$ 49	$ 5	$ 98	$ (124)	$ (65)

Source: AHN Financial Reporting compiled by Raymond James, August 2021 and April 2022.

D. Inpatient and Observation Volume at AHN by Payor

Through its most recent 2021 Condition 14 reporting, Highmark has provided data on inpatient and observation volume at AHN by payor and insurance type. Table 18 shows these data for 2020 and 2021 and the year-to-year percentage change for commercial, Medicaid, Medicare, and other inpatient and observation volume.

[61] National Hospital Flash Report, August 2022. Date accessed: 12/1/2022. https://www.kaufmanhall.com/sites/default/files/2022-09/KH-NHFR-2022-08_FINAL_9.2.22.pdf. While we note the overall labor cost trends and adverse impact on healthcare delivery systems, further analysis of competition in WPA healthcare labor markets was beyond the intended scope of this report.

Table 18: Inpatient and Observation Volume at AHN by Payor and Insurance Type, 2020-2021

Insurance Company	Year	Period Ending December 31 Commercial	Medicaid	Medicare	Other	Total	Share of AHN Volume
All AHN	2020	34,210	16,992	55,685	5,604	112,491	100%
	2021	36,729	18,419	59,979	3,305	118,432	100%
	% change	**7%**	**8%**	**8%**	**-41%**	**5%**	
HIGHMARK	2020	23,097		15,121		38,218	34%
	2021	24,628		15,582		40,210	34%
	% change	**7%**		**3%**		**5%**	
UPMC	2020	1,033	5,013	2,310		8,356	7%
	2021	1,159	5,957	3,043		10,159	9%
	% change	**12%**	**19%**	**32%**		**22%**	
AETNA	2020	3,404	1,350	9,708		14,462	13%
	2021	3,313	1,710	11,017		16,040	14%
	% change	**-3%**	**27%**	**13%**		**11%**	
CIGNA	2020	1,174				1,174	1%
	2021	1,323		2		1,325	1%
	% change	**13%**				**13%**	
GATEWAY	2020		4,963	3,144		8,107	7%
	2021		5,423	3,343		8,766	7%
	% change		**9%**	**6%**		**8%**	
UNITED_HEALTHCARE	2020	1,798	1,857	3,128		6,783	6%
	2021	1,925	1,964	4,071		7,960	7%
	% change	**7%**	**6%**	**30%**		**17%**	
GOVERNMENT	2020		1,932	20,172		22,104	20%
	2021		1,619	20,022		21,641	18%
	% change		**-16%**	**-1%**		**-2%**	
SELF_PAY	2020				1,203	1,203	1%
	2021				1,275	1,275	1%
	% change				**6%**	**6%**	
OTHER	2020	3,704	1,877	2,102	4,401	12,084	11%
	2021	4,381	1,746	2,899	2,030	11,056	9%
	% change	**18%**	**-7%**	**38%**	**-54%**	**-9%**	

Source: Highmark Condition 14 report, March 25, 2022.

These data show an increase in commercial, Medicaid and Medicare volumes at AHN between 2020 and 2021. The 5% increase in total inpatient and observation volume from 2020 to 2021 reflects a moderate increase from the lowest Pandemic hospital volumes. The decline in Other is likely due to a shift from some uninsured in the Other category to Medicaid coverage through revised eligibility standards under the CARES Act. The data indicate increases in commercial patient volumes from UPMC, Aetna, Cigna, and UnitedHealthcare members significantly above volumes reported in 2016.[62] Commercial volumes are critical to AHN as Medicaid, Medicare and Other insurance types typically reimburse below cost of service. The largest 2020-2021 increase in payor volumes at AHN was UPMC insured members with increases in commercially insured, Medicaid, and Medicare member plans.

[62] Gateway was partially owned by Highmark until September 2021 when Highmark acquired the remaining share. It has since rebranded Gateway to be Highmark Wholecare, which provides Medicaid and Medicare plans. Highmark acquired 355,000 members with the Gateway acquisition. Highmark Wholecare's array of BCBS and BS plans were offered across the Commonwealth beginning January 1, 2022.

E. Highmark/AHN's effect on the status of community hospitals

Rural and community hospitals have not fared well in recent years and even at the time of the 2013 Order. Prior to 2013, Highmark had a history of investing funds in community hospitals, many of which are now affiliated with Highmark, such as Jefferson, Saint Vincent and WPAHS. Highmark's strategic vision for its IDN included continued investment in community hospitals, although at the time, it did not identify what those investments would be, or which hospitals would receive funding. In its initial Form A filing, Highmark's Strategic Vision stated that "community hospitals play a central role in Highmark's envisioned network as they both (a) provide a lower-cost and more convenient site of care for many policyholders and subscribers who have secondary and tertiary healthcare needs and (b) serve as a focal point for investing in education and training programs."[63] Highmark expected to enter into relationships with these community hospitals which will include: (1) shared vision for aligning care providers in a market, (2) shared investment in new care protocols and operating models, (3) joint investment in outpatient assets, (4) more incentive based reimbursement contracts, and (5) integration into a single HIE platform.[64]

These community hospitals in public comments raised legitimate economic concerns on the potential implications of patient volume flow and location of care re-alignment in the Pittsburgh area. Hospital admissions are a zero-sum game in that inpatients can only consume inpatient hospital services at one location per admission.

Since 2010, nearly 90 rural hospitals have shut their doors and by one estimate, hundreds of other rural hospitals are at risk of doing so.[65]

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[63] Highmark's Strategic Plan, Amendment No. 1 to Confidential Supplement (Volume II) Submitted with Form A, Tab 2 at 14.

[64] Highmark's Strategic Plan, Amendment No. 1 to Confidential Supplement (Volume II) Submitted with Form A at Tab 2 at 15.

[65] "A Sense of Alarm as Rural Hospitals Keep Closing," New York Times, October 29, 2018. In its June report to Congress, the Medicare Payment Advisory Commission found that of the 67 rural hospitals that closed since 2013, about one-third were more than 20 miles from the next closest hospital. A study published in Health Affairs found that over half of rural counties now lack obstetric services. Hung, Peiyin, Carrie E. Henning-Smith, Michelle M. Casey, and Katy B. Kozhimannil. "Access to obstetric services in rural counties still declining, with 9 percent losing services, 2004–14." *Health Affairs* 36, no. 9 (2017): 1663-1671. Another study, published in Health Services Research by researchers from the University of Minnesota, showed that such closures increase the distance pregnant women must travel for delivery. Hung, Peiyin, Katy B. Kozhimannil, Michelle M. Casey, and Ira S. Moscovice. "Why are obstetric units in rural hospitals closing their doors?." *Health services research* 51, no. 4 (2016): 1546-1560. See, also American Hospital Association. "Rural Hospital Closures Threaten Access: Solutions to Preserve Care in Local Communities." *American Hospital Association* (Sept. 2022). Date accessed: May 22, 2023. https://www.aha.org/system/files/media/file/2022/09/rural-hospital-closures-threaten-access-report.pdf.

Moreover, hospitals may have closed for financial reasons that affected their ability to provide proper levels of care. This may include a cycle of underfunding that adversely affects quality of care or results in decreases in services provided. This dynamic may subsequently result in associated declines in discharges which further adds to hospital's financial woes and can lead to their closure.

Hospitals nationwide closed 2019 with an uptick in margin results. Multiple factors contributed to the increases, including higher volumes and revenues, despite increases in Bad Debt and Charity care and mixed performance on expenses. The Pandemic reversed these positive trends. Community and rural hospitals were especially affected by the low volumes and cancellation of services during the Pandemic. Initial funding through the CARES Act protected hospital profitability. However, CARES funding was distributed based on patient revenues so the largest hospitals in the U.S. received a disproportionate amount of CARES funding which left many smaller community and rural hospitals without adequate funding. Moreover, once funding was cut back, these hospitals have borne the cost burden of delivering the Pandemic care as well as the failure of prior volumes of patient activity returning.

Table 19: Financial Status of Rural Hospitals in WPA, October 2022

Financial Status of Rural Hospitals in Western Pennsylvania							
Hospital	**City**	**State**	**Closed?**	**Closure Year**	**Inpatient Beds**	**Patient Services Margin**	**Total Margin**
UPMC Kane	Kane	PA	Open		26	-64.9%	-9.5%
Ellwood City Medical Center	Ellwood City	PA	Closed	2019	56	-16.6%	2.3%
LECOM Health Corry Memorial Hospital	Corry	PA	Open		20	-14.9%	6.3%
Washington Health System Greene	Waynesburg	PA	Open		69	-7.7%	0.0%
Titusville Hospital	Titusville	PA	Open		21	-7.4%	7.2%
Chan Soon- Shiong Medical Center at Windber	Windber	PA	Open		48	-7.1%	-6.6%
UPMC Jameson	New Castle	PA	Open		123	-6.4%	-12.9%
Grove City Medical Center	Grove City	PA	Open		60	-5.9%	-1.7%
Warren General Hospital	Warren	PA	Open		69	-4.3%	9.2%
UPMC Horizon	Greenville	PA	Open		157	-2.3%	-12.1%
Penn Highlands Brookville	Brookville	PA	Open		35	-2.1%	28.2%
Conemaugh Miners Medical Center	Hastings	PA	Open		25	-1.8%	1.7%
Penn Highlands Huntingdon	Huntingdon	PA	Open		62	-1.4%	1.9%
Conemaugh Meyersdale Medical Center	Meyersdale	PA	Open		20	-1.2%	4.5%
UPMC Cole	Coudersport	PA	Open		25	-0.9%	1.6%
ACMH Hospital	Kittanning	PA	Open		123	-0.7%	6.3%
Clarion Hospital	Clarion	PA	Open		60	2.8%	3.5%
Punxsutawney Area Hospital	Punxsutawney	PA	Open		35	2.9%	8.4%
UPMC Somerset	Somerset	PA	Open		103	3.3%	8.8%
Penn Highlands Elk	Saint Marys	PA	Open		28	4.9%	11.4%
Indiana Regional Medical Center	Indiana	PA	Open		166	5.0%	5.5%
Penn Highlands Dubois	Dubois	PA	Open		191	5.5%	8.7%
UPMC Northwest	Seneca	PA	Open		90	6.7%	-3.1%
UPMC Bedford Memorial	Everett	PA	Open		45	13.2%	-1.7%
Butler Memorial Hospital	Butler	PA	Open		266	13.3%	9.3%
Meadville Medical Center	Meadville	PA	Open		189	13.4%	6.3%
Edgewood Surgical Hospital	Transfer	PA	Open		10	38.4%	17.9%
Philipsburg Area Hospital	Philipsburg	PA	Closed	2006	25		
Data Sources: CMS Provider of Services and Hospital Cost Report files; as of October 2022; Closure status from Cecil G. Sheps Center for Health Services Research							

The affiliation of Highmark with AHN raised concerns that Highmark would favor AHN over community hospitals which might competitively and financially disadvantage these hospitals from competing with AHN and UPMC. Under Condition 21 of the 2013 Order, Highmark must provide an assessment of the impact of its IDN Strategy on the viability of competing independent

community hospitals in WPA to monitor whether the ability of community hospitals in WPA to effectively compete for patients in WPA has been limited or improved on a year-to-year basis.

According to the PHC4 data, the share of Highmark member inpatient discharges from non-Highmark or non-UPMC owned community hospitals decreased (36.3% in 2017 to 35.1% in 2021), in addition to volume decreases in Highmark membership and total discharges (43,320 discharges in 2017 versus 28,738 discharges in 2021) (Table 20). The decrease in community hospital inpatient discharges is equivalent to a 34% decline between 2017 and 2021. This decline is consistent with decreases in the overall, UPMC, and AHN inpatient discharges for Highmark members in WPA –31%, 30%, and 28% respectively. Despite an overall decline in shares, UPMC gained Highmark members in 2020 and 2021 due to its mid-2019 contract with Highmark.

Similarly, Highmark commercial plan members' inpatient discharges declined during this period as well. The independent (non-AHN or non-UPMC owned) community hospitals experienced a 25% decline, with 18,228 discharges in 2017 and 13,623 discharges in 2021 (Table 22). The overall commercial discharges for Highmark members also decreased by 20% in this period, and AHN had a 30% decline. UPMC discharges for Highmark commercial plan members increased overall, with a significant increase in 2020 and 2021, likely due to its 2019 contract with Highmark.

As part of its IDN strategy, Highmark identified eight community hospitals as facilities for "aligned secondary care." These included Heritage Valley, Washington Health, St. Clair Memorial Hospital, Excela Health, and Butler Memorial Hospital. These AHN IDN community hospitals also had a drop in inpatient discharges between 2017 and 2021, like the rest of the providers in WPA.

Based on PHC4 data post-2017, it is our view that Highmark members have likely continued to remain loyal to community hospitals instead of shifting to AHN hospitals, enabling these hospitals to maintain their ability to compete for inpatient admissions. If this were not the case, we would expect to see an increase in discharges for Highmark members at AHN hospitals during this time. However, since the 2019 UPMC-Highmark contract, the discharge volumes and shares at UPMC increased significantly in 2020-2021, while discharges declined at community hospitals and AHN hospitals, indicating that this contract may have resulted in more Highmark members shifting to UPMC facilities to receive care. Overall, there was a decrease in Highmark member discharges collectively across all WPA providers, similar to all members inpatient discharges in the area (Figure 6).

In its most recent Condition 21 report, Highmark reported that net decreases in Highmark member overall inpatient acute admissions at these community hospitals between 2013 and 2021 was not materially attributable to Highmark Health's affiliation with WPAHS (now AHN) or implementation of the IDN Strategy. Highmark's claims are consistent with our analysis of PHC4 Highmark members discharge data between 2017 and 2021. However, our analysis finds that some community hospitals' Highmark member discharges may be shifting to UPMC facilities

commensurate with Highmark's most recent contract with UPMC. The Condition 21 results from Highmark's submission are further discussed in Section IV.A.

Table 20: Discharge Shares for Highmark Members at Community Hospitals, All Highmark Plans, 29 County WPA, 2017-2021

IP Discharge Share for Highmark Members- All Services, All Payors, 2017-2021										
Hospital	Discharge 2017	Share 2017	Discharge 2018	Share 2018	Discharge 2019	Share 2019	Discharge 2020	Share 2020	Discharge 2021	Share 2021
Total	**119,205**	**100.0%**	**104,541**	**100.0%**	**88,993**	**100.0%**	**81,608**	**100.0%**	**81,987**	**100.0%**
UPMC	35,555	29.8%	30,830	29.5%	22,236	25.0%	23,428	28.7%	24,925	30.4%
AHN	34,728	29.1%	31,037	29.7%	28,902	32.5%	25,575	31.3%	24,864	30.3%
Community Hospitals Total	**43,320**	**36.3%**	**38,651**	**37.0%**	**34,002**	**38.2%**	**29,525**	**36.2%**	**28,738**	**35.1%**
Excela	6,882	5.8%	6,611	6.3%	6,145	6.9%	5,286	6.5%	5,253	6.4%
Excela Health Westmoreland Hospital	4,438	3.7%	4,359	4.2%	4,073	4.6%	3,511	4.3%	3,361	4.1%
Excela Health Latrobe Hospital	1,958	1.6%	1,822	1.7%	1,632	1.8%	1,422	1.7%	1,450	1.8%
Excela Health Frick Hospital	486	0.4%	430	0.4%	440	0.5%	353	0.4%	442	0.5%
Heritage Valley	7,987	6.7%	6,939	6.6%	5,628	6.3%	5,200	6.4%	4,710	5.7%
Heritage Valley Beaver	4,157	3.5%	3,581	3.4%	3,021	3.4%	2,804	3.4%	2,711	3.3%
Heritage Valley Sewickley	2,809	2.4%	2,509	2.4%	2,030	2.3%	1,921	2.4%	1,528	1.9%
Heritage Valley Kennedy	1,021	0.9%	849	0.8%	577	0.6%	475	0.6%	471	0.6%
Penn Highlands	3,842	3.2%	3,561	3.4%	3,337	3.7%	2,960	3.6%	2,909	3.5%
Penn Highlands DuBois	1,541	1.3%	1,548	1.5%	1,621	1.8%	1,429	1.8%	1,383	1.7%
Penn Highlands Mon Valley	1,350	1.1%	1,077	1.0%	854	1.0%	912	1.1%	946	1.2%
Other	951	0.8%	936	0.9%	862	1.0%	619	0.8%	580	0.7%
DHL	3,248	2.7%	2,908	2.8%	2,625	2.9%	2,235	2.7%	1,782	2.2%
Conemaugh Memorial Medical Center	2,751	2.3%	2,483	2.4%	2,212	2.5%	1,877	2.3%	1,488	1.8%
Conemaugh Nason Medical Center	464	0.4%	382	0.4%	365	0.4%	319	0.4%	232	0.3%
Conemaugh Miners Medical Center	33	0.0%	43	0.0%	48	0.1%	39	0.0%	62	0.1%
Washington Health System	2,755	2.3%	2,300	2.2%	1,816	2.0%	1,735	2.1%	1,738	2.1%
The Washington Hospital	2,622	2.2%	2,192	2.1%	1,734	1.9%	1,665	2.0%	1,670	2.0%
Washington Health System Greene	133	0.1%	108	0.1%	82	0.1%	70	0.1%	68	0.1%
Meadville Medical Center	1,375	1.2%	1,162	1.1%	1,008	1.1%	846	1.0%	1,114	1.4%
Meadville Medical Center	1,240	1.0%	1,072	1.0%	914	1.0%	776	1.0%	1,027	1.3%
Titusville Area Hospital	135	0.1%	90	0.1%	94	0.1%	70	0.1%	87	0.1%
LECOM	406	0.3%	389	0.4%	317	0.4%	204	0.2%	208	0.3%
Millcreek Community Hospital	361	0.3%	342	0.3%	284	0.3%	165	0.2%	158	0.2%
LECOM Health Corry Memorial Hospital	45	0.0%	47	0.0%	33	0.0%	39	0.0%	50	0.1%
Other Community Hospitals	16,825	14.1%	14,781	14.1%	13,126	14.7%	11,059	13.6%	11,024	13.4%
St. Clair Hospital	4,822	4.0%	4,237	4.1%	4,667	5.2%	4,171	5.1%	4,216	5.1%
Butler Memorial Hospital	3,374	2.8%	3,214	3.1%	2,815	3.2%	2,124	2.6%	2,209	2.7%
Indiana Regional Medical Center	2,130	1.8%	1,777	1.7%	1,470	1.7%	1,405	1.7%	1,416	1.7%
ACMH Hospital	1,527	1.3%	1,221	1.2%	1,060	1.2%	815	1.0%	846	1.0%
Other Community Hospitals	4,972	4.2%	4,332	4.1%	3,114	3.5%	2,544	3.1%	2,337	2.9%
Other Total	5,602	4.7%	4,023	3.8%	3,853	4.3%	3,080	3.8%	3,460	4.2%

Source: PHC4 Discharge Data
Note: Excludes MDCs 19 and 20 and DRGS 795, 945, and 946.

For comparison, Table 21 below shows Highmark member discharges across all plans from certain community hospitals from 2012 through 2016. As the table above indicates, AHN's share of Highmark member discharges increased pre-Pandemic and fell at UPMC. However, about half of AHN's share increase switched back to favor UPMC in the period after the mid-2019 UPMC contract with Highmark.

Excela's share, as well as Excela Westmoreland Hospital's share, of Highmark member discharges increased from 2017 through 2019 (pre-Pandemic) and remained above its 2017 share. These shares were above those in the 2012-2016 period. This indicates that Excela has not been materially affected by Highmark's affiliation with AHN nor Highmark's recent contract with UPMC. This is similar for Washington Health where its share of Highmark member discharges has

fluctuated within a very narrow share range since 2012. For St. Clair, it has increased Highmark member discharges over the period and has gained a full percentage point increase in the 2018-2021 period. Similarly, Butler's share of Highmark member discharges also increased from its pre-transaction 2012 share of 2.2% although it has declined from its high of 3.2% achieved in 2019.

Heritage Valley's share of Highmark member discharges does not appear to have been materially affected by Highmark's affiliation as its share increased post-transaction, but it may have been materially affected by Highmark's most recent UPMC contract. Heritage Valley's share of Highmark member discharges in this most recent review period is above that which existed in the 2012-2016 period. Its share, however, has declined in the 2019 to 2021 period and the majority of lost discharges appear to be Highmark members (918 of 1,570 lost discharges).

Table 21: Discharge Shares for Highmark Members at Community Hospitals, All Highmark Plans, 29 County WPA, 2012-2016

Discharge Shares for Highmark Members at Community Hospitals, All Highmark Plans, 29 County WPA, 2012-2016										
Hospital	Discharges 2012	Shares 2012	Discharges 2013	Shares 2013	Discharges 2014	Shares 2014	Discharges 2015	Shares 2015	Discharges 2016 (Q1-Q3)	Shares 2016 (Q1-Q3)
Total Highmark Members	**170,088**	**100%**	**165,156**	**100%**	**155,810**	**100%**	**141,811**	**100%**	**101,579**	**100%**
Total (Community Hospitals)	**31,558**	**18.6%**	**29,830**	**18.1%**	**28,787**	**18.5%**	**25,890**	**18.3%**	**19,350**	**19.0%**
Heritage Valley	9,942	5.8%	9,290	5.6%	9,145	5.9%	8,121	5.7%	6,132	6.0%
Heritage Valley Beaver	5,868	3.4%	5,497	3.3%	5,432	3.5%	4,958	3.5%	3,767	3.7%
Heritage Valley Sewickley	3,950	2.3%	3,724	2.3%	3,660	2.3%	3,105	2.2%	2,314	2.3%
Kindred Hospital at Heritage Valley	124	0.1%	69	0.0%	53	0.0%	58	0.0%	51	0.1%
Washington Health	4,466	2.6%	4,036	2.4%	3,704	2.4%	3,344	2.4%	2,565	2.5%
Washington Hospital, The	4,068	2.4%	3,708	2.2%	3,485	2.2%	3,171	2.2%	2,425	2.4%
Washington Health System Greene	398	0.2%	328	0.2%	219	0.1%	173	0.1%	140	0.1%
Non-System Community Hospitals	17,150	10.1%	16,504	10.0%	15,938	10.2%	14,425	10.2%	10,653	10.5%
St. Clair Memorial Hospital	6,737	4.0%	6,705	4.1%	6,484	4.2%	5,429	3.8%	4,182	4.1%
Excela Health Westmoreland Regional Hospital	6,600	3.9%	5,874	3.6%	5,650	3.6%	5,288	3.7%	3,746	3.7%
Butler Memorial Hospital	3,813	2.2%	3,925	2.4%	3,804	2.4%	3,708	2.6%	2,725	2.7%
Non-Community Hospitals	138,530	81.4%	135,326	81.9%	127,023	81.5%	115,921	81.7%	82,229	81.0%

Source: PHC4 Discharge Data
Note: Excludes MDCs 19 and 20 and DRGS 795, 945, and 946. 2016 data contains only Q1-Q3 discharges. 2016 shares are annualized.

Looking specifically at Highmark's commercial plan member discharges, Table 22 shows Highmark member discharges under its commercial plans from 2017 through 2021 and Table 23 shows Highmark commercial plan member discharges only from certain community hospitals for the period 2012 through 2016. As Table 22 indicates, AHN's share of Highmark member discharges increased slightly pre-Pandemic and fell thereafter. UPMC's share of Highmark commercial member discharges has increased significantly since the mid-2019 contract between Highmark and UPMC. UPMC's share increased 7.2 percentage points in 2020 compared with 2019 and increased in absolute volume terms despite the Pandemic's overall negative impact on patient volumes during the 2020-2021 period. These data indicate that the 2019 UPMC/Highmark contract has resulted in higher share of Highmark members seeking care at UPMC facilities.

Table 22: Discharges Shares for Highmark Members at Community Hospitals, Highmark Commercial Plans, 29 County WPA, 2017-2021

IP Discharge Share for Highmark Members- All Services, Commercial Payors, 2017-2021										
Hospital	Discharge 2017	Share 2017	Discharge 2018	Share 2018	Discharge 2019	Share 2019	Discharge 2020	Share 2020	Discharge 2021	Share 2021
Total	**47,720**	**100.0%**	**41,349**	**100.0%**	**38,063**	**100.0%**	**36,920**	**100.0%**	**38,069**	**100.0%**
UPMC	11,146	23.4%	9,660	23.4%	7,972	20.9%	10,383	28.1%	11,934	31.3%
AHN	15,651	32.8%	13,833	33.5%	12,833	33.7%	11,464	31.1%	11,010	28.9%
Community Hospitals Total	**18,228**	**38.2%**	**16,230**	**39.3%**	**15,605**	**41.0%**	**13,741**	**37.2%**	**13,623**	**35.8%**
Excela	2,872	6.0%	2,766	6.7%	2,747	7.2%	2,611	7.1%	2,740	7.2%
Excela Health Westmoreland Hospital	2,097	4.4%	2,009	4.9%	1,948	5.1%	1,859	5.0%	1,904	5.0%
Excela Health Latrobe Hospital	630	1.3%	626	1.5%	625	1.6%	606	1.6%	652	1.7%
Excela Health Frick Hospital	145	0.3%	131	0.3%	174	0.5%	146	0.4%	184	0.5%
Heritage Valley	2,455	5.1%	2,213	5.4%	1,982	5.2%	1,807	4.9%	1,635	4.3%
Heritage Valley Beaver	1,081	2.3%	948	2.3%	894	2.3%	838	2.3%	885	2.3%
Heritage Valley Sewickley	1,146	2.4%	1,075	2.6%	954	2.5%	862	2.3%	613	1.6%
Heritage Valley Kennedy	228	0.5%	190	0.5%	134	0.4%	107	0.3%	137	0.4%
Penn Highlands	2,207	4.6%	1,960	4.7%	1,870	4.9%	1,558	4.2%	1,523	4.0%
Penn Highlands DuBois	1,347	2.8%	1,167	2.8%	1,205	3.2%	1,031	2.8%	1,000	2.6%
Penn Highlands Mon Valley	302	0.6%	239	0.6%	189	0.5%	191	0.5%	219	0.6%
Other	558	1.2%	554	1.3%	476	1.3%	336	0.9%	304	0.8%
DHL	221	0.5%	177	0.4%	175	0.5%	146	0.4%	55	0.1%
Conemaugh Nason Medical Center	221	0.5%	177	0.4%	166	0.4%	138	0.4%	35	0.1%
Conemaugh Memorial Medical Center	-	0.0%	-	0.0%	9	0.0%	8	0.0%	19	0.0%
Conemaugh Miners Medical Center	-	0.0%	-	0.0%	-	0.0%	-	0.0%	1	0.0%
Washington Health System	794	1.7%	646	1.6%	502	1.3%	471	1.3%	505	1.3%
The Washington Hospital	747	1.6%	609	1.5%	478	1.3%	452	1.2%	479	1.3%
Washington Health System Greene	47	0.1%	37	0.1%	24	0.1%	19	0.1%	26	0.1%
Meadville Medical Center	1,108	2.3%	934	2.3%	799	2.1%	602	1.6%	814	2.1%
Meadville Medical Center	997	2.1%	857	2.1%	721	1.9%	563	1.5%	764	2.0%
Titusville Area Hospital	111	0.2%	77	0.2%	78	0.2%	39	0.1%	50	0.1%
LECOM	188	0.4%	187	0.5%	145	0.4%	91	0.2%	90	0.2%
Millcreek Community Hospital	162	0.3%	164	0.4%	128	0.3%	73	0.2%	61	0.2%
LECOM Health Corry Memorial Hospital	26	0.1%	23	0.1%	17	0.0%	18	0.0%	29	0.1%
Other Community Hospitals	8,383	17.6%	7,347	17.8%	7,385	19.4%	6,455	17.5%	6,261	16.4%
St. Clair Hospital	3,694	7.7%	3,196	7.7%	3,694	9.7%	3,332	9.0%	3,393	8.9%
Indiana Regional Medical Center	669	1.4%	589	1.4%	832	2.2%	848	2.3%	850	2.2%
Butler Memorial Hospital	1,434	3.0%	1,219	2.9%	874	2.3%	655	1.8%	568	1.5%
ACMH Hospital	558	1.2%	408	1.0%	401	1.1%	338	0.9%	374	1.0%
Other Community Hospitals	2,028	4.2%	1,935	4.7%	1,584	4.2%	1,282	3.5%	1,076	2.8%
Other Total	2,695	5.6%	1,626	3.9%	1,653	4.3%	1,332	3.6%	1,502	3.9%

Source: PHC4 Discharge Data

Note: Excludes MDCs 19 and 20 and DRGS 795, 945, and 946.

Table 23: Discharges Shares for Highmark Members at Community Hospitals, Highmark Commercial Plans, 29 County WPA, 2012-2016

Discharge Shares for Highmark Members at Community Hospitals, Highmark Commercial Plans, 29 County WPA, 2012-2016										
Hospital	Discharges 2012	Shares 2012	Discharges 2013	Shares 2013	Discharges 2014	Shares 2014	Discharges 2015	Shares 2015	Discharges 2016 (Q1-Q3)	Shares 2016 (Q1-Q3)
Total Highmark Members	**83,639**	**100%**	**78,778**	**100%**	**75,531**	**100%**	**62,517**	**100%**	**42,047**	**100%**
Total (Community Hospitals)	**15,477**	**18.5%**	**14,273**	**18.1%**	**13,763**	**18.2%**	**12,138**	**19.4%**	**8,689**	**20.7%**
Heritage Valley	3,483	4.2%	3,393	4.3%	3,336	4.4%	2,851	4.6%	1,936	4.6%
Heritage Valley Beaver	1,761	2.1%	1,721	2.2%	1,663	2.2%	1,439	2.3%	1,019	2.4%
Heritage Valley Sewickley	1,701	2.0%	1,649	2.1%	1,650	2.2%	1,377	2.2%	890	2.1%
Kindred Hospital at Heritage Valley	21	0.0%	23	0.0%	23	0.0%	35	0.1%	27	0.1%
Washington Health	2,160	2.6%	1,380	1.8%	1,363	1.8%	1,147	1.8%	827	2.0%
Washington Hospital, The	1,925	2.3%	1,175	1.5%	1,208	1.6%	1,033	1.7%	746	1.8%
Washington Health System Greene	235	0.3%	205	0.3%	155	0.2%	114	0.2%	81	0.2%
Non-System Community Hospitals	9,834	11.8%	9,500	12.1%	9,064	12.0%	8,140	13.0%	5,926	14.1%
St. Clair Memorial Hospital	5,331	6.4%	5,205	6.6%	4,910	6.5%	4,096	6.6%	3,150	7.5%
Excela Health Westmoreland Regional Hospital	2,955	3.5%	2,715	3.4%	2,555	3.4%	2,543	4.1%	1,662	4.0%
Butler Memorial Hospital	1,548	1.9%	1,580	2.0%	1,599	2.1%	1,501	2.4%	1,114	2.6%
Non-Community Hospitals	68,162	81.5%	64,505	81.9%	61,768	81.8%	50,379	80.6%	33,358	79.3%

Source: PHC4 Discharge Data

Note: Excludes MDCs 19 and 20 and DRGS 795, 945, and 946. 2016 data contains only Q1-Q3 discharges. 2016 shares are annualized.

We also examined whether Highmark's affiliation with AHN and its new insurer/contract with UPMC have adversely affected community hospitals' ability to attract Highmark commercial plan members. Excela's share of Highmark commercial member discharges increased from 2017 through 2019 (pre-Pandemic) and remained above its 2017 share. These shares were above that in the 2012-2016 period. This indicates that Excela has not been materially affected by Highmark's affiliation with AHN nor Highmark's recent contract with UPMC.

At the Washington Health system, its share of Highmark member discharges declined significantly from 2012 to 2013, then stabilized somewhat, but has declined to even lower levels in the post 2017 period. In absolute volume terms, the decline from 2017 to 2021 is about the same level as that for overall commercial discharges at WPA, suggesting that it may be a loss of Highmark member discharges that accounts for the overall lower commercial discharges at this health system.

For St. Clair, it has gained Highmark commercial member discharges over the 2012 to 2021 period and has gained nearly a full percentage point increase in the 2019-2021 period. For Butler, its share of Highmark commercial member discharges increased from its pre-transaction 2012 share of 1.9% to 3.0% by 2017, indicating that it was not adversely affected by Highmark's affiliation with AHN. However, since 2019, Butler has lost approximately 0.8 percentage points in share, indicating that it may have been adversely affected by the UPMC/Highmark contract. However, Butler's absolute volume decline began in 2018, which was before the UPMC contract took effect, thus indicating that we cannot determine with any certainty whether or not its Highmark commercial member share decline can be attributed to the UPMC/Highmark contract.

Heritage Valley's share of Highmark member discharges grew during the 2012 to 2018 period indicating that it was not adversely impacted by Highmark's affiliation. Since 2018, however, Heritage Valley's share of Highmark commercial member discharges significantly declined to a low of 4.3%, the same level as 2013. Its share of overall commercial payor discharges has also been declining since 2017 having lost 843 discharges since 2018 of which Highmark discharges declined 578. The decline in Highmark member discharges is responsible for a significant portion of the overall decline in commercial discharges at Heritage Valley. The system's Sewickley Hospital, which suffered the bulk in lost share, is located relatively close to both AHN and UPMC Pittsburgh hospitals, and therefore, may have been affected at least in part by the 2019 UPMC/Highmark contract.

Hospital Capacity and Utilization at Independent Community Hospitals

The number of beds, admissions, inpatient days, and utilization are important measures in evaluating the operational success of a hospital. Table 24 presents these capacity and utilization metrics for 2017 and 2021 for independent community hospitals in the WPA. The total number of licensed beds at these community hospitals decreased by 397 beds. Additionally, staffed beds declined by a net 570 beds. Duke LifePoint had the largest increase in licensed beds (36), followed by LECOM (27), Penn Highlands, Washington Health, and Meadville Medical Center in 2021. Steward Health had reduced licensed beds, while Upper Allegheny and Heritage Valley had no change between 2017 and 2021. The overall decline in patient care days, total length of stay, and bed days available at these community hospitals resulted in excess capacity and declining occupancy rates. Overall occupancy rate decreased slightly from 51.1% in 2017 to 50.3% in 2021.

Table 24: 2017 and 2021 Hospital Capacity and Utilization at Independent Community Hospitals

Hospital Capacity and Utilization by Community Hospital, 2017 and 2021										
Facility	Licensed Beds 2017	Staffed Beds 2017	Admissions 2017	Patient Care Days 2017	Occupancy Rate 2017	Licensed Beds 2021	Staffed Beds 2021	Admissions 2021	Patient Care Days 2021	Occupancy Rate 2021
Community Hospital Total	**5,386**	**4,938**	**207,790**	**916,349**	**51.1%**	**4,989**	**4,368**	**158,500**	**805,483**	**50.3%**
Excela	**576**	**425**	**23,944**	**100,413**	**64.7%**	**578**	**469**	**21,257**	**98,164**	**58.2%**
EXCELA HEALTH WESTMORELAND REGIONAL HOSPITAL	373	270	14,982	66,724	67.7%	375	309	13,246	63,511	57.1%
EXCELA HEALTH LATROBE HOSPITAL	170	122	6,821	25,138	56.5%	170	127	5,881	25,323	55.1%
EXCELA HEALTH FRICK HOSPITAL	33	33	2,141	8,551	71.0%	33	33	2,130	9,330	79.6%
Duke LifePoint Healthcare	**563**	**539**	**20,545**	**95,235**	**48.8%**	**599**	**573**	**16,743**	**88,542**	**42.3%**
CONEMAUGH MEMORIAL MEDICAL CENTER	468	444	18,114	86,903	53.6%	509	483	14,275	78,887	44.7%
CONEMAUGH NASON MEDICAL CENTER	45	45	1,792	5,224	31.8%	45	45	1,714	6,014	36.5%
CONEMAUGH MINERS MEDICAL CENTER	30	30	360	1,502	15.8%	25	25	432	1,785	20.7%
DLP CONEMAUGH MEYERSDALE MEDICAL CENTER, LLC	20	20	279	1,606	22.0%	20	20	322	1,856	25.4%
Heritage Valley	**565**	**565**	**23,874**	**106,925**	**51.8%**	**565**	**402**	**17,519**	**86,386**	**58.9%**
HERITAGE VALLEY BEAVER	285	285	12,527	55,384	53.2%	285	222	10,020	50,897	62.8%
HERITAGE VALLEY SEWICKLEY	176	176	7,861	31,546	49.1%	160	130	5,303	21,949	46.3%
HERITAGE VALLEY KENNEDY	104	104	3,486	19,995	52.7%	120	50	2,196	13,540	74.2%
Penn Highlands	**690**	**682**	**25,559**	**117,756**	**46.0%**	**683**	**613**	**19,504**	**113,713**	**51.1%**
PENN HIGHLANDS DUBOIS	219	219	9,372	40,608	50.8%	266	266	9,582	53,450	53.8%
PENN HIGHLANDS MON VALLEY	200	200	6,834	35,986	49.3%	200	145	5,187	32,199	60.8%
PENN HIGHLANDS HUNTINGDON	62	62	2,282	9,575	40.2%	71	56	1,741	10,303	50.1%
PENN HIGHLANDS	64	64	1,884	8,517	36.5%	61	61	1,000	6,261	35.6%
PENN HIGHLANDS BROOKVILLE	35	34	1,025	6,194	43.2%	35	35	573	5,085	39.8%
PENN HIGHLANDS ELK	35	35	1,864	8,486	60.9%	25	25	1,199	5,818	63.8%
PENN HIGHLANDS TYRONE	25	25	765	1,670	18.2%	25	25	222	597	10.3%
PENN HIGHLANDS CLEARFIELD	50	43	1,533	6,720	37.0%	-	-	-	-	0.0%
Washington Health System	**309**	**255**	**13,485**	**56,511**	**60.7%**	**301**	**216**	**9,559**	**35,653**	**54.3%**
WASHINGTON HOSPITAL	260	206	11,890	48,750	64.8%	278	193	8,984	33,140	57.1%
WASHINGTON HEALTH SYSTEM GREENE	49	49	1,595	7,761	43.3%	23	23	575	2,513	30.4%
Meadville Medial Center	**242**	**199**	**8,960**	**43,199**	**57.9%**	**225**	**225**	**6,828**	**38,081**	**47.8%**
MEADVILLE MEDICAL CENTER	217	174	7,957	38,388	60.4%	200	200	6,009	33,425	47.4%
TITUSVILLE AREA HOSPITAL	25	25	1,003	4,811	43.4%	25	25	819	4,656	51.0%
Steward Health Care System	**220**	**183**	**7,354**	**34,568**	**51.8%**	**163**	**163**	**6,376**	**31,730**	**59.1%**
SHARON REGIONAL MEDICAL CENTER	220	183	7,354	34,568	51.8%	163	163	6,376	31,730	59.1%
LECOM	**164**	**164**	**4,787**	**29,893**	**49.9%**	**191**	**191**	**4,246**	**29,448**	**43.8%**
MILLCREEK COMMUNITY HOSPITAL	144	144	4,216	27,261	51.9%	171	171	3,825	27,525	45.9%
CORRY MEMORIAL HOSPITAL	20	20	571	2,632	36.1%	20	20	421	1,923	26.3%
Upper Allegheny Health System	**107**	**87**	**2,910**	**14,912**	**47.0%**	**107**	**29**	**1,428**	**10,018**	**25.7%**
BRADFORD REGIONAL MEDICAL CENTER	107	87	2,910	14,912	47.0%	107	29	1,428	10,018	25.7%
Other	**1,950**	**1,839**	**76,372**	**316,937**	**48.5%**	**1,577**	**1,487**	**55,040**	**273,748**	**49.8%**

Source: Pennsylvania Department of Health Hospital Reports 2017 and 2021
Note: 2017 occupancy rates were calculated using Patient Care Days divided by Bed Days Available.
2021 occupation rate was calculated using Total Length of Stay divided by Bed Days Available.
Includes General Acute Care hospitals only.

F. Effect of the 2019 UPMC/Highmark Agreement on Highmark subscribers

With the mid-2019 insurer/provider contract negotiated between Highmark and UPMC, Highmark members in the WPA region may receive treatment at in-network prices at UPMC facilities. The agreement also included in-network prices for the majority of UPMC's facilities throughout the remainder of the state where Highmark offers healthcare insurance. In addition, because of the length of the new contract and certain other terms, Highmark requested, and the Department granted based in part upon Highmark's assurances in the request certain limited waivers of the Condition 3 (length of contract), Conditions 5 and 6 (MFN), and Condition 20 (consumer choice initiatives) of the 2013 Order.

This contract is intended to offer Highmark members broader access to UPMC, AHN, and independent community hospitals, as well as to offer narrow network products that include AHN,

independent hospitals, and UPMC exception hospitals.[66] According to the agreement, as of July 1, 2019, UPMC providers in WPA became participating providers in Highmark's designated commercial and Medicare Advantage products. The 2020 and 2021 PHC4 inpatient and outpatient discharge shares are expected to capture the first- and second-year effects of this agreement although simultaneously, these two years of inpatient and outpatient discharge data are greatly affected by the Pandemic which severely restricts our ability to draw any definitive conclusions on the impact of the contract on AHN or UPMC.

Table 25 shows that while total Highmark commercial member inpatient discharges in the WPA declined since 2017, discharges increased from 36,920 to 38,069 between 2020 and 2021. UPMC hospitals in particular, grew in share from 20.9% in 2019 to 31.3% in 2021, resulting from a 50% increase in discharges. As the Pandemic did not hit Pennsylvania until March 2020, the substantial increase in Highmark commercial discharges at UPMC likely stems from a shift in patient preference from AHN or other hospitals to the newly accessible UPMC hospitals due to the new contract. UPMC Magee-Women's Hospital had the largest increase since 2019 (433%), followed by UPMC Presbyterian Shadyside (70%). AHN shares declined from 33.7% in 2019 to 28.9% in 2021. Independent community hospitals' commercial shares also declined during this time. The greatest AHN loss in Highmark commercial discharge share since 2019 was at Allegheny General Hospital (two full percentage points).

Of note, however, are AHN's Saint Vincent and UPMC Hamot hospitals which are located near each other in Erie. Both Saint Vincent and UPMC Hamot have lost Highmark commercial member discharges since 2017. There is no indication that the 2019 UPMC/Highmark contract adversely affected Saint Vincent's ability to compete with UPMC Hamot for these declining shares of discharges. Two other hospitals, AHN Forbes and UPMC East, also are within close proximity to one another. UPMC East doubled its Highmark commercial member discharges from 2019 to 2021 although AHN Forbes lost more than twice the volume gained by UPMC East. This suggests that the new contract may have adversely impacted AHN Forbes' volumes.

[66] Exception Hospitals and Providers include: UPMC's Bedford, UPMC Northwest, UPMC Altoona, WPIC (UPMC Western Psychiatric Hospital), UPMC Physicians and Ancillary Providers, and UPMC Children's Hospital.

Table 25: Inpatient Discharges Shares for Highmark Members, Highmark Commercial Plans, 29 County WPA, 2017-2021

WPA IP Discharge Share for Highmark Members- All Services, Commercial Payors, 2017-2021										
Hospital	Discharge 2017	Share 2017	Discharge 2018	Share 2018	Discharge 2019	Share 2019	Discharge 2020	Share 2020	Discharge 2021	Share 2021
Total	**47,720**	**100.0%**	**41,349**	**100.0%**	**38,063**	**100.0%**	**36,920**	**100.0%**	**38,069**	**100.0%**
UPMC	**11,146**	**23.4%**	**9,660**	**23.4%**	**7,972**	**20.9%**	**10,383**	**28.1%**	**11,934**	**31.3%**
UPMC Children's Hospital of Pittsburgh	2,042	4.3%	2,092	5.1%	1,862	4.9%	1,945	5.3%	2,339	6.1%
UPMC Presbyterian Shadyside	2,061	4.3%	1,707	4.1%	1,268	3.3%	1,836	5.0%	2,152	5.7%
UPMC Magee-Womens Hospital	348	0.7%	262	0.6%	338	0.9%	1,339	3.6%	1,856	4.9%
UPMC Hamot	2,391	5.0%	2,032	4.9%	1,239	3.3%	1,458	3.9%	1,492	3.9%
UPMC Altoona	1,327	2.8%	1,305	3.2%	1,198	3.1%	1,185	3.2%	1,158	3.0%
UPMC Passavant	682	1.4%	429	1.0%	488	1.3%	607	1.6%	619	1.6%
UPMC Mercy	493	1.0%	324	0.8%	304	0.8%	418	1.1%	511	1.3%
UPMC Northwest	411	0.9%	428	1.0%	332	0.9%	337	0.9%	373	1.0%
UPMC East	150	0.3%	90	0.2%	105	0.3%	216	0.6%	206	0.5%
UPMC East	150	0.3%	90	0.2%	105	0.3%	216	0.6%	206	0.5%
UPMC Other	1,241	2.6%	991	2.4%	838	2.2%	1,042	2.8%	1,228	3.2%
AHN	**15,651**	**32.8%**	**13,833**	**33.5%**	**12,833**	**33.7%**	**11,464**	**31.1%**	**11,010**	**28.9%**
West Penn Hospital	4,417	9.3%	4,211	10.2%	4,033	10.6%	3,658	9.9%	3,483	9.1%
Allegheny General Hospital	4,065	8.5%	3,624	8.8%	3,332	8.8%	2,917	7.9%	2,553	6.7%
Forbes Hospital	2,348	4.9%	2,284	5.5%	2,015	5.3%	1,765	4.8%	1,706	4.5%
Jefferson Hospital	2,099	4.4%	1,748	4.2%	1,552	4.1%	1,461	4.0%	1,410	3.7%
Saint Vincent Hospital	2,026	4.2%	1,325	3.2%	1,436	3.8%	1,137	3.1%	1,295	3.4%
Allegheny Valley Hospital	436	0.9%	450	1.1%	315	0.8%	301	0.8%	248	0.7%
Canonsburg Hospital	260	0.5%	191	0.5%	150	0.4%	134	0.4%	137	0.4%
AHN Hempfield Neighborhood Hospital	-	0.0%	-	0.0%	-	0.0%	16	0.0%	100	0.3%
Grove City Hospital	-	0.0%	-	0.0%	-	0.0%	75	0.2%	78	0.2%
Independent Community Hospitals	**18,228**	**38.2%**	**16,230**	**39.3%**	**15,605**	**41.0%**	**13,741**	**37.2%**	**13,623**	**35.8%**
Other Hospitals	**2,695**	**5.6%**	**1,626**	**3.9%**	**1,653**	**4.3%**	**1,332**	**3.6%**	**1,502**	**3.9%**

Source: PHC4 Discharge Data

Note: Excludes MDCs 19 and 20 and DRGS 795, 945, and 946.

Other Hospitals include hospitals in WPA that were not listed as community hospitals in the Condition 21 report.

Highmark members' commercial outpatient discharges at UPMC facilities increased a significant 73% between 2019 and 2021 indicating that more Highmark members were seeking care at UPMC facilities relative to other care facilities following the 2019 contract (Table 26). AHN shares remained consistent during this time, although absolute volumes were higher in 2021 than in 2017, which is consistent with national trends. West Penn, Allegheny General, and Saint Vincent hospitals experienced significant share and volume declines post-2019 while UPMC's Magee Women's Hospital and Presbyterian Shadyside saw substantial gains in share and volume. This could be due to an expansion of services at these outpatient facilities as well as attracting Highmark commercial members away from other hospitals. Independent community hospitals' share of Highmark commercial outpatient discharges declined as did overall volumes, which is not consistent with the national trend of increasing outpatient volumes. We cannot determine from the information available on independent non-hospital-based outpatient facilities whether these facilities were affected by the newly available Highmark member access to UPMC facilities and physicians, or whether the loss at community hospital-based outpatient facilities, whether independently owned or owned by UPMC or AHN hospitals, contributed to this decline.

Table 26: Outpatient Discharges Shares for Highmark Members, Highmark Commercial Plans, 29 County WPA, 2017-2021

WPA OP Discharge Share for Highmark Members- All Services, Commercial Payors, 2017-2021										
Facility	Discharge 2017	Share 2017	Discharge 2018	Share 2018	Discharge 2019	Share 2019	Discharge 2020	Share 2020	Discharge 2021	Share 2021
Total	**180,649**	**100.0%**	**169,499**	**100.0%**	**163,445**	**100.0%**	**153,774**	**100.0%**	**174,019**	**100.0%**
UPMC	**24,517**	**13.6%**	**24,279**	**14.3%**	**22,979**	**14.1%**	**31,055**	**20.2%**	**39,646**	**22.8%**
UPMC Magee-Womens Hospital	1,061	0.6%	972	0.6%	1,109	0.7%	5,319	3.5%	9,029	5.2%
UPMC Children's Hospital of Pittsburgh	4,231	2.3%	4,537	2.7%	4,675	2.9%	4,597	3.0%	4,686	2.7%
UPMC Presbyterian Shadyside	2,175	1.2%	1,548	0.9%	1,505	0.9%	2,759	1.8%	3,414	2.0%
UPMC Altoona	2,802	1.6%	2,809	1.7%	2,781	1.7%	2,828	1.8%	3,182	1.8%
UPMC Passavant	704	0.4%	546	0.3%	651	0.4%	1,345	0.9%	2,373	1.4%
UPMC Hamot	3,140	1.7%	2,908	1.7%	1,379	0.8%	1,837	1.2%	1,991	1.1%
UPMC Children's Hospital of Pittsburgh North	-	0.0%	1,575	0.9%	2,150	1.3%	1,563	1.0%	1,715	1.0%
UPMC Hamot Surgery Center, LLC	720	0.4%	2,489	1.5%	1,530	0.9%	1,804	1.2%	1,703	1.0%
UPMC Other	9,684	5.4%	6,895	4.1%	7,199	4.4%	9,003	5.9%	11,553	6.6%
AHN	**49,959**	**27.7%**	**47,709**	**28.1%**	**48,776**	**29.8%**	**46,537**	**30.3%**	**51,535**	**29.6%**
Allegheny General Hospital	10,370	5.7%	9,512	5.6%	10,042	6.1%	8,385	5.5%	8,384	4.8%
West Penn Hospital	8,297	4.6%	8,066	4.8%	8,047	4.9%	6,834	4.4%	7,147	4.1%
Grove City Hospital	-	0.0%	-	0.0%	-	0.0%	4,130	2.7%	5,626	3.2%
Forbes Hospital	4,753	2.6%	5,153	3.0%	5,057	3.1%	4,276	2.8%	4,756	2.7%
Jefferson Hospital	4,840	2.7%	4,492	2.7%	4,223	2.6%	4,075	2.6%	4,615	2.7%
Wexford Surgery Center	3,629	2.0%	3,744	2.2%	3,877	2.4%	3,553	2.3%	4,316	2.5%
Saint Vincent Hospital	5,098	2.8%	3,750	2.2%	4,108	2.5%	3,794	2.5%	3,790	2.2%
Allegheny Health Network Monroeville Surgery Center	3,118	1.7%	2,781	1.6%	2,572	1.6%	2,380	1.5%	2,903	1.7%
Allegheny Valley Hospital	1,935	1.1%	2,116	1.2%	2,618	1.6%	2,167	1.4%	2,325	1.3%
McCandless Endoscopy Center, LLC	2,063	1.1%	2,220	1.3%	2,209	1.4%	1,694	1.1%	1,699	1.0%
AHN Other	5,856	3.2%	5,875	3.5%	6,023	3.7%	5,249	3.4%	5,974	3.4%
Independent Community Hospitals	**46,435**	**25.7%**	**51,005**	**30.1%**	**49,111**	**30.0%**	**39,272**	**25.5%**	**39,550**	**22.7%**
Other Facilities	**59,738**	**33.1%**	**46,506**	**27.4%**	**42,579**	**26.1%**	**36,910**	**24.0%**	**43,288**	**24.9%**

Source: PHC4 Discharge Data

Note: Other facilities include hospital and non-hospital-based OP facilities in WPA that were not listed as community hospitals in the Condition 21 report.

Medicare Advantage total inpatient discharges for Highmark members in the WPA declined significantly from 2017 through 2019 (Table 27). This decline is consistent with Highmark's overall decline in Medicare Advantage enrollment during this period (Table 4). UPMC, AHN, and independent community hospital MA discharges declined during this time period although on a share of Highmark Medicare Advantage discharge basis, AHN gained share during this period while UPMC lost Highmark member share. None of the UPMC hospitals saw a significant share gain from 2019 to 2021 although both UPMC Presbyterian Shadyside and UPMC Mercy saw share gains of about 0.5 percentage points. Several AHN hospitals experienced a share loss of more than 0.5 percentage points while Allegheny General saw a share gain of 1.7 percentage points. However, Allegheny General's share was almost two percentage points higher in 2019 than in 2017. These trends suggest that the UPMC/Highmark contract is unlikely to have negatively impacted AHN relative to UPMC with respect to Highmark Medicare Advantage inpatient discharges. Moreover, although community hospitals as a group lost significant Highmark Medicare Advantage member discharges between 2017 and 2021, their overall share of these discharges actually increased relative to 2017, although decreasing slightly post 2019.

Table 27: Inpatient Discharges Shares for Highmark Members, Highmark Medicare Advantage Plans, 29 County WPA, 2017-2021

WPA IP Discharge Share for Highmark Members- All Services, Medicare Advantage, 2017-2021										
Hospital	Discharge 2017	Share 2017	Discharge 2018	Share 2018	Discharge 2019	Share 2019	Discharge 2020	Share 2020	Discharge 2021	Share 2021
Total	**56,446**	**100.0%**	**49,455**	**100.0%**	**38,116**	**100.0%**	**32,856**	**100.0%**	**31,739**	**100.0%**
UPMC	**16,945**	**30.0%**	**14,213**	**28.7%**	**7,768**	**20.4%**	**7,151**	**21.8%**	**6,690**	**21.1%**
UPMC Presbyterian Shadyside	4,614	8.2%	3,938	8.0%	1,935	5.1%	1,746	5.3%	1,755	5.5%
UPMC Altoona	1,778	3.1%	1,520	3.1%	1,204	3.2%	1,008	3.1%	894	2.8%
UPMC Mercy	1,504	2.7%	1,333	2.7%	860	2.3%	862	2.6%	860	2.7%
UPMC Passavant	2,373	4.2%	1,903	3.8%	777	2.0%	748	2.3%	582	1.8%
UPMC Hamot	1,163	2.1%	939	1.9%	474	1.2%	454	1.4%	425	1.3%
UPMC St. Margaret	1,884	3.3%	1,448	2.9%	581	1.5%	481	1.5%	422	1.3%
UPMC East	938	1.7%	853	1.7%	348	0.9%	399	1.2%	402	1.3%
UPMC Jameson	841	1.5%	664	1.3%	427	1.1%	437	1.3%	386	1.2%
UPMC Other	1,850	3.3%	1,615	3.3%	1,162	3.0%	1,016	3.1%	964	3.0%
AHN	**15,610**	**27.7%**	**14,004**	**28.3%**	**12,923**	**33.9%**	**11,174**	**34.0%**	**10,886**	**34.3%**
Allegheny General Hospital	4,972	8.8%	4,030	8.1%	4,039	10.6%	3,906	11.9%	3,912	12.3%
Jefferson Hospital	2,604	4.6%	2,460	5.0%	2,120	5.6%	1,746	5.3%	1,741	5.5%
Forbes Hospital	3,122	5.5%	2,822	5.7%	2,363	6.2%	1,871	5.7%	1,702	5.4%
Saint Vincent Hospital	1,150	2.0%	1,257	2.5%	1,283	3.4%	1,060	3.2%	1,040	3.3%
West Penn Hospital	1,449	2.6%	1,547	3.1%	1,475	3.9%	1,117	3.4%	953	3.0%
Allegheny Valley Hospital	1,654	2.9%	1,397	2.8%	1,287	3.4%	990	3.0%	908	2.9%
Canonsburg Hospital	659	1.2%	491	1.0%	356	0.9%	360	1.1%	352	1.1%
AHN Hempfield Neighborhood Hospital	-	0.0%	-	0.0%	-	0.0%	46	0.1%	180	0.6%
Grove City Hospital	-	0.0%	-	0.0%	-	0.0%	78	0.2%	98	0.3%
Independent Community Hospitals	**21,180**	**37.5%**	**18,992**	**38.4%**	**15,373**	**40.3%**	**13,013**	**39.6%**	**12,445**	**39.2%**
Other Hospitals	**2,711**	**4.8%**	**2,246**	**4.5%**	**2,052**	**5.4%**	**1,518**	**4.6%**	**1,718**	**5.4%**

Source: PHC4 Discharge Data

Note: Excludes MDCs 19 and 20 and DRGS 795, 945, and 946.

Other Hospitals include hospitals in WPA that were not listed as community hospitals in the Condition 21 report.

For outpatient Highmark Medicare Advantage member discharges, AHN shares have been increasing since 2017 and absolute volumes in 2021 were the highest during the period (Table 28). Comparatively, UPMC's share of Highmark Medicare Advantage member discharges peaked in 2017 and ended with a decline of 37% below 2017 levels, a 5.7 percentage point decline. AHN experienced a 11.5 percentage point increase during the period. Although UPMC's share increased from 2019 to 2021, it did not make up the difference in loss share experienced prior to 2019. In contrast, independent community hospital shares were increasing 2017 through 2019, but declined in both 2020 and 2021. Shares at other hospitals continued to decline from 2017 levels with only a slight uptick in 2021.

On an individual hospital basis, UPMC Magee-Women's Hospital experienced significant share gains in outpatient Highmark Medicare Advantage member discharges after the 2019 contract. This may be at least in part due to new access afforded under the contract or it may be due in part to an expansion of services at the facility making it more attractive. Both Allegheny General and West Penn lost volumes and share post-2019. The same outpatient share increase is apparent in the Highmark commercial member discharge data at UPMC Magee-Women's Hospital (Table 26).

Table 28: Outpatient Discharges Shares for Highmark Members, Highmark Medicare Advantage Plans, 29 County WPA, 2017-2021

WPA OP Discharge Share for Highmark Members- All Services, Medicare Advantage, 2017-2021										
Facility	Discharge 2017	Share 2017	Discharge 2018	Share 2018	Discharge 2019	Share 2019	Discharge 2020	Share 2020	Discharge 2021	Share 2021
Total	**87,179**	**100.0%**	**86,720**	**100.0%**	**73,881**	**100.0%**	**65,646**	**100.0%**	**71,391**	**100.0%**
UPMC	**21,170**	**24.3%**	**18,502**	**21.3%**	**11,383**	**15.4%**	**12,197**	**18.6%**	**13,269**	**18.6%**
UPMC Magee-Womens Hospital	1,392	1.6%	1,350	1.6%	864	1.2%	3,042	4.6%	3,553	5.0%
UPMC Altoona	1,642	1.9%	1,787	2.1%	1,841	2.5%	1,722	2.6%	1,729	2.4%
UPMC Presbyterian Shadyside	3,867	4.4%	3,469	4.0%	1,675	2.3%	1,455	2.2%	1,443	2.0%
UPMC Passavant	2,136	2.5%	1,871	2.2%	642	0.9%	636	1.0%	944	1.3%
UPMC Mercy	1,757	2.0%	1,601	1.8%	874	1.2%	796	1.2%	893	1.3%
UPMC St. Margaret	2,151	2.5%	1,829	2.1%	675	0.9%	591	0.9%	700	1.0%
UPMC Other	8,225	9.4%	6,595	7.6%	4,812	6.5%	3,955	6.0%	4,007	5.6%
AHN	**21,768**	**25.0%**	**24,304**	**28.0%**	**25,136**	**34.0%**	**23,783**	**36.2%**	**26,035**	**36.5%**
Allegheny General Hospital	5,454	6.3%	6,123	7.1%	6,336	8.6%	5,649	8.6%	5,708	8.0%
West Penn Hospital	3,655	4.2%	4,280	4.9%	4,100	5.5%	3,432	5.2%	3,454	4.8%
Jefferson Hospital	2,819	3.2%	3,070	3.5%	3,234	4.4%	2,875	4.4%	3,114	4.4%
Forbes Hospital	2,587	3.0%	2,648	3.1%	2,915	3.9%	2,516	3.8%	2,813	3.9%
Allegheny Valley Hospital	1,640	1.9%	1,918	2.2%	2,667	3.6%	2,408	3.7%	2,452	3.4%
Grove City Hospital	-	0.0%	-	0.0%	-	0.0%	1,596	2.4%	2,310	3.2%
Saint Vincent Hospital	1,568	1.8%	1,703	2.0%	1,808	2.4%	1,857	2.8%	2,041	2.9%
Allegheny Health Network Monroeville Surgery Center	950	1.1%	1,013	1.2%	914	1.2%	736	1.1%	845	1.2%
Wexford Surgery Center	885	1.0%	1,000	1.2%	795	1.1%	679	1.0%	756	1.1%
Canonsburg Hospital	742	0.9%	734	0.8%	728	1.0%	621	0.9%	679	1.0%
AHN Other	1,468	1.7%	1,815	2.1%	1,639	2.2%	1,414	2.2%	1,863	2.6%
Independent Community Hospitals	**20,713**	**23.8%**	**22,315**	**25.7%**	**20,368**	**27.6%**	**16,098**	**24.5%**	**16,646**	**23.3%**
Other Facilities	**23,528**	**27.0%**	**21,599**	**24.9%**	**16,994**	**23.0%**	**13,568**	**20.7%**	**15,441**	**21.6%**

Source: PHC4 Discharge Data

Note: Excludes MDCs 19 and 20 and DRGS 795, 945, and 946.

Other facilities include hospital and non-hospital-based OP facilities in WPA that were not listed as community hospitals in the Condition 21 report.

IV. EFFECTS OF THE COMPETITIVE AND PUBLIC INTEREST CONDITIONS/WAIVERS UNDER THE 2013 ORDER

A. Intended and Unintended Consequences of the Conditions in the 2013 Order and Waivers Granted to Highmark by the Department

This section evaluates the extent to which the Conditions imposed originally and waivers granted, have achieved their purpose of preserving the competitive dynamics in the WPA market among healthcare insurers and healthcare providers since 2017, as well as examining the benefits to consumers and policyholders. We also evaluate whether the continued presence or absence of each of the specific Conditions remain necessary to ensure adequate protections for competition and the public interest going forward. This evaluation is intended to inform the Department as to the competitive and economic merits of continuing the scope of the 2013 Order's Conditions or whether modifications to the 2013 Order are warranted.

Conditions 1 and 2—Exclusive Contracting Prohibition: These exclusive dealing contract Conditions prohibit Highmark's Pennsylvania-based health plans from entering into a contract or arrangement with any Highmark healthcare provider that would require the provider to contract exclusively with the plan. These conditions further assure that no Highmark entity may prohibit

or limit any other Highmark Health provider from entering into any contract or arrangement with any insurer. Exclusive contracting arrangements may be anticompetitive in a vertically integrated healthcare system when a particular provider is needed for a health plan to meet network adequacy requirements, thereby excluding all other health plans from building a viable network.

Exclusive contracting by insurers or providers has been challenged in courts with mixed results. In *Methodist Health Services Corp. v. OSF Healthcare System*, Saint Francis, the 'must-have' hospital in Peoria, Illinois, entered into exclusive contracts with insurance companies, which prevented the companies from contracting with other providers in the market, including Methodist. In 2013, Methodist alleged that these contracts violated both sections of the Sherman Act by restricting trade and unlawfully maintaining monopoly power through the use of exclusive contracts.[67] In 2017, the district court found that the use of these exclusive contracts was not anticompetitive on the basis that Methodist was "simply an unsuccessful competitor" because it did not provide the services required by patients and health plans.[68] It also found that Methodist had the ability to compete against St. Francis for an exclusive contract with these insurers when these existing contracts expired.

In contrast, in 2011, the U.S. Department of Justice ("DOJ") and Texas Attorney General alleged that *United Regional Health Care System's* exclusive contract provisions with commercial health insurers violated Section 2 of the Sherman Act. The government contended that United Regional offered a substantial discount to insurers if United Regional was the only local hospital/outpatient surgical provider in the insurer's network.[69] The parties reached an agreement with a consent decree that prohibited United Regional from preventing commercial health insurers contracting with their competitors for 7 years.[70] In a merger context, the *Ballad COPA Agreement* in 2017, following the merger of Mountain States Health Alliance and Wellmont Health System, contained a limitation on exclusive physician contracting, with an exception for

[67] See, e.g., Gudiksen, Katherine L., Alexandra D. Montague, Jaime S. King, Amy Y. Gu, B. Fulton, and Thomas L. Greaney. "Preventing anticompetitive contracting practices in healthcare markets." (2020).
[68] Methodist Health Services Corp vs. OSF Healthcare System Saint Francis Medical Center. Date accessed: 12/1/2022. https://caselaw.findlaw.com/us-7th-circuit/1863937.html.
[69] United States of America and State of Texas v. United Regional Health Care Systems. Date accessed: 12/1/2022. https://www.justice.gov/atr/case-document/file/514151/download.
[70] United States of America and State of Texas v. United Regional Health Care Systems. Date accessed: 12/1/2022. https://www.justice.gov/d9/atr/case-documents/attachments/2011/09/29/276027.pdf.

hospital-based physicians.[71]

Some states such as New York and Wisconsin address exclusive practices under their general regulation of trade laws and require that managed care organizations or insurers negotiating for exclusive contracts with a healthcare provider need to obtain prior approval from the authorities, subject to relevant exceptions.[72] These limitations on the use of exclusive contract terms, especially in dominant provider/insurer contracts, are designed to address potentially anticompetitive behaviors.

Although exclusive contract terms can have procompetitive effects in competitive markets such as better rates for payors, concerns arise about potential anticompetitive effects that can outweigh these benefits when used by a dominant provider in a non-competitive or highly concentrated market.[73] From an economic theory perspective, if the exclusivity period is short and the contract is contestable thereafter, there should be no adverse competitive effect on the public interest. Those particular conditions were not consistent with Highmark's past contracting practices. The 2013 Order imposed a prohibition on exclusive contracting. We conclude that these Conditions are consistent with the present state of play in healthcare in WPA and that there is no competitive reason to change Conditions 1 and 2.

Condition 3—Provider/insurer Contract Length Limitation (5 years): This Condition prohibits Highmark, without prior approval, from entering into any contract or arrangement with another provider where the length of the contract or arrangement exceeds five years.

The DOJ expressly indicated its concerns on this issue in its 2012 statement regarding the transaction stating that in this case, "the long-term contract between Highmark and UPMC did diminish the incentives of each to compete and expand competition in these highly concentrated

[71] According to this provision, the new health system was "prohibited from entering into an exclusive arrangement with a sole healthcare provider of any service in the Geographic Service Area without prior approval from the Department. Hospital-based physicians including anesthesiologists, radiologists, pathologists, emergency department physicians, radiation oncologists, pediatric specialties (including neonatology and intensivists), behavioral health physicians and extenders, and hospitalists [were] excepted from this requirement." Section 5.02 (h). Tennessee COPA Terms of Certification. January 31, 2018 https://www.balladhealth.org/sites/default/files/documents/TN-COPA-Terms-of-Certification-Jan-31-2018.pdf; See also: Commonwealth of Virginia Cooperative Agreement Authorization. October 30, 2017 https://www.balladhealth.org/sites/default/files/documents/VA-Cooperative-Agreement-Authorization.pdf.

[72] See, e.g., Gudiksen, Katherine L., Alexandra D. Montague, Jaime S. King, Amy Y. Gu, B. Fulton, and Thomas L. Greaney. "Preventing anticompetitive contracting practices in healthcare markets." (2020).

[73] Ibid.

healthcare insurance and hospital markets."[74] The 2013 Order imposed a contract length restriction to facilitate timely renegotiated to better reflect current market conditions. The Condition also allowed Highmark to seek a waiver to this Condition from the PID if circumstances arose that necessitated a longer contract term.

Since the 2013 Order, Highmark has made several requests to enter into contracts that exceed the five-year term under the 2013 Order. In 2016, the Department granted Highmark a Condition 3 waiver for a 10-year contract with UPMC Jameson. The Commission also granted a waiver in August 2017 to enable Highmark to enter into a contract with Pinnacle/UPMC for a seven-year term. More recently in 2019, the Department granted Highmark Condition 3 waivers enabling Highmark to enter into a ten-year insurer/provider contract with Geisinger. The Department also granted a Condition 3 waiver for Highmark's 10-year contract with UPMC after requiring Highmark to modify some of the Department's competitive concerns.

In each waiver request, the contract at issue included terms which required the contract to adjust annually to market rates. In addition, Highmark identified pro-competitive benefits that would not be achieved without the waiver. For example, the UPMC contract waiver makes it possible for Highmark members in the WPA region to receive treatment at in-network prices at UPMC facilities for 10 years. Highmark's position was that this contract would increase Highmark's members' access to affordable, high-quality, and cost-effective care by giving them broader access to choose providers in the WPA. Highmark also assured the Department that this agreement does not violate the Most Favored Nation (Conditions 5 and 6) or Consumer Choice Initiative (Condition 20) provisions.[75] Outside the WPA, Highmark also entered into a 10-year contract with Penn State Hershey Medical Center in 2007 with the stated purpose of improving the quality of health care through investments and collaborative community health initiatives, and increased access for the people of Central Pennsylvania and across the Commonwealth.[76]

It is our view that this Condition does not adversely affect Highmark's ability to compete because

[74] 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, April 10, 2012. https://www.justice.gov/opa/pr/statement-department-justice-s-antitrust-division-its-decision-close-its-investigation. ("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.").

[75] Letter from Jack Stover to Deputy Insurance Commissioner Joseph DiMemmo. September 20, 2019.

[76] Highmark, Penn State and Penn State Hershey Medical Center announce a 10-year partnership. Date accessed: 12/1/2022. https://www.dept.psu.edu/ur/healthcare/.

the Condition allows Highmark to seek approval for a waiver in circumstances where an extended contract is demonstrated to be or likely to be beneficial for Highmark's members and the public. In those instances, the Department has granted waivers such as those cited above. These arrangements indicate that this Condition is working well and that there is no economic or competitive justification for modifying or eliminating the Condition.

Conditions 5 and 6—Prohibition on Most Favored Nation ("MFN") Contracts or Arrangements: These Conditions prohibit a Highmark Domestic insurer from entering into an MFN contract with any healthcare provider, and similarly, prohibits a Highmark Health entity that is a healthcare provider from entering into an MFN contract with any insurer. An MFN contract clause stipulated by the insurer requires a health care provider to grant the insurer the most favorable terms, usually including the lowest (i.e., the most-favored) price among the insurers with which it contracts.[77] The concern is that a dominant insurer may negotiate an MFN with healthcare providers to ensure that no other insurer can offer a new insurance product (such as narrow network) at lower rates and that no rival insurers can enter the market with lower payment rate in exchange for this competitive advantage and ultimately pass this inflated price to consumers in the form of higher premiums causing harm. These potential exclusionary and collusive effects from MFN contracts may also be present in markets with dominant providers.[78] MFNs in healthcare are generally considered by competition authorities, and in some cases, by the Courts as anticompetitive.[79]

Legal precedents and antitrust regulators generally raise competitive concerns or seek to limit the use of MFNs in insurer/provider contracts. In 2010, the DOJ filed a civil antitrust lawsuit against BCBS of Michigan alleging that the use of an MFN by the dominant health plan raised prices to consumers and created barriers to entry for rival plans. Ultimately, the complaint was dismissed in 2013 when the state legislature passed an MFN ban. In the accompanying press statement, the DOJ stated it would continue to investigate the use of MFN clauses in health plans

[77] Arnold, Daniel R., Katherine L. Gudiksen, Jaime S. King, Brent D. Fulton, and Richard M. Scheffler. "Do State Bans of Most-Favored-Nation Contract Clauses Restrain Price Growth? Evidence From Hospital Prices." *The Milbank Quarterly* (2022). https://www.milbank.org/quarterly/articles/do-state-bans-of-most-favored-nation-contract-clauses-restrain-price-growth-evidence-from-hospital-prices/.

[78] Gudiksen, Katherine L., Alexandra D. Montague, Jaime S. King, Amy Y. Gu, B. Fulton, and Thomas L. Greaney. "Preventing anticompetitive contracting practices in healthcare markets." (2020).

[79] An extensive review of MFNs and other contracting provisions and their treatment by Courts and the antitrust enforcement agencies in enforcement actions and settlement agreements are provided in Chapter IV, Section D "Most Favored Nations, Antisteering, and Antitiering Provisions." Antitrust Health Care Handbook. (Fifth edition.). (2022). Section of Antitrust Law, American Bar Association. This treatise also includes substantial review of the economics of selective and exclusive managed care contracting practices between payors and providers and the economic and market conditions under which such contracting practices can raise substantial competitive concerns or alternatively can provide benefits along with a detailed discussion of relevant cases and literature. See also Chapter V. Section D for further discussion.

in other areas.[80]

The 2017 Ballad COPA Agreement includes prohibitions on MFNs. The Tennessee COPA law required that the Department of Health evaluate any potential disadvantages that could reduce competition, resulting from the agreement. Some third parties were concerned that this merger would give Ballad Health market power to charge higher prices for non-government payors, limit patient choice through restrictive contracts with payors and providers and reduce incentives to improve the quality of care. To prevent adverse effects on payors, the merging Parties made a commitment not to engage in 'most favored nation' pricing with any health plans.[81]

Due to concerns about potential anticompetitive effects that MFNs bring to healthcare markets, such as weaker price competition, exclusion of competitors, and increased prices for healthcare services, lawmakers at both the state and federal level have introduced bills to prohibit their use in healthcare.[82] As of January 2023, 19 states have restricted the use of MFN clauses in health care contracts and the state of New York requires approval of the insurance commissioner before a provider and insurer can include an MFN provision in a contract.[83]

Neither Highmark nor AHN had any MFN contracts during the time of the 2013 Order. We find that this Condition has protected Highmark members and competition in WPA.

Conditions 7-9—Firewall Policy: Firewalls are an important consideration in ensuring vertically integrated firms maintain competition at each level of business. "Firewalls prevent the flow of

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[80] The Source, accessed May 2023. https://sourceonhealthcare.org/issue-brief-most-favored-nation-clauses/; United States and the State of Michigan v. Blue Cross Blue Shield of Michigan. Date accessed: 12/1/2022. https://sourceonhealthcare.org/litigation/united-states-and-the-state-of-michigan-v-blue-cross-blue-shield-of-michigan/ and https://sourceonhealthcare.org/litigation/aetna-inc-v-blue-cross-blue-shield-of-michigan/. For an overview of these cases and the assessment of MFNs and their competitive risks and potential competitive benefits, see generally Chapter IV, Section D. "Most Favored Nations, Antisteering , and Antitiering Provisions." Antitrust Health Care Handbook. Fifth Edition (2022). Section of Antitrust Law, American Bar Association.

[81] This provision ensured that "The New Health System shall not bargain or insist on 'most favored nations' or similar clauses in Payor Contracts." Section 5.02 (k). Tennessee COPA Terms of Certification. January 31, 2018 https://www.balladhealth.org/sites/default/files/documents/TN-COPA-Terms-of-Certification-Jan-31-2018.pdf; See also: Commonwealth of Virginia Cooperative Agreement Authorization. October 30, 2017 https://www.balladhealth.org/sites/default/files/documents/VA-Cooperative-Agreement-Authorization.pdf.

[82] Gudiksen, Katherine L., Alexandra D. Montague, Jaime S. King, Amy Y. Gu, B. Fulton, and Thomas L. Greaney. "Preventing anticompetitive contracting practices in healthcare markets." (2020).

[83] Arnold, Daniel R., Katherine L. Gudiksen, Jaime S. King, Brent D. Fulton, and Richard M. Scheffler. "Do State Bans of Most-Favored-Nation Contract Clauses Restrain Price Growth? Evidence From Hospital Prices." *The Milbank Quarterly* (2022). https://www.milbank.org/quarterly/articles/do-state-bans-of-most-favored-nation-contract-clauses-restrain-price-growth-evidence-from-hospital-prices/. In addition to reviewing state activity, this study examined whether MFN bans reduced hospital price growth in MSAs with highly concentrated insurer markets.

Competitively Sensitive Information (CSI) between certain personnel and business units in the firm, thereby reducing the possibility of collusion and inhibiting unilateral anticompetitive conduct."[84] These Conditions require that Highmark develop, implement, and strictly comply with firewalls to restrict Highmark and AHN from obtaining or sharing information on the terms and conditions of rival contracts. The underlying concept for firewalls is to restrict Highmark's knowledge of and ability to influence AHN's negotiations with rival insurers, and conversely, AHN's influence on Highmark's negotiations with rival hospitals.[85]

The primary focus in vertical transactions is to ensure that the acquisition of an upstream or downstream firm does not result in anticompetitive increases in rivals' costs or facilitate collusion. A vertical merger creates the opportunity for exposure to a competitor's CSI. Hence, antitrust authorities and counsel for merging companies have expanded efforts to identify potential CSI issues and maintain appropriate firewall provisions to prevent the inappropriate exchange of sensitive information within the vertically integrated firms.[86]

The Federal Trade Commission ("FTC"), DOJ, and other regulatory antitrust authorities make use of firewalls as part of consent orders for vertical and horizontal mergers. FTC and DOJ have recently expressed concern that firewalls are not as effective as assumed,[87] although neither antitrust agency has provided evidence for this change in position. An FTC study and DOJ speeches on use of consent orders that incorporated firewalls indicate they are successful in ensuring competitively sensitive information does not cross established boundaries.[88]

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[84] Gerald A. Stein and Albert Jui Li. "Handling Competitively Sensitive Information in a Vertically Integrated Firm: Practical Advice for In-house Counsel." *American Bar Association* 10/29/2021. Date accessed: 12/1/2022. https://www.americanbar.org/groups/antitrust_law/resources/magazine/2021-october/handling-competitively-sensitive-information/.

[85] Highmark Inc.: Policy Protecting Competitively Sensitive Information. September 20, 2013 (Revised: January 23, 2017).

[86] Gerald A. Stein and Albert Jui Li. "Handling Competitively Sensitive Information in a Vertically Integrated Firm: Practical Advice for In-house Counsel." *American Bar Association* 10/29/2021. Date accessed: 12/1/2022. https://www.americanbar.org/groups/antitrust_law/resources/magazine/2021-october/handling-competitively-sensitive-information/.

[87] See, for example, Assistant Attorney General Jonathan Kanter of the Antitrust Division Delivers Remarks to the New York State Bar Association Antitrust Section, Jonathan Kanter, January 24, 2022 (" I am concerned that merger remedies short of blocking a transaction too often miss the mark. Complex settlements, whether behavioral or structural, suffer from significant deficiencies. Therefore, in my view, when the division concludes that a merger is likely to lessen competition, in most situations we should seek a simple injunction to block the transaction. It is the surest way to preserve competition.")

[88] Gerald A. Stein and Albert Jui Li. "Handling Competitively Sensitive Information in a Vertically Integrated Firm: Practical Advice for In-house Counsel." 10/29/2021. Date accessed: 12/1/2022. https://www.americanbar.org/groups/antitrust_law/resources/magazine/2021-october/handling-competitively-sensitive-information/; The FTC's Merger Remedies 2006-2012: A Report of the Bureaus of Competition and Economics. January 2021. Date accessed: 12/1/2022. https://www.ftc.gov/reports/ftcs-merger-remedies-2006-2012-report-bureaus-competition-economics.

Recent examples of firewalls in healthcare transactions include the December 2020 conditional approval by the California Attorney General of the Cedars-Sinai and Huntington cross market affiliation. A part of the final 2001 approval for the transaction, the parties agreed to revised conditions for 10 years including "a firewall separating Huntington and Cedars-Sinai teams for insurer negotiations."[89] Other examples of firewall guidance include non-healthcare related consent decrees including the *Staples Inc.* and *Essendant Inc.* settlement agreement in 2019, which required Sycamore and Staples to create a firewall separating Staples' business-to-business end customer selling functions from Essendant's wholesale selling function, and additionally a monitor for ten years to assure both parties' compliance with these terms.[90] Similarly, the consent agreement between *Northrop Grumman* and *Orbital ATK, Inc*., and between *Broadcom Limited* and *Brocade Communications Systems Inc*. requires the establishment of firewalls to remedy FTC's anti-competitive concerns. [91]

Highmark's and AHN's enforcement of their firewall policy protecting CSI is intended to prevent potential competitive concerns such as reduction in competition or competitive innovation, or collusive pricing between Highmark/AHN and their rival insurers/hospitals.[92] Highmark also has monitoring processes in place for assuring compliance of its CSI Policy and annual audits to verify that these policies and all supporting procedures are followed. If a violation of CSI occurs, the Chief Privacy and Data Ethics officer must begin an investigation, and necessary remediation, mitigation, and disciplinary steps are taken that comply with Highmark's Policy and the 2013 Order.[93] Highmark is required to report on compliance of its CSI Policy and alert the Department to any breaches; both policies and these compliance reports, which are certified by Highmark's CEO and Chief Privacy Officer, are available publicly.

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[89] Amy Y. Gu. Cedars-Sinai/Huntington Cross-Market Affiliation Settle with Revised Competitive Impact Conditions. August 16, 2021. Date accessed: 12/1/2022. https://sourceonhealthcare.org/cedars-sinai-huntington-cross-market-affiliation-settle-with-revised-competitive-impact-conditions/.

[90] Analysis of Agreement Containing Consent Order to Aid Public Comment: In the matter of Sycamore Partners II, L.P. Staples Inc., and Essendant Inc., File No. 181-0180, Docket No. C-4667. Date accessed: 12/1/2022. https://www.ftc.gov/system/files/documents/cases/1810180_staples_essendant_analysis_1-28-19.pdf.

[91] FTC Accepts Proposed Consent Order in Broadcom Limited's $5.9 Billion Acquisition of Brocade Communications Systems, Inc. Date accessed: 12/1/2022. https://www.ftc.gov/news-events/news/press-releases/2017/07/ftc-accepts-proposed-consent-order-broadcom-limiteds-59-billion-acquisition-brocade-communications; Analysis of Agreement Containing Consent Order to Aid Public Comment: In the Matter of Northrop Grumman Corporation and Orbital ATK, Inc., File No. 181-0005. Date accessed: 12/1/2022. https://www.ftc.gov/system/files/documents/cases/1810005_northrop_grumman_orbital_analysis_6-5-18.pdf.

[92] Highmark Inc.: Policy Protecting Competitively Sensitive Information. September 20, 2013 (Revised: January 23, 2017).

[93] Letter to Jack Stover to Deputy Insurance Commissioner Joseph DiMemmo. May 1, 2019.

Firewall policies are a highly effective tool to ensure competition and compliance in a vertical integrated firm. Our assessment concludes that the firewall policy developed and enforced by Highmark has been successful in preventing inappropriate transfer of competitively sensitive information. We recommend that the Department continue to consider mechanisms by which other vertically integrated systems would be required to enforce a firewall policy as well as strict monitoring protocols to maintain compliance and reduce the breach of sensitive information. In sum, our analysis indicates that although Highmark is not operating under the same level playing field in terms of adhering to firewalls when its rivals are not required to do so, there is no indication that these Conditions have adversely affected Highmark members or insurer and provider competition in WPA.

Condition 20—Consumer Choice Initiatives: This Condition requires that, without prior approval from the Department, Highmark is prohibited from entering into any contract or arrangement with a healthcare provider that prohibits or limits the ability of the insurer to use tools, such as tiered networks or steering. In a tiered network, insurers group providers into tiers based on their costs and quality relative to other comparable providers that treat similar patients. Healthcare providers with higher quality and lower costs typically are placed on the most preferred tier to encourage members to choose those providers in selecting care. Insurers may also use various incentive mechanisms, including setting out-of-pocket costs or lower co-payments, to steer patients to lower-cost or higher-value providers. Thus, consumer choice initiatives, e.g., tiered network products, are procompetitive, as they may assist consumers in making informed healthcare decisions based on receiving higher quality of care at lower prices. There is increased interest at the state and policy level to promote such consumer initiatives, including for example in Massachusetts, where they form part of the healthcare economy since 2012 legislation; and Nevada where the legislature passed a law in 2021 prohibiting anti-tiering/anti-steering provisions in health care contracts.[94]

In the context of mergers, for example, the California Attorney General in its recent merger reviews, has imposed competitive impact conditions aimed at addressing and reducing potential anticompetitive effects of specific healthcare transactions in California. In July 2021, the conditional approval of the cross-market affiliation of *Cedars-Sinai and Huntington* was settled with revised conditions including "prohibition of interference with narrow and tiered network

[94] See S.B. 329, 2021 Leg., 81st Session (Nev. 2021). The Nevada law prohibits health systems from entering into a contract or soliciting a contract that (1) restricts the ability of the insurer to steer enrollees to other providers, (2) restricts the insurer from tiering providers within a network, (3) requires that the insurer place all providers in the health system into the same tier, (4) requires all-or-nothing contracting, or (5) prohibits or penalizes an insurer from contracting with other health systems that are not a party to the contract.

design or tiering/steering practices (for 10 years)."[95] The 2021 competitive conditions for the *Acadia/Adventist affiliation* also included "prohibition of interference with narrow, tiered, or steering commercial products or value-based benefit designs (for 10 years)."[96] Similar to the Cedars-Sinai/Huntington and Acadia/Adventist conditional approvals, the competitive impact conditions for the *USC Health System and Methodist affiliation* required "prohibition of interference with payor benefit designs that reward providers for affordability or quality such as narrow, tiered, steering, or value-based benefit designs."[97]

The 2021 conditional approval of the *Kaiser and Providence St Mary Medical Center* merger prohibits Providence from engaging in "all-or-nothing" contracting or requiring a payor to enter an exclusive contract or agree to "anti-tiering" or "anti-steering" contract terms.[98]

The DOJ, FTC, and states have litigated against anti-tiering and anti-steering contract provisions in insurer/provider contracts and/or have reached settlements with the parties involving related provisions. In *United States and North Carolina v. Charlotte-Mecklenburg Hospital Authority*

[95] Amy Y. Gu. Cedars-Sinai/Huntington Cross-Market Affiliation Settle with Revised Competitive Impact Conditions. August 16, 2021. Date accessed: 12/1/2022. https://sourceonhealthcare.org/cedars-sinai-huntington-cross-market-affiliation-settle-with-revised-competitive-impact-conditions/; see Attorney General Xavier Becerra conditional approval for Cedars-Sinai/Huntington. 12/10/2020. Date Accessed: 1/5/2023. https://oag.ca.gov/sites/all/files/agweb/pdfs/charities/nonprofithosp/ag-decision-huntington-121020.pdf; see also, Joint Stipulation and Order, *Pasadena Hospital Association d/b/a Hunting Hospital and Cedars-Sinai Health System v. Rob Bonta,* 21STCP00978 (Cal. Super. Ct. Cty. Of Los Angeles).

[96] Amy Y. Gu. California Attorney General Imposes Conditions of Price Cap and Prohibition of Anticompetitive Practices on Cross-Market Acquisition in Northern California. 10/14/2021. Date accessed: 12/1/2022. https://sourceonhealthcare.org/california-attorney-general-imposes-conditions-of-price-cap-and-prohibition-of-anticompetitive-practices-on-cross-market-acquisition-in-northern-california/; Attorney General Bob Bonta summary list of conditions. 10/5/2021. Date accessed: 1/5/2023. https://oag.ca.gov/system/files/media/ahv-ag-decision-conditionally-approving-transaction.pdf.

[97] Amy Y. Gu. California AG Considers Cross-Market Effects in Merger Review and Conditional Approval of USC Health System and Methodist Hospital Affiliation. 7/14/2022. Date accessed.12/1/2022. https://sourceonhealthcare.org/california-ag-considers-cross-market-effects-in-merger-review-and-conditional-approval-of-usc-health-system-and-methodist-hospital-affiliation/; General Attorney Rob Bonta Conditional approval for USC Health System and Methodist Hospital. 6/3/2022. Date accessed: 1/5/2023. https://oag.ca.gov/system/files/media/mhsc-conditions-packet-06032022.pdf.

[98] Amy Y. Gu. California Attorney General Imposes Conditions of Price Cap and Prohibition of Anticompetitive Practices on Cross-Market Acquisition in Northern California. 10/14/2021. Date accessed: 12/1/2022. https://sourceonhealthcare.org/california-attorney-general-imposes-conditions-of-price-cap-and-prohibition-of-anticompetitive-practices-on-cross-market-acquisition-in-northern-california/; Attorney General Bonta Conditionally Approves Ownership Change of High Desert Hospital. 12/17/2021. Date accessed: 12/1/2022. https://oag.ca.gov/news/press-releases/attorney-general-bonta-conditionally-approves-ownership-change-high-desert. Attorney General's Summary List of Conditions. Date Accessed 12/1/2022. https://oag.ca.gov/system/files/media/smmc-conditions-packet-12172021.pdf.

*d/b/a Carolinas Healthcare System or Atrium Health***,** the DOJ alleged that Atrium, the dominant hospital system in the Charlotte area, used its market power to restrict health insurers from encouraging consumers to choose healthcare providers that offer better overall value. The settlement agreement reached between the parties in 2019 prohibited Atrium from using such steering restrictions in contracts between commercial health insurers and its providers in the Charlotte, North Carolina metropolitan area.[99]

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. They provide a market-based mechanism rather than regulation for encouraging choice and competition. In highly consolidated markets, there is concern that dominant health systems may demand anti-tiering or anti-steering provisions in contracts as a condition of participating in an insurer's network. The competitive concern is that in the presence of market power, such provisions can restrict the insurers from directing patients to higher-value/lower-cost providers, thus increasing the likelihood that higher insurer costs would be passed on to patients through increased premiums. Therefore, the anticompetitive use of anti-tiering and anti-steering provisions may harm both competing payors and patients.

In July 2018, the Department granted Highmark limited waiver of the Condition to enter into a contract with UPMC's Bedford, UPMC Northwest, UPMC Altoona, UPMC Western Psychiatric Hospital ("WPIC"), and UPMC Physicians and Ancillary Providers as part of a "most beneficial tier." This waiver was needed to resolve some anticipated MFN and anti-tiering issues. In December 2020, the Department granted Highmark a waiver that extends the July 2018 waiver to include UPMC Children's Hospital.[100] In Highmark's letter and request for approval, Highmark asserted that these providers all qualify as "Exception Hospitals and Providers" as they are (i) either sole community hospitals due to their geographic location, i.e., UPMC Altoona, Bedford,

[99] Atrium Health Agrees to Settle Antitrust Lawsuit and Eliminate Anticompetitive Steering Restrictions. Date accessed: 12/1/2022. https://www.justice.gov/opa/pr/atrium-health-agrees-settle-antitrust-lawsuit-and-eliminate-anticompetitive-steering; Joint Stipulation and order for settlement agreement. 11/15/18. Date accessed: 1/5/2023. See, Chapter IV, Section D. "Most Favored Nations, Antisteering, and Antitiering Provisions," and Chapter V, Section C "Vertical Nonprice Exclusionary Conduct." Antitrust Health Care Handbook. Fifth Edition (2022). Section of Antitrust Law, American Bar Association for further substantive discussion of consent decrees in mergers or reached by parties in settlements and actions related to these contracting practices; these sections review both the potential anticompetitive risks and potential competitive benefits of the use of these provisions. For discussion on two different outcomes in litigation involving these types of contracting provisions, see also: Bird, Daniel G. and Emilio E. Varanini. "Deciphering Sutter Health's State-Court Settlement And Federal-Court Win In Parallel Antitrust Cases." Health Affairs (May 10, 2022). https://www.healthaffairs.org/content/forefront/deciphering-sutter-health-s-state-court-settlement-and-federal-court-win-parallel.

[100] Letter from Deputy Insurance Commissioner Melissa Greiner to Jack Stover. December 28, 2020.

and Northwest, or (ii) providers of unique services not otherwise widely available, i.e., comprehensive psychiatric care through UPMC WPIC and comprehensive children's care through UPMC Children's Hospital. In granting this waiver, the Department concluded that including these facilities in Highmark's highest benefit tier or the most preferred network level is in the public interest and would assure that Highmark members will have full access to these UPMC facilities on the most affordable terms, thus improving member accessibility and healthcare affordability. Highmark further assured the Department that the highest benefit tier would not be exclusive to UPMC and that other providers are expected to be included in that tier.[101]

From a competition perspective, we view this Condition in its application here as procompetitive and that there is merit to its broader use by healthcare insurers and providers, although we recognize that the Department may not have the authority to impose this Condition on other parties. Our analysis indicates that neither Highmark members nor competition in WPA have been adversely impacted by Highmark's compliance with this Condition, and that when appropriate and justified, the Department has shown its willingness to grant limited waivers to ensure that Highmark members are able to receive benefits that would not be available but for the waiver. It is our opinion that Condition 20 continues to serve in the public interest members in a community and healthcare providers without harming competition and it is consistent with the current state of play of enforcement by other regulators. Therefore, there is no economic or competitive justification for modifying or eliminating Condition 20.

Condition 21—Affiliation and IDN impact on community hospitals: This Condition requires that Highmark report on the impact of its IDN Strategy on community hospitals.[102] The intent of this Condition is to monitor the impact of the Highmark/AHN IDN on the viability of competing independent community hospitals to ensure that Highmark's affiliation with AHN and implementation of its IDN would not adversely harm the competitive position of community hospitals in serving Highmark members. The Highmark/AHN transaction raised concerns that Highmark would favor AHN over community hospitals which might competitively and financially disadvantage these hospitals from competing for Highmark members' business.

We have examined these reports as well as independent reporting of hospital and outpatient discharges from PHC4 data. We find that there have been decreases in Highmark members inpatient discharges across the majority of WPA facilities between 2017 and 2021, including AHN facilities, UPMC facilities, AHN/UPMC owned community hospitals, as well as independent community hospitals (Table 20 and Table 22). These trends are consistent with declining inpatient services and increasing outpatient services in WPA over time (Figure 2), as well as declining Highmark enrollment in the Commonwealth of PA (Table 6). Based on the data available to us, we do not find any trend that would indicate that Highmark has engaged in a systematic strategy

[101] Letter from Jack Stover to Deputy Insurance Commissioner Melissa Greiner. December 10, 2020.
[102] We did not address Condition 21 in the 2017 Updated Competitive Assessment.

to switch its members from community hospitals to AHN facilities. As described above in Sections III.D and III.E, we find that there appears to be some recent shifting of discharges from some community and AHN hospitals to UPMC hospitals, most likely as a result of the 2019 Highmark/UPMC contract.

Condition 21 is unique among regulatory approvals for healthcare transactions. We are unaware of other jurisdictions or specific transactions that have required parties to a transaction to monitor and report on its members' "purchase" of its rivals' products and services. The basis for imposing this Condition emanates from a concern that Highmark was (and remains) the largest commercial insurer in WPA and community hospitals are highly dependent on Highmark members for patient volume. Community hospitals voiced concerns that Highmark might favor its affiliated AHN healthcare providers, either through contracting, steering, or other mechanisms, and this would shift patients away from these community providers to AHN providers.

We are aware that smaller and independent hospitals face significant financial viability and other challenges today. Many community hospitals have either closed, continue to struggle, or have sought affiliation or buyouts with larger healthcare systems. Given this challenging environment and our assessment that this Condition provides the Department additional transparency on the healthcare delivery marketplace in a timely manner. As this is a reporting requirement, we do not find the burden of providing the Department information under this Condition to be overly burdensome given its importance. We do not find an economic justification for eliminating this Condition.

Condition 23—Community Health Reinvestment ("CHR"): CHR investments include community health services and projects that improve health care or make health care more accessible.[103] CHR does not include investments towards advertising, public relations, sponsorships, bad debt, administrative costs associated with any Domestic Insurer, programs provided as an employee benefit, use of facilities for meetings held by community groups, or expenses for in-service training, continuing education, orientation or mentoring of employees.[104] This Condition requires Highmark to continue to provide funding for non-profit health activities that will provide positive community healthcare outcomes. Highmark must dedicate 1.25% of all its aggregated direct written premiums towards CHR activity. Highmark must annually report CHR activity expenditures for the prior calendar year.

In transactions where competitive concerns of insurer or provider market concentrations have been raised, or other public interest concerns, it is not unusual in approving a transaction for the regulating authority, particularly states, to impose specific investments requirements to ensure

[103] We did not address Condition 23 in the 2017 Updated Competitive Assessment.
[104] Letter from Deputy Insurance Commissioner Joseph DiMemmo to Jack Stover. May 30, 2018.

that public and consumer welfare is enhanced or preserved by the transaction, such as targeted investments in healthcare delivery, including programs, facilities, etc. For instance, the conditional approval of *USC Health System and Methodist Hospital of Southern California* in 2022 required that the parties invest at least $39.6 million in community benefit programs, increased annually by 3.3%, for 5 years.[105] Similarly, the consent decree of *Kaiser and Providence St Mary* in 2021 required that $750,000 be allocated annually to St. Joseph Health Community Partnership Fund for five years to support low income and unmet populations in SMMC's and the new Victorville hospital's service areas.[106]

Providing transparency into Highmark's specific community health reinvestments is critical information necessary for the Department to ensure that Highmark is meeting its obligations to make meaningful public interest investments under the 2013 Order. Such conditions are not unique among state approvals of healthcare transactions. Most healthcare transactions approved under COPA statutes or other state authority require investments to promote the general welfare of the healthcare community, particularly where the transaction enhances the ability of the parties to exercise market power.

Our analysis of the competitive conditions in the insurer and provider markets within WPA do not indicate that either Highmark members or competition in WPA has been adversely affected by Condition 23. Rather, it suggests that this requirement may lead Highmark to direct funds to projects that benefit its members and the community. We view Condition 23 as a key competitive element of the Department's 2013 Order.

B. Evaluation of the specific 2013 Order's Condition

This assessment finds that the presence of each of these specific competitive and consumer initiative Conditions remain necessary to ensure competition in the public interest going forward. We find that state regulators as well as federal regulators are increasingly raising substantive concerns about these types of contracting practices where there are concerns about market power, often due to a merger. These issues are being addressed with targeted conditions along with a consent decree in order for a merger or transaction to proceed.

[105] Letter from Deputy Attorney General Heidi Lehrman to Jill H. Gordon. "RE: USC Health System, Methodist Hospital of Southern California." (June 3, 2022). Date accessed: 12/1/2022. https://oag.ca.gov/system/files/media/mhsc-conditions-packet-06032022.pdf.

[106] Attorney General Bonta Conditionally Approves Ownership Change of High Desert Hospital. 12/17/2021. Date accessed: 12/1/2022. https://oag.ca.gov/news/press-releases/attorney-general-bonta-conditionally-approves-ownership-change-high-desert. Attorney General's Summary List of Conditions. Date Accessed 12/1/2022. https://oag.ca.gov/system/files/media/smmc-conditions-packet-12172021.pdf. See, also Beth Israel-Lahey consent decree, and Ballad COPA cited above.

V. OVERALL ASSESSMENT OF THE 2013 ORDER'S EFFECT ON COMPETITION SINCE 2017

After evaluating the developments and trends in the WPA healthcare insurance markets and healthcare delivery markets, we find that competition has strengthened in the WPA health insurer markets and competition has been maintained in the WPA healthcare delivery marketplace following the 2013 Order. Our assessment finds no indication that the 2013 Order has had any adverse effects on healthcare insurance, healthcare delivery, or the quality of care and variety of plans available to Highmark members or other consumers in WPA.

Since 2017, the competitive dynamics in Pennsylvania and WPA have continued to change in the healthcare insurance markets. UPMC health plan is now a formidable competitor of Highmark. Both Highmark and UPMC are expanding their geographic reach further across the Commonwealth. Besides UPMC, there remain national insurers, such as UnitedHealthcare, Aetna, and Cigna, competing for business in the Commonwealth and WPA marketplace. Additionally, potential increased competition from other BCBSA insurers may provide additional insurance choices for plan enrollees in the future, opening up more direct competition among BCBSA members in WPA and across Pennsylvania. Our competitive assessment indicates that the 2013 Order and Conditions have not placed Highmark at a competitive disadvantage with its health insurer rivals. Since 2017, Highmark continues to successfully compete in the WPA marketplace by maintaining and attracting new members with its network products. Although Highmark has been losing members over time, membership increased in 2020 and 2021 following the 2019 Highmark-UPMC contract.

Our assessment of the healthcare delivery markets finds that the two major vertically integrated systems, AHN and UPMC, are operating competitively by expanding access to care. Moreover, both Highmark and UPMC are expanding their geographic reach further across the Commonwealth—UPMC acquiring hospital systems and physicians, followed by offering its UPMC health plans, and Highmark via its health plan footprint, followed by hospital system affiliations/partnerships. Competition has been maintained by Highmark's investments in AHN via new and improved existing healthcare facilities and services. Nonetheless, AHN's operations are unprofitable with net operating losses incurred in 2020 through first half of 2022, and AHN receives regular infusions of funds from Highmark. AHN has been able to maintain its share of WPA inpatient and outpatient discharges within a narrow range but has been unsuccessful in diverting discharges from UPMC over time. However, our analysis also finds that Highmark member discharges at community hospitals as well as some AHN hospitals may be shifting to UPMC facilities due to Highmark's most recent contract with UPMC in 2019.

Competition among healthcare providers remains strong, as compared with the level of competition before the 2013 Order. Our assessment indicates that vertically-integrated healthcare systems can operate competitively including under circumstances where conditions

are imposed that assist in mitigating some of the potential harm from vertically-aligned buyers and customers that compete with other rivals. The competitive conditions included in the 2013 Order appear to continue to achieve their purpose of preserving or enhancing the competitive dynamics in WPA for both healthcare delivery services. In addition, the competitive Conditions in the 2013 Order to address specific concerns do not exhibit any material impact that would suggest the Conditions have placed Highmark or AHN at a competitive disadvantage in the period from 2017 to the present.

We also find that the 2013 Order and Conditions do not appear to have hampered Highmark's and AHN's ability to respond to material changes in the conditions of competition, i.e., the Pandemic and Highmark and UPMC's insurer/provider contract. The ability for Highmark to request waivers to the competition and public interest conditions provides a safeguard for Highmark to respond to changing competitive condition. Highmark has made such waiver requests and the Department has approved such waiver requests since the 2013 Order was issued.

Lastly, we find that the presence of each of these specific Conditions is consistent with current competition policy and regulatory enforcement. Our research demonstrates that state regulators as well as federal regulators are increasingly raising substantive concerns about these types of potentially anticompetitive contracting practices where there are concerns about market power, often due to a merger. These issues are being addressed with targeted conditions along with a consent decree in order for a merger or transaction to proceed. It is our view that the 2013 Order's Conditions remain necessary to promote competition and the public interest going forward in the WPA.