OVERVIEW OF HIGHMARK'S STRATEGIC VISION

For nearly 75 years, Highmark's mission has been to provide ready access to high-quality, affordable health care services for the communities it serves. Several forces at work today, emerging principally over the last decade, threaten Highmark's ability to sustain both the affordability and the access components of this mission.

With the advent of federal health reform legislation nearly two years ago, Highmark began a series of initiatives seeking to restore affordability to health insurance. Specifically, Highmark began to undertake an effort to transform market dynamics, from a market where the price and volume of services are determined by how much market power a provider could exercise to one where price and volume of services are determined by how much value a provider delivers. Highmark has already launched at least two programs in support of this transformation. One, a pilot, tests the concept of an accountable care organization, where providers assume more accountability for managing the cost of care. The other, a program called Quality Blue, has been in the market for a number of years and seeks to link clinical quality to reimbursement for provider services. Approximately three percent of Highmark's reimbursements are linked to several quality metrics at the present time.

Highmark's vision is simple and compelling: structure reimbursements to providers on the basis of how well providers perform these services, measured by quality and customer satisfaction: Do providers adhere to the best evidence available? Is the clinical outcome favorable? Did the patient have a satisfying experience? This reimbursement structure, known in the industry as "pay for performance" or "P4P," is intended to be combined with a set of tools providing the consumer with the knowledge, transparency, and freedom needed to make well-informed decisions regarding whether, and from whom, to obtain health services. Accordingly,

Highmark no longer intends to simply negotiate prices with providers, but rather intends to create the market conditions for a much more efficient exchange of dollars for services. These new market conditions, once developed, are intended to empower both physicians and consumers to make much better decisions, to focus on the rapidly growing area of outpatient services (now close to 80% of all costs in the commercial population), to sharpen the vital role of the secondary acute care hospitals, and to restore positive choice at the tertiary acute care level.

Consistent with this strategy, Highmark approached UPMC, the single largest provider system in western Pennsylvania, in early 2010 with a proposal to engage it in a contract based principally on the terms described above: linking payments to a demonstrated ability to deliver high-quality services and to create an exceptional customer experience for Highmark's policyholders and subscribers. UPMC refused to entertain the proposal and, instead, demanded a 20% increase covering its entire revenue base (including physician fees and hospital fees for both commercial and Medicare Advantage products). This demand would translate into a 40% increase for the subset of UPMC facilities with contracts currently up for renewal (Magee, Presbyterian-Shadyside, Passavant, McKeesport, Northwest, Horizon, Bedford and St. Margaret), or an increase of approximately $400 million per year by Highmark's calculation. If Highmark were to meet this demand, it believes that employers and individuals in western Pennsylvania would experience an approximately 7% increase in commercial premiums solely attributable to the UPMC contract position.

While Highmark attempted to engage UPMC in a new reimbursement structure, the only other health system in the region with comparable tertiary services, West Penn Allegheny Health System, Inc. ("WPAHS"), was experiencing growing financial troubles. WPAHS's bond ratings were downgraded and Highmark became concerned that WPAHS was approaching the point

where it would violate its bond covenants. WPAHS also announced that it would close one of the largest acute care facilities in the region. In light of these developments, Highmark began to consider ways that it could assist WPAHS.

Upon becoming aware of discussions between Highmark and WPAHS, UPMC announced that it would no longer contract with Highmark. UPMC has accumulated provider assets and physicians in western Pennsylvania over the last decade and now controls over 55% of all healthcare provider capacity in Allegheny County by Highmark's count. UPMC's position creates a fundamental issue of access to UPMC facilities for Highmark. Highmark needs to take action to assure that its policyholders and subscribers will have access to lower cost, high quality providers in the event UPMC is no longer in the Highmark network.

Having witnessed the disruption that a major Chapter 11 bankruptcy filing had on providers, policyholders and subscribers, and the overall community a decade ago, and in light of the threat by UPMC that it will not enter into new contracts for hospital and physician services, Highmark now faces a situation where over 59% of its inpatient provider network capacity (UPMC and WPAHS) in southwestern Pennsylvania (Allegheny, Beaver, Butler, Westmoreland, Washington Counties) is at risk. In some locations within the region, the percentage of Highmark inpatient provider network capacity at risk is even higher; for example, where a UPMC or WPAHS facility is the only hospital in reasonable proximity to a policyholder/subscriber. It is in this context that Highmark is seeking approval to affiliate with WPAHS as part of a broader strategy to preserve and assure for the future long-term access to affordable, high-quality health care including both hospital and physician services for its policyholders and subscribers.

Highmark provided $50 million in funding support to WPAHS in June 2011. This intervention, however, only preserved a fragile financial status quo for a limited time. Highmark needs to affiliate with WPAHS now to stabilize the situation more permanently and in so doing to preserve WPAHS as an essential choice in the market and as the anchor to a higher-performing network based on the efficient market principles described above: pay for performance, transparency, and value-based exchange of services for dollars. When the affiliation with WPAHS is complete and other elements of the strategy are in place, Highmark policyholders and subscribers in western Pennsylvania will see four major benefits.

- *Lower Premiums.* A vibrant WPAHS will give Highmark's policyholders and subscribers access to high-quality healthcare services built around a commercial product that will be less expensive than any product that includes UPMC at the contract rates it demanded. Implementation of Highmark's strategic plan, including improvements in the care delivery model to assure better quality and better patient experience, should result in an ability to control the healthcare costs which drive premium increases.

- *More transparency and, ultimately, higher quality.* WPAHS and other community hospitals already have agreed to engage in a quality-based reimbursement system linking payments directly to quality health care provision. This new payment system, the quality metrics of which will be broadly available to every policyholder and subscriber for evaluation, will induce providers, including community hospitals, to adhere to the highest standards of medicine and to ensure that the policyholder/subscriber knows much more precisely what he or she is consuming and what the cost of services will be.

- *More choice of, and access to, providers.* Preserving the financial integrity of WPAHS will permit policyholders and subscribers and patients from all insurance carriers (not just Highmark) to have greater access and choice in western Pennsylvania. Aetna, Cigna and United Health, for example, also have contracts with WPAHS.

- *More integrated care and better subscriber experience.* By creating a system which can coordinate health insurance and health provision and by introducing reimbursement structures that reward care coordination and the patient's experience, Highmark will create an organization that improves the overall satisfaction and clinical outcomes of its policyholders and subscribers when they seek care.

Even if UPMC were to change its contracting posture toward Highmark, the need to maintain provider choice in the western Pennsylvania market will remain, not only for Highmark's policyholders and subscribers, but for the benefit of all other insurers (e.g.,

Medicaid, Medicare, national carriers) and their policyholders and subscribers. This balance is essential to a well performing health services market. For reasons presented below, only a direct affiliation between Highmark and WPAHS will provide the degree of structure necessary to turn around WPAHS's financial condition, improve the WPAHS care model, and restore a basic level of choice in the western Pennsylvania provider market on a timely basis.

A. The imperative for change in the western Pennsylvania delivery system and Highmark's vision and strategy for promoting this change.

The growing costs of health care in western Pennsylvania have made health insurance increasingly unaffordable for a larger percentage of individual and employer populations resulting in a growing number of uninsured. In the last decade alone, health insurance premiums in western Pennsylvania have increased at a rate greater than 6% per year while wages and salaries have only increased 2-3% per year. Highmark believes that this unsustainable growth in healthcare costs has several root causes: the exercise of market power on the part of providers leading to steep reimbursement increases; reimbursement methodologies encouraging overutilization of health services and encouraging the use of higher cost, not lower cost, settings of care; provider system strategies leading to redundant overinvestment in physical assets and clinical technology; and benefit structures that do not encourage value-conscious consumption of services on the part of policyholders and subscribers.

Highmark's vision and strategy for addressing these issues has two critical elements:

- For providers, Highmark envisions a multi-pronged approach to achieve a positive impact on practice patterns. Four provider imperatives constitute Highmark's provider network strategy:

    1. Re-aligning physician incentives through new reimbursement models.

2. Securing access to a "full-service" network of lower-cost, higher quality, highly efficient care providers that both share in the vision of improving the care model and are willing to enter into alternative contract relationships and make investments, where appropriate, to promote the adoption of new protocols and/or alter care offerings.

3. Promoting the introduction of innovative care models and lower-cost sites of treatment.

4. Building platforms to support care redesign and cost reduction within the provider community.

All of these imperatives will need to be addressed in order for Highmark to fully achieve its vision of affordable access for its policyholders and subscribers.

- For policyholders and subscribers, Highmark will develop products that create incentives for value conscious decision-making and will support policyholders and subscribers in making these decisions by providing access to the next generation of cost and quality transparency tools.

Highmark believes that these actions, taken together, will help to control costs, increase quality, maintain continued choice and access, and improve the overall policyholder/subscriber experience. Specifically, Highmark believes that policyholders and subscribers will benefit ultimately in several ways:

- Highmark will avoid the approximately 7% increase in commercial premiums which Highmark calculates would have resulted from UPMC's contract positions, thus improving affordability of health insurance. Premiums may still increase, but they will increase less than had Highmark met UPMC's contract demands.

- Consumers will have more provider choices overall in the marketplace and improved access to providers regardless of the health insurer they choose.

- Consumers will benefit over the longer term from a market transformation. They will be less likely to face premium increases driven by providers with market power and they will be permitted to make informed choices about which provider offers the greatest value.

B. Why this change needs to happen now.

The urgency behind the decision to affiliate with WPAHS is a function of three recent events.

- UPMC's posture in recent rate negotiations and its threat to withdraw from Highmark's network is discussed above. Either possibility (substantially increased reimbursements leading to higher premiums for policyholders and subscribers or withdrawal from the network), combined with the specter of a financially troubled WPAHS, could compromise Highmark's ability to fulfill its mission, by either increasing premium costs beyond affordability, disrupting access, or both.

- WPAHS has expressed a willingness and desire to engage in new reimbursement and transparency practices that will help to control costs, enhance quality, and improve customer satisfaction, thereby accelerating the transformation of the market.

- National healthcare reform will be fully implemented whereby Highmark will need to offer products costing less, through a state-based exchange in

two years. Consumers in other states like Massachusetts, which has implemented a similar set of reforms, have demonstrated that they prefer insurance products that are 10-15% less expensive even if the provider network excludes several hospitals and doctors.

C. Why Highmark's affiliation with WPAHS is the most effective way to accomplish this change.

- Highmark has the tools necessary to ensure a robust turnaround for WPAHS without resorting to reimbursement increases (e.g., ability to realign reimbursement incentives, align independent physicians, deploy shared service platforms, etc.).

- WPAHS has asserted its willingness and eagerness to engage in Highmark's new approach to reimbursement, consumer engagement, choice and transparency.

- A direct affiliation reduces traditional barriers to speedy and effective implementation of these changes.

THE IMPERATIVE FOR CHANGE AND HIGHMARK'S VISION FOR THE FUTURE

The need for a new approach to the market and Highmark's decision to pursue the affiliation with WPAHS stem from Highmark's conviction that the current market structure, the recent pattern of provider consolidation and the current model of care delivery are increasingly in conflict with the mission of ensuring policyholders and subscribers, employers, and the broader patient community long-term access to an open network of affordable, high-quality providers. The impending changes in the environment induced by healthcare reform will exacerbate these

challenges by altering the means by which health insurance is underwritten, priced, and distributed. Accordingly, Highmark believes a fundamental change in the role of the provider (delivering value, not just volume) and the consumer (making informed decisions about who delivers the best value) is necessary.

A. Why the Current System Needs to Change

As the national debate over healthcare has highlighted, the current fee-for-service reimbursement methodology has led to perennial increases in provider costs without a corresponding increase in quality or positive consumer experience. A recent study by Milliman, for example, showed that the percentage of a family's income spent on health care in the Pittsburgh metropolitan area is the highest of twelve comparable areas across the nation. Highmark believes that many well-documented reasons for this result have been identified, including the incentives for utilization that fee-for-service creates, the fragmented nature of the delivery system, the lack of transparency and information for patients and policyholders and subscribers, and the need on the part of providers to subsidize lower-paying patients.

Highmark believes that similar structural factors are making insurance increasingly unaffordable in western Pennsylvania. In the last 5 years, Highmark has experienced an annual trend of medical cost increases of 6.6% (versus 2-3% increase in the Consumer Price Index) despite efforts to manage utilization and negotiate lower provider rate increases. Highmark believes this is a typical result in a market dominated by a large provider which can lead to behaviors such as overutilization, movement of services to higher reimbursement locations, building of unnecessary facilities, and requests for unreasonable reimbursement increases. UPMC has been an active consolidator in the last 10 years (largely though hospital acquisitions, employment of thousands of physicians, and extension of key clinical specialties like oncology

into the community in ways that promote dependency even on the part of the remaining "independent hospitals"). This consolidation, in Highmark's view, has resulted in market power that in turn leads to excessive reimbursement demands, which would result in much higher premiums for Highmark's policyholders and subscribers.

Highmark also believes that there are three other, less obvious, reasons for the escalation of health care cost increases:

1. Provider overutilization and inappropriate settings of care

The fee for service reimbursement structure defining the industry for decades is one of the major contributors to this utilization pattern. Most providers benefit financially from performing additional services. Highmark estimates, for example, that for services such as clinical laboratory diagnostics and radiology, its policyholders and subscribers utilize up to 65% more services than comparable, risk adjusted regions in the mid-Atlantic area.

In addition, many decisions about the location at which a patient receives care are made without a full understanding of the cost and quality implications. For many services, Highmark believes that the setting can be a major determinant of the cost. For example, ambulatory surgery services performed in a hospital are typically 50% more expensive than the same services performed in a stand-alone center; diagnostic imaging is 45% less expensive when performed in a free-standing imaging center compared to a hospital; urgent care is delivered at roughly half the cost in an urgent care setting compared to a hospital emergency room. Approximately 17% of all emergency room visits can be addressed by a free-standing care facility, which is typically two-thirds less costly than hospital-based emergency rooms.

In the future, Highmark intends to design products with cost sharing incentives to encourage value-conscious decision-making by policyholders and subscribers. Highmark will

engage in a pay-for-performance reimbursement system with WPAHS and other willing providers that considers both utilization rates and cost differences between hospitals and other settings. Through its transparency tools, Highmark will give policyholders and subscribers information to help them determine the best value when choosing providers. By providing actionable data on both quality performance and cost of a provider, they will have the opportunity to choose the highest value providers. These providers will also likely benefit from higher patient volume, as they become recognized as being associated with delivering higher quality at lower cost. In addition, Highmark estimates that medical costs can be reduced by 2-6% simply by redirecting to appropriate, lower cost settings, while assuring quality and likely improving the patient experience.

2. Overinvestment in physical assets and clinical technology

Highmark believes that, in a market where supply is not value-driven and consumption is not value conscious, the providers with the greatest market power can charge higher prices and use the surplus from these high prices to "overinvest" in unnecessary physical assets, which, in turn, causes them to require even higher reimbursement levels. Hospital systems often invest in the latest technology, even if that new technology does not lead to improved outcomes justifying this cost. In turn, those hospitals and the physicians they employ have an incentive to utilize this new equipment, effectively increasing utilization and overall service costs. Input costs to the system (e.g., drugs and medical devices) often follow similar patterns, with continued innovation and patent protections leading to accelerated inflation relative to other sectors. These costs represent sources of inflation that do not create value for policyholders and subscribers or the broader patient community, meaning that insurers can mitigate inflation without negative impact. For example, Highmark's information indicates that orthopedic implants nationally account for

approximately 20% of episode costs for total knee replacement, and vary by up to 33% across knee implant types. Inappropriate matching of implants is estimated to cost the healthcare system in the U.S. $200 million per year. Encouraging physicians to utilize more cost-effective though comparable quality implants and appropriately match the implant to the clinical situation should reduce episode costs considerably.

3. Lack of value-conscious consumption

Consumers have not historically been given the tools to make informed, value-conscious decisions about whether, and from whom, they will procure health services. The basic benefit designs embedded within health insurance products have also failed to encourage proper evaluation on the part of the consumer, and this raises costs for all policyholders and subscribers. Accordingly, Highmark is now combining efforts to engage the consumer more deeply, introduce much greater transparency into the market for provider services, and develop products that financially reflect the differences in value in the marketplace. Under Highmark's strategic plan, consumers will be offered products at a more economical price point resulting from incentives to consumers to use the highest value providers.

Highmark already has several tools in the marketplace or under development to accomplish this goal: (1) "Provider Search" permitting a policyholder/subscriber to conduct side by side comparisons of providers and to identify which tier of cost a provider is in; (2) "Patient Experience Review" giving policyholders and subscribers access to other patients' reviews and comments of specific providers and institutions; (3) "Out of Pocket Cost Estimator" permitting patients to clearly understand the personal financial obligations and quality tradeoffs associated with going to one provider versus another. Other, related tools are under development as well.

At no time will Highmark force a consumer to select one provider over another. Rather, Highmark intends to enhance choice based on value.

B. Highmark's Strategy to Address Affordability and Access Issues

Highmark understands these issues and has developed a comprehensive strategy to address these dynamics. This strategy includes changing the delivery of care via a new reimbursement approach that encourages providers to use the most cost-effective venue for care, adhere to evidence-based standards of care, and deliver superior outcomes by reducing such issues as unnecessary re-admissions and post-surgical infections. Highmark's strategy is focused on driving value for the consumer; that is, assuring high quality at an affordable price. From a policyholder/subscriber perspective, the strategy includes providing transparency regarding differences among providers with respect to cost, quality, patient experience, and overall value so that policyholders and subscribers can make informed choices around their healthcare services. This strategy should enable Highmark to deliver a lower cost, higher quality product in the marketplace for its policyholders and subscribers when the strategy is fully implemented.

CONCLUSION

A Highmark-WPAHS affiliation will represent the coming together of two organizations dedicated to common goals and objectives, including changing the way in which health care is delivered to their customers and patients. Both are committed to improving the quality and affordability of health care and enhancing the patient experience through collaborative relationships with physicians and operational excellence. Highmark believes that an affiliation with WPAHS will result in a stable integrated health system which will be a valuable community asset offering high quality, lower cost health services across the continuum of care.