BEFORE THE INSURANCE DEPARTMENT
OF THE
COMMONWEALTH OF PENNSYLVANIA

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

Hospital Service Association of Northeastern Pennsylvania
d/b/a Blue Cross of Northeastern Pennsylvania;
First Priority Life Insurance Company, Inc.;
HMO of Northeastern Pennsylvania, Inc.,
d/b/a First Priority Health

By Highmark Inc.

HIGHMARK INC. ("Highmark") SUPPLEMENTAL RESPONSE TO INFORMATION REQUESTS 5.2 AND 5.2.1 THROUGH 5.2.9 FROM THE PENNSYLVANIA INSURANCE DEPARTMENT

REQUESTS:

5.2 Provide an Expert Opinion concerning whether the effect of the Transaction would, over the identified relevant time period, be to substantially lessen competition in insurance in the Commonwealth or tend to create a monopoly therein, including without limitation (i) the application of 40 P.S. § 991.1402(f)(1)(ii) that incorporates by reference provisions of 40 P.S. § 991.1403.

5.2.1 Identify the relevant time period for which the analysis in Section 5.2 is to be provided and describe the basis for determining that such period is relevant for the purpose of the analysis.

5.2.2 The Expert Opinion should describe whether there would be a prima facie violation of the competitive standard under 40 P.S. §§1403(d) (2) (i), (ii), discussing the involved insurers and the Relevant Product and geographical markets;

5.2.3 The Expert Opinion should describe whether the Transaction would have an anticompetitive effect under 40 P.S. § 991.1403(d) (2) (iv) or otherwise, discussing the following:

- **(A) market shares;**
- **(B) volatility of ranking of market leaders;**
- **(C) number of competitors;**
- **(D) concentration;**
- **(E) trend of concentration in the industry;**
- **(F) ease of entry and exit into the market; and**
- **(G) any other material factors that relate to any anticompetitive effect.**

5.2.4 The Expert Opinion should describe any pro-competitive justifications for the Transaction and the specific pro-competitive benefits likely to be achieved by the Transaction;

5.2.5 The Expert Opinion should describe whether the Transaction will yield substantial economies of scale or economies of resource allocation providing specific data and analysis, together with all applicable Documents, to support such justifications; and

5.2.6 The Expert Opinion should describe whether the Transaction will substantially increase the availability of insurance

5.2.7 Provide detail for all market share and geographical market data relied on or considered in responding to the above questions or compiling the Statement Regarding Compliance With the Competitive Standard of 40 P.S. § 991.1403(d) and describe the source and the basis for the selection of the market share and geographical data, together with any supporting programs or data sources required to replicate the analysis

5.2.7.1 Provide a full and complete description of: (i) each geographic market in which any Highmark Entity or BCNEPA Entity provides any products or services and (ii) any specific limitations or restrictions as to the geography or products that may be offered or sold by any Highmark Entity or BCNEPA Entity under any contract or agreement, license or arrangement including, without limitation, its applicable Blue Cross Blue Shield licenses.

5.2.8 Provide a full and complete copy of all Expert Opinions supporting or not supporting your response to the above questions or the Statement Regarding Compliance with the Competitive Standard of 40 P.S. § 991.1403(d).

5.2.9 For each product identified in your response to this PID Request for Information or in connection with the Statement Regarding Compliance With the Competitive Standard of 40 P.S. § 991.1403(d) (the "Relevant Product"), identify whether the product is offered on a Blue-branded or unbranded basis.

SUPPLEMENTAL RESPONSE:

Highmark hereby supplements its prior responses to the foregoing Requests.

Highmark hereby certifies to the best of its knowledge, information and belief that the following Economist Reports, copies of which are attached hereto, are responsive to these Requests:

(1) *Analysis Under 40 P.S. § 991.1403*, dated December 23, 2014; and

(2) *Analysis of Efficiencies*, dated December 23, 2014.

Highmark Inc.
Fifth Avenue Place
120 Fifth Avenue
Pittsburgh, PA 15222

Divider Page

THE PROPOSED MERGER OF HIGHMARK INC.
AND
HOSPITAL SERVICE ASSOCIATION OF NORTHEASTERN PENNSYLVANIA
(D/B/A BLUE CROSS OF NORTHEASTERN PENNSYLVANIA)

ANALYSIS UNDER 40 P.S. § 991.1403

CORY S. CAPPS, PHD

DECEMBER 23, 2014

Table of contents

I. Summary and key findings 1

II. Qualifications, scope of charge, and regulatory framework 5
- II.A. Qualifications 5
- II.B. Scope of charge 6
- II.C. Regulatory framework 6

III. The parties 8
- III.A. Highmark 8
- III.B. BCNEPA 9

IV. Commercial health insurance products 11
- IV.A. Product and geographic markets relevant to health insurers 11
  - IV.A.1. For most types of customers, the relevant geographic unit of analysis is at most regional 11
  - IV.A.2. Pragmatic and industry factors focus the analysis on enrollment rather than premiums 13
- IV.B. Blue health plans in the Commonwealth of Pennsylvania 14
  - IV.B.1. Blue entities and Service Areas 14
  - IV.B.2. BCBSA rules governing which Blue licensees can pursue specific customers 15
  - IV.B.3. Highmark's and BCNEPA's joint commercial insurance offerings 15
- IV.C. Commercial enrollment share estimates 16
  - IV.C.1. Data sources 16
  - IV.C.2. Enrollment share estimates 19

V. Other commercial products 21
- V.A. Dental and vision products 21
- V.B. Stop loss insurance products 22
- V.C. Smaller products 24

VI. Medicaid and CHIP products 25
- VI.A. HealthChoices (managed Medicaid) 25
- VI.B. The Children's Health Insurance Program (CHIP) 26

VII. Medicare-related products 28
- VII.A. Medicare Advantage 28
  - VII.A.1. Medicare Advantage overview 28
  - VII.A.2. Highmark and BCNEPA do not offer competing Medicare Advantage plans 31
- VII.B. Medicare prescription drug benefit products 32
- VII.C. Medicare Supplemental (Medigap) products 34

Appendix A. Curriculum vitae of Cory S. Capps, PhD A-1

Appendix B. Additional exhibits B-1

List of figures

Figure 1. Service Areas of Blue entities operating in Pennsylvania 15
Figure 2. Statewide dental plan enrollment shares, 2012 21
Figure 3. Statewide vision plan enrollment shares, 2012 22
Figure 4. Statewide stop loss insurance enrollment shares 24
Figure 5. Counties in which Highmark and BCNEPA contract to provide CHIP coverage 27
Figure 6. The Medicare Plan Finder web page 30
Figure 7. Enrollment shares in Medicare Advantage plans, by carrier and region 32
Figure 8. Enrollment shares in PDP plans 34
Figure 9. Statewide Medigap enrollment shares 36
Figure 10. Insurers providing Medigap Plan A products to residents of zip code 18503 ..... B-1
Figure 11. Insurers providing Medigap Plan C products to residents of zip code 18503 ..... B-3
Figure 12. FEHB plans available to Pennsylvania federal employees (“open to all” plans only) B-4

I. Summary and key findings

(1) This report is a public version of the report on competitive overlap that I submitted to the Pennsylvania Insurance Department (PID) on February 14, 2014.[1]

(2) To analyze the extent of competitive overlap between Highmark Inc. (Highmark) and Hospital Service Association of Northeastern Pennsylvania, d/b/a Blue Cross of Northeastern Pennsylvania (BCNEPA), I apply the framework contained within Article XIV of the Pennsylvania Insurance Company Law, as well as the economics of competition in health insurance and related markets. Using this approach, I evaluate the extent to which the two companies sell competing, similar products to similar customers. I analyze both commercial and noncommercial products.

(3) With respect to commercial insurance products, I reach the following conclusions:

A. The appropriate relevant geographic market in which to analyze competition among health insurers is at most regional (i.e., smaller than statewide). This is because managed care organizations compete by assembling networks of healthcare providers in an area and marketing those networks to individuals and employers in that same area. Enrollees strongly prefer networks that give them access to local providers. In effect, health insurance markets are localized because the demand for the services they insure and administer is localized.

B. In the 13-county area in which BCNEPA is licensed by the Blue Cross Blue Shield Association (BCBSA) to use the "Blue Cross" mark, shares of enrollment are as follows:

- The two Highmark and BCNEPA joint ventures, HMO of Northeastern Pennsylvania, d/b/a First Priority Health (FPH) and First Priority Life Insurance Company (FPLIC), have enrollment shares of about 5% and 27%, respectively. Highmark and BCNEPA are partners, not competitors, for these products.
- A small number of additional enrollees are covered by products offered under the joint operating agreement (JOA) between Highmark and BCNEPA. For these products, Highmark and BCNEPA divide responsibility for professional and facility services coverage, meaning that Highmark and BCNEPA provide complementary, not competing, services. These products combined account for about 1% of commercial enrollment in the BCNEPA Service Area.
- Highmark has close to a 9% share of commercial enrollment in the area, but this does not reflect competition between Highmark and BCNEPA. Nearly all—99.9%—of Highmark's

[1] Cory S. Capps, PhD, "The Proposed Merger of Highmark Inc. and Hospital Service Association of Northeastern Pennsylvania (D/B/A Blue Cross of Northeastern Pennsylvania)," Feb. 14, 2014.

enrollment is attributable to groups headquartered outside BCNEPA's Service Area. With very limited exceptions, BCNEPA cannot pursue the health coverage business of those customers on a branded basis.

- Outside of the joint offerings, BCNEPA has no commercial enrollment and Highmark essentially has only enrollees of customers headquartered outside the BCNEPA Service Area.

C. Given that BCNEPA has no commercial enrollment outside of its joint offerings with Highmark, the companies do not compete and there is no prima facie evidence of a violation of competitive standards with respect to commercial insurance:

- If I allocate all joint enrollment to BCNEPA and exclude Highmark's enrollees from customers for which BCNEPA generally cannot bid, Highmark's share is less than 1%.
- If I instead allocate all joint enrollment to Highmark, then BCNEPA's has no remaining commercial enrollees, meaning its share is less than 1%.

D. Dental and Vision products. BCNEPA does not offer its own dental or vision products (it does sell Highmark's dental and vision products). There is no competition between Highmark and BCNEPA and the transaction will not lessen competition with respect to dental or vision plans.

E. Stop Loss insurance products. Stop loss insurance provides customers with a hedge against excess financial risk. It does not provide core health insurance services, such as provider contracting, care management, and routine claims processing. Because, in the event of a covered loss, covered entities have no reason to prefer that their payment comes from a local source as opposed to a source outside their locality, the relevant geographic market is likely nationwide (perhaps larger) and clearly no smaller than the Commonwealth of Pennsylvania. On a statewide basis, Highmark's share of enrollment in stop loss products is about 22% and BCNEPA's share is less than 0.5%. Thus, there is no prima facie evidence of a violation with respect to stop loss insurance.

F. Other, smaller products. BCNEPA has no workers' compensation, disability, or long-term care products, although Highmark does. There is no competition between Highmark and BCNEPA with respect to these products.

(4) With respect to noncommercial products, my main conclusions are as follows:

A. Medicaid and Children's Health Insurance Program (CHIP) managed care products. The transaction presents no violation of competitive standards with respect to these products. As of March 31, 2014, BCNEPA stopped offering a managed Medicaid product, although Highmark does offer one (but not currently in the BCNEPA Service Area). With respect to CHIP, the counties in which Highmark and BCNEPA offer CHIP products do not overlap, indicating that the two parties do not compete. Because there is no competitive overlap, there is no change in concentration for these products in any part of Pennsylvania.

B. Medicare Advantage (MA) products. The transaction presents no violation of competitive standards. Highmark has two MA contracts in Pennsylvania: one that it offers only in the Western Region (Security Blue) and a second (Freedom Blue) that, in the BCNEPA Service Area, it offers jointly with BCNEPA. Except for its partnership with Highmark, BCNEPA has no MA plan offering. Because Highmark and BCNEPA are not competitors, the transaction will result in no reduction in competition.

C. Medicare prescription drug benefit (PDP) products. Highmark has one PDP contract that covers Pennsylvania and West Virginia. Highmark markets this contract under the "Blue Rx" brand name. BCNEPA does not offer a Part D PDP product. Thus, there is no competitive overlap or change in concentration with respect to these products.

D. Medicare Supplemental (Medigap) products. Under the Centers for Medicare & Medicaid Services (CMS) rules, seniors enrolled in Medicare Part A and Part B (i.e., Traditional Medicare) can purchase a Medigap policy from any insurer licensed in their state of residence. Thus, the appropriate level of analysis for analyzing competition with respect to Medigap is the state. Superficially, Highmark and BCNEPA's shares exceed the thresholds for a prima facie violation. However, as I explain below, this is because Highmark and BCNEPA market a joint Medigap product, with BCNEPA assuming responsibility for Medicare Part A hospital services and Highmark assuming responsibility for Medicare Part B professional and outpatient services. As a result, Highmark and BCNEPA provide complementary services; they are not competing providers of substitute services. The transaction will not reduce competition with respect to Medigap products.

(5) In the remainder of this report, I explain each of these conclusions in more detail.

(6) As described in section II.B of this report, Article XIV of the Pennsylvania Insurance Company Law contains a default definition of the relevant product market as "direct written insurance premiums for a line of business" as indicated in the annual statement. Article XIV also defines, as a default, the relevant geographic market as the Commonwealth of Pennsylvania. Both defaults are deemed applicable *absent* "sufficient information to the contrary."[2] For some products, a statewide analysis is economically reasonable and appropriate; however, for other products it is not. In each of the following analyses, I adopt a geographic level of analysis that is economically appropriate to the product in question, and I explain why that level of analysis is appropriate.

[2] 40 P.S. § 991.1403(d)(2)(iii)(B) (1992).

(7) In the analysis herein, shares are based on enrollment and not on premiums. The primary reason for this is pragmatic: for many products and data sets, suitable premium data for insurers other than Highmark and BCNEPA are not available, and this has the effect of precluding share calculations. A further reason I focus on enrollment is that more than half of commercial health plan enrollment is attributable to self-funded products. These are products for which customers—firms and other plan sponsors—bear the financial risk for medical expenditures and the insurer or third-party administrator provides only administrative services, such as provider contracting and claims administration. Premiums are only well defined for fully-funded products, not for self-funded products. Thus, shares of premiums cannot readily be calculated for all commercial business, meaning both fully-funded and self-funded products. In general, shares based on premiums are unlikely to differ substantially from shares based on enrollments.

II. Qualifications, scope of charge, and regulatory framework

II.A. Qualifications

(8) I am a Partner in the Antitrust and Healthcare Practices at Bates White Economic Consulting, a professional services firm that conducts economic and statistical analyses in a variety of industries and forums. I specialize in performing economic and statistical analyses of competition, market definition, and market power in antitrust cases, with a particular emphasis on the healthcare industry. Before joining Bates White, I was a Staff Economist at the Economic Analysis Group in the Antitrust Division of the Department of Justice. While at the Department of Justice, I worked on a large number of antitrust cases, including cases involving hospitals, physician groups, and insurers. Prior to joining the Department of Justice, I was on the faculty at Northwestern University's Kellogg School of Management and, before that, at the Department of Economics at the University of Illinois at Urbana-Champaign.

(9) I have a PhD in Economics from Northwestern University and a BA in Economics from the University of Texas at Austin. I have taught courses to all levels of students, including a PhD course in Industrial Organization, undergraduate and graduate courses in Microeconomics, and MBA courses on strategy and organizations (the theory of incentives within firms and the interaction of those incentives with the competitive strategies of firms), competition and strategy in technology markets, and healthcare markets. My study of competition in healthcare markets began with my doctoral dissertation, in which I studied hospitals' technology adoption decisions and hospital pricing and market power.

(10) I have published articles on competition issues in the healthcare industry in scholarly journals, including *Antitrust Bulletin*, *RAND Journal of Economics*, *Journal of Health Economics*, and *Health Affairs*. I have also been an invited panelist on topics involving healthcare and competition in a variety of forums, including events sponsored by the American Bar Association, the American Health Lawyers Association, the National Congress on Health Insurance Reform, the Institute of Medicine, and the National Bureau of Economic Research. I regularly attend and present my research at a variety of academic conferences. I also serve as a referee for the *Journal of Law and Economics*, the *Journal of Industrial Economics*, *Health Affairs*, and other journals.

(11) I am a member of the American Economic Association, the Industrial Organization Society, and the International Health Economics Association. I am also a member of the Economic Reference Group, an advisory panel that provides expertise and advice on healthcare competition and antitrust policy issues to the Cooperation and Competition Panel. The Cooperation and Competition Panel is the

division of the United Kingdom's National Health Service that is charged with antitrust and competition monitoring in the British healthcare sector.

(12) Since joining Bates White, I have served as an expert for the US Department of Justice, the Federal Trade Commission, several state agencies, and a variety of private entities in the healthcare industry, including both providers and insurers, as well as in other industries. For example, I was retained by the DOJ as its testifying expert on antitrust issues in *United States v. United Regional Health Care System*, a case involving alleged exclusionary contracts between United Regional and area health insurers (the case settled in February 2011). Additionally, I was retained by the FTC in *In re OSF Healthcare System* as a testifying expert on competitive effects questions. I provided written, deposition, and hearing testimony regarding the proposed merger, which the parties abandoned after US District Judge Frederick Kapala found that the FTC had demonstrated a likelihood of success on the merits and granted the FTC's request for a preliminary injunction.

(13) A copy of my curriculum vitae is attached as Appendix A.

II.B. Scope of charge

(14) Highmark and BCNEPA have asked me to evaluate the likely competitive effects of their proposed merger under the applicable regulatory framework. In my analysis, I have relied on confidential enrollment data from both parties, public data, and a variety of other public sources. My analysis is focused on evaluating the current extent of competition between Highmark and BCNEPA with respect to a variety of commercial and noncommercial insurance and related products.

II.C. Regulatory framework

(15) The Pennsylvania Insurance Company Law, Article XIV, presents share thresholds above which a merger creates prima facie evidence of violation of competitive standards.[3] Different thresholds apply based on whether a market is defined as "highly concentrated" or not. The Pennsylvania statute defines a market as highly concentrated when the market share of the four largest insurers combined is 75% or greater.[4]

(16) If the market is highly concentrated, then prima facie evidence of a violation of competitive standards exists if any one of the following applies:

1. Both insurers have 4% or more of the market.
2. One insurer has 10% and the other has 2% or greater.

[3] 40 P.S. § 991.1403(d)(2)(i)(A–B) (1992).

[4] 40 P.S. § 991.1403(d)(2)(i)(A–B) (1992).

3. One insurer has 15% and the other has 1% or greater.

(17) If the market is not highly concentrated, then prima facie evidence of a violation of competitive standards exists if any one of the following applies:

1. Both insurers have 5% or more of the market.
2. One insurer has 10% and the other has 4% or greater.
3. One insurer has 15% and the other has 3% or greater.
4. One insurer has 19% and the other has 1% or greater.

(18) Section 1403 of the Act defines markets as follows:[5]

> The term "market" means the relevant product and geographical markets. In determining the relevant product and geographical markets, the department shall give due consideration to, among other things, the definitions or guidelines, if any, promulgated by the NAIC and to information, if any, submitted by parties to the acquisition. *In the absence of sufficient information to the contrary*, the relevant product market is assumed to be the direct written insurance premium for a line of business, such line being that used in the annual statement required to be filed by insurers doing business in this Commonwealth and the relevant geographical market is assumed to be this Commonwealth. (Emphasis added.)

(19) As I explain below, I focus on enrollment rather than premiums. There are a number of reasons for this, including (1) that better enrollment data are available for insurers other than Highmark and BCNEPA and (2) fully-insured and self-insured premiums cannot readily be combined in an apples-to-apples fashion. As I also explain below, I focus on regional markets, not a statewide market, in most of my analyses, because insurer competition is predominantly local.

(20) Even where a prima facie violation exists, the relevant statute allows for a determination that a transaction is not anticompetitive:[6]

> Even though an acquisition is prima facie violative of the competitive standard under subparagraphs (i) and (ii), a party may establish the absence of the requisite anticompetitive effect based upon other substantial evidence. Relevant factors in making a determination under this paragraph include, but are not limited to, the following: market shares, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry and ease of entry and exit into the market.

[5] 40 P.S. § 991.1403(d)(2)-(iii)(B) (1992).

[6] 40 P.S. § 991.1403(d)(2)(iv) (1992).

III. The parties

III.A. Highmark

(21) The information presented below is primarily drawn from conversations with Highmark business personnel as well as from a 2011 PID financial examination report regarding Highmark Inc.[7] Highmark's insurance subsidiaries operating in Pennsylvania are as follows (Highmark's ownership shares are in parentheses):[8]

- United Concordia Companies, Inc. (100%).[9]
  - United Concordia Life and Health Insurance Company.
  - United Concordia Dental Plans of Pennsylvania, Inc.
- FPLIC (40.1%, balance owned by BCNEPA).
- FPH (40%, balance owned by BCNEPA).
- Highmark Select Resources Inc. (100%), formerly Highmark Senior Resources Inc.
- HM Health Insurance Company (HHIC) (100%).
- HM Insurance Group, Inc. (100%; a holding company).
  - HM Life Insurance Company.
  - HM Casualty Insurance Company.
  - Highmark Casualty Insurance Company.
- Inter-County Health Plan, Inc. (50%).
- Inter-County Hospitalization Plan, Inc. (50%).
- Keystone Health Plan West, Inc. (KHPW) (100%). On November 14, 2013, KHPW applied to convert its status from a business corporation to a nonprofit corporation, effective January 1,

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7 Pennsylvania Insurance Department, "Report of Examination of Highmark Inc.," Dec. 31, 2011, *available at* http://www.portal.state.pa.us/portal/server.pt/document/1350228/highmark_inc_final_exam_posted_to_web_pdf.

8 Whether a subsidiary operates in the insurance business was determined by comparing the list of companies in the financial examination report with the list of companies included in the PID's 2011–2012 annual statistics. *See* Pennsylvania Insurance Department, "Annual Statistical Report for the Period July 1, 2011 to June 30, 2012," n.d., *available at* http://www.portal.state.pa.us/portal/server.pt/document/1307198/commissioner_report_final_2011-2012_pdf.

9 United Concordia Companies, Inc. offers self-insured dental products, while its subsidiaries, United Concordia Life and Health Insurance Company and United Concordia Dental Plans of PA, offer fully-insured dental products.

2014.[10] The Pennsylvania Insurance Commissioner approved the request on December 30, 2013.[11]

- Gateway Health Plan, L.P. (50%, with Mercy Health Plan).
  - Gateway Health Plan, Inc.[12]
  - On November 13, 2013, Gateway Health Plan applied to convert its status from a business corporation to a nonprofit corporation, effective January 1, 2014.[13] The Pennsylvania Insurance Commissioner approved the request on December 30, 2013.[14]
- Highmark offers dental plans through its subsidiaries United Concordia Life & Health Insurance Company and United Concordia Dental Plans of Pennsylvania, Inc., and it offers vision plans through itself and its subsidiaries HM Life Insurance Company and United Concordia Life & Health Insurance Company.[15]

III.B. BCNEPA

(22) The information on BCNEPA subsidiaries is based on conversations with BCNEPA business personnel and BCNEPA's September 2013 *Legal Entity Organization Chart*.[16] The following entities are BCNEPA subsidiaries:

- FPLIC. BCNEPA owns 59.9% of FPLIC and Highmark owns the other 40.1%. Net income from FPLIC products is divided between BCNEPA and Highmark in proportion to ownership. From an operational perspective, BCNEPA controls FPLIC, though Highmark also holds certain reserve rights.
- FPH. BCNEPA owns 60% of FPH and Highmark owns the remainder. Net income from FPH products is also shared in proportion to ownership. BCNEPA has operational control over FPH, though Highmark also holds certain reserve rights.
- AllOne Health Group, Inc. (100%), a Pennsylvania for-profit holding company.[17]

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[10] Letter from Keystone Health Plan West representative to Stephen J. Johnson, Pennsylvania Deputy Insurance Commissioner, Re: Request for Approval of Conversion of Keystone Health Plan West, Inc. (Nov. 14, 2013).

[11] Decision and Order, *In re Application of Keystone Health Plan West, Inc. Requesting Approval to Convert from a Business Corporation into a Nonprofit Corporation*, No. ID-RC-13-23 (Pa. Ins. Comm'r Dec. 30, 2013).

[12] Letter from Gateway Health Plan representative to Pennsylvania Insurance Department, Re: Request for Approval of Conversion of Gateway Health Plan, Inc. (Nov. 13, 2013).

[13] Letter from Gateway Health Plan representative to Pennsylvania Insurance Department, Re: Request for Approval of Conversion of Gateway Health Plan, Inc. (Nov. 13, 2013).

[14] Decision and Order, *In re Application of Gateway Health Plan, Inc. Requesting Approval to Convert from a Business Corporation into a Nonprofit Corporation*, No. ID-RC-13-24 (Pa. Ins. Comm'r Dec. 30, 2013).

[15] Information on Highmark's Dental and Vision subsidiaries is based on the list of Highmark-owned companies filing annual statements with the National Association of Insurance Commissioners (NAIC).

[16] "Hospital Service Association of Northeastern Pennsylvania Legal Entity Organizational Chart," Sept. 2013.

- AllOne Health Service, Inc.
- AllOne Health Management Solutions, Inc., an entity focused on wellness and population health management services.
- Health Resources Corporation, an entity focused on occupational health and employee assistance programs.
- On September 19, 2013, BCNEPA sold the Significa Insurance Group, Inc., which had previously been a subsidiary of AllOne Health Group. In August 2010, BCNEPA also sold Significa Benefits Services, a third-party administrator (TPA) that provides services, but not insurance coverage, to self-funded entities.

- As of March 31, 2014, BCNEPA stopped offering managed Medicaid products.[18]

[17] "Hospital Service Association of Northeastern Pennsylvania Legal Entity Organizational Chart," Sept. 2013.

[18] Hospital Service Association of Northeastern Pennsylvania, Quarterly Statement filed with the Pennsylvania Insurance Department, June 30, 2014, at Q10.6.

IV. Commercial health insurance products

(23) A structural antitrust analysis, meaning an analysis that draws inferences regarding competitive effects from market shares, requires defining a relevant product market and a relevant geographic market. Identification of both dimensions of a relevant market also identifies the participants in that market, and this in turn facilitates the calculation of market shares. In this section, I first explain why the geographic market relevant to most commercial insurance products is smaller than statewide and why my analysis is focused on shares as measured by enrollments. I then review provisions of BCBSA's licensing rules that govern which Blue plans can bid for which customers. I then describe Highmark's and BCNEPA's commercial offerings and present market shares. All of BCNEPA's commercial enrollment is attributable to one of its two commercial insurance joint ventures with Highmark or, to a lesser extent, to products offered jointly by Highmark and BCNEPA under the joint operating agreement between the companies. One important implication of this is that, with respect to the sale of commercial health insurance, Highmark and BCNEPA are partners, not competitors.

IV.A. Product and geographic markets relevant to health insurers

IV.A.1. For most types of customers, the relevant geographic unit of analysis is at most regional

(24) A long line of antitrust analyses and economic research either concludes or assumes that the geographic market relevant to analyzing insurer competition is primarily local, typically amounting to a set of counties, a metropolitan area, or a single county.[19] The rationale for analyzing insurer competition through this lens is inherent in what modern managed care organizations (MCOs) do. Specifically, MCOs compete by assembling networks of healthcare providers and marketing those networks to individuals and employers in an area. Enrollees strongly prefer networks that give them access to *local* providers.

(25) Thus, for an insurer seeking to market its plans in a given area, it is a business imperative to contract with healthcare providers in that same area. For example, MCOs competing in the Pittsburgh area must contract with Pittsburgh-area providers, because Pittsburgh employers and enrollees would reject any MCO that did not do so. This illustrates why it is appropriate to focus on relatively localized areas (e.g., metropolitan areas) as relevant geographic markets when analyzing insurer competition—such areas approximate the areas from which employers draw their employees, and those employees demand access to local providers. In this section, I briefly review major antitrust

[19] *See* Cory Capps and David Dranove, "Healthcare Provider and Payer Markets," *International Handbook of Antitrust Economics*, Roger Blair and Daniel Sokol, eds. (Oxford University Press, 2014).

cases involving health insurers, all of which have focused on competition at a local level (e.g., Dallas, Tucson, and Las Vegas).

(26) An exception may arise for particularly large employers with operations spread over a large area (i.e., statewide, over a set of states, or nationwide). For example, such employers may prefer to reduce administrative costs by purchasing a single nationwide health insurance plan, and they would be limited in that selection to choosing among insurers with sufficiently broad regional or national networks. Importantly, however, nearly all such large customers self-fund and, therefore, can purchase administrative services from either a health insurer or a non-insurer third-party administrator (some large employers, though fewer than in the past, not only self-fund but also self-administer their health insurance benefits). This means that these customers also have a wider array of competitive alternatives when they seek administrative services. For purposes of the instant transaction, this issue is not significant, because the BCBSA rules, as summarized in section IV.B.2, clearly specify when a Blue plan is eligible to bid, on a branded basis, for a customer's business. Under those rules, either Highmark or BCNEPA—but not both—could be eligible to bid for such a customer. Thus, they are not competitors for such customers.

(27) Reflecting the logic above, all of the US Department of Justice (DOJ) cases involving health insurers have focused on competition in areas comprising a single county or several adjacent counties.

- In *Aetna-Prudential*, DOJ sought divestitures in Houston and Dallas.[20] There, DOJ offered the following explanation:[21]

> Patients seeking medical care generally prefer to receive treatment close to where they work or live, and many employers require managed care companies to offer a network that contains a certain number of health care providers within a specified distance of each employee's home. As a result, virtually all managed care companies establish provider networks in the localities where employees live and work, and they compete on the basis of their local provider networks. . . . The relevant geographic markets for which relief is sought here are the United States Department of Commerce Metropolitan Statistical Areas ("MSAs") in and around Houston and Dallas, Texas.

- In *United-PacifiCare*, DOJ imposed divestitures in two relevant geographic markets: Tucson, Arizona, and Boulder, Colorado.[22] DOJ again emphasized the local nature of healthcare services and the consequent local nature of health insurer competition.

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[20] Complaint, *United States v. Aetna, Inc*., No. 3-99-cv-398-H (N.D. Tex. June 21, 1999), ¶¶ 13–26, *available at* http://www.justice.gov/atr/cases/f2500/2501.pdf.

[21] *Id*., ¶¶ 19–20.

[22] Complaint, *United States v. UnitedHealth Grp., Inc.*, No. 1:05-cv-02436 (D.D.C. Dec. 20, 2005), ¶¶ 15–43, *available at*

- In *BCBS of Montana-New West Health Services*, DOJ alleged four distinct relevant geographic markets within the State of Montana.[23] Again, the DOJ emphasized the importance of local markets:

  > Consumers in these [four relevant geographic markets] cannot practicably turn to commercial health insurers that do not have a network of providers in these areas. Consequently, a small but significant increase in the price of commercial health insurance in these areas would not cause a sufficient number of consumers to switch to insurers outside of these areas to make such a price increase unprofitable. These areas are, therefore, the relevant geographic markets.

- DOJ also sought divestitures in two distinct mergers of Medicare Advantage plans, United-Sierra and Humana-Arcadian. In both cases, the DOJ focused on relevant markets comprising counties or a small set of counties.[24]

(28) Finally, as noted above, many economists have studied health insurer competition. Nearly all have focused on competition at the metropolitan level, county level, or some other unit that is significantly smaller than statewide.[25]

IV.A.2. Pragmatic and industry factors focus the analysis on enrollment rather than premiums

(29) I focus my analysis of market shares on enrollment rather than on premiums for two main reasons. First, more than half of commercial health plan enrollment is attributable to self-funded products. These are products for which customers—firms and other plan sponsors—bear the financial risk for medical expenditures and the insurer or third-party administrator provides only the administrative services, such as provider contracting and claims administration. Premiums are well-defined for fully-funded products but not for self-funded products, whereas enrollment is well-defined for both types of products. Therefore, analyzing enrollment results in shares that are based on comparable figures.

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http://www.justice.gov/atr/cases/f213800/213815.pdf. In Tucson, the DOJ focused on a relevant small-group insurance product market, rather than on commercial insurance generally.

[23] Complaint, *United States v. Blue Cross and Blue Shield of Mont.*, No. 1:11-cv-00123 (D. Mont. Nov. 8, 2011), ¶ 28, *available at* http://www.justice.gov/atr/cases/f277100/277177.pdf.

[24] Complaint, *United States v. United Health Grp. Inc.*, No. 1:08-cv-00322 (D.D.C. Feb. 25, 2008), ¶ 19, *available at* http://www.justice.gov/atr/cases/f230400/230447.pdf (alleging a relevant geographic market of Clark and Nye Counties in Nevada); Complaint, *United States v. Humana, Inc.*, No. 1: 12-cv-00464 (D.D.C. Mar. 27, 2012), ¶¶ 22–23, *available at* http://www.justice.gov/atr/cases/f281600/281618.pdf.

[25] For example, in a recent survey chapter in the *Handbook of Health Economics*, Martin Gaynor and Robert Town observed that "Since the vast majority of health insurance restricts enrollees' choices to a network of providers, most of whom are local, the geographic market for health insurance is local, and smaller than a state." Martin Gaynor and Robert Town, "Competition in Health Care Markets," Ch. 11 in *Handbook of Health Economics* vol. 2, Mark Pauly, Thomas McGuire, and Pedro Barros, ed. (Elsevier: 2011), 598.

(30) Second, there is no good source for premium data for insurers other than BCNEPA and Highmark at a less than statewide level. In contrast, reliable estimates of enrollment for all insurers other than BCNEPA and Highmark (taken as a group, not one-by-one) are available at a county level.

IV.B. Blue health plans in the Commonwealth of Pennsylvania

IV.B.1. Blue entities and Service Areas

(31) The Blue Cross Blue Shield Association (BCBSA) is a "national federation of 37 independent, community-based and locally operated Blue Cross® and Blue Shield® companies."[26] The BCBSA grants the various Blue companies exclusive licenses to use the Blue Cross and/or the Blue Shield trademarks in specified geographic areas, or Service Areas. A Blue plan cannot offer Blue products outside of its particular licensed Service Area. Forty-five states and territories have only one Blue plan; Pennsylvania, California, and New York are among the exceptions.[27]

(32) In Pennsylvania, four licensees hold five Blue licenses:

- Highmark Blue Shield (Statewide license)
- Highmark Blue Cross (Western)
- Blue Cross of Northeastern Pennsylvania (Northeastern)
- Capital BlueCross (Central)
- Independence Blue Cross (Eastern)

(33) Each license gives the licensee the right to use the Blue marks to market to customers only within one of the four BCBSA regions of Pennsylvania, except for Highmark, which has a statewide Blue Shield license. On its own, Highmark Blue Shield offers service only in the Central Region; Highmark Blue Shield also offers service in conjunction with BCNEPA and Independence Blue Cross in the Northeastern and Eastern Regions, respectively.[28]

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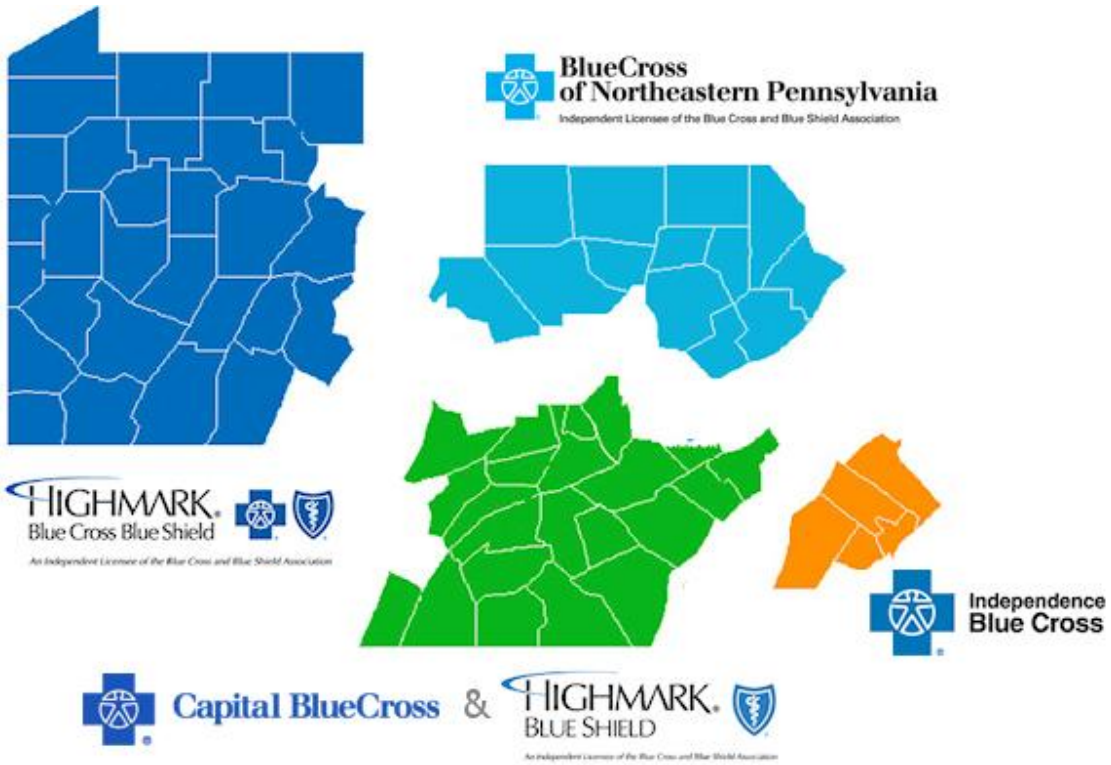
[26] Blue Cross and Blue Shield Association, "About the Blue Cross and Blue Shield Association," accessed Jan. 30, 2014, http://www.bcbs.com/about-the-association/.

[27] Blue Cross and Blue Shield Association, "About the Blue Cross and Blue Shield Association," accessed Jan. 30, 2014, http://www.bcbs.com/about-the-association/.

[28] Highmark Inc., "Our Businesses," accessed Dec. 9, 2014, https://www.highmark.com/hmk2/about/ourBusinesses.shtml. Through affiliation agreements, Highmark also controls Highmark Blue Cross Blue Shield West Virginia and Highmark Blue Cross Blue Shield Delaware.

Figure 1. Service Areas of Blue entities operating in Pennsylvania



Source: P.A. Blue Agent, "Coverage Areas for Blue Cross Pennsylvania," accessed Feb. 5, 2014, http://pablueagent.com/coverage.php.

IV.B.2. BCBSA rules governing which Blue licensees can pursue specific customers

(34) In general, licensees of the Blue Cross and Blue Shield marks, which are governed by the BCBSA, have an exclusive right to use each Blue trademark within a defined geographic area, commonly referred to as the "Service Area" of a licensee. Under this licensing system, a Blue entity can only pursue the business of a specific customer, on a Blue branded basis, if that customer is headquartered in the Blue entity's Service Area. The BCBSA licensing rules include a limited exception for National Accounts that have a *local* "plant, office or division headquarters" in a Blue entity's Service Area. I understand that BCNEPA generally does not pursue the business of local branches of large firms headquartered outside of its Service Area.

IV.B.3. Highmark's and BCNEPA's joint commercial insurance offerings

(35) As described in more detail below, essentially all of Highmark's commercial enrollment in the BCNEPA Service Area is attributable to one of the following two categories:

1. Group plans headquartered *outside* the BCNEPA Service Area that have enrollees residing in the BCNEPA Service Area. With very limited exceptions, BCNEPA is not a competitor to Highmark for these individuals.
2. Enrollees in other, much smaller commercial products offered under the joint operating agreement between Highmark and BCNEPA. These are products for which Highmark and BCNEPA do not compete. Instead, Highmark underwrites and administers the professional component of coverage and BCNEPA underwrites and administers the facility component.

(36) Highmark and BCNEPA have two commercial insurance joint ventures—FPLIC and FPH—that sell insurance and administrative services to customers located in the BCNEPA Service Area. Highmark owns 40.1% of FPLIC and BCNEPA owns the remaining 59.9%. FPLIC issues preferred provider organization (PPO) and exclusive provider organization (EPO) plans, as well as traditional indemnity health insurance products. Net income from FPLIC products is divided between Highmark and BCNEPA in proportion to ownership. On a day-to-day basis, BCNEPA controls FPLIC, though Highmark maintains certain reserve rights.

(37) Similarly, Highmark also owns 40% of FPH and BCNEPA owns the remaining 60%. FPH issues HMO plans; additionally, BCNEPA offers its CHIP product through FPH. Net income from FPH products is also shared in proportion to ownership. BCNEPA operates FPH on a day-to-day basis, though Highmark maintains certain reserve rights.

(38) As shown below, the bulk of BCNEPA's commercial enrollment is attributable to FPLIC and FPH products.

IV.C. Commercial enrollment share estimates

IV.C.1. Data sources

(39) Computing shares requires both a numerator (i.e., total enrollment for each of the parties in the specified geographic area) and a denominator (i.e., total enrollment for all insurers in the specified geographic area). Obtaining information on the total enrollment of the parties within specific counties or regions or statewide is straightforward, and Highmark and BCNEPA have provided the necessary information. The challenge arises with respect to enrollment data for *other* health plans. This information is necessary to construct the denominator for the share calculations. Although I cannot generally estimate the commercial enrollment attributable to specific other health plans, I can reliably estimate the commercial enrollment attributable to all health plans combined. This is all that is needed in order to calculate enrollment shares for Highmark and BCNEPA at the county, regional, or state levels. I describe the data sources used for these calculations below.

(40) As noted above, because insurers primarily compete locally (marketing networks of local providers to individuals and firms), county and regional enrollment shares are more relevant to a competitive effects analysis than statewide shares.

IV.C.1.a. ACS three-year estimates

(41) My primary data source for total commercial enrollments used in the commercial share calculations is county-level insurance enrollment estimates from the American Community Survey (ACS).

(42) ACS is an ongoing Census Bureau survey.[29] The Bureau releases one-year, three-year, and five-year ACS datasets on an annual basis. These data are a reliable source of regional enrollment information, because they are based on a survey that is completed by about two million households every year, dating back to 2005.[30] By design, ACS insurance enrollment estimates are based on the locations of insured individuals, not the location of insurance contracts (i.e., they are based on where people live, not where their employers are located). Highmark's and BCNEPA's enrollment data also provide enrollment by product type and county of enrollee residence; consequently, the numerators and denominators in the shares presented below are calculated in a comparable fashion.

(43) I rely on ACS three-year estimates (from 2010–2012) because they are more precise than one-year estimates and they include data for nearly all of Pennsylvania.[31] Additionally, I cross-validate the ACS data with three other independent data sources—Kaiser data from the Current Population Survey (CPS), employment data from the Local Area Unemployment Statistics (LAUS) program, and Supplemental Health Care Exhibit (SHCE) data from the National Association of Insurance Commissioners (NAIC).

IV.C.1.b. Highmark and BCNEPA enrollment data

(44) Highmark and BCNEPA provided county-level enrollment data by product (e.g., Highmark, FPLIC, FPH, etc.) and type of product (e.g. fully-funded and self-funded). The data are based on enrollee location: rather than allocating all enrollees to the county in which their employer is headquartered, the data report total enrollment based on where enrollees live (ACS data are reported in the same way). The Highmark and BCNEPA commercial data identify enrollees in each of the following product categories: individual, small group, mid/large group, and the BCBS Federal Employee Program (FEP Blue). Where applicable, enrollment is also separately tallied for fully-funded (i.e., risk business) and self-funded plans (i.e., non-risk business).

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[29] *See* United States Census Bureau, "About Health Insurance," accessed Feb. 5, 2014, http://www.census.gov/hhes/www/hlthins/about/index.html; Missouri Secretary of State, "Missouri Census Data Center," accessed Feb. 5, 2014, http://mcdc.missouri.edu/data/acs/Readme.shtml.

[30] *See* United States Census Bureau, "American Community Survey," accessed Jan. 29, 2014, http://www.census.gov/acs/www/methodology/sample_size_data/index.php.

[31] The 3-year ACS data account for about 99.5% of the state population (61 out of 67 Pennsylvania counties) as compared with 1-year ACS data, which account for 95% of the population (39 out of 67 counties).

(45) In the share calculations presented below, I exclude Federal Employees Health Benefits (FEHB) enrollees.[32] Neither Highmark nor BCNEPA offers an FEHB plan; instead, they both market and administer the FEP Blue National Plans, which are sold under a contract between the BCBSA and the federal Office of Personnel Management (OPM).[33] In the BCNEPA Service Area, Highmark is responsible for professional services benefits and BCNEPA is responsible for hospital services benefits. However, the premium and benefit packages are determined by the BCBSA and OPM, and they are the same throughout the country.[34] I exclude FEHB enrollees because they are in a distinct relevant product market: firms and individuals not employed by the federal government cannot switch into FEHB plans; for all intents and purposes, the reverse is also true.[35] Thus, FEHB plans and commercial insurance plans are not substitutes.

IV.C.1.c. NAIC SHP and SHCE data

(46) One of the sources of state-level commercial enrollment data is the NAIC, which makes available state-level data based on information reported by insurers in their annual financial statements submitted to the NAIC. Two primary sources of commercial accident and health insurance enrollment and premium data are the State Health Page (SHP) data and the SHCE data mentioned above. While both SHP and SHCE can be used for state-level analysis, SHP data are less reliable because of the following limitations:

- Some insurers that offer health coverage file their reports with NAIC under the Life or Property & Casualty categories, instead of under the Accident & Health category (insurers' Accident & Health filings include the SHP and other information).[36] The SHP data do not include enrollment or premium information for such insurers. The effect of this is that the SHP data are missing roughly 15% of premiums for the Accident & Health market.[37] Accurately identifying the set of health insurers and measuring their size requires data on health insurance offered by all companies, whether they file as Life insurance companies, Property & Casualty companies, or Accident & Health companies.

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[32] *See* United States Office of Personnel Management, "Healthcare," accessed Feb. 5, 2014, http://www.opm.gov/healthcare-insurance/healthcare/.

[33] A listing of the FEHB plans available to federal workers in Pennsylvania is in Appendix B.2.

[34] Premiums for FEHB plans are available from United States Office of Personnel Management, "Non-Postal Premium Rates for the Federal Employees Health Benefits Program," 2014, *available at* http://www.opm.gov/healthcare-insurance/healthcare/plan-information/premiums/2014/nonpostal-ffs.pdf; benefits for the two FEP Blue plans are described in Blue Cross and Blue Shield Association, "Blue Cross and Blue Shield Service Benefit Plan," 2013, *available at* https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-codes/2013/brochures/71-005.pdf.

[35] A federal worker could in theory purchase an individual or family plan outside the FEHB; doing so would be costly because such a worker would bear the entire cost of the premium instead of just the fraction not covered by the federal government.

[36] For example, UnitedHealthcare Insurance Company has A&H business but files the Life Statement, as does Aetna Life Insurance Company.

[37] In 2011, the SHP reported approximately $34.6 billion in A&H premiums, while the PID reported that the total A&H

- The SHP data do not include any information on self-funded plans.
- The SHP data provide comprehensive group enrollment information without breakdowns by small and large group.
- The SHP data include CHIP as part of the commercial comprehensive coverage category.

(47) The SHCE data, which have only been available since 2010, do not suffer from these limitations. However, like the SHP, the SHCE data are only available on a statewide basis. As noted in section IV.A, for most of their customers, health insurers compete on a relatively localized basis (e.g., a county, set of contiguous counties, or a metropolitan statistical area); therefore, an analysis of statewide market shares is less reliable and less informative than a more disaggregated analysis.

IV.C.2. Enrollment share estimates

(48) As I explain in this section, competition between Highmark and BCNEPA is negligible. An initial examination of commercial market shares in the BCNEPA region shows some apparent overlap (i.e., Highmark enrollees residing in BCNEPA's region), but this apparent overlap does not reflect competition between Highmark and BCNEPA.

(49) My analysis of competitive overlap focuses on the Northeastern Region (i.e., the BCNEPA Service Area), which is the only region in which Highmark and BCNEPA both have a significant number of enrollees. Measured by enrollment, shares in the BCNEPA Service Area are as follows:

- The two Highmark and BCNEPA jointly owned entities, FPH and FPLIC, have enrollment shares of about 5% and 27%, respectively—Highmark and BCNEPA are partners, not competitors, for these products.
- Under the joint operating agreement (JOA), Highmark and BCNEPA divide responsibility for professional and facility services with respect to several products that, combined, account for about 1% of commercial enrollment in the BCNEPA Service Area. Highmark and BCNEPA are not competitors for these enrollees.
- BCNEPA has no standalone commercial product offerings and, thus, has a 0% share.
- Highmark enrollees account for less than 10% of commercial enrollment in the BCNEPA Service Area. As I explain below, essentially all of that is attributable to enrollees for whom BCNEPA is not a competitor.

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across all companies was approximately $40.6 billion. *See* Pennsylvania Insurance Department, "Annual Statistical Report for the Period July 1, 2011 to June 30, 2012," n.d., at 251, 267, *available at* http://www.portal.state.pa.us/portal/server.pt/document/1307198/commissioner_report_final_2011-2012_pdf. The $6 billion gap cannot readily be itemized into A&H premiums.

(50) Because BCNEPA and Highmark do not compete in the BCNEPA region, the transaction will not reduce competition.[38] Specifically, Highmark's enrollment share of less than 10% in the Northeastern Region does not reflect competition between Highmark and BCNEPA. Almost all—99.9%—of that is attributable to customers headquartered outside the BCNEPA Service Area, but with enrollees residing in the Northeastern Region. Specifically, out of more than 50,000 Highmark enrollees residing in the BCNEPA Service Area, all but 33 are attributable to customers (e.g., firms and unions) located outside that area.[39]

(51) In summary, the merger will combine three categories of already existing *joint* offerings in which Highmark and BCNEPA do not compete: (1) products offered under the JOA (for which Highmark and BCNEPA divide responsibility for professional and facility claims), (2) products offered through FPH (a 60/40 joint venture), and (3) products offered through FPLIC (a 60/40 joint venture). Outside of those joint offerings, BCNEPA has no commercial enrollment and Highmark has only enrollees of customers headquartered outside the BCNEPA Service Area (as I explain in section IV.B.2, BCNEPA cannot bid for all or nearly all of these customers). Given that BCNEPA has no commercial enrollment outside of the joint offerings, its share is 0%; therefore, there is no prima facie evidence of a violation of competitive standards with respect to commercial insurance.[40]

[38] As I explain in section IV.A, health insurers generally compete locally, which implies that it may be more accurate to evaluate competition locally (e.g., a county, set of counties, or metropolitan area) than at the state level. Although the precise numbers vary, shares within the various counties in the BCNEPA Service Area do not vary dramatically. Thus, results for the overall BCNEPA Service Area also apply to the component counties individually and to any collection of those counties.

[39] I have not determined why these 33 residents of the BCNEPA Service Area are covered by Highmark, or appear to be. However, because 33 is such a small number of enrollees, the answer to this question is inconsequential and would not substantively affect my analysis or conclusions.

[40] If I allocate all joint lives to BCNEPA and exclude Highmark's enrollees in customers for which BCNEPA generally cannot bid, then Highmark's share is less than 1%. If I instead allocate all joint lives to Highmark, then BCNEPA has no remaining enrollees, meaning that its share is less than 1% (0%, in fact).

V. Other commercial products

V.A. Dental and vision products

(52) BCNEPA does not offer its own vision or dental products. Instead, BCNEPA offers dental products underwritten by Highmark's United Concordia Life and Health Insurance Company subsidiary and vision products underwritten by Highmark and its life insurance subsidiaries. As noted on BCNEPA's web page, BCNEPA and its affiliates are "not responsible for the payment of claims or provision of dental and vision coverage."[41] Because BCNEPA has no dental or vision products of its own, there is no competition between Highmark and BCNEPA and the transaction will not lessen competition with respect to dental or vision products.

(53) Statewide shares based on enrollment for dental and vision plans are in Figure 2 and Figure 3, respectively.

Figure 2. Statewide dental plan enrollment shares, 2012

Insurer	Share
Highmark	73.4%
United Concordia Life & Health Ins. Co.	*69.0%*
United Concordia Dental Plan PA Inc.	*4.4%*
Dentegra Group	23.1%
Cigna	1.1%
Other	2.3%
Total enrollment	**2,203,585**

Source: NAIC SHP data, 2012. The NAIC does not endorse any analysis or conclusions based upon the use of its data.
Note: Includes fully-funded enrollees only. Numbers may not sum to 100%, because of rounding.

[41] Blue Cross of Northeastern Pennsylvania, "Dental & Vision," accessed Jan. 28, 2014, https://www.bcnepa.com/Products/DentalVision.aspx.

Figure 3. Statewide vision plan enrollment shares, 2012

Insurer	Share
Highmark	7.0%
Highmark Inc.	*4.3%*
HM Health Ins. Co.	*2.6%*
Vision Service Plan Group	46.1%
Vision Benefits of America Inc.	43.4%
UPMC	3.5%
Other	0.1%
Total enrollment	**1,566,551**

Source: NAIC SHP data, 2012. The NAIC does not endorse any analysis or conclusions based upon the use of its data.
Note: Includes fully-funded enrollees only. Numbers may not sum to 100%, because of rounding.

V.B. Stop loss insurance products

(54) Stop loss coverage shields entities (employers, unions, etc.) that self-fund their enrollees' health insurance benefits against the risk of exceptionally high medical expenditures in any given year. Though the exact extent of coverage varies, a typical stop loss policy would provide protection against very high individual claims (e.g., one extremely premature delivery) and very high aggregate claims (e.g., an atypically large number of covered lives with medical costs that are above average).

(55) A clear distinction between stop loss coverage and health insurance coverage is that a stop loss product only provides a hedge against excess financial risk; it does not provide core health insurance services, such as provider contracting, care management, and routine claims processing. In this respect, it is more akin to property and casualty insurance (e.g., a policy that provides a building owner with protection against earthquakes, fires, and floods). This has an important implication: whereas health insurance competition is localized because of the importance of provider networks, stop loss insurance is not. In other words, covered entities have no reason to prefer that, in the event of a covered loss, their payment comes from a local source as opposed to a source outside their locality.

(56) Thus, the relevant geographic market in which to analyze competitive effects in markets for stop loss coverage is likely national and may even include other countries.[42] The broader geographic scope of markets for stop loss coverage is evident in data from Highmark and BCNEPA:

- Highmark has over 1,000 stop loss customers.

[42] For example, Lloyd's of London offers stop loss coverage to some self-funded entities in the United States. Lloyd's of London, "Update - Accident & Health Cover in the United States," accessed Feb. 6, 2014, http://www.lloyds.com/the-market/communications/regulatory-communications-homepage/regulatory-communications/regulatory-news-articles/2012/09/update-accident--health-cover-in-the-united-states.

- Slightly more than two-thirds of those do not purchase health insurance administrative services from Highmark. This shows that self-funded customers can and frequently do purchase stop loss coverage and health insurance administration from distinct entities.
- Less than one-third of Highmark's stop loss customers are domiciled inside Pennsylvania. This makes clear that customers do not need to purchase stop loss coverage from an insurer located in their home state.
- Only about one-quarter of Highmark's self-funded enrollment in Pennsylvania is covered by a Highmark stop loss product. The remainder is in a plan where the employer purchased stop loss coverage elsewhere (or, in a few cases, may not have purchased stop loss coverage at all).

- BCNEPA has fewer than 20 stop loss customers, all of whom purchase health insurance administrative services from BCNEPA.
  - The majority of BCNEPA's self-funded customers purchase stop loss coverage from an entity other than BCNEPA (or, in a few cases, may not purchase stop loss coverage at all).[43] BCNEPA customers that purchase both insurance administrative services and stop loss coverage are smaller, on average, than its health insurance administrative services customers that purchase stop loss coverage elsewhere.

(57) I do not have data with which to analyze stop loss market shares in a national market. Consequently, my analysis of stop loss market shares is confined to Pennsylvania; by doing so, I overestimate shares relative to the more appropriate national relevant geographic market. Even based on such overestimated shares, I find that BCNEPA's share of Pennsylvania commercial enrollees covered by stop loss policies is below 0.5%.[44] Thus, there is no evidence of a prima facie violation with respect to stop loss insurance products.

[43] Given that only about one-quarter of Highmark's self-funded enrollees are in groups that have stop loss coverage from Highmark, it is unlikely that a significantly larger percentage of these BCNEPA customers purchases stop loss coverage from Highmark.

[44] For purposes of this calculation, I compute shares under the assumption that all self-funded groups purchase stop loss coverage. Thus, the denominator is all self-funded enrollees who are in a contract that was signed in the Commonwealth of Pennsylvania; I construct this denominator by using the SHCE and the Centers for Medicare and Medicaid Service's Medical Loss Ratio (MLR) data. For the numerator, BCNEPA provided the number of enrollees for all of its stop loss customers domiciled in Pennsylvania. Highmark provided the number of covered employees (not enrollees) for customers domiciled in Pennsylvania. I map Highmark's employee figure into a number of enrollees by multiplying the number of employees by Highmark's number of enrollees per primary policy holder. Data for both Highmark and BCNEPA include all employees and enrollees, respectively, associated with a Pennsylvania-domiciled stop loss customer, and not just those who reside in Pennsylvania.

Figure 4. Statewide stop loss insurance enrollment shares

Entity providing stop loss coverage	Share
Highmark	15% to 25%
BCNEPA	< 0.5%
Other	> 75 %
Total	**100.0%**

Source: 2012 SHCE, 2012 MLR; 2013 BCNEPA stop loss data on enrollees and 2012 Highmark stop loss data on employees; Highmark PA employer data (50+ employees). The NAIC does not endorse any analysis or conclusions based upon the use of its data.

Note: The denominator represents the total number of self-funded enrollees in a contract that was signed in the Commonwealth of Pennsylvania. For the purposes of share calculation, I assume that all self-funded groups purchase stop loss coverage and, thus, that all self-funded enrollees are covered by a stop loss policy.

V.C. Smaller products

(58) Other smaller products include disability insurance, long-term care insurance, and workers' compensation. While Highmark offers all three of these products, BCNEPA does not offer any of them.[45] Hence, there is no competition between Highmark and BCNEPA with respect to these products and, therefore, no evidence of a prima facie violation.

[45] Highmark's website indicates that it offers disability insurance. *See* Highmark Inc., "Highmark Disability Income Insurance," accessed Feb. 5, 2014, https://www.hmig.com/products/supplementalgroup/disabilityincome.shtml. The PID annual statistical report shows worker's compensation premiums for Highmark. *See* Pennsylvania Insurance Department, "Annual Statistical Report for the Period July 1, 2011 to June 30, 2012," at 690, *available at* http://www.portal.state.pa.us/portal/server.pt/document/1307198/commissioner_report_final_2011-2012_pdf (select "Current Report 2013"). Highmark revenue data show that it offers long-term care products. Similar sources do not provide any indication that BCNEPA offers these products, and BCNEPA business personnel have confirmed that BCNEPA does not offer these products.

VI. Medicaid and CHIP products

(59) As I explain in this section, the transaction presents no violation of competitive standards with respect to Medicaid or CHIP products. BCNEPA no longer offers a managed Medicaid product and the counties in which Highmark and BCNEPA offer CHIP coverage do not overlap. Thus, there is no change in concentration for either product in any part of Pennsylvania. In addition, I understand that neither entity has submitted a bid to serve areas outside their respective core areas of operation.

VI.A. HealthChoices (managed Medicaid)

(60) In early 2013, Pennsylvania began administering its Medicaid program solely through the HealthChoices mandatory managed care program.[46] As of March 31, 2014, BCNEPA stopped offering a managed Medicaid product.[47] In the BCNEPA Service Area, which is contained within the New East zone as defined by HealthChoices, three contractors offer managed Medicaid products: AmeriHealth NE, Coventry, and Geisinger.[48]

(61) Highmark does offer managed Medicaid products through Gateway Health Plan, a joint venture between Highmark and Mercy Health Plans, but this product is not offered in the New East zone. Instead, Gateway Health Plan offers its products in HealthChoices' New West, Southwest, and Lehigh/Capital zones.[49] Based on discussions with business personnel at Highmark, I understand that Highmark has not bid for any regions beyond these three.

(62) Given that BCNEPA does not offer a managed Medicaid product and that Highmark does not offer such a product in the BCNEPA Service Area, there is no overlap and no evidence of a prima facie violation with respect to managed Medicaid services.

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[46] The HealthChoices program was implemented in 1997, but, until 2013, it was voluntary in many parts of the state. *See* Pennsylvania Department of Public Welfare, "HealthChoices Physical Health Expansion to the New East Zone March 2013," Provider Quick Tips #142, n.d., *available at* http://www.dpw.state.pa.us/cs/groups/webcontent/documents/communication/p_014605.pdf; Pennsylvania Department of Public Welfare, "HealthChoices Physical Health Expansion 2012-13: The New East Zone," Feb. 2013, at 2, *available at* http://nepahfma.org/images/2_22_13_presentation_4.pdf.

[47] Hospital Service Association of Northeastern Pennsylvania, Quarterly Statement filed with the Pennsylvania Insurance Department, June 30, 2014, at Q10.6.

[48] Pennsylvania Department of Public Welfare, "Monthly Managed Care Program Report," October 23, 2014, *available at* http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/c_115450.pdf.

[49] For a map of the HealthChoices zones, see Pennsylvania Department of Public Welfare, "Statewide Managed Care Map," accessed Dec. 1, 2014, http://www.dhs.state.pa.us/provider/healthcaremedicalassistance/managedcareinformation/statewidemanagedcaremap/index.htm.

VI.B. The Children's Health Insurance Program (CHIP)

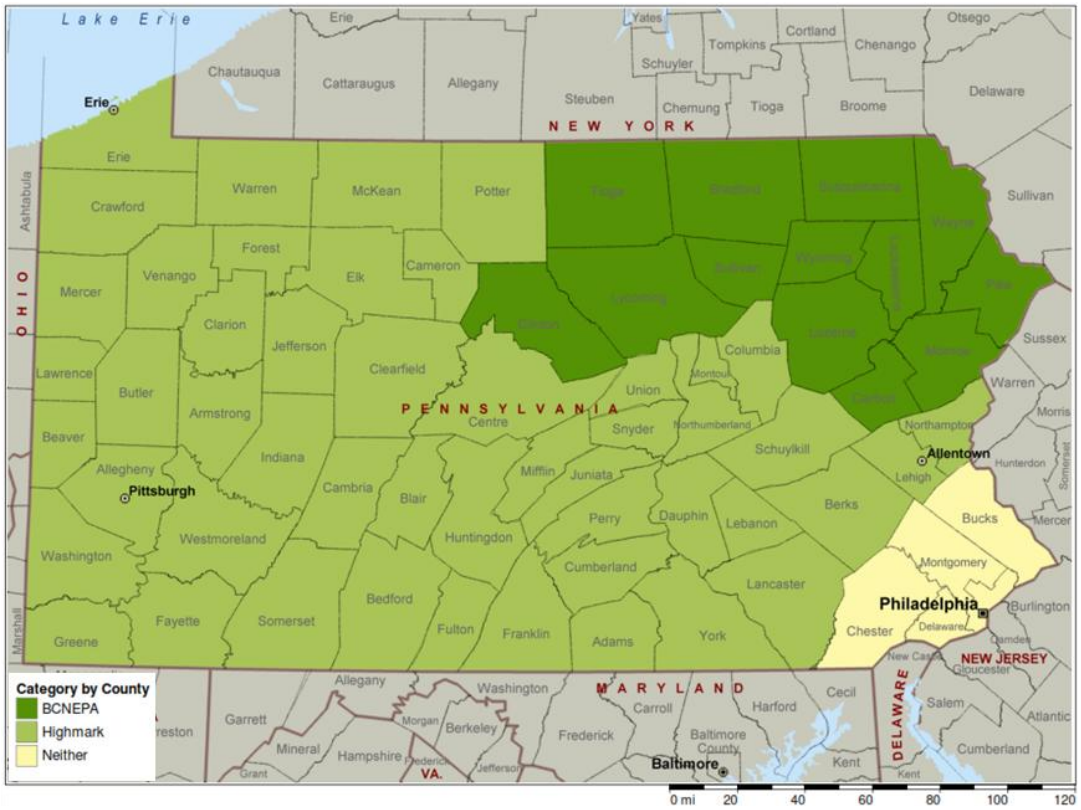
(63) Pennsylvania's Children's Health Insurance Program (CHIP) provides free or low-cost health insurance to eligible children throughout the state. Similar to the Medicaid program, the Commonwealth of Pennsylvania contracts with private insurance companies to manage CHIP in each county.[50] In particular, the set of plans available to a CHIP-eligible child is determined by the child's county of residence. Therefore, it would be inappropriate to examine competition on a statewide basis; instead, the more informative unit of analysis is the county.

(64) BCNEPA and Highmark both provide coverage under the CHIP program in certain counties. However, as shown in Figure 5, BCNEPA and Highmark do not compete in any county. Because their coverage areas do not overlap, the merger creates no prima facie violation of competitive standards in any market for CHIP services.

(65) I understand from Highmark business personnel that Highmark has only submitted bids for counties in the Western and Central Regions. Likewise, I understand that BCNEPA has only submitted bids for counties in its Service Area.

[50] Pennsylvania CHIP, "County Coverage," accessed Jan. 28, 2014, http://www.chipcoverspakids.com/find-chip-coverage/county-coverage/. The Commonwealth also uses an RFP process to award CHIP contracts. *See* Pennsylvania eMarketplace, "RFP CHIP 2008-4: Children's Health Insurance Program Services," accessed Feb. 5, 2014, http://www.emarketplace.state.pa.us/Solicitations.aspx?SID=INS%20CHIP%202008-4.

Figure 5. Counties in which Highmark and BCNEPA contract to provide CHIP coverage



Source: Pennsylvania CHIP, "Enrollment by Contractor and County," Dec. 2013, *available at* http://www.chipcoverspakids.com/assets/media/pdf/chip_enrollment_by_contactor.pdf.

Note: There are no counties in which both Highmark and NEPA offer CHIP coverage.

VII. Medicare-related products

(66) In this section, I analyze competitive overlap with respect to three Medicare-related product categories: Medicare Advantage, Part D Prescription Drug Benefits, and Medicare Supplemental coverage (i.e., Medigap). In each case, the merger presents no risk of harm to competition.

VII.A. Medicare Advantage

VII.A.1. Medicare Advantage overview

(67) Since the 1970s, as an alternative to the Traditional Medicare program, Medicare beneficiaries have had the option to receive Medicare benefits through private health plans. The Balanced Budget Act (BBA) of 1997 named Medicare's managed care program "Medicare+Choice." The Medicare Modernization Act (MMA) of 2003 made a number of reforms to the program and renamed it "Medicare Advantage."[51] Medicare Advantage (MA) plans are offered by private plans ("carriers") and regulated by the CMS. MA plans cover all services covered by the Traditional Medicare program (i.e., Part A and Part B services). They also commonly feature lower cost-sharing and may also provide additional benefits. The large majority of MA enrollment is in plans that include prescription drug benefits.

(68) CMS publishes monthly data on enrollment by carrier, plan, and county. It also publishes data on the benefits offered by the various plans, the populations served (e.g., dual Medicare/Medicaid eligibles, those with chronic conditions), and the penetration rates of MA plans within counties.[52]

(69) Every specific MA plan offering is identified by a contract/plan number combination, such as H3954-100 ("Geisinger Gold Classic 3"). Each contract/plan number combination is authorized to provide coverage in one or more counties; such counties constitute the plan's "service area."

(70) The set of MA plans available to a Medicare-eligible person is determined by the county of residence. For example, as shown in Figure 6, the first step a potential enrollee must take in order to see the plans in which she can enroll is to enter her zip code on the Medicare Plan Finder website.[53] Because

[51] Kaiser Family Foundation, "Medicare Advantage Fact Sheet," accessed Feb. 5, 2014, http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/.

[52] The main source of data on enrollment is the "contract/plan/state/county" (CPSC) data set. *See* Centers for Medicare & Medicaid Services, "Medicare Advantage/Part D Contract and Enrollment Data," accessed Jan. 28, 2014, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html?redirect=/MCRAdvPartDEnrolData/MCESR/List.asp. This site also provides information on enrollment in Part D Prescription Drug Benefit plans, which I discuss in section VII.B.

[53] Plan offerings rarely vary across zip codes within a county.

seniors cannot enroll in plans whose service areas do not include their counties of residence, MA plans not offered in a given county are not substitutes for the MA plans that are offered in that county.[54] (Although this is not common, local HMO and local PPO MA plans can have service areas that include less than an entire county.)

(71) All enrollees in an MA plan are eligible to change plans, and they can switch to Traditional Medicare between January 1 and February 14 of each year. Most new MA enrollees are eligible to switch to Traditional Medicare at any time during their first 12 months of enrollment.[55]

[54] In both of the consent decrees that it issued in mergers of Medicare Advantage carriers, the DOJ focused on the effects of the merger in specific counties. *See* Final Judgment, *United States v. UnitedHealth Grp. Inc.*, No. 08-cv-0322 (D.D.C. Sept. 24, 2008) (analyzing competitive effects in Clark and Nye Counties in Nevada); Order, *United States v. Humana Inc.*, No. 12-cv-00464 (RBW) (D.D.C. Oct. 22, 2012) (analyzing competitive effects in 45 specific counties and parishes within five states).

[55] Centers for Medicare & Medicaid Services, "Medicare Advantage Plans and Other Medicare Plans," 2013 training module workbook, at 12–13, *available at* http://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Downloads/2013-Medicare-Advantage-Plans-Workbook.pdf.

Figure 6. The Medicare Plan Finder web page

Source: Centers for Medicare & Medicaid Services, "Medicare Plan Finder," accessed Jan. 27, 2014, https://www.medicare.gov/find-a-plan/questions/home.aspx.

(72) The major categories of MA plans are as follows:

- Individual, non-special needs plans.
- Special Needs Plans (SNPs). This category includes plans for dual Medicare/Medicaid eligibles (D-SNPs), those with chronic conditions (C-SNPs), and those who require institutional care (I-SNPs).
- Employer- and union-sponsored group plans ("800 series plans"). These plans primarily provide health benefits to retirees.

VII.A.2. Highmark and BCNEPA do not offer competing Medicare Advantage plans

(73) Highmark has two Medicare Advantage contracts:

1. H3957 is an HMO plan offered through Highmark's Keystone Health Plan West (KHPW) subsidiary and marketed under the "Security Blue" brand name.
   - Security Blue is offered only in the Western Region (i.e., the 29-county area Highmark defines as its Western Region).
2. H3916 is a PPO plan marketed under the brand name "Freedom Blue" and offered in all areas of Pennsylvania except the Eastern Region (i.e., the IBC Region).
   - In the Northeastern Region, Highmark offers the Freedom Blue product in association with BCNEPA.[56] All CMS data indicate that Highmark is the sole entity responsible for all Freedom Blue plans.[57]
   - I understand from conversations with Highmark and BCNEPA business personnel that, under Highmark's arrangement with BCNEPA, profits attributable to enrollees residing in the BCNEPA Region are shared between BCNEPA and Highmark; for group business, profits are shared for all groups headquartered in the BCNEPA Region.
   - BCNEPA has no interest or participation in Freedom Blue offerings outside of the BCNEPA counties.

(74) With the exception of its partnership with Highmark, BCNEPA has no MA plan offering. Highmark and BCNEPA are not competitors and the merger will result in no increase in concentration with respect to any category of MA plan. This is demonstrated in Figure 7, which shows shares of MA enrollment by carrier and Medicare region.[58] Specifically, Highmark's only enrollment in the Northeastern Region is through its partnership with BCNEPA.

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[56] Blue Cross of Northeastern Pennsylvania, "Medicare Eligible Plans," accessed Dec. 9, 2014, https://www.bcnepa.com/Products/Medicare.aspx. For "details about FreedomBlue," BCNEPA directs users to Highmark's website.

[57] *See, e.g.*, Centers for Medicare & Medicaid Services, "Plan Directory for Medicare Advantage, Cost, PACE, and Demonstration Organizations, Sorted by Legal Entity Name," Jan. 2014, at 83 (showing Highmark as the "Legal Entity," "Marketing Name," and "Parent Organization" for contract H3916 but making no reference to BCNEPA). Similarly, a search of the Medicare Plan Finder by using a zip code in the BCNEPA region will identify Freedom Blue PPO as among the available offerings but identify the offering organization as "Highmark Health Services." *See, e.g.*, Centers for Medicare & Medicaid Services, "Medicare Plan Finder," accessed Jan. 22, 2014, https://www.medicare.gov/find-a-plan/questions/home.aspx.

[58] As noted above, it may be appropriate in some contexts to analyze competition at the county or set-of-counties level. Likewise, it may be appropriate in some cases to analyze competition separately by type of plan (e.g., SNP and non-SNP plans). In this case, because there is no overall competitive overlap, there is necessarily no competitive overlap in any county or MA plan type. Similarly, in some cases, it may be appropriate to evaluate competition between MA plans and Traditional Medicare. However, because Highmark and BCNEPA do not compete with respect to MA plans, the degree

(75) In the Northeastern Region, Freedom Blue has a 19.3% share of MA enrollment. This makes it a distant second to Geisinger Health Plan, which has a 42.2% share of MA enrollment. Aetna has a 17.6% share and Humana a 13.3% share. The Northeastern Region is also the area of Pennsylvania in which MA products have gained the least traction: 77.4% of all Medicare eligibles in the Northeastern Region are enrolled in Traditional Medicare, whereas the comparable figure for other regions ranges from 45% (Western Region) to 67.5% (Eastern Region).

Figure 7. Enrollment shares in Medicare Advantage plans, by carrier and region

Carrier		Region				
		Northeastern	Western	Central	Eastern	Centre County[1]
Highmark	Security Blue	-	27.5%	-	-	-
	Freedom Blue -- excl. NEPA region	-	20.7%	23.6%	1.0%	47.2%
	Freedom Blue -- NEPA partnership	19.3%	-	-	-	-
Capital BlueCross		-	-	14.0%	-	2.8%
Independence Blue Cross		-	-	0.0%	37.6%	-
Geisinger Health System		42.2%	1.0%	15.2%	0.3%	29.5%
Aetna Inc.		17.6%	13.6%	26.2%	21.9%	15.9%
Humana Inc.		13.3%	1.2%	5.8%	2.4%	3.9%
Universal American Corp.		5.2%	0.1%	1.0%	0.2%	-
UnitedHealth Group, Inc.		2.2%	3.2%	6.8%	1.4%	0.6%
Gateway Health Plan, LP		0.0%	4.6%	6.7%	0.4%	-
UPMC		-	27.6%	-	-	-
CIGNA		-	0.2%	0.4%	34.1%	-
Others		0.2%	0.5%	0.3%	0.8%	-
	Medicare eligibles (1000s)	258.3	827.5	663.3	673.8	20.9
	MA enrollees (1000s)[3]	58.4	453.8	223.0	219.3	9.4
	% Traditional	77.4%	45.2%	66.4%	67.5%	55.2%

Source: CMS CPSC file for October 2013 (enrollment figures); CMS, Medicare Penetration Files for Oct. 2013 (eligibles data).

Notes:
1. Part of Centre County is in the Western BCBSA Tegion and part is in the Central Region. Because not all companies make the same division, Centre County is included separately in the table above. *See* Highmark Inc., "What Region Am I?," n.d., *available at* https://www.highmarkblueshield.com/pdf_file/hbsom-map.pdf.
2. Values reported as 0.0% represent small, but non-zero shares. Dashes represent true zeros.
3. Total MA enrollment figures are approximately 1.3% higher than enrollment values used to calculate the regional shares. This is because CMS suppresses county/plan-level observations with fewer than 10 enrollees.

VII.B. Medicare prescription drug benefit products

(76) Most Medicare eligibles can obtain prescription drug coverage in one of two ways: they can enroll in Traditional Medicare and then purchase a Part D prescription drug plan (PDP) or they can enroll in a Medicare Advantage Part C plan that includes prescription drug benefits (most enrollees in MA plans

of competition between such plans and Traditional Medicare is immaterial in this case.

are in plans with drug coverage).[59] In 2010, about 38% of Medicare beneficiaries had standalone PDP coverage (21% had drug coverage through an MA plan). The remainder had no coverage or some other source of coverage (FEHB, TRICARE, retiree drug subsidy, state pharmacy assistance, etc.).[60]

(77) Unlike MA plans, in which the offerings can vary by county, CMS has defined regions for PDPs. If an insurer offers a PDP in one part of a region, that insurer must offer the PDP product throughout that entire region. All of Pennsylvania is in Region 6 (also referred to as the "Philadelphia Region"), which also includes West Virginia.[61] Thus, Pennsylvania is an appropriate geographic area for analyzing PDP competition. As of January 2014, 37 Prescription Drug Plans are offered in Pennsylvania by over 20 distinct entities.[62]

(78) Highmark has one PDP contract covering Pennsylvania and West Virginia, contract S5593, which is marketed under the "Blue Rx" brand name.[63] BCNEPA does not offer Part D PDP products.[64] Therefore, the merger will result in no increase in concentration with respect to PDP products.

(79) Figure 8 shows enrollment shares in PDP plans in Pennsylvania as of October 2013. In addition to offerings from health insurers, eligibles may also select the products of pharmacy benefit managers such as Express Scripts and CVS Caremark. In fact, these products have significant enrollment. Statewide, Highmark's enrollment share is 4.7% (and BCNEPA's is 0%).

[59] Enrollees in Private Fee-For-Service (PFFS) plans that do not offer drug coverage can enroll in a separate Part D PDP.

[60] Kaiser Family Foundation, "Medicare: A Primer," 2010, at 8, *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7615-03.pdf.

[61] Q1 Group LLC, "2014 Medicare Part D Prescription Drug Plans: Overview by CMS Region," accessed Jan. 28, 2014, http://www.q1medicare.com/PartD-Medicare-PartD-Overview-byRegion.php.

[62] Centers for Medicare & Medicaid Services, "Medicare Plan Finder," accessed Jan. 28, 2014, https://www.medicare.gov/find-a-plan/questions/home.aspx.

[63] Highmark offers two plans under this contract, Blue Rx Complete (S5593-003) and Blue Rx Plus (S5593-002).

[64] Centers for Medicare & Medicaid Services, "PDP Plan Directory," Dec. 2013, *available at* http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/PDP-Plan-Directory-Items/CMS1203268-PDP-Plan-Directory.html?DLPage=1&DLSort=1&DLSortDir=descending.

Figure 8. Enrollment shares in PDP plans

Carrier	Statewide enrollment share
CVS Caremark Corporation	31.4%
UnitedHealth Group, Inc.	19.6%
Express Scripts	11.8%
Humana Inc.	9.1%
Aetna Inc.	8.7%
Highmark (S5593)	4.7%
CIGNA	4.7%
Envision Pharmaceutical	2.8%
WellCare Health Plans, Inc.	2.3%
Independence Blue Cross	1.4%
Torchmark Corporation	1.3%
Capital BlueCross	0.9%
Others	1.4%
Total enrollment	**901,531**

Source: PDP Enrollment by SCC file for October 2013.

VII.C. Medicare Supplemental (Medigap) products

(80) Traditional Medicare only covers about 80% of covered medical expenditures. To cover part of the remainder, Traditional Medicare enrollees can purchase Medicare Supplemental coverage, also known as Medigap. As of December 2012, about 625,000 Pennsylvania Traditional Medicare enrollees had Medigap coverage.[65] Under CMS rules, seniors enrolled in Medicare Part A and Part B (i.e., Traditional Medicare) can purchase a Medigap policy from any insurer licensed in their state of residence.[66] Thus, the appropriate level of analysis for analyzing competition with respect to Medigap is the state.

(81) All carriers offering Medigap coverage must offer one or more benefit packages from a set of 10 standardized Medigap plans (as of June 1, 2010, these are identified by the letters A, B, C, D, F, G, K, L, M, and N). All insurers that offer a specific benefit package offer the same degree of coverage and benefits. For example, United's Plan A will offer the same benefits as Humana's Plan A. All insurers that offer any Medigap plan must offer Plan A; if an insurer wishes to offer more than one plan, it

[65] AHIP, "Trends in Medigap Coverage and Enrollment, 2012," May 2013, at 9, *available at* http://www.ahip.org/TrendsMedigap2012PDF/.

[66] Centers for Medicare & Medicaid Services, "Choosing a Medigap Policy," 2013, at 13, *available at* http://www.medicare.gov/Pubs/pdf/02110.pdf.

must also offer at least Plan C or Plan F.[67] Although the benefit packages do not vary, the premiums can.[68]

(82) The most popular plans in Pennsylvania are Plan C (261,430 enrollees statewide), Plan F (108,347), and Plan B (51,068).[69] A wide variety of carriers offer Medigap plans; for example, over 30 companies offer Plan C to Scranton residents (see Appendix B).

(83) BCNEPA offers two Medigap products, both in conjunction with Highmark. The first is "BlueCare Security," which is sold to individuals.[70] The second is BlueCare Senior, which is sold to employers.[71] In the BCNEPA Service Area, BCNEPA is responsible for the costs of Part A Medicare services (primarily hospital and other facility services), and Highmark is responsible for the costs of Part B services (primarily physician and other outpatient services). Each company determines the premiums for its component of coverage, and the rates are added together to determine the overall premium. In the Northeastern Region, BCNEPA markets and administers the product. Highmark also markets a Medigap product separately from BCNEPA, MedigapBlue. However, nearly all of Highmark's enrollment in the BCNEPA Service Area is attributable to the joint product, BlueCare Security.

(84) One implication of this joint product is that each individual enrollee in a Medigap plan marketed by BCNEPA will appear in both Highmark's data (as an enrollee receiving Part B benefits) and BCNEPA's data (as an enrollee receiving Part A benefits).[72] Importantly, with respect to these Medigap enrollees, Highmark and BCNEPA are selling *complementary* products, not competing or substitute products.[73] In other words, a senior with Traditional Medicare coverage who is considering purchasing Medigap cannot choose to receive that coverage from Highmark *or* BCNEPA; instead, the

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67 Carol Rapaport, "Medigap: A Primer," Congressional Research Service, Sept. 19, 2012, at 19, *available at* https://www.fas.org/sgp/crs/misc/R42745.pdf.

68 Centers for Medicare & Medicaid Services, "Costs of Medigap Policies," accessed Jan. 28, 2014, http://www.medicare.gov/find-a-plan/staticpages/learn/how-insurance-companies-price-policies.aspx.

69 AHIP, "Trends in Medigap Coverage and Enrollment, 2012," May 2013, at 9, *available at* http://www.ahip.org/TrendsMedigap2012PDF/.

70 BlueCare Security is offered jointly by Highmark and BCNEPA and administered by BCNEPA. Blue Cross of Northeastern Pennsylvania, "Your Blue Book," 2013, *available at* https://d1tpfj3hind0fx.cloudfront.net/Media/Documents/Handbooks/SecurityHB.pdf.

71 BlueCare Senior is also offered jointly by Highmark and BCNEPA and administered by BCNEPA. Blue Cross of Northeastern Pennsylvania, "Your Blue Book," 2013, *available at* https://d1tpfj3hind0fx.cloudfront.net/Media/Documents/Handbooks/BlueCareSeniorHandbook.pdf. Formally, as stated in the handbook, BlueCare Senior is "a Medicare Complementary health insurance plan offered by Blue Cross of Northeastern Pennsylvania (BCNEPA) and Highmark Blue Shield and administered by Blue Cross of Northeastern Pennsylvania." Although it is similar to a Medigap plan—BlueCare Senior offsets Part A and Part B cost-sharing—its benefit design does not adhere to any of the standardized Medigap benefit packages.

72 That the same individuals are counted twice is clearly evident in Highmark's and BCNEPA's enrollment data: on a county-by-county basis in BCNEPA's service area, enrollments for both Highmark and BCNEPA are nearly identical.

73 IBC's Medigap product, MedigapSecurity, is similarly structured. *See* Independence Blue Cross Medicare, "MedigapSecurity," accessed Feb. 11, 2014, http://www.ibxmedicare.com/plan_finder/medigapsecurity/ ("MedigapSecurity is a group of six . . . Medicare Supplement insurance (Medigap) plans from Independence Blue Cross and Highmark Blue Shield").

choice is between the product offered jointly by Highmark *and* BCNEPA and one of the dozens of offerings from other carriers.

(85) Statewide enrollment shares in Medigap products are shown in Figure 9. Enrollments are separately itemized into products offered by a single entity and products offered jointly in order to avoid double counting enrollees whose Part A and Part B coverage is attributable to different Blue entities.

(86) All Medigap plans cover some amount of cost-sharing for both Part A and Part B service.[74] BCNEPA, however, does not cover Part B services and, therefore has no standalone enrollment in any Medigap plan. Therefore, BCNEPA's share in the market for Medigap plans is 0% and there is no prima facie violation of competitive standards.

Figure 9. Statewide Medigap enrollment shares

Enrollees with Medigap Part A and Part B coverage	Share
Highmark only (Part A and Part B)	10% to 20%
Highmark (Part B) and IBC (Part A)	5% to 10%
Highmark (Part B) and BCNEPA (Part A)	5% to 10%
BCNEPA only	0.0%
All others	60% to 70%
Total	**100.0%**

Source: BCNEPA 2012 enrollment data, Highmark 2012 enrollment data; AHIP, "Trends in Medigap Coverage and Enrollment, 2012," May 2013, at 9, *available at* http://www.ahip.org/TrendsMedigap2012PDF/.

Note: The "All others" category includes entities offering Medigap products in which neither Highmark nor BCNEPA has any involvement or interest.

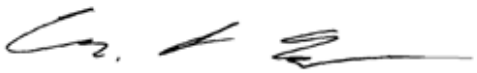
(87) In addition to BCNEPA's lack of a standalone product, there are other reasons why the transaction does not pose a risk of harm to competition or consumers with respect to Medigap:

- Benefit packages for Medigap products are standardized; every plan offering corresponds to one of 10 prespecified packages of benefits. Thus, consumers generally have little reason other than price to choose one plan over another. Standard results from microeconomics indicate that under these conditions, price competition is likely to be intense.
- Dozens of carriers offer Medigap products throughout Pennsylvania (the exact number varies by benefit package). These carriers are listed in Appendix B for Plan A (the mandatory plan) and Plan C (the plan with the highest enrollment).[75]

[74] Centers for Medicare & Medicaid Services, "How to compare Medigap policies," accessed Feb. 6, 2014, http://www.medicare.gov/supplement-other-insurance/compare-medigap/compare-medigap.html.

[75] These listings are derived by searching for zip code 18503 at http://www.medicare.gov/find-a-plan/questions/medigap-

- Entry barriers are low. Medigap insurers do not need to form networks or negotiate pricing with providers—CMS does that. That is, because Medigap plans simply cover portions of the deductibles and cost-sharing not covered by Part A and Part B, much of the operational and administrative work necessary for entry is performed by CMS.



Name

December 23, 2014

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home.aspx (Centers for Medicare & Medicaid Services, "Medigap Policy Search," accessed Jan. 27, 2014, http://www.medicare.gov/find-a-plan/questions/medigap-home.aspx). The search results identify 57 companies that offer Policy A and 38 that offer Policy C. These figures slightly overcount the number of competitors because several insurers are listed twice and BCNEPA is listed separately from Highmark.

Appendix A. Curriculum vitae of Cory S. Capps, PhD

(88) Cory Capps has more than 15 years of experience as an economist specializing in industrial organization, empirical methods, and antitrust, with a focus on the healthcare industry. He has advised and offered testimony on behalf of private firms and government agencies on issues relating to market power and competition in the healthcare sector, and he has experience analyzing mergers, joint ventures, price-fixing and market allocation, and exclusionary conduct. Prior to joining Bates White, Dr. Capps was a Staff Economist at the Antitrust Division of the US Department of Justice (DOJ), where he concentrated on the analysis of competition in healthcare markets, including merger and civil non-merger investigations of health insurers, hospitals, physicians, nurses, home health agencies, and ambulatory surgery centers. In 2012, 2013, and 2014, Dr. Capps was selected by *Global Competition Review* for inclusion in its *International Who's Who of Competition Economists*.

(89) In addition to Dr. Capps' broad healthcare experience, he has conducted economic analysis for investigations and cases involving a variety of industries such as airlines, semiconductors, newspapers, online content providers, and agriculture. Dr. Capps has also provided economic consulting services to corporations on business and strategy issues.

(90) Dr. Capps' academic career includes professorships at the University of Illinois at Urbana-Champaign and at Northwestern University's Kellogg School of Management. He has published widely in academic journals, including *RAND Journal of Economics*; *Journal of Economics and Management Strategy*; *Journal of Health Economics*; *Antitrust Bulletin*; *Health Affairs*; and *Health Economics, Policy and Law*. Dr. Capps is currently also a lecturer in the Health Industry Management Program at Northwestern University's Kellogg School of Management and a member of an advisory panel providing expertise on healthcare competition and policy issues to the National Health Service in the United Kingdom.

A.1. Education

- PhD, Economics, Northwestern University
- BA, Economics, University of Texas at Austin

A.2. Areas of expertise

- Industrial organization
- Antitrust

- Health economics
- Applied econometrics
- Innovation and technology

A.3. Professional experience

- Partner, Bates White, LLC, 2009–present
- Principal, Bates White, LLC, 2007–2009
- Economist, Economic Analysis Group, Department of Justice, 2004–2007
- Associate Director, Center for Health Industry Management, Kellogg School of Management, Northwestern University, 2002–2004
- Research Assistant Professor, Department of Management and Strategy, Kellogg School of Management, Northwestern University, 2001–2004
- Visiting Economist, Economic Analysis Group, Department of Justice, 2001–2002
- Assistant Professor, Department of Economics, University of Illinois at Urbana-Champaign, 1999–2000

A.4. Selected experience

- In *United States ex rel. Chris McGowan v. Kaiser Foundation Health Plan*, on behalf of Kaiser Foundation Health Plan (KFHP), provided expert analysis in connection with alleged False Claims Act violations concerning Medicare Advantage gain/loss bid margins. Authored expert report that identified logical and economic inconsistencies in plaintiff's allegations and that critically assessed damages assertions made by plaintiff's expert.
- In *In re WellPoint, Inc. Out-of-Network "UCR" Rates Litigation*, lead the team that supported the expert work of Dr. Eric M. Gaier on economic issues associated with class certification including ascertainability of the putative classes, identification and measurement of economic harm, and reliability of class-wide damages methodologies on behalf of defendant WellPoint in connection with alleged underpayment of out-of-network benefits associated with alleged violations of Employee Retirement Income Security Act (ERISA), California Unfair Competition Law (UCL), breach of warranty, and breach of implied covenant of good faith obligations. The court denied plaintiffs' motion for class certification.

- Serving as consulting expert to the Massachusetts Health Policy Commission, an agency created in 2012 to increase value and access in the delivery of healthcare. Providing industry expertise and competition policy advice to the commission.
- Health Care Cost Institute (HCCI)/Robert Wood Johnson Foundation, member of the Technical Expert Panel for the *Health Market Index* (HMI) research project. The Robert Wood Johnson Foundation provided the HCCI with a planning grant to assess the feasibility of creating a measure of healthcare market performance—the HMI. Key components of the HMI are indices that measure medical productivity, provider competition, and prices for hospital and physician services.
- Provided detailed analysis on behalf of McKesson Corporation in connection with its $2.1 billion acquisition of PSS World Medical Inc. The analysis, which was presented to the FTC, showed that the proposed merger of the two medical and surgical supplies distributors was unlikely to lead to any anticompetitive effects. After McKesson pulled and re-filed its HSR filing, the FTC granted early termination of the waiting period and approved the merger without issuing a second request for additional information to the parties.
- In *Federal Trade Commission v. St. Luke's Health System, Ltd.*, led the team that supported the expert work of Professor David Dranove on behalf of the FTC and the State of Idaho. The agency, along with Idaho Attorney General and rival hospitals, challenged the acquisition of Saltzer Medical Group by St. Luke's Health System. Provided economic analysis support on issues of market definition, competitive effects, and efficiencies. Judge B. Lynn Winmill, of the US District Court in the District of Idaho, ordered St. Luke's to divest Saltzer Medical Group.
- In *In the Matter of OSF Healthcare System*, a corporation, and Rockford Health System, retained as a testifying expert on behalf of the FTC to analyze the competitive effects of OSF Healthcare System's proposed acquisition of Rockford Health System in Rockford, Illinois. Provided written, deposition, and hearing testimony. After US District Judge Frederick Kapala found the FTC had demonstrated a likelihood of success on the merits and granted the FTC's request for a preliminary injunction, the parties abandoned the merger.
- Provided economic analysis of the likely competitive effects of UnitedHealth Group's proposed acquisition of XL Health, an innovative provider of Medicare Advantage plans that focus on better coordinating care for seniors with chronic conditions. Assisted counsel for UnitedHealth and XL Health in preparing analyses that highlighted the limited direct competition between the two health insurers and the broad scope for post-merger efficiencies. The arguments were presented to the DOJ, which allowed the transaction to close without a second request.
- In *In re Proposed Acquisition of Coventry Health Care of Missouri, Inc.; Healthcare USA of Missouri, L.L.C.; Cambridge Life Insurance Company and Coventry Health and Life Insurance Company by Aetna, Inc.*, Case No. 120920539C (2013). On behalf of the Missouri Department of

Insurance, authored report and provided hearing testimony on the competitive effects of the proposed acquisition of Coventry by Aetna.

- Assisted Vermont-based Fletcher Allen Partners (FAP) in securing FTC clearance for FAP's proposed affiliation with New York-based Community Providers, Inc. (CPI). Performed analyses that demonstrated a high degree of complementarity between FAP's and CPI's service offerings and minimal head-to-head competition. After presentation using our analyses, the FTC permitted the waiting period to expire without further investigation.
- In *United States and State of Texas v. United Regional Health Care System*, retained as a testifying expert on behalf of DOJ to analyze the competitive effects of United Regional's exclusionary contracts with health insurers. DOJ reached a settlement with United Regional that prohibits the hospital from entering into contracts that improperly inhibit commercial health insurers from contracting with United Regional's competitors.
- In *Sheridan Healthcorp, Inc. v. AvMed Inc*, authored expert report and provided deposition testimony on issues of market definition, market power, and competitive effects on behalf of AvMed Health Plans, a Florida health insurer. The case settled before trial.
- On behalf of the FTC, retained as a testifying expert to analyze the competitive effects of a proposed merger in the healthcare sector.
- On behalf of the Centers for Medicare and Medicaid Services (CMS), coauthored a report on strategic modifications to the long-term care insurance program proposed under the "CLASS Act." The report examined the competitive structure of the long-term care insurance industry and offered proposals to increase the likelihood that the CLASS option could maintain solvency while operating under a guaranteed issue mandate without medical underwriting.
- Member of the Economic Reference Group, Cooperation & Competition Panel, National Health Service, United Kingdom. Providing industry expertise and competition policy advice to the agency charged with overseeing the application of antitrust and consumer protection laws to the healthcare sector in the United Kingdom.
- Providing a hospital client with antitrust and industry expertise to define relevant markets and assess the competitive effects of alleged exclusionary conduct.
- Retained by the Rhode Island Department of Health to analyze the competitive effects of the proposed merger of the two largest hospital systems in Rhode Island, Care New England and Lifespan. The parties ultimately abandoned the proposed merger.
- Provided economic consulting support to Delta Air Lines and Northwest Airlines in connection with the DOJ's investigation of their proposed merger. Evaluated antitrust risks, potential price effects, and developed a retrospective merger analysis for the airline industry. The merger consummated without divestitures.

- Coauthored a report on behalf of Alberta Health Services in Alberta, Canada, identifying structural changes that would improve the performance of its system for procuring certain healthcare services, such as cataract surgery.
- Performed market definition and competitive effects analyses on behalf of the DOJ in a merger investigation in the healthcare sector. Analysis of competitive effects included an econometric study to predict the likely shares incoming entrants would obtain in the market. Subsequent events have borne out the predictions of this analysis.
- Advised the Netherlands Competition Authority (NMa) and the Netherlands Healthcare Authority (NZa) on competitive issues engendered by new legislation that partially deregulated pricing in the Dutch hospital sector.
- On behalf of a client in the financial data and software industry, analyzed bidding data and provided assistance to attorneys responding to agency requests in both the United States and Europe in connection with a transatlantic merger.
- Conducted economic analysis in *United States and State of Arizona v. Arizona Hospital and Healthcare Association and AzHHA Service Corporation*. Advised DOJ officials on settlement and enforcement issues.
- Conducted economic analysis in *United States v. UnitedHealth Group Inc. and PacifiCare Health Systems, Inc*. Advised DOJ officials on settlement and enforcement issues.
- Provided testimony on for-profit and nonprofit hospital pricing and on geographic hospital market definition before the DOJ/FTC Hearings on Health Care Competition, Policy, and Law, spring 2003.

A.5. Expert testimony

- *Sheridan Healthcorp, Inc. v. AvMed Inc.* (2011). Offered expert analysis and deposition testimony on behalf of defendant/counterclaimant AvMed Inc.
- *In re OSF Healthcare System, a corporation, and Rockford Health System* (2012). Offered written, deposition, and hearing testimony on behalf of the Federal Trade Commission to analyze the competitive effects of OSF Healthcare System's proposed acquisition of Rockford Health System.
- *In re Proposed Acquisition of Coventry Health Care of Missouri, Inc.; Healthcare USA of Missouri, L.L.C.; Cambridge Life Insurance Company and Coventry Health and Life Insurance Company by Aetna, Inc.*, Case No. 120920539C (2013). Authored report and provided hearing testimony on behalf of the Missouri Department of Insurance.

A.6. Papers and publications

- "From Rockford to Joplin and Back Again: The Impact of Economics on Hospital Merger Enforcement," *Antitrust Bulletin*, 59, no. 3 (2014): 443–78.
- "Healthcare Provider and Payer Markets" (with David Dranove), *International Handbook of Antitrust Economics*, Roger Blair and Daniel Sokol, eds., chap. 4. New York: Oxford University Press, 2014.
- "The Economists' Supreme Court Amicus Brief in the Phoebe Putney Hospital Acquisition Case" (with David Dranove, Marty Gaynor, Robert Town, and others), Introduction by Robert Town, *Health Management, Policy and Innovation* 1, no. 1 (2012): 60–71.
- "Strategic Analysis of HHS Entry into the Long Term Care Insurance Market under the CLASS Plan" (with Leemore Dafny and David Dranove), White paper, *Centers for Medicare and Medicaid Services*, 2011.
- "Price Implications of Hospital Consolidation," *The Healthcare Imperative: Lowering Costs and Improving Outcomes*, Ch. 5, Institute of Medicine of the National Academies (2010): 177–187.
- "Buyer Power in Health Plan Mergers," *Journal of Competition Law and Economics* 6, no. 2 (2010): 375–91.
- "Hospital Closures and Economic Efficiency" (with David Dranove and Richard Lindrooth), *Journal of Health Economics* 29, no. 1 (2010): 87–109.
- "A Competitive Process for Procuring Health Services" (with Leemore Dafny and David Dranove), *University of Calgary SPP Research Papers: The Health Series* 2, no. 5 (2009).
- "Defining Hospital Markets for Antitrust Enforcement: New Approaches and Their Applicability to The Netherlands" (with Marco Varkevisser and Frederik T. Schut), *Health Economics, Policy and Law* 3, no. 1 (2008): 7–29.
- "Patient Admission Patterns and Acquisitions of 'Feeder' Hospitals" (with Sayaka Nakamura and David Dranove), *Journal of Economics and Management Strategy* 16, no. 4 (2007): 995–1030.
- "Hospital Consolidation and Negotiated PPO Prices" (with David Dranove), *Health Affairs*, Mar./Apr. 2004, 175–81.
- "Competition and Market Power in Option Demand Markets" (with David Dranove and Mark Satterthwaite), *RAND Journal of Economics* 34, no. 4 (2003): 737–63.
- "Geographic Market Definition in Hospital Merger Cases" (with David Dranove, Shane Greenstein, and Mark Satterthwaite), Joint Statement before the *Federal Trade Commission and Department of Justice Hearings on Health Care and Competition Law and Policy*, Apr. 2004.
- "Antitrust Policy and Hospital Mergers: Recommendations for New Approaches" (with David Dranove, Shane Greenstein, and Mark Satterthwaite), *Antitrust Bulletin*, Winter 2002, 677–714.

- "The Silent Majority Fallacy of the Elzinga-Hogarty Criteria: An Application to Hospital Mergers" (with David Dranove, Shane Greenstein, and Mark Satterthwaite), *NBER Working Paper* No. 8216, Nov. 2002.

A.7. Working papers

- "Economic Analysis of Tying and Bundling in Healthcare Cases"
- "Antitrust Treatment of Nonprofits," with Dennis Carlton and Guy David

A.8. Recent presentations and panels

- Excellus BlueCross BlueShield, "Healthcare Competition in an Era of Reform," Rochester, NY, October 2014
- AHLA Annual Meeting, "Payer Transactions and Consolidations," New York, NY, June 2014
- National Academy of Social Insurance, "Can Antitrust Policy Address Pricing Power in Health Care Markets?" Washington, DC, June 2014
- ABA Section of Antitrust Law, "Diagnosing Retrospective Studies in Hospital Merger Enforcement," Washington, DC, April 2014
- Kaiser Permanente Industrial Organization and Healthcare Workshop, Washington DC, November 2013
- Catalyst for Payment Reform Market Power Summit, "Approaches to Monitoring Provider Consolidation and its Impact on Health Care Costs and Quality," Washington, DC, June 2013
- AHIP National Policy Forum, "Hospital Consolidation: The Good, the Bad and the Ugly," Washington, DC, March 2013
- Robert Wood Johnson Foundation Changes in Health Care Financing and Organization Initiative, "How Do Health Insurer Market Concentration and Bargaining Power with Hospitals Affect Health Insurance Premiums?" Washington, DC, November 2012
- Kellogg School of Management Business of Healthcare Conference, "Healthcare Consumerism and Accountability," Evanston, IL, November 2012
- Federal Trade Commission Microeconomics Conference, "Economics of Hospital Competition," Washington, DC, November 2012
- 10th Annual Southeastern Health Economics Study Group, Fairfax, VA, October 2012

- Catalyst for Payment Reform, "Expert Panel Discussion on Provider Market Power and Enhancing Competition," Washington, DC, June 2012
- ABA/AHLA Antitrust in Healthcare Conference, "New Economic Toolkit for Assessing Hospital Mergers," Washington, DC, May 2012
- American Health Lawyers Mid-Year Luncheon, "The Role of Economic Analysis in Healthcare Antitrust," Orlando, FL, February 2012
- The National Congress on Health Insurance Reform, "Antitrust—Making The Market Work," Washington, DC, January 2011
- America's Health Insurance Plans, "Accountable Care Organizations and Market Power Issues," Washington, DC, September 2010
- Cooperation and Competition Panel for National Health Service Taking the Temperature: Competition In Healthcare Conference, "Healthcare Antitrust in the United States," London, United Kingdom, September 2010
- American Society of Health Economists, "Antitrust Treatment of Nonprofits: Should Hospitals Receive Special Care?" Ithaca, NY, June 2010
- Antitrust in Healthcare AHLA/ABA Conference, "Tying and Bundling in Healthcare Cases," Washington, DC, May 2010
- National Bureau of Economic Research Healthcare Program Meeting, "Antitrust Treatment of Nonprofits: Should Hospitals Receive Special Care?" Cambridge, MA, March 2010
- Department of Justice, Economic Analysis Group Seminar Series, "Antitrust Treatment of Nonprofits: Should Hospitals Receive Special Care?" Washington, DC, 2009
- Institute of Medicine Workshop, The Healthcare Imperative: Lowering Costs and Improving Outcomes, "The Approximate Effect of Hospital Consolidation on National Healthcare Expenditures," Washington, DC, May 2009
- 57th ABA Antitrust Law Spring Meeting, "Economic Analysis of Buyer Power in Health Plan Mergers," Washington, DC, March 2009
- American Health Lawyers Association Antitrust Practice Group, "Economic Perspective on Vertical Integration in Health Care and Antitrust," Washington, DC, February 2009

A.9. Distinctions and honors

- *International Who's Who of Competition Economists*, 2012–present
- *Best Empirical Work by an EAG Staff Economist*, Department of Justice Economic Analysis Group, June 2005

- Dissertation Year Fellow, Northwestern University
- Phi Beta Kappa
- *Magna cum laude*, University of Texas at Austin

A.10. Courses taught

- Intermediate Microeconomics
- Industrial Organization (PhD)
- Competition and Strategy in Technology Markets (MBA)
- Strategy and Organizations (MBA)
- Healthcare Markets (MBA)

A.11. Professional associations

- American Economic Association
- Industrial Organization Society
- American Health Lawyers Association
- International Health Economics Association

A.12. Referee

- *B.E. Journal of Economic Analysis & Policy*
- *Health Affairs*
- *International Journal of the Economics of Business*
- *Journal of Economics and Management Strategy*
- *Journal of Health Economics*
- *Journal of Industrial Economics*
- *Journal of Law and Economics*
- *RAND Journal of Economics*

Appendix B. Additional exhibits

B.1. Medigap Policy Search results for zip code 18503

B.1.a. Medigap Plan A

Figure 10. Insurers providing Medigap Plan A products to residents of zip code 18503

Company	Pricing method	Notes
AARP HealthCare Options (United Healthcare Insurance Company)	Community-Rated	Individual and Group Plans
Aetna Life Insurance Co	Attained-Age-Rated	Individual Plan
American Continental Insurance Company	Attained-Age-Rated	Individual Plan
American Progressive Life & Health Insurance Co. of NY	Attained-Age-Rated	Individual Plan
American Republic Corp. Ins.	Information Not Available	Individual Plan
American Republic Insurance Company/United Savers Association	Attained-Age-Rated	Individual Plan
American Retirement Life Insurance	Information Not Available	Individual Plan
Assured Life Association	Attained-Age-Rated	Individual Plan
Avalon Insurance Co.	Information Not Available	Individual Plan
Bankers Fidelity Life Insurance Co	Issue-Age-Rated	Individual Plan
Blue Cross of Northeastern PA (Hospital Service Association)	Issue-Age-Rated	Individual Plan
Capital Blue Cross/Capital Advantage Insurance Co	Issue-Age-Rated	Individual Plan
Central States Indemnity Co. of Omaha	Attained-Age-Rated	Individual Plan
Colonial Penn Life Insurance Co (formerly Conseco Direct Life Insurance Co)	Information Not Available	Individual Plan
Columbian Mutual Life Insurance Company	Information Not Available	Individual Plan
Combined Insurance Company of America	Issue-Age-Rated	Individual Plan
Continental General Insurance Company	Attained-Age-Rated	Individual Plan
Equitable Life & Casualty Insurance Co	Attained-Age-Rated	Individual Plan
Everence Association Inc.	Issue-Age-Rated	Enrollment open to people eligible for membership in the association, a fraternal benefit society.
Family Life Insurance Company	Information Not Available	Individual Plan
Forethought Life Insurance Company	Information Not Available	N/A
Geisinger Indemnity Insurance Company	Information Not Available	N/A
Gerber Life Insurance Co	Information Not Available	Individual Plan
Globe Life & Accident Insurance Company	Attained-Age-Rated	Individual and Group Plans
Governmental Personnel Mutual Life Insurance Company	Information Not Available	Individual Plan
Highmark Blue Cross Blue Shield	Attained-Age-Rated	Individual Plan
Highmark Inc. d/b/a Highmark Blue Shield	Attained-Age-Rated	Individual Plan
Humana Insurance Company	Attained-Age-Rated	Individual Plan
Independence Blue Cross	Issue-Age-Rated	Individual and Group Plans
KSKJ American Slovenian Catholic Union	Information Not Available	Individual Plan

Company	Pricing method	Notes
Liberty National Life Insurance Co	Information Not Available	Individual Plan
Loyal American Life Insurance Company	Attained-Age-Rated	Individual Plan
Madison National Life Insurance Company, Inc.	Information Not Available	Individual Plan
Manhattan Life Insurance Company	Information Not Available	Individual Plan
Marquette National Life Insurance	Attained-Age-Rated	Individual Plan
Medico Insurance Company	Attained-Age-Rated	Individual Plan
New Era Life Insurance Companies	Attained-Age-Rated	Individual Plan
Order of United Commercial Travelers of America	Attained-Age-Rated	Individual Plan
Oxford Life Insurance Company	Information Not Available	Individual Plan
Philadelphia American Life Insurance Co	Information Not Available	Individual Plan
Physicians Mutual Insurance Co	Information Not Available	Individual Plan
Royal Neighbors of America	Issue-Age-Rated	Individual Plan
Standard Life and Accident Insurance Company	Attained-Age-Rated	Individual Plan
Standard Security Life Insurance Company of New York	Information Not Available	Individual Plan
State Farm Mutual Auto Insurance Co	Attained-Age-Rated	Individual Plan
Sterling Investors Life Insurance	Attained-Age-Rated	Individual Plan
Sterling Life Insurance Co	Attained-Age-Rated	Individual Plan
Stonebridge Life Insurance Company (formerly JC Penney Life Insurance Company)	Information Not Available	Individual Plan
Thrivent Financial for Lutherans	Attained-Age-Rated	Individual Plan
Transamerica Life Insurance Company (formerly PFL Life Insurance Company)	Issue-Age-Rated	Group Plan
United American Insurance Co	Community-Rated	Individual Plan
United American Insurance Co	Issue-Age-Rated	Individual Plan
United of Omaha Life Insurance Company	Information Not Available	Individual Plan
United World Life Insurance Company	Attained-Age-Rated	Individual Plan
UPMC Health Plan	Attained-Age-Rated	Individual Plan
USAA Life Insurance Co	Attained-Age-Rated	Individual Plan
World Insurance Co	Attained-Age-Rated	Individual Plan

Source: Search of http://www.medicare.gov/find-a-plan/questions/medigap-home.aspx for plans available in Scranton, Pennsylvania, zip code 18503.

B.1.b. Medigap Plan C

Figure 11. Insurers providing Medigap Plan C products to residents of zip code 18503

Company	Pricing method	Notes
AARP HealthCare Options (United Healthcare Insurance Company)	Community-Rated	Group Plan
American Progressive Life & Health Insurance Co. of NY	Attained-Age-Rated	Individual Plan
American Republic Insurance Company/United Savers Association	Attained-Age-Rated	Individual Plan
Assured Life Association	Attained-Age-Rated	Individual Plan
Avalon Insurance Co.	Information Not Available	Individual Plan
Blue Cross of Northeastern PA (Hospital Service Association)	Issue-Age-Rated	Individual Plan
Capital Blue Cross/Capital Advantage Insurance Co	Issue-Age-Rated	Individual Plan
Central States Indemnity Co. of Omaha	Attained-Age-Rated	Individual Plan
Columbian Mutual Life Insurance Company	Information Not Available	Individual Plan
Everence Association Inc.	Attained-Age-Rated	Enrollment open to people eligible for membership in the association, a fraternal benefit society.
Family Life Insurance Company	Information Not Available	Individual Plan
Forethought Life Insurance Company	Information Not Available	N/A
Geisinger Indemnity Insurance Company	Information Not Available	N/A
Gerber Life Insurance Co	Information Not Available	Individual Plan
Globe Life & Accident Insurance Company	Attained-Age-Rated	Individual and Group Plans
Governmental Personnel Mutual Life Insurance Company	Information Not Available	Individual Plan
Highmark Blue Cross Blue Shield	Attained-Age-Rated	Individual Plan
Highmark Inc. d/b/a Highmark Blue Shield	Attained-Age-Rated	Individual Plan
Humana Insurance Company	Attained-Age-Rated	Individual Plan
Independence Blue Cross	Issue-Age-Rated	Individual and Group Plans
KSKJ American Slovenian Catholic Union	Information Not Available	Individual Plan
Loyal American Life Insurance Company	Attained-Age-Rated	Individual Plan
Manhattan Life Insurance Company	Information Not Available	Individual Plan
New Era Life Insurance Companies	Attained-Age-Rated	Individual Plan
Order of United Commercial Travelers of America	Attained-Age-Rated	Individual Plan
Oxford Life Insurance Company	Information Not Available	Individual Plan
Philadelphia American Life Insurance Co	Information Not Available	Individual Plan
Standard Life and Accident Insurance Company	Attained-Age-Rated	Individual Plan
State Farm Mutual Auto Insurance Co	Attained-Age-Rated	Individual Plan
Sterling Investors Life Insurance	Attained-Age-Rated	Individual Plan
Sterling Life Insurance Co	Attained-Age-Rated	Individual Plan
Thrivent Financial for Lutherans	Attained-Age-Rated	Individual Plan

Company	Pricing method	Notes
Transamerica Life Insurance Company (formerly PFL Life Insurance Company)	Issue-Age-Rated	Group Plan
United American Insurance Co	Community-Rated	Individual Plan
United American Insurance Co	Issue-Age-Rated	Individual Plan
United of Omaha Life Insurance Company	Information Not Available	Individual Plan
United World Life Insurance Company	Attained-Age-Rated	Individual Plan
World Insurance Co	Attained-Age-Rated	Individual Plan

Source: Search of http://www.medicare.gov/find-a-plan/questions/medigap-home.aspx for plans available in Scranton, Pennsylvania, zip code 18503.

B.2. FEHB plans available in Pennsylvania

Figure 12. FEHB plans available to Pennsylvania federal employees ("open to all" plans only)

Type	Plan
National Plans	Blue Cross and Blue Shield Service Benefit Plan Nationwide (Basic)
	Blue Cross and Blue Shield Service Benefit Plan Nationwide (Standard)
	GEHA Benefit Plan Nationwide
	NALC Nationwide
	GEHA High Deductible Health Plan Nationwide
	MHBP - Value Plan Nationwide
	SAMBA Nationwide
	MHBP - Std Nationwide
	APWU Health Plan Nationwide
	MHBP - Consumer Option Nationwide
	NALC Value Option Nationwide
State-specific plans	Aetna HealthFund All of Pennsylvania
	HealthAmerica Pennsylvania Greater Pittsburgh Area
	UPMC Health Plan Western Pennsylvania
	Geisinger Health Plan Northeastern/Central/South Central areas
	Aetna HealthFund CDHP and Value Plan All of Pennsylvania
	Aetna Open Access Philadelphia
	UPMC Health Plan Western Pennsylvania
	HealthAmerica Pennsylvania - HDHP Greater Pittsburgh Area
	Aetna Open Access Pittsburgh and Western PA Areas

Source: United States Office of Personnel Management, "2014 Plan Information for Pennsylvania," accessed Jan. 27, 2014, http://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-codes/2014/states/pa.asp.

Note: Excludes "plans open only to specific groups." Not all state-specific plans are available throughout Pennsylvania.

Divider Page

THE PROPOSED MERGER OF HIGHMARK INC.
AND
HOSPITAL SERVICE ASSOCIATION OF NORTHEASTERN PENNSYLVANIA
(D/B/A BLUE CROSS OF NORTHEASTERN PENNSYLVANIA)

ANALYSIS OF EFFICIENCIES

CORY S. CAPPS, PHD

December 23, 2014

Table of contents

I. Executive summary 1

II. Regulatory framework 5

III. Health plan cost drivers 7
- III.A. Components of the cost of health insurance 7
- III.B. How health plans can reduce healthcare spending 8

IV. Likely savings from reduced administrative costs 9
- IV.A. Administrative costs and medical loss ratios 11
- IV.B. The savings potential from administrative cost reductions exceeds $25 million annually 12
  - IV.B.1. Administrative cost comparison 12
  - IV.B.2. A merger with Highmark is superior to other options 13
- IV.C. Sources of Highmark's administrative efficiency 14
- IV.D. Highmark's experience in West Virginia and Delaware 17
- IV.A. Highmark's administrative costs for its Medicare Advantage products in Pennsylvania 19

V. Highmark and BCNEPA pharmacy spending analysis 21

VI. Savings from advances in medical management 22
- VI.A. Most investments in medical management exhibit economies of scale 22
- VI.B. BCNEPA's medical management initiatives 25
- VI.C. Highmark's medical management programs 27
  - VI.C.1. Measuring and rewarding value in Highmark's PCMHs and Alliances 32
  - VI.C.2. Tools and support for PCMH and Alliance providers 34
- VI.D. Implications 35

VII. Efficiencies from the transaction will benefit consumers 37
- VII.A. The merger is likely to ameliorate and then reverse BCNEPA's operating loss 37
- VII.B. Lower administrative costs and improved medical management benefit consumers 37
- VII.C. Capital cost avoidance 39

List of figures

Figure 1. Itemization of medical spending, privately insured population in 2012.....7
Figure 2. Comparison of annual administrative savings estimates 15
Figure 3. Illustration of ROI calculation for a medical management initiative 25
Figure 4. Comparison of *Joint Principles* for PCMHs with Highmark's PCMH model.....28
Figure 5. Highmark quality measures for PCMH and Alliance providers.....33
Figure 6. Highmark quality score calculation.....34

I. Executive summary

(1) This public report presents the materials contained in two reports on efficiencies that I submitted to the Pennsylvania Insurance Department (PID) on June 9, 2014, and October 31, 2014.[1]

(2) In this report, I analyze efficiencies likely to be realized by Highmark Inc. (Highmark) should it merge with and integrate Hospital Service Association of Northeastern Pennsylvania, d/b/a Blue Cross of Northeastern Pennsylvania (BCNEPA). For an insurer, efficiencies are changes that reduce the costs of providing health insurance coverage, improve the quality of medical services rendered, or both. Cost reductions can occur through several channels: (1) reductions in the administrative costs of operating an insurance company, (2) more favorable pricing of healthcare goods and services, such as prescription drugs, and (3) programs that reward improved medical decision-making and better align incentives along the continuum of care, such as through replacing payments based on the volume of services rendered—i.e., fee-for-service—with payments based on the quality and efficiency of services rendered. I use the term "medical management" to describe this category of efficiencies.

(3) I find that, in each category, the merger is likely to create significant efficiencies that will benefit consumers. Moreover, as I showed in my previous report on competition, there are no substantial competitive concerns that might weigh against these benefits.[2] I summarize my conclusions for each category of efficiencies in this executive summary and I provide details in the body of this report.

(4) **Administrative cost savings.** Dating back to at least 2011, BCNEPA has known that its administrative costs are high, yet it has been unable to reduce those costs. Over time, replacing BCNEPA's high administrative costs with Highmark's lower administrative costs will generate substantial, recurring savings.

- Based on my analysis of Centers for Medicare & Medicaid Services (CMS) data on health plans' membership, administrative costs, and medical expenditures, I find that in 2013, per member per month (PMPM) administrative costs for First Priority Health (FPH) and First Priority Life Insurance Company (FPLIC) were 42% higher than those of Highmark.
- Replacing BCNEPA's administrative cost structure with Highmark's would result in administrative cost savings of about $25 million annually for FPH and FPLIC. This range of potential savings is based on my analysis of CMS data; it is also consistent with internal analyses

[1] Cory S. Capps, PhD, "The Proposed Merger of Highmark Inc. and Hospital Service Association of Northeastern Pennsylvania (D/B/A Blue Cross of Northeastern Pennsylvania): Analysis of Efficiencies," June 9, 2014; Cory S. Capps, PhD, "Supplement to the Analysis of Efficiencies," Oct. 31, 2014.

[2] Cory S. Capps, PhD, "The Proposed Merger of Highmark Inc. and Hospital Service Association of Northeastern Pennsylvania (D/B/A Blue Cross of Northeastern Pennsylvania)," Dec. 23, 2014 [hereinafter Capps Competition Report].

by Highmark. In addition, given that BCNEPA's operations other than FPH and FPLIC are similar in nature and use shared resources, it is likely that efficiencies that accrue to FPH/FPLIC would carry over to other BCNEPA operations.

- BCNEPA is already partially integrated with Highmark through BCNEPA's use of Highmark's platform for claims processing and because of the parties' two equity joint ventures, FPH and FPLIC. This is likely to facilitate more rapid realization of efficiencies from the merger.
- Consistent with the ability to leverage its information technology (IT) platform and business processes to achieve lower administrative costs even where it lacks the scale that it has in Western Pennsylvania, Highmark's Freedom Blue Medicare Advantage product (offered in all of Pennsylvania except the Philadelphia area) has similar administrative costs in the Western, Central, and Northeastern regions of Pennsylvania. This pattern indicates that Highmark can realize comparable administrative costs both in areas where it has a high number of enrollees and areas where it has fewer enrollees.
- Not all of the administrative cost savings will accrue immediately upon completion of the merger; rather, they are likely to accumulate over time, as BCNEPA's operations are integrated into Highmark's platform.
- BCNEPA projects significant operating losses for FPH and FPLIC through at least 2017. BCNEPA cannot sustain those losses indefinitely: it must eventually either lower its costs or increase its premiums. Indeed, the loss projections for FPH and FPLIC already incorporate expected premium increases in 2015. Further sharp premium increases in years after 2015 would likely be necessary to eliminate FPH/FPLIC's operating loss. In contrast, given its lower cost structure, as the integration proceeds and administrative costs fall, Highmark likely would not need to increase premiums at the same rate as BCNEPA in order to eliminate projected operating losses. This would benefit employers and enrollees in the BCNEPA Service Area.

(5) **Improved prescription drug pricing.** Highmark recently completed a request-for-proposal process and has signed a new pharmacy benefits management contract. Because the new Highmark contract has more favorable drug pricing than the most comparable BCNEPA contract, extension of Highmark's contract to the BCNEPA Service Area is likely to reduce spending on prescription drugs by more than $5 million annually.

(6) **Improved medical management.** Although both Highmark and BCNEPA have programs designed to reward providers for improving the efficiency and quality of care, Highmark's programs are more advanced and have stronger cost and quality incentives for providers than BCNEPA's. A likely and significant efficiency of the proposed merger is that it would bring these programs and greater capabilities to the BCNEPA Service Area more rapidly and at lower cost than could otherwise be achieved, just as Highmark has done in West Virginia and Delaware. Reductions in the costs of care directly benefit employers and end-consumers through lower premiums, lower medical expenditures,

and lower cost-sharing. Quality improvements provide a direct benefit to health plan enrollees. Selected findings related to medical management include the following:

- Investments in medical management generally exhibit economies of scale—programs that would not be cost-effective for a smaller health plan, such as BCNEPA, to undertake can be cost-effective for a larger health plan, such as Highmark, to pursue. That is, lack of scale is one important reason that BCNEPA's medical management programs are behind Highmark's.
- Highmark's patient-centered medical home (PCMH) pilot, launched in 2011, achieved a 2% reduction in PMPM medical costs for participants, as well as fewer inpatient admissions and re-admissions. As a result of the success of the pilot, in 2012 Highmark moved the program out of the pilot stage and into full implementation, first in Pennsylvania and then in West Virginia and Delaware. As of April 2014, nearly 900,000 Highmark enrollees were in a PCMH. Highmark has also introduced Accountable Care Alliances (Alliances), which extend the PCMH model to include not just primary care physicians but also hospitals and specialists.
- Based on 2012 data, a 2% reduction in the costs of care for BCNEPA's FPH and FPLIC enrollees—the reduction Highmark achieved under its PCMH pilot—would result in savings of more than $10 million per year.
- On November 1, 2013, BCNEPA launched its initial Patient Centered Medical Home (PCMH) pilot. The pilot will continue through the end of 2015. Because it was launched so recently, results are not yet available.
- In 2011, BCNEPA extended its Quality Incentive Program (QIP) for physicians from just HMO products (i.e., FPH) to PPO products (i.e., FPLIC). However, in comparison to Highmark's PCMH and Alliance models, a substantially smaller percentage of physician compensation is based upon quality and efficiency performance under BCNEPA's QIP.
- BCNEPA's comparatively modest physician incentive is diluted because it is only payable on BCNEPA's controlled enrollees, not BlueCard enrollees who reside in the BCNEPA Service Area. This is because professional services for BlueCard enrollees in the BCNEPA Service Area are governed by physicians' contracts with Highmark, not BCNEPA. The merger would eliminate this schism.

(7) These types of efficiencies—i.e., reductions in the administrative and medical costs to serve BCNEPA enrollees—are likely to translate into lower rates of premium growth and improved plan offerings for consumers than would otherwise prevail. For example, premium levels that are not sustainable for BCNEPA because they are projected to generate current and future operating losses would be sustainable under Highmark's lower administrative cost structure. Reductions in medical expenditures, through reduced prescription drug spending and improved medical management, are similarly likely to facilitate lower premiums than would otherwise prevail. In addition, quality improvements, by their very nature, will benefit enrollees.

(8) Finally, by its own account, BCNEPA's information technology infrastructure is outdated and fragmented. The merger is likely to modernize BCNEPA's information technology infrastructure at a much lower cost than BCNEPA could achieve on its own. In 2011, a national consultant retained by BCNEPA estimated that updating its infrastructure would require BCNEPA to make an initial investment of $27 million and to incur annual expenses of $10.5 million to $15.7 million, for a total of about $75 million to $100 million over five years. The costs of integrating BCNEPA into Highmark, which Highmark estimates at $64 million, are well below this level. Thus, in addition to recurring savings from administrative and medical cost efficiencies, the merger is likely to also generate significant one-time savings from a net reduction in capital expenditures.

II. Regulatory framework

(9) In my report dated December 23, 2014, I analyzed the extent of competitive overlap between Highmark and BCNEPA under the framework contained within Article XIV of the Pennsylvania Insurance Company Law, as well as the economics of competition in health insurance and related markets.[3] I analyzed both commercial and noncommercial products and concluded that the merger would neither substantially lessen competition in any line of insurance nor tend to create a monopoly.

(10) Article XIV also includes a provision related to the efficiencies stemming from a merger:[4]

> An order [disapproving the application] may not be entered under subsection (e)(1) if:
>
> (i) the acquisition will yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way, and the public benefits which would arise from such economies exceed the public benefits which would arise from not lessening competition; or
>
> (ii) the acquisition will substantially increase the availability of insurance, and the public benefits of such increase exceed the public benefits which would arise from not lessening competition.

(11) Consistent with the statute, in this report, I evaluate the efficiencies or synergies—e.g., economies of scale and economies of resource utilization—that the merger is likely to create. I also evaluate the extent to which such efficiencies are unlikely to be achieved through means other than Highmark's merger with BCNEPA. Economically, if the merger satisfies criterion (i) and at least some of the efficiencies are likely to be passed on to consumers, then criterion (ii) will necessarily also be satisfied. This is because cost savings that are passed on to consumers will result in lower premiums than would otherwise prevail and, thereby, will increase the availability of insurance. The statute requires only that either of the two criteria be satisfied, not both; however, as I show in this report, both are likely to be satisfied.

(12) Both of the above statutory criteria call for a balancing between the benefits of allowing a merger to close and the benefits of not allowing a merger to close. If the benefits of allowing the merger to close exceed the benefits of not doing so, then the statute indicates that the merger should not be disapproved. There would be benefits from not allowing the merger to close if the merger would result in a lessening of competition (the benefit would be the avoidance of adverse effects from a

[3] Capps Competition Report.

[4] 40 P.S. § 991.1403(d)(3) (1992). The statute encompasses mergers as well as acquisitions.

lessening of competition). In the specific case of Highmark's proposed merger with BCNEPA, competition between Highmark and BCNEPA is negligible. Therefore, the "public benefits which would arise from not lessening competition" are also negligible. In contrast, the merger does offer "substantial economies of scale or economies in resource utilization" (i.e., efficiencies) and increased "availability of insurance." Thus, the balancing entails, on the one hand, large benefits from allowing the merger to close and, on the other hand, negligible if any benefits from not doing so. When this applies, as it does with respect to Highmark's proposed merger with BCNEPA, the statute indicates that the merger should not be disapproved.

III. Health plan cost drivers

III.A. Components of the cost of health insurance

(13) The premiums associated with a health plan or, in the case of self-funded entities, the expected total costs of providing health insurance coverage to enrollees, are the sum of medical costs and non-medical costs. Major categories of medical costs include payments to physicians, hospitals, and other service providers, as well as payments for prescription drugs, lab work, and durable medical equipment. Figure 1 shows the breakdown of these components of spending among the privately insured population (most lab work is included in the "physician and clinical services" category).

Figure 1. Itemization of medical spending, privately insured population in 2012

Medical expenditure category		Spending ($ million)	Percentage of total medical expenditures
Hospital care		**$320,889**	**39.8%**
Professional services	*Physician and clinical services*	$258,345	32.0%
	Other professional services	$28,237	3.5%
	Dental services	$53,370	6.6%
	SUBTOTAL	**$339,952**	**42.1%**
Other service providers	*Other health, residential, and personal care*	$6,855	0.8%
	Home healthcare	$5,582	0.7%
	Nursing care and retirement facilities	$12,033	1.5%
	SUBTOTAL	**$24,470**	**3.0%**
Medical products	*Prescription drugs*	$117,027	14.5%
	Durable medical equipment	$4,688	0.6%
	Other nondurable medical products	n/a	0.0%
	SUBTOTAL	**$121,715**	**15.1%**
Total Medical Expenditures		**$807,026**	**100.0%**

Source: CMS National Health Expenditure Accounts, 2012.

(14) Total medical cost is driven by three primary factors: (1) the site or level of service, (2) the volume of and quality of services rendered, and (3) the applicable unit prices. The site or level of service describes where care is delivered and by whom; examples include inpatient versus outpatient, physician versus physician extender, surgical versus medical intervention, and home care versus facility-based care. The applicable unit prices are the costs of each unit of services rendered (e.g., a per diem rate for an inpatient stay, or the conversion factor for physician services).

(15) The total cost of health insurance is the sum of medical expenses and non-medical expenses. The latter category is the net cost of health insurance, which CMS defines as including "compensation of the employees that are administering the insurance, capital costs, taxes, other costs (such as rent, advertising, certain commissions, etc.), and, in some cases, changes to reserves and underwriting gains or losses."[5]

III.B. How health plans can reduce healthcare spending

(16) The itemization of spending components in the prior section illustrates the mechanisms by which a health plan can reduce healthcare expenditures:

- Reducing non-medical expenditures. This category includes reductions in operational costs from realizing economies of scale, reductions in employees (i.e., full-time equivalents, or FTEs), improved management and infrastructure, and other savings from shared overhead. I discuss this category of savings in section IV.
- Reducing medical expenditures.
  - *Reductions in unit prices*. Price decreases will reduce the costs of rendering any given amount of healthcare services. I address savings likely to arise from lower unit prices for prescription drugs in section V.
  - *Improved medical management*. Generally, medical management refers to programs aimed at reducing wasteful utilization of healthcare services. Medical management can occur through efforts to change provider incentives (e.g., pay for performance), through efforts to change patient incentives (e.g., high-deductible plans), and through utilization management (e.g., prior authorization and referral requirements). I address likely savings related to medical management in section VI.

[5] CMS, "National Health Expenditures Accounts: Methodology Paper," 2012, 38.

IV. Likely savings from reduced administrative costs

(17) Both Highmark and BCNEPA have identified increased efficiency as a primary motivation for the merger. For example, BCNEPA stated that two of the major business objectives of a transaction are to increase scale to optimize administrative infrastructure/costs and to avoid/reduce capital investment required to ready BCNEPA for the post Health Care Reform environment. As another example, a November 2011 presentation prepared by a national consultant retained by BCNEPA to recommend strategies to enhance BCNEPA's long-term prospects concluded that, under any scenario, it was imperative that BCNEPA significantly reduce its administrative costs. However, the same cost problem that existed for BCNEPA in 2011 has continued to the present.

(18) As I explain in this section, a number of factors indicate that the merger with Highmark is likely to reduce the administrative costs of serving BCNEPA's enrollees.

- 2013 data on PMPM administrative costs from the CMS show that Highmark's administrative costs are significantly below those of BCNEPA. Were BCNEPA to serve its FPH and FPLIC enrollees under Highmark's administrative cost structure, total administrative costs would fall by more than $25 million per year. CMS data for 2011 and 2012 generate the same conclusion.
- Consistent with my analysis of CMS data, Highmark's internal evaluation of the administrative cost savings potential indicates that Highmark expects administrative cost savings to grow over time to $30 million per year as the integration progresses.

(19) Because Highmark intends to migrate the entirety of BCNEPA's business functions to the Highmark information technology platform, Highmark's cost structure is, ultimately, likely to apply to BCNEPA. That is, Highmark will apply the same systems and processes that it already uses to serve its existing enrollees to BCNEPA's enrollees.

(20) However, although substantial in magnitude, the likely savings will take time to be realized fully. Insofar as Highmark is able to grow BCNEPA's enrollment more quickly, PMPM administrative costs are likely to fall more rapidly.

(21) As noted, BCNEPA has been aware that its administrative costs have been high since at least 2011, but it has been unable to meaningfully lower those costs. This indicates that incremental measures on the part of BCNEPA are unlikely to reduce its administrative costs. For example, outsourcing appears to be insufficient—BCNEPA already sources some information technology functions, primarily claims processing, to Highmark, yet BCNEPA's administrative costs have remained high.[6]

[6] BCNEPA uses Highmark's IT systems for claims processing and certain other functions. BCNEPA personnel and not

(22) Therefore, a solution to BCNEPA's high costs is likely to require a more substantial restructuring. One possibility is for BCNEPA to remain independent and invest in upgrading its systems so that it can increase efficiency and expand its capabilities. In 2011, a national consultant retained by BCNEPA estimated that doing so would require an initial investment of $27 million and recurring annual expenses of $10.5 million to $15.7 million, or about $75 million to $100 million over five years. These investments would be required for BCNEPA to add the capabilities necessary for compliance with the Affordable Care Act (ACA), implement accountable care principles and programs, improve customer service, and generally modernize its information technology infrastructure.

(23) In comparison, Highmark projects that it will spend up to $64 million over three years to complete the merger and integrate BCNEPA's operations into Highmark's platform. Even assuming that Highmark spends the full $64 million, the merger is $11 million to $36 million less expensive than it would be for BCNEPA to remain independent and upgrade its outdated systems. Highmark's projection of up to $64 million in merger and integration costs appears reasonable, because Highmark's actual costs of integrating BCBS of Delaware were $61 million, and BCNEPA's integration costs are likely to be below those for BCBS of Delaware, for two reasons. First, unlike BCBS of Delaware, BCNEPA already uses Highmark's platform for claims processing. Second, Highmark has a high degree of existing familiarity with BCNEPA. It has gained that from its minority ownership of FPH and FPLIC and from its even longer running cooperation with BCNEPA on jointly offered products (i.e., products in which BCNEPA administers the facility component and Highmark the professional component).[7]

(24) Because Highmark does not control BCNEPA's operations, many BCNEPA business functions and much of its infrastructure will be redundant after the merger. Efficiencies are likely to accrue through several channels. First, redundant staff from either company will be assigned new job functions, either serving legacy BCNEPA functions or Highmark enterprise-wide functions, if suitable alternatives are available, or, if such alternatives are not reasonably available, eliminated. Second, less effective business processes will be replaced by more efficient business processes. BCNEPA continues to have high administrative costs and to forecast significant ongoing operational losses for FPH and FPLIC (it would be irrational for Highmark to pursue the merger if it did not expect to reverse these losses). Third, duplicative IT infrastructure and other overhead will be eliminated. Over time, as Highmark assumes control of BCNEPA's operations and migrates BCNEPA's business functions to the Highmark IT platform, it is likely that Highmark's cost structure will increasingly apply to BCNEPA.

Highmark's actually use the systems, with the exception that Highmark personnel are responsible for maintaining the functionality of those systems.

[7] Capps Competition Report, §§ III, IV.B.3, VII.A.2, VII.C.

(25) In short, a merger with Highmark is less costly than the alternative of BCNEPA remaining independent. Not only is the up-front cost lower, but the execution risk is also lower. This is because the merger will transition BCNEPA's operations to Highmark's established, lower-cost platform rather than to a newly created platform. Moreover, even if BCNEPA did pursue the option of substantial investments in its infrastructure, it would still be operating those systems at a comparatively low scale. In contrast, migrating BCNEPA's operations to Highmark will, increasingly over time, reduce the administrative costs of serving BCNEPA's enrollees and extend Highmark's greater IT capabilities to BCNEPA's enrollees.

(26) Importantly, as I showed in my report on competition, there are no substantial competitive concerns that might offset these benefits.[8]

IV.A. Administrative costs and medical loss ratios

(27) The ACA created new rules requiring health plans to maintain minimum medical loss ratios (MLRs) on their fully-funded business.[9] For purposes of enforcing these MLR limits, the ACA requires insurers to annually submit to CMS certain information needed to compute MLRs. Specifically, insurance companies are required to report data in seven categories: premium revenue, claims (i.e., medical expenditures), taxes and licensing and regulatory fees, costs to improve healthcare quality, other administrative costs, income from fees of self-funded plans (referred to as "uninsured" plans in the CMS MLR instructions), and enrollment. CMS compiles these reports into a publicly available database. This is my primary source of data on administrative costs for Highmark and BCNEPA.

(28) All companies that offer fully-funded comprehensive health insurance products are required to report annual MLRs for their fully-funded business.[10] The CMS database also includes other information not directly used to calculate the MLR, such as enrollment figures and income from fees of self-funded plans. Despite collecting information on self-funded plans, the minimum MLR does not apply to such plans (MLRs are not well defined for self-funded plans, because there are no premiums). Thus, while

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[8] Capps Competition Report, *passim.*

[9] The MLR, a commonly used metric in the health insurance industry, is typically defined as expenses on medical claims (i.e., clinical spending, or medical care costs) expressed as a percentage of the premiums that a health plan collects. For example, if a health plan has an MLR of 84%, then for every $100 in premium revenue that it receives, it spends $84 on the provision of medical care. The remaining $16 is nonmedical expenditure, which consists of administrative costs and gain/loss margin. (The actual CMS formula is more complex, but this illustration reflects the core concept that underlies the MLR.)

The ACA requires insurers to issue rebates to enrollees if the proportion of premium revenue spent on medical services and healthcare quality improvements does not surpass certain minimum MLR standards. The minimum MLR is 80% for the individual and small-group segments and 85% for the large-group segment. Issuer Use of Premium Revenue: Reporting and Rebate Requirements, 45 C.F.R. pt. 158 (2010).

[10] If a company offers fully-funded comprehensive products and offers self-funded products as well, then that insurer must also report data on fees from uninsured plans and some information on self-funded members. This information does not affect MLR calculations or rebates—it is simply additional data collected by CMS.

I examine fully-funded business as well as self-funded business, not all statistics can be calculated for or are applicable to self-funded business.

IV.B. The savings potential from administrative cost reductions exceeds $25 million annually

(29) My administrative cost analysis is focused on PMPM administrative costs for Highmark and BCNEPA.[11] Specifically, I use various components of the CMS MLR data, primarily data on administrative costs, to evaluate Highmark's overhead costs relative to BCNEPA's. I find that Highmark's PMPM administrative costs are well below those of BCNEPA and that the cost savings that would result from replacing BCNEPA's cost structure with Highmark's are substantial—likely over $25 million per year, though the full savings potential will likely be increasingly realized over time. My estimates of potential administrative cost savings are consistent with Highmark's internal analyses.

IV.B.1. Administrative cost comparison

(30) I calculate the savings that would result from serving FPH and FPLIC enrollees at Highmark's administrative costs separately for self-funded and fully-funded customers; total potential savings are the sum of self- and fully-funded savings. For fully-funded business, Highmark's PMPM administrative costs were significantly lower than those of BCNEPA. Multiplying the cost difference by BCNEPA's 1.25 million fully-funded member months in 2013 yields savings of approximately $17 million. Similarly, for self-funded business, Highmark's 2013 PMPM administrative costs were significantly below those of BCNEPA; applied to BCNEPA's 1.45 million self-funded member months, this yields savings of over $13 million. Combined, these fully-funded and self-funded BCNEPA commercial enrollees would generate about $30 million in total administrative costs savings if these FPH and FPLIC enrollees were served under Highmark's administrative cost structure.[12]

(31) One factor that could bias this comparison is the differential accounting for Federal Employee Program (FEP) enrollees by BCNEPA and Highmark. For BCNEPA, the FEP is administered outside of FPH/FPLIC; consequently, FEP costs are not included in my calculation of BCNEPA's administrative costs. In contrast, Highmark serves the majority of its enrollees, including FEP

[11] Examples of administrative costs include claims adjustment expenses, direct sales salaries and benefits, agent and broker fees and commissions, nondeductible taxes, fines and penalties from regulatory authorities, and other general and administrative expenses. Centers for Medicare & Medicaid Services, "Medical Loss Ratio (MLR) Annual Reporting Form for the 2012 MLR Reporting Year Filing Instructions for All Parts," n.d., 37, *available at* http://www.cms.gov/CCIIO/Resources/Files/Downloads/mlr_annual_form_instructions_2012.pdf.

[12] The fully-funded lives are all enrolled in commercial products; self-funded businesses may include small numbers of enrollees in noncomprehensive products such as Medicare Supplement.

enrollees, through a single reporting entity identified in the CMS data as Highmark Inc.[13] If the administrative costs of serving FEP enrollees is different than the costs of serving other enrollees, then including FEP for Highmark but not BCNEPA could bias the comparison of administrative costs. In order to account for this possibility, I use an approximation to remove FEP enrollees from my calculation of Highmark's administrative cost. I find a savings potential of over $25 million per year. This is lower than the estimate that includes Highmark's FEP enrollees, but the annual savings potential remains substantial.[14] CMS data for 2011 and 2012 identify a similar administrative cost gap and therefore generate consistent estimates of potential administrative cost savings.

(32) Scale is likely to be the most significant factor underlying the persistent administrative cost difference between BCNEPA and Highmark: Highmark has over 20 times more self-funded member months and over 10 times more fully-funded member months. Highmark's actual scale advantage relative to BCNEPA is even larger because other Blue plans use Highmark's platform to provide claims processing and other administrative services to their enrollees. Highmark's greater volume allows it to realize economies of scale by distributing its fixed costs more broadly.

(33) These calculations exclude additional savings from scale economies that would flow to Highmark following the merger. Upon completion of the merger, based on the 2013 member months, the merged entity would have nearly 46.0 million member months, a 6% increase over Highmark's current 43 million member months. Because Highmark provides administrative services to other Blue plans, including BCNEPA, the effective increase in scale for Highmark will be positive, but less than 6%.

(34) Not all of the administrative cost savings will accrue immediately upon completion of the merger; rather, they will accumulate over time, as BCNEPA's operations are integrated into Highmark's platform. Finally, these estimates are conservative in that they factor in administrative savings that accrue to FPH and FPLIC but not savings for other, non-FPH/FPLIC BCNEPA products. Although I have not evaluated these savings directly, given that the various components of BCNEPA, FPH/FPLIC, and otherwise have similar operations and share resources, efficiencies that accrue to FPH/FPLIC are likely to carry over more broadly.

IV.B.2. A merger with Highmark is superior to other options

(35) As noted, BCNEPA has known since at least 2011 that its administrative costs are high. Despite this knowledge, BCNEPA's administrative cost disadvantage relative to Highmark has persisted over

[13] The CMS MLR data reports information for three Highmark entities: HM Health Insurance Company, Keystone Health Plan West, Inc., and Highmark Inc.

[14] Another distinction between BCNEPA and Highmark is that BCNEPA administers only the facility component of coverage under the FEP, whereas Highmark administers the professional component statewide and the facility component in the Western Region. This means that, on average, an FEP enrollee is likely more costly for Highmark than for BCNEPA.

time. In 2013, PMPM administrative costs for FPH and FPLIC were 42% higher than Highmark's comparable costs. In 2012, the difference was 57%, and in 2011, the difference was 43%.

(36) BCNEPA's options for addressing its high administrative costs and expanding its capabilities include (1) remaining independent and making substantial investments (estimated by a national consultant retained by BCNEPA to exceed $75 million over five years) and (2) merging with some other plan with more efficient operations and broader capabilities than BCNEPA currently possesses. With respect to the first option, the expected costs of integrating BCNEPA into Highmark are well below the estimated cost to BCNEPA of updating its systems to increase efficiency and expand its capabilities (even so, BCNEPA still would be using such systems at a much lower scale). Building new systems on its own is also likely to be more time consuming and risky for BCNEPA than the merger. Given that Highmark has already entered into joint ventures and outsourcing agreements with BCNEPA, and that Highmark has recent experience integrating Blue plans, Highmark's integration costs are likely to be lower than those of other buyers.

(37) Other evidence also indicates that a merger with Highmark offers substantial administrative cost savings relative to other possible acquirers:

- Highmark's administrative cost advantage relative to other plans, including many other Blue plans, appears to be long-standing. Based on analyses by outside consultants, Highmark's PMPM administrative costs were roughly $4.00 to $6.00 PMPM below the industry average in 2006–2008.
- Highmark's efficiency is also evidenced by the fact that several other Blues use Highmark to provide claims processing and/or other information technology and services.
- A 2013 survey of Blue plans by a national sales and marketing organization evaluated a group of Blue plans on a number of metrics related to their efficiency and capabilities for serving national accounts. Highmark had the highest overall score and the highest (i.e., most favorable) score on "lowest total cost of care"—a metric that captures both administrative efficiency and medical costs. Highmark was also near the top for "care delivery innovation" and "customized solutions" such as value-based benefit designs.

IV.C. Sources of Highmark's administrative efficiency

(38) As part of integration planning, two independent Highmark teams—the cost management team and the due diligence team—each used a different approach to project administrative cost savings. The cost management team reached its conclusions based on a comparison of Highmark's administrative costs in the Central Region of Pennsylvania with BCNEPA's administrative costs. The due diligence team estimated the administrative costs savings potential through a bottom-up approach in which

teams from different business units within Highmark reviewed Highmark and BCNEPA documents and financial reports and evaluated potential savings and risk factors in areas related to each team's expertise. The due diligence team categorized the savings it estimated as either infrastructure savings (non-FTE efficiencies) or staffing savings (FTE efficiencies). Both Highmark teams identified potential administrative cost savings of about $30 million per year—an estimate that is in line with my own evaluation of the potential for administrative cost savings, as described above and summarized in Figure 2. As the integration proceeds, Highmark is likely to realize a greater proportion of this savings potential each year.

Figure 2. Comparison of annual administrative savings estimates

Analysis	Annual savings potential	Basis
CMS MLR data	$25 to $30 million per year	Comparison of PMPM administrative costs as reported to CMS for Highmark, BCNEPA, and other area plans.
Due diligence	$27 million per year	Evaluation by Highmark functional teams, based on Highmark staffing ratios and experiences in WV and DE.
Cost management team	$30 million per year	Highmark comparison of administrative costs in Central PA with FPH and FPLIC administrative costs, with broker costs excluded and an assumed closing of the PMPM cost gap by 60%.

(39) Specific areas of administrative cost savings include the following:

- *Corporate services*. This area includes the executive office, as well as operational departments such as finance, legal, human resources, audit, and actuarial. When the difference between Highmark's administrative cost PMPM in the Central Region and the administrative cost PMPM for FPH/FPLIC is applied to FPH/FPLIC's 235,000 members, the potential annual savings are about $9 million. Highmark expects, over time, to reduce the number of FTEs devoted to these functions, many through normal attrition.
- *Information technology*. In 2013, the difference between FPH/FPLIC's PMPM cost related to IT and Highmark's comparable PMPM cost indicates potential savings of more than $3 million. In addition to these savings, Highmark's more modern and automated infrastructure would supplant BCNEPA's more dated systems.
  - BCNEPA stated that its own IT systems for clinical management infrastructure could require a substantial investment for additional connectivity, and establishing electronic medical records systems for primary care physicians would also require substantial investment. A merger with Highmark, however, is likely to bring these improvements to BCNEPA's

infrastructure at a much lower cost by migrating these functions to Highmark's IT platform. Highmark implemented an analogous IT system migration and upgrade when it affiliated with BCBS of West Virginia and again when it affiliated with BCBS of Delaware.[15]

- The president of Highmark West Virginia credited the affiliation with improving "claims processing, customer service, membership, enrollment utilization management and related [Highmark] systems" for BCBS of West Virginia.[16]
- Blackstone, a consulting firm retained by the Delaware Insurance Commissioner, looked back at the West Virginia affiliation as part of its review of the proposed Delaware affiliation. Blackstone reported that Highmark West Virginia (HMWV) had "experienced full integration with Highmark from an IT platform perspective," which brought enhanced corporate services—such as "product innovation," "pricing/actuarial support," and "National Account support"—to West Virginia.[17]
- With respect to the BCNEPA merger, Highmark's synergy analysis identifies additional post-merger savings of nearly $11.8 million in other data center, IT, and non-staff expense reductions such as hardware, software, and services.

- *Operations*. This category includes claims, customer service, and enrollment and billing. The difference between BCNEPA's and Highmark's related PMPM costs implies potential savings of up to $8.2 million per year.

(40) In total, Highmark projects that it will ultimately be able to serve BCNEPA's current book of business using fewer FTEs than BCNEPA currently uses to administer its business. Highmark expects to execute BCNEPA's current functions with fewer staff by partially or fully centralizing significant portions of BCNEPA's operations, which would allow it to reduce and reassign staff (to and from anywhere within Highmark's many locations) and to shut down obsolete BCNEPA infrastructure. Many BCNEPA employees will likely take on new job functions, either serving legacy BCNEPA functions or providing services across Highmark's enterprise-wide operations.

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[15] Blackstone, as part of its review of the BCBS-DE affiliation, reviewed the West Virginia affiliation. Blackstone observed that "Highmark West Virginia achieved full integration with Highmark incrementally over a 10-year period" and that "**[f]ull systems integration ("Blue Print") and system replacement**" occurred in Phase II of that affiliation. (Emphasis added.) Blackstone, "Report on the Proposed Affiliation between Blue Cross Blue Shield of Delaware and Highmark Inc.," Sept. 13, 2011, 107.

Likewise, with respect to the Delaware affiliation, Blackstone observed that "[a] significant factor in BCBSD's decision to affiliate with Highmark was the ability of Highmark to work with BCBSD on a **comprehensive upgrade of BCBSD's technology systems**." (Emphasis added.) *Id.* at 75.

[16] Direct Testimony at the Hearing of October 5–7, 2011, *In re The Proposed Affiliation of BCBSD, Inc.*, No. 1509-10 (Del. Ins. Comm'r), 8–9. Other noted improvements include "increasing functionality and automation," becoming "more capable of delivering sophisticated benefit plan designs," and having "claims throughput rates [that] increased dramatically, as did [its] capacity to accept claims in an electronic format."

[17] Blackstone, "Report on the Proposed Affiliation between Blue Cross Blue Shield of Delaware and Highmark Inc.," Sept. 13, 2011, 106–109 ("Highmark West Virginia achieved full integration with Highmark incrementally over a 10-year period" and "HMWV has experienced a growth in employees and financial health as a result of its affiliation with Highmark").

(41) These functional consolidations and the accompanying administrative cost savings and expansion of capabilities will not be realized immediately upon completion of the merger; instead, they are likely to accumulate over time, as BCNEPA's operations are integrated into Highmark's platform.

(42) In addition to annual savings on day-to-day administrative costs, the merger is likely to result in substantial one-time savings from reduced capital expenditures. For example, the national consulting firm retained by BCNEPA in 2011 projected that, as a stand-alone entity, BCNEPA would need to incur capital costs of at least $75 million to bring its systems up to date.[18] More recent Highmark projections indicate that the merger will allow BCNEPA to avoid capital costs of $85 million to $110 million.[19]

IV.D. Highmark's experience in West Virginia and Delaware

(43) Highmark's track record in West Virginia and Delaware also supports the conclusion that administrative cost savings are likely. Highmark previously entered into affiliations—not full mergers—with the BCBS plans in these states.[20] Highmark's integration of BCBS of West Virginia occurred gradually, beginning in 1999 and culminating in 2009 when BCBS of West Virginia, now known as Highmark West Virginia, completed the process of integrating operational and financial functions with Highmark.[21] Highmark's affiliation with BCBS of Delaware was approved by the State of Delaware in December 2011.[22] Highmark completed the BCBS of Delaware integration in December 2013.[23]

(44) In testimony before the Delaware Insurance Commissioner, the President of Highmark West Virginia identified a number of benefits realized from the affiliation:

[18] More specifically, the national consulting firm's report indicated that modernizing BCNEPA's infrastructure would require an initial investment of $27 million and recurring annual expenses of $10.5 million to $15.7 million, or about $75 million to $100 million over five years. Beyond noting the many, consistent indicia that BCNEPA's infrastructure is outdated and would be very costly to update, I have not performed an independent analysis of capital cost avoidance.

[19] Blue Cross of Northeastern Pennsylvania, "Hospital Service Association of Northeastern Pennsylvania d/b/a Blue Cross of Northeastern Pennsylvania ('BCNEPA') Perspective on a Merger with Highmark Inc. ('Highmark')," n.d., 10.

[20] Because these were affiliations, Highmark must maintain separate legal entities in West Virginia and Delaware. Relative to a full merger, this results in some degree of duplication and a less fully integrated organizational structure.

[21] Direct Testimony at the Hearing of October 5–7, 2011, *In re The Proposed Affiliation of BCBSD, Inc.*, No. 1509-10 (Del. Ins. Comm'r).

[22] Highmark, "Blue Cross Blue Shield of Delaware Renamed Highmark Blue Cross Blue Shield Delaware," news release, July 9, 2012, *available at* http://www.bcbs.com/healthcare-news/plans/blue-cross-blue-shield-of-18.html.

[23] Highmark, "The Conditions to Affiliation," n.d. (noting that integration with BCBS of Delaware was completed by Dec. 31, 2013). The system migration took place in May 2013, and the remaining integration steps were completed by the end of December 2013.

- "Exceptional growth in enrollment, gains in efficiency, and enhanced financial stability," a "significant gain in operating efficiencies, as reflected in our increase in electronic claims submission," and "increases in market share, financial strength and stability."[24]
- Increased automation, faster claims processing, and an expanded ability to accept electronic claims submissions.[25]
- The ability to offer more sophisticated benefit designs and products, such as value-based insurance design, tiered benefits, and wellness initiatives.[26]
- The addition of patient and provider portals.[27]

(45) In conjunction with its 2011 review of Highmark's affiliation with BCBS of Delaware (BCBS-DE), Blackstone, a consultant retained by the State Insurance Commissioner, reached consistent conclusions regarding the benefits of the West Virginia affiliation.[28] In particular, Blackstone observed that HMWV had "experienced full integration with Highmark from an IT platform perspective," which brought enhanced corporate services, such as "product innovation," "pricing/actuarial support," and "National Account support," to West Virginia.[29] Additionally, Blackstone noted that the affiliation brought technology upgrades to West Virginia that "have generally been beneficial to the company and its customers and providers."[30] In its evaluation of Highmark's proposal, Blackstone also observed that BCBS-DE had concluded that it would "need to spend a considerable amount greater than the Affiliation case in order to fully upgrade its IT system as a standalone entity and would also need to budget for expenses to maintain this upgraded equipment." In addition, as Blackstone noted, BCBS-DE "projects that it would have to **raise premium rates in a standalone scenario** in order to recoup a portion of the capital costs required to upgrade its IT platform; this increase in rates would further drive membership declines."[31] (Emphasis added.) The affiliation scenario, in contrast, did not identify a premium increase to fund IT investments. BCBS-DE business functions now run on Highmark's platform.

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24 Direct Testimony, *supra* note 21, at 11, 14.

25 Direct Testimony, *supra* note 21, at 9.

26 Direct Testimony, *supra* note 21, at 14.

27 Direct Testimony, *supra* note 21, at 14.

28 Blackstone, "Report on the Proposed Affiliation between Blue Cross Blue Shield of Delaware and Highmark Inc.," Sept. 13, 2011, 106–109 ("Highmark West Virginia achieved full integration with Highmark incrementally over a 10-year period" and "HMWV has experienced a growth in employees and financial health as a result of its affiliation with Highmark").

29 *Id.* at 106–107.

30 *Id.* at 109.

31 *Id.* at 84.

(46) In addition, in 2013, Highmark extended its PCMH to West Virginia.[32] Highmark has also extended its PCMH program to Delaware.[33]

(47) As noted above, the Delaware affiliation is more recent, and the results are still early—the agreement was executed in 2011 and the integration of operations was completed at the end of 2013. For 2013, Highmark's budget forecast for Delaware included $9.7 million in savings from reduced administrative expenses; Highmark met that budget. Highmark projects $15 million in savings for Highmark Delaware in 2014, in addition to the $9.7 million in savings in 2013.

IV.A. Highmark's administrative costs for its Medicare Advantage products in Pennsylvania

(48) Highmark offers its Freedom Blue Medicare Advantage product in the Western, Central, and Northeastern regions of Pennsylvania (i.e., statewide, except for the Philadelphia area).[34] As an additional check of whether it is likely that Highmark will be able, over time, to close the gap between BCNEPA's high administrative costs and Highmark's lower administrative costs, I also examined Highmark's Medicare Advantage (MA) offerings in Pennsylvania. Specifically, if Highmark is in fact able to leverage its IT platform and business processes to achieve low administrative costs even where Highmark's enrollment is not on par with its enrollment in Western Pennsylvania, then Highmark's administrative costs for MA products in lower enrollment areas should be comparable to its administrative costs in higher enrollment areas. Conversely, if Highmark is not able to leverage its IT platform and business processes to reduce administrative costs in this way, then Highmark's administrative costs would be lower where it has more enrollment and higher where it has less enrollment.

(49) For its Freedom Blue MA product, Highmark has the greatest enrollment (over 125,000) in Western Pennsylvania. It has less enrollment in the Central Region (about 80,000) and less still in the Northeastern Pennsylvania Region (slightly more than 10,000). I examined two sources of data on Highmark's administrative costs in each of these regions: (1) accounting data provided by Highmark and (2) data contained in the MA bid margins Highmark submitted to CMS for plan year 2015.

(50) Both sources show that Highmark incurs similar administrative costs in each region. That is, rather than having the lowest administrative costs where it has the greatest scale and higher administrative

[32] Highmark, "Highmark to Expand Patient-Centered Medical Home Efforts to Improve Care and Health Outcomes for Members," news release, Jan. 23, 2013, https://www.highmark.com/hmk2/newsroom/2013/pr012313.shtml.

[33] Highmark, "Highmark Blue Shield's Patient-Centered Medical Home Pay-For-Value Program Has a Positive Impact for Members in Central Pa.," news release, Apr. 25, 2014, https://www.highmark.com/hmk2/newsroom/2014/pr042514.shtml.

[34] BCNEPA does not offer its own MA product. Instead, BCNEPA assists Highmark in marketing plans to seniors in the BCNEPA Service Area. Capps Competition Report, § VII.A.2. . Highmark only offers its Security Blue product, an HMO, in the Pittsburgh area.

costs where it has less scale, Highmark has similar administrative costs in all three regions. For example, CMS bid data show that Highmark's administrative costs for Freedom Blue differ by less than 5% between the Western Region and the rest of Pennsylvania. Overall, this pattern indicates that Highmark can realize comparable administrative costs both in areas where it has a high number of enrollees and areas where it has fewer enrollees.

V. Highmark and BCNEPA pharmacy spending analysis

(51) Health insurers frequently contract with Pharmacy Benefit Management (PBM) firms to provide prescription drug benefits to their enrollees. In addition to offering reduced drug spending through negotiated rates with pharmacies, PBMs also offer management services such as claims processing, mail-order pharmacy service, drug formulary development and management, and assistance to some customers in negotiating rebates from pharmaceutical manufacturers.[35]

(52) Generally, PBMs earn a margin based on the difference between the rates that they negotiate with participating pharmacies and the rates that they charge their health insurer and commercial customers. Larger PBM customers often negotiate lower prescription drug pricing from PBMs, reflecting a variety of factors including scale, lower costs to serve, and more sophisticated bargaining.

(53) I have compared the drug pricing in the Highmark PBM contract that will be in effect in 2016 to the drug pricing specified in the most comparable BCNEPA PBM contract. Consistent with the general phenomenon of larger customers receiving lower drug prices, I find that Highmark's prescription drug pricing is more favorable than BCNEPA's. To analyze the implication of that difference for BCNEPA and its customers, I examined the pricing differences for the four primary categories of prescription drugs: generic retail, generic mail, branded retail, and branded retail. I estimated the likely savings for BCNEPA by applying the price difference in each category to the volume of purchases in the corresponding categories. Based on this analysis, I conclude that, beginning in 2016, extension of Highmark's contract to the BCNEPA Service Area is likely to reduce spending on prescription drugs by more than $5 million annually.

(54) This analysis does not include a comparison of Highmark's and BCNEPA's manufacturer rebates or dispensing fees. Because scale also generally allows plans to negotiate more favorable rebates, the merger is likely to result in savings from higher rebates for BCNEPA's enrollees. Both BCBS of West Virginia and BCBS of Delaware are similar in size to BCNEPA, and, following each affiliation, Highmark was able to increase manufacturer rebates.

[35] Peter R. Kongstvedt, *Essentials of Managed Health Care*, 6th ed. (Burlington, MA: Jones & Bartlett Learning, 2013), 262; Don Weber, John Reddan, and Michael J. Keegan, "Study of Pharmaceutical Benefit Management," PricewaterhouseCoopers LLP, June 2001, 5.

VI. Savings from advances in medical management

(55) As described in section III of this report, the total cost of providing health insurance coverage is the sum of medical costs and non-medical costs. Medical costs are determined by the price of services rendered as well as the nature and volume of services rendered. The term "medical management" describes efforts to reduce the costs and/or improve the quality of healthcare by (1) managing the site of service by creating incentives for the provision of care in the lowest cost setting that is medically appropriate and (2) reducing the total volume of services rendered in ways that do not adversely affect patient health, such as by creating incentives for improved preventive care or better compliance with treatment regimens.

(56) Contrasting BCNEPA with Highmark shows that Highmark's medical management programs, most especially its PCMH and Accountable Care Alliance models, are more advanced, more mature, and more broadly deployed than BCNEPA's. Highmark's programs also feature higher-powered quality and efficiency incentives than BCNEPA's. A likely and significant efficiency of the proposed merger is that it would bring these greater capabilities and medical management programs to the BCNEPA Service Area more rapidly and at lower cost than could otherwise be achieved.

VI.A. Most investments in medical management exhibit economies of scale

(57) Scale is likely the most significant factor explaining why BCNEPA's medical management programs are less well developed than Highmark's. Investments in medical management generally exhibit economies of scale: programs that would not be cost-effective for a smaller health plan, such as BCNEPA, to undertake can be cost-effective for a larger health plan, such as Highmark, to pursue.

(58) In general, a program to improve medical management will entail up-front costs and, depending on the nature of the program, may also entail recurring costs post-launch. Up-front costs include the costs of designing a program, developing the required IT infrastructure, engaging patients and employers, obtaining provider buy-in, etc. Recurring costs include, for example, staffing costs, vendor costs, and the costs of incentive payments. The purpose of medical management programs is to improve the quality and efficiency of care delivery. Particularly with respect to efficiency, the goal is to reduce or at least slow the growth rate of medical expenditures among a given population while holding quality constant if not also improving quality.

(59) The total cost savings from a program will, in most cases, increase with the size of the population affected by the program. This combination of features—a significant portion of costs are fixed and

incurred up-front while the savings increase with the size of the affected population—inherently creates economies of scale in the design and launch of medical management programs. Highmark's internal process for evaluating the attractiveness of potential medical management programs illustrates this economic relationship between costs and benefits.

(60) In early 2011, Highmark formed an interdepartmental working group with the goal of helping Highmark reduce the overall rate of medical spending growth. The working group does this through a bottom-up approach of soliciting ideas from staff in multiple departments, evaluating those ideas on a cost-benefit basis, and making specific recommendations to Highmark leadership. Thus, the working group seeks to reduce overall cost growth through a continuous process of identifying and advancing incremental improvements. Examples of initiatives of this working group include the following:

- Prior authorization for PPO products for select outpatient services
- Concentrating durable medical equipment purchases with fewer vendors
- Medical policy review—that is, refining the structure of health benefits in order to encourage more efficient decision-making by patients
- Directing lab work to the most efficient setting
- Expanding the use of urgent care centers in order to reduce emergency room utilization

(61) The interdepartmental working group assesses the attractiveness of a potential medical management improvement through a return on investment (ROI) evaluation that compares the up-front implementation costs of a program with the future returns (i.e., reduction in medical expenditures) from that program. The working group generally models implementation costs as an initial lump-sum expenditure and some recurring costs. It models savings on a PMPM basis such that total savings are the product of PMPM savings and the applicable number of member months. Future savings are discounted and expressed in terms of present value.

(62) As described above, this combination of fixed up-front investment costs and PMPM savings that vary with enrollment generates economies of scale in the pursuit of medical management programs. Specifically, many programs will not be economically rational to implement when the number of affected enrollees is small but will be economically rational to pursue when the number of affected enrollees is large. More generally, for any Highmark medical management program, the net return is as follows (for simplicity, I consider an initiative that has a fixed up-front cost but no post-launch operating costs):

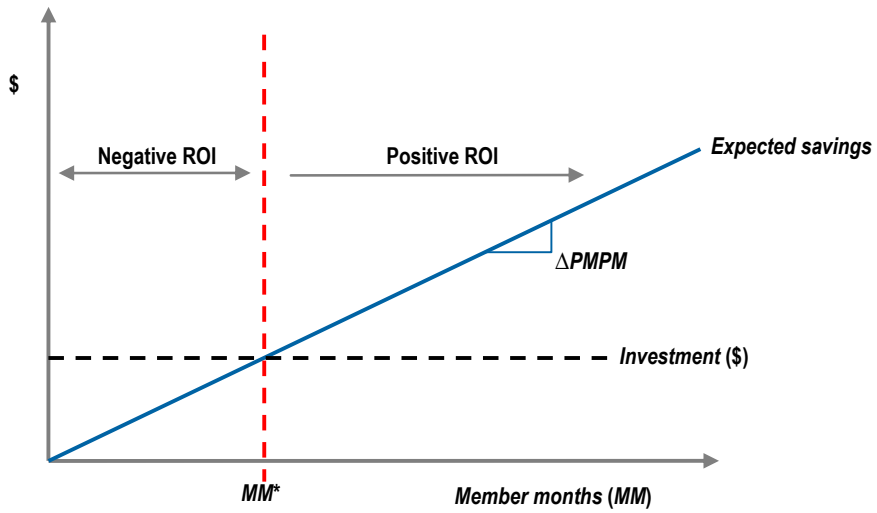
$$E(ROI) = \sum_{t=1}^{T} \delta^t \left(E(\Delta PMPM_t) \times Member\_months_t \right) - I,$$

where δ is the applicable discount rate, $E(\Delta PMPM_t)$ is the expected reduction in PMPM expenditures in year *t* (i.e., PMPM savings in each year), *Member_months* is the number of member months to which the expected savings would apply, *T* is the lifetime of the program, and *I* is the up-front investment cost.

(63) Figure 3 illustrates this graphically. The blue *Expected savings* line depicts the aggregate expected savings, which is the present value of the product of the expected per member monthly savings and the number of member months; the slope of this line is the expected change in PMPM costs. When, for a given program, the up-front investment cost *I* exceeds the expected savings (i.e., $E(\Delta PMPM_t) \times MM$), the initiative will have a negative expected net return and will not be rational for the insurer to undertake. The exact same program, however, would have a positive ROI if it can be applied to a larger number of members. In Figure 3, the critical number of member months, MM^*, is defined by the point where the investment cost exactly equals the expected savings. If the actual member months are below MM^*, then a rational insurer will forego the investment; beyond MM^*, a rational insurer will pursue the investment.[36]

[36] Figure 3 is simplified for purposes of exposition. However, the basic point regarding economies of scale in pursuing cost-reducing medical management investments will remain true for any initiative for which (1) the investment cost includes a fixed component (and possibly also a variable component such that the *Investment* line slopes upward) and (2) the *Expected savings* are increasing (possibly not linearly) in the number of member months.

Figure 3. Illustration of ROI calculation for a medical management initiative



(64) As Figure 3 shows, the ROI of a program increases with the number of affected members. This implies that the optimal extent of medical management initiatives will exhibit economies of scale: all else equal, the optimal investment level in efforts to reduce medical care costs is greater for a larger health plan than for a smaller health plan. In particular, insurers have many possible medical management programs, and an ROI evaluation similar to Figure 3 applies to each one of them. As an insurer's membership is greater, all else equal, it will find it optimal to pursue more such initiatives.[37] This prediction from economic theory is borne out in Highmark's evaluation and adoption of medical management programs, particularly in comparison to BCNEPA.

(65) Economic theory indicates that the converse also applies: all else equal, smaller health plans will find it irrational on a cost-benefit basis to pursue a large number of programs (or to pursue a smaller number of more expensive programs).

VI.B. BCNEPA's medical management initiatives

(66) BCNEPA's main medical management program for physicians caring for FPH and FPLIC enrollees is its QIP, which includes incentive programs for both PCPs and for specialists and non-physician health professionals. BCNEPA has long used incentive programs for its HMO business, which has been shrinking over time. In 2011, BCNEPA implemented a QIP for its PPO products, which account

[37] This does not mean that only large insurers will pursue advanced medical management. Some insurers may have different costs and benefits from medical management initiatives. This is most likely to be the case with respect to insurers that have a distinct organizational structure and strategy. In contrast, in comparing two insurers that are similar in terms of organizational structure and market strategies, scale is more likely to be a predominant factor driving investment decisions regarding medical management programs.

for the bulk of its commercial enrollment, and extended the QIP to include specialists in addition to PCPs. Under the QIP, physicians are scored on a variety of performance metrics. Those who score above the median earn an incentive payment, while those with scores below the median do not. Roughly 3% to 3.5% of total FPH/FPLIC payments to physicians are based on QIP incentive payments. Incentive payments are made in the form of fixed amounts per attributed member per month (PAMPM).[38]

(67) BCNEPA's QIP uses different performance metrics for PCPs and specialists. For PCPs, BCNEPA makes incentive payments in the form of fixed PAMPM amounts. The performance metrics are based on effectiveness, clinical quality, and cost of care. For specialists, BCNEPA's incentive payments also take the form of fixed PAMPM amounts.[39] The specialist metrics relate to effectiveness, board certification, attainment of recognition status under one or more NCQA recognition programs, and administrative metrics (e.g., maintaining extended office hours, accepting new patients, participation with CMS incentive programs, and accepting electronic claims payments from BCNEPA).

(68) One limitation of BCNEPA's QIP is that incentive payments are only payable on BCNEPA's controlled enrollees (i.e., enrollees in FPH or FPLIC), not on BlueCard enrollees who reside in the BCNEPA Service Area. This is because professional services for BlueCard enrollees in the BCNEPA Service Area are governed by physicians' contracts with Highmark (i.e., through Highmark's PremierBlue Shield network), not BCNEPA. The merger would eliminate this schism.

(69) BCNEPA has a second, much smaller program, the Episode Incentive Program (EIP). As noted above, physicians must score above the median in order to receive a QIP payment. The EIP is targeted at physicians whose scores do not qualify for a QIP payment because their scores are in the bottom half of the performance distribution. These physicians can receive an additional payment for showing "significant improvement in the delivery of healthcare services." Under both the QIP and the EIP, BCNEPA provides each participating physician a "Cost of Care and Effectiveness Report" that shows all of the metrics BCNEPA uses to score the physician's performance, shows how the physician compares with other physicians in the same specialty, and includes an itemization of care costs by medical condition. The reports are intended to make the QIP and EIP transparent and to provide physicians with actionable information on their performance.

(70) Finally, on November 1, 2013, BCNEPA launched a PCMH pilot in conjunction with Susquehanna Health. The pilot will continue through the end of 2015. From the pilot, BCNEPA hopes to identify "best practices and methodologies that can be implemented by other practices across the region."[40]

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[38] For HMO products (i.e., FPH), patients are attributed to their designated PCP. For PPO products (i.e., FPLIC), patients are attributed to the PCP they visited most often for primary care services. For specialists, patients are attributed to the specialist they visited most often.

[39] Even for HMOs, enrollees do not select designated specialists; thus, all attribution is on the basis of the number of visits; a given patient can be attributed to at most one specialist.

[40] BCNEPA, "Susquehanna Health and Blue Cross of Northeastern Pennsylvania Launch Patient Centered Medical Home

Under the pilot, BCNEPA will provide funding to Susquehanna Health physicians to help them make technology investments and hire care coordinators. In June 2014, Guthrie Medical Group became a second participant in BCNEPA's PCMH pilot. Because the pilot was launched so recently, results are not yet available.

VI.C. Highmark's medical management programs

(71) With respect to medical management, Highmark's current strategic focus is on two major initiatives, its PCMH program and its Accountable Care Alliance (Alliance) program.[41] Highmark fully implemented its PCMH model, a physician pay-for-value program, in 2012, after the successful completion of its PCMH pilot.[42] Highmark has already extended its PCMH program into West Virginia and Delaware.

(72) The structure of Highmark's PCMH program is in accord with the features of model PCMHs as identified by researchers and medical professionals. Figure 4 compares (1) core features of PCMHs as identified by four primary care oriented medical societies with (2) core features of Highmark's PCMHs. Although the wording varies, the objectives and methods are in close alignment.

Pilot," news release, Dec. 19, 2013, https://www.bcnepa.com/OurCompany/News/Press/Release.aspx?id=785.

41 *See* Highmark, "Corporate Profile: Innovation," accessed Dec. 19, 2014, https://www.highmark.com/hmk2/about/corpprofile/innovation.shtml.

42 Before the launch of its PCMH program, Highmark had a physician pay-for-performance program ("Quality Blue physician pay-for-performance") in place that rewarded primary care physicians with incentive payments for improving patient care. Currently, Highmark is transitioning providers from pay-for-performance to pay-for-value programs, in which the incentives are linked to improving the quality of care as well as meeting benchmarks for cost and utilization of healthcare services.

Figure 4. Comparison of *Joint Principles* for PCMHs with Highmark's PCMH model

Aspect	Joint Principles of the Patient-Centered Medical Home	Highmark, Introducing Patient-Centered Medical Home
Role of the PCP	• An ongoing patient relationship with a PCP trained to provide comprehensive care and to manage and take responsibility for care at all levels—acute, chronic, preventive, etc.	• "Physicians and care coordinators . . . [a]re focused on each patient's needs . . . talk with patients about preventive care plans that lower risk . . . [c]oordinate care with specialists and community resources."
IT	• Use of advanced IT to coordinate care across the continuum of care.	• "Benefit from shared data and technology."
Value-based payment	• Commitment to quality and safety improvement strategies through evidence-based medicine, performance measurement, decision-support tools, and patient feedback. • Payment structures that reward performance instead of volume.	• "Rather than making payments based on the number of office visits or procedures, we pay your doctors and hospitals based on how well they deliver quality and cost efficiency."
Provider accessibility	• Expanded access to care, including open scheduling, extended hours, and multiple options for communicating with providers.	• "When you have time to discuss your concerns with your doctors, you are more involved in your health care. You are more likely to: Comply with instructions and follow-up appointments, Save money on health care, Improve lifestyle habits, Stay healthier." • Programs to encourage expanded PCP office hours to improve access and reduce ED utilization.

Source: AAFP et al., "Joint Principles of the Patient-Centered Medical Home," Feb. 2007, *available at* http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf; Highmark, "Introducing Patient-Centered Medical Home (PCMH)," May 2014, *available at* http://discoverhighmark.com/employer/content/03-care/02-pay-for-value/pdf-links/centralpa/02-P4V_Member_BS_201405.pdf; letter from Highmark to PCMH/ACA participants, Apr. 1, 2014 (presenting the schedule of additional payments for after-hours services provided by PCMH and Alliance participants).

(73) In general, entities implementing PCMHs around the country have shown improvements in quality across a number of metrics, as well as some evidence of cost savings. Early evaluations of these programs have found improvements in patient satisfaction; increased clinician satisfaction; reductions in emergency room utilization, inpatient admissions, and readmissions; improved utilization of preventive services; and some evidence of cost savings within several years.[43]

(74) Highmark's other major medical management initiative, the Alliance model, is a more advanced program that Highmark launched in 2013 in conjunction with physicians employed by the Allegheny

[43] Robert J. Reid et al., "Patient-Centered Medical Home Demonstration: A Prospective, Quasi-Experimental, before and after Evaluation," *American Journal of Managed Care* 15, no. 9 (2009): e71–87; Robert J. Reid et al., "The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers," *Health Affairs* 29, no. 5 (2010): 835–43; Jeanne M. Ferrante et al., "Principles of the Patient-Centered Medical Home and Preventive Services Delivery," *Annals of Family Medicine* 8, no. 2 (2010): 108–16; Richard J. Gilfillan et al., "Value and the Medical Home: Effects of Transformed Primary Care," *American Journal of Managed Care* 16, no. 8 (2010): 607; Michael L. Paustian et al., "Partial and Incremental PCMH Practice Transformation: Implications for Quality and Costs," *Health Services Research* 49, no. 1 (2014): 52–74. While the study by Reid et al. (2009) did not find a statistically significant reduction in total costs after one year at one clinic implementing a pilot PCMH program, Reid et al. (2010) find some evidence of cost savings after 18 and 21 months. Paustian et al. (2014), studying more than 2,400 physician practices in Michigan, find larger cost savings after 12 months of full PCMH implementation.

Health Network (AHN).[44] While the PCMH model is primarily focused on PCPs, the Alliance model is aimed at developing accountable care organizations that can also include specialists and hospitals. The Alliance model is open only to providers participating in Highmark's PCMH program and is designed to induce various providers, not just PCPs, to improve the quality and efficiency of patient care by coordinating and sharing responsibility for managing patient care.

(75) Highmark's newer pay-for-value PCMH and Alliance programs build upon its long-running experience with pay-for-performance programs. For example, Highmark launched the Quality Blue hospital pay-for-performance program in 2002. Highmark's Quality Blue hospital pay-for-performance program is focused on improving patient outcomes by creating financial incentives based on hospitals' performance on safety and quality metrics.[45] Although focused directly on quality, this program also addresses the costs of care, because many of the metrics reward performance that both improves quality and reduces costs. For instance, healthcare costs are reduced when rates of hospital-acquired conditions (HACs) fall, when readmissions decline, or when surgical complications decline. In 2013, 92 hospitals participated in the pay-for-performance program. A summary of the program reports that over the period spanning 2007 through 2013, the Quality Blue hospital program helped save between $31 million and $100 million by avoiding more than 4,000 infections.[46]

(76) Highmark also has a long-standing Quality Blue program for PCPs that offers increased per-visit fees to PCPs based primarily on their performance on clinical quality measures and generic prescription rates.

(77) Highmark is continuing to operate the hospital and PCP Quality Blue programs, though it is seeking to work with providers to transition them into a PCMH or Alliance program. The main distinction between Highmark's newer PCMHs and Alliances and its older Quality Blue programs is that the Quality Blue programs primarily measured and rewarded providers' performance on quality metrics.[47] The PCMH and Alliance models are focused on measuring and rewarding performance on population health management, which directly encompasses both quality and cost effectiveness metrics. Recognizing this distinction, Highmark often refers to its Quality Blue as a "pay-for-performance" program and its PCMHs and Alliances as "pay-for-value" programs.

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[44] Highmark, "Highmark Health Services Forms Accountable Care Alliance to Improve Care and Health Outcomes for Western Pennsylvania Residents," news release, July 18, 2013, https://www.highmark.com/hmk2/newsroom/2013/pr071813.shtml.

[45] Highmark, "Highmark Makes Change to Hospital Pay-For-Performance Program to Place More Emphasis on Decreasing Preventable Readmissions," news release, July 11, 2012, *available at* https://www.highmark.com/hmk2/newsroom/2012/pr071112.shtml.

[46] Highmark, "Quality Blue Hospital Results, Fiscal Year 2013 Report," Dec. 2013, 8, *available at* https://www.highmark.com/hmk2/pdf/presskits/qualityblue2013.pdf.

[47] Cost of care metrics were not absent under the Quality Blue program. For example, the Quality Blue PCP program included measures of generic prescribing rates, which is a cost metric rather than a quality metric. In addition, many forms of quality improvement will also reduce costs.

(78) Generally, the goal of a PCMH is to improve quality and reduce overall healthcare costs by vesting a single entity, typically led by PCPs, with responsibility for the bulk of the care needed by the PCMH's patients. Care responsibility includes responsibility for clinical processes, heath status and outcomes, and care costs. A PCMH could be fully responsible for care costs (e.g., global risk) or it could be partly responsible for costs (e.g., gainsharing, pay-for-performance, pay-for-value). Mechanisms by which PCMHs can improve value include the following:[48]

- Replacing or reducing the importance of reimbursement that is based predominantly on the volume—not the quality or efficacy—of care that providers render (i.e., moving away from fee-for-service reimbursement)
- Shifting from care delivery by a diversity of weakly coordinated providers—none of whom are directly responsible for the overall, longer-term well being of their patients—towards designated "homes" that do bear that responsibility
- Enhancing patient engagement in order to increase patient satisfaction and adherence to treatment regimens
- Developing and promulgating improved performance metrics and incentive payments

(79) Consistent with these characteristics, Highmark's PCMH model includes higher reimbursement incentives for providers who meet performance thresholds related to coordination of care, clinical quality indicators, and cost and utilization targets. Highmark began its pay-for-value effort with a pilot PCMH program in June 2011. The pilot included 160 PCPs across 12 practices and served more than 40,000 enrollees across Central Pennsylvania, Western Pennsylvania, and West Virginia. The pilot ended in 2012, and its notable results included the following:[49]

- A decrease in PMPM medical costs for participants of about 2% within six months
- A roughly 9% decline in inpatient admissions
- A decline in both 7-day and 30-day inpatient readmission rates by more than 13%

(80) Highmark's analysis of quality and cost information for cohorts launched after the pilot (these cohorts include PCMHs as well as Alliances) found that, irrespective of the initial level of quality, every cohort realized an increase in quality (I describe how Highmark measures quality in more detail below). Older cohorts had larger quality improvements between their initial measurement

[48] In 2007, the four medical societies most focused on primary care issued a set of principles that characterize PCMHs. AAFP, AAP, ACP, and AOA, "Guidelines for Patient-Centered Medical Home (PCMH) Recognition and Accreditation Programs," Feb. 2011, *available at* http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/GuidelinesPCMHRecAccredit.pdf.

[49] Highmark, "Quality Blue FY 2012 Achievement Compendium," 6; Highmark, "Highmark to Expand Patient-Centered Medical Home Efforts to Improve Care and Health Outcomes for Members," news release, Jan. 23, 2013, *available at* https://www.highmark.com/hmk2/newsroom/2013/pr012313.shtml.

("Baseline") and their December 2013 measurements ("Current"). The initial 2012 cohort also realized a slight reduction in PMPM healthcare costs relative to trend. The later cohorts have small but mixed cost results to date, but they were less than one year old at the end of 2013. Even under a pessimistic read, the results from Highmark's initial PCMH and Alliance cohorts indicate that Highmark's new models improve quality without driving up care costs.

(81) As a result of the success of the pilot, Highmark set a goal of expanding its pay-for-value programs to cover 75% of its enrollees by 2015. Over the course of 2013, the number of physician practices, physicians, and covered enrollees (i.e., those under the care of a PCMH or an Alliance PCP) roughly doubled. As of April 2014, nearly 900,000 Highmark enrollees in Pennsylvania, Delaware, and West Virginia were in a pay-for-value program such as a PCMH or an Alliance. In Pennsylvania, 69% of members in the Western Region and 60% of members in the Central Region now receive care as part of a PCMH or Alliance program. Given that the increase in provider participation occurred steadily throughout 2013, it is too early to make a clear determination with respect to the results for providers in the 2013 cohorts. Nonetheless, the early results strongly suggest that, at a minimum, quality improvements can be attained without a significant increase in cost.

(82) Ultimately, accountable care implementation is a long-term engagement that requires substantial tacit learning from experimentation with new incentive structures to alter provider practice patterns. While CMS wants ACOs to accept both upside and downside financial risk for Medicare patients within three years, researchers have observed that full implementation may take more than five years.[50] Relative to this timeline, Highmark is currently in the middle stage of development, while BCNEPA is at an early, pilot stage.[51] With the merger, Highmark will be able to bring more fully-developed PCMH and Alliance models to the BCNEPA Service Area much sooner than could BCNEPA on its own.

(83) As another example, BCNEPA pays for hospital outpatient services, which account for nearly half of payments to hospitals, on a fee-for-service basis (i.e., a percentage-of-charge basis), a payment methodology that incents volume but does little to encourage quality or efficiency.[52] Highmark's hospital contracts (subject to the consent of the counterparty hospital) pay for these services on a prospective basis, meaning that hospitals are not paid more for simply rendering more services. As part of its evaluation of the proposed merger with BCNEPA, Highmark projected that, through

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[50] Lawton R. Burns and Mark V. Pauly, "Accountable Care Organizations May Have Difficulty Avoiding the Failures of Integrated Delivery Networks of the 1990s," *Health Affairs* 31, no. 11 (2012): 2407–16. *See also* Bridget K. Larson et al., "Insights from Transformations under Way at Four Brookings-Dartmouth Accountable Care Organization Pilot Sites," *Health Affairs* 31, no. 11 (2012): 2395–06.

[51] BCNEPA, "Susquehanna Health and Blue Cross of Northeastern Pennsylvania Launch Patient Centered Medical Home Pilot," news release, Dec. 19, 2013, *available at* https://www.bcnepa.com/OurCompany/News/Press/Release.aspx?id=785.

[52] American Hospital Association, "Chart 4.3: Distribution of Outpatient vs. Inpatient Revenues, 1992–2012," 2014, *available at* http://www.aha.org/research/reports/tw/chartbook/2014/chart4-3.pdf. In 2014, BCNEPA implemented a non-FFS payment system for outpatient services with one hospital, Wilkes-Barre General Hospital.

prospective payment for hospital outpatient services, it could reduce hospital outpatient costs relative to trend in the BCNEPA Service Area by several percentage points.

(84) PCPs in a Highmark PCMH or Alliance face comparatively high-powered incentives that can result in additional payments that amount to 20% to 30% of base payments, or can result in no additional payments for low-performing PCPs. Because Highmark's incentive payments are made on the basis of value—i.e. the quality and total cost of care—it is possible for Highmark to increase its payments to high-performing PCPs in a PCMH or an Alliance while still reducing the overall costs of care. Indeed, it is the additional payment that provides the financial incentive for PCPs to make decisions that lower overall care costs.

VI.C.1. Measuring and rewarding value in Highmark's PCMHs and Alliances

(85) Under Highmark's PCMH and Alliance programs, primary care providers are rewarded for both improving quality and controlling healthcare costs. The programs were designed to provide an upside, in the form of additional payments for evaluation-and-management (E&M) visits, that can exceed 20% of upside to primary care physician revenue. In comparison, under BCNEPA's QIP program, less than 5% of payments to physicians depend on QIP incentives.[53]

(86) Overall, PCPs in a Highmark PCMH are able to earn additional payments per evaluation and management visit based on each of the following categories of metrics:

- A performance score based on cost and quality metrics
- Meeting CMS meaningful use standards
- Receiving PCMH recognition from an accreditation organization, such as the NCQA[54]

(87) For PCMH providers, 50% of the performance score is based on HEDIS measures of quality of care, and 50% is based on overall healthcare costs.[55] Participating providers earn quality points by

[53] As noted earlier, BCNEPA's physician incentives are heavily diluted because QIP incentive payments apply only to FPH and FPLIC enrollees but not to BlueCard enrollees residing in the BCNEPA Service Area. (In total, there are similar numbers of BCNEPA-controlled enrollees and BlueCard enrollees in the BCNEPA Service Area.) This reflects the existence of distinct physician networks in the BCNEPA Service Area: Highmark's network, which governs physician services rendered to BlueCard enrollees, and the FPH and FPLIC networks, which govern physician services rendered to BCNEPA's controlled members. The merger will unify these networks.

[54] NCQA, "Patient-Centered Medical Home Recognition," accessed Dec. 19, 2014, http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx.

[55] For several decades, the National Committee for Quality Assurance (NCQA) has advanced and promulgated the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS measures are widely used to quantify the performance of health plans. HEDIS includes 81 metrics related to the effectiveness of care, access to and availability of care, patient satisfaction, the costs of care, and health plan descriptive information. For a general summary of the HEDIS measures, *see* NCQA, "HEDIS & Quality Measurement," accessed Dec. 19, 2014, http://www.ncqa.org/HEDISQualityMeasurement.aspx. For a list of the 2014 HEDIS measures, *see* NCQA, "Summary Table of Measures, Product Lines and Changes," 2013, *available at* http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2014/List_of_HEDIS_2014_Measures.pdf.

exceeding the relevant benchmark, which is the greater of (1) the median of the national NCQA HEDIS metric and (2) the median among Highmark network providers (including providers in West Virginia and Delaware) for the metric.

(88) For Alliance providers, 50% of the performance score is based on HEDIS measures of quality of care, 20% is based on overall healthcare costs, and the remaining 30% is based on care alignment performance. Care alignment measures the percentage of patients who are kept within the Accountable Care Alliance; this metric is designed to encourage physicians to refer patients to Alliance-participating hospitals and to facilitate care coordination, data sharing, and communication among providers in the Alliance. Physicians start earning points for care alignment when at least 50% of inpatient admissions are within the Alliance.

(89) The metrics that Highmark incorporates into quality scores for PCMH and Alliance providers are listed in Figure 5. In addition to these metrics, Highmark tracks other quality measurements that are not incorporated into the quality score. Figure 6 shows an example of how Highmark aggregates the various quality measures into a single quality score, which is 50% of a PCMH provider's overall score (the other half is medical expenditures). The quality score is determined based on the number of eligible metrics for which a provider passes the applicable benchmark.

Figure 5. Highmark quality measures for PCMH and Alliance providers

Prevention
Breast Cancer Screening
Colorectal Cancer Screening
Cervical Cancer Screening

Geriatric Care
Glaucoma Screening in Older Adults
Urinary Incontinence Assessment for Older Women
Urinary Incontinence Plan of Care for Older Women
Fall Risk Assessment for Older Adults
Fall Plan of Care for Older Adults

Chronic Condition Care
Comprehensive Diabetes Care
Pediatric Diabetes Care: HbA1c Testing
Follow-Up Care for Children on ADHD Medication:
CAD: Lipid Profile or LDL-C Testing
Use of Spirometry Testing in the Assessment and Diagnosis of COPD
Diabetes, CHF, COPD: Office Visits 2 or more per year
Use of Appropriate Medications for People With Asthma
Cholesterol Mgmt. for Patients with Cardiovascular Conditions: LDL-C Screening

Pediatric and Adult Well Care
Appropriate treatment for children with URI
Appropriate Testing for Children with Pharyngitis
Adolescent Well-Care Visits
Well-Child Visits in the First 15 Months of Life: Six or more visits
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
Adults' Access to Preventive/Ambulatory Health Services
Childhood Immunization Status: MMR Vaccination
Childhood Immunization Status: Varicella (VZV) Vaccination

Figure 6. Highmark quality score calculation

	Metrics Meeting Minimum Denominator	10
	Maximum Quality Score	50
	Measures for Which Entity Meets Minimum Denominator	Measure Passed?
Performance Measurement	Appropriate Treatment for Children with URI	N
	Colorectal Cancer Screening	N
	Cervical Cancer Screening	Y
	Use of Appropriate Medications for People With Asthma	Y
	Well-Child Visits in the First 15 Months of Life: Six or more visits	Y
	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Y
	Breast Cancer Screening	N
	Appropriate Testing for Children with Pharyngitis	N
	Fall Risk Assessment for Older Adults	N
	Childhood Immunization Status: MMR Vaccination	N
	Measures Passed	4
Calculating Score:	(Total Measures Passed/Quality Metrics For Which Entity Has Sufficient Volume) * Maximum Quality Score	(4/10)*50
	Entity A Total Quality Score	20

(90) In general, PCMH physicians receive additional reimbursement when they achieve 1% to 4% slower cost growth relative to nonparticipating physicians. High-performing physicians with already low costs are rewarded for any cost savings starting at 0%, while the least-efficient providers must achieve a minimum cost savings of 2% relative to market trend in order to earn additional payments. Providers receive quarterly performance reports, and results are scored every six months to determine their future payments. They also receive reports of care utilization rates—such as inpatient hospital admissions and emergency department visits—that highlight opportunities for cost reductions.

VI.C.2. Tools and support for PCMH and Alliance providers

(91) Consistent with the principles of the PCMH model, Highmark also provides services and consultation to PCMH and Alliance providers and their patients:

- "Highmark Health Coaches"—support patients with care transitions, disease management, case management, and wellness coaching services; providers can refer patients to a coach by using Highmark's NaviNet portal.[56]
- "Clinical Transformation Consultants"—support new PCMH providers by providing technical and clinical consultation, including evidence-based practices, technology, data gathering and analysis, physician performance measurement, chronic care management, and meaningful use standards.

[56] Highmark sometimes refers to "Health Coaches" as "Care Coordinators."

- "Highmark Medical Informatics"—allow PCMH physicians to access data not normally available to PCPs, such as medication adherence and specialist visits and costs. Absent such tools, PCPs often will not know whether patients followed up on referrals to specialists or when a patient visits a specialist without a referral, both of which impede effective care management. All PCMH providers have access to these tools.[57]

(92) Highmark also assigns a designated provider relations representative (PRR) to PCMHs and Alliance providers. The PRR's role is to support contracting and to coordinate interactions between providers and Highmark's Transformation Consultants and Health Coaches.

(93) Highmark's informatics tools give PCMH and Alliance providers access to information needed to better manage care and to reduce costs. For example, a small subset of the population accounts for a disproportionate share of healthcare spending. Based on a recent report by the Agency for Healthcare Research and Quality, 1% of the population accounts for 22.7% of total healthcare spending, and 5% of the population accounts for half of healthcare spending.[58] Highmark's informatics tools allow PCMH and Alliance providers to identify such high-risk patients and to access data on compliance with care protocols appropriate to those patients.

(94) PCMH and Alliance providers also have access to detailed data on healthcare utilization and healthcare costs for their patients. Highmark provides a dashboard that, for specific categories of medical services (e.g., surgical inpatient, radiology, and emergency room), allows providers to see costs and utilization rates for populations under their care, along with benchmark levels for cost and utilization. With these data, PCMH and Alliance providers can identify specific areas of excess cost or utilization and target their efforts at better managing care with respect to those services. PCMH and Alliance providers have a financial incentive to do so, because, as described above, total medical costs are a substantial component of providers' performance scores (along with HEDIS-based quality measures), and higher scores entitle providers to higher payments.

VI.D. Implications

(95) Contrasting BCNEPA with Highmark shows that Highmark's medical management programs, most especially its PCMH and Accountable Care Alliance programs, are more advanced and more broadly deployed than BCNEPA's. Highmark's programs feature quality and efficiency incentives that are more high-powered than BCNEPA's. For example, whereas BCNEPA makes less than 5% of total physician compensation (excluding BlueCard) contingent upon performance, the comparable

[57] These services and tools are also available to PCPs in Alliance programs and their patients.

[58] Steven Cohen, "Differentials in the Concentration of Health Expenditures across Population Subgroups in the U.S., 2012," AHRQ Statistical Brief #448, Sept. 2014, *available at* http://meps.ahrq.gov/mepsweb/data_files/publications/st448/stat448.shtml.

incentive for Highmark's PCMH and Alliance PCPs exceeds 20%. Additionally, whereas BCNEPA launched a PCMH pilot in late 2013, Highmark concluded its pilot in 2012 and is nearing one million enrollees under the care of a PCMH.

(96) A likely and significant efficiency of the proposed merger is that it would bring these greater capabilities and stronger incentives to the BCNEPA Service Area much more rapidly than could otherwise be achieved—just as Highmark has done in West Virginia and Delaware. Because Highmark's incentive payments are made on the basis of value—i.e., the quality and total cost of care—it is possible for Highmark to increase its payments to high-performing providers while still reducing the overall costs of care.

(97) A related benefit of the merger is that it would allow for unification of the currently disparate performance and value incentive programs maintained by BCNEPA and Highmark. As noted above, because physician services rendered to the many BlueCard enrollees in the BCNEPA Service Area are governed by Highmark's PremierBlue Shield professional network, BCNEPA's QIP programs for PCPs and for specialists offer incentive payments for FPH/FPLIC members but not for BlueCard enrollees in the BCNEPA Service Area. At the same time, Highmark does not currently apply any of its incentive programs to physicians in the BCNEPA Service Area, because it cannot observe important components of total medical spending, such as spending on hospital services, for patients treated by those physicians. Highmark only observes spending on professional services in the BCNEPA Service Area because those are the only services that are administered under its PremierBlue Shield network. With some minor exceptions, facility services for BlueCard enrollees in the BCNEPA Service Area are governed by BCNEPA's facility contracts. Post-merger, Highmark intends to use its PremierBlue Shield network to serve all of its enrollees, including those in the BCNEPA Service Area. At that point, Highmark expects to deploy its own QIP program for PCPs to all enrollees in the BCNEPA Service Area, including BlueCard enrollees.

VII. Efficiencies from the transaction will benefit consumers

VII.A. The merger is likely to ameliorate and then reverse BCNEPA's operating loss

(98) As previously discussed, BCNEPA's high administrative costs date back to at least 2011. As a result of these high costs and the lack of significant enrollment growth, BCNEPA's enterprise-wide operating gain fell in 2013. Based on its most recent projections, BCNEPA's operating performance is expected to further deteriorate in 2014. BCNEPA also projects that, absent the merger, it will have overall operating losses in 2015 and 2016.

(99) By using BCNEPA's financial projections for 2014, I calculated the reduction in PMPM administrative costs for FPH and FPLIC that would be required in order for BCNEPA to operate in the black. This evaluation shows that converting from an operating loss to a gain requires closing of only a fraction of the PMPM administrative cost gap between Highmark and BCNEPA. (Note that BCNEPA's projection of operating losses through 2016 embeds the assumption that BCNEPA cannot practically achieve this cost reduction on its own.) Specifically, even assuming no other savings accrue, closing about 50% to 70% of the administrative cost gap between Highmark and BCNEPA would eliminate the projected operating losses for FPH and FPLIC.

VII.B. Lower administrative costs and improved medical management benefit consumers

(100) The proposed merger is likely to result in substantial recurring administrative and medical cost savings. Similarly, as discussed in section V, beginning in 2016, the merger is also likely to result in savings on prescription drug costs. In this section I explain why, as a matter of economics, these types of efficiencies—i.e., reductions in the cost to serve BCNEPA enrollees—are likely to translate into lower premiums for consumers (i.e., employers, unions, and enrollees) than would otherwise prevail. Self-funded entities that do not pay premiums but instead assume direct responsibility for the medical costs of their beneficiaries will directly benefit from reduced medical costs.

(101) Standard microeconomic principles indicate that, in most settings, firms are likely to share the benefits of reductions in variable costs with customers in the form of lower pricing than would otherwise prevail.[59] The logic underlying this result is that lower variable costs imply higher margins

[59] US Department of Justice and Federal Trade Commission, *Horizontal Merger Guidelines*, Aug. 19, 2010, § 10; Joseph Farrell and Carl Shapiro, "Antitrust Evaluation of Horizontal Mergers: An Economic Alternative to Market Definition," *BE Journal of Theoretical Economics* 10, no. 1 (2010): art. 9.

on additional sales. When the margin on additional sales increases, a firm will increase its profits by increasing its sales, which it accomplishes by lowering its price. The lowering of price relative to what the firm would otherwise charge has the effect of sharing the benefits of the variable cost savings with consumers.

(102) In the case of the proposed merger, many of the cost savings discussed in this report are likely, over time, to reduce the variable costs of serving BCNEPA's enrollees post-merger (some of the likely cost savings are reductions in fixed costs). There are two categories of likely variable cost reductions from the proposed merger:

- *Reductions in administrative costs that are likely to reduce BCNEPA's marginal costs or variable costs* (*see* section IV). For business reasons (e.g., open enrollment season) and regulatory reasons (e.g., rate filings), insurers generally set their pricing and product characteristics for a given year and then sell to all customers at those prices. Therefore, any cost that would be adjusted from year to year in response to enrollment changes should be taken as variable for purposes of evaluating pricing incentives. For example, staffing costs that scale with enrollment changes with a lag of roughly one year or less are appropriately viewed as variable costs. Examples of staffing costs that scale up and down with enrollment include customer service, claims administration, provider relations, broker fees, and the elimination of fees for outsourced infrastructure or services.
- *Medical costs are predominantly if not entirely variable*. Whether through reducing the volume of service, rationalizing the site of service, or improved pricing, any reduction in the expected total medical expenditures associated with an enrollee will necessarily reduce the marginal cost of additional enrollees. As described in section VI.C, Highmark's PCMH pilot achieved a roughly 2% decrease in PMPM medical costs, and, on that basis, Highmark has rapidly expanded its PCMH model in the Western and Central Regions, as well as in West Virginia and Delaware. Successful extension of Highmark's PCMH model into the BCNEPA Service Area would reduce the variable costs of serving BCNEPA's enrollees and, therefore, create an incentive to lower premiums relative to the levels that would prevail absent the cost reduction. Similarly, likely savings on prescription drug costs, discussed in section V, would also lower the variable costs of serving BCNEPA enrollees.

(103) These sorts of variable cost savings, which are likely to accrue over time, will create an economic incentive for Highmark to set lower premiums than would prevail absent the cost savings. That is, the rate of premium growth over time is likely to be lower as a result of reductions in the variable costs of serving BCNEPA enrollees.[60]

[60] In many settings, the beneficial incentives created by variable cost savings must be weighed against any harmful incentives caused by a lessening of competition. *Id.* However, as I have shown elsewhere, Highmark and BCNEPA do not compete in any economically meaningful sense, so the loss of direct competition is negligible and no such weighing

(104) The discussion in the previous section of BCNEPA's projected operating losses for FPH and FPLIC provides a more concrete illustration of how consumers in the BCNEPA area would benefit from cost savings. In part, BCNEPA expects those losses because it has lowered premiums in a moderately successful effort to expand its enrollment. However, BCNEPA cannot sustain those losses indefinitely: it must eventually either lower its costs or increase its premiums. Given that BCNEPA has not been able to meaningfully lower its administrative costs over at least the last four years, the more likely outcome is that premiums will have to increase. Indeed, BCNEPA's loss projections for 2015 and 2016 assume significant premium increases. In sharp contrast, however, if even a fraction of the potential administrative cost savings from the merger are realized, those losses would be eliminated, and the corresponding pressure to escalate premiums would be reduced or eliminated. Put more simply, given its lower costs, Highmark can sustain lower rates of premium growth than can BCNEPA.

(105) In addition, although they do not pay premiums, self-funded BCNEPA customers would also benefit from cost savings. First, the administrative fees that health plans or non-insurer third-party administrators (TPAs) charge to self-funded customers need to cover the associated administrative costs. Thus, just as with premiums, lower administrative costs can enable lower administrative fees. Second, self-funded customers are directly responsible for medical expenses incurred by their covered enrollees (excluding deductibles and coinsurance). Accordingly, changes that reduce medical expenditures will reduce self-funded customers' healthcare expenditures. Lower medical costs benefit patients as well, through lower cost sharing. As a leading example, consider again the potential for reduced medical expenditures among BCNEPA's enrollees from an extension of Highmark's PCMHs into the BCNEPA Service Area. If this results in a 2% reduction in healthcare costs, as was the case with Highmark's PCMH pilot, then self-funded customers in the BCNEPA area will immediately realize savings.

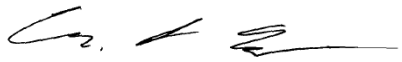
(106) Finally, quality improvements such as those associated with Highmark's PCMH and Alliance models will, by their very nature, benefit consumers in the BCNEPA area.

VII.C. Capital cost avoidance

(107) In addition to recurring benefits from variable cost reductions, consumers would also benefit from one-time fixed cost savings. Namely, post-merger, economies of scale are likely to bring expanded capabilities to the BCNEPA Service Area that BCNEPA likely would not make on its own or would make to a lesser extent. These greater capabilities, including enhanced and expanded medical management initiatives as discussed in section VI, are likely to translate into more efficient care delivery and improved health outcomes for patients. Moreover, avoiding extensive capital investment

is necessary.

on the part of BCNEPA will help maintain reserves (i.e., what had been BCNEPA's reserves and will be added to Highmark's reserves) and may free up capital for other purposes, such as maintaining community benefit programs.



Name

December 23, 2014

Date