Testimony Before The
Pennsylvania Insurance Department
Public information Hearing - May 1, 2024

Good morning. My name is Dr. Susan Manning. I am testifying today along with my colleague, Margaret Guerin-Calvert, as the principal authors of the Competitive Assessment of the Western Pennsylvania Insurance and Healthcare Markets Report prepared for the Pennsylvania Insurance Department, which was issued in May 2023 and reissued in January 2024. That report (which I will refer to as the "2023 Report"), our earlier reports and this testimony reflect the professional opinions and assessments of the authors, and not necessarily of Compass Lexecon or FTI Consulting as a firm or their professionals.

The Department requested that Compass Lexecon conduct a 10-year re-examination and update of developments and trends in the Western Pennsylvania healthcare insurance markets and healthcare delivery markets under the Department' s Approving Determination and Order dated April 29, 2013, as amended. In this testimony I will refer to that Order as the "2013 Order" and the conditions under the 2013 Order as the "Conditions."

As you may know, the Department published on its website the 2023 Report and our two earlier reports issued in 2013 and 2017. Also included on the Department's website is our letter in response to the issues related to Highmark Health's Request for Modification submitted in March 2024. Given the time permitted I will summarize certain of our conclusions from these reports and other observations. We encourage anyone who has not already had the opportunity, to review these materials to do so.

I will briefly summarize our three primary conclusions, which **are based on our extensive review of the healthcare insurance and provider markets in Western Pennsylvania.**

First, it is our conclusion that the 2013 Order's competitive and public interest Conditions appear to achieve their purposes of preserving and protecting competitive dynamics while not placing Highmark at a competitive disadvantage. We have not identified any economic evidence in the data and information provided to us or through public sources that these Conditions have impaired Highmark's and Allegheny Health Network's ability to respond to material changes in competitive conditions. Highmark Health's ability to request waivers of these Conditions, when necessary, provides a safeguard for Highmark to respond to changing competitive conditions. Highmark has made waiver requests and waivers have been granted by the Department for such requests.

The potential for anticompetitive harm that we found in 2013 remains. Market factors that pose potential competitive risks include the concentrated healthcare insurance and healthcare provider space in Western Pennsylvania and the predominance of Highmark and UPMC and their increasingly similar vertical structures. These vertical structures can lead either to diminished competition where they accommodate each other's strategies or intense competition. Other factors that pose potential competitive risks include the circumstances arising from the removal of restrictions via the Blue Cross Blue Shield Association antitrust settlement and the Highmark Inc./UPMC insurer-provider contract. The competitive Conditions were designed to mitigate potential adverse effects on competition, and these factors can create the potential for anticompetitive harm and the likelihood and incentive for anticompetitive conduct.

Second, as we expressed in our 2017 Report, **we conclude that the 2013 Order, including its competition and public interest Conditions, have had no adverse effect on healthcare insurance, healthcare delivery, or the quality of care and variety of healthcare plans available to Highmark members or other healthcare consumers in Western Pennsylvania**. Nor do we believe the 2013 Order and its Conditions had an adverse effect on Highmark or Allegheny Health Network's ability to compete.

Third, we conclude that competition within the Western Pennsylvania healthcare insurance marketplace has strengthened since 2017, and healthcare delivery services competition in Western Pennsylvania, i.e., inpatient, outpatient, and physician services, is strong as compared with the level of competition present before the 2013 Order. Highmark had lost membership from 2013 to 2021 as we describe in the 2023 Report; but, more recently, Highmark has been re-gaining membership as it continues to develop new and innovative network products to use in competing for members. UPMC is a formidable competitor of Highmark in the overall insurance sector, although the two competitors tend to focus on different health plan products. In Western Pennsylvania and the Commonwealth, there remains a national insurer presence, which includes UnitedHealthcare, Aetna, and Cigna, among others.

On the healthcare delivery side, Allegheny Health Network provides a viable competitive alternative to UPMC for Highmark members and other Western Pennsylvania patients. That said, Allegheny Health Network's operations are unprofitable with net operating losses incurred in 2020 through 2023 and Highmark Health continues to infuse Allegheny Health Network with significant capital.

Key issues/concerns with Highmark Health's Request to Modify the 2013 Order

Our concerns with modifying the 2013 Order as requested by Highmark Health, specifically the competitive and public interest Conditions, take into account foregoing and focus on the potential vertical effects from the 2013 transaction in terms of the ability to foreclose or diminish competition or raise rivals' costs of competing in Western Pennsylvania healthcare insurance and provider markets.

With respect to these vertical competitive concerns, and specifically **Conditions 1 and 2 restricting exclusive contracting and Conditions 5 and 6 prohibiting Most Favored Nation or, as they are commonly referred to, "MFN" provisions**, Highmark Health claims that it has no intention to engage in these insurer-provider contracting practices. It also claims that it faces independent oversight for any such conduct under the antitrust laws and Pennsylvania and federal law governing charitable organizations. Such contracting practices have been successfully challenged in courts and are prohibited in some states. However, we are not aware of any general prohibition on such practices in Pennsylvania or under federal law governing charitable organizations. If Highmark Health and its affiliated entities intend not to engage in such contracting practices, it would seem that Highmark Health and its affiliated entities would not be competitively harmed or disadvantaged by these Conditions. This is true especially if, as Highmark Health alleges, its rivals face similar constraints to Highmark Health under other laws or regulations. Maintaining the 2013 Order's Conditions against exclusive contracting and the use of MFNs will assure the Department and Commonwealth residents that these commitments are kept. Moreover, these Conditions are useful to protect against potential vertical

concerns about foreclosure of competition or raising rivals' costs, as potential rivals enter a healthcare market, such as in Western Pennsylvania.

In advocating for the modification or elimination of **Condition 3, the 5-year limit on insurer-provider contracts**, Highmark Health claims that it is reluctant to invest in innovative, pro-consumer arrangements with providers because it cannot obtain an appropriate return on investment. According to Highmark Health, this Condition poses particular competitive disadvantages for Highmark because other payors may enter into the long-term contracts necessary for risk and value-based arrangements, while Highmark must request a waiver from the Department, which can cause significant delays in negotiations.

Highmark has not provided information to substantiate its claim of being competitively disadvantaged by this Condition. That said, studies have shown that long-term insurer-provider contracts which do not allow contracts to adjust to changing market conditions can have anticompetitive effects. This was a key concern articulated by the Department of Justice in its review of the Highmark/WPAHS transaction in 2013 and evaluated in the Department's review of the transaction. We acknowledge that seeking waivers to Condition 3 can take time. Should the Department decide to make a change, it may wish to consider some modifications to the 2013 Order's Condition 3 to address the waiver delay, but with the proviso that insurer-provider contracts exceeding 5 years should incorporate a market-adjustment mechanism to assure that neither the insurer nor provider become competitively or financially disadvantaged over time.

With respect to the **Firewall Provisions of Conditions 7, 8, and 9**, we strongly disagree with Highmark Health's position that the Federal Price Transparency Rules have the

equivalent effect of the 2013 Order's Firewall Provisions, thus mooting the need for these Conditions. The Federal Price Transparency Rules require group health plans and insurance issuers to publish provider-specific reimbursement rates. Similarly, hospitals must publish payor-specific rates for services and discounted cash prices. These Rules do not prohibit the transfer of rivals' competitively sensitive information along the vertical chain, i.e., from Allegheny Health Network (the provider) to Highmark Inc (the insurer), or vice versa. Such information transfers have the potential to diminish competition among rivals and raise rivals' costs, with adverse effects on consumers. The Firewall Conditions, as effectuated in Highmark's published firewall policy and enforcement provisions, are useful to protect against potential adverse vertical effects, such as foreclosure and raising rivals' costs, as new rivals potentially enter the Western Pennsylvania healthcare markets.

The 2013 Order also includes several Conditions that specifically address the public interest. I will address those Conditions now.

We understand that Highmark Health agrees that the 2013 Order's **Condition 20, which prohibits anti-tiering and anti-steering**, is pro-consumer and procompetitive, and it prevents artificial and unnecessary inflation of health care costs. We understand that Highmark Health and its affiliated entities have not included, and Highmark Health claims that none of those entities will include, anti-tiering and/or anti-steering provisions in its insurer-provider contracts. As such, we do not see how Condition 20 would cause Highmark to be competitively disadvantaged. Maintaining Condition 20 will assure the Department and healthcare consumers that these commitments are kept.

With respect to **Condition 21 relating to Highmark member admissions at other community hospitals,** this Condition addresses concerns expressed that Highmark's

affiliation with Allegheny Health Network could potentially result in Highmark steering its members to Allegheny Health Network and away from community hospitals. Such steering would cause considerable financial harm to such hospitals. This Condition requires Highmark to report on the impact of its integrated delivery network strategy with respect to community hospitals. We understand Highmark Health considers this Condition to be unnecessary because other payors also have significant membership volume at community hospitals. Highmark Health views the reporting or monitoring standard of this Condition to be a burden that constrains it from designing and offering products that would be in the best interest of policyholders and subscribers.

We are aware that smaller and independent hospitals in Western Pennsylvania and across the Commonwealth face significant financial viability and other challenges today. Many community hospitals have either closed, continue to struggle, or have sought affiliation with or buyouts by larger healthcare systems. Given this challenging environment, this Condition provides the Department with additional transparency with respect to the area's largest insurer's patient volumes at community hospitals, which ultimately compete with Highmark's own hospitals. We have not identified any evidence that this reporting or monitoring has had an adverse competitive or financial effect on Highmark, and therefore, we do not find an economic justification for eliminating this Condition.

Community Health Reinvestment, Condition 23 requires Highmark to continue its commitment to non-profit health activities for the betterment of overall community healthcare. Highmark must dedicate 1.25% of all its aggregated direct written premiums towards CHR activity and report such funding to the Department. In its

Modification Request, Highmark Health recognizes that it has a commitment to the community and a statutory obligation to report Community Health Reinvestment activities. However, it states that no other Pennsylvania payors are required to pay a specific dollar amount for community health reinvestment. We note that other regulators across the country have required five-year or longer financial investments in community benefit programs in similar transactions where there are competitive concerns about insurer or provider market concentration. Our analysis of the competitive conditions in Western Pennsylvania do not indicate that either Highmark members or competition in the area have been adversely affected by Condition 23.

With respect to Highmark Health's position that consent orders with similar conditions **expire after 5-10 years**, which position appears to be primarily based on some consent orders cited in our 2023 Report, in our review, we find there is no "hard and fast rule" for how long such orders stay in effect. Rather, the issue is context dependent. In a context in which both provider and insurer markets are concentrated with two large vertically integrated firms, existing and prospective vertical competition concerns weigh in favor of continuing the 2013 Order.

Highmark Health also claims in its Modification Request that it is the **only insurer-provider entity subject to these competitive and public interest requirements**. At the time of Highmark Health's Request, this may have been true but since then, we understand that the Department imposed similar conditions on the acquisition of Geisinger Health, citing competition, the public interest benefit, and that such conditions are procompetitive and consumer welfare enhancing to the residents of Pennsylvania.

Competitive Concerns Should the PID Terminate the 2013 Order's Competition and Public Interest Conditions

To summarize our competitive concerns with Highmark's Request to Modify the 2013 Order, **it is our overall conclusion that the competitive and public interest Conditions remain necessary to strengthen and maintain competition in both the health insurance and healthcare provider market sectors**.

"But-for" the 2013 Order, there may exist an increased risk of potential anticompetitive behavior in the concentrated healthcare insurance and provider sectors and the long-term contract between UPMC and Highmark Inc., and these rivals' increasing symmetrical vertical structures. Specifically, as stated in our 2023 Report, "[w]ith two large and more symmetrical vertically-integrated healthcare delivery and financing networks competing against one another in Western Pennsylvania, competition can take one of two forms—intense competition or tacit collusion, or more specifically, diminished competition as rivals tend to accommodate rather than react to competitor's actions in order to raise price or reduce the quantity or quality of products and services."

It is also important to emphasize that we have not conducted an analysis, nor have we ever stated or concluded, that if the 2013 Order's competitive and consumer choice conditions were terminated, competition in Western Pennsylvania would remain robust to the benefit of Highmark members or healthcare consumers. To the contrary, it is our opinion that the available evidence indicates the 2013 Order, and its competitive and public interest Conditions continue to serve to mitigate potential adverse competitive effects.