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BEFORE THE INSURANCE DEPARTMENT
OF THE
COMMONWEALTH OF PENNSYLVANIA

Statement Regarding the Acquisition of Control of or Merger with Domestic Insurers

Highmark Inc.; First Priority Life Insurance Company, Inc.;
Gateway Health Plan, Inc.; Highmark Casualty Insurance Company;
Highmark Senior Resources Inc.; HM Casualty Insurance Company;
HM Health Insurance Company, d/b/a Highmark Health Insurance Company;
HM Life Insurance Company; HMO of Northeastern Pennsylvania, Inc.,
d/b/a First Priority Health; Inter-County Health Plan, Inc.;
Inter-County Hospitalization Plan, Inc.; Keystone Health Plan West, Inc.;
United Concordia Companies, Inc.; United Concordia Dental Plans of Pennsylvania, Inc.;
United Concordia Life and Health Insurance Company

By UPE, a Pennsylvania nonprofit corporation

RESPONSE OF UPE AND HIGHMARK INC. TO VARIOUS POINTS IN:

(1) DRAFT REPORT ON HIGHMARK INC.'S PROPOSED CHANGE OF CONTROL AND AFFILIATION WITH WEST PENN ALLEGHENY HEALTH SYSTEM, INC. DATED APRIL 8, 2013 AND PREPARED FOR THE PENNSYLVANIA INSURANCE DEPARTMENT BY BLACKSTONE ADVISORY PARTNERS L.P.;

AND

(2) DRAFT ECONOMIC ANALYSIS OF HIGHMARK'S AFFILIATION WITH WPAHS AND IMPLEMENTATION OF AN INTEGRATED HEALTHCARE DELIVERY SYSTEM DATED APRIL 8, 2013 AND PREPARED FOR THE PENNSYLVANIA INSURANCE DEPARTMENT BY COMPASS LEXECON

WITH

(3) RESPONSE TO SELECTED POINTS CONTAINED IN COMPASS LEXECON'S "ECONOMIC ANALYSIS OF HIGHMARK'S AFFILIATION WITH WPAHS AND IMPLEMENTATION OF AN INTEGRATED HEALTHCARE DELIVERY SYSTEM," PREPARED BY DR. BARRY C. HARRIS, ECONOMISTS INCORPORATED, DATED APRIL 18, 2013

I. Background.

Highmark Inc.'s ("Highmark") mission is to provide its customers and subscribers access to affordable, high quality healthcare. To advance that mission, and to preserve and promote consumer healthcare choice, and after substantial consideration and review by its senior management and Board of Directors, Highmark has proposed to create an integrated delivery network ("IDN") in the western Pennsylvania healthcare market. The IDN will include Highmark, which will provide insurance and healthcare financing, and select hospitals, physician groups and other healthcare providers, which will provide healthcare services.

To implement the IDN, a newly formed nonprofit organization, currently known as UPE, which intends to become the parent of both Highmark and certain healthcare providers, filed an application (known as a "Form A" filing) with the Pennsylvania Insurance Department (the "Department") in November 2011, requesting approval for a change in control of Highmark. At the time of the filing, UPE and Highmark had signed an Affiliation Agreement with West Penn Allegheny Health System, Inc. ("WPAHS") for the purpose of making WPAHS a principal component of the IDN (the "Transaction" or "Affiliation").

At the time of the initial Form A filing, the total cost of the IDN strategy was anticipated to be approximately $750 million. During the time the Form A has been under review and as the details of the IDN have been refined, the projected cost has increased, and the total is now expected to be approximately $1 billion. This amount includes the costs of the affiliation with WPAHS, proposed affiliations with Jefferson Regional Medical Center ("JRMC") and Saint Vincent Health System ("SVHS"), physician recruitment, medical malls, community hospital support/outpatient development and IDN infrastructure.[1]

Recently, Highmark initiated a tender offer to acquire up to $709 million of bonds issued by the Allegheny Hospital Development Authority for the benefit of WPAHS at a discount of 12.5%, for a potential total savings of between $65 and $90 million for the UPE enterprise. Highmark's acquisition of the bonds will allow the parties to alter the terms of the debt represented by the bonds, thus freeing funds for WPAHS to upgrade its facilities and address operating needs sooner than it otherwise would be able to do. Highmark does not expect to hold the bonds on a long-term basis, but rather expects that they will be refinanced within 3 years. By refinancing the debt, at current market rates, WPAHS will also save millions of dollars in interest payments over the life of the bonds. The bonds are secured by various WPAHS assets.

The IDN has broad public support. At an April 2012 public hearing on the Form A application, speakers representing consumers, employers, union leaders, legislators, physicians, nurses, spiritual leaders and community groups overwhelmingly urged the Department to approve the Form A transaction, which would allow the Affiliation to be consummated. Speaker after speaker emphasized the benefits of the proposed Affiliation, noting that it would preserve

[1] UPE and Highmark reject the suggestion made in the Reports referred to below that the costs of the IDN strategy are $1.6 billion or $2.4 billion. The $1.6 billion figure includes the entire principal amount of WPAHS's bond debt, which Highmark is not assuming, overstates Highmark's anticipated expenditures to JRMC by ignoring anticipated "credits" for amounts funded by JRMC and gives no effect to Highmark's financing plans for the medical malls. The $2.4 billion figure further includes all of WPAHS's unsecured liabilities, including pension and other liabilities, for which, again, Highmark is not responsible.

healthcare choice for individuals, employers, physicians and other healthcare professionals; help control healthcare costs; save jobs; create new employment opportunities; and help to preserve strong, economically viable, communities throughout Pennsylvania.

Even the leadership of Highmark and WPAHS's competitor, UPMC, has professed support for the IDN in the past – and for the same reasons as mentioned above. On September 22, 2011, in legislative testimony, UPMC President and CEO Jeffrey Romoff welcomed the proposed Affiliation:

> "We believe that competition between UPMC and the new Highmark/West Penn Allegheny Integrated Health System will foster more cost-effective ways to keep people healthy. It will drive out administrative inefficiencies, and it will spur both organizations to better serve the patients, physicians and community."

After a comprehensive and extensive review, on April 8, 2013, the Department's advisors, Compass Lexecon, a consulting firm that specializes in antitrust economics and applied microeconomics, and Blackstone Advisory Partners L.P., financial advisor to the Department ("Blackstone"), submitted draft reports detailing their findings with respect to the proposed Affiliation (collectively, the "Reports").[2] The public comment period for the Form A proceeding initially was opened by the Department on November 19, 2011; closed on June 1, 2012; was reopened on July 28, 2012, and has remained open at all times since – meaning that the public has had more than fourteen months to comment on the Affiliation. The comment period now is scheduled to finally close on April 19, 2013. In anticipation of the closing of the comment period, UPE and Highmark submit the following comments to address certain issues raised in the Reports.

II. The IDN, including the Proposed Affiliation, will Benefit Policyholders, Subscribers, Employees, Employers, Other Providers and the Western Pennsylvania Community at Large.

Highmark's investment in the IDN is essential to protect and benefit Highmark policyholders and subscribers, and the entire western Pennsylvania healthcare market. Provider choice is critical to ensure that costs are controlled for the benefit of all subscribers, employers and the local communities in which the subscribers, employers and providers live or operate.

[2] Compass Lexecon, "Economic Analysis of Highmark's Affiliation with WPAHS and Implementation of an Integrated Healthcare Delivery System" redacted draft as of April 8, 2013 (the "Compass Lexecon Report"); and Blackstone, "Report on Highmark's Inc.'s Proposed Change of Control and Affiliation with West Penn Allegheny Health System, Inc." redacted draft as of April 8, 2013 (the "Blackstone Report").

A. The Current Healthcare Delivery Model is Unsustainable and is in Need of Change.

The overwhelming support for the proposed IDN including, specifically, the Affiliation, as expressed at the April 2012 public hearing, and in the public record since, underscores that the western Pennsylvania healthcare delivery system is in urgent need of change. Healthcare costs in the region are increasing at an unsustainable rate, and coordination of patient care among doctors and other providers is inadequate, leading to (at best) duplication of effort and confusion for patients. As has been indicated by recent studies, patients in western Pennsylvania undergo 47% more advanced imaging procedures, 44% more laboratory services and 27% more outpatient surgeries than persons living elsewhere; and residents of Pittsburgh experience more emergency-room visits and hospital "bed days" than those in comparable cities. Higher utilization means higher revenues for healthcare providers, but not necessarily better healthcare for patients. Studies have shown that the average Pittsburgh resident spends 25% of his or her income on health insurance – substantially more than that spent by residents of similarly sized cities – yet Allegheny County ranks in the bottom half of Pennsylvania's counties on various population health measures.[3]

Highmark recognizes that preserving healthcare choice is not enough to reduce costs and improve the quality of care; it also must redefine how healthcare is delivered. The current healthcare reimbursement model rewards overutilization and cannot be sustained. A key component of the IDN strategy is the realignment of provider incentives to promote lower cost, high quality, highly efficient care. Highmark intends to introduce reimbursement structures that reward care coordination and quality and provide alternative sites for care delivery, such as medical malls and ambulatory surgery centers, so that the right care is delivered in the right place at the right time, which will result in lower healthcare costs and healthier, more satisfied patients.

B. Preservation and Promotion of Access and Consumer Choice are Key Components to Highmark's IDN Strategy.

Central to its proposed affiliation with WPAHS is Highmark's desire to preserve and promote access and consumer choice for healthcare services in the western Pennsylvania market. The Compass Lexecon Report recognizes that the western Pennsylvania healthcare market is somewhat unique in that UPMC and WPAHS are the primary competitors, and, in many cases, the only providers of highly complex tertiary and quaternary hospital services. As a result, one of the matters of foremost public interest is the preservation of a vigorous and financially healthy WPAHS as an alternative that can discipline and constrain UPMC's ability to act in an anti-competitive manner to the detriment of consumers and insurers.

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[3] The twin problems of high utilization and high cost in western Pennsylvania are compounded by the lack of provider competition because the price of many medical services is essentially set by one health system, UPMC. For example, approximately 80% of the southwest Pennsylvania market for oncology services is controlled by UPMC, either directly through services that its oncologists provide or indirectly through UPMC affiliates or joint ventures.

i. Access to and Choice of Healthcare Providers.

Compass Lexecon recognizes that, given WPAHS's current precarious financial status, it has a limited ability to continue to constrain UPMC.[4] In the absence of the Transaction, WPAHS would be forced to substantially cut services, close facilities and reduce staffing, and physicians likely would start referring patients away from WPAHS, thus increasing the dependence of consumers and insurers on UPMC for healthcare.[5] In this event, both consumers and insurers would directly feel the negative impact of a lack of competition in the western Pennsylvania healthcare market. Compass Lexecon notes –

> "Absent this [A]ffiliation and WPAHS's compromised ability to constrain UPMC, it is likely that UPMC has the incentive and ability to raise reimbursements to insurers materially above current levels. To some extent, WPAHS constrains UPMC's current rates ... Without a stronger WPAHS, there are reduced competitive constraints on UPMC's ability to raise its rates to other insurers and shift substantially larger numbers of enrollees to its own plan, with lower reimbursement rates . . . ."[6]

Thus, Compass Lexecon concludes, a strong WPAHS is needed to control health insurance premiums in western Pennsylvania.[7]

Moreover, Compass Lexecon further notes that a substantial portion of Highmark-insured patients treated at WPAHS facilities would have few alternatives to UPMC if WPAHS were forced to exit the marketplace.[8] Without WPAHS as a viable alternative, consumer choice, even to the limited extent that it exists today, will no longer be an option in the western Pennsylvania healthcare market.

Highmark's stabilization of WPAHS's financial position will preserve WPAHS as an essential choice in the western Pennsylvania market. Without constraint (in the form of a viable competitor), UPMC will be able to demand whatever rates it wishes from insurers and the public -- as it attempted to do with Highmark in 2011-2012. Even prior to the announcement of Highmark's plans to affiliate with WPAHS – and before it determined that it would not contract with Highmark at any price -- UPMC sought a 40% increase in rates from Highmark as a condition of extending existing contracts. With no WPAHS in the market, UPMC's future reimbursement demands will no doubt be even more outrageous for all insurance carriers in the market, and other healthcare providers will have their market shares further diminished as UPMC's dominant position grows even more imposing.[9]

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[4] Compass Lexecon Report, 185 - 186.
[5] Compass Lexecon Report, 186.
[6] Compass Lexecon Report, 186.
[7] Compass Lexecon Report, 186.
[8] Compass Lexecon Report, 185.
[9] Highmark calculates that the average cost of health insurance for a family of four would be at least $3,000 higher annually in the absence of a constraint on UPMC market power. This increase is in addition to the already significantly higher healthcare costs on a per person basis currently experienced by Highmark subscribers who use UPMC compared to subscribers who do not use the UPMC system to the same extent.

ii. Access to and Choice of Differentiated Insurance Products.

Increased consumer choice does not mean only that a consumer can choose his or her healthcare provider. Beyond merely existing as an alternative provider of healthcare services, an affiliated Highmark-WPAHS will allow Highmark to offer differentiated insurance products in the market. By virtue of its current dominant position in the provider market, UPMC is able to insist on anticompetitive contract terms with Highmark and other health insurers that deny consumers the opportunity to make choices and that have the effect of raising overall healthcare costs. These anticompetitive contract terms include so-called "no-tiering, no-steering" clauses.[10] The ability for insurers to tier and steer provide numerous benefits to consumers by spurring competition on the part of doctors, hospitals and larger healthcare provider networks, as each seeks to gain a greater number of patients by offering superior products and services. These procompetitive provisions, then, help to reduce insurers' costs and thereby customers' premiums.

As noted in the Compass Lexecon Report, with the exception of the recent introduction of Highmark's narrow network product, Community Blue, UPMC has prevented Highmark from offering consumer choice products by requiring no-tiering, no-steering provisions in all hospital contracts that UPMC and Highmark have signed since 2002.[11] Highmark has had no choice but to agree to such provisions in the past because the alternative was to deny Highmark customers/subscribers to UPMC's doctors, hospitals and facilities.[12] In a competitive market, healthcare insurers, including Highmark, would not enter into provider contracts that restrict their ability to tier and steer because insurers who did would lose sales to competitors that were free to tier and steer.

The anticompetitive effects of no-tiering, no-steering provisions are significant. They constitute retail pricing constraints that prevent healthcare insurers from reducing the price that they charge consumers seeking treatment from higher-rated healthcare providers. UPMC's no-tiering, no-steering provisions enable it to increase its prices without losing sales because the restrictions increase the cost to insurers of substituting away from UPMC and toward cheaper provider alternatives, such as WPAHS or community hospitals. Higher wholesale prices, in turn, cause healthcare insurance premiums to rise, harming consumers and insurers. As Compass Lexecon says –

> "[C]onsumer 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

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[10] "Tiering" allows healthcare insurers to separate healthcare providers into distinct groups based on the providers' costs and/or quality. "Steering" allows insurers to provide customers and subscribers with more favorable terms - such as lower co-payments, coinsurance, or deductibles - for obtaining treatment from higher-rated providers.

[11] Indeed, Compass Lexecon notes that UPMC requires such anti-competitive provisions in its contracts with all insurers in the market.

[12] The new contracts with UPMC permitted Highmark to re-introduce its Community Blue product, a narrow network product that, at UPMC's choice, does not include UPMC doctors and facilities. However, the re-introduction of Community Blue does not ameliorate the adverse effects of UPMC's preclusion of Highmark's ability to design insurance products that permit customers and subscribers to choose among healthcare providers including UPMC.

in choosing providers with the objective of lowering overall healthcare expenditures."[13]

Compass Lexecon confirms that Highmark (or other insurers) should be able in principle to make use of either tiered or limited networks with WPAHS to effectively attract considerable volumes from UMPC with appropriately configured and priced products – such as Community Blue – which allow insurers to market lower cost products to price-sensitive consumers who might otherwise forego purchasing insurance.[14] With specific reference to Highmark's Community Blue network, which is designed to encourage patients to use lower cost but at least equal quality hospitals, Compass Lexecon concludes that the network has substantial capacity to service current patient volumes.[15] The anticipated impact of Community Blue is to drive patient volumes to WPAHS and other facilities such as community hospitals that offer lower-cost, high quality healthcare services.

C. Positive Impact on Employers, the Western Pennsylvania Economy and Benefits to Local Communities.

Lower healthcare costs and the resultant lower health insurance premiums for customers also will have a positive impact on businesses and the economy of western Pennsylvania. Surveys indicate that new employers believe that the current healthcare environment makes the region unattractive for investment, and existing employers are threatening to scale back growth or shut down operations entirely unless healthcare costs are brought under control. By providing western Pennsylvania with a choice of financially sound healthcare delivery systems, independent community providers and a progressive integrated delivery network that rewards quality and ensures care delivered in the right place at the right time, healthcare cost increases can be brought under control, making the area more attractive to employers.

Preserving WPAHS is important to the local communities currently serviced by the system's hospitals and physician practices and their nearly 12,000 employees. In addition to providing quality healthcare services, these hospitals and physicians and their employees provide economic vitality to the communities through their purchase of goods and services, which, in turn, helps to support additional job growth and creates more revenue for the communities. The loss of the WPAHS system would have a devastating effect, not only on the individual employees, but also on the communities in which the WPAHS hospitals operate – much like the effect the loss of the Braddock Hospital had on the Braddock community when UPMC closed its doors.

The community value and public benefits of the IDN and the WPAHS and JRMC affiliations in particular have already been validated by recent actions of governmental and judicial authorities charged with protecting charitable assets. After thoroughly reviewing the proposed WPAHS and JRMC transactions, the Office of Attorney General, Charitable Division, advised the Orphans' Court Division of the Allegheny County Court of Common Pleas that it did

[13] Compass Lexecon Report, 193.
[14] Compass Lexecon Report, 50.
[15] Compass Lexecon Report, 50.

not object to the changes of control of WPAHS and JRMC in favor of UPE, and, following a formal hearing, the Orphans' Court quickly approved the transactions.

Both of the Reports contain conclusions that recognize the value of the proposed Affiliation. The conclusions of the Blackstone Report include the following:

- Highmark's projected benefits to policyholders (that is, the savings from the IDN) are "feasible" even though there is little precedent under the circumstances prevailing in the western Pennsylvania market.[16]

- In addition to quantifiable benefits potentially accruing to policyholders directly from savings arising from the IDN, "non-quantifiable benefits may also be realized indirectly from WPAHS being maintained as a viable provider competitor."[17]

- It is possible that the value received by policyholders via the savings from the IDN will cover the gap between (i) the total amount of Highmark's transaction-contingent capital commitments related to the IDN strategy and (ii) the value of tangible financial assets received by Highmark in exchange for those capital commitments.[18]

- The projected "franchise" benefit to Highmark in the form of increased enrollment, market share and revenue arising from the proposed Affiliation appear "plausible" when compared to a scenario in which no Affiliation occurs and "may enhance Highmark's size, market presence and financial profile."[19]

Similarly, the Compass Lexecon Report notes that, although there is uncertainty associated with achieving the projected results, "Highmark has put forth a reasonable economic basis to support the conclusion that the Affiliation will benefit its policyholders and is in the public interest . . .."[20] UPE and Highmark concur with these conclusions to the extent they validate the real and significant value of the IDN to Highmark, its policyholders and the public.

[16] Blackstone Report, 97.
[17] Blackstone Report, 97.
[18] Blackstone Report, 98. Highmark believes that such IDN savings result in both intangible and tangible benefits to its members and the community at large.
[19] Blackstone Report, 97.
[20] Compass Lexecon Report, 12.

III. Highmark and UPE have a Well-Defined Plan to make WPAHS a Financially Strong Healthcare System.

UPE and Highmark have developed a carefully considered plan with specific steps to restore WPAHS to financial health over both the short and long term. This plan is part of the broad strategy for making WPAHS a key component of the proposed IDN – not to mention preserving WPAHS's 12,000 jobs.

Highmark has agreed to invest $475 million in WPAHS to assist WPAHS in stabilizing its financial condition and to allow it to upgrade its programs and facilities. The projections for WPAHS take into account WPAHS operating losses and other liabilities, which are addressed in part by Highmark's funding commitments under the Affiliation Agreement; in part by the deferral of debt obligations arising from Highmark's purchase of the WPAHS bonds; and in part by improved operating results. The projections also provide for substantial capital expenditures in the first several years of the Affiliation.

Even while the change in control of Highmark has been pending Department approval, WPAHS has implemented early phases of its recovery plans, with Highmark support. In February 2012, West Penn Hospital reopened its emergency department. Since the re-opening, patient volumes at West Penn Hospital have exceeded expectations, a point acknowledged by the rating agency Moody's in its February 5, 2013 rating update on WPAHS. In 2012, Forbes Regional Hospital in Monroeville ("Forbes") opened a new breast cancer center and added a new wing in the emergency department with more beds and triage rooms. These improvements were highlighted in a *Pittsburgh Post-Gazette* article, which noted Forbes's strength in the face of stiff competition from an unnecessary and costly new facility that UPMC constructed approximately two miles away.[21] By the end of 2013, Forbes expects to have renovated operating rooms and state certification as a level II trauma center, which will help the facility grow patient volume.

Highmark has continued its recruitment of new primary care and specialty physicians for the IDN; helped to stabilize the existing staff at WPAHS; and is working to improve the productivity and care coordination of affiliated physicians, all of which will assist the turnaround of WPAHS. In addition, Highmark has launched new purchasing and supply chain companies to support WPAHS and other affiliated healthcare providers in achieving their strategic objectives of reducing costs and improving quality. Highmark and WPAHS also have begun to work together to lower healthcare costs through new care delivery models focused on better coordination of patient care, including patient-centered medical homes and an accountable care alliance ("ACA"), improved care quality and patient satisfaction, all of which will further stabilize WPAHS and allow it to flourish. Lower cost insurance product options which Highmark has introduced in the western Pennsylvania market also will benefit the IDN.

The consultants employed by the Department have reached preliminary conclusions with respect to the IDN strategy:

- In the Compass Lexecon Report, its author, Margaret E. Guerin-Calvert, states that, "[b]ased on my independent review of supporting information provided, the

[21] Twedt, Steve, "Forbes Regional and UPMC East stake their claims in Monroeville," Pittsburgh Post-Gazette (February 14, 2013).

economic and healthcare literature, and application of appropriate criteria to the Highmark IDN, I conclude that the IDN contemplated by Highmark, with WPAHS as its core, has the characteristics of a successful IDN, thereby making it more likely to achieve improved clinical and fiscal outcomes for some defined population in [western Pennsylvania]."[22]

- Ms. Guerin-Calvert also indicates that, "[w]hile I believe that another purchaser of [WPAHS] would have the incentive to work with Highmark on favorable terms to attract volumes from UPMC, I find that Highmark makes a well-reasoned economic case as to why aligning the quality and efficiency of healthcare incentives through tight affiliation with WPAHS may better and more immediately insure WPAHS's ability to achieve the inpatient volumes, financial changes, and cost reductions necessary for a more efficient healthcare delivery system."[23]

- Similarly, Ms. Guerin-Calvert notes: "[m]y conclusion with regard to the IDN and the public benefits from the Affiliation and the Transaction is that there is a reasonable economic basis for substantial benefits to the public in the form of improved delivery of care, reduced rate of increase in healthcare costs and enhanced competition particularly in the hospital sector with an invigorated WPAHS."[24]

- Significantly, the Compass Lexecon Report notes:

> "Highmark's IDN strategy, with WPAHS as the core of its provider offerings, would potentially create a viable WPAHS hospital system that will incentivize providers and patients to choose WPAHS, presumably at lower cost and comparable quality for full range of services, instead of UPMC or other hospitals. Highmark's WPAHS 'diversion' strategy, incentivizing patients and physicians to choose WPAHS instead of UPMC, includes realigning physicians' incentives, both employed and affiliated, with Highmark's incentives to reinvigorate WPAHS by attracting more patients from other, higher-cost facilities, and deliver the IDN benefits Highmark projects. In addition, it incentivizes enrollees to choose WPAHS and other community hospitals as lower cost alternatives for inpatient services compared with UPMC."[25]

- Ms. Guerin-Calvert also comments regarding Highmark's contingency plans in the event of a possible shortfall in WPAHS's performance:

> "In my view, Highmark's contingency plan, although lacking in specificity, nonetheless assures me that Highmark has an array of

[22] Compass Lexecon Report, 12.
[23] Compass Lexecon Report, 14.
[24] Compass Lexecon Report, 15.
[25] Compass Lexecon Report, 86.

> strategies that it can implement to restore WPAHS to a competitively viable hospital system were the projected volume shifts not to materialize. Given Highmark's idea and strategy, its available resources and alignment with consumers to reduce unnecessary healthcare costs while maintaining quality, it may be in the best position to restore WPAHS as a competitively viable hospital alternative for consumers in [western Pennsylvania]."[26]

UPE and Highmark believe that, as illustrated by the comments noted above, the Department's consultants have properly identified the core strengths of the IDN strategy and the importance of that strategy to the western Pennsylvania market.

IV. Highmark is a Financially Strong Organization and Will Remain So After the Proposed Affiliation.

Highmark has a seventy-five year history of assuring that its policyholders and subscribers receive high quality healthcare at a reasonable cost. It also has a history of delivering stable financial results, enabled by a broad geographic footprint and a diversified portfolio of businesses. Its pragmatic approach to operating its business, entering new markets, and developing sensible strategic partnerships has resulted in a financially strong and vibrant company.

As the largest Blue plan in Pennsylvania and the ninth largest health insurance company in the United States, Highmark is financially able to make the investments necessary for the development of the IDN without jeopardizing its financial status. With over $6 billion in liquid assets and total assets of over $11 billion, the Highmark system clearly has the financial capacity to invest $1 billion in the IDN and to invest in the WPAHS bonds. In fact, of the $1 billion investment ear-marked for the IDN strategy, over $300 million has already been disbursed. The remaining $700 million is scheduled to be disbursed over the next four years.

As noted above, the combined earnings of Highmark and its subsidiaries are highly diversified across geographies and business lines, allowing the Highmark enterprise to withstand financial stresses and adverse financial results in any one segment. The enterprise's diversified business lines (including dental, vision and stop loss) generate significant returns that are available for Highmark's use to reinvest in the business and to support Highmark's nonprofit mission and the communities it serves throughout the Commonwealth of Pennsylvania. The investment in the IDN will further diversify earnings.

Blackstone analyzed the financial impact of the Affiliation and the IDN strategy on Highmark by evaluating Highmark's capital adequacy rating (commonly referred to as risk-based capital or "RBC") and the effect on Highmark's investment portfolio and liquidity. We address each of these items below.

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[26] Compass Lexecon Report, 153.

A. Highmark's RBC.

After providing for all of its liabilities, on a combined enterprise basis, the Highmark system currently has reserves of $5.5 billion. This places Highmark's RBC significantly above the minimum level required by the Blue Cross Blue Shield Association and the Commonwealth of Pennsylvania. Highmark projects that, after its investments in the IDN, its RBC will remain at current levels, due in part to the annual earnings of Highmark's diversified businesses and the quality of its investment portfolio. At current RBC levels, described by the Department as "sufficient", the Department will not allow Highmark to include any risk or contingency factors in filed premium rates, indicating that the Department also considers Highmark's capital position to be adequate.

The Blackstone Report acknowledges Highmark's financial strength in concluding that, based on year-end 2012 capital, surplus and net worth balances, Highmark would be able to satisfy the requirements for the issuance of licenses to write the lines of insurance for which it is presently licensed after the proposed Affiliation. Blackstone also concludes that UPE's balance sheet, with projected $327 million in total assets and $80.1 million of capital at the time of closing of the Affiliation, also appears "well capitalized" and "unlikely to jeopardize Highmark's financial stability at that time."[27]

Blackstone assessed Highmark's projected RBC under various circumstances, and, in all cases, including various downside scenarios, concluded that Highmark's RBC would remain well above regulatory thresholds. In fact, in all scenarios analyzed, Highmark's projected RBC remains within, or just below, the "sufficient" range.

B. Highmark's Liquidity.

As of December 31, 2012, Highmark had a well-diversified investment portfolio on a combined enterprise basis of just over $6 billion available to support the business in periods of underperformance and uncertainty. This portfolio is, and will continue to be, well diversified. Additionally, Highmark has the ability to access additional funds if confronted with any liquidity event, including an existing line of credit totaling $125 million and through the issuance of debt.

Blackstone also completed an assessment of Highmark's liquidity which demonstrated that, even in a case where all related IDN investments were made at one time and that all of Highmark's liabilities, some of which are not due for nearly 30 years, need to be satisfied immediately, Highmark is still left with liquid assets of over $1.5 billion. Blackstone acknowledges that its analysis reflects a conservative measure of Highmark's financial strength and liquidity.[28]

Blackstone states that its analyses suggest that Highmark's commitments related to the IDN strategy will result in a material change in Highmark's financial profile, but that the IDN strategy on its own is not likely to jeopardize Highmark's financial stability.[29]

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[27] Blackstone Report, 124.
[28] Blackstone Report, 37.
[29] Blackstone Report, 75-76.

In Highmark's view, its ability to afford the IDN strategy is not in question. While it acknowledges their significance, Highmark believes that the enterprise's financial resources are sufficient to execute on the IDN strategy; that it will remain a financially strong organization with adequate financial resources and surplus to meet its financial obligations on behalf of its subscribers and to meet the needs and challenges of the insurance and healthcare marketplace, even after making the investments in the IDN. The real question is whether Highmark's subscribers and the western Pennsylvania community can afford for Highmark not to complete the Affiliation – whether they can afford to allow a single healthcare provider, in the absence of any check on its power, to set whatever rates it chooses to demand for the provision of healthcare services.

V. Select Observations on Consultant Analyses of Projections.

The Reports refer to the WPAHS projections that Highmark filed with the Department on January 16, 2013 as the "Base Case" projections. On March 8, 2013, at the direction of Blackstone, Highmark also submitted a set of projections based on certain assumptions provided by Blackstone, which assumptions included a 50% reduction in volume and a lack of any remedial response by management. The Reports refer to the latter projections as the "Downside Case" projections.

The Reports conclude that the Base Case projections for WPAHS are optimistic and that the Downside Case appears to be reasonable.[30] Highmark respectfully disagrees with these conclusions.

A. Observations on the Base Case Projections.

The Reports challenge the analyses performed by Highmark and its consultants on a variety of bases.

The Reports criticize the Base Case projections on the basis that "there is a great deal of uncertainty underlying many of the key assumptions."[31] Of course, projections, by their very nature, are based on assumptions that are uncertain. If the future were certain, projections would be a purely mechanical exercise. In light of the uncertainty, in developing the Base Case projections, Highmark and its consultants examined a number of different alternative assumptions and approaches. These assumptions were neither the most aggressive nor the most conservative among the range of possible outcomes. In fact, as described below, the Base Case projections included various elements of conservatism.

For example:

- Highmark's projected physician affiliation volumes do not include all potential volume from the physicians who are expected to affiliate with the IDN. A number of approaches were considered to estimate the number of incremental discharges that would result from affiliations with several hundred physicians.

[30] Blackstone Report, 75.
[31] See, e.g., Compass Lexecon Report, 13.

The number of incremental discharges from this initiative would have been higher under alternative assumptions.

The projected physician affiliation patient volumes were reduced to reflect an assumption that UPMC will allow physicians affiliated with Highmark to admit patients to UPMC hospitals. There are more than 2,000 potential incremental admissions annually that were not included in the projections based on this assumption. If UPMC's current behavior (denying access to Highmark subscribers, even if they are willing to pay cash for services) were to continue and be extended to all Highmark subscribers following termination of existing contracts, it would be reasonable to assume that UPMC would not allow these admissions. Many – if not most – of these admissions would become WPAHS admissions.

- The Base Case assumptions regarding the reduction in out-of-network referrals by WPAHS physicians also take a conservative approach in assuming that only 50% of potential improvement is achieved and that 80% of WPAHS-employed physicians' patients are referred to WPAHS hospitals. If WPAHS were to reduce non-WPAHS referrals to the same level that UPMC achieves in the same marketplace, there would be an increase of over 800 discharges annually. This was not factored into the projections. It is anticipated that new management of WPAHS will invest in the necessary infrastructure so that WPAHS physicians will be more inclined to refer more of their patients to hospitals within the WPAHS network.

- The approach used to derive the Physician Organization ("PO") productivity analysis was to assume that the entire WPAHS PO would operate in line with the median industry benchmark levels across all services. If it is assumed that each of the underperforming physicians achieves the median level of productivity while the physicians who have been operating above that level continue to do so, the improvement would significantly exceed the volumes projected in the Base Case projections.

  If the PO fails to reach industry median levels across all services, we believe that it is reasonable to assume that management will take appropriate remedial actions including the termination and replacement of underperformers and/or instituting appropriate cost cutting measures.

  UPE and Highmark believe that it also is reasonable to conclude that increased PO productivity will result in incremental inpatient discharges. While Ms. Guerin-Calvert states that it is unclear how increasing the number of patients seen by physicians increases the number of inpatient hospital referrals,[32] at least some portion of the additional patients will require inpatient care.

[32] Compass Lexecon Report, 133.

- Projected patient volumes for Forbes reflect a reduction in volume related to UPMC East's opening, but conservatively do not incorporate potential increases in patient volumes related to its ongoing efforts to be certified as a level II trauma center. WPAHS management has projected that certification will have a significant and positive impact on the future results of Forbes. This potential improvement is not reflected in the Base Case projections.

- Patient volumes related to two new Highmark products, Community Blue and the ACA, are also conservative. In the case of Community Blue, the projections assume that some amount of patient volume remains at UPMC at a higher member benefit. In light of UPMC's recent decision not to see any of these patients, a more likely and reasonable estimate would result in approximately 1,700 additional admissions to WPAHS annually by the end of the projection period. This estimate would be further increased if UPMC were to turn away emergency and cancer care patients.

  With respect to the ACA, Highmark's estimates were conservative in three areas: the number of regional physicians that would participate, the anticipated success of physicians in aligning care, and the fact that the anticipated admissions were based primarily on Highmark commercial members and included only a very limited sentinel effect of alignment for Highmark's Medicare Advantage members. If Highmark is able to achieve the highest levels of success in these three areas, volume estimates could increase by up to 3,700 admissions annually by the end of the projection period.

- The Highmark projections are also conservative in that they do not give effect to cost reduction programs at WPAHS, which already have been implemented or have begun to be implemented. WPAHS management estimates that these programs will generate in excess of $30 million annually in addition to the $30 million of annual savings already achieved for the fiscal year ending June 30, 2013. In fact, the Base Case reflects *increases* in costs associated with planned incremental expenditures for information technology, advertising and branding.

In one of the more significant challenges to the Base Case projections, the Compass Lexecon Report asserts that Highmark failed to take into account competitor responses to its actions, concluding that, "without consideration of the reaction of competitors to the loss of significant discharges these [Base Case] projections must be viewed with a great deal of skepticism."[33] In fact, although they are not expressly so stated, Highmark's Base Case projections do take competitor responses into account.

Attempting to foresee competitors' actions and Highmark's counter actions is, by definition, speculative. Thus, rather than attempt to itemize each action and reaction, counter-action and reaction, etc., the Base Case relies on assumptions that reflect the likely outcome of all of the moves by market participants. However, they also reflect that WPAHS has a significant cost advantage over UPMC, its major competitor. As described above, the

[33] Compass Lexecon Report, 136 -137.

assumptions related to each initiative conservatively reflect less than the full impact of each initiative. If it had been assumed that WPAHS's competitors would not react to each initiative, the assumptions could have reflected 100% success in each area.

B. Observations on the PID-Required Downside Case Projections.

As noted above, the Department's advisors directed Highmark to produce the Downside Case projections based on an assumption that only 50% of projected WPAHS incremental patient volumes for each initiative were achieved. However, Highmark also was instructed to assume that management would take no actions to counter this shortfall in performance – for five full years. UPE and Highmark do not believe that this is a realistic scenario. Accordingly, they believe that the Base Case projections (including, as they do, the conservative assumptions referred to above) reflect the more likely outcome.

VI. Impact of the Affiliation on Community Hospitals.

Both the Compass Lexecon and Blackstone Reports discuss the impact a Highmark-WPAHS Affiliation may have on community hospitals.[34] They do not discuss in detail the actions that UPE and Highmark are taking and will take to support the community hospitals and to assist them in enhancing the care they deliver, improving their bottom lines and maintaining their independence. They also do not discuss the implications to the community hospitals of existing in a world occupied by one self-proclaimed monopolist provider system. In this regard, it is telling that, before it made a final decision to proceed with the Affiliation, Highmark was approached by a number of community hospitals urging it to intervene and save the WPAHS system. Those hospitals recognized the value of having a counterbalance to UPMC in the market.

UPE and Highmark believe strongly in the value of community hospitals. They understand that community hospitals provide high quality care at a lower cost and that they play a critical role in their communities. Accordingly, community hospitals are a key focus of the IDN strategy. Put simply, the success of the strategy hinges on the community hospitals: Highmark cannot realize the savings it projects to obtain through the strategy without vibrant community hospitals participating in the IDN.

A fundamental component of the IDN strategy is to keep care in the community whenever possible. Highmark, as an insurer, has an interest in this result for the impact it can have on care costs. The community setting also is more convenient to patients, resulting in higher subscriber satisfaction, and enhancing continuity of care, which improves outcomes and further reduces costs.

Today, a significant amount of healthcare services that could be provided in the community are being unnecessarily diverted to higher cost settings. UPMC has been a key driver, and beneficiary, of this diversion. Based on Highmark claims data, over $3 billion worth of healthcare services have shifted from western Pennsylvania community hospitals to UPMC since 2007. Highmark projects that, between 2011 and 2015, UPMC will capture $11.25 billion

[34] Compass Lexecon Report, 92, 129, 131.

of total healthcare spending that could be performed in community hospitals. This outmigration will result in care costs that are at least $2.7 billion higher than if reimbursed at community hospital rates, while also diverting $8.5 billion of revenues from the community hospitals -- additional revenues that would go a long way to helping to preserve the community hospitals.

As a part of it IDN strategy, Highmark has deployed and intends to deploy insurance products that feature the community hospitals, and to assist the hospitals in enhancing their clinical operations. This combination of activities will assure that patients obtain more convenient care while also enhancing the value proposition of the community hospitals.

In 2012, Highmark launched its Community Blue product to provide consumers in western Pennsylvania with a lower-cost alternative for high quality care based in the community. The Community Blue product includes every community hospital in southwestern Pennsylvania. The designs of the Community Blue product and network assure that there will be an increase in discharges at community hospitals.

Highmark also has been working with community hospitals in the development of a value-based reimbursement program as part of its ACA. This program is designed to provide reimbursement incentives and enhanced information and care management tools to community health systems and their physicians to assist them in improving health care quality and lowering health care costs. One of the key features of the ACA program is the introduction of incentives for coordination of care within a local healthcare system. Coordination of care is better for the patient and helps to reduce unnecessary variation and duplication of services such as occur in the case of avoidable readmissions. Highmark currently is in discussions with several key community healthcare systems with respect to the ACA value-based model.

The shift of care from UPMC to the community hospitals in conjunction with the Community Blue product and the ACA program will result in significant financial benefits to the community hospitals. Based on conservative assumptions, implementation of the ACA could result in at least 20% of the services now being performed by UPMC being shifted back to the community hospitals, where they belong. A hospital such as JRMC, for example, could expect an improvement of over $25 million to its net operating margin.

The programs described above underscore Highmark's commitment to keep care in the local community using local community providers as opposed to the UPMC approach of moving care from the community to higher cost, less coordinated settings. In the absence of the Affiliation, the UPMC model is the future of health care in western Pennsylvania.

It is important to note that community hospitals do not need to become affiliated with Highmark in order to benefit from the IDN. As the examples above show, the IDN strategy is designed to assist those community hospitals that wish to remain independent to remain independent.

VII. Highmark's Response to Certain Proposed Conditions.

The Reports include a listing of possible conditions for the Department to consider in connection with any approval of the proposed Transaction. The following section sets forth Highmark's responses to certain of these proposed conditions.

A. **Financial Restrictions.**

Proposed Condition: Limiting the amount of unrestricted payments Highmark may commit to in the future without Department approval

Proposed Condition: Limiting the amount of capital that may be expended by Highmark in the form of unrestricted grants to 501(c)(3) organizations

Blackstone Comments:

In its Report, Blackstone states that, "Whereas the degree of [Department] oversight with respect to Highmark's ordinary investment portfolio generally increases with the degree of risk and size of the related investment, Highmark asserts that there is a decreased level of oversight with respect to unrestricted grants given to other charitable organizations; Highmark characterizes these grants as business expenses that are subject to very limited [Department] review even though they have been made in conjunction with the receipt of certain governance rights with respect to the recipients of the grants."[35] The Blackstone Report concludes that, ". . . only $41 million of total IDN related unrestricted payments are contingent upon approval of the Form A, although the total expenditures may still fall under the [Department]'s jurisdiction given its general authority to regulate the surplus of Pennsylvania-domiciled Hospitals and Professional Health Service Plans . . . "[36] and adds that, "if the Transaction is approved, the [Department] may wish to consider conditions that may limit the amount of unrestricted payments that Highmark may commit in the future without [Department] review."[37] In a later part of its Report, Blackstone states that, "Taken as a whole, Highmark's IDN strategy will materially decrease its liquidity and will reduce the quality of its investment portfolio"[38] and that, "Given the above, the [Department] may wish" to impose a condition "related to financial stability: . . . Conditions limiting the amount of capital that may be expended by Highmark in the form of unrestricted grants to 501(c)(3) organizations."[39]

Highmark Response:

Highmark does not dispute the Department's authority to monitor and oversee its investments, the adequacy of its surplus levels or its financial stability. It does take issue with the notion that the Department should (or would want to) monitor and control its day-to-day decision-making over business expenses, including the making of grants to community organizations, provided, of course, that in making these grants, it complies with all applicable statutory and regulatory requirements, including properly accounting for the activities and reflecting their impact on Highmark's financial condition (which the Department may, of course, then review).

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[35] Blackstone Report, 27.
[36] Blackstone Report, 27 (footnote omitted).
[37] Blackstone Report, 27.
[38] Blackstone Report, 76.
[39] Blackstone Report, 76.

Highmark has a long and proud tradition of making grants to organizations which perform services to the communities that Highmark serves. In the last five years, Highmark has contributed over $77 million to health and human services, education, economic development, arts and civic organizations. This is in addition to the $100 million it contributed to the affiliated Highmark Foundation during 2006-2012 to support a children's health initiative, Highmark Healthy High 5, which addressed nutrition, physical activity, bullying, self-esteem and grieving through grants to schools and other organizations. There has never been a question that any of these activities was a proper use of Highmark' resources or that any type of review of them was necessary.

Highmark views the types of activities referred to above as an integral part of its nonprofit mission to promote the health and well-being of the communities in which it operates. Further, a blanket prohibition or restriction on Highmark's ability to engage in these types of activities not only would put it in a different posture than any other insurer in the Commonwealth, it also places needless obstacles in the way of assistance to organizations that perform valuable community services.

In light of the above, Highmark believes that, if the Department wishes to impose a condition on approval of the Transaction that Highmark be restricted in making grants or charitable contributions to other organizations, that condition should be narrowly tailored specifically to the situations that are addressed by Blackstone's comments; *i.e.*, where the grants or contributions are made in conjunction with Highmark (or an affiliate) obtaining governance rights over the recipient organization and there is a material adverse impact on Highmark's financial condition (*e.g.*, a material adverse effect on its RBC).

Proposed Condition: Limiting the amount of future capital that Highmark may commit to "non-insurance initiatives" and specifying the standard of review that must be undertaken prior to Highmark entering into agreements to commit such capital

Proposed Condition: Limiting the amount of capital that Highmark may commit in the context of an acquisition, affiliation, asset purchase or other business alliance to entities whose primary business is not health insurance and/or which would not be structured as a subsidiary of Highmark without providing the Department with consent and/or notification, with specified standards of review

Proposed Condition: Limit distributions from Highmark to UPE based on certain thresholds, which may include RBC, credit ratings, or other triggering metrics

Blackstone Comments:

In its Report, Blackstone states that, ". . . the manner in which Highmark pursued the Transaction may have resulted in significant expenditures for which Highmark's policyholders may receive limited value in the form of tangible financial assets . . ." concluding that, ". . . if the [Department] were to approve the Transaction, conditions limiting the amount of future capital that Highmark may commit to non-insurance initiatives, and specifying the standard of review that must be undertaken prior to Highmark entering into agreements to commit such capital, may

help to address the possibility of similar circumstances occurring in the future."[40] Later in its Report, Blackstone states that, "Taken as a whole, Highmark's IDN strategy will materially decrease its liquidity and will reduce the quality of its investment portfolio" and that, "Given the above, the [Department] may wish to consider the following types of conditions related to Highmark's financial stability: . . . Conditions limiting the amount of capital that Highmark may commit in the context of an acquisition, affiliation, asset purchase or other business alliance to entities whose primary business is not health insurance and/or which would not be structured as a subsidiary of Highmark, without providing the [Department] with consent and/or notification subject to specified standards of review."[41]

Highmark Response:

Highmark strongly disagrees with Blackstone's comments regarding "the manner in which it pursued the Transaction and the alleged effects of its approach." As noted in the Introduction to this response, both Highmark's senior management and its Board of Directors undertook a careful and comprehensive review of Highmark's options when confronted with the realities of the current healthcare landscape in western Pennsylvania, especially in light of its negotiations with UPMC. Such a review entailed the engagement of multiple advisors and consultants and the formation of a Special Board Committee on Network Strategy to address concerns specific to the IDN. As set forth elsewhere herein, Highmark strongly believes that its investment in the IDN strategy, while significant, will not jeopardize its financial stability as the enterprise's financial resources are sufficient to execute on the strategy and ensure its long-term success in all relevant markets.

Highmark acknowledges the Department's rightful interest in overseeing and monitoring its investment activities, the adequacy of its surplus and its financial stability. However, Highmark also believes that undue limitations (*i.e.*, limitations that go beyond the provisions of current law applicable to all other Pennsylvania-domiciled insurers) on its ability to make investments or participate in other activities[42] with organizations "whose primary business is not health insurance" is contrary to an objective that should be encouraged by the Department that it diversify its business and take such other actions as may be necessary to allow it to respond to a dynamic and constantly changing health insurance market.[43]

For the above reasons, Highmark suggests that, if the Department believes that it is necessary to impose a condition on its approval of the Transaction that Highmark be restricted in making investments in non-affiliated organizations, that that condition also should be narrowly tailored not to inhibit its ability to make business decisions that make sense to it (or any investments in entities which will be its subsidiaries – for which adequate limitations already exist in the law), but rather to address actual material negative effects on its financial condition (*e.g.*, a material adverse effect on its RBC). Highmark further suggests that the consent and/or notification provisions, as well as the standards set forth in the Insurance Holding Companies

[40] Blackstone Report, 28.
[41] Blackstone Report, 76.
[42] The term "business alliance" used in Blackstone's report is undefined and of uncertain meaning.
[43] Blackstone notes the value of diversification of investments in its Report. See Blackstone Report, 30.

Act, would be an appropriate model for the Department in tailoring any condition in response to Blackstone's comments relating to this topic.

Highmark does not believe that any additional restriction is necessary to be placed on its ability to make distributions to UPE as that subject is already adequately addressed by the Insurance Holding Companies Act.

B. Restrictions on Contracting Practices.

In the Compass Lexecon Report, Ms. Guerin-Calvert states that she reviewed a number of conditions recommended by commenters with regard to contracting between Highmark and hospitals and between WPAHS and "rival" insurers. She states that certain of these conditions could be more readily enforceable and could provide protection of competition without significant cost, while others appear to pose more substantial costs and uncertain benefits. Ms. Guerin-Calvert then addresses certain of these proposed conditions.[44]

Proposed Condition: Prohibition on anti-consumer choice initiative (*e.g.*, anti-tiering/anti-steering) language

Compass-Lexecon Comment:

Ms. Guerin-Calvert states that development of limited and tiered networks is still in nascent stages in western Pennsylvania and limited by current contracting provisions imposed by UPMC on insurers. She states that exclusion of provisions in any future Highmark or WPAHS/JRMC/SVHS contract with any provider or insurer that would prohibit either party from offering a tiered network product as a condition to the contract would enable market participants to independently negotiate mutually beneficial contracts for rival products of this type. Ms. Guerin-Calvert concludes that, "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."[45]

Highmark/UPE Response:

Highmark concurs in Ms. Guerin-Calvert's conclusion that anti-tiering/anti-steering provisions which she says are contained in UPMC contracts with all payors are anti-competitive. As Ms. Guerin-Calvert notes, they clearly have the effect of preventing insurers from taking actions that would allow patients to choose lower cost providers that can provide equal or higher quality service. Highmark would favor – and actively support -- legislation (or appropriate regulatory or other action) that would prevent all payors and all providers from entering into contracts that contain such provisions. In the absence of such action, however, it is Highmark's view that the Department should not impose on it, as a condition of approving the pending Transaction a rule that would be applicable solely to it; that would reward UPMC's anticompetitive behavior; and that UPMC would use as a weapon against Highmark in its

[44] Compass Lexecon Report, 192-195.
[45] Compass Lexecon Report, 193.

ongoing efforts to deprive consumers of choice. UPE does not intend that any of its hospitals will require payors to enter into contracts that contain anti-tiering/anti-steering clauses.

Proposed Condition: Limitations on contract lengths beyond customary and usual duration (2-5 years)

Compass-Lexecon Comment:

Ms. Guerin-Calvert states that contracts that "substantially exceed normal and customary lengths" (which she defines as "usually 2-5 years" have the potential to limit the ability of hospitals/insurers to respond to changes in the market place and may inhibit competitive change. She adds that "there does not appear to be any pro-competitive or business justification for substantially longer contracts that have been raised in the record here."[46]

Highmark/UPE Response:

The issue of contract length was never raised as an issue or discussed during the Department proceeding on the Form A. Thus, it is not surprising that Ms. Guerin-Calvert finds no discussion of it in the record. In addition, because it was never raised before, UPE and Highmark are unclear as to the precise thrust of her comment. However, to the extent that she is suggesting that, as a condition of its approval of the pending Transaction, the Department should order that neither Highmark nor any UPE hospital or provider should be permitted to enter into any contract with any provider or payor (as the case may be) in any market that would have a term longer than 2-5 years, the suggestion would appear to go beyond the matters that are before the Department in this matter (*e.g.*, Highmark's contracting practices in central Pennsylvania are not at issue in this proceeding). Further, controlling the length of contracts that WPAHS (or any other UPE hospital or provider) might enter into with payors other than Highmark also would not appear to be particularly germane. In addition, neither UPE nor Highmark believes that it would be desirable for it to be in a constant state of negotiation with payors or providers, respectively. Moreover, UPE and Highmark do not believe that it would be appropriate to impose such a condition only on them while every payor and provider in the Commonwealth is free to enter into contracts of whatever lengths they choose.

To the extent, however, that the Department is inclined to impose a condition of the type suggested by Ms. Guerin-Calvert here, UPE and Highmark would request that it do so only on a narrowly tailored basis and that it take into account the unique nature of the western Pennsylvania market. For example, Highmark must have the ability to obtain access to unique community resources such as Children's Hospital of Pittsburgh, Western Psychiatric Institute and sole community hospitals such as Bedford Hospital – all of which are controlled by UPMC – without arbitrarily imposed time limits. UPE would request that the Department also take into account the unique nature of its provider system (*i.e.*, it does not have the market power that UPMC does, which, UPE submits, was the real genesis of the Department of Justice's concern in the statement cited by Ms. Guerin-Calvert).[47]

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[46] Compass Lexecon, 193-194.

[47] To the extent that Ms. Guerin-Calvert relies on the Department of Justice's statement for support for her position in this regard, we note that that statement related only to western Pennsylvania and only to the contractual

Proposed Condition: Prohibition on exclusivity requirements between Highmark and UPE hospitals/providers or between Highmark and third party providers

Compass-Lexecon Comment:

Ms. Guerin-Calvert states that the proposed Transaction "does not appear to require exclusivity for its success" and, therefore, that, "it would appear that prohibitions on exclusive contracting could protect the ability of rivals to compete for business and contracts without imposing costs or limitations on the ability of WPAHS or Highmark to achieve relevant goals . . ."[48]

Highmark/UPE Response:

Highmark does not intend to enter into exclusive contracts with UPE providers as Highmark understands Ms. Guerin-Calvert to mean such term (*i.e.*, contracts which provide that Highmark subscribers may obtain services only from UPE providers). Similarly, UPE does not intend that its providers will enter into exclusive contracts with Highmark (*i.e.*, contracts which provide that the providers may render services only to Highmark subscribers).

Proposed Condition: Requirements to contract or contract on identical terms

Compass-Lexecon Comment:

Ms. Guerin-Calvert states that while some have suggested that UPE hospitals/providers and Highmark should be required to contract with all entities, there are potentially high costs that recommend against this approach, noting, among other things, that this could undermine efforts to develop narrow or tiered network products that lower costs.[49]

Highmark/UPE Response:

Highmark and UPE concur in Ms. Guerin-Calvert's conclusions.

Proposed Condition: Express conditions on pricing and non-price terms

Compass-Lexecon Comment:

Ms. Guerin-Calvert states that the specific and targeted conditions she discusses elsewhere with respect to firewalls and contracting make other suggested conditions that would set Highmark prices based on what its competitors pay. She states that this has the potential to distort competition.[50]

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arrangements between Highmark and UPMC, which the statement referred to as arrangements between a "dominant hospital" and a "dominant insurer."

[48] Compass Lexecon Report, 194.

[49] Compass Lexecon Report, 194.

[50] Compass Lexecon Report, 195.

Highmark Response:

Highmark concurs in Ms. Guerin-Calvert's comments in this regard.

Proposed Condition: Limitations on new contracts with UPMC

Compass-Lexecon Comment:

Ms. Guerin-Calvert reviews the suggestion made by some commenters that Highmark be precluded from renewing or entering into new contracts with UPMC and concludes that, "it is better to permit Highmark to attempt to respond to market demand, which appears to include consumer demand for a Highmark-UPMC product [sic.] and to develop strategies for successful revitalization of WPAHS, than to artificially restrict Highmark's options . . .." She adds that Highmark's current UPMC contract brings Highmark's rates up substantially from the prior contract and that Highmark's and consumers' incentives align if Highmark can achieve lower costs at WPAHS and pass those benefits along to consumers.[51]

Highmark Response:

Highmark wholeheartedly endorses Ms. Guerin-Calvert's comments in this regard. The suggestion that Highmark be precluded from contracting with UPMC as a condition to approval of the proposed Transaction is a transparent attempt by rival insurers to marginalize or eliminate competition from Highmark and by UPMC to maintain its monopolistic hold on the provider market. As has been made clear by overwhelming public comment, and as indicated by Ms. Guerin-Calvert, the market wants – demands – that there be a Highmark-UPMC contract, as well as a revitalized WPAHS in the market.

Sunset

UPE/Highmark Comment:

UPE and Highmark respectfully suggest that any conditions that the Department might impose in connection with any approval of the proposed Transaction should have a reasonable sunset provision so as to put the parties on an equal footing with their peers in the market.

[51] Compass Lexecon Report, 195.

DIVIDER SHEET

Response to Selected Points Contained in Compass-Lexecon's "Economic Analysis Of Highmark's Affiliation with WPAHS and Implementation of an Integrated Healthcare Delivery System," (Submitted April 8, 2013)

Barry C. Harris
Economists Incorporated
April 18, 2013

I. Introduction

1. My name is Barry C. Harris. In April 2012, I submitted a report to the Pennsylvania Insurance Department ("PID"), the "April Report." I also submitted several supplements to my April Report in May 2012, June 2012 and July 2012.[1] In October 2012, I submitted an amended version of my April Report ("Amended April Report"), as well as amended versions of my Supplement 3, Supplement 4 and Supplement 5.[2] I also submitted a sixth supplement to my Amended April Report ("Harris Supplement 6") in October 2012.

2. I have been asked to review and provide comments on Compass-Lexecon's "Economic Analysis Of Highmark's Affiliation with WPAHS and Implementation of an Integrated Healthcare Delivery System," submitted by Margaret E. Guerin-Calvert to the Pennsylvania Insurance Department, draft as of April 8, 2013 ("Compass-Lexecon Report").

II. Overview

3. Through the proposed affiliation, Highmark plans to create an integrated delivery network (IDN) that will include WPAHS. Highmark anticipates that the IDN will be able to create a structure that will coordinate care, align physician incentives, introduce innovation and promote evidence-based

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1 Supplement 1 to Report of Barry C. Harris, May 31, 2012, Supplement 2 to Report of Barry C. Harris, May 31, 2012, Supplement 3 to Report of Barry C. Harris, June 8, 2012, Supplement 4 to Report of Barry C. Harris, July 12, 2012 and Supplement 5 to Report of Barry C. Harris, July 12, 2012.

2 Hereafter, "Harris Amended Supplement 3," "Harris Amended Supplement 4" and "Harris Amended Supplement 5."

protocols and a differentiated patient experience. Highmark believes these efforts by the IDN will result in improved quality of care and service for its health plan enrollees. Highmark also anticipates that the IDN will achieve cost savings and improved access to care for its health plan enrollees.

4. Ms. Guerin-Calvert generally agrees with the Highmark expectations and concludes:

> The IDN contemplated by Highmark, with WPAHS as its core, has the characteristics of a successful IDN, thereby making it more likely to achieve improved clinical and fiscal outcomes for some defined population in WPA. [footnote omitted][3]

Ms. Guerin-Calvert further concludes:

> Given Highmark's IDN strategy, its available resources, and alignment with consumers to reduce unnecessary healthcare costs while maintaining quality, it may be in the best position to restore WPAHS as a competitively viable alternative for consumers in WPA.[4]

These conclusions are consistent with the analysis and findings presented in my Amended Supplement 4.[5]

5. Ms. Guerin-Calvert and I also both considered the impact on Highmark and the marketplace if the proposed affiliation did not occur.[6] Ms. Guerin-Calvert analyzes the impact on Highmark premiums if the affiliation does not occur and finds that the methodology and assumptions used by Highmark in reaching its estimates are not unreasonable. In this regard, Ms. Guerin-Calvert states:

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3 Compass-Lexecon Report, p. 12.

4 Compass-Lexecon Report, p. 153.

5 Harris Amended Supplement 4, pp. 2-18.

6 See Harris Supplement 1 and Harris Amended Supplement 5.

> If Highmark's estimates are correct, the consumer welfare effects will be significant. A family of four will face a 10% higher (about $3,000 for a family of four) health plan premium if the affiliation does not occur. The Affiliation would significantly benefit Highmark's members and likely spur additional price and quality competition from competing insurers.[7]

Further, Ms. Guerin-Calvert finds that "WPAHS is an especially important competitive constraint on UPMC"[8] and concludes:

> Without a stronger WPAHS, there are reduced significant competitive constraints on UPMC's ability to raise its rates to other insurers and shift substantially larger numbers of enrollees to its own plan, with lower reimbursement rates. Thus, a stronger WPAHS would act to constrain insurance premiums in WPA.[9]

I agree with these conclusions.[10] Further, these findings indicate that healthcare consumers in WPA likely would face reduced competition and higher health care premiums if the affiliation does not occur.

6. In coming to these conclusions, Ms. Guerin-Calvert analyzes the markets for health insurance, hospitals and physician services. I also conducted analyses of these markets.[11] Ms. Guerin-Calvert further considers the potential competitive effects from the proposed affiliation. I also considered the potential competitive effects.[12] While Ms. Guerin-Calvert and I agree on the conclusions concerning the likely benefits from the proposed IDN and the likely impact on health

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7 Compass-Lexecon Report p. 169.

8 Compass-Lexecon Report p. 185.

9 Compass-Lexecon Report, p. 186.

10 See Harris Supplement 1, Harris Amended Supplement 4 and Harris Amended Supplement 5.

11 See Harris Amended April Report.

12 See Harris Amended April Report and Harris Amended Supplement 3.

insurance consumers and patients in WPA if the proposed affiliation does not occur, I do not agree with her analysis and conclusions concerning the health insurance marketplace in WPA and the potential competitive effects concerning vertical foreclosure. Specifically, my analyses indicate that Highmark does not have market power and that WPAHS will continue to have the incentive to contract with other health insurers following the proposed affiliation. I provide a detailed discussion of my analyses of these issues in Sections III and IV. In Section V, I discuss why Highmark's estimated IDN savings associated with the utilization shift category are based on a reasonable assumption.

III. Analyses of insurance premiums and medical-loss ratios and recent competitive dynamics in the WPA marketplace indicate that Highmark does not have market power

7. Ms. Guerin-Calvert states that she is "not able to reject the conclusion that Highmark has market power in the insurance sector."[13] This conclusion is based largely on her analyses of share history in WPA and win-loss data from Highmark for 2008-2012 (partial 2012). These analyses do not provide a sufficient basis for ascertaining whether Highmark has market power. While share history and a review of win-loss data may be useful starting points for analyzing competition in a market, absent a consideration of relative prices, price changes or other possible changes (such as quality or service), they are not sufficient to determine whether a firm has market power. Share history and a review of win-loss data also are not sufficient to assess the ability of competitors to enter or expand in a marketplace if Highmark were to attempt to exercise

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13 Compass-Lexecon Report, p. 10.

market power.[14] My analyses of share history and the win-loss data, as well as my analyses of premium and medical-loss ratios (MLRs) and the recent competitive dynamics in the WPA marketplace, indicate that Highmark does not possess market power.

8. The fundamental importance of relative prices in analyzing market power is highlighted by the definition of market power. Market power is the ability of a group of firms within a relevant market or an individual firm to profitably charge prices above the competitive level for a sustained period of time.[15] A firm with high shares, at a point in time or over time, does not necessarily or typically reflect competitive harm. Rather, high shares often reflect the desirability of a product, in terms of price and/or quality, to consumers.[16]

9. I considered evidence on Highmark's pricing in my analyses of whether Highmark has market power in the WPA marketplace.[17] In my Amended April

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14 The U.S. Department of Justice and Federal Trade Commission state that the Agencies "give more weight to market concentration when market shares have been stable over time, *especially in the face of historical changes in relative prices or costs.*" [emphasis added] These Agencies further state "lack of successful entry *in the face of non-transitory increases in the margins* earned on products in the relevant market tends to suggest that successful entry is slow or difficult." [emphasis added] See U.S. Department of Justice and Federal Trade Commission, *Horizontal Merger Guidelines*, issued August 19, 2010, pp. 18 and 28. Ms. Guerin-Calvert's analysis did not consider relative prices, price changes or possible changes in other competitive factors. (Compass-Lexecon Report, p. 69)

15 See Section of Antitrust Law of the American Bar Association, *Market Power Handbook: Competition Law and Economic Foundations*, Second Edition, American Bar Association, 2012, p. 1.

16 See Thomas O. Barnett, at the time the Assistant Attorney General in charge of the U.S. Department of Justice Antitrust Division, "The Gales of Creative Destruction: The Need for Clear and Objective Standards for Enforcing Section 2 of the Sherman Act," June 20, 2006.

17 Ms. Guerin-Calvert acknowledges the importance of relative prices when she cites to studies assessing insurer market power: "Academic studies include empirical studies that examine competitive conditions in health insurance; concluding, for example, that some markets are characterized by high concentration, dominant insurers, and limited ability of competitors to enter and expand, and *that these conditions are related empirically to the ability of certain insurers to*

Report, I compared Highmark's premiums to those of other health insurers in the WPA area and also considered Highmark's MLRs using publicly available information on rates and MLRs.[18] My findings from these analyses are consistent with a conclusion that Highmark's prices are ***not*** above competitive levels and that Highmark does not have market power.

10. First, I compared pricing directly between Highmark and other health insurers for products with publicly available premium information. These included insurance products sold to individual purchasers both for policies covering an individual and policies covering a family. (See Tables 1 and 2 of Exhibit 3, Amended April Report, which are included in this report as Exhibit 1.) I compared premiums, deductibles, out-of-pocket payment levels and coinsurance for Highmark's Advance Blue and PPO Blue products to comparable products of other health insurers. I found that the premiums for the Highmark Advance Blue plan are lower (often considerably lower) than the premiums for the comparable products (in terms of benefit designs and deductibles) of its competitors. I also found Highmark's PPO Blue health plan premiums are similar to those of its competitors for health plans with comparable deductibles. However, Highmark's PPO Blue health plan typically offers a richer benefit design than those of its competitors, including substantively lower maximum out-of-pocket payments, higher coinsurance rates and prescription drug benefits.

11. Second, I considered MLRs for products sold to small groups and products sold to large groups, because price quotes are made directly to the specific group by

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achieve higher premiums than would otherwise exist if the market were competitive." [emphasis added] Compass-Lexecon Report p. 67.

18 Harris Amended April Report, pp. 22-26.

the insurance company and are not generally publicly available. I found that Highmark's MLRs for small groups ranged from 86.8% to 97.6%, compared to a statewide median MLR for small group of 82.8%, and statewide mean of 84.2%. I also found the Highmark's MLRs for large groups ranged from 93.1% to 95.0% for Highmark Inc. and Keystone Health Plan West.[19] The statewide median MLR for large group products is 87.6%, and the mean is 88.3%.[20]

12. The definition of an MLR under the Patient Protection and Affordable Care Act is the percentage of the premiums collected by insurers that is spent on medical services and quality improvement activities for the people they insure. In other words, the MLR reflects a measure of costs, including medical claims, relative to premiums. A comparison of MLRs by itself is not sufficient to indicate relative pricing across Highmark and its competitors (as the above premium comparison was able to do). However, a review of Highmark's MLRs is informative about Highmark's premiums relative to its own costs. For any level of cost, a higher MLR reflects lower premium levels. Ms. Guerin-Calvert reports that Highmark has relatively low costs.[21] Thus, by definition, Highmark's high MLRs reflect that it has low premiums as well. Ms. Guerin-Calvert agrees that Highmark has offered lower premium rates: "This has provided the means for it [Highmark] profitably to offer lower rates..."[22]

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19 HM Health Insurance Company has a MLR of 51.1%. However, less than 2/100th of 1% of Highmark's large group sales is made through HM Health Insurance Company.

20 Harris Amended April Report, Exhibit 4, Table 2 and Table 3.

21 See Compass-Lexecon Report, pp. 10, 35 and 68, indicating that Highmark has been able to negotiate substantially better reimbursement rates with UPMC and has relatively low reimbursement rates at both WPAHS and UPMC.

22 Compass-Lexecon Report, p. 69.

13. In sum, my analyses of premiums and MLRs indicate that Highmark offers relatively low premiums to its customers. Lower rates make a health insurance product more attractive to consumers, which, in turn, increases sales and thus share. This finding is nothing more than a recognition that as prices decrease the quantity demanded increases, which is inconsistent with a claim that Highmark's share history is indicative of market power. Moreover, Highmark's low premiums are consistent with Highmark's prices being constrained by competition from other health insurers.

14. Ms. Guerin-Calvert also considers past win-loss data reported by Highmark.[23] These data report losses from Highmark to competing health insurers, including UPMC Health Plan, Aetna, Cigna, HealthAmerica and United Healthcare. Ms. Guerin-Calvert concludes from her review of these win-loss data that rivals have had limited competitive success against Highmark.[24] These data, however, "do not show the prices at which Highmark retained the business or other competitive terms and conditions."[25] These data also do not consider the competitive dynamics of the health insurance marketplace in WPA going forward.

15. My review of Highmark's win-loss data indicates that there was a significant change in the losses that occurred in 2011 compared to earlier years.[26] This comparison reflects a potential change in quality and service, because in 2011,

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23 Highmark provided win-loss data for 2008 through partial year 2012.

24 Compass-Lexecon Report, p. 69.

25 Compass-Lexecon Report, p. 69.

26 Data are reported from February through January in each year, for 2008 through 2011. Data for 2012 are reported for only a partial year, from February through July.

UPMC Health System threatened that it may not continue to be an in-network provider for Highmark. Highmark experienced increased losses in 2011 when compared to 2010 to UPMC Health Plan, Aetna, Cigna, HealthAmerica and United Healthcare combined, with proportionately greater losses to UPMC Health Plan, Aetna and Cigna.[27]

16. Additionally, the competitive dynamics of the health insurance marketplace are changing, the beginning of which is reflected in the Highmark 2011 win-loss data. First, rival insurers to Highmark have recently negotiated in-network member access to UPMC Health System, which Ms. Guerin-Calvert acknowledges has increased the competitive pressure on Highmark:

> I view that the competitive pressure on Highmark increased with rival insurers' new contracts with UPMC, and their ability to offer broader networks inclusive (now) of UPMC, as well as WPAHS and other hospitals. Rivals appear to be more robust competitors in their ability to attract enrollees and share from Highmark with these broader networks as compared to prior offerings without UPMC, which were more limited than Highmark's.[28]

17. Second, UPMC Health System is the largest hospital network located in Highmark's WPA service area, and it is integrated with the UPMC Health Plan. If the UPMC hospitals are not included in Highmark's health plan networks, a scenario that Highmark considers in the projections it submitted as a supplement to the Form A filing, Highmark projects losses in its commercial enrollment and a loss in share. The reason for this projection is that health insurance customers in Highmark's WPA service area can readily switch to the UPMC Health Plan or the other rival health insurers if they prefer a provider network that includes the

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27 Compass-Lexecon Report, Appendix II, Table 6b.

28 Compass-Lexecon Report, p. 69.

UPMC hospitals. These competitive dynamics further indicate that an analysis limited to share history and past win-loss data is not sufficient to assess the ability of UPMC Health Plan and rival national insurers to expand in the WPA marketplace.

18. In sum, my analyses on premium and medical-loss ratios (MLRs), as well as additional analyses of share history, Highmark win-loss data and the recent competitive dynamics in the WPA marketplace indicate that Highmark does not possess market power.

IV. WPAHS will continue to have the incentive to contract with other health insurers following the proposed affiliation and will not be able to increase reimbursement rates with the effect of harm to competition

19. Ms. Guerin-Calvert considers whether there are competitive effects arising from the vertical aspects of the proposed affiliation between Highmark and WPAHS. She concludes:

> A number of conclusions are required for a vertical merger or arrangement to have anticompetitive effects. My analysis here suggests a plausible basis for the possibility that the affiliated entity would have an *incentive* to increase reimbursement rates at WPAHS for national insurers that differ from those of WPAHS as an independent hospital because of the internalization of profits at both WPAHS and Highmark. *This conclusion, by itself, does not indicate whether the affiliated entity would engage in this behavior, and if it did, whether it would be anticompetitive.* [emphasis added to last sentence][29]

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29 See Compass-Lexecon Report, p. 80, fn. 173. See also Cooper, James C., Luke M. Froeb, Dan O'Brian and Michael G. Vita, "Vertical Antitrust Policy as a Problem of Inference," *International Journal of Industrial Organization*, 23 (7-8), 2005, pp. 639-664, in which these authors note that even if a firm's strategy of raising rivals' costs were profitable for the firm, it may nonetheless lead to a decrease in downstream price (at p. 643).

20. I agree with Ms. Guerin-Calvert that several conditions are all necessary for a vertical merger or arrangement to have anticompetitive effects.[30] A recent review of empirical studies on the effects of vertical integration finds that, "The data appear to be telling us that efficiency considerations overwhelm anticompetitive motives in most contexts. Furthermore, even when we limit attention to natural monopolies or tight oligopolies, the evidence of anticompetitive harm is not strong."[31] This same review concludes that

> Under most circumstances, profit-maximizing vertical-integration decisions are efficient, not just from the firms' but also from the consumers' point of view. Although there are isolated studies that contradict this claim, the vast majority support it... We therefore conclude that, faced with a vertical arrangement, the burden of evidence should be placed on competition authorities to demonstrate that that arrangement is harmful before the practice is attacked. Furthermore, we have found clear evidence that restrictions on vertical integration that are imposed, often by local authorities, on owners of retail networks are usually detrimental to consumers. Given the weight of the evidence, it

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30 I also note, as does Ms. Guerin-Calvert, that it is well established that vertical mergers create a significant potential for procompetitive efficiencies. This is indicated in Riordan, Michael H. and Steven C. Salop, "Evaluating Vertical Mergers: A Post-Chicago Approach," *Antitrust Law Journal*, 513 (1995), at p. 522: "Antitrust takes the general view that cooperation among firms in a vertical relationship in general has greater efficiency potential than does cooperation among horizontal competitors. It is consistent with basic antitrust principles, therefore, to place greater weight on efficiency benefits in analyzing vertical mergers than in analyzing horizontal restraints."

31 See Lafontaine, Francine and Margaret Slade, "Vertical Integration and Firm Boundaries: The Evidence," *Journal of Economic Literature*, vol. XLV (September 2007), pp. 629-685, at p. 677. See also Jeffrey Church, "Vertical Mergers," in *Issues in Competition Law and Policy*, ABA Section of Antitrust Law, 2008, pp. 1455-1501: "As discussed above, a key consideration in determining optimal vertical merger policy is the economic presumption, on both theoretical and economic grounds, that vertical mergers are likely efficiency enhancing and beneficial for consumers... The empirical evidence supports this presumption. That evidence is consistent with two propositions: (1) that instances of vertical integration and merger are consistent with the hypothesis of transaction cost economics, and (2) that instances of vertical merger that are harmful for consumers are very infrequent." (at p. 1495) Further, Cooper *et al* state: "Our review of the empirical evidence – which informs our priors – suggests that vertical restraints are likely to be benign or welfare enhancing." (at p. 662)

behooves government agencies to reconsider the validity of such restrictions.[32]

21. I also considered whether there are competitive effects arising from the vertical aspects of the proposed affiliation.[33] Specifically, I considered whether UPE through WPAHS would have the incentive to raise costs to other health insurers (or refuse to contract with other health insurers) and could harm competition as a result. My analysis found that UPE through WPAHS will continue to have the incentive to contract with other health insurers and will not be able to harm competition. I reached these conclusions for the following reasons:

- It is costly to WPAHS if patients switch from WPAHS to alternative facilities if WPAHS were to attempt a price increase.
- UPMC Health Plan cannot be affected by WPAHS contracting practices or reimbursement rates, because UPMC Health Plan does not include WPAHS in its provider networks.[34] As a result, UPMC Health Plan's ability to act as a competitive constraint in the marketplace cannot be diminished. UPMC Health Plan is a significant health insurer competitor to Highmark.[35] Moreover, recent competitive dynamics in the marketplace suggest that if the proposed affiliation occurs, UPMC Health Plan will be well positioned and has the incentive to gain enrollment to keep admissions at UPMC Health System.
- UPMC Health System is a significant competitor to WPAHS for hospital services, as are other hospitals competing in WPAHS' 90% service area. The extent of this competition is reflected by WPAHS' relatively low share

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32 See Lafontaine and Slade, at p. 680.

33 See Harris Amended Supplement 3.

34 In her analysis of the incentive of UPE through WPAHS to increase reimbursement rates to other insurers Ms. Guerin-Calvert does not consider the role of UPMC Health Plan and that it cannot be impacted by any contracting practice or reimbursement rates of WPAHS.

35 UPMC Health Plan has experienced the most enrollment gains from Highmark (see Compass-Lexecon Report, pp. 30, 32 and 34 and Appendix II, Table 6b), and these enrollment gains grew in 2011 compared to 2010.

of discharges in its 90% service area. As such, UPMC Health System is a significant alternative for rival health insurers if WPAHS were to attempt to increase its reimbursement rates. UPMC Health System is now included as an in-network provider for the rival national insurers, and these insurers already are shifting some patient admissions away from WPAHS to UPMC Health System.[36] Because UPMC Health System and the other hospitals competing in WPAHS' 90% service area are significant alternatives, WPAHS does not have the ability to substantially affect the costs of the rival national insurers.[37] Consequently, these other health insurers likely would not have to substantively increase premiums above levels that otherwise would occur in Highmark's WPA service area (and thus, likely would not lose significant numbers of enrollees).

- UPMC Health System faces the potential loss of a substantial number of admissions if the proposed affiliation occurs and Highmark implements its IDN strategy. As a consequence, UPMC Health System will have strong incentives to maintain its hospital admissions and to attract admissions from the national insurers (as well as from its integrated health plans).[38] Recent competitive dynamics indicate that more enrollees of the rival national insurers currently are utilizing UPMC Health System[39] and more could (without switching health insurers) if WPAHS were to attempt to raise reimbursement rates.

Thus, any attempt to raise reimbursement rates at WPAHS or refuse to contract with rival national health insurers would result in substantial lost margins with

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36 See Compass-Lexecon Report, p. 186.

37 Harris Amended Supplement 3, pp. 2-3 (fn. 2 and fn. 3) and pp. 11-13. See also Compass-Lexecon Report, p. 40: "For example, the use of new benefit designs, including high-deductible plans, encourage consumers to take price into greater consideration in choice of hospital, which can increase consumer's incentives to bypass a more convenient hospital to go to one that is lower priced."

38 As Ms. Guerin-Calvert indicates, the UPMC Health System will fight for admissions if the proposed affiliation occurs and Highmark implements its IDN strategy. (See Compass-Lexecon Report, see e.g., pp. 14, 129, 132) She also indicates that a strong competing hospital system can constrain an attempt by an integrated hospital/insurer to raise hospital reimbursement rates to competing insurers. Compass-Lexecon Report, p. 186.

39 See Compass-Lexecon Report, p. 186.

high probability, while any potential enrollment shifts to Highmark (and any potential recapture of patients by WPAHS through enrollment shifts to Highmark) are uncertain.[40] For these reasons, UPE through WPAHS will continue to have the incentive to contract with other rival insurers and cannot raise rivals' costs with a result of harm to competition.

22. Additionally, I consider the likely effect of Highmark's planned investment of approximately $1 billion to improve WPAHS and implement its IDN strategy[41] on whether UPE through WPAHS would have the incentive to continue to contract with other health insurers.[42] The risks and costs associated with this approximately $1 billion investment significantly affect the incentives of UPE through WPAHS to negotiate with other health insurers. Highmark plans to engage in several efforts to gain admissions at WPAHS and aligned community hospitals.[43] These efforts are part of its strategy to improve profitability at WPAHS and to generate cost savings of approximately $447 million per year.[44] If admissions do not increase substantially at WPAHS, the profitability of WPAHS and the cost savings from the IDN strategy will be negatively affected and Highmark may have to undertake further efforts to achieve a profitable return on

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40 Further, if Highmark loses UPMC Health System as an in-network provider, as it projects in its Form A Filing, its ability to attract enrollment from the rival national insurers will be even more uncertain.

41 See Compass-Lexecon Report, p. 108.

42 Ms. Guerin-Calvert does not consider this important factor in her competitive effects analysis.

43 These efforts are detailed in the Grant Thornton analysis and Harris Supplement 6 and include, among others, aligning with physicians, introducing new products such as Community Blue and creating an IDN.

44 Compass-Lexecon Report, p. 108.

its $1 billion investment.[45] Thus, a key focus of Highmark's IDN strategy is to increase admissions at WPAHS. The rival national insurers are an important source of admissions at WPAHS, and it does not make economic sense for UPE through WPAHS to risk losing these admissions when a key focus of Highmark's IDN strategy is to substantively increase admissions at WPAHS.[46]

23. Simply, as Ms. Guerin-Calvert states, "I would also expect Highmark and WPAHS to pursue all potentially lucrative business opportunities, such as Medicaid, as part of the turnaround plan."[47] Commercial contracts with the national insurers would also fall into this category of "lucrative business opportunities." Ms. Guerin-Calvert further states:

> the success and impact of Highmark's affiliation with WPAHS depends critically on the ability of the IDN and Highmark to attract large numbers of inpatients away from UPMC to WPAHS. These shifts in volume could achieve many objectives, including improved profitability and sustainability of WPAHS, potential reduction in costs due to best practices and higher volumes, improvements in quality and strengthening WPAHS as a competitor. To achieve these objectives, however, Highmark must accomplish two elements of its strategy: (1) incentivize patients to select WPAHS and other aligned hospitals rather than UPMC for inpatient services by adopting Community Blue and by increasing the transparency of cost information relevant for consumer decisions, and (2) encourage physicians to use and refer patients to WPAHS and other aligned

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45 For example, Highmark has been requested by the PID to identify several contingency actions that it would likely undertake if admissions to WPAHS do not reach at least break-even admission levels. These contingency actions identify ways to improve the financial condition of WPAHS, because insufficient gains in admissions to WPAHS would result in income losses at WPAHS. However, the contingency actions also can impact the operations and costs at WPAHS. See Compass-Lexecon Report, pp. 138-139.

46 UPE's plans if the affiliation occurs are for WPAHS to continue to negotiate with other health insurers and to participate in these health insurers' provider networks. (Harris Amended Supplement 3, pp. 5-6)

47 Compass-Lexecon Report, p. 153.

> hospitals as appropriate points of care rather than UPMC. Without achieving these goals, it will be substantially more difficult for Highmark to attract sufficient numbers of patients to WPAHS to make this Affiliation successful in terms of (1) financially stabilizing WPAHS, (2) lowering the cost of care to Highmark members, (3) lowering Highmark's risk exposure to possible WPAHS financial failure, and (4) providing improved competitive healthcare delivery to the WPA community. [footnote omitted][48]

24. In sum, Highmark's substantial investment in its IDN strategy indicates a strong incentive for UPE through WPAHS to continue to negotiate with rival national insurers.

25. Ms. Guerin-Calvert also reports findings from an economic model she constructed that attempts to analyze the change in economic profits to WPAHS and Highmark if the combined entity attempted to increase WPAHS' reimbursement rates to national insurers.[49] Ms. Guerin-Calvert's model generates a range of possible outcomes from a hypothesized WPAHS price increase, including the possibility of both negative and positive changes in profit for the combined entity if it attempted such a price increase. Moreover, the model Ms. Guerin-Calvert uses to estimate these findings does not consider several important factors, including some factors I already have discussed. These factors include:

- Highmark's planned investment of approximately $1 billion to improve WPAHS and implement its IDN strategy. The risks and costs associated with such an investment significantly affect the combined entity's incentives to negotiate with rival health insurers. The result is that a key focus of Highmark's IDN strategy is to increase admissions at WPAHS.

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48 Compass-Lexecon Report, pp. 92-93.

49 See Compass-Lexecon Report, pp. 78-79 and Appendix V.

- Highmark's estimated cost savings of approximately $447 million per year if the proposed affiliation occurs and Highmark implements its IDN strategy with WPAHS at its core. These potential cost savings depend in significant part on increased admissions to WPAHS and other aligned hospitals. Moreover, these potential costs savings dominate any of the possible additional costs to consumers generated by Ms. Guerin-Calvert's model that considers a hypothetical attempted price increase at WPAHS. Basic economics indicates that a significant portion of these cost savings would likely be passed on to health care consumers in WPA.[50]

26. Further, the model Ms. Guerin-Calvert uses to estimate these findings is sensitive to specific assumptions and assumed values for a small number of parameters. Most of the findings that she reports assume that a high percent of the patient admissions that leave WPAHS due to the hypothetical attempted price increase also will change their health insurer (and many will switch to Highmark). Whether these patients will switch health insurers and to which health insurer they switch is highly uncertain for the following reasons: 1) national insurers already are shifting some volumes from WPAHS to UPMC Health System, and Highmark experienced increased losses to some of these national insurers in 2011; 2) Highmark's provider network will change significantly if Highmark's contract with UPMC Health System is not renewed;[51] and 3) Ms. Guerin-Calvert's model does not account for potential increased competition from UPMC Health Plan, which is well positioned and has the incentive to gain

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50 See Harris Amended Supplement 4, pp. 19-21.

51 Thus, Ms. Guerin-Calvert's assumption that admissions switching from national insurers will move to Highmark based on Highmark's current share fails to address real-world competitive dynamics in WPA.

enrollment to keep admissions at UPMC Health System if the proposed affiliation occurs.[52]

27. To conclude, it is costly for WPAHS to lose hospital admissions. Further, competition from UPMC Health Plan and UPMC Health System, the competitive dynamics of the marketplace and Highmark's planned $1 billion investment in its IDN strategy indicate that UPE through WPAHS will have the incentive to negotiate with rival national insurers and will not be able to increase reimbursement rates to these national insurers with the effect of harming competition. My findings are consistent with those of the Department of Justice in its review of the proposed affiliation:

> Moreover, the DOJ determined that the affiliation agreement would not reduce WPAHS' incentives to offer competitive rates to other insurers because its incentives are to increase patient volumes. Likewise, the Antitrust Division determined that the affiliation would not facilitate horizontal collusion among health plans because expansion by national insurers is occurring now in an attempt to undermine Highmark's dominant market share. It also recognized the significant capital infusion that Highmark would provide to WPAHS, which would increase competition in WPA's health care markets by increasing "the incentives of market participants to compete vigorously." [footnote omitted][53]

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52 Another important assumption in Ms. Guerin-Calvert's model is that the elasticity for WPAHS is equal to 1/(WPAHS' contribution margin) or 1/(WPAHS's contribution margin) + 0.5. Elasticity is defined as the percentage by which a firm's sales would decrease for a 1% increase in the firm's price on those sales. If I apply this same assumption to estimate Highmark's own elasticity, I find that Highmark's own elasticity exceeds estimates that would be consistent with a claim that Highmark has market power.

53 See Compass-Lexecon Report, p. 84.

V. Highmark's estimated IDN savings associated with the utilization shift category are based on a reasonable assumption

28. Ms. Guerin-Calvert questions Highmark's assumption that only 10% of its hospital spend at UPMC Health System for the patients who are projected to remain Highmark enrollees will remain at UPMC Health System.[54] Highmark's assumption is reasonable, and Highmark has provided information to support it. First, Highmark projects that in FY15 and FY16, it will no longer have a contract with UMPC Health System and UPMC Health System will be an out-of-network provider of hospital services to Highmark enrollees. Second, approximately 70% of hospital admissions for Highmark enrollees are non-emergency-related.[55] Highmark estimates that all of these non-emergency admissions for its projected enrollment in FY15 and FY16 (which includes only those members who choose to remain with Highmark even though UPMC Health System will no longer be in-network) will go to in-network hospital facilities and not to UPMC Health System.[56] Third, approximately 30% of hospital admissions for Highmark enrollees are emergency-related admissions. Highmark studied its experience for members located in Monroeville, prior to the opening of UPMC East. Based on this study, Highmark found that approximately two-thirds of its members chose to obtain emergency care at a non-UPMC hospital facility. Thus, Highmark estimates that only 10% (i.e. one-third of 30%) of the hospital admissions associated with its projected membership will be UPMC Health System admissions.

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54 Compass-Lexecon Report, p. 102.

55 Compass-Lexecon Report, p. 102, fn. 209.

56 Based on its experience, Highmark anticipates its projected membership will choose in-network hospital facilities for non-emergency care. Highmark projects membership losses in FY15 and FY16 due to the expected non-renewal of its contract with UPMC Health System.

VI. Conclusion

29. Ms. Guerin-Calvert concludes that the IDN contemplated by Highmark is likely to achieve improved clinical and fiscal outcomes for some defined population in WPA. She also concludes that Highmark may be in the best position to restore WPAHS as a competitively viable alternative for consumers in WPA and a stronger WPAHS would act to constrain insurance premiums in WPA. I agree with these conclusions. I do not agree with her analysis and conclusions concerning the health insurance marketplace in WPA and the potential competitive effects concerning vertical foreclosure. My analyses indicate that Highmark does not have market power and that UPE through WPAHS will have the incentive to negotiate with rival national insurers and will not be able to increase reimbursement rates to these national insurers with the effect of harming competition.

Barry C Harris 4/18/13

Barry C. Harris

Exhibit 1
Table 1
Comparison of Insurance Plan Prices - Individual

Plan	Premium	Deductible	Out of Pocket (in network)	Coinsurance (in-network)	Note
Advance Blue	$208.35	$1,200	$1,000	90%	100% coverage after copays for office visits
Aetna PPO	$268.00	$1,500	$3,000	80%	100% coverage after copays for office visits
Advance Blue	$180.25	$2,600	$1,200	90%	100% coverage after copays for office visits
Aetna PPO	$213.00	$2,500	$5,000	80%	100% coverage after copays for office visits
United Copay Select	$261.33	$2,500	$3,000	80%	100% coverage after copays for office visits
UPMC EPO*	$216.66	$2,500	$5,000	80%	100% coverage after copays for office visits
Advance Blue	$166.15	$3,500	$1,500	90%	100% coverage after copays for office visits
Aetna PPO	$180.00	$3,500	$7,500	80%	100% coverage after copays for office visits
United Copay Select	$235.11	$3,500	$3,000	80%	100% coverage after copays for office visits
PPO Blue	$193.85	$1,200	$1,000	90%	90% coverage for office visits
Aetna PPO (Value)	$190.00	$1,500	$3,000	80%	100% coverage after copays for a limited number of office visits
United HSA 70	$345.05	$1,250	$3,000	70%	70% after deductible
UPMC HSA*	$197.62	$1,300	$2,600	80%	80% after deductible
PPO Blue	$165.75	$2,600	$1,200	90%	90% coverage for office visits
Aetna PPO (Value)	$160.00	$2,500	$5,000	80%	100% coverage after copays for a limited number of office visits
United HSA 70	$209.74	$2,500	$3,000	70%	70% after deductible
United Plan 80	$211.43	$2,500	$3,000	80%	80% after deductible
UPMC HSA*	$159.12	$2,500	$3,550	80%	80% after deductible

Source: https://www.highmarkbcbs.com/chmptl/chm/jsp/findInsurance_redesign.do?tab=0
https://www.uhone.com/Quote/QuotePerson.aspx
http://www.upmchealthplan.com/index.html
http://healthinsurance.aetna.com/?WT.svl=GetAQuote_nav

Notes: *No out of network for UPMC.
Estimates are based on a 45 year old female residing in zip code 15217.
All insurers' rates accessed on 9/5/2012.

Exhibit 1
Table 2
Comparison of Insurance Plan Prices - Family

Plan	Premium	Deductible	Out of Pocket (in network)	Coinsurance (in-network)	Note
Advance Blue	$524.20	$2,400	$2,000	90%	100% coverage after copays for office visits
Aetna PPO	$653.00	$3,000	$6,000	80%	100% coverage after copays for office visits
United Copay Select**	$956.96	$2,000	$12,000	80%	100% coverage after copays for office visits
UPMC EPO*	$631.99	$2,000	$4,000	80%	100% coverage after copays for office visits
Advance Blue	$455.20	$5,200	$2,400	90%	100% coverage after copays for office visits
Aetna PPO	$518.00	$5,000	$10,000	80%	100% coverage after copays for office visits
UPMC EPO*	$557.61	$5,000	$10,000	80%	100% coverage after copays for office visits
United Copay Select**	$702.10	$5,000	$12,000	80%	100% coverage after copays for office visits
Advance Blue	$420.60	$7,000	$3,000	90%	100% coverage after copays for office visits
Aetna PPO	$439.00	$7,000	$15,000	80%	100% coverage after copays for office visits
United Copay Select**	$632.76	$7,000	$12,000	80%	100% coverage after copays for office visits
PPO Blue	$488.65	$2,400	$2,000	90%	90% coverage for office visits
Aetna PPO (Value)	$462.00	$3,000	$6,000	80%	100% coverage after copays for a limited number of office visits
United HSA 70	$875.42	$2,500	$6,000	70%	70% after deductible
United Plan 80**	$748.90	$3,000	$12,000	80%	80% after deductible
UPMC HSA*	$512.10	$2,600	$5,200	80%	80% after deductible
PPO Blue	$419.65	$5,200	$2,400	90%	90% coverage for office visits
Aetna High Deductible	$469.00	$6,000	$6,000	100%	100% coverage after deductible
Aetna PPO (Value)	$390.00	$5,000	$10,000	80%	100% coverage after copays for a limited number of office visits
United HSA 70	$506.24	$5,000	$6,000	70%	70% after deductible
United Plan 80**	$566.84	$5,000	$12,000	80%	80% after deductible
UPMC HSA*	$420.39	$5,000	$7,100	80%	80% after deductible
PPO Blue	$390.90	$7,000	$3,000	90%	90% coverage for office visits
United HSA 70	$443.84	$7,000	$4,200	70%	70% after deductible
United Plan 80**	$442.02	$10,000	$12,000	80%	80% after deductible

Source: https://www.highmarkbcbs.com/chmptl/chm/jsp/findInsurance_redesign.do?tab=0
https://www.uhone.com/Quote/QuotePerson.aspx
http://www.upmchealthplan.com/index.html
http://healthinsurance.aetna.com/?WT.svl=GetAQuote_nav

Notes: *No out of network for UPMC.
**Deductible must be met by two individuals, so deductible amounts are doubled. Out-of-pocket costs are per person, so costs are quadrupled.
Estimates are based on a 45 year old married female with two kids residing in zip code 15217.
All insurers' rates accessed on 9/5/2012.