Buchanan Ingersoll & Rooney PC

Jack M. Stover
717 237 4837
jack.stover@bipc.com

409 North Second Street
Suite 500
Harrisburg, PA 17101-1357
T 717 237 4800
F 717 233 0852
www.bipc.com

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Corporate & Financial Regulation
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Pennsylvania
Insurance Department

May 1, 2017

VIA HAND DELIVERY

Joseph DiMemmo, CPA
Deputy Insurance Commissioner
Office of Corporate and Financial Regulation
Pennsylvania Insurance Department
1345 Strawberry Square
Harrisburg, PA 17120

Re: Highmark Health
Response to Condition 19 of the April 29, 2013
Approving Determination and Order (Order No. ID-RC-13-06)

Dear Mr. DiMemmo:

I am hand delivering herewith a non-confidential report in response to Condition 19 of the Approving Determination and Order issued on April 29, 2013, relating to IDN Savings.

I have provided a copy by electronic means to Mr. Beaser and Mr. DeLacey.

Thank you for your consideration.

Very truly yours,

Jack M. Stover

JMS/gmt
Enclosure
cc: Lawrence J. Beaser, Esquire (via email: Beaser@BlankRome.com)
Patrick T. DeLacey (via email: pat.delacey@raymondjames.com)

Highmark Health Report Pursuant to Condition 19 of the Pennsylvania Insurance Department Approving Determination and Order (Order No. ID-RC-13-06)

IDN SAVINGS REPORT FOR CALENDAR YEAR 2016

EXECUTIVE SUMMARY

Highmark Health, f/k/a UPE, submits this report concerning realized IDN Savings in calendar year 2016 and cumulatively since 2013 in compliance with Condition 19 of the Pennsylvania Insurance Department's Approving Determination and Order ID-RC-13-06 (*Approving Order*).

Condition 19 requires an annual report showing actual results achieved on four metrics relative to savings benchmarks in Appendix 3 of the Approving Order:

Metric 1: Total IDN Savings
Metric 2: Savings for a Family of Four
Metric 3: Inpatient Spend
Metric 4: Outpatient Spend

The analytics included in the approved Form A filing, as amended, began with baseline costs for 2012 through 2016. These baseline costs included a fixed trend assumption based on historical observed trends. Highmark Health developed two scenarios, the *No Transaction* scenario (where the affiliation was not approved) and the *IDN* scenario (where the affiliation was approved), by layering adjustments on top of the projected baseline costs. The expected IDN Savings is the difference between these scenarios. The actual IDN Savings is the difference between the actual costs and the *No Transaction* costs.

In this Report, the term *benchmarks* will refer to the numbers in Appendix 3 of the Approving Order (as amended in the IDN Savings Report for 2013).

Since the benchmarks in Appendix 3 of the Approving Order only go through 2016, Highmark Health presents this Report as the final Report to be submitted for Condition 19 under the Approving Order.

Measuring as prescribed by the Approving Order and as detailed in subsequent pages, Highmark Health realized IDN Savings in 2016 of $1,075 million versus a benchmark of $446 million. Cumulatively since 2013, Highmark Health realized actual IDN Savings of $2,310 million versus a cumulative benchmark of $834 million. These results are summarized in Exhibit 1.

The Approving Order specifies that the reported actual IDN savings are to be calculated versus the *No Transaction* scenario contained in the approved Form A filing. Highmark Health recognizes this approved methodology is influenced by the trend assumption within the original work dated from 2012. Industry-wide utilization trends have dropped across the country since 2012. We recognize therefore that part of the utilization decline within Highmark Inc. (hereafter termed *Highmark*) membership within the 29 counties may be attributed to systemic changes in

population and provider behavior not directly attributed to results of activities surrounding the IDN, but are unable to accurately reflect those systematic trends.

In this Report, Highmark Health presents results of the IDN Savings measurement in the manner prescribed by the Approving Order. In addition, Highmark Health has quantified the impact of some of the specific initiatives that have been implemented in pursuit of improving quality and enhancing value for Highmark members and for the entire community. Since these specific initiatives are not a comprehensive list of all of Highmark's IDN activities, the quantification is meant only as a comparison to the prescribed measures.

Highmark Health recognizes that some initiatives could have been implemented without an IDN. However, if the affiliation had not been approved (*No Transaction*), Highmark Health believes the impact of these efforts would have been limited. Without integration, the effectiveness of Highmark Health's efforts would have been significantly hampered (or in some instances never able to have been pursued).

Since the affiliation was approved, Highmark Health has begun efforts to begin to change the health care paradigm, moving from a reimbursement structure that rewards volumes to one that rewards outcomes and one where care is delivered locally within communities. The initiatives listed in this Report, and in fact all of the IDN Savings, are designed to improve quality and provide better value to Highmark members, Allegheny Health Network (hereafter termed *AHN*) patients, and the whole community. This represents a significant change for all the players, including providers. Change is never easy to execute. The key to success is engaged providers, not just at AHN but also community providers. Highmark Health believes in leading by example. By implementing these initiatives with its own providers, Highmark Health has advanced the agenda with community physicians in its commitment to changing the paradigm. Community providers, who are a critical part of the IDN strategy, would have been less likely to engage effectively with Highmark Health without this credibility.

In the approved Form A filing, Highmark Health assumed the *No Transaction* broad product would realize only 25% of the full potential savings for most of the IDN Savings components. Therefore, unless otherwise noted, Highmark Health assumes 25% of the savings for each quantified initiative would have been achieved without an IDN and that the remaining 75% is directly related to the IDN strategy pursued with the transaction.

As prescribed in the Approving Order, an independent actuarial consulting firm, Milliman, has reviewed the methodologies used to determine the realized IDN Savings. A copy of Milliman's opinion relating to the reasonableness of these methodologies is included as Exhibit 2.

IDN SAVINGS RESULTS

TOTAL IDN SAVINGS

The first measure of IDN Savings is the total IDN Savings, calculated as the sum across segment and product of the *Actual* enrollment times the difference between the *Actual* PMPM and composite *No Transaction* PMPM. This measure includes Commercial Group and Medicare Advantage segments.

As summarized in Exhibit 1, Highmark realized $1,075 million of IDN Savings for Highmark members living in Western Pennsylvania relative to the *No Transaction* scenario in 2016 and compares favorably to the $446 million savings benchmark. The actual savings equates to $98.69 per member per month.

Cumulatively since 2013, Highmark realized $2,310 million of IDN Savings relative to the *No Transaction* scenario through 2016, which compares favorably to the $834 million cumulative benchmark. The actual cumulative savings equates to $46.92 per member per month.

SAVINGS FOR A FAMILY OF FOUR

The second measure is the annual savings to a Western Pennsylvania family of four in Highmark's commercial group IDN product relative to a Highmark broad network group product under the *No Transaction* scenario.

The 2016 IDN Savings amounts to $4,524 per year for a family of four in Highmark's commercial group IDN product compared with a benchmark of about $3,000 by the end of 2016.

INPATIENT SPEND

The third IDN Savings metric relates to commercial inpatient spend. This statistic is calculated as the percent difference in the *Actual* commercial inpatient composite PMPM and the *No Transaction* commercial inpatient PMPM. In 2016, the inpatient savings was 23.3%, which is above the benchmark of 10% by the end of 2016.

OUTPATIENT SPEND

The final IDN Savings metric relates to commercial outpatient spend. This statistic is calculated as the percent difference in the *Actual* commercial non-oncology outpatient composite PMPM and the *No Transaction* commercial non-oncology outpatient PMPM. In 2016, the outpatient savings was 22.6%, which is above the benchmark of 10% by the end of 2016.

IDN SAVINGS BY COMPONENT

The Approving Order requires a discussion of realized IDN Savings by the components listed in Attachment 4 of the Approving Order. Consistent with prior years, Highmark Health relabeled and combined some of these components. The final components are described and discussed below.

While the aggregate IDN Savings calculation is prescribed and deterministic, the methodology to segregate the IDN Savings into the prescribed components requires some actuarial judgment, which has been reviewed by Milliman.

As mentioned, Highmark Health is engaging AHN and community providers to change the health care paradigm to one that rewards outcomes and delivers care in local communities. The key to success is engaged providers, not just at AHN but also among community providers.

ONCOLOGY

In 2016, Highmark Health realized $72 million in *Oncology* savings.

Originally, this component measured the savings related to reversing non-value added billing practices by UPMC and other providers in switching from physician-based CMS-1500 billing forms to facility UB-04 billing forms for physician oncology services, which more than doubled the cost without changing anything in the delivery of care, including the site or setting of care, or improving quality in any way.

As detailed in the IDN Savings Report for 2013, the definition for this component has been expanded to cover all savings related to outpatient and physician oncology services. The broadened definition includes initiatives that control utilization or cost at any Western Pennsylvania provider, not just UPMC. Also, the new definition does not discriminate on the method used to achieve the savings but instead focuses on the final result - lower costs.

The driver of the Oncology savings in this Report is lower Oncology utilization. Highmark has worked diligently to manage oncology care more effectively. For example, the *Oncology Prior Authorization Program*, a new program in 2014, requires prior authorization of oncology drugs, thus ensuring appropriate dosage, number of treatments, and type of treatment for oncology patients. The program realizes savings by eliminating unnecessary utilization and encouraging less costly services while maintaining quality through efficient and effective treatment protocols.

FACILITY MIX

Highmark Health recognizes the importance of keeping care in the local communities.

The *Facility Mix* component of IDN Savings measures savings related to shifting facility care to facilities that provide better value to the patient. In 2016, Highmark Health realized $33 million in savings for *Facility Mix*.

Highmark has added significant enrollment in *CommunityBlue* and *ConnectBlue*, narrower network products built around community providers and AHN. The products produce savings by encouraging care to high quality and better value providers through a smaller network, which includes both AHN and community hospitals.

Additionally, Highmark Health has worked proactively to stem the tide of care moving away from community hospitals by sending AHN physicians into both community hospitals and independent physician offices with the goal of keeping as much care as possible in the local communities. The goal of this initiative is to create a partnership that results in higher quality, integrated care - especially when it is necessary to refer the patient to a tertiary facility and/or a regional specialist.

Finally, as a result of the affiliation with Highmark, AHN reopened *Labor & Delivery services at Jefferson Regional Medical Center (JRMC)* in an effort to keep care in the local community. Prior to the reopening, local residents in need of obstetric care were forced to make the long commute into the city of Pittsburgh. All patients in the community, not just Highmark members, benefit from having a local option for obstetric care.

REIMBURSEMENT

The *Reimbursement* component of IDN Savings relates to Highmark's ability to manage medical costs versus the *No Transaction* scenario where the large provider system in the region becomes the one monopolistic provider and exerts leverage to influence reimbursement. In 2016, Highmark Health realized $283 million in savings for *Reimbursement*.

There are a number of drivers for the realized savings in 2016, the largest of which is the avoided provider contracting increases under the *No Transaction* scenario. Highmark Health believes that, without support, WPAHS would have gone bankrupt and found another suitor, which would have shut down poor performing service lines and sold assets that generated insufficient returns and then demanded a large increase for the remaining assets. Additionally, UPMC would have had more market power as the only tertiary facility in the region and been able to extract double digit increases from payers. With the IDN affiliation approval, these extra costs were averted.

HEALTHIER POPULATION / RIGHT TREATMENT

Both the *Healthier Population* and *Right Treatment* components of IDN Savings relate to lower utilization as a result of more effective and coordinated care management. In 2016, Highmark Health realized $187 million in savings for *Healthier Population*, which is specific to inpatient, and $481 million in savings for *Right Treatment*, which relates to outpatient and physician services.

Admittedly, these two components could be affected by the lower utilization trends seen across the industry in recent years. As a result, some of the reported IDN Savings may be unrelated to the IDN. Highmark Health addresses this issue by quantifying some of the Highmark Health IDN initiatives as a comparison.

Highmark Health has implemented many initiatives aimed at managing inappropriate and unnecessary utilization. The largest, most ambitious initiative is our pay for value program. The goal of the program is to change the financial incentives so that providers are rewarded for effectively managing the care, resulting in lower cost and higher quality. Much of this savings is achieved through lower utilization as providers deliver the right care, both through keeping patients healthy and through reducing waste.

Beginning in 2016 in Western Pennsylvania, Highmark has partnered with *Quartet* to coordinate care and manage the total spend for patients with behavioral health needs. While the program is too new to definitely measure savings, the early results are promising and support the notion that coordinating all of a patient's care leads to better patient satisfaction, higher quality, and lower cost.

Beginning in 2015, Highmark has partnered with *Aspire* to manage end of life care for Medicare Advantage members. This program is especially effective because of referrals from engaged providers, like AHN, to enroll members into the program who can most benefit from the service.

In 2016, Highmark began the *Complex Care Model* program to manage patients with multiple chronic conditions.

The *Cardiac Management Program* includes prior authorization to ensure imaging care is delivered in a high quality manner with better value.

The *Code Edits Payment Policy* includes extensive review of the complex coding instructions which determine how claims will be paid. The focus is to identify situations in which incorrect or insufficient coding results in overpayment of claims.

The *Radiation Oncology Program* manages utilization for radiation oncology treatment. Through a combination of prior authorization and claims review, this program ensures that techniques used to deliver radiation therapy are proven, medically appropriate, and lead to enhanced quality

and value for patients. Savings is realized through both decreased inappropriate and unnecessary utilization and lower cost per service where medically appropriate.

The *Post-Acute Care Management Program* manages skilled nursing, rehab, and long term acute care services for Medicare Advantage members by reviewing and managing courses of treatment and billing practices. Started on August 1, 2014, the program targets inappropriate care, inappropriate upcoding of severity, and excessive lengths of stay.

Diamond Care focuses on improving quality and efficiency by AHN and independent physicians. The program emphasizes standardized clinical protocols and care delivery, including educating providers on efficient facilities and sites. The bundled payment eliminates providers' financial incentive to deliver as much care as possible. The result is more standardized care that is higher quality and lower cost. While the initial focus has been orthopedics, the plan is to extend the program to other subspecialties.

The *Advanced Illness Services (AIS) Program* is available to Highmark's Medicare Advantage members who are terminally ill. The objective of the program is to bridge the gap between standard curative medical care and hospice care by addressing the needs of members proactively and thus avoiding costly crisis and/or acute incidents. Uniquely qualified professionals provide emotional support, facilitate decision-making, prepare members for effective communication with physicians, and arrange referrals to community resources.

The *Dialysis Pay for Value Program* delivers care management for patients with end stage renal disease (ESRD) with the goal of improving quality of care and reducing complications.

In 2014, Highmark piloted several *Medicare Advantage Gain Share Programs* for Highmark Medicare Advantage members attributed to engaged doctors. The programs focused on lowering claim costs through more efficient and effective treatment in addition to eliminating STARS gaps. The increased STARS ratings and lower medical loss ratios in 2014 are a testament to the success of the program, resulting in improved quality and reduced costs. The considerable effort by AHN and community physicians to close the identified gaps in care was a significant reason Highmark achieved STARS ratings of 4.0 or greater. As a result, Highmark received additional revenue from CMS in 2016, which benefited Highmark Medicare Advantage members in the form of lower premiums than had the STARS ratings not improved.

Finally, AHN's *Community Care Network (CCN) Health Coaching Program* trains undergraduate pre-med students to be health coaches for high risk community members. The program has been expanded to train nursing students, EMTs and even members of the community to be coaches. The coaches reach out to certain high risk members in their homes in order to establish a personal connection, understand their issues and living conditions and then coach them on how to improve their care and quality of life.

RIGHT SETTING

The current health care paradigm incents providers to deliver care in more costly settings, such as inpatient instead of outpatient or outpatient instead of the physician's office. Not only does this make insurance more expensive, but also patients must pay more cost sharing as a result of the higher bill. The *Right Setting* component of IDN Savings relates to providing care in settings that provide better value without sacrificing quality. In 2016, Highmark Health realized $77 million in savings for *Right Setting*.

Some of the *Right Treatment* initiatives already mentioned also have some effect on *Right Setting*, including pay for value programs, *Post-Acute Care Management Program*, *Advanced Illness*, and *Dialysis Pay For Value*. Additionally, there are a few other initiatives that target the appropriate setting for care to be delivered.

As mentioned with Oncology, some hospitals have been maximizing revenue by acquiring physician groups and then changing the billing from physician-based CMS 1500 forms to the facility-based UB-04 forms in order to extract higher reimbursement from insurance companies. This change in billing practice, with no change in care delivery, results in a significant burden on the health care financing system and ultimately on consumers, who pay higher cost sharing and ultimately higher premiums. AHN has decided to buck this trend by intentionally using the *Physician Billing Forms* for new facilities such as the Wexford Medical Mall (which opened in October 2014) and Monroeville Surgery Center (which opened in October 2013). Further, AHN has consciously chosen to shift care from more expensive facility outpatient settings to these new freestanding settings that provide better value. This has resulted in lower claim costs and lower cost sharing for AHN patients.

With the *Outpatient Joint Replacement Program*, which began in 2014, AHN became the first provider system in the region to offer hip replacement surgery in an outpatient setting, where it is almost half the cost. Highmark Health considers this a step in the right direction and expects more services to transition to the outpatient setting, which is better for the patient in terms of experience, quality, and cost.

OTHER - PRESCRIPTION DRUG

The *Other* component of IDN Savings relates to prescription drug spend. In 2016, this component was an $58 million expense.

The primary driver behind the poor results is the emergence of the Hepatitis C drug Sovaldi as well as compound drugs, neither of which was included in the baseline costs from the approved Form A filing.

On the other hand, Highmark has implemented several initiatives that have mitigated the costs, including two initiatives to encourage members to make choices that provide better value. A member's copayment for a prescription drug depends on the benefit tier into which the drug is classified. Highmark's *Progressive Formulary* has a preferred tier of generic equivalents (a generic with the same chemical composition as the brand) and, where available, generic alternatives (a generic with a different chemical composition as the brand). *Optimum Plan Designs* encourage members to use drugs in the preferred tier through more appropriate copayment relationships by tier.

The *Compound Drugs Payment Policy* focuses on the recent growth in compound drug spend. A pharmacist creates a compound drug by mixing two or more drug ingredients to make a new customized drug that may or may not differ in strength, inactive ingredients, or form from existing standardized medications. Highmark has concerns about quality when a pharmacist is creating customized mixes that may not be an FDA-approved form or dosage. While there are some valid uses, compound drugs are susceptible to overutilization because the reimbursement is significantly higher than standardized prescription drugs. This initiative seeks to curb the excessive utilization by enforcing medical necessity of a customized mix over the standard form.

Highmark Health assumes 25% of pharmacy initiatives relate directly to the IDN.

NOT CLASSIFIED

Finally, there are several activities that do not fit into any of the IDN Savings components but provide significant value to Highmark Health.

First, Highmark and AHN realized administrative savings by moving some administrative functions to Highmark Health, the parent entity and streamlining and simplifying administrative processes. For some functions, such as Internal Audit, Compliance, and Treasury, the centralized area is more cost effective. For other functions, such as Tax and Actuarial Services, the centralized area provides more sophisticated support than previously available. Finally, for some functions, such as Procurement, the centralized area is able to achieve greater enterprise savings through economies of scale.

Second, Highmark Health and AHN have invested in EPIC, a system that enables creation, storage, and sharing of electronic medical records for care delivery and population health management. Highmark Health expects that EPIC will enhance the savings already seen in other programs, including the *ACA* PCMH and the *Medicare Advantage Gain Shares*. This is the type of investment that helps to make the long term IDN savings goals achievable.

Finally, Highmark Health has expanded affordable access to care in the communities through initiatives like telemedicine, the operation of an urgent care center in Braddock, and adding labor and delivery services at JRMC.

CONCLUSION

Highmark Health is trying to change the health care paradigm, moving from a reimbursement structure that rewards volumes to one that rewards outcomes and keeps care in local communities. As the results for 2016 demonstrate, the IDN strategy is working. Highmark Health's IDN initiatives are designed to improve quality and provide better value to Highmark members, AHN patients, and the whole community. The key to success is engaged providers, not just at AHN but also among community providers. AHN has led the way in the provider community in embracing this change. As a result, Highmark Health has been able to partner with community providers, who are a critical part of the IDN strategy, to deliver IDN Savings.

Exhibit 1

IDN Savings Report

Period Ending 12/31/16

	CALENDAR YEAR 2016			CUMULATIVE SINCE 2013		
	Benchmark	Actual	Difference	Benchmark	Actual	Difference
IDN SAVINGS PMPM						
(1) Oncology		($6.65)			($1.54)	
(2) Facility Mix		($3.05)			($1.38)	
(3) Reimbursement		($25.93)			($11.84)	
(4) Healthier Population		($17.16)			($9.13)	
(5) Right Setting		($7.06)			($3.06)	
(6) Right Treatment		($44.17)			($24.94)	
(7) Other Savings		$5.34			$4.96	
Utilization Shift ([1] to [3])	($1.38)	($35.63)	($34.26)	$0.22	($14.76)	($14.98)
IDN Implementation ([4] to [7])	($42.93)	($63.05)	($20.13)	($24.34)	($32.16)	($7.82)
TOTAL SAVINGS	**($44.31)**	**($98.69)**	**($54.38)**	**($24.12)**	**($46.92)**	**($22.80)**
IDN SAVINGS ***(in millions)***						
(1) Oncology		($72)			($76)	
(2) Facility Mix		($33)			($68)	
(3) Reimbursement		($283)			($583)	
(4) Healthier Population		($187)			($449)	
(5) Right Setting		($77)			($151)	
(6) Right Treatment		($481)			($1,227)	
(7) Other Savings		$58			$244	
Utilization Shift ([1] to [3])	($14)	($388)	($374)	$8	($727)	($734)
IDN Implementation ([4] to [7])	($432)	($687)	($255)	($842)	($1,583)	($741)
TOTAL SAVINGS	**($446)**	**($1,075)**	**($629)**	**($834)**	**($2,310)**	**($1,475)**
SAVINGS TO A FAMILY OF FOUR						
PMPM Savings x 4 Members x 12 Months		**($4,524)**			**($3,808)**	
Savings as a percent		**(20.1%)**			**(18.3%)**	
FACILITY COST SAVINGS						
Inpatient Cost		(23.3%)			(15.9%)	
Outpatient Cost		(22.6%)			(13.8%)	

NOTE: All savings are presented as negative numbers. Dollars are in millions.

1550 Liberty Ridge Drive, Suite 200
Wayne, PA 19087-5572
Tel +610 687.5644
Fax +610 687.4236
www.milliman.com

April 28, 2017

Mr. David Berry
Vice President, Actuarial Services
Highmark Health
1800 Center Street
Building 1A – Level 3
Camp Hill, PA 17011-1702

Re: Highmark Health's Methodology for Quantifying 2016 IDN Savings

Dear Dave,

Purpose

In an accompanying document, Highmark Health has submitted its report for calendar year 2016 to comply with Condition 19 of the Pennsylvania Insurance Department's Approving Determination and Order ID-RC-13-06 ("Approving Order" or "the Order") in which Highmark Health is required to file annually several measures for *Actual* IDN savings relative to savings benchmarks detailed in Appendix 3 of the Approving Order, which came from the initial Form A filing.

As required by Condition 19 of the Approving Order, Highmark Health has requested that Milliman review its quantification of savings and the methodology for measuring and reporting IDN Savings and opine as to the reasonableness of the methodologies used for quantifying the savings and the related explanation of variances. The purpose of this letter is to provide our opinion of the reasonableness of such methodologies.

Opinion

In my opinion, the methodologies used for quantifying the calendar year 2016 IDN savings are reasonable.

The reporting of savings is consistent with the methodology as previously provided to the PA Insurance Department (PID), except as specifically described in the accompanying report.

I have also reviewed the related explanations of variance and find them to be reasonable.

In addition, although not required by the order, Highmark Health's second approach for quantifying specific relevant initiatives related to components of the IDN Savings as a way to validate the reported results is reasonable.

We did not review the development of the savings targets, which amounts are described in the Order. We do not have an opinion on the achievability of such savings.

Discussion of Milliman's Review of Highmark Health's Methodology

We have reviewed the following documents provided to Milliman by Highmark Health:

1. Condition 19 of the Order: "Meeting IDN Savings Benchmarks."
2. Methodology for Calculating IDN Savings
3. IDN Savings Report for Calendar Year 2016
4. An Excel file showing development of the PMPMs for each Segment, for the benchmarks and the actual PMPMs for 2016, including the differences.

Milliman reviewed the calculations of the allocations of experience into the measurement categories and found them consistent with the description in the methodology description.

There may be more than one reasonable way to allocate the overall savings results, and any such method depends on the availability of data. In assessing the cause of actual results, it may not be possible to specifically determine the impact of each of multiple interventions. However, the overall savings are a function of actual measurable financial results. The allocation to each category is explanatory only, and the methods employed by Highmark Health to assign the results to categories are reasonable.

Identification

I, John P. (Jack) Burke, am a Principal and Consulting Actuary employed by Milliman. I am a Fellow in the Society of Actuaries and a Member of the American Academy of Actuaries. I am qualified and meet the Academy's requirements to provide the actuarial opinion set forth in this letter.

Caveats and Limitations

The intended use of this opinion is for Highmark Health to provide to the Pennsylvania Insurance Department for the purpose of evaluating the reasonableness of Highmark Health's methodologies used

for the quantification of savings as described herein. Our analysis and results may not be appropriate for any other use.

In performing this analysis, we relied on data and other information provided by Highmark Health. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual results will differ from projected amounts to the extent that actual experience deviates from the assumptions used in the projection.

This analysis has been prepared solely for the internal business use of and is only to be relied upon by the management of Highmark Health. No portion of this report may be provided to any other party without Milliman's prior written consent. Milliman hereby gives permission to share with the Pennsylvania Insurance Department (PID) and the professionals engaged by the PID to review Highmark Health's methodology. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work.

Sincerely,

John P. Burke, FSA, MAAA
Principal and Consulting Actuary

JPB/go