Economic Analysis of Highmark Inc.'s Acquisition of Control of Blue Cross of Northeastern Pennsylvania and Subsidiaries

Submission to Pennsylvania Insurance Department

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This report has been prepared and is being filed to assist the PID in its ongoing consideration of the Form A Application regarding Hospital Service Association of Northeastern Pennsylvania, doing business as Blue Cross of Northeastern Pennsylvania, First Priority Life Insurance Company, Inc., and HMO of Northeastern Pennsylvania, Inc., doing business as First Priority Health, filed February 18, 2014, as amended.

Contents

I. INTRODUCTION

A. The Highmark and BCNEPA Merger Agreement

Highmark Inc.'s ("Highmark") Form A filed on February 18, 2014 seeks approval for a change of control of the Hospital Service Association of Northeastern Pennsylvania d/b/a Blue Cross of Northeastern Pennsylvania (hereafter "BCNEPA") and its subsidiaries First Priority Life Insurance Company, Inc., (hereafter "FPLIC") and HMO of Northeastern Pennsylvania, Inc. d/b/a First Priority Health (hereafter "FPH"). BCNEPA is a Pennsylvania non-profit corporation licensed to operate a non-profit hospital plan. BCNEPA will be merged with and into Highmark, a Pennsylvania non-profit corporation licensed to operate a non-profit hospital plan and a non-profit professional health service plan.[1] FPLIC (a Pennsylvania insurance company) and FPH (a Pennsylvania non-profit corporation licensed as an HMO), will also be acquired by Highmark. Highmark currently owns 40.1% of FPLIC and 40% of FPH. Under the merger agreement, Highmark will not acquire three other subsidiaries of BCNEPA—Hospital Service Association of Northeastern Pennsylvania Foundation, AllOne Health Group, Inc. and Health Resources Corporation. Highmark will acquire two of the three subsidiaries of AllOne Health Group, Inc.—AllOne Health Management Solutions, Inc. (HMS) and AllOne Health Services, Inc. (AHS).[2]

B. Assignment and Scope of Review

I am Margaret Guerin-Calvert, a Senior Consultant of Compass Lexecon, a consulting firm that specializes in antitrust economics and applied microeconomics, and a founding director of its predecessor, Compass (Competition Policy Associates). I am an industrial organization economist, which is the branch of economics that involves the study of firms, industries, consumer behavior, and pricing. I have worked as an economist in public and private sectors on issues related to competition and competition policy involving a variety of industries since 1979, including as an Assistant Chief in the Economic Regulatory Section, Antitrust Division of the Department of Justice, as an Economist at the Federal Reserve Board, and as an Adjunct Lecturer at Duke University Institute of Policy Sciences. My credentials and experience, which encompass almost three decades of work in antitrust and regulatory policy, including qualification as an expert economist in the U.S., Canada, and New Zealand, and almost 20 years in healthcare antitrust and policy, are set out in my Curriculum Vitae attached as Appendix A.

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[1] Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab B: Merger Agreement ("Agreement of Merger, dated as of February 18, 2014, among Hospital Service Association of Northeastern Pennsylvania d/b/a Blue Cross of Northeastern Pennsylvania, a Pennsylvania nonprofit non-stock corporation, Highmark Inc., a Pennsylvania nonprofit non-stock corporation, and Highmark Health, a Pennsylvania nonprofit non-stock corporation").

[2] Ibid. at 1 and 41 (5.3(d)).

Compass Lexecon staff and I have been retained by the Pennsylvania Insurance Department (hereafter "PID") through its counsel, Blank Rome LLP, to conduct an independent review of the competitive effects and asserted benefits to the insurance buying public of the proposed transaction between BCNEPA and Highmark as set out in the Form A application. Some of our analysis in this regard will be performed in conjunction with the Blackstone Advisory Partners LP which, among other issues, is assessing the financial aspects of the merger transaction.

I and Compass Lexecon staff assisting me on this matter have specialized expertise in healthcare including work on many hospital and insurance sector mergers. We have performed an economic evaluation of the competitive effects and consumer welfare benefits of those transactions. We have advised state insurance departments, health regulators, and antitrust agencies on these issues and have provided analysis and support to providers and insurers on various health insurance and healthcare transactions. We advised the PID on the completed affiliation of the West Penn Allegheny Health System with Highmark, where I submitted a comprehensive economic report on issues related to competition, efficiencies, and benefits arising from the transaction.

I have been advised that standards set forth in 40 P.S. § 991.1402, (the "Act" or "Section 991.1402") are relevant to the PID's determination with regard to this transaction. I have been asked to address 40 P.S. § 991.1402(f) (1) (ii) and (vi):

> The department shall approve any merger, consolidation or other acquisition of control referred to in subsection (a) unless it finds any of the following:
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> ...ii. The effect of the merger, consolidation or other acquisition of control would be to substantially lessen competition in insurance in the Commonwealth or tend to create a monopoly therein. In applying the competitive standard in this subparagraph:
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> a. the informational requirements of section 1403(c)(2) and the standards of section 1403(d)(2) shall apply;
> b. the merger, consolidation or other acquisition of control shall not be disapproved if the department finds that any of the situations meeting the criteria provided by section 1403(d)(3) exist; and
> c. the department may condition the approval of the merger, consolidation or other acquisition of control on the removal of the basis of disapproval within a specified period of time.
>
> ...vi. The merger, consolidation or other acquisition of control is likely to be hazardous or prejudicial to the insurance buying public...

I also have been asked to address claimed efficiencies by Highmark under the above standard as well as under the benefits to policyholders and public interest standards of 40 P.S. § 991.1402(f) (iv):

> iv. The plans or proposals which the acquiring party has to liquidate the insurer, sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable and fail to confer benefit on policyholders of the insurer and are not in the public interest.

As part of this assessment, the inquiry and analysis encompass the following broad areas relating to these provisions:

Evaluation of the competitive effects of this merger. In undertaking this evaluation, we applied standard principles of economic analyses used by economists in merger analyses, including product and geographic market definition – that is, the evaluation of competitive alternatives available to consumers or employers. A competition effects analysis focuses on whether post-transaction there remain sufficient competitive alternatives to the merged parties to constrain price and quality competition, or whether the transaction substantially reduces that competition to the detriment of consumers.

We conducted this analysis, as well as an evaluation of dynamic factors such as entry and expansion, for the range of insurance products and services offered by Highmark and BCNEPA. We focused on competition within candidate geographies including Northeastern Pennsylvania.[3] Among other things, we examined the products and services offered by one or more of the parties such as commercial insurance, Medicaid, and Medicare Advantage. Our analysis of competition took into consideration that Highmark and BCNEPA currently have two joint ventures for commercial health insurance products – FPLIC and FPH – that they offer jointly in the area in which BCNEPA operates. In addition to the possible effect on consumers, we evaluated the impact of the transaction on contracting for services, including negotiated contracts with physicians and hospitals. [4]

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[3] There are some geographic areas routinely referenced in the parties' documents such as the BCNEPA Service Area, which is a 13-county area (defined more fully below). At other points in these documents, the geography in which BCNEPA operates and offers its products and services is referred to as Northeastern Pennsylvania. These are service areas denoted by BCNEPA although not necessarily relevant antitrust geographic markets.

[4] I developed market shares and concentration as the starting point for my analysis and assessed factors and conditions other than shares and concentration relevant to the assessment of competition and competitive effects. I was also asked to consider these shares and concentration levels in the context of standards set forth in 40 P.S. § 991.1403 3(d)(1)-(2)(i)-(ii), ("Section 991.1403"), and to compare them to the specific shares and concentration levels set out therein as well as relevant trends in concentration and share measures over time. I have included these calculations and comparisons in my report.

In addition to our independent economic analysis, we took into consideration the opinions, economic analysis, facts, and data provided by Highmark's economic expert, Cory S. Capps, PhD, which were provided in reports or in back-up information.[5] Our analysis was also informed by the comments on the public record, interviews of industry participants and community stakeholders, and proprietary as well as public data and information.

Evaluation of whether the merger is likely to be hazardous or prejudicial to the insurance-buying public. We evaluated the benefits and efficiencies (or synergies) claimed by Highmark to arise from the proposed transaction and their impact on costs or quality of products and services. We focused particularly on the claimed benefits for consumers and the community from the transaction, i.e., merger-specific benefits, including those identified by Highmark and BCNEPA, as well as Highmark's economic expert Dr. Capps. Among other elements, this inquiry involved an independent assessment of the specific sources of cost savings as the parties move from the joint venture to a fully-merged entity, and those incremental to the joint venture. We considered the rationale for the transaction, integration and other plans, past affiliations and results, and evidence on the sources of potential benefits and efficiencies.

II. SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

My competitive effects analysis finds no substantial lessening of competition from the proposed merger of Highmark and BCNEPA in any relevant antitrust market. I base this evaluation and assessment on review of data and information provided by the parties, including the rationales for the transaction; review of their expert's reports; information in the PID record; interviews of market participants; and a detailed evaluation of the competitive alternatives for each of the several insurance products and services offered by Highmark and BCNEPA. These include commercial insurance products, as well as other products such as managed Medicaid, Children's Health Insurance Program (hereafter "CHIP"), Medicare Advantage, and supplemental coverage for Medicare (Medigap).

[5] Confidential Supplement to Form A, Tab 12, 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 Under 40 P.S. § 991.1403," Feb. 14, 2014 (hereafter "Capps Confidential Report"); Addendum No. 2 to Confidential Supplement to Form A, 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 (hereafter "Capps Confidential Efficiencies Report"); and Addendum No. 6 to Confidential Supplement to Form A, Cory S. Capps, PhD, "Supplement to the Analysis of Efficiencies," October 31, 2014 (hereafter "Capps Confidential Efficiencies Supplement"). Dr. Capps also provided public versions of his aforementioned reports: Highmark Inc. ("Highmark") Supplemental Response to Information Requests 5.2 and 5.2.1 Through 5.2.9 from the Pennsylvania Insurance Department, 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 Under 40 P.S. § 991.1403," Dec. 23, 2014 (hereafter "Capps Public Report"); and Highmark Inc. ("Highmark") Supplemental Response to Information Requests 5.2 and 5.2.1 Through 5.2.9 from the Pennsylvania Insurance Department, 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," Dec. 23, 2014 (hereafter "Capps Public Efficiencies Report"). Where possible, we refer to these latter two reports in our assessment.

Based on my evaluation of the evidence, I have reached the following opinions with regard to the competitive effects:

- For several products, the parties either currently jointly provide the product(s) through specific ventures, or only one of the parties currently provides the product, or the products are provided to non-overlapping customer groups suggesting that the other party is not the next best or closest alternative for the other. I was able to determine that there are competitive alternatives that remain to discipline price and quality competition for each of the product lines. The transaction appears unlikely to reduce competition substantially for these products, when taken in the context of these available alternatives and the fact that BCNEPA was neither a maverick nor an especially strong or low cost competitor in any of the product lines. Moreover, for a variety of reasons, BCNEPA was unlikely to be able to address these issues particularly on its own or through potentially available alternatives.[6]
- For most of the commercial insurance products offered in overlapping geographic areas, Highmark and BCNEPA are engaged in joint ventures – FPH and FPLIC – and are not currently offering independent competitive alternatives to consumers. The transaction appears unlikely to reduce competition substantially for these products, when taken in the context of the available alternatives for these commercial insurance products. For other commercial insurance products – e.g. dental & vision, disability insurance, long-term care insurance, and workers' compensation – BCNEPA does not offer any plans directly and appeared unlikely to do so independently. As a result, the transaction is unlikely to reduce competition substantially for these products.
- For Stop Loss insurance, a type of product that both BCNEPA and Highmark offer to some extent in overlapping geographic areas, the extent of overlap appears limited. I was able to identify a number of alternative providers to whom potentially affected businesses seeking stop loss products could turn. As a result of BCNEPA's low incremental share and the fact that competitors can include those within and outside the state, the transaction is unlikely to lessen competition substantially in this product market.
- For Medicaid and CHIP related insurance products, Highmark and BCNEPA do not currently offer plans in any overlapping areas in Pennsylvania and tend not to be bidding in the same areas. There remain competitive alternatives for each of these products in the area served by BCNEPA, including large firms. Moreover, BCNEPA chose to exit the Medicaid line very recently. Therefore, the transaction is unlikely to lessen competition substantially for these types of insurance.
- For Medicare Advantage plans and Medigap plans, BCNEPA and Highmark are engaged in joint ventures in the BCNEPA Service Area. BCNEPA does not offer its own Medicare Advantage Plan or its own Medigap plan independent of Highmark. Further, BCNEPA does not offer any PDP plans. For each of these products, I was also able to identify a number of

[6] As noted herein, I assume for purposes of this report that limitations on the ability of BCNEPA to expand beyond its 13-county area were unlikely to change in the foreseeable future.

alternative providers. The transaction is unlikely to lessen competition substantially for Medicare-related insurance products.

- My examination of dynamic factors including expansion illustrated that competitors were offering alternative products to customers across the range of potentially affected products, and in many categories were increasing share relative to BCNEPA in recent years.

I note that these opinions are consistent with those reached by Dr. Capps.

Based on my analyses and review of the claimed cost savings and benefits that could result from this transaction, I have reached the following opinions:

- I believe the economic evidence presented in the PID record supports the merger's ability to confer some benefits on policyholders of BCNEPA, and, possibly Highmark, and would be in the public interest of policyholders. Based on established principles of antitrust review of claimed efficiencies, such as those under the DOJ/FTC Merger Guidelines[7], merger-specific efficiencies do not have to be large to result in positive benefits when adverse competitive effects are unlikely.[8] Moreover, non-merger-specific, but nonetheless important, additional costs savings also will benefit the merging parties and potentially the public.
- In sum, I find sufficient – although limited – support in the PID record for the specific claimed cost savings. I also find positive economic support in Highmark's intention to introduce care management strategies in Northeastern Pennsylvania designed to improve the quality of care at reduced costs. In addition, sufficient evidence exists in the literature to support these types of claimed benefits.

III. THE PARTIES

A. Highmark[9]

Highmark is licensed by the PID to offer health insurance plans in the Commonwealth. It is an independent licensee of the Blue Cross Blue Shield Association and operates under the name "Highmark Blue Cross Blue Shield" in the 29 western-most counties of Pennsylvania and "Highmark Blue Shield" in the remaining counties in the Commonwealth. Its parent corporation, Highmark Health, is the sole member of Highmark. Highmark is also affiliated with the Allegheny Health Network, the parent corporation of which is Highmark Health. Highmark is the sole member of Highmark BCBSD Inc. and Highmark West Virginia Inc.

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[7] Horizontal Merger Guidelines, U.S. Department of Justice and Federal Trade Commission, issued August 19, 2010 (hereafter "Merger Guidelines").

[8] In addition, where there are limited competitive effects, there may be less need to demonstrate substantial merger-specific efficiencies.

[9] The information in this section is derived from the Highmark-BCNEPA Merger Agreement Form A and related attachments, and accepts it as accurate. See, Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Feb. 18, 2014 at 6-12.

Highmark has interests in several insurance and other subsidiaries. The major subsidiaries are listed below[10]:

- HVHC Inc. (100% Highmark-owned)
  - Davis Vision Inc.
- United Concordia Companies, Inc. (100% Highmark-owned)
  - United Concordia Dental Plans of Pennsylvania, Inc.
  - United Concordia Life and Health Insurance Company
- HM Insurance Group, Inc. (100% Highmark-owned), including:
  - Highmark Casualty Insurance Company
  - HM Life Insurance Company
  - HM Casualty Insurance Company
- Keystone Health Plan West, Inc.
- Inter-County Hospitalization Plan, Inc. (50% Highmark-controlled, 50% Independence Blue Cross-controlled)
  - Preferred Health Systems, Inc.
- Inter-County Health Plan, Inc. (50% Highmark-controlled, 50% Independence Blue Cross-controlled)
- HMO of Northeastern Pennsylvania, Inc. d/b/a First Priority Health (40% Highmark-owned, 60% BCNEPA-owned)
- First Priority Life Insurance Company, Inc. (40.1% Highmark-owned, 59.9% BCNEPA-owned)
- Gateway Health Plan, L.P. (49% L.P. held by Highmark, 1% G.P. held by Highmark Ventures Inc., 50% Mercy Health Plan-owned)
  - Gateway Health Plan, Inc.
- Highmark Affiliates outside Pennsylvania
  - Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield Delaware (100% Highmark-controlled)
  - Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield West Virginia (100% Highmark-controlled)

[10] Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab C: Highmark Corporate Organizational Chart at 1-3; Testimony of David L. Holmberg, President and CEO of Highmark Health, Public Informational Hearing, RE: Proposed Merger Between Highmark, Inc., and Blue Cross of Northeastern Pennsylvania, Nov. 12, 2014 at 78:1-5; Capps Public Report at ¶ 21 citing Letter from Gateway Health Plan, to Pennsylvania Insurance Department, Re: Request for Approval of Conversion of Gateway Health Plan, Inc. (Nov. 13, 2013).

B. BCNEPA[11]

BCNEPA is licensed by the PID to provide traditional indemnity health care insurance coverage to groups and individuals. It is an independent licensee of the Blue Cross Blue Shield Association and offers its insurance products in 13 counties in northeastern and north central Pennsylvania. BCNEPA primarily administers health insurance plans through two entities, both in conjunction with Highmark:

- First Priority Life Insurance Company, Inc. (59.9% BCNEPA-owned, 40.1% Highmark-owned)
  - FPLIC is licensed to issue life and annuities and accident and health insurance products. It is also able to issue non-gatekeeper preferred provider organization, exclusive provider organization, and traditional indemnity health insurance products.
- HMO of Northeastern Pennsylvania, Inc. d/b/a First Priority Health (60% BCNEPA-owned, 40% Highmark-owned)
  - FPH is licensed to offer health maintenance organization coverage to employers. It also participates in the Pennsylvania CHIP.

Its subsidiary is AllOne Health Group (100% BCNEPA-owned).

BCNEPA faced considerable financial and operating challenges that prompted its search for a suitable merger partner. Testimony and record evidence indicates that BCNEPA's decision to select Highmark is based on its understanding of the substantial benefits it would involve, including improving its administrative cost structure, ensuring the necessary capital funding to improve operations and fund care management strategies needed to conform to the intentions of the Affordable Care Act (ACA)[12] and enabling the merged firm to compete more effectively.

C. Relationship Between the Parties

Although BCNEPA and Highmark are nominally competitors in the Pennsylvania insurance marketplace for a variety of products and services, their commercial relationship is complicated because they are engaged in a number of joint ventures, and other co-marketing of several insurance products. This is particularly the case for insurance products for which the area of competition is the BCNEPA Service Area or similar local or regional areas that are smaller than

[11] The information in this section is from the Highmark-BCNEPA Merger Agreement Form A and related attachments and accepts that information as accurate. Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Feb. 18, 2014 at 6-12.

[12] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6001, 124 Stat. 119, 684–89 (2010). See, also Brennan, J., & Guerin-Calvert, M. (2013). Assessing Hospital Mergers and Rivalry in an Era of Health Care Reform. Antitrust, 27(3), 63-71.

the state of Pennsylvania and where the products include, for example, commercial insurance products.[13]

In specific:

- Highmark and BCNEPA offer commercial health insurance products in the BCNEPA Service Area through the joint ventures FPLIC and FPH.[14]
- Highmark and BCNEPA have a Joint Operating Agreement (hereafter "JOA") that covers some additional insurance products.[15]
- BCNEPA does not offer dental and vision insurance products, generally or in the area. It contracts these plans out to Highmark-owned entities, United Concordia Life and Health Insurance Company and HM Life Insurance Company (administered by Davis Vision, also a wholly owned subsidiary of Highmark), respectively.[16]
- Highmark and BCNEPA jointly administer and market the Medicare Advantage "Freedom Blue" plans in the BCNEPA Service Area.[17]
- BCNEPA and Highmark jointly offer two Medigap plans: BlueCare Security (to individuals) and BlueCare Senior (to employers). According to the BCNEPA-published "Your Blue Book",

[13] For convenience of exposition in this section, we refer to the BCNEPA Service Area as a localized or regional area of competition as well as the area in which BCNEPA operates. Documents and materials also refer to Northeastern Pennsylvania. We define the relevant geographic aspect of markets for specific insurance products in subsequent sections after applying the more specific economic criteria for geographic aspects, which involves identification of the specific suppliers and their locations that serve to constrain price or quality. For a visual depiction of the BCNEPA Service Area, see, Testimony of Denise S. Cesare, President and CEO of Blue Cross of Northeastern Pennsylvania, Pennsylvania Insurance Department Public Informational Hearing, Slide Presentation, Nov. 12, 2014 at 4-5.

[14] Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Feb. 18, 2014 at 10.

[15] Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Feb. 18, 2014 at 10. See also, BCNEPA Confidential Response to Information Request 5.2.18.1 from the Pennsylvania Insurance Department at NEPA-000435; and Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Confidential Supplement, Tab 8: Existing Agreements Between Highmark and BCNEPA, "Joint Operating Agreement Between Highmark Inc. and Hospital Service Association of Northeastern Pennsylvania d/b/a Blue Cross of Northeastern Pennsylvania," Apr. 29, 2005 at Attachment A.

[16] Blue Cross of Northeastern Pennsylvania, "Dental & Vision," accessed Nov. 19, 2014, available at https://www.bcnepa.com/Products/DentalVision.aspx; Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab C: Highmark Corporate Organizational Chart.

[17] Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab E: Overview of Highmark Business Perspective at 15, and Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab F: Overview of BCNEPA Business Perspective at 11. See also, Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Confidential Supplement, Tab 8: Existing Agreements Between Highmark and BCNEPA, "Joint Operating Agreement Between Highmark Inc. and Hospital Service Association of Northeastern Pennsylvania d/b/a Blue Cross of Northeastern Pennsylvania," Feb. 25, 2005 at 1. The 3rd amendment to the JOA was signed on December 1, 2008 and is effective until December 31, 2020 unless terminated by either party. (BCNEPA Confidential Response to Information Request 2.1.13 from the Pennsylvania Insurance Department at NEPA-003786-87)

the BlueCare Security and the BlueCare Senior plan are offered in partnership with Highmark.[18]

Furthermore, for many of the insurance products for which Highmark and BCNEPA are not engaged in a joint venture or other partnership BCNEPA and Highmark tend not to market their insurance products and services in the same areas to common customers.[19] For insurance products such as Medicaid and CHIP plans, there currently is little, if any, geographic overlap between BCNEPA and Highmark; i.e., neither currently has commercial relationships of any consequence in the other's primary region of operation. Furthermore, BCNEPA has recently exited the provision of managed Medicaid services.

Taken collectively, these facts indicate that the bulk of BCNEPA's insurance offerings are made either in conjunction with Highmark or the products do not involve any substantive overlap with Highmark.

IV. BUSINESS JUSTIFICATION FOR THE TRANSACTION

A. Challenges Facing BCNEPA

An independent consultant retained by BCNEPA in 2011 identified several challenges that BCNEPA faced that would make it difficult to sustain its mission financially and to continue to serve its stakeholders as an independent entity. Among the identified trends and factors were

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[18] Blue Cross of Northeastern Pennsylvania, "Your Blue Book – BlueCare Security," accessed Nov. 21, 2014, available at https://d1tpfj3hind0fx.cloudfront.net/Media/Documents/Handbooks/SecurityHB.pdf. See also, Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Confidential Supplement, Tab 9: Highmark Confidential Financial Projections and DOI 135's, Highmark Inc. DOI-135 at 7 and Highmark Confidential Response to Information Request 4.4.3 from the Pennsylvania Insurance Department at HMI-001825-60 (Blue Cross of Northeastern Pennsylvania, Request for Proposal, March 2013) for descriptions of the plans and products that BCNEPA offers.

[19] In addition, there are limitations that we discuss below on the ability of either BCNEPA or Highmark to offer competing commercial insurance and other products in each other's areas. For purposes of this report, we will assume that external restrictions that limit the ability of BCNEPA and Highmark to expand their scope of operations outside of their current service areas remain in place. See, Blue Cross and Blue Shield Association, "About Blue Cross Blue Shield Association," accessed Nov. 25, 2014, available at http://www.bcbs.com/about-the-association/; Testimony of Denise S. Cesare, President and CEO of Blue Cross of Northeastern Pennsylvania, Public Informational Hearing, RE: Proposed Merger Between Highmark, Inc., and Blue Cross of Northeastern Pennsylvania, Nov. 12, 2014 at 20:24-21:4 ("In comparison to its competitors BCNEPA's Blue-branded service area is limited to 13 counties, thus constraining its ability to grow its membership base in an increasingly competitive market, and hampering its ability to withstand the membership mix risks associated with the ACA."); and Capps Public Report ¶ 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.").

continuing higher-than-expected medical care costs associated with technological advances, an aging population, higher pharmaceutical costs, new taxes, and requirements under the ACA. Additionally, BCNEPA's financial position was likely to be adversely affected by lower revenues associated with an increase in conversions of employers in its area to self-funded plans, and the concomitant reduction in full premium revenues. BCNEPA faced the additional challenge of a lower membership base and relatively higher administrative costs as compared to larger health insurance providers. Finally, the consultant identified changes with consolidation on the provider side and competition within the BCNEPA Service Area as placing increased financial pressure on BCNEPA as competitors including Geisinger offered lower-cost health care plans and gained share.[20]

In response to these challenges, the BCNEPA Board of Directors explored several options. They first attempted to find options that would enable BCNEPA to remain a standalone entity, including diversifying into other non-Blue-granted businesses outside the BCNEPA Service Area and examining current provider affiliations for opportunities to remain independent. They also explored the option of becoming an integrated delivery system, which they attempted and ultimately failed to do. BCNEPA then looked at the feasibility of other partnerships. In particular, they looked for partners who shared the same goals, culture, values, and vision that focused on the local community.[21]

After exploring its strategic options, BCNEPA made the decision to pursue an affiliation with another healthcare insurer. It initiated a Request for Proposal in March 2013, citing "changing

[20] See, Testimony of Denise S. Cesare, President and CEO of Blue Cross of Northeastern Pennsylvania, Public Informational Hearing, RE: Proposed Merger Between Highmark, Inc., and Blue Cross of Northeastern Pennsylvania, Nov. 12, 2014 at 18:8-20:22. In November 2011, [redacted] presented the BCNEPA Sustainable Growth Plan to the BCNEPA Board of Directors. It specifically identified the following challenges that face BCNEPA: environmental uncertainty, membership and margin dilution, local provider consolidation, and health plan competition. (Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Confidential Supplement, Tab 7: BCNEPA [redacted] Report [redacted] (hereafter [redacted] Presentation") at 4.

[21] See, Testimony of Denise S. Cesare, President and CEO of Blue Cross of Northeastern Pennsylvania, Public Informational Hearing, RE: Proposed Merger Between Highmark and Blue Cross of Northeastern Pennsylvania, Nov. 12, 2014 at 57:4-58:21. In its presentation, [redacted] offered three alternative paths for BCNEPA to consider. First, go it alone by pursuing an independent, insurance focused business model, noting the difficult challenges they will face in this approach. Second, more aggressive collaboration with providers through exclusive or deeper provider networks, noting that no one provider would be able to support full market coverage across the BCNEPA Service Area. And third, pursue targeted or limited alliances with select Blues vs. Statewide network, noting that while a targeted or limited strategy would offer benefits, optimal leverage (geographic/pricing) would be gained through a full alliance, particularly with Highmark. [redacted] also emphasized the importance of BCNEPA significantly reducing its administrative costs and recommended for BCNEPA to move forward with pursuing capital and strategic partners while its market position was still relatively strong. ([redacted] Presentation at 28)

health care landscape and various other environmental changes and challenges."[22] Among others, BCNEPA cited five objectives in pursuing an affiliation with another insurer: (1) increase market competitiveness, (2) establish innovative relationships with providers to reduce the overall cost of patient care, (3) ensure access to government business, (4) improve scale, and (5) enhance non-medical margin (e.g., AllOne Health Group).[23]

BCNEPA received offers and ultimately selected Highmark. In its filing with the PID, BCNEPA also cited (1) pressure on operating results, (2) heightened exposure to risk, (3) need for significant investment, (4) capital strength of its competitors, (5) scale limitations, and (6) an expanding government marketplace, as the reasons for pursuing its merger with Highmark.[24] BCNEPA's reasons for selecting Highmark as its best option include: [25]

- Positions the merged company as continuing to provide affordable, high quality healthcare options and excellent customer service under an enhanced Blue brand;
- Continues BCNEPA's longstanding mission as a non-profit, community-based and community-minded company while adding scale that draws on the merged company's long-term financial strength and ability;
- Expands access to capital for new investments that will benefit subscribers through (a) innovative tools and technology that improve care quality and patient wellness, (b) more cost-effective and quality-driven partnerships with providers, (c) expanded access to health insurance with efficiencies that can be passed on to customers.
- Provides a larger geographic footprint which is necessary to effectively compete for commercial and government business;
- Provides minimal disruption to customers and health care providers since BCNEPA is already utilizing certain Highmark systems and IT infrastructure to support its operations;[26]
- Highmark has a proven track record of integrating organizations for mutual success;
- Provides significant commitments of importance to BCNEPA, including:
    - Continued local presence in terms of regional operations and staffing;
    - Local advisory board and local representation on Highmark Board of Directors;

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[22] Highmark Inc. ("Highmark") Confidential Response to Information Request 4.4.3 from the Pennsylvania Insurance Department at HMI-001830 (Blue Cross of Northeastern Pennsylvania, Request for Proposal, March 2013).

[23] Ibid. at HMI-001831. AllOne Health Group consists of AllOne Health Management Solutions, which provides health, wellness and disease management programs to BCNEPA employers and businesses outside of BCNEPA's service area; AllOne Health Services, an inactive company; and AllOne Health Resources, which provides occupational health services, onsite clinical care and employee assistance programs. (HMI-001834-35) BCNEPA indicated that AllOne Health Group could be either part of the transaction or not. (HMI-001830)

[24] Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab F: Overview of BCNEPA Business Perspective at 2-11.

[25] Ibid. at 17-18.

[26] See BCNEPA Confidential, "Information Technology Systems Discussion," undated at 4 for a description of infrastructure services currently outsourced to Highmark.

- 18-month commitment to existing employees for continued employment or severance;
- Significant funding to one or more charitable organizations.

B. Highmark's Business Rationale and Alleged Benefits from the Transaction

In Highmark's presentation to its Board of Directors seeking authorization to proceed with the signing of the definitive agreement with BCNEPA, Highmark stated that the proposed merger would yield significant benefits to both BCNEPA and Highmark. Specifically, the merger would:

- Benefit Highmark's existing strategic and financial interests in the Northeastern Pennsylvania region and its larger employer group markets. In addition, it cited growth opportunities and scale-based fixed cost reductions; and
- Benefit BCNEPA's continuing presence in the Northeastern Pennsylvania region and would enhance capabilities and generate cost reductions.[27]

In addition, Highmark stated that the merger would generate annual administrative synergies of more than $25 million per year and additional PBM contract savings of more than $5 million per year once fully implemented. The merger would require an upfront investment of $64 million which would be offset by long-term annually recurring synergies of approximately $[redacted] million.[28]

Highmark discussed its rationale for entering into this transaction in its Form A filing. Highmark sees itself as "uniquely positioned" to meet the challenges identified by BCNEPA.[29] Highmark currently holds a 40% stock interest in BCNEPA's FPH subsidiary and a 40.1% interest within BCNEPA's FPLIC subsidiary. It also provides BCNEPA with systems and data center services under contract agreements. Highmark believes these existing relationships would make the ownership transition less disruptive for BCNEPA and its subscribers. According to Highmark, the merger also provides the strategic imperative of ensuring that "consumers have access to innovative, high-quality and high-value products and services offered by a financially stable health plan with sufficient scale and scope, and a competitive cost structure, to succeed, and to continue to serve local communities."[30]

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[27] Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Confidential Supplement, Tab 6: Highmark Board of Directors Presentation and Resolution, "The Case for Highmark Inc.'s Merger with Blue Cross of Northeastern PA, Prepared for Highmark Inc. Board Consideration, February 13, 2014," at 3.

[28] Ibid. at 3 and 13-14. Confidential actual estimates are (1) annual administrative synergies of [redacted] per year and (2) additional PBM contract savings of more than [redacted] per year.

[29] Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab E: Overview of Highmark Business Perspective at 2.

[30] Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab E: Overview of Highmark Business Perspective at 2-3.

Highmark also articulated benefits that will accrue to Highmark and its existing subscriber base. Highmark states that the merger will generate additional economies of scale that will create synergies and benefits to subscribers in the BCNEPA service area, as well as Highmark's other service areas.[31] It will also preserve Highmark's existing business interests in Northeastern Pennsylvania and contiguous areas. Other benefits to Highmark include:

- Continuation of the significant annual contribution towards Highmark's fixed IT costs generated by the existing relationships with BCNEPA;
- Geographic diversification and strengthening of Highmark's financial and product portfolio of its health insurance business as well as its diversified businesses that offer dental, vision and stop loss products and services;
- Geographic expansion to better serve Highmark's large regional and national employers with employees and operations in multiple locations in Pennsylvania;
- Better positioning to participate more effectively in federal- and state-sponsored health insurance programs; and
- Enhanced ability to compete for national account customers through financial diversification and synergies and administrative efficiencies.[32]

I consider the stated BCNEPA challenges, the claimed benefits accruing to both BCNEPA and Highmark individually, and the combined firm's enhanced ability to meet BCNEPA's stated challenges as important factors weighing in my evaluation and analysis of the efficiencies and benefits to policyholders of this transaction. Moreover, in conducting the competitive effects analyses, I consider the alternatives and "but-for" world of BCNEPA continuing to operate on its own.[33]

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[31] Ibid. at 4. As I discuss further below, I do not find, nor does Dr. Capps, that there are significant synergies or new economies of scale or cost reductions accruing to Highmark from the transaction. Rather, these are primarily to BCNEPA.

[32] Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab E: Overview of Highmark Business Perspective at 5-7.

[33] Technically, BCNEPA had the ability to exit from the joint ventures with Highmark and operate them independently based upon Highmark's change of control if BCNEPA exercised its right to acquire the interests of Highmark. See, Shareholders Agreement between First Priority Life Insurance Company, Inc., Hospital Service Association of Northeastern Pennsylvania (BCNEPA), and Highmark Inc., Apr. 29, 2005 at 11(a). ("In the event of a Change of Control (as defined in Paragraph 25(h)(vi) below) of either Shareholder (the "Affected Party"), the Shareholder which is not subject to the Change of Control (the "Non-Affected Party") shall have the right and option, for a period of 180 calendar days following the date on which written notice of the Change of Control is received by the Non-Affected Party, to do either of the following: (a) to purchase and/or to cause the Company to purchase (the "CoC Call Option") all of the Shares owned (of record or beneficially) by the Affected Party at a purchase price equal to the *product of* (i) the Agreed Value per Share, *multiplied by* (ii) 0.75; provided, however, that if the Affected Party is BCNEPA, then the purchase price shall equal the Agreed Value per Share, The Non-Affected Party may exercise the CoC Call Option at any time before the expiration of the 180-calendar day period by delivering to the Affected Party written notice of such exercise. Settlement of the purchase and sale of the Shares shall be conducted in accordance with Paragraph 15 below. (b) to sell (the "CoC Put Option") to the Affected Party all of the Non-Affected Party's Shares at a purchase price equal to the *product of* (i) the Agreed Value per Share, *multiplied by* (ii) 1.25; provided, however, that if the Affected Party is

V. EVALUATION OF THE COMPETITIVE EFFECTS OF THE TRANSACTION

A. Overview

In undertaking our competitive effects evaluation of the proposed transaction between BCNEPA and Highmark, we start with an overview of the products and services offered by each. In conducting that evaluation, I reviewed documents and testimony from the parties, and reviewed the analyses and information set out in the Capps Confidential Report and Capps Public Report and the opinions expressed therein. Dr. Capps identifies several distinct insurance products and services provided either by Highmark or BCNEPA and focuses particularly on those products and services offered to customers in the BCNEPA Service Area. In his analysis and cataloguing of these products, he notes which are offered by Highmark, by BCNEPA, by both, or by the parties in a joint venture or JOA arrangement.

After a review of the principles of product market definition and substitution using the framework of the US DOJ/FTC Merger Guidelines, Dr. Capps opines that there are a number of discrete relevant products for consideration in the competitive effects analyses (and for which competitive alternatives should be identified as part of the geographic aspect of relevant antitrust market definition). For purposes of my report, I accept the classifications set out by Dr. Capps, and note herein any differences with my opinions. I would note that any such differences do not materially affect the competitive effects conclusions.

In this section, I evaluate relevant antitrust product markets and assess competitive overlaps between Highmark and BCNEPA. I identify and evaluate relevant information about their competitive influence as well as measures of size. I also discuss the geographic aspect of the relevant market and identify information and facts on competitors including relevant information on changes in share or competitive significance. In each section, I reference the conclusions or opinions drawn by Dr. Capps and review them and their bases. I also address any supplemental information relevant for competitive effects analyses upon which I rely in my conclusions. For convenience, I organize the discussion by product.

In conducting my review, I apply the principles routinely used by economists in the evaluation of relevant antitrust markets: identification of alternative competitors for inclusion in the relevant market, and assessment of shares and other measures of structure. The analyses that I conducted for defining relevant antitrust product and geographic markets applied the same principles and methodology used by Dr. Capps. This included evaluation of substitution

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BCNEPA, then the purchase price shall equal the Agreed Value per Share. The Non-Affected Party may exercise the CoC Put Option at any time before the expiration of the 180-calendar day period by delivering to the Affected Party written notice of such exercise. Settlement of the purchase and sale of the Shares shall be conducted in accordance with Paragraph 15 below.")

possibilities by consumers of various types of insurance (e.g., HMO, PPO), how products are developed and priced by insurers, factors that induce switching between them for price or quality terms, and the areas over which insurers provide various insurance products. As discussed herein, economists define product and geographic antitrust markets based on substitution patterns of consumers. Markets should include the products (and corresponding geographic area for suppliers) to which consumers could turn in response to a hypothetical significant, non-transitory increase in price. I reviewed both factual information and business documents among other information in my assessment.[34]

I note that the latter are useful starting points of analyses but that additional dynamic factors should also be considered. In evaluating the relevant product market, I took into consideration the factors addressed in the relevant statutes, and also the experience of reviewing agencies such as the DOJ in past insurance mergers, and my own experience. The standards relevant to the assessment of competitive effects identify the following information and evidence for the PID to consider in making its determination: market definition, shares, and concentration.[35]

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[34] For a discussion of product and geographic market definition in the context of healthcare insurance, see e.g. Chapter 6, Section II.A in Improving Health Care: A Dose of Competition, A Report by the Federal Trade Commission and the Department of Justice, July 2004; ABA Section of Antitrust Law, Health Care Mergers and Acquisitions Handbook at Chapter 7 and Hyman, David A. and William E. Kovacic, "Monopoly, Monopsony, And Market Definition: An Antitrust Perspective On Market Concentration Among Health Insurers," Health Affairs, November 2004 vol. 23 no. 6, 25-28.

[35] See, Merger Guidelines at Section 4 for underlying principles of market definition. The Department of Justice has reviewed a number of insurance mergers and matters involving business practices and alleged anticompetitive effects in a variety of geographic areas in the past two decades, and has set out market definitions in press releases and complaints. See, e.g., Competitive Impact Statement, United States v. Blue Cross and Blue Shield of Montana, Inc., Billings Clinic, Bozeman Deaconess Health Services, Inc., Community Medical Center, Inc., New West Health Services, Inc., Northern Montana Health Care, Inc., and St. Peter's Hospital (noting two relevant product markets: the "sale of commercial group health insurance" and the "sale of commercial individual health insurance" and four relevant geographic markets: "Billings MSA (Yellowstone and Carbon Counties);" "Bozeman MSA (Gallatin County);" Helena MSA (Lewis and Clark County and Jefferson County); and "Missoula MSA (Missoula County)"); Competitive Impact Statement, United States v. UnitedHealth Group, Inc. and Sierra Health Services, Inc., filed February 25, 2008 (noting a relevant antitrust market "no broader than the sale of Medicare Advantage health insurance plans to senior citizens ("seniors") and other Medicare-eligible individuals in the Las Vegas area" and including market share estimates for relevant product markets defined as "all Medicare Advantage plans" and "Medicare Advantage coordinated-care plans (MA-HMO and MA-PPO plans)"); and Competitive Impact Statement, United States v. UnitedHealth Group, Inc. and PacifiCare Health Systems, Inc., filed March 3, 2006 (indicating that the "sale of commercial health insurance to small-group employers in Tucson, Arizona" is a relevant antitrust market)., No. 1:05 CV 2436 (D.D.C. filed Dec. 20, 2005). I refer also to a comprehensive set of principles on market definition that are set out in ABA Section of Antitrust Law, Market Definition in Antitrust: Theory and Case Studies, 2012. See also, Schwartz, Marius, Economics Director of Enforcement, Antitrust Division, U.S. Department of Justice. "Buyer Power Concerns and the Aetna-Prudential Merger," October 20, 1999, Text Released November 30, 1999. For a review of the methodologies employed by the DOJ, see, "The Case for Reinvigorating Antitrust Enforcement for Health Plan Mergers and Anticompetitive Conduct to Protect Consumers and Providers and Support Meaningful Reform," American Hospital Association (May 2009), available at http://www.aha.org/aha/content/2009/pdf/09-05-11-antitrust-rep.pdf. There is also extensive literature addressing potential effects of insurance mergers on premiums and on providers.

In conducting my assessment of the Capps Confidential Report and Capps Public Report, I examined the definition of each of the relevant antitrust markets (both product and geographic) and then examined information and analysis provided in the report with regard to the identity of competitors as well as structural information such as shares.

In evaluating share measures and concentration, I took into consideration the alternative share measures that one can employ in evaluating the strength of competitive alternatives for evaluating health insurance transactions. Two commonly used measures are premiums underwritten (which is equivalent to a revenue or sales estimate) and enrollment or number of members or enrollees. Counts of enrollees typically include both the policyholder and family members. Availability of data often constrains the choice of measure, particularly for comparison across various entities, and there are a number of reasons to use enrollees in this circumstance. Where possible, I reference both measures. Many of Dr. Capps' analyses rely primarily on enrollment data in calculating share measures. This occurs where the unit of observation for geography is smaller than the state or national data, and where enrollment is the only common unit of observation.

In analyzing the competitive effects of the proposed transaction, an additional relevant factor to consider is the ease by which competitors can either enter the insurance market or expand their current offerings to compete with incumbent insurance providers. Some of the products at issue require competition in a formal RFP process. For example, Medicaid insurance providers must engage with a formal RFP process with the Department of Public Welfare (hereafter "DPW") in order to be eligible to serve a given region. Medigap plans offered by private insurers must be standardized according to rules set forth by the Centers for Medicare & Medicaid Services (CMS). Expansion by competitors in Pennsylvania and in the BCNEPA Service Area appears practical for commercial insurance offerings and for products such as Medicare Advantage. There is evidence of the ability to expand in the area in which BCNEPA operates, as demonstrated by gains in share by Geisinger, Aetna and United; there appears to be other entities that have expanded for other products.[36] Another factor with regard to competitive dynamics is that BCNEPA appears to be limited in its ability to expand beyond its current geographic footprint for several products.[37] The newly merged entity could provide a set of unified insurance offerings beyond the BCNEPA Service Area to respond to existing competition.

In the following, I review all of these elements and Dr. Capps' assessment of the relevant geographic market for each of the products (e.g., commercial health insurance), the analysis in the Capps Confidential Report and Capps Public Report with regard to competitive alternatives for customers that are capable of constraining price or quality competition, and finally measures of share and structure. I conclude each sub-section (organized by product) with an assessment

[36] See, BCNEPA Confidential Supplemental Response to Information Request 5.2.9.2(A) from the Pennsylvania Insurance Department.
[37] See Footnote 19 *supra*.

of the likely competitive effect of the transaction, and assess the conclusions and opinions of Dr. Capps in that regard.

B. Overview of Competitive Effects from Merger of Healthcare Insurers

Commercial health insurers play multiple roles within the healthcare marketplace. They function as purchasers of healthcare services from providers, including hospitals, physicians, and other healthcare service providers on behalf of their enrollees or their employers. They act as negotiators and administrators on behalf of self-insured employers. In these roles, the commercial health insurer is engaged in negotiations with a variety of entities to form networks of providers to deliver the required healthcare services to the commercial insurer's enrollees, where those negotiations result in contracts that cover a variety of terms including reimbursements for services. They act as providers and sellers of health insurance and related healthcare services to individuals and groups of consumers; and develop and offer plans and products that include various terms and conditions, including premiums and out-of-pocket payments such as deductibles and co-payments.

A merger between two competing commercial health insurers could result in anticompetitive market power where there are insufficient competitive alternatives to avoid a substantial lessening of competition. Given the two functions of the commercial health insurer as a purchaser and a seller, there are two ways in which such an anticompetitive exercise of market power can materialize: *monopsony power*, which is in the insurer's function as a buyer and negotiator of healthcare services, and *monopoly power*, which arises from the insurer's role as a seller of health insurance to individuals or groups of consumers, administrative services and/or negotiator on behalf of self-insured employers.[38] The exercise of market power as a likely result of a merger or acquisition is a recognized concern by Courts and also in agency enforcement.[39]

The exercise of monopsony power in the input (provider) market for healthcare services leads to competitive harm and a welfare loss for society.[40] Both the quantity and price of healthcare

[38] See Marius Schwartz, Buyer Power Concerns and the *Aetna-Prudential* Merger, Address Before the 5th Annual Health Care Antitrust Forum at Northwestern University School of Law 4-6 (October 20, 1999) *available at* http://www.usdoj.gov/atr/public/speeches/3924.wpd for a discussion of these theories and effects. For additional discussion of these concepts in context of health insurance see, e.g., Dafny, Leemore, Mark Duggan, and Subramaniam Ramanarayanan. 2012. "Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry." *American Economic Review*, 102(2): 1161-85.

[39] See, e.g., Kartell v. Blue Shield of Massachusetts (1st Circuit, 1984, 749 F.2d 922) cert. denied (1985, 471 U.S. 1029); Ball Memorial Hospital, Inc. v Mutual Hospital Insurance, Inc. (7th Circuit, 1986, 784 F.2d 1327); Ocean State Physicians Health Plan, Inc. et, al. v. Blue Cross and Blue Shield of Rhode Island (1st Circuit, 1989, 883 F. 2d 1101) cert. denied (1990, 494 U.S. 1027); and St. Bernard Hospital v. Hospital Service Association of New Orleans (5th Circuit, 1982, 712 F. 2d 978), and cases addressed herein.

[40] The issue of competitive harm and welfare loss to society from monopsony is addressed in the FTC/DOJ 2004 Report on competition in the healthcare industry "Conceptually, monopsony power is the mirror image of monopoly power. A buyer has monopsony power when it can profitably reduce prices in a market below competitive levels by curtailing purchases of the relevant product or services. The exercise of monopsony power causes competitive harm because the monopsonist will reduce purchases of the input, shift some

services will be less than that which would have occurred were the market operating competitively. In theory, the benefit of these lower negotiated prices through the exercise of monopsony power could result in a lower marginal cost of production for the insurer which could be passed on to consumers. Pass-through, however, depends on a number of factors, including the competitive pressure at the point of selling health insurance and administrative services to subscribers. Without sufficient competitive pressure at the selling end, the insurer may retain the gains for itself. The exercise of an insurer's *monopoly power* in the market for healthcare insurance results in higher premiums which lead to less insurance consumed than would occur in a competitive market and less likelihood that the benefits of its monopsony power are passed on to consumers.

An important characteristic of healthcare markets is that health insurers, whether they be commercial or government, do not choose the actual quantity of healthcare services purchased. In effect, health insurers buy access at a negotiated price, but consumers determine the actual quantity demanded, based on a number of factors. Consumers often do not bear the full actual cost of the healthcare services they consume; as a result, consumers will demand more healthcare services than the insurer would want to consume or the healthcare provider would want to sell at a monopsony price. Past attempts at controlling the quantity demanded of healthcare services, using certain forms of HMOs, failed for a number of reasons. More recent attempts at demand management may prove more effective because they rely on more clinically-based models of care.

C. Competitive Analyses of BCNEPA and Highmark by Product

1. Overview of Commercial Health Insurance Products

Both BCNEPA and Highmark offer commercial health insurance products within the BCNEPA Service Area through the joint ventures with FPLIC and FPH.[41] BCNEPA and Highmark also have a JOA that covers some additional products.[42] Highmark has additional commercial insurance product enrollees resident in the BCNEPA Service Area; these are enrollees whose employers or

purchases to a less efficient source, supply too little output in the downstream market, or do all three. When a monopsonist reduces purchases of inputs to reduce input prices, society foregoes the production of output whose value to consumers exceeds the resource costs of associated inputs, thereby creating a welfare loss to society. The report notes that "the Agencies have brought several cases that challenged the actual or potential exercise of monopsony power. *United States v. Aetna, Inc.* involved a challenge to the merger of two health care insurers, Aetna and Prudential." https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf at pp 13-14.

[41] The BCNEPA Service Area includes the following counties in Pennsylvania: Wayne, Pike, Monroe, Carbon, Luzerne, Lackawanna, Wyoming, Susquehanna, Bradford, Sullivan, Lycoming, Clinton and Tioga. (Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab F: Overview of BCNEPA Business Perspective at Footnote 1)

[42] Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Feb. 18, 2014 at 10; BCNEPA Confidential Response to Information Request 5.2.18.1 from the Pennsylvania Insurance Department at NEPA-000435.

organizations contract with Highmark for products and services and are headquartered outside of the BCNEPA Service Area.[43] We understand that certain licensing agreements limit the ability of BCNEPA from doing business directly with these employers or organizations.[44]

The FPLIC joint venture offers group insurance plans for a range of products, including PPO (e.g. "BlueCare® PPO"), EPO (e.g. "BlueCare EPO"), and traditional commercial insurance products (e.g. "BlueCare Traditional").[45] These plans are branded under the "Blue" trademark and are designed for small (2-50 employees) and large (51+ employees) groups.[46] As noted in the Capps Public Report, BCNEPA has operational control of FPLIC but Highmark holds "certain reserve rights".[47] BCNEPA has a 59.9% equity stake and Highmark has a 40.1% equity stake in FPLIC and net income related to FPLIC is split according to the equity shares of each party.[48] Based on the most recent data cited in the Capps Confidential Report, FPLIC has 164,100 enrollees in the Northeastern Pennsylvania Region and $415.5 million in revenues.[49]

The FPH joint venture offers HMO products (e.g. "BlueCare HMO" and "BlueCare HMO Plus") and CHIP products branded under the "Blue" trademark.[50]

As with FPLIC, BCNEPA oversees the day-to-day operations but Highmark holds "certain reserve rights".[51] Highmark has a 40% equity stake in FPH and BCNEPA has a 60% equity stake in FPH

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[43] Highmark Confidential Enrollment Data. The Highmark enrollment data provides data for Commercial Risk/Non-Risk plans in the following "segmentations": Group, Group – Small Group, Individual, Individual – Medigap, Mid-Atlantic, Mid-Atlantic – Small Group, Mid-Atlantic – Small Group Medigap, National, National – Ceded Partnership, National – Medigap, National – Non-Ceded Partnership, Regional, Regional – Small Group, Regional – Small Group Medigap, Small Group Medigap, and Statewide FEP. See also, Capps Public Report at ¶ 44-46 for Dr. Capps' discussion of the Highmark enrollment data.

[44] See Footnote 19 *supra*.

[45] For a list of FPLIC products and services, see Blue Cross of Northeastern Pennsylvania, "Group Insurance," accessed Nov. 25, 2014, available at https://www.bcnepa.com/Products/Group.aspx.

[46] Ibid.

[47] Capps Public Report at ¶ 36. The Capps Confidential Report specifically mentions while BCNEPA runs FPLIC's day-to-day operations, any "Major Decisions" require board approval, which can be unilaterally withheld by either Highmark or BCNEPA. (Capps Confidential Report at ¶ 38) See also, Shareholders Agreement between First Priority Life Insurance Company, Inc., Hospital Service Association of Northeastern Pennsylvania (BCNEPA), and Highmark Inc., Apr. 29, 2005 at 5(c); 25(h)(iv).

[48] Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab C: Highmark Corporate Organizational Chart; Joint Operating Agreement between Highmark Inc. and Hospital Service Association of Northeastern Pennsylvania d/b/a Blue Cross of Northeastern Pennsylvania, Apr. 29, 2005, II.N. [redacted]

[49] Highmark Confidential Enrollment Data; BCNEPA Confidential Enrollment Data; Highmark's Form A Regarding the Acquisition of Control of BCNEPA, Confidential Supplement, Tab 5: BCNEPA Confidential Combined GAAP Financial Statements ("Hospital Service Association of Northeastern Pennsylvania (d/b/a Blue Cross of Northeastern Pennsylvania, Consolidated Financial Statements for the Years Ended December 31, 2012 and 2011, Additional Information and Independent Auditor's Report") at 47.

[50] Blue Cross of Northeastern Pennsylvania, "BlueCare HMO," accessed Nov. 25, 2014, available at https://www.bcnepa.com/Products/Group/HMO.aspx; Blue Cross of Northeastern Pennsylvania, "BlueCare HMO Plus," accessed Nov. 25, 2014, available at https://www.bcnepa.com/Products/Group/HMOPlus.aspx; First Priority Health, "CHIP Member Handbook," accessed Nov. 25, 2014, available at https://d1tpfj3hind0fx.cloudfront.net/Media/Documents/Handbooks/CHIPHB.pdf.

and any net income is split according to the equity shares or each party.[52] Based on the most recent data included in the Capps Confidential Report, FPH has 30,402 enrollees in the Northeastern Pennsylvania Region and $99.8 million in revenues.[53]

In addition to FPLIC and FPH, Highmark and BCNEPA have had a cooperative relationship for over 70 years. Through the JOA, both entities jointly administer Blue Cross Blue Shield insurance products within the BCNEPA Service Area.[54] Based on the most recent data available in the Capps Confidential Report the JOA products have 6,198 enrollees in the Northeastern Pennsylvania Region.[55]

As noted above, the majority of BCNEPA enrollees in commercial insurance products are through the FPLIC and FPH joint ventures, with a smaller number of enrollees purchasing insurance through JOA administered plans or by BCNEPA, which offers some traditional indemnity services.[56] And, as discussed above, Highmark enrollees residing in the BCNEPA Service Area insured under commercial insurance products other than those offered by the FPLIC and FPH joint ventures are generally not eligible for BCNEPA commercial insurance plans.[57]

Within the context of his defined relevant antitrust product and geographic market, Dr. Capps provides estimated market shares for FPH and FPLIC, Highmark, and the separate JOA entity

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[51] Capps Public Report at ¶ 36. The Capps Confidential Report specifically states that BCNEPA maintains operational control of FPH but "Major Decisions" require approval from both Highmark and BCNEPA. (Capps Confidential Report at ¶ 39); Shareholders Agreement between HMO of Northeastern Pennsylvania, Hospital Service Association of Northeastern Pennsylvania (BCNEPA), and Highmark Inc., Apr. 29, 2005 at 5(c); 25(h)(iv).

[52] Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab C: Highmark Corporate Organizational Chart; Joint Operating Agreement between Highmark Inc. and Hospital Service Association of Northeastern Pennsylvania d/b/a Blue Cross of Northeastern Pennsylvania, Apr. 29, 2005, II.N. [redacted]

[53] Highmark Confidential Enrollment Data; BCNEPA Confidential Enrollment Data; Highmark's Form A Regarding the Acquisition of Control of BCNEPA, Confidential Supplement, Tab 5: BCNEPA Combined GAAP Financial Statements ("Hospital Service Association of Northeastern Pennsylvania (d/b/a Blue Cross of Northeastern Pennsylvania, Consolidated Financial Statements for the Years Ended December 31, 2012 and 2011, Additional Information and Independent Auditor's Report") at 47.

[54] See Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Feb. 18, 2014 at 10; Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab E: Overview of Highmark Business Perspective at 8; and Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab F: Overview of BCNEPA Business Perspective at 17.

[55] Highmark Confidential Enrollment Data; BCNEPA Confidential Enrollment Data.

[56] Highmark Confidential Enrollment Data; BCNEPA Confidential Enrollment Data. See also, Capps Public Report at ¶ 49 and Capps Confidential Report at Figure 2. According to Highmark's Form A, "BCNEPA provides traditional indemnity, or 'fee for service', health care insurance coverage to groups and individuals". (Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Feb. 18, 2014 at 10)

[57] See Footnote 19 *supra*. See also, Blue Cross and Blue Shield Association, "About Blue Cross Blue Shield Association," accessed Nov. 25, 2014, available at http://www.bcbs.com/about-the-association/. ("The Association grants licenses to independent companies to use the trademarks and names in exclusive geographic areas.")

between Highmark and BCNEPA, as well as the combined shares of both parties for commercial insurance products. He calculates these shares specifically for the Northeastern Region, which is where both Highmark and BCNEPA have a considerable amount of enrollees.[58]

Dr. Capps uses 2012 county-level enrollment data provided by Highmark and BCNEPA for the numerator of these share calculations and 2012 county-level insurance enrollment data from the American Community Survey (ACS) for the denominator.[59]

The Highmark and BCNEPA enrollment data are based on the location of individual enrollees and include all enrollees located in 67 counties.[60] Commercial enrollees are identified for each of the following product categories of commercially insured individuals: individual, small group, mid/large group, and Federal Employee Program Blue.[61] Dr. Capps excludes individuals who are enrolled in the Federal Employees Health Benefits (FEHB) program from the share calculations because, he states, they are "in a distinct relevant product market: firms and individuals not employed by the federal government cannot switch into FEHB plans."[62]

The ACS enrollment data are based on the locations of the insured individuals. Dr. Capps compares and cross-validates the ACS data with other data sources such as Kaiser's compilation of Current Population Survey data, employment data from the Local Area Unemployment Statistics program, and Supplemental Health Care Exhibit (SHCE) data from the National Association of Insurance Commissioners (NAIC). He concludes that the ACS data are

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[58] Capps Public Report at ¶ 49. In the Capps Confidential Report, Dr. Capps calculates shares for all plans (individual and group) in the four Highmark-defined regions and separately for Centre County. (Capps Confidential Report at Figure 2) The Northeastern Pennsylvania region overlaps with the BCNEPA Service Area. (See Capps Public Report at Section IV.B.1) The other Highmark defined regions are Western, Central, Eastern, and Centre County. According to Dr. Capps: "Part of Centre County is in the Western BCBSA Region and part is in the Central Region. Because not all companies make the same division, Centre County is included separately in the table." We examined his share calculations of the different regions and find his methodology and share estimates reasonable.

[59] Capps Public Report at Sections IV.C.1.a and IV.C.1.b. The ACS data are based on mandatory surveys of a sample of the U.S. population and are updated periodically. They cover topics such as sex, race, age, family/relationships, health insurance, as well as other areas. These data are widely used in a variety of health insurance analyses. See, U.S. Census Bureau, "About the American Community Survey," accessed Nov. 25, 2014, available at http://www.census.gov/acs/www/about_the_survey/american_community_survey/.

[60] The 67 counties are: Adams, Allegheny, Armstrong, Beaver, Bedford, Berks, Blair, Bradford, Bucks, Butler, Cambria, Cameron, Carbon, Centre, Chester, Clarion, Clearfield, Clinton, Columbia, Crawford, Cumberland, Dauphin, Delaware, Elk, Erie, Fayette, Forest, Franklin, Fulton, Greene, Huntingdon, Indiana, Jefferson, Juniata, Lackawanna, Lancaster, Lawrence, Lebanon, Lehigh, Luzerne, Lycoming, McKean, Mercer, Mifflin, Monroe, Montgomery, Montour, Northampton, Northumberland, Perry, Philadelphia, Pike, Potter, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Tioga, Union, Venango, Warren, Washington, Wayne, Westmoreland, Wyoming, York. Note that in the share analysis, the following counties were excluded because their data were not in the ACS data: Cameron, Forest, Fulton, Montour, Potter, and Sullivan. Capps Public Report at footnote 31 identifies the count of 67 but does not identify the counties by name. See also Figure 1 of Capps Public Report which depicts these counties on a map.

[61] Capps Public Report at ¶ 44.

[62] Capps Public Report at ¶ 45. Dr. Capps also notes that he excludes FEHB enrollees because they participate in the national BCBS FEHB plan (Capps Public Report at ¶ 45), and therefore do not require a competitive analysis.

the most accurate and most comparable to the Highmark and BCNEPA enrollment data.[63] I find it reasonable to include into a common grouping HMO, PPO, and traditional indemnity products, as Dr. Capps has done, for purposes of evaluating commercial insurance.

The following is a summary of the estimated market shares in the Northeastern Pennsylvania region, which is an approximation of the BCNEPA Service Area, for commercial insurance products (e.g., HMO and PPO):[64]

- FPH (HMO), FPLIC (PPO), and the JOA have estimated market shares of about 5%, 27%, and 1%, respectively;
- Highmark has a less than 10% market share for commercial insurance products unrelated to FPLIC, FPH, and the JOA; and
- BCNEPA does not offer a separate or standalone commercial insurance product outside of the joint ventures, and has no independent share.[65]

Collectively, BCNEPA and Highmark have less than 43% share. This suggests that other competitors have a large share of HMO and PPO covered lives or enrollment in the area. I identified Geisinger, Aetna-Coventry, UnitedHealthcare, and Cigna as alternative competitors in the BCNEPA Service Area, which I discuss below.[66]

Dr. Capps bases his competitive assessment on the premise that because Highmark and BCNEPA jointly own FPH and FPLIC, they do not currently compete in the BCNEPA region and a merger would not reduce competition. He also opines that Highmark's less than 10% share in the BCNEPA region does not indicate direct competition with BCNEPA because, while the vast majority of those Highmark enrollees are customers residing in the Northeastern Region, their employers are headquartered outside the BCNEPA Service Area and purchased the coverage in their headquarters' region.[67]

To verify the share results presented by Dr. Capps, we used the publicly available data provided as part of the backup to the Capps Confidential Report.[68] We validated his analyses by replicating the analyses using the programs provided by Dr. Capps. After confirming that the results were reported correctly as described in his report, we then analyzed the data in more

[63] Capps Public Report at ¶¶ 42-43 and Capps Confidential Report at Appendix B.
[64] Capps Public Report at ¶ 49. See also, Confidential Appendix C, Table C-1 for more detailed market shares of BCNEPA and Highmark commercial insurance products.
[65] See Footnote 56 *supra*.
[66] See, Highmark Inc. ("Highmark") Confidential Response to Information Request 4.4.3 from the Pennsylvania Insurance Department at HMI-001850-51 (Blue Cross of Northeastern Pennsylvania, Request for Proposal, March 2013) for a more detailed description of each of these competitors.
[67] Capps Public Report at ¶ 50.
[68] For a more thorough discussion of the data used by Dr. Capps, see Capps Confidential Report at Appendix B.

detail to examine the assumptions and methodology used by Dr. Capps. These appear to be reasonable measures for the geographies and products assessed.

In addition, we took the analyses an additional step for the commercial insurance products offered in the region, and, where possible, examined information and data on the alternative providers. This included documentary and other evidence regarding the competitive alternatives. Based on the available evidence, we were able to identify that competitors including Geisinger, Aetna-Coventry, and United have been able to gain share at BCNEPA's expense between 2010 and 2014, suggesting that they are alternatives that could constrain price and enhance quality competition. For example, a September 2014 BCNEPA competitive assessment document shows that, in the 13-county area in which BCNEPA operates, BCNEPA has a [redacted] share of commercial enrollees, [redacted]. The Blue Card members account for the remainder.[69] Blue Card is accounted for by over [redacted].[70] Around [redacted] of the Blue Card enrollees are enrolled in one of the Blues products other than Highmark.[71]

Furthermore, these competitors offer a range of HMO and PPO commercial insurance products to fully insured and self-funded customers. [redacted][72][73][74][75][76]

[69] BCNEPA Confidential Supplemental Response to Information Request 5.2.9.2(A) from the Pennsylvania Insurance Department at NEPA-006851 (Blue Cross of Northeastern Pennsylvania, "2014 Competitive Assessment, Market Analytics," Sept. 2014). The 13 counties covered reflect the BCNEPA Service Area: Clinton, Tioga, Lycoming, Bradford, Sullivan, Susquehanna, Wyoming, Luzerne, Lackawanna, Wayne, Carbon, Monroe, and Pike.

[70] Highmark Inc. ("Highmark") Confidential Response to Information Request 4.4.3 from the Pennsylvania Insurance Department at HMI-001804 [redacted].

[71] Ibid.

[72] BCNEPA Confidential Supplemental Response to Information Request 5.2.9.2(A) from the Pennsylvania Insurance Department at NEPA-006867 [redacted].

[73] Ibid. at NEPA-006869.

[74] Ibid. at NEPA-006871.

[75] Ibid.

[76] Ibid. at NEPA-006870-71.

[redacted][77] [redacted][78]

After reviewing the facts and conducting additional analyses, I reach a conclusion similar to that of Dr. Capps, which is that the transaction will not substantially lessen competition for commercially insured customers. The relevant geographic market is reasonably defined as the BCNEPA Service Area for commercial insurance products and includes a number of suppliers. BCNEPA and Highmark currently collaborate for the vast majority of commercial insurance products in the area through joint ventures or the JOA, and there remain other independent competitors that would compete with the combined entity post-merger.

Some providers raised concerns about Highmark's current or anticipated post-transaction contracting practices or policy changes.[79] While characterized in some cases as anticompetitive, these concerns tend to be about the need for greater transparency in methodologies for assignment of providers to tiers for new tiered and limited insurance products, for changes in policy and related communications to the public, and issues related to contractual obligations under current contracts as they transition post-transaction or upon expiration. Based on my review of these sources and of confidential materials and submissions, I conclude that evidence from providers does not raise substantial competitive concerns.

The PID also received comments on the proposed transaction from Highmark's health insurance competitors expressing concern about the competitive effect of the merger on "the competitive abilities of those other insurers" in the relevant market.[80] These concerns center around an allegation that Highmark already has a "sizeable market share in this region" and asks that the PID investigate the proposed merger's impact on post-merger actual and potential competition from other insurers in the market. I have been advised that under the relevant statute, I must focus my analysis on whether "[t]he effect of the merger, consolidation or other acquisition of

[77] Ibid. at NEPA-006873.
[78] Ibid. at NEPA-006877.
[79] In reaching my opinions about the competitive effects of the transaction, I also reviewed information provided to the PID or from interviews of providers about the proposed transaction and its impact. I also reviewed the Highmark response to public submissions. These interviews and submissions include support as well as identifying some concerns. For example, some independent hospitals have provided public support for the proposed transaction. See Testimony of Steve Johnson, President and CEO of Susquehanna Health, Public Informational Hearing, Re: Proposed Merger Between Highmark, Inc., and Blue Cross of Northeastern Pennsylvania, Nov. 12, 2014 at 169:13-20. Other providers have raised some concerns about specific contracting practices and policy changes by Highmark. See, Public Comment of Case S. Phillips, President of the Pennsylvania Chiropractors Association, Oct. 28, 2014 (See, also Response of Highmark Inc. to Comments of Case S. Phillips, DC, Dated October 28, 2014, Dec. 3, 2014).
[80] See, Letter to Cressinda Bybee from Samuel R. Marshall, President and CEO of The Insurance Federation of Pennsylvania, Inc., dated February 2, 2015. The letter requests that the PID stay the merger pending further analysis of the merger's impact on other insurers' competitive abilities and the viability of the merger based on Highmark's 2014 year-end results. I address only the first concern as part of this competitive effects report. The letter also recommended the PID impose conditions on the merger. I address only those relating to competition.

control would be to substantially lessen competition in insurance in the Commonwealth or tend to create a monopoly therein."[81] Highmark and BCNEPA effectively "go to market" in the northeastern service area through a joint venture. Based on the analysis and review presented below, I find no economic evidence in the record before the PID which suggests that after the merger, Highmark would be able to exercise market power and substantially lessen competition in commercial health insurance.

Moreover, my analysis indicates that BCNEPA's competitors have been able to gain share at BCNEPA's expense between 2010 and 2014, suggesting that these competitive alternatives could constrain any attempt to raise price above competitive levels. I did not find any change in conditions that suggest that the ability of these competitors to continue to be competitive, potentially to gain share by offering products or services or competitive pricing, or otherwise to discipline the merged firm would be diminished by the transaction. Moreover, with BCNEPA's weakened financial prospects, it is likely that Highmark would bring to the marketplace additional resources and expertise in innovative products and services that BCNEPA may not be able to offer in northeastern Pennsylvania on its own, thereby maintaining or perhaps enhancing the competitive landscape. Highmark, with its additional resources and expertise, may be perceived as a stronger competitor than BCNEPA, which may have some business impact on its competitors, but this does not translate to an adverse effect on competition. Antitrust in practice is designed to protect competition, not individual competitors from competition.

2. Overview of Other Commercial Products

a. Dental and Vision Products

BCNEPA does not offer its own individual dental and vision products.[82] Rather, it provides dental coverage through United Concordia Life and Health Insurance Company and vision coverage through HM Life Insurance Company (administered by Davis Vision, Inc.).[83] Both entities are wholly owned subsidiaries of Highmark.[84] Dr. Capps opines that there is no direct competition between Highmark and BCNEPA.

I reviewed the dental and vision products that BCNEPA is currently marketing through its website and confirmed that 1) BCNEPA does not offer standalone dental and vision insurance and 2) BCNEPA offers dental and vision insurance through Highmark's subsidiaries.[85] After

[81] 40 P.S. § 991.1402(f) (1) (ii)
[82] Blue Cross of Northeastern Pennsylvania, "Dental & Vision," accessed Nov. 19, 2014, available at https://www.bcnepa.com/Products/DentalVision.aspx.
[83] Ibid.
[84] Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab C: Highmark Corporate Organizational Chart.
[85] Blue Cross of Northeastern Pennsylvania, "Dental & Vision," accessed Nov. 19, 2014, available at https://www.bcnepa.com/Products/DentalVision.aspx.

reviewing the facts related to dental and vision insurance products in Pennsylvania, I concur with the conclusions put forth by Dr. Capps. In particular, I conclude that because BCNEPA does not offer dental and vision products and is unlikely to do so on its own, competition for these products would not be substantially lessened by the transaction.

b. Stop Loss Insurance Products

Both BCNEPA and Highmark offer stop loss insurance products. BCNEPA offers this product as part of a bundle of services for business customers purchasing self-funded or administrative services-only (hereafter "ASO") products from BCNEPA. As a result, it is my understanding that BCNEPA historically has not offered stop loss insurance products as standalone offerings, and has no intention to do so.[86]

Based on data and information provided by BCNEPA and publicly available data, it is my understanding that BCNEPA currently has 120,958 covered lives in self-funded products; e.g., enrollees of customers that obtain self-funded or ASO products from BCNEPA. Of these covered lives, [redacted] are from companies that also obtain stop loss insurance products and services from BCNEPA. I estimate the latter number by comparing the number of stop loss enrollees for BCNEPA with their total self-funded enrollees. Available data and information are shown in the Table 1 below.[87]

Table 1[88]

Share of BCNEPA and Highmark Self-Funded Enrollees with Stop Loss Product

Company	Self-Funded Number of Covered Lives in PA	Stop Loss Number of Covered Members in PA	Share of Self-Funded Enrollees Who Have Stop Loss
BCNEPA	120,958	[redacted]	[redacted]
Highmark	2,451,328		
Independence Blue Cross Group	878,878		
Cigna Health Group	435,678		
Capital Blue Cross Group	316,033		
The Trustmark Companies	95		
Total	4,202,970		

[86] Blue Cross of Northeastern Pennsylvania, "Stop Loss Coverage," accessed Nov. 19, 2014, available at https://www.bcnepa.com/Employers/GroupAdministration/StopLossCoverage.aspx. BCNEPA lets existing customers of self-funded or ASO health plans to add stop loss coverage, which can "ultimately reduce costs and add value".

[87] The table was compiled by Compass Lexecon staff using the same data relied upon by Dr. Capps.

[88] Notes to table: [redacted]

Sources: Self-Funded numbers from public MLR data.

Highmark offers a standalone stop loss insurance product.[89] Of the Highmark customers' employees for stop loss products in Pennsylvania, about [redacted] are purchasing them as standalone products. [90] Moreover, based on available data, it is my understanding that around [redacted] of Highmark's stop loss customers' employees reside outside Pennsylvania. The underlying data are shown in the table in Confidential Appendix C, Table C-2.

These facts suggest that competition between BCNEPA and Highmark for the provision of stop loss insurance products is more limited than if each were offering them as standalone products to broader sets of customers, and that BCNEPA's book of business is relatively small compared to other companies.

In order to evaluate the other companies providing these services, we examine the product in some greater detail. Stop loss insurance products will tend to be purchased by businesses that self-fund their enrollees' health insurance plans. These products serve to protect these organizations from large, unexpected, one-time claims (both individual and aggregate).[91] As such, the product mitigates the effects of such potential losses, it does not necessarily need to be purchased from a local supplier or the same supplier as the entity from which the employer obtains administrative services or for coverage for employees seeking to access specific healthcare providers. Dr. Capps concludes that the pool of suppliers to which self-funded businesses can turn to for stop loss insurance products includes firms at the regional, state, or even national level.[92]

Dr. Capps states that the relevant geographic market for stop loss products is "likely national and may even include other countries" because stop loss insurance is fundamentally a financial insurance product rather than a health insurance product (which might be linked to local provider availability).[93] While he states that he does not have the data to provide national market shares (as would be called for by an insurance product where the alternative providers include all those in the nation), he estimates market shares at the state level for Pennsylvania. State level market share analysis may be conservative where shares may be overstated relative

[89] Highmark, "The HM Employer Stop Loss Product," accessed Nov. 19, 2014, available at https://www.hmig.com/products/stoploss/product.shtml.
[90] Highmark has approximately [redacted] covered employees of customers/businesses purchasing stop loss insurance products from Highmark in Pennsylvania, of which [redacted] of covered employees are customers which purchase these as standalone products.
[91] Capps Public Report at ¶¶ 54-55. For a discussion of stop loss insurance, see, e.g., Chollet, Deborah, "Self-Insurance and Stop Loss for Small Employers," Mathematica Policy Research, available at http://www.naic.org/documents/committees_b_erisa_120626_chollet_self_insurance.pdf; Brien, Michael and Constantin Panis, "Self-Insured Health Benefit Plans," Deloitte LLP and Advanced Analytical Consulting Group, Inc., 2011; Hall, Mark, "Regulating Stop-Loss Coverage May Be Needed to Deter Self-Insuring Small Employers from Undermining Market Reforms," Health Affairs 31(2), 2012: 316-323.
[92] Capps Public Report at ¶¶ 55-56.
[93] Ibid.

to a national market share. I find it plausible that the relevant geographic market for this product includes at least suppliers in the state.

To estimate market shares, Dr. Capps assumes that all self-funded groups also bought stop loss coverage.[94] He combines Supplemental Health Care Exhibit (SHCE) data from the National Association of Insurance Commissioners (NAIC) and Medical Loss Ratio (MLR) data from the Centers for Medicare & Medicaid Services (CMS) to calculate the total number of self-funded enrollees in Pennsylvania.[95] The SHCE data include relevant information on insurance companies (e.g., enrollment, member months, data on self-funded businesses, etc.) at the state level. The MLR data collects similar information on insurance companies. However, as Dr. Capps indicates, the data from both sources do not necessarily match. As such, where there are discrepancies between the SHCE and MLR data, Dr. Capps utilizes the latter.[96]

Dr. Capps uses BCNEPA data on the number of enrollees of its stop loss product who are located in Pennsylvania.[97] He estimates that BCNEPA has a less than 0.5% market share of stop loss insurance measured as a share of such enrollees in Pennsylvania.[98] To calculate Highmark's market share, Dr. Capps uses Highmark data on the number of covered employees for customers domiciled in Pennsylvania. He converts this number to the number of covered enrollees by multiplying the number of plans by Highmark's average number of enrollees per primary policyholder.[99] Dr. Capps calculates that Highmark's statewide market share of stop loss insurance is between 15% and 25%.[100] Based on these market shares and related analyses, Dr. Capps concludes that there is no competitive concern in stop loss products.

We reviewed Dr. Capps' analyses of stop loss products in Pennsylvania. Specifically, we reviewed the accuracy of combining both the SHCE and MLR data for the denominator and verified the market share calculation using BCNEPA's and Highmark's data. The parties do appear to be somewhat limited competitors in the provision of stop loss insurance.[101] In specific, BCNEPA has chosen not to offer a standalone stop loss product but bundles this product for existing self-funded customers. Highmark is a competitive alternative for BCNEPA

[94] Capps Public Report at Footnote 44.
[95] Ibid. See, Capps Confidential Report at Appendix B. The numbers for self-funded enrollees in Pennsylvania match between the MLR and SHCE data for all companies except for Highmark (2.45 million in the MLR data, 1.37 million in the SHCE data). The Highmark Confidential Enrollment Data reports that there are [redacted] million self-funded enrollees. As such, the Highmark number of 2.45 million self-funded enrollees from the MLR data is more conservative and is used in the calculation. Dr. Capps uses the same methodology. (See Capps Confidential Report at Footnote 120.)
[96] Ibid. See also Capps Confidential Report at ¶¶ 121-122 and Footnote 120.
[97] Capps Confidential Report at ¶¶ 121-122. BCNEPA does not have enrollees of stop loss outside Pennsylvania.
[98] Capps Public Report at ¶ 57; Figure 4; and Footnote 44.
[99] Capps Public Report at Footnote 44. Highmark's average number of enrollees per primary policyholder is roughly 1.77.
[100] Capps Public Report at Figure 4.
[101] See, Table 1 and Appendix C, Table C-2.

customers. I have been able to identify a number of alternative suppliers of stop loss insurance products in the BCNEPA area that would serve to constrain any adverse competitive effect. We understand from the data and information that other providers of stop loss products include Independence Blue Cross Group, Cigna Health Group, Capital Blue Cross Group, and The Trustmark Companies. Taken collectively, these facts indicate that there is not sufficient evidence to raise concerns about substantial lessening of competition post-transaction for stop loss insurance. These conclusions are consistent with those reached in the Capps Confidential Report and Capps Public Report.

3. Other Insurance Products

Dr. Capps notes that there are other products that Highmark offers, such as disability insurance, long-term care insurance, and workers' compensation. We verified that BCNEPA does not currently offer these products, based on information from the BCNEPA website.[102] Therefore, there is no current competition between Highmark and BCNEPA.[103]

4. Overview of Medicaid and CHIP products

a. Medicaid

Pennsylvania administers its Medicaid program through an entity known as HealthChoices, "a risk-based managed care program that was initially offered on a voluntary basis".[104] Although in the past, Pennsylvania administered other managed care programs (e.g. "ACCESS Plus") through the DPW, these programs have been gradually phased out in favor of HealthChoices.[105] Starting in February 2013, Pennsylvania migrated to a *mandatory* enrollment program through HealthChoices, eliminating all of the prior programs that involved *voluntary* enrollment in a managed care organization (hereafter "MCO").[106]

As part of the new mandatory enrollment in MCOs program, Pennsylvania divided the state into five zones for purposes of obtaining competitive bids: Southeast, Southwest, New East, New West, and Lehigh/Capital.[107] The BCNEPA Service Area is comprised of 13 counties that are

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[102] See Blue Cross of Northeastern Pennsylvania, "Health Insurance Plans," accessed Nov. 21, 2014, available at https://www.bcnepa.com/Products.aspx.
[103] Capps Public Report at ¶ 58.
[104] "Managed Care in Pennsylvania," accessed Nov. 25, 2014, available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/pennsylvania-mcp.pdf.
[105] Ibid.
[106] Ibid.
[107] Pennsylvania Department of Human Services, "Pennsylvania HealthChoices Map," accessed Nov. 25, 2014, available at http://www.dhs.state.pa.us/provider/healthcaremedicalassistance/managedcareinformation/statewidemanagedcaremap/index.htm. These zones are specifically designated for Medicaid insurance products by the DPW.

located entirely within the New East zone.[108] Insurance providers are selected by the DPW for each zone through an RFP process, with some providers selected to serve multiple zones.[109] The insurance providers selected by the DPW become exclusive providers for a specific zone. As a result, it is useful to consider each of these zones as the areas in which Highmark and BCNEPA may be competitors.

While neither Highmark nor BCNEPA offer these products independently and directly, each has been engaged in joint ventures that currently participate in the HealthChoices program. Until earlier in 2014, BCNEPA was engaged in a joint venture with AmeriHealth Caritas Pennsylvania called AmeriHealth Northeast, which provides the managed Medicaid insurance products in the New East zone (i.e., the venture was one of the current winners of the RFP for that zone).[110] Highmark has a joint venture with Mercy Health Plan called Gateway Health Plan, which provides the managed Medicaid insurance products in the Southwest, New West, and Lehigh/Capital zones.[111] As I discuss further below, it is my understanding that the Highmark joint venture (Gateway Health Plan) has not previously bid in the New East zone.

As of March 31, 2014, BCNEPA discontinued its Medicaid joint venture with AmeriHealth Caritas Pennsylvania.[112] As such, BCNEPA does not currently offer a Medicaid product.

For completeness of the record, we reviewed and validated Dr. Capps' analyses of Medicaid services using the data he provided as part of the backup to the Capps Confidential Report as well as analyzed updated data as a sensitivity test. We also confirmed that BCNEPA exited its joint venture with AmeriHealth Northeast. We concur that the lack of overlap between

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[108] Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab F: Overview of BCNEPA Business Perspective at Footnote 1; Pennsylvania Department of Human Services, "Pennsylvania HealthChoices Map," accessed Nov. 25, 2014, available at http://www.dhs.state.pa.us/provider/healthcaremedicalassistance/managedcareinformation/statewidemanagedcaremap/index.htm.

[109] For a description of the process, see, e.g., Pennsylvania Department of Public Welfare, "Subject: RFP #20-11, HealthChoices Physical Health Services for the New West and New East Zones," Nov. 16, 2011, accessed Nov. 25, 2014, available at http://www.emarketplace.state.pa.us/FileDownload.aspx?file=RFP%2020-11/Solicitation_4.pdf.

[110] AmeriHealth Northeast, "About Us," accessed Nov. 25, 2014, available at http://www.amerihealthnortheast.com/about/index.aspx; Pennsylvania Department of Public Welfare, "Monthly Physical Health Managed Care Program Enrollment Report," Oct. 23, 2014, accessed Nov. 25, 2014, available at http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/c_115450.pdf.

[111] Gateway Health, "Medical Assistance (Medicaid) Plan for Individuals and Parents with Children," accessed Nov. 24, 2014, available at http://gatewayhealthplan.com/plans/medicaid-plans; Pennsylvania Department of Public Welfare, "Monthly Physical Health Managed Care Program Enrollment Report," Oct. 23, 2014, accessed Nov. 25, 2014, available at http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/c_115450.pdf; Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab C: Highmark Corporate Organizational Chart.

[112] On June 18, 2014, BCNEPA terminated the AmeriHealth Northeast joint venture with a retroactive effective date of March 31, 2014. (BCNEPA Response to Supplemental Information Request 5.6.10 from the Pennsylvania Insurance Department at NEPA-005450. See also Capps Public Report at ¶ 60.

Highmark's and BCNEPA's Medicaid products, and the fact that BCNEPA was unlikely to bid on its own, indicate that the merger will not substantially lessen competition for Medicaid.

Dr. Capps evaluated the shares of BCNEPA's and Highmark's Medicaid products by looking at November 2013 enrollment data from the DPW. The data show that Highmark's and BCNEPA's current Medicaid products do not overlap with each other in any of the five different DPW-designated zones. Gateway Health Plan is offered in the Southwest, New West, and Lehigh/Capital zones while AmeriHealth Northeast is only offered in the New East zone.[113] Use of these zones for purposes of identifying competitors in a relevant geographic market and for evaluating shares is a reasonable approach.[114]

As a way of performing a sensitivity check on the analysis, we performed the same analysis using updated data (September 2014 rather than November 2013). The results of the updated analysis, shown in Table 2 below, largely confirm Dr. Capps' conclusion that Highmark's and BCNEPA's Medicaid products are only offered in the non-overlapping zones and, as such, the transaction would not lessen existing competition for Medicaid services. Moreover, it appears unlikely that Highmark was an alternative bidder in the area in which BCNEPA offered services. The charts below in Figure 1 using similar DPW data show the different companies that offer Medicaid products by DPW-designated zone, highlighting the fact that there is competition in each zone.[115]

More recent data (January 2014) on Managed Medicaid enrollment specifically in the 13-county BCNEPA Service Area reveals that [redacted][116]

[redacted][117]

[113] Capps Confidential Report at Figure 9.

[114] I note that the number of current providers can understate competitive alternatives where there is bidding as is the case here.

[115] Pennsylvania Department of Public Welfare, "Monthly Physical Health Managed Care Program Enrollment Report," October 23, 2014, available at http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/c_115450.pdf at 9.

[116] BCNEPA Confidential Supplemental Response to Information Request 5.2.9.2(A) from the Pennsylvania Insurance Department at NEPA-006854 [redacted] The 13 counties covered reflect the BCNEPA Service Area: Clinton, Tioga, Lycoming, Bradford, Sullivan, Susquehanna, Wyoming, Luzerne, Lackawanna, Wayne, Carbon, Monroe, and Pike.

[117] [redacted] (See BCNEPA Confidential Supplemental Response to Information Request 5.2.9.2(A) from the Pennsylvania Insurance Department at NEPA-006868)

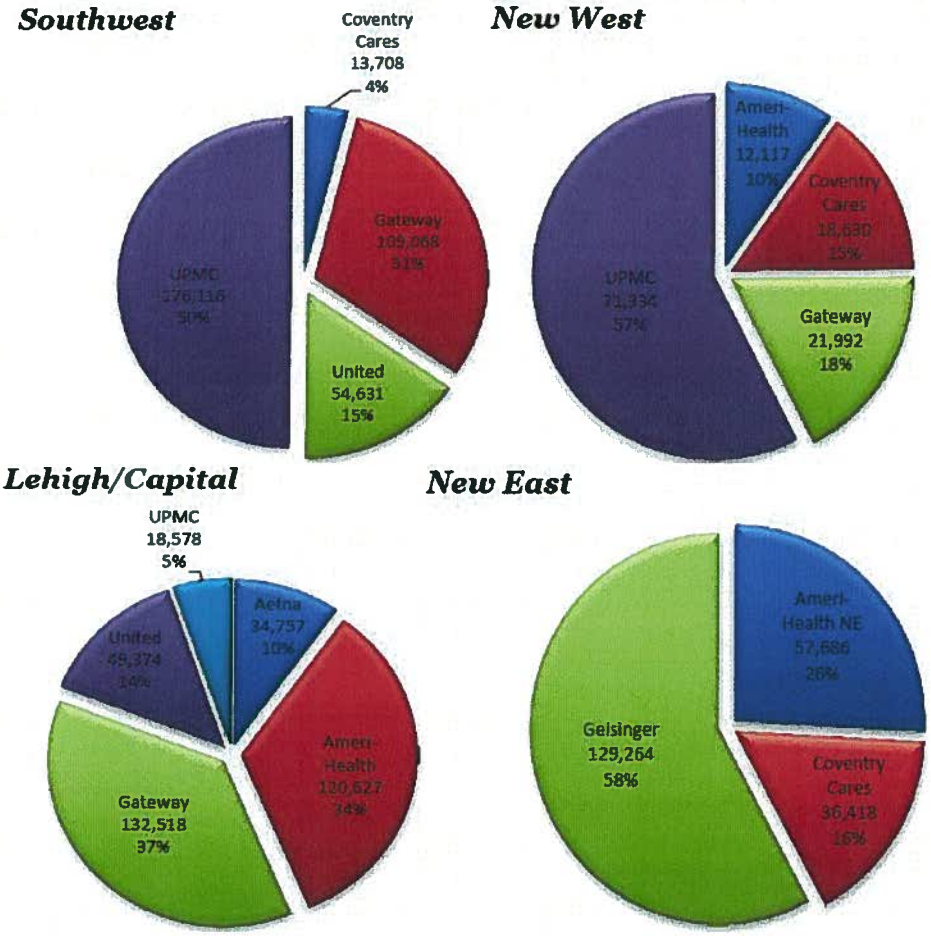
Table 2[118]

HealthChoices Managed Medicaid Shares by DPW-Designated Zone

Zone	Gateway Health (Highmark / Mercy Health Plan)	AmeriHealth Northeast
Southeast	-	-
Southwest	31%	-
New West	18%	-
Lehigh/Cap	37%	-
New East	-	26%

Figure 1

HealthChoices Managed Medicaid Enrollment Shares by DPW-Designated Zone and Plan



[118] Pennsylvania Department of Public Welfare, "Monthly Physical Health Managed Care Program Enrollment Report," October 23, 2014, available at http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/c_115450.pdf. Note that the null shares indicate that the companies do not have any Medicaid enrollees in the respective zones. The zones are specifically designated for Medicaid insurance products by the DPW. The BCNEPA Service Area is comprised of 13 counties that are located entirely in the New East zone.

b. CHIP products

The Children's Health Insurance Program (CHIP) in Pennsylvania offers health insurance for uninsured children and teens "who are not eligible for or enrolled in Medical Assistance".[119] As with Medicaid, the DPW selects a set of insurers to administer and offer CHIP products in each county. These insurers are selected for each county through a competitive RFP process.

Both BCNEPA and Highmark are among the CHIP providers in Pennsylvania.[120] However, Highmark and BCNEPA are not currently providers in any common counties.[121] That is, BCNEPA is not currently a provider in any counties where Highmark is a provider and Highmark is not a provider in any counties where BCNEPA is a provider. Moreover, it is my understanding that they have not bid in the same sets of counties.

Dr. Capps evaluated Highmark's and BCNEPA's CHIP coverage areas by looking at December 2013 CHIP enrollment data by contractor and county from the Pennsylvania CHIP website.[122] In particular, he looked at whether there were CHIP enrollees for Highmark and BCNEPA in the same county. Dr. Capps concludes that the merger will not adversely affect competition for CHIP products in specific areas in Pennsylvania because the counties in which Highmark and BCNEPA offer these products do not overlap with each other.[123]

We also examined updated enrollment data (October 2014) by contractor and county from the Pennsylvania CHIP website. Using these enrollment data, we confirmed that Highmark and BCNEPA currently do not have CHIP enrollees in the same county, as shown in Figure 2 below. In addition, using the same data, we identified the following companies that also provide CHIP products: Aetna, Capital BlueCross, United – AmeriChoice, Independence Blue Cross, United – Unison, University of Pittsburg Medical Center (UPMC), Geisinger, and Health Partners.

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[119] Pennsylvania Children's Health Insurance Program, "What is CHIP?" accessed Nov. 25, 2014, available at http://www.chipcoverspakids.com/about-chip/what-is-chip/.

[120] Pennsylvania Children's Health Insurance Program, "CHIP Enrollment by Contractor and County," Oct. 2014, accessed Nov. 25, 2014, available at http://www.chipcoverspakids.com/assets/media/pdf/chip_enrollment by_contactor.pdf.

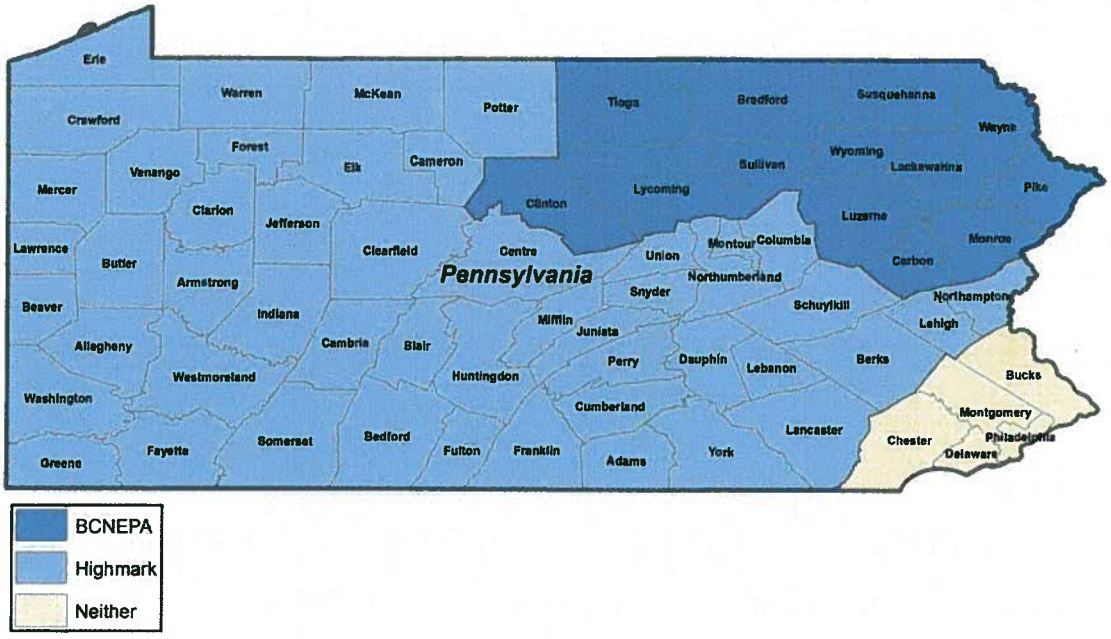
[121] Ibid. Highmark has CHIP enrollees in the following 49 counties: Adams, Allegheny, Armstrong, Beaver, Bedford, Berks, Blair, Butler, Cambria, Cameron, Centre, Clarion, Clearfield, Columbia, Crawford, Cumberland, Dauphin, Elk, Erie, Fayette, Forest, Franklin, Fulton, Greene, Huntingdon, Indiana, Jefferson, Juniata, Lancaster, Lawrence, Lebanon, Lehigh, McKean, Mercer, Mifflin, Montour, Northampton, Northumberland, Perry, Potter, Schuylkill, Snyder, Somerset, Union, Venango, Warren, Washington, Westmoreland, and York.
BCNEPA has CHIP enrollees in the following 13 counties: Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne, and Wyoming.

[122] A more detailed discussion of the CHIP data can be found in Capps Public Report at Section VI.B.

[123] See, Capps Public Report at Figure 5.

Figure 2[124]

Pennsylvania CHIP Enrollment by Contractor and County



[redacted]125

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[124] Pennsylvania Children's Health Insurance Program, "CHIP Enrollment by Contractor and County," Oct. 2014, accessed Nov. 20, 2014, available at http://www.chipcoverspakids.com/assets/media/pdf/chip_enrollment_by_contactor.pdf. Highmark operates in 49 counties. BCNEPA operates in separate 13 counties.

[125] BCNEPA Confidential Supplemental Response to Information Request 5.2.9.2(A) from the Pennsylvania Insurance Department at NEPA-006855 [redacted] The 13 counties covered reflect the BCNEPA Service Area: Clinton, Tioga, Lycoming, Bradford, Sullivan, Susquehanna, Wyoming, Luzerne, Lackawanna, Wayne, Carbon, Monroe, and Pike. [redacted]

[126] BCNEPA Confidential Supplemental Response to Information Request 5.2.9.2(A) from the Pennsylvania Insurance Department at NEPA-006868.

Our analyses confirm Dr. Capps' assessment that Highmark and BCNEPA do not have enrollees in the same county and, his opinion that competition would not be substantially lessened as a result of the transaction. Further, there appear to be a number of alternatives in each of the areas where Highmark and BCNEPA offer CHIP products.

5. Overview of Medicare-related Products

a. Medicare Advantage Products

Highmark offers two sets of Medicare Advantage plans: "Security Blue" (an HMO plan) and "Freedom Blue" (a PPO plan).[127] The Security Blue plan is administered by Keystone Health Plan West, a subsidiary of Highmark.[128] It is my understanding that the Security Blue plans are marketed only to individuals resident in a Highmark-defined Western Region, a region which does not overlap with the BCNEPA Service Area.[129] The Freedom Blue plan is offered by Highmark in all areas of Pennsylvania other than the IBC area (the Eastern Region).[130]

The Freedom Blue plans are offered by Highmark in Northeastern Pennsylvania "in association with Blue Cross of Northeastern Pennsylvania."[131] The available information indicates that Highmark is solely responsible for marketing and administering the Freedom Blue plans.[132] The JOA that applies to the joint-administration of Freedom Blue indicates [redacted]

[127] Highmark's Form A Regarding Acquisition of Control of BCNEPA and Subsidiaries, Confidential Supplement, Tab 9: Highmark Confidential Financial Projections and DOI 135's at Table 10a and 10b; Highmark Security Blue HMO from Keystone Health Plan West, "Security Blue HMO 2013 Summary of Benefits," accessed Nov. 25, 2014, available at https://www.highmarkbcbs.com/redesign/pdf/SecurityBlue_SB.pdf. The Security Blue plans include a number of sub-plans, including, e.g., "Value", "Deluxe", and "Standard". The Freedom Blue plans include a number of sub-plans, including, e.g., "Standard", "Classic", and "Deluxe". See, AON Hewitt, "Medicare Advantage Plans Offered by Highmark," accessed Nov. 25, 2014, available at https://www.aonhewittnavigators.com/find-plans/Highmark-medicare-advantage-plans. Security Blue plans begin with the codes "H3957". Freedom Blue plans begin with the codes "H3916" or "H5106".

[128] Highmark Security Blue HMO from Keystone Health Plan West, "Security Blue HMO 2013 Summary of Benefits," accessed Nov. 25, 2014, available at https://www.highmarkbcbs.com/redesign/pdf/SecurityBlue_SB.pdf; Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab C: Highmark Corporate Organizational Chart.

[129] See, Highmark Security Blue HMO from Keystone Health Plan West, "Security Blue HMO 2013 Summary of Benefits," accessed Nov. 25, 2014, available at https://www.highmarkbcbs.com/redesign/pdf/SecurityBlue_SB.pdf; Capps Public Report at ¶ 73.

[130] See, e.g., Capps Public Report at ¶ 73.

[131] See, "Provider Guide to Freedom Blue," accessed Nov. 25, 2014, available at https://www.bcnepa.com/Providers/freedomblue/FBCoreManual72104.doc at 3; Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab E: Overview of Highmark Business Perspective at 16. The Northeastern Region is the 13-county BCBSA-defined area (i.e., "BCNEPA Service Area").

[132] A search of the BCNEPA website finds no indication that they sell this plan directly. Rather, the links on the BCNEPA website to the Freedom Blue plans redirect the user to the Highmark website. Further, the available CMS data shows Highmark as the selling entity for this plan.

[redacted][133] The same JOA also delineates responsibilities for each party.[134]

Highmark and BCNEPA offer the Freedom Blue plans as part of a JOA; they currently collaborate rather than serve as direct independent competitors for these Medicare Advantage plans.

Dr. Capps utilizes 2013 enrollment data from the CMS to show that the Highmark-BCNEPA Freedom Blue product has a 19.3% share in the Northeastern region.[135] Since BCNEPA does not offer its own Medicare Advantage product, it does not have an independent share.

Table 3 below shows a number of competitive alternatives for Medicare Advantage:

[133] Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Confidential Supplement, Tab 8: Existing Agreements Between Highmark and BCNEPA, "Joint Operating Agreement Between Highmark Inc. and Hospital Service Association of Northeastern Pennsylvania d/b/a Blue Cross of Northeastern Pennsylvania," Feb. 25, 2005 at 1. [redacted] (BCNEPA Response to Information Request 2.1.13 from the Pennsylvania Insurance Department at NEPA-003786-87)

[134] Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Confidential Supplemental, Tab 8: Existing Agreements Between Highmark and BCNEPA, "Joint Operating Agreement Between Highmark Inc. and Hospital Service Association of Northeastern Pennsylvania d/b/a Blue Cross of Northeastern Pennsylvania," Feb. 25, 2005 at Attachment A.

[135] Capps Public Report at Figure 7.

Table 3
Medicare Advantage Enrollment Shares by Carrier and Region from Capps Public Report

Carrier	Region				
	Northeastern	Western	Central	Eastern	Centre County[1]
Security Blue	-	27.5%	-	-	-
Freedom Blue – excl. NE	-	20.7%	23.6%	1.0%	47.2%
Highmark 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%	-
CIGNA	-	0.2%	0.4%	34.1%	-
UPMC	-	27.6%	-	-	-
Others	0.2%	0.5%	0.3%	0.6%	-
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 Region 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.

[redacted][136]

[redacted]

[redacted]

[redacted]

[136] BCNEPA Confidential Supplemental Response to Information Request 5.2.9.2(A) from the Pennsylvania Insurance Department at NEPA-006853 [redacted] The 13 counties covered reflect the BCNEPA Service Area: Clinton, Tioga, Lycoming, Bradford, Sullivan, Susquehanna, Wyoming, Luzerne, Lackawanna, Wayne, Carbon, Monroe, and Pike. [redacted]

Dr. Capps concludes that Highmark and BCNEPA are not current competitors in the Medicare Advantage product market and, therefore, the transaction will not lessen the competition for Medicare Advantage products in the BCNEPA Service Area.[138]

We reviewed Dr. Capps' Medicare Advantage enrollment data from the CMS. We also confirmed that BCNEPA does not offer its own standalone Medicare Advantage product, and appears unlikely to do so. It thus appears there is no existing competition between Highmark and BCNEPA for Medicare Advantage products, and that the transaction is unlikely substantially to lessen competition in Medicare Advantage products.

b. Part D Prescription Drug Benefits

Medicare Part D Prescription Drug Benefits (hereafter "PDP") plans are offered to Medicare eligible enrollees as a way to cover the cost of prescription drugs. PDP plans are one of two ways in which eligible Medicare enrollees can purchase coverage for prescription drugs, the other being Medicare Advantage Part C plans. According to data from the Kaiser Family Foundation, roughly 46% of Medicare enrollees purchase standalone Part D plans.[139] The PDP plans are administered by private insurers under the guidance of the Centers for Medicare & Medicaid Services (hereafter "CMS").[140] CMS has defined 39 regions for which qualified insurers may sell PDP plans.[141] These regions are mostly state (or multiple states) level regions, including region 6 that covers Pennsylvania and West Virginia.[142] This implies that a useful geographic area for evaluating the choices for PDP plans is the state of Pennsylvania (recognizing that some suppliers are located outside of Pennsylvania).

Highmark offers contract "S5593" for PDP that covers Pennsylvania. It markets this product under the "Blue Rx" brand name. Similar to the Medicare Advantage analysis described above,

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[137] BCNEPA Confidential Supplemental Response to Information Request 5.2.9.2(A) from the Pennsylvania Insurance Department at NEPA-006868.
[138] Capps Public Report at ¶ 74.
[139] The Henry J. Kaiser Family Foundation, "The Medicare Prescription Drug Benefit Fact Sheet," Sept. 19, 2014, accessed Nov. 25, 2014, available at http://kff.org/medicare/fact-sheet/the-medicare-prescription-drug-benefit-fact-sheet/.
[140] See, Centers for Medicare & Medicaid Services, accessed Nov. 25, 2014, available at http://www.cms.gov/.
[141] Q1Group, LLC, "2015 Medicare Part D Prescription Drug Plans: Overview by CMS Region," accessed Nov. 25, 2014, available at http://www.q1medicare.com/PartD-Medicare-PartD-Overview-byRegion.php.
[142] Ibid; The Pennsylvania region is sometimes referred to as the Philadelphia region.

Dr. Capps uses 2013 enrollment data from the CMS to show that Highmark's PDP product has a 4.7% share in Pennsylvania.[143] BCNEPA does not offer any PDP products. Dr. Capps concludes, therefore, that the transaction will not change market structure for Part D PDP products.[144]

For completeness for the record, we examine information on other providers. Table 4 below shows that there are several competitive alternatives for PDP product coverage. As noted by Dr. Capps, Highmark has a 4.7% share of PDP plans for the state of Pennsylvania, making it the sixth largest PDP provider in the state according to enrollment share.[145]

Table 4
PDP Plans Enrollment Shares from Capps Public Report

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.

We reviewed the Part D Prescription Drug enrollment data from the CMS and how Dr. Capps processed it. Further, we evaluated Dr. Capps' analyses of the data to estimate Highmark's share. We also confirmed that BCNEPA does not offer Part D Prescription Drug Benefits coverage using data from the CMS.[146]

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[143] Capps Public Report at Figure 8.
[144] Capps Public Report at ¶ 78.
[145] Capps Public Report at Figure 8.
[146] CMS PDP enrollment data from Centers for Medicare & Medicaid Services, "PDP Plan Directory," accessed Nov. 24, 2014, available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-

c. Medicare Supplemental Coverage (Medigap)

Individuals and groups can purchase Medicare Supplemental Coverage (Medigap) to defray any remaining health care costs not covered by Medicare. Seniors enrolled in Medicare Plan A and Plan B are eligible to purchase Medigap plans.[147] Medigap plans are sold by private insurers licensed by the CMS for each state. Thus, a useful geographic area for assessing suppliers for Medigap is the state level.

According to the CMS-published "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare", "Medigap insurance companies in most states can sell a 'standardized' Medigap policy identified by letters A through N. Each standardized Medigap policy must offer the same basic benefits, no matter which insurance company offers it. Cost is usually the difference between Medigap policies with the same letter sold by different insurance companies."[148] Thus, the average consumer may base their selection of Medigap products primarily on price.

BCNEPA offers two Medigap plans: BlueCare Security (to individuals) and BlueCare Senior (to employers).[149] According to the BCNEPA-published "Your Blue Book", the BlueCare Security and the BlueCare Senior plan are offered in collaboration with Highmark.[150] This handbook also describes how the BCNEPA portion of the BlueCare products covers benefits that supplement Medicare Part A and "hospital outpatient benefits that supplement Medicare Part B" while the Highmark portion covers "[f]or all other benefits that supplement Medicare Part B".[151] Further, as noted in the Capps Public Report, BCNEPA and Highmark determine the premiums for their portions of the BlueCare plans independently and these premiums are added together to arrive at an overall premium for the BlueCare plans.[152] Highmark also sells its own Medigap plan

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Reports/MCRAdvPartDEnrolData/PDP-Plan-Directory-Items/CMS1203268-PDP-Plan-Directory.html?DLPage=1&DLSort=1&DLSortDir=descending.

[147] Medicare.gov, "What's Medicare Supplement Insurance (Medigap)?" accessed Nov. 25, 2014, available at http://www.medicare.gov/supplement-other-insurance/medigap/whats-medigap.html.

[148] Centers for Medicare & Medicaid Services, "2015 – Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare," accessed Nov. 25, 2014, available at http://www.medicare.gov/pubs/pdf/02110.pdf at 9. Massachusetts, Wisconsin, and Minnesota are the exceptions to the Medigap standardization.

[149] Blue Cross of Northeastern Pennsylvania, "Medicare Eligible Plans," accessed Nov. 19, 2014, available at https://www.bcnepa.com/Products/Medicare.aspx. As noted by Dr. Capps, BlueCare Senior is not formally a Medigap plan but a "Medicare complement plan". (Capps Public Report at Footnote 71).

[150] Blue Cross of Northeastern Pennsylvania, "Your Blue Book – BlueCare Security," accessed Nov. 21, 2014, available at https://d1tpfj3hind0fx.cloudfront.net/Media/Documents/Handbooks/SecurityHB.pdf; Blue Cross of Northeastern Pennsylvania, "Your Blue Book – BlueCare Senior Medicare Complementary Insurance," accessed Nov. 21, 2014, available at https://d1tpfj3hind0fx.cloudfront.net/Media/Documents/Handbooks/BlueCareSeniorHandbook.pdf.

[151] Blue Cross of Northeastern Pennsylvania, "Your Blue Book – BlueCare Security," accessed Nov. 21, 2014, available at https://d1tpfj3hind0fx.cloudfront.net/Media/Documents/Handbooks/SecurityHB.pdf at 10.

[152] Capps Public Report at ¶ 83. ("BCNEPA offers two Medigap products, both in conjunction with Highmark. The first is "BlueCare Security," which is sold to individuals. the second is BlueCare Senior, which is sold to employers. In the BCNEPA Service Area, BCNEPA is responsible for the costs of Part A Medicare services

called MedigapBlue. Dr. Capps notes, "nearly all of Highmark's enrollment in the BCNEPA Service Area is attributable to the joint product, BlueCare Security".[153] BCNEPA and Highmark currently jointly offer the BlueCare Medigap products.

Dr. Capps uses 2012 Medigap enrollment data from BCNEPA and Highmark (for the numerator) and 2012 total Medigap enrollment data in Pennsylvania from the AHIP Center for Policy and Research (for the denominator) to estimate Medigap enrollment shares. Highmark-BCNEPA jointly-offered Medigap products have between 5% to 10% market share in Pennsylvania.[154] Furthermore, as Dr. Capps explains, while all Medigap plans include a degree of cost-sharing for Part A and Part B services, BCNEPA only covers Part A benefits and a portion of Part B benefits while Highmark covers the remainder of Part B benefits. Therefore, BCNEPA does not offer its own standalone Medigap plan and is assigned no share.[155]

Highmark and BCNEPA are effectively collaborators rather than direct competitors in the Medicare Supplemental Coverage product. Dr. Capps therefore opines that the transaction will not reduce competition.[156] We reviewed Dr. Capps' analyses and his identification of a large number of companies that competitively offer Medigap product in Pennsylvania.[157] Based on our review, I conclude the transaction is unlikely to result in a substantial lessening of competition.

D. Additional Analyses of Share and Concentration

I was also asked to evaluate relevant data and information about the transaction for each of the above products, including shares, concentration and concentration trends under the standards Under 40 P.S. § 991.1403 (d)(2)(i)-(ii), ("Section 991.1403"). I present those calculations here.

The starting point for the calculations is the relevant markets including product and geographic aspects of markets.[158] For the reasons set forth Section V, I found that there were six separate

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(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.")

[153] Capps Public Report at ¶ 83.

[154] Capps Public Report at Figure 9.

[155] Capps Public Report at ¶ 86.

[156] Capps Public Report at ¶¶ 84-86.

[157] See, e.g., Capps Public Report at Appendix B.1.

[158] The statute defines a highly concentrated market as one in which the share of the four largest insurers is 75% or more of the market. Under this statute, the term "market" means a relevant product or geographic market. In the absence of sufficient information to the contrary, the relevant market is assumed to be the direct written insurance premium line of business. 40 P.S. § 991.1403 (d)(2)(i)-(ii) (C). These standards include specific shares for Insurer A and Insurer B in highly concentrated markets (A) and shares for the combining

sets of products relevant to evaluation of the proposed transactions: (1) commercial health insurance, (2) other commercial products including dental and vision, (3) stop-loss products, (4) Medicaid products, (5) CHIP products, and (6) Medicare-related products. I set out above the reasoning as to why these are useful separate relevant products based on standard economic principles and consistent with approaches taken by reviewing agencies such as the DOJ. I also identified the geographic aspect for each, which is based on the alternative suppliers for the specific services.

As discussed above, BCNEPA does not currently offer products in competition with Highmark in dental and vision, other commercial products, Medicaid products,[159] CHIP products, or Medicare-related products. In effect, BCNEPA has no market share for purposes of the calculation and there is no change in concentration.[160]

In commercial health insurance, BCNEPA and Highmark offer products within the relevant geographic area defined as BCNEPA's service area in northeastern Pennsylvania. I need not determine whether or not the relevant market is concentrated because even though both insurers technically compete in this market, they jointly offer the products at issue, and there is currently no direct competition between the two, and their shares of the market are jointly determined.

I was also asked to address trends toward increased concentration for the same product and geographic areas.[161] With respect to the commercial health insurance relevant market, I consider that BCNEPA and Highmark currently are not direct competitors but go to market jointly in this relevant market, and their shares are jointly determined. The BCNEPA/Highmark joint venture invokes the criterion that "one of the insurers involved is one of the insurers in a grouping of such large insurers showing the requisite increase in the market share"; however, as Highmark and BCNEPA do not currently independently compete in the same market, this merger would not contribute towards increased concentration.

In the stop-loss product market, there is no information available from which to calculate shares in the relevant Commonwealth of Pennsylvania geographic market. Dr. Capps estimates

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insurers where the market is not highly concentrated. There are additional concentration measures that include: "There is a significant trend toward increased concentration when the aggregate market share of any grouping of the largest insurers in the market, from the two largest to the eight largest, has increased by seven per centum (7%) or more of the market over a period of time extending from any base year five (5) to ten (10) years prior to the acquisition up to the time of the acquisition... and share estimates for one of the insurers involved is one of the insurers in a grouping of such large insurers showing the requisite increase in the market and another involved insurer's market is two per centum (2%) or more.

[159] BCNEPA has exited the provision of Medicaid, and hence would have had no presence going forward.

[160] I note here that I nonetheless provide analyses and assessment of competition and alternatives in these products for completeness for the PID in its evaluation.

[161] I did not examine trends in products that BCNEPA does not currently offer any products independently including the dental and vision commercial products, or other commercial insurance products, Medicaid products, CHIP products, and Medicare-related products

BCNEPA's share of commercial enrollees in Pennsylvania covered by stop-loss policies to be less than 0.5%.[162] In addition, BCNEPA currently only offers stop-loss coverage as part of a bundle of coverage. Highmark is a competitive alternative, though less directly for BCNEPA customers, I conclude that at best, there is only limited competition between Highmark and BCNEPA for this product.

VI. ECONOMIC EVALUATION OF ALLEGED BENEFITS TO POLICYHOLDERS, THE NORTHEASTERN PENNSYLVANIA COMMUNITY, AND THE PARTIES

Under 40 P.S. § 991.1402(f) (1) (ii), (vi) and (iv), the Department shall approve any merger unless, among other factors, it finds the merger will "substantially lessen competition in insurance", "is likely to be hazardous or prejudicial to the insurance buying public" or it finds the consolidation, merger, or other "material change in its business or corporate structure or management, are unfair and unreasonable and fail to confer benefit on policyholders of the insurer and are not in the public interest."

It is under these standards that I evaluate the claimed efficiencies presented by the parties as business justification for this transaction.

A. Economic Approach to Efficiencies and Consumer Welfare Benefits from Health Insurance Transactions

The DOJ/FTC Horizontal Merger Guidelines state that "...a primary benefit of mergers to the economy is their potential to generate significant efficiencies and thus enhance the merged firm's ability and incentive to compete, which may result in lower prices, improved quality, enhanced service, or new products."[163] These Guidelines recognize that achieved cost savings may reduce a merged firm's incentive to raise price and also may lead to new or improved products.[164] When a merger has the effect of lessening competition, cognizable efficiencies (i.e., efficiencies that are merger-specific, verified and do not arise from anticompetitive reductions in output or service) may be of a nature and magnitude that would mitigate a lessening of competition. Under these circumstances, the Federal antitrust agencies will not challenge a proposed merger among horizontal competitors.[165] The greater the anticompetitive effects, the less likely it is that efficiencies will offset or mitigate the lessening of competition such that consumers will not be harmed.

[162] Capps Public Report at ¶ 57.
[163] Merger Guidelines at 29.
[164] Merger Guidelines at 29.
[165] Merger Guidelines at 30.

A merger may generate variable and fixed costs savings. Variable cost savings generally have been given weight since they more directly affect short term pricing, a primary consideration of the federal antitrust agencies. Fixed costs savings, however, also warrant consideration in my view since these types of savings may impact long term pricing decisions as well as innovation and investment decisions. As stated by FTC Commissioner Joshua Wright and Judd Stone,

> The economics literature has long recognized the competitive importance of reductions in fixed-cost savings. For example, the Antitrust Modernization Commission concluded that "the agencies should account for the value of fixed-cost efficiencies in assessing the likely competitive effects of a merger" and that failure to do so "could deprive consumers and the U.S. economy of significant benefits from a procompetitive merger." (Antitrust Modernization Commission, Report and Recommendations 58 (2007)). In particular, while ignoring the potential short-term price effects attributable to fixed-cost efficiencies is a serious problem, there is substantial concern that merger analysis which does not take into account the full impact of fixed-cost savings on competition may ignore the effect that such reductions have on incentives to invest in research and development and introduce new products.[166]

In addition to cost savings efficiencies, a merger may provide benefits that are not merger-specific, but nonetheless accrue to both the merged firm and consumers. A merger-specific efficiency is one that is unlikely to be achieved in the absence of either the proposed merger or via other means having similar anticompetitive effects, such as a joint venture among the parties. These cost savings and consumer benefits should not be ignored and remain an important consideration in determining the true economic impact of any proposed merger or acquisition.

Particularly in today's healthcare reform and transformation environment, one that can be characterized through the "Triple Aim," i.e., actions that seek to simultaneously improve the health of the population, enhance the experience and outcomes of patients, and reduce the per capita cost of care for the benefit of communities,[167] mergers among healthcare firms should be evaluated based on their enhanced ability to deliver on these actions. This goes towards the development of new products and services that could not otherwise efficiently be offered by

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[166] Stone, Judd E. and Joshua Wright, "The Sound of One Hand Clapping: The 2010 Merger Guidelines and the Challenge of Judicial Adoption," Review of Industrial Organization (2011) 39:145-158 at 156, also citing Antitrust Modernization Commission, Report and Recommendations 59 (2007) concluding that "the enforcement policy of the FTC and the DOJ may give insufficient recognition to innovation efficiencies in some mergers in which they believe anticompetitive effects may result in the short term". See, e.g., Comment of David Scheffman, Director, Bureau of Economics, Federal Trade Commission (2002) at 228:7-11 ("[E]conomists have known...forever ...that actual business decisions are often made in part based on average costs rather than incremental costs."). For a broader compilation of sources on this topic, see generally Muris, Timothy J. and Bilal Sayyed, "Three Key Principles for Revising the Horizontal Merger Guidelines," The Antitrust Source, April 2010.

[167] Institute for Healthcare Improvement, "Triple Aim for Populations," accessed Nov. 25, 2014, available at www.ihi.org/Topics/TripleAim/Pages/default.aspx.

parties individually due to economies of scale or scope. These efficiencies may not be "cognizable" because they are difficult to verify or quantify. Nonetheless, these efficiencies may significantly improve the ability of the merged firm to achieve necessary healthcare transformation and reforms that ultimately benefit consumers of healthcare services.

I consider these factors in evaluating the claimed cost saving efficiencies cited and analyzed by Dr. Capps in the Capps Confidential Efficiencies Report, Capps Public Efficiencies Report, and Capps Confidential Efficiencies Supplement.

B. Parties' Claimed Benefits from the Transaction

In Section IV, I describe both BCNEPA and Highmark's perspectives on their business rationales for the transaction and alleged benefits that each will attain from the combined business. In this section, I examine the support for these claimed benefits to determine the likelihood that these benefits will materialize post-transaction and whether the benefits are merger-specific. I focus on those benefits that would impact the cost of providing insurance products and healthcare in the combined service area and those benefits that improve the quality of and access to healthcare in keeping with the goals of healthcare transformation and reform.

Highmark's economics expert, Dr. Capps, submitted a report describing the primary efficiencies that would emerge from this transaction, with supporting evidence, once the transaction is fully implemented.[168] The efficiencies examined included:

- Administrative cost savings. Dr. Capps estimates that the potential administrative cost savings exceed $25 million annually;[169]
- Pharmacy spend cost savings. Dr. Capps estimates that including BCNEPA subscribers under Highmark's new pharmacy benefits management ("PBM") contract will "likely" result in a net cost savings of more than $5 million annually;[170] and

[168] Highmark and Dr. Capps provided more extensive support and updates for the efficiencies and benefits discussed in the Capps Confidential Efficiencies Report and Capps Public Efficiencies Report. Dr. Capps provided his response in the Capps Confidential Efficiencies Supplement. My assessment examined all of these reports but primarily relied on the updated and more detailed Supplement for quantification of these claimed benefits. Throughout this section, I refer generally to the efficiencies estimates once the transaction is fully implemented; this in some cases differs from the reported information in the Report of the Blackstone Advisory Partners LP. In addition, I refer to efficiencies estimates where realized or as projected by Highmark once realized.

[169] Capps Public Efficiencies Report at ¶ 29

[170] Capps Public Efficiencies Supplement at ¶ 53. [redacted] Capps Confidential Efficiencies Supplement at ¶ 1. PBMs contract with plan sponsors, e.g., health insurance plans and employers, to manage the coverage of drugs to subscribers by out-of-hospital pharmacies. Management may include (1) creating networks of contracted retail pharmacies, (2) processing pharmacy claims, (3) creating drug formularies to manage utilization and costs, (4) negotiating drug rebates with pharmaceutical manufacturers, (5) mail-order pharmacy dispensing, (6) specialty pharmaceutical dispensing and related services, (7) drug utilization review, and (8) compliance and therapy management programs. (See, Danzon, Patricia M., "PBM Compensation and Fee

- Medical population health management.[171]

In addition, Highmark alleges that the transaction will continue the significant annual reduction towards Highmark's fixed IT costs. Highmark and Dr. Capps do not provide any supporting information on the contribution of BCNEPA's current operations to Highmark's fixed IT costs. Highmark also states in its Form A that it "expects to realize additional scale improvement to its administrative efficiency as a result of the addition of BCNEPA's full subscriber base to the Highmark platform."[172] It will also enhance the opportunity to moderate healthcare cost trends in the BCNEPA Service Area by introducing new reimbursement and incentive programs with providers, such as Highmark's provider-driven accountable care organization (Quality Blue Accountable Care Alliance), its patient centered medical homes ("PCMH") programs (Quality Blue Patient Centered Medical Home), its Blue Distinction Total Care Program, and two new value-based programs (gain-sharing model and a bundled payment program for key specialists).[173,174] Highmark reports that similar programs have yielded a 3% reduction in health care cost trends.[175]

Disclosure," 2014 ERISA Advisory Council, accessed on Nov. 30, 2014, available at http://www.dol.gov/ebsa/pdf/ACDanzon061914.pdf).

[171] Capps Public Efficiencies Report at ¶ 6. The term "medical management" is used by Highmark and Dr. Capps to describe "(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 preventative care or better compliance with treatment regiments." (Capps Public Efficiencies Report at ¶ 55). In practice, the term "medical management" often refers only to IT that is used to promote health, disease, and care management. I prefer the term "care management" in keeping with most healthcare practitioners to describe the functions described under medical management by Dr. Capps and will use that term hereafter to denote care management that is broader than IT strategies. I note that Dr. Capps does not provide a specific estimate of cost savings for these care management programs.

[172] See, Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab E: Overview of Highmark Business Perspective at 22. See also, Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Confidential Supplement, Tab 6: Highmark Board of Directors Presentation and Resolution at 7. ("Drives scale and efficiency for Highmark to spread fixed costs and significant capital investments required to meet current and new-ACA market needs.") Neither Highmark nor Dr. Capps provide an estimate of these additional scale efficiencies. When asked about these scale efficiencies at the public hearing, Dr. Capps testified that "adding BCNEPA to Highmark is a relatively small expansion in the overall membership base. So even the scale there would be proportionately smaller. That doesn't mean it would be zero, but they're not likely to have the significant impact over time that they will have going in the other direction." Testimony of Dr. Cory Capps, Public Informational Hearing, RE: Proposed Merger Between Highmark, Inc., and Blue Cross of Northeastern Pennsylvania, Nov. 12, 2014 at 141:18-23.

[173] Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab E: Overview of Highmark Business Perspective at 5-7, 11 and 18. Highmark's Blue Distinction Total Care is a program for national accounts with subscribers located in multiple areas of the country. It integrates local value-based care programs from Blue plans across the country into a comprehensive solution (at 19).

[174] Highmark also describes other benefits that enhance its competitive positioning, such as geographic expansion of its dental, vision and stop loss products and services, better positioning to compete for national accounts, and better positioning to participate in federal and state sponsored health insurance programs. I address these specific benefits in the competitive effects section of this report.

[175] Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab E: Overview of Highmark Business Perspective at 20.

C. Economic Analyses of the Alleged Benefits from the Transaction

1. Reduced BCNEPA administrative costs

Highmark stated that the merger would generate annual administrative synergies of more than $25 million through streamlining and consolidating administrative functions, consolidating vendor service providers, and fully integrating IT systems and IT vendor consolidation.[176] Dr. Capps provided a discussion of these claimed benefits. He identified two primary sources of administrative savings: (1) staff optimization,[177] and (2) information technology infrastructure, i.e., IT systems that provide claims processing, customer service, provider relations, enrollment, patient portals, medical management, provider incentives, actuarial, and sales.[178]

According to Dr. Capps, Highmark undertook two separate analyses to estimate potential administrative cost savings. The first estimated staff optimization by applying Highmark staffing ratios to BCNEPA enrollment.[179] Approximately $[redacted] million would result from eventual reductions or redeployment in BCNEPA's or Highmark's workforce of about [redacted] FTEs:

- Operations—applying Highmark staffing ratios to BCNEPA volumes and including 2/3 of the difference to the synergy opportunity;
- Clinical programs/medical management—applying Highmark staffing ratios to BCNEPA volumes and including 1/2 the difference to the synergy opportunity;
- Information technology—estimated [redacted]% of BCNEPA's IT FTEs would be included in the synergy opportunity;
- Corporate, sales and marketing, and provider services—no specific estimate provided.

In total, the cumulative synergy opportunity was identified to be a reduction of [redacted] FTEs providing $[redacted] million in administrative cost savings of which $[redacted] million would derive from non-FTE sources, such as vendor service provider consolidation.[180]

Dr. Capps also discussed a separate due diligence analysis undertaken by the cost management team which compared PMPM administrative costs in Highmark's Central Region

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[176] Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Confidential Supplement, Tab 6: Highmark Board of Directors Presentation and Resolution at 3 and 13-14.
[177] Capps Confidential Efficiencies Report at ¶ 39. Dr. Capps relies on Highmark Confidential "Project Bluestone Synergy Analysis," undated at 2, and Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Confidential Supplement, Tab 9: Highmark Confidential Financial Projections and DOI 135's at 3, for Capps' opinion of estimated staff reduction cost savings. Dr. Capps does not appear to have undertaken any independent analysis to validate these estimated cost savings. Sufficient underlying data and analyses were not provided in either source documents on which to validate these claimed cost savings.
[178] Capps Public Efficiencies Report at ¶¶ 38-39.
[179] See Highmark Confidential, "Project Bluestone Synergy Analysis," undated at Attachment 3, which shows the significant differences between BCNEPA and Highmark's staffing ratios by administrative function.
[180] Capps Confidential Efficiencies Report at ¶ 40. For details cited above, see also Highmark Confidential, "Project Bluestone Synergy Analysis," undated at 1-7. See also Capps Public Efficiencies Report at ¶ 24.

with that of FPH and FPLIC. This analysis estimated that administering the FPH and FPLIC products were about 40% higher (about $[redacted] PMPM than administering Highmark's comparable products in its Central Region, excluding broker commissions). This analysis estimated that closing this PMPM cost gap by 50% would result in $[redacted] million in cost savings or a PMPM of $[redacted]. The analysis also estimated additional administrative cost savings of $[redacted]-$[redacted] million for non-FPH/FPLIC products.[181]

Dr. Capps undertook his own independent estimate of administrative cost savings. Using publicly available MLR data, Dr. Capps analyzes various components of the CMS MLR to evaluate Highmark and BCNEPA's PMPM administrative costs. He finds that Highmark's PMPM administrative costs are significantly below that of BCNEPA. Using 2013 CMS MLR data, he applies Highmark's lower administrative cost to BCNEPA'S enrollment for the FPH and FPLIC products to calculate cost savings. His estimates are presented below in Table 5.

Table 5
Replication of 2012 Administrative Cost Savings Analysis Using 2013 Data from Capps Confidential Efficiencies Supplement

Membership, costs, and savings	Including FEP		Excluding FEP	
	Fully-funded	Self-funded	Fully-funded	Self-funded
Administrative cost PMPM, FPH/FPLIC	[redacted]			
Administrative cost PMPM, Highmark				
Member months (in millions), FPH/FPLIC	1.25	1.45	1.25	1.45
PMPM difference in admin costs	$13.61	$9.22	$9.69	$9.22
Savings (in millions)	$17.05	$13.40	$12.14	$13.40
Total savings in millions	$30.45		$25.54	

Source: CMS MLR 2013 data

Dr. Capps concludes that his estimated $[redacted]-$[redacted] million in estimated administrative cost savings validates the $[redacted] million cost savings estimated by the due diligence team and presented to the Board of Directors and that of the cost management team's estimated $[redacted] million in administrative cost savings.[182]

I considered each of the three methods for estimating cost savings in my review. None of these methods provided sufficient supporting documentation to test the sensitivity of the estimates to specific industry factual assumptions or sources, or to provide a specific understanding of how these cost savings would be achieved. I find Dr. Capps' MLR method to be the least persuasive since it provides no information on the specific source of the differences in administrative costs

[181] Capps Confidential Efficiencies Report at ¶ 35. See also Confidential, "Project Bluestone Synergy Analysis," undated at 1. See also Capps Public Efficiencies Report at ¶ 34.
[182] Capps Public Efficiencies Report at ¶ 38 and Figure 2.

between Highmark and BCNEPA, and therefore, no direction on the steps necessary to achieve these estimated savings. Moreover, it assumes without support that aggregate MLRs across the entire book of business provide a sound basis here for evaluating efficiencies. Finally, it is a cost comparison analysis, not an efficiencies analysis of the type required to verify and support merger-specific efficiencies.

Likewise, although there may be more detailed information on the sources and, hence, opportunities for savings in Highmark's cost management team's estimated $[redacted] million in annual recurring cost savings, Highmark does not provide any explanation as to why the Central Region's cost structure should readily apply or be achievable for the BCNEPA region in this transaction. There is no specific basis, for example, as to why the infrastructure and staffing per enrollee or for certain functions in the Central Region would apply readily to the BCNEPA Region. It is similar to Dr. Capps' analysis in that it is essentially a cost comparison analysis.

The better source for estimating cost savings rests with the due diligence team. It assumes that Highmark's staffing ratio can be applied to BCNEPA's volume, which seems like a reasonable assumption. It examines the source of these FTE reductions. [redacted] BCNEPA personnel will be reorganized and integrated into Highmark's structure. BCNEPA's business operations will continue to be administered by the same BCNEPA personnel.[183]

Other than simply referencing an expected $[redacted] million in additional non-FTE administrative cost savings such as vendor consolidation, Highmark provides no support for these additional sources of cost savings. Nor did Dr. Capps explore the underlying basis for these additional cost savings. For this reason, I must conclude that these last specific savings are not well supported in the PID record.

[183] See, Testimony of Denise S. Cesare, President and CEO of Blue Cross of Northeastern Pennsylvania, Public Informational Hearing, RE: Proposed Merger Between Highmark, Inc., and Blue Cross of Northeastern Pennsylvania, Nov. 12, 2014 at 63:9-19 ("[T]he commitment to jobs and employment in Northeastern Pennsylvania, Highmark has committed to continue operations in Northeastern and North Central Pennsylvania with the workforce, the current workforce of Blue Cross of Northeastern Pennsylvania for four years following the transition of, or the approval of the merger. What Highmark is committed to do is use commercially reasonable [sic] efforts to maintain this presence in Northeastern and North Central Pennsylvania.") and Testimony of David L. Holmberg, President and CEO of Highmark Health, Public Informational Hearing, RE: Proposed Merger Between Highmark, Inc., and Blue Cross of Northeastern Pennsylvania, Nov. 12, 2014 at 104:3-13 ("So Highmark's commitment is to do everything that's commercially and reasonably sound. We believe in sustainable jobs. We believe in making sure that we create opportunities wherever possible. And so what that means is, you know, we're committed to, you know, to keeping as many jobs as possible in the region. But that will be market driven. That will be based on our ability to grow the number of members that we have. It will be based on our ability to bring new innovative solutions to the marketplace.")

Highmark believes that, over time, however, changes would occur including the replacement of Highmark systems or processes for BCNEPA ones and that BCNEPA employees (who will have become Highmark employees) would increasingly use these to conduct what had been BCNEPA business, and potentially some Highmark business as well.[184] Highmark further believes that over 24 months or so following closure, potential synergies from these changes could also lead to reduction or redeployment of FTEs to other Highmark entities.[185] Highmark estimates [redacted] FTEs located in Wilkes-Barre or other Highmark locations will be reduced or redeployed to other Highmark businesses in the first year, some from retirements, natural attrition, or unfilled vacancies.[186] Highmark does not address the source of the remaining [redacted] FTEs ([redacted] less [redacted] reductions or timing included in its efficiencies analysis. [redacted][187] [redacted][188] These cost savings appear to be consistent with Highmark's 18-month commitment to existing employees for continued employment or severance should they be displaced.[189, 190]

Another source of additional cost savings which is cited but not explored in detail by any of the three methods are the savings from scale economies that would flow to Highmark following the merger. Dr. Capps states that the volume of subscribers that would be administered by Highmark will increase to an estimated 46.0 million member months, a 6% increase in

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[184] Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Confidential Supplement, Tab 9: Highmark Confidential Financial Projections and DOI 135's, DOI 135 at 3.
[185] Ibid. at 3.
[186] Ibid. at 3-4.
[187] Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Confidential Supplement, Tab 6: Highmark Board of Directors Presentation and Resolution at 14.
[188] Ibid.
[189] See, Testimony of Denise S. Cesare, President and CEO of Blue Cross of Northeastern Pennsylvania, Public Informational Hearing, RE: Proposed Merger Between Highmark, Inc., and Blue Cross of Northeastern Pennsylvania, Nov. 12, 2014 at 75:2-16. ("For a period of 18 months all of the employees who have been with the organization for, I believe it is a year prior to the approval...are protected, for the 18 month period with Highmark. For the four year period, there are no specified numbers or guarantees, if you will. The goal is to maintain a significant presence in the organization. And again, using commercially reasonable efforts. If we grow market share we can grow jobs. Obviously if we do not grow market share we cannot grow jobs. And to require the organization to maintain a level would actually hurt the policyholders, which we don't want to do.")
[190] In public comments received by the PID, The Hospital & Healthsystem Association of Pennsylvania stated the importance of sustaining a regional presence to serve subscribers and to support health care providers, which would "foster innovative and effective approaches to addressing the provisions of cost-effective, affordable health coverage and meeting subscriber care needs." See, Letter to Ms. Cressinda Bybee from Paula A. Bussard, Chief Strategy Officer of The Hospital & Healthsystem Association of Pennsylvania, dated February 2, 2015. In response to these comments, Highmark reiterated its commitment in the Merger Agreement to employees of BCNEPA and to take further actions "to identify and create new employment opportunities in the region as business needs permit." (See, Response of Highmark Inc. to Comments of Paula A. Bussard Dated February 2, 2015, dated February 19, 2015) These comments reinforce the need for Highmark to honor its commitment to the region to mitigate any adverse impact on employment in the BCNEPA service area from this merger.

Highmark's existing 43 million member months.[191] He opines that the effect on administrative scale economies will be positive, but does not attempt an estimate. In his testimony at the PID hearing on this transaction, he indicated that the savings are likely small.[192]

It is my opinion that the parties have set forth a logic that the expected FTE reduction could lead to cost savings; and that the estimated approximately $[redacted] million in cost savings appears reasonable as an estimate for the hypothesized reduction, and somewhat supported by the data and information provided, provided these reductions in workforce actually occur. If there were significant competitive effects to offset with these back office fixed cost savings, I would expect much greater detail and supporting evidence for these estimated cost savings.

2. Reduced BCNEPA Pharmacy Spend

PBM spending is a healthcare cost area that is undergoing transformation due to demographics, healthcare trends, and competition. Factors such as an aging population, increased prevalence of chronic medical conditions, such as diabetes and obesity, and technological innovations, exert pressure on purchasers to better manage prescription benefits.

Dr. Capps reports that experts opine that industry conditions are favorable for more aggressive PBM negotiations by insurers to lower overall pharmacy costs, citing PBM market consolidation as cause for aggressive negotiations.[193] My research indicates that there are five industry trends cited by experts as having an immediate impact on PBM contracting:

- Market consolidation—insurers can use their market share as leverage to negotiate better deals as PBMs compete for share in a consolidating industry;
- Specialty drug management—an important and focused category of drugs to effectively manage as these drugs become an increasing proportion of overall drug costs prescribed in treatment protocols, includes channel management to stabilize costs;
- Retail network participation—some plan sponsors (insurers, employers) are using limited preferred provider organization retail pharmacy networks which represents increased competition for PBM;

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[191] Capps Public Efficiencies Report at ¶ 33.

[192] Testimony of Dr. Cory Capps, Public Informational Hearing, RE: Proposed Merger Between Highmark, Inc., and Blue Cross of Northeastern Pennsylvania, Nov. 12, 2014 at 140:23-142:6. See also Footnote 172 *supra*. Highmark also references these scale economies, but provides no supporting documentation or analysis of these savings. See Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab E: Overview of Highmark Business Perspective at 22.

[193] Dr. Capps cites Frasch, Kristen, "Don't Forget Your PBM Contracts!" Human Resources Executive Online, June 13, 2013, available at http://www.hreonline.com/HRE/view/story.jhtml?id=534355574&ss=don%27t+forget+your+pbm+contracts for support.

- New generics entering the market—brand name drugs loss of exclusivity to generics reached a high point in 2012, which improved the bargaining position for plan sponsors negotiating post-2013 rates; and
- The 2010 Patient Protection and Affordable Care Act (PPACA), which has increased transparency.[194]

Both BCNEPA and Highmark appear to have benefited in recent negotiations from these trends.

Dr. Capps estimates approximately $[redacted]-$[redacted] million annually in cost savings by moving BCNEPA's pharmaceutical spending to Highmark's recently renegotiated PBM contract with Express Scripts (formerly Medco). Dr. Capps estimates BCNEPA's projected July 2014 through June 2015 spending on prescription drugs under the terms of its recently negotiated PBM contract extension. He then assumes Highmark's newly negotiated Express Scripts contract is applicable to BCNEPA starting in 2016. He adjusts the amount downward by $[redacted] million for BCNEPA's improved savings under its own contract for the July 2015 through June 2016 period. The savings largely derive from [redacted].[195] These estimated savings are presented in Appendix C, Table C-3.

There is no indication in the supporting materials provided by Dr. Capps that Express Scripts and Highmark were able to negotiate more favorable rates as a result of the pending BCNEPA merger. Consequently, BCNEPA subscribers will enjoy the benefits of Highmark's better PBM contract, but Highmark subscribers will not derive any incremental benefits from any increased volume discounting from having BCNEPA flowing through the PBM contract. I would characterize these cost savings as merger-specific, but not synergistic since they do not derive from economies of scale or scope, i.e., these savings are not generated from the integration of any productive or service assets, or from any combined input volumes. In my view, it is highly unlikely that these savings could be accomplished through other means, such as some form of joint contracting for PBM services, and therefore, are merger-specific. These cost savings are generated from moving volume from one existing supplier contract to another existing contract with improved prices, not from scale economies of combining unique productive assets. However, this technicality does not make these cost savings less important to the bottom line of the combined firm.

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[194] Zimmerman, Allan, "Finding More Value in Pharmacy Benefits: Five Trends that Matter," Benefits Magazine, June 2013 at 29-33.

[195] Dr. Capps provided Compass Lexecon with the underlying data and models used to calculate these estimates. We were able to validate the process, assumptions and calculations reported by Dr. Capps. We note that the source for Dr. Capps' analysis was Confidential BCNEPA RFP Modelling Draft new Format 1.16.12.xlsx and Confidential Highmark ESI Pricing Terms 2016-2018 NEW.xlsx. The former spreadsheet is a comparative analysis of BCNEPA's current and proposed PBM rates. We have no ability based on information provided to verify the accuracy of these analyses which are cited as source documents. Rebates are not included in the calculation of cost savings, but we would expect rebates to increase available cost savings.

3. Care management strategy savings in the BCNEPA Service Area

In examining efficiencies and synergies, both Highmark and BCNEPA address care management savings as a cost reduction in terms of avoided capital expenditures and ongoing annual expenditures that are necessary to transform partnerships with local provider systems to ensure access by consumers to high quality and affordable healthcare in the Northeastern Pennsylvania marketplace.[196] [redacted] presentation to BCNEPA on provider partnership opportunities (medical management savings) indicates that BCNEPA may face difficulty in undertaking such investments alone, stating:

- [redacted];
- Primary care capabilities are the initial step in a long-term, multi-phase approach to population health management;
- Additional investment will be required for the infrastructure and capabilities related to primary care and other joint venture opportunities;
- Population health management results typically require 5-10 years to achieve; the short-term impact of utilization reduction initiatives may only be $3M per year;
- While critical to long-term success, the necessary investment in care management capabilities will further exacerbate BCNEPA's short-term capital constraints.[197]

[redacted] recommended that BCNEPA seek a partner to provide needed capital support and co-invest in the development of an enhanced primary care network with multiple area providers that would support the evolution of enhanced population health management.[198]

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[196] See Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab E: Overview of Highmark Business Perspective at 22-23. See also Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Confidential Supplement, Tab 6: Highmark Board of Directors Presentation and Resolution at 8 and Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab F: Overview of BCNEPA Business Perspective at 6-7 citing investments in PCMH and ACOs, better management of chronically-ill patients, improving overall population health, outcomes-based contracting with providers, reduction of outmigration for care, and expansion of primary care access. [redacted] estimated that BCNEPA would require an initial investment of $[redacted] million ($[redacted] million with a joint venture partner) and $[redacted]-$[redacted] million in ongoing annual expenditures (half assuming a 50% JV partner) to obtain the capability to provide an expanded primary care network, IT systems for clinical management infrastructure, and to proactively manage high risk patients and reduce utilization. However, [redacted] also reported that necessary investment in care management capabilities would further exacerbate BCNEPA's short-term capital constraints. ([redacted] Presentation at 21 and 23)

[197] [redacted] Presentation at 24. See also BCNEPA Confidential, "Capital Requirements, Presentation to the Board of Directors," Dec. 14, 2011 at 2, [redacted]

Highmark views new reimbursement and incentive programs with independent providers as a means of moderating care cost trends in Northeastern Pennsylvania. It reports its intention to introduce its "innovative group and retail products and benefit designs and provider pay-for-value programs, which integrate with its disease management and wellness programs, including its provider-driven ACO and PCMH programs... to the northeastern Pennsylvania region."[199] With these programs, it plans to "shift the consumer and provider experience toward value-based care and products."[200] This objective is consistent with the healthcare transformation and reforms encouraged under the ACA and actively being pursued by BCNEPA's competitors, such as Geisinger.

Dr. Capps describes BCNEPA's current care management programs. My review of these programs suggests that they are limited in scope, relatively new, and without the type of infrastructure supporting Highmark's more expansive programs. BCNEPA's current programs include:

- BCNEPA's Quality Incentive Program ("QIP") for physicians caring of subscribers to FPH and FPLIC. QIP rewards incentive payments for physicians that score above the median for specified performance metrics. Incentive payments take the form of fixed amounts per attributed member per month ("PAMPM"). No information is provided on estimated cost savings from the program. Approximately $[redacted] million in incentive payments were made to physicians for meeting performance targets.[201]
- BCNEPA's Episode Incentive Program ("EIP"). This program applies to physicians that do not quality for QIP. To date, BCNEPA has paid out about $[redacted] in total to [redacted] physician groups for improved performance under this program.[202]
- BCNEPA's PCMH pilot program with Susquehanna Health.[203] This program has been in effect for a short period of time (about one year). BCNEPA provides funding for technology investments and care coordinators. Participants receive incentive payments

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[198] [redacted] Presentation at 27.

[199] Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab E: Overview of Highmark Business Perspective at 17 and Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Tab F: Overview of BCNEPA Business Perspective at 17.

[200] Ibid.

[201] Capps Public Efficiencies Report at ¶¶ 66-70, citing BCNEPA, "FPLIC & FPH Physicians Quality Incentive Program (QIP): QIP Distribution Summary October 1, 2011-June 30. 2013," n.d.

[202] Capps Confidential Efficiencies Report at ¶ 87.

[203] Capps Public Efficiencies Report at ¶ 70, citing BCNEPA, "Susquehanna Health and Blue Cross of Northeastern Pennsylvania Launch Patient Centered Medical Home Pilot," news release, Dec. 19, 2013, https://www.bcnepa.com/OurCompany/News/Press/Release.aspx?id=785. PCMHs consists of four key elements: (1) commitment to primary care, (2) emphasis on the patient, (3) implementation of new models of care, including EHRs, use of disease registries, guidelines, and patient self-management support programs, and active participation in continuous quality improvement initiatives), and (4) increased payment incentives for providing more coordinated care. See Shortell, Stephen M., Robin Gillies, and Frances Wu, "United States Innovations in Healthcare Delivery," Public Health Reviews, (1990), Vol. 32, No. 1 at 192-193.

if they meet agreed upon performance targets. Because the pilot program is so new, no information is available on results.[204]

Highmark's care management programs consist of its PCMH and ACA programs. Highmark's BlueCore Platform shows the significant infrastructure supporting these programs.[205] As of April 2014, Highmark reported that its Quality Blue and PCMH programs had over 900,000 attributed members in Pennsylvania, Delaware, and West Virginia (19.1% of total comprehensive insurance enrollees), 840 participating practices, and more than 3,700 participating practitioners.[206] Highmark does not provide information on the number of enrollees in each program.

- PCMH. Implemented broadly in 2012, this program incentivizes physicians to meet performance targets related to coordinated care, clinical quality indicators, and cost and utilization targets. Highmark does not report on outcomes relating to its 2012 broader implementation. The pilot program generated a decrease in PMPM medical costs of about 2% within six months, a decline in inpatient admissions of about 9% and a decline in both 7-day and 30-day readmissions rate by more than 13%.[207]
- H-ACA (Alliance), originally offered only to physicians employed by Allegheny Health Network, now includes three other hospitals systems in the Pittsburgh area. It includes specialists and hospitals who also participate in Highmark's PCMH. The intent is to incentivize physicians to coordinate and share responsibility for managing patient care.
- Quality Blue. This program offers increased per-visit fees to PCPs that meet performance targets on clinical quality and generic drug prescribing. Highmark is working to transition PCPs under this program to its PCMH and H-ACA programs which reward physicians on both quality and cost effectiveness metrics.[208]

Dr. Capps applies the results from the pilot PCMH of 2% in cost savings and provides a quantification of the potential cost savings if the pilot's results applied to full coverage of BCNEPA's FPH and FPLIC products. This quantification would result in calculated savings of approximately $16 million per year. I do not find that an extrapolation of these cost savings from the pilot PCMH provides an appropriate indication of cost savings that might occur in this transaction. First, there is no support for the underlying assumption that all physicians serving

[204] Capps Public Efficiencies Report at ¶ 70.
[205] See Highmark, "BlueCore Platform, A Visual Guide to the People, Processes and Tools of Highmark," 2014 at 50-81, which provides a description of the infrastructure supporting Highmark's healthcare delivery management neighborhood, including care management and informatics programs.
[206] Capps Public Efficiencies Report at ¶ 81. See also Highmark, "Medical Management Savings," undated at 2 contained in Economist Follow Up 081913.pdf.
[207] Capps Public Efficiencies Report at ¶ 79.
[208] Capps Public Efficiencies Report at ¶¶ 75-79. See supporting documents at Highmark, "Quality Blue, FY2012 Achievement Compendium, Executive Summary" and Highmark, "Quality Blue Hospital Results, Fiscal Year 2013 Report".

FPH and FPLIC participants would participate or meet the program's targets. Second, results from the 2012 broader rollout are not consistent with the results from the pilot study.

We requested that Dr. Capps provide information in the health policy and health economics literature on the importance of care management in improving value in healthcare. Although Dr. Capps cited many articles, not all articles provided specific cost savings. For example, Reid et al. (2009) reported slightly more than a 1% gain in composite quality for PCMH patients compared with non-PCMH patients, but no increase in total cost savings at 12 months.[209] Examining the same pilot program, Reid et al. (2010) reports results at 21 months, finding patients in the medical home experienced 29 percent fewer emergency visits and 6 percent fewer hospitalizations, and estimated total savings of $10.3 per patient per month. Paustian et al. (2014) found cost savings after 12 months of full PCMH implementation. In sum, these articles suggest cost savings are likely from implementing care management strategies although these savings may take a few years to materialize.

We also requested that Dr. Capps provide additional information on the components of Highmark's PCMH and ACA programs that have resulted in cost savings and quality improvements, and to provide an update on the rollout of these programs to a broader participant base. Dr. Capps reports that Highmark's broader rollout of its PCMH and H-ACA programs have shown mixed cost savings results to date.[210] This is consistent with our discussions with Highmark executives. Based on my own research over many years on the quality and cost benefits of PCMH programs, I find support in the literature for such savings.[211]

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[209] Articles cited in Capps Public Efficiencies Report at Footnote 43 that reported cost savings information: Reid, Robert J., 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 at 71. The same Group Health study appears in Reid, Robert J., 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; Paustian, Michael L., et al., "Partial and Incremental PCMH Practice Transformation: Implications for Quality and Costs," Health Services Research 49, no. 1 (2014): 52–74.

[210] Capps Public Efficiencies Report at ¶ 80.

[211] Shortell, Stephen M., Robin Gillies, and Frances Wu, "United States Innovations in Healthcare Delivery," Public Health Reviews, (2010), Vol. 32. No. 1 at 193-194. The authors cite to Group Health Cooperative of Puget Sound in Seattle, WA and their use of PCMHs which resulted in a 29% reduction in emergency room visits and an 11% reduction in ambulatory care sensitive admissions compared to control sites. There were also significantly higher patient experience scores and less staff burnout. The Community Care of North Carolina PCMH also showed positive effects compared with control sites. This PCMH achieved a 40% decrease in hospitalization for asthma and an 11% lower rate of emergency room visits. The program also resulted in significant total savings to North Carolina's Medicaid and SCHIP programs. In Pennsylvania, Geisinger's use of PCMH's used "health navigators" to achieve a 14% reduction in hospital admissions relative to a control group, and a 9% reduction in total costs over a 24-month period. Its return on investment in this program was greater than 2 to 1. For Intermountain Healthcare in Salt Lake City, UT, its use of a PCMH resulted in an absolute reduction of 3.4% in two-year mortality for high risk elderly patients relative to the control group. In addition, Intermountain achieved a 10% relative reduction in hospital admissions and a net reduction in total costs per patient per year. Shortell *et al.* also state that for a PCMH to be successful, it "must be coupled with a larger

Similar to other PCMH and ACA products, Highmark's drivers of quality improvements and cost savings are based on financial incentives for meeting targeted quality and cost metrics. To meet these targets, Highmark provides physicians with information on care coordinators that support patients with care transitions, disease and case management, and wellness coaching.[212] Highmark also provides new PCMH providers with clinical transformation consultants for technical and clinical consultation.[213] Another tool is Highmark Medical Informatics which provides access to information on medication adherence and specialist visits and costs and detailed data on healthcare utilization and costs. These data assist PCMH providers in managing care and reducing costs.[214]

In my view, reported information to date on care management strategies show significant promise in improving quality of care at reduced costs. Improvement in these metrics will not be immediate after implementation, but will be slower to emerge. Nonetheless, if Highmark follows through on its intentions to implement PCMHs and some form of ACA in Northeastern Pennsylvania, subscribers are likely to see improvements in quality of care, and the potential for lower costs over time.[215]

D. Implementation Costs and Timeline for Achieving Benefits

1. Cost of achieving administrative cost savings

Highmark estimates the cost of achieving the identified administrative cost savings is approximately $64 million when fully implemented.[216] This includes transaction costs of $[redacted]

entity that can bring in other components of the delivery system, provide resources, create economies of scale, and implement accountability for performance." (at 195).

[212] Capps Public Efficiencies Report at ¶ 91, citing Highmark, "Quality Blue Patient Centered Medical Home: ACME PCP Physician Group" Presentation, undated at 33.

[213] Capps Public Efficiencies Report at ¶ 91.

[214] Ibid.

[215] In public comments received by the PID, The Hospital & Health System Association of Pennsylvania stated the importance of a commitment from Highmark "to continue innovative health care insurance products and services in the Blue Cross of Northeastern Pennsylvania service area." The Association further stated the need for a commitment from Highmark "to work with employers and with the continuum of health care providers in innovative ways to meet health care needs [that] will foster delivery system transformation and improved value." See, Letter to Ms. Cressinda Bybee from Paula A. Bussard, Chief Strategy Officer of The Hospital & Healthsystem Association of Pennsylvania, dated February 2, 2015. In response to these comments, Highmark cited to its introduction of ACOs and PCMHs in other parts of its service area and its intent to deploy its expertise in offering these types of programs to northeastern and north central Pennsylvania following the merger. (See, Response of Highmark Inc. to Comments of Paula A. Bussard Dated February 2, 2015, dated February 19, 2015) These comments reinforce the need for Highmark to honor its commitment to the region to follow through on its plans to introduce PCMHs and some form of ACA in the BCNEPA service area. With the Association's recognized importance of bringing innovative and effective approaches to foster delivery system transformation and improved value, both the Hospital Association and Highmark appear to be willing to work together to bring innovative change to fruition in northeastern and north central Pennsylvania service areas.

[216] Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Confidential Supplement, Tab 9: Highmark Confidential Financial Projections and DOI 135's at 3; Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Confidential Supplement, Tab 6: Highmark

million and integration costs of $[redacted] million and severance costs of an additional $[redacted] million. Highmark provides no details behind these estimates. Consequently, I am unable to validate these estimates.

2. Timeline for achieving cost savings

Highmark's timeline for achieving cost savings is based on the merger closing as of January 1, 2015. Based on the current timeline for PID review and decision making, the closing date will likely occur several months after January 2015. Highmark expects it will be able to meet its timeline if the closing occurs by April 1, 2015.[217] Highmark's Board of Directors presentation laid out a timeline to achieve synergies in Appendix C, Table C-4.

E. Alternatives to the Proposed Transaction

In the evaluation of merger-specific efficiencies, the Merger Guidelines credit efficiencies that are merger-specific under the definition that these efficiencies are "unlikely to be accomplished in the absence of either the proposed merger or another means having comparable anticompetitive effects."[218] Although my analysis indicates that there are no significant anticompetitive effects from the proposed merger of Highmark and BCNEPA, I nevertheless explore possible options open to BCNEPA that might be considered by others as preferred alternatives to the merger. These include:

- Go it alone—attempt to reduce administrative costs and raise sufficient capital to restore BCNEPA to financial stability;
- Select an alternative merger partner—BCNEPA received alternative bids in response to its RFP;
- Contracting—BCNEPA could contract with Highmark to more fully integrate BCNEPA'S administrative functions under the Highmark platform.

In my view, none of these alternatives would be likely to generate cost savings comparable to those claimed to result from the BCNEPA's merger with Highmark once the transaction is fully implemented. I have seen no evidence in the PID record that would indicate BCNEPA has the ability to6 unilaterally reduce its administrative costs to the level exhibited by Highmark.[219] BCNEPA asserts that it does not have the scale of operations, and that it is not likely to be able to expand its volume of business, to replicate Highmark's existing scale economies. Nor have I

Board of Directors Presentation and Resolution at 14. Highmark did not address severance cost in its Board of Directors presentation.

[217] Highmark Confidential Supplemental Response , Information Request 5.2.9.1 from the Pennsylvania Insurance Department ("Highmark Inc.'s Merger with Blue Cross of Northeastern PA. Highmark-BCNEPA Joint Steering Committee, October 27, 2014").

[218] Merger Guidelines at Section 10.

[219] See discussion in Section IV.A and Footnote 21 *supra*.

found evidence in the PID record contrary to the proposition made by BCNEPA that it does not have the ability to raise the necessary capital funds to invest in the required infrastructure to support the development and implementation of care management strategies necessary to compete with those of its competitors, including Geisinger. Although BCNEPA has some limited experience in implementing a PCMH pilot program, I would agree that its experience wanes in comparison to that of Highmark. Even Highmark's own experience suggests that moving from a pilot program to a much broader implementation does not guarantee similar cost savings will be replicated on a broader scale. For these reasons, I do not find a go-it-alone alternative is a practical alternative for achieving similar costs savings.

BCNEPA received other bids in response to its RFP. Dr. Capps presents data in Figure 6 of his efficiencies report showing that Highmark has the lowest PMPM administrative costs for fully-funded products among a comparable set of Blues plans, [redacted].[220]

Highmark also provides administrative services for much of BCNEPA's business, including (1) the platform for claims processing and customer service (for all BCNEPA entities other than FPH), and (2) data center and IT infrastructure. Similarly, Highmark currently provides other Blue plans with claims processing and other administrative services to their enrollees via contract.[221] Highmark could enter into a contractual agreement with BCNEPA which would more fully integrate BCNEPA's administrative services under the Highmark platform. Although it seems possible that a contractual arrangement could extend the administrative support functions beyond those currently provided to BCNEPA by Highmark, I find no evidence in the PID record that would suggest that a contractual agreement would provide a superior alternative to the merger with Highmark, particularly in light of the lack of significant competitive effects from the proposed merger.

F. Pass-Through of Benefits to Policyholders and the Northeastern Pennsylvania Community

Dr. Capps opines that competition from other insurers operating in Northeastern Pennsylvania, particularly Geisinger, will force the merged firm to pass on its achieved cost savings.[222] Based on my assessment of competitive conditions, it appears that other competitors do provide an important constraint on pricing and quality competition, sufficient to limit any exercise of market

[220] Capps Confidential Efficiencies Report at Figure 6.
[221] Capps Public Efficiencies Report at ¶ 32. [redacted] (See, Capps Confidential Efficiencies Report at ¶ 30).
[222] Capps Public Efficiencies Report at ¶¶ 100-101.

power.[223] Moreover, it appears that but for the transaction, BCNEPA may have been under financial pressure to increase rates going forward as asserted by BCNEPA. Dr. Capps stated in the public informational hearing, "Since operating losses are not sustainable indefinitely, and since BCNEPA has not been able to reduce its administrative costs, that leads to the primary leverage by which they could close out the operating loss, that would be on the revenue side, that is, a premium increase. In fact, its loss projections for 2015 include some substantial premium increases on different lines of business. So from BCNEPA's perspective, with challenges on the cost side, they would have to make up the gap, the operating loss, close the operating loss primarily through sharp premium increases, as they will do in 2015 on their own."[224]

Dr. Capps opines that since Highmark and BCNEPA are not direct competitors, there would be limited or no incentive to raise prices post-transaction. Moreover, Dr. Capps asserts that many of the cost savings will reduce variable costs and thereby create an economic incentive to lower prices. Dr. Capps opines that staffing costs which scales with enrollment as variable costs, citing customer service, claims administration, provider relations, broker fees, and the elimination of fees for outsourced infrastructure or services. I disagree with Dr. Capps' views that these cost categories are variable; rather, I view them as semi-fixed costs varying in a step-wise function with material changes in volume. For example, it is unlikely that an incremental change in subscriber volume will result in the need for fewer customer service representatives or provider relation specialists. It is more likely that a significant change in subscriber volume over an extended period of time would cause an insurer to adjust its staffing downward for these functions.

Dr. Capps further opines that medical costs are predominantly if not entirely variable. He bases this view on the position that a reduction in the expected total medical expenditures associated with an enrollee will inevitably reduce the marginal cost of additional enrollees.[225] In my view

[223] I note that market power and bargaining power can be distinguished, in that firms may have greater acumen and skill in negotiations and achieve better outcomes than firms that lack such skills. Any changes in outcomes due to these latter factors are not antitrust issues.

[224] Testimony of Dr. Cory Capps, Public Informational Hearing, RE: Proposed Merger Between Highmark, Inc., and Blue Cross of Northeastern Pennsylvania, Nov. 12, 2014 at 122:19-123:13. See also, Capps Confidential Efficiencies Supplement at ¶ 50. [redacted]

[225] Capps Public Efficiencies Report at ¶ 102.

this overstates the extent to which these costs are variable, and Dr. Capps does not provide an estimate of these claimed variable costs.

Highmark provides some disclosure of its expected pass-through of savings opportunity to consumers. It projects administrative cost savings of $[redacted] million in 2015 with $[redacted] million allocated to Northeast Pennsylvania products and the remainder allocated to other legacy Highmark products. Highmark reports that the savings allocated to legacy Highmark business would be passed through to policyholder/subscribers. Savings allocated to Northeast Pennsylvania products ($[redacted] million) would be directed towards improving the operating results of those products rather than passed through to customers. In 2016, administrative cost savings are estimated to be $[redacted] million. Highmark projects that $[redacted] million of those savings would be passed back to policyholders/subscribers.[226] For PBM savings achieved in 2015 and 2016, pharmacy savings for non-risk customers would be passed through to those groups via claims costs.[227]

VII. OVERVIEW OF CONCLUSIONS

A. Conclusions on the Competitive Effects of the Acquisition

After reviewing the record evidence presented by the parties, the Capps Confidential Report, Capps Public Report, and supporting analyses and data, third party submissions, and conducting my own independent analysis and verification of the record evidence, I reach the following opinions related to the competitive effects of the acquisition of BCNEPA by Highmark:

- For the bulk of the commercial insurance products offered in overlapping geographic areas, Highmark and BCNEPA are engaged in joint ventures – FPH and FPLIC – and are thus partners rather than offering independent alternatives to consumers. The transaction appears unlikely to reduce competition substantially for these products, when taken in the context of the available alternatives for commercial insurance products and the fact that BCNEPA was neither a maverick nor an especially strong or low cost competitor.

- For the remainder of the commercial insurance products – e.g. Dental & Vision and other commercial products (such as disability insurance, long-term care insurance, and workers' compensation) – BCNEPA does not offer any plans directly. As a result, the transaction is unlikely to reduce competition substantially for these products.

- The one exception to this conclusion is Stop Loss insurance, a type of product that both BCNEPA and Highmark offer to some extent in overlapping geographic areas. However, Stop

[226] Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Confidential Supplement, Tab 9: Financial Projections and DOI 135's at 2.
[227] Ibid.

Loss insurance providers compete at a national or (at least) a state level rather than a local level. While Highmark does have between 15% and 25% share (of enrollees covered by firms assumed to be purchasing stop loss coverage) in Pennsylvania, BCNEPA has a less than 0.5% share (of enrollees) in Pennsylvania for Stop Loss insurance products. We are able to identify a number of alternative providers to whom businesses seeking stop loss products could turn to even within the state. As a result of BCNEPA's low incremental share and the fact that competitors can include those outside the state, the transaction is unlikely to lessen competition for Stop Loss insurance in Pennsylvania.

- For Medicaid and CHIP related insurance products, Highmark and BCNEPA do not currently offer plans in any overlapping areas in Pennsylvania and tend not to be bidding in the same area. There remain competitive alternatives for each of these products, including several large firms. Moreover, BCNEPA chose to exit the Medicaid line very recently. Therefore, the transaction is unlikely to lessen competition for these types of insurance.

- For Medicare Advantage plans and Medigap plans, BCNEPA and Highmark are engaged in joint ventures in the BCNEPA Service Area. BCNEPA does not offer its own Medicare Advantage Plan or its own Medigap plan independent of Highmark. Further, BCNEPA does not offer any PDP plans. For each of these products, we were also able to identify alternative providers. As a result, the transaction is unlikely to lessen competition substantially for Medicare-related insurance products.

- The transaction does not appear to substantially change the ability or incentive of competing entities to pursue expansion or new product offerings, and some are well-situated to offer more integrated care delivery offerings.[228]

B. Conclusions on the Claimed Benefits of the Transaction

My competitive effects analysis finds no significant lessening of competition from the proposed merger of Highmark and BCNEPA. Based on established principles of antitrust review of claimed efficiencies , such as under the Merger Guidelines, merger-specific efficiencies do not have to be large to result in positive benefits. Moreover, non-merger-specific, but nonetheless important additional costs savings also will benefit the merging parties. I find sufficient support, although limited, for these claimed cost savings, if they were to be realized. I also find positive economic support in Highmark's intention to introduce care management strategies in Northeastern

[228] In Highmark's February 19, 2015 Response of Highmark Inc., to Comments of Samuel R. Marshall Dated February 2, 2015, Highmark states the publication of five expert reports, including my preliminary report, demonstrate "the procompetitive effects of the Merger and the benefits of the transaction to the insurance-buying public..." To be clear, it is not my opinion that this Merger is procompetitive. Rather, I conclude that the Merger will not result in a substantial lessening of competition as directed by 40 P.S. § 991.1402(f) (1) (ii). Moreover, although I find that the economic evidence supports the merger's potential to confer benefits on policyholders of BCNEPA, whether these benefits enhance competition, i.e., procompetitive, depends on whether these benefits actually materialize and the competitive reaction of Highmark's competitors.

Pennsylvania designed to improve the quality of care at reduced costs. Sufficient evidence exists in the literature to support these claimed benefits. Based on my analyses and review of the claimed cost savings and benefits that are claimed to result from this transaction, I believe the economic evidence presented in the PID record supports the merger's potential to confer benefits on policyholders of BCNEPA, and possibly Highmark, and would be in the public interest of policyholders.

C. Recommendations to the PID

In developing my expert opinion on the proposed transaction, the PID asked me to assess the competitive effects and benefits, and any specific potential conditions, including any that may have been set forth in the public record on the proposed transaction, and to address the circumstances under which conditions could achieve the goals of protecting competition while permitting the benefits and efficiencies of the transaction. As I have discussed earlier, I do not find economic evidence to support a lessening of competition in any relevant product market that would warrant requiring conditions to protect competition.[229] In specific, the competitive effects analysis finds no significant lessening of competition from the proposed merger of Highmark and BCNEPA. In addition, I find that there are some merger-specific efficiencies as well as additional non-merger-specific, but nonetheless important, costs savings, projected for when the transaction is fully implemented, that will benefit the merging parties. I find sufficient support in the PID record, although limited, for these claimed cost savings.

BCNEPA faces considerable financial and operating challenges that have prompted its search for a suitable merger partner. BCNEPA's decision to select Highmark is based on its understanding of substantial benefits that would improve its administrative cost structure and provide the necessary capital funding to improve operations and fund care management strategies needed to conform to the intentions of the ACA and enable the merged firm to compete more effectively with competitors in its service area to the benefit of consumers.

For these reasons, it is my view that the PID should consider carefully the evidence on the specific benefits and particularly, the likelihood that there will be steady progress towards achieving the cost savings set forth by Highmark for BCNEPA, as well as whether the plans for implementation of Highmark management strategies in the Northeastern Pennsylvania area are likely to result in the achievement of quality improvements and cost reductions.

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[229] As to the competition related conditions proposed by The Insurance Federation of Pennsylvania, Inc., namely the firewall condition contained in the April 29, 2013 approving order for Highmark's merger with WPAHS, I find no competitive reason for requiring a firewall in this transaction since this is not a vertical merger between a buyer of hospital services and a seller of hospital services within the same relevant market. As to provider contracting, I remain in favor of imposing conditions prohibiting the use of exclusive contracting and most favored nation or "prudent buyer" contract provisions. However, as this merger does not raise substantial lessening of competition concerns, it is my opinion that such conditions are not required to mitigate adverse competitive effects in this transaction.

APPENDICES

Appendix A—Curriculum Vitae

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EDUCATION

1976	A.B., Economics, Brown University
1979	M.P.A., (Masters in Public Affairs), Woodrow Wilson School of Public and International Affairs, Princeton University

PROFESSIONAL EXPERIENCE

2012-present	Senior Consultant, Compass Lexecon, and President, Center for Healthcare Economics and Policy and Senior Managing Director, FTI Consulting, Inc.
2008-2012	Vice Chairman and Senior Managing Director, Compass Lexecon (formerly Competition Policy Associates)
2003-2008	President, Competition Policy Associates (As of January 2006, also Senior Managing Director, FTI Consulting Inc.)
1994-2003	Principal, Economists Incorporated
1990-1994	Assistant Chief, Economic Regulatory Section, Economic Analysis Group, Antitrust Division, U.S. Department of Justice
1987-1990	Senior Economist, Economists Incorporated
1986-1987	Director of Analytical Resources Unit, Economic Analysis Group, Antitrust Division
1985-1986	Economist, Economic Analysis Group, Antitrust Division, U.S. Department of Justice

1982-1985	Economist, Financial Structure Section, Division of Research and Statistics, Board of Governors of the Federal Reserve System
1979-1982	Economist, Economic Policy Office, Antitrust Division, U.S. Department of Justice
1976-1977	Research Associate, Energy Economics Group, Arthur D. Little, Inc.

TEACHING EXPERIENCE

1984	Adjunct Lecturer, Institute of Policy Sciences, Duke University
1984-1989	Executive Education for Top State Managers, conducted by The Institute of Policy Sciences, Duke University
1983	Lecturer, Board of Governors of the Federal Reserve System and American Institute of Banking
1979	Teaching Assistant, Princeton University

TESTIMONY

Investigation into the Competitive Marketing of Air Transportation, CAB

Arbitration Between First Texas Savings Association and Financial Interchange Network

In Re "Apollo" Air Passenger Computer Reservation System (CRS) MDL DKT. No. 760 M-21-49-MP

U.S. v. Ivaco, Inc.; Canron, Inc.; and Jackson Jordan, Inc.

Consent Order Proceeding before the Competition Tribunal, Canada Between The Director of Investigation and Research and Air Canada, Air Canada Services, Inc., PWA Corporation, Canadian Airlines International, and the Gemini Group Automated Distribution Systems Inc.

In the Matter of an Application by the Director of Investigation and Research under Section 79 of the Competition Act and in the Matter of certain practices by the D & B Companies of Canada Ltd. (Respondent), before the Competition Tribunal

Beville v. Curry, et al.; Comanche County District Court, Case No. CJ-95-115

U.S. v. Northshore Health System, et al.

Testimony before Committee on Banking and Financial Services, U.S. House of Representatives (April 29, 1998)

Easy Gardener, Inc. v. Dalen Products, Inc.

Trigen – Oklahoma City Energy Corporation v. Oklahoma Gas & Electric Company

State of California v. Sutter Health; Alta Bates; and Summit Medical Center

Ernest T. Smith, III et al. v. N. H. Department of Revenue Administration, et al.

St. Luke's Hospital v. California Pacific Medical Center; Sutter Health System

In Re: Cigarette Antitrust Litigation and related cases, *Holiday Wholesale Grocery Co., et al. v. Philip Morris Inc., et al.*, MDL Docket No.: 1342 Civil Action No.: 1:00-cv-0447-JOF and *Artemio Del Serrone, Steven Ren, Heather Snay, Jon Ren, Keith Pine, and Bill Reed, on behalf of themselves and all others similarly situated v. Philip Morris Inc., R.J. Reynolds Tobacco Co., Brown & Williamson Tobacco Corp., Lorillard Tobacco Co., Liggett Group, Inc., and Brooke Group, Ltd.*, Case No. 00-004035 CZ, State of Michigan in the Circuit Court for the County of Wayne

In Re: Vitamin Antitrust Litigation; Misc. No. 99-197 (THF) MDL No. 1285

Economic Report in Response to European Commission's Statement of Objections Dated 22 May 2003

European Commission Hearing, Case No Comp/E-2/37.533-Choline Chloride

Report of Robert D. Willig and Margaret E. Guerin-Calvert to the NZCC *An Economic Analysis of the Consumer Benefits and Competitive Effects of the Proposed Alliance Between Qantas Airways and Air New Zealand*

Report of Robert D. Willig and Margaret E. Guerin-Calvert to the NZCC *An Economic Assessment of Professor Tim Hazledine's Model of the Proposed Alliance Between Qantas and Air New Zealand*

Presentations by Robert D. Willig and Margaret E. Guerin-Calvert to the NZCC *An Economic Analysis of the Consumer Benefits and Competitive Effects of the Proposed Alliance Between Qantas Airways and Air New Zealand; Consumer Benefits*

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Federal Trade Commission, et al. v. Arch Coal, Inc., et al. Case No.1:04CV00534 (JDB).

Comments of Margaret E. Guerin-Calvert, Competition Policy Associates, Inc., Washington, DC on Revision of Regulation (EEC) 2299/89 on a code of conduct for computerized reservation systems (CRS), July 8, 2004

In the Matter of an Appeal from Determinations of the Commerce Commission, Between Air New Zealand Limited and Qantas Airways Limited and Commerce Commission, High Court of New Zealand, CIV 2003 404 6590

Economic Assessment of Issues in FERC NOPR for the Alaska Natural Gas Pipeline, December 17, 2004

In Re: DRAM Antitrust Litigation, Master File No. M-02-1486PJH, MDL No. 1486, United States District Court, Northern District of California

In Re: Carbon Black Antitrust Litigation, MDL Docket No. 1543, No. 03-CV-10191-DPW (D. Mass.)

Ryan Rodriguez, et.al. v. West Publishing Corporation, et. al., Central District of California, Case No. CV 05-3222 R(MCx).

Neotonus, Inc. v. American Medical Association and American Urological Association, In the United States District Court for the Northern District of Georgia Atlanta Division Civil Case No. 1: 04-CV-2050

Budget Pest Prevention, Inc., et. al. v. Bayer Corporation, Bayer CropScience, L.P., and BASF Corporation, In the United States District Court for the Western District of North Carolina Asheville Division, Case No. 1:05-CV-90

National Recycling, Inc. v. Waste Management of Massachusetts, Inc., Browning-Ferris Industries, Inc., and SEMASS Partnership LP, United States District Court for the District of Massachusetts, Case No. 03-12174-NMG

In the Matter of Mechanical and Digital Phonorecord Delivery Rate Adjustment Proceeding, Testimony before the Copyright Royalty Board of the Library of Congress, Washington, DC, Docket No. 2006-3 CRB DPRA

In the matter of *United States v. ASCAP Application of America Online, Inc.; United States v. ASCAP, Application of RealNetworks, Inc.* and *United States v. ASCAP, Application of Yahoo! Inc.,* United States District Court Southern District of New York, Civil Action No. 41-1395 (WCC). May 4, 2007

Lockheed Martin Corporation, Plaintiff, v. *L-3 Communications Corporation, Mediatech, Inc.*, Kevin Speed, Steve Flemming, and Patrick St. Romain, Defendants. *L-3 Communications Corporation*, Counterclaim and Third-Party Plaintiff, v. *Lockheed Martin Corporation,* Counterclaim Defendant, and Jack Kelly, Thomas Dorsey, Michael Homan, and Thomas Hull, Third-Party Defendants. US District Court for the Middle District of Florida, Orlando Division, Case Nc. 6:05-cv- 1580-Orl-31KRS, Expert Report August 15, 2007

Abbott Laboratories, an Illinois corporation, *Fournier Industrie et Sante*, a French corporation, and *Laboratoires Fournier, S.A.*, a French corporation, Plaintiffs, v. *Teva Pharmaceuticals USA, Inc.*, a Delaware corporation, Defendant; Civil Action No. 02-1512

(KAJ); *Teva Pharmaceuticals USA, Inc.*, a Delaware corporation, *Teva Pharmaceutical Industries, Ltd.*, an Israeli corporation, and *Novopharm, Ltd.*, a Canadian Corporation, Counterclaim Plaintiffs, v. *Abbott Laboratories*, an Illinois corporation, *Fournier Industrie et Sante*, a French corporation, and *Laboratoires Fournier, S.A.*, a French corporation, Counterclaim Defendants; *Abbott Laboratories*, an Illinois corporation, *Fournier Industrie et Sante*, a French corporation, and *Laboratoires Fournier, S.A.*, a French corporation, Plaintiffs, v. *Impax Laboratories, Inc.*, a Delaware corporation, Defendant; Civil Action No. 03-120-KAJ; *Impax Laboratories, Inc.*, a Delaware corporation, Counterclaim Plaintiff, v. *Abbott Laboratories*, an Illinois corporation, *Fournier Industrie et Sante*, a French corporation, and *Laboratoires Fournier, S.A.*, a French corporation, Counterclaim Defendants.; *in re TriCor direct purchaser antitrust litigation*; Civil Action No. 05-340 (KAJ); *in re TriCor indirect purchaser antitrust litigation*; Civil Action No. 05-360 (KAJ)

State of California ex rel. Lockyer et al., Plaintiffs *v. Infineon Technologies AG et al.*, Defendants. Case No. C-06-04333 PJH US District Court for the Northern District of California, San Francisco Division

Natchitoches Parish Hospital Service District, on behalf of itself and all others similarly situated, Plaintiff, v. Tyco International, Ltd., Tyco International, (U.S.), Inc., Tyco Healthcare Group, L.P., The Kendall Healthcare Products Company, Civil Action No. 05-12024 PBS.

Daniels Sharpsmart, Inc. v. Tyco International, (US) Inc., Tyco Healthcare Group, L.P., Becton Dickinson and Company, Novation, LLC, VHA, Inc., Premier Inc., Premier Purchasing Partners, and Consorta, Inc., United States District Court for the Eastern District of Texas, Texarkana Division, Civil Action No. 5:05-cv-169

In re Wellbutrin SR antitrust litigation (direct purchaser actions), Civil Case no. 2:04-cv-5525 (E.D. Pa.); *Sheet Metal Workers Local 441 Health and Welfare Plan, et al. v. GlaxoSmithKline, plc, et al. (indirect purchaser actions),* Civil Case no. 2:04-cv-5898 (E.D. Pa.); *Medical Mutual of Ohio, Inc. v. GlaxoSmithKline, plc, et al.,* Civil Case no. 2:05-cv-396 (E.D. Pa.)

In the Matter of the Form A Application by The Doctors Company, An Interinsurance Exchange, with Respect to the Acquisition of American Healthcare Indemnity Company, Hearing before the Insurance Commissioner of the State of Delaware, Docket No. 678

L-3 Communications Integrated Systems, LP, Plaintiff v. Lockheed Martin Corporation, Defendant, United States District Court for the Northern District of Texas, Dallas Division, Civil Action No. 3-07CV0341

DataTreasury Corporation v. Wells Fargo & Company, et al., Defendants, United States District Court for the Eastern District of Texas, Marshall Division, Civil Action No. 2:06CV-72(DF)

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OTHER PROFESSIONAL ACTIVITIES

Member, International Task Force, Section of Antitrust Law, American Bar Association and its Committees, including Healthcare and Pharmaceuticals

Member, American Economics Association

PAST PROFESSIONAL ACTIVITIES

Chair, Interagency Task Force on Bank Competition (at the U.S. Department of Justice, Antitrust Division)

Co-Chair, Economics Task Force, Member, Technology and Financial Resources Task Force, Chair of the Membership Committee, Transition Task Force Member, Chair of the Exemptions and Immunities Task Force, Council Member, Chair, Financial Markets and Institutions Committee, Member Advisory Board on Section Reserves, Long Range Planning Committee, Section of Antitrust Law, American Bar Association

Appendix B—Materials Considered in the Analysis

All confidential and non-confidential materials produced by the parties to the Pennsylvania Insurance Department

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ADDITIONAL MATERIALS

In addition, I include by reference all materials cited in my report, its footnotes, and its Appendices.

Appendix C—Additional Tables

Table C-1[230]
Contains Some Confidential Proprietary/Trade Secret Information
Summary of Estimated Market Shares from Capps Confidential Report

Region	Total commercial enrollees (ACS 3-year)	Market shares					
		Highmark	BCNEPA	Existing joint Highmark/BCNEPA products			Combined Share
				FPH	FPLIC	JOA	
Northeast	[redacted]						
Western							
Central							
Eastern							
Centre County							

Source: 2012 Confidential Highmark enrollment data, 2012 Confidential BCNEPA enrollment data, ACS 2010-2012 3-year insurance estimates

Notes:

1. The ACS total commercial enrollees denominator includes individuals with direct purchase insurance, employer-based coverage, employer-based and direct purchase insurance, and other private combinations.
2. The Highmark and BCNEPA enrollment numerators are the sum of individual, small group, and mid/large group enrollments, across both risk and non-risk categories.
3. Highmark's enrollment data does not include FPLIC enrollees.
4. The ACS does not report county-level insurance data for residents of Sullivan County (Northeastern); Potter, Forest, or Cameron Counties (Central); Delaware or Chester Counties (Eastern).
5. Shares exclude FEHB enrollment.
6. Part of Centre County is in the Western BCBSA Region 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.

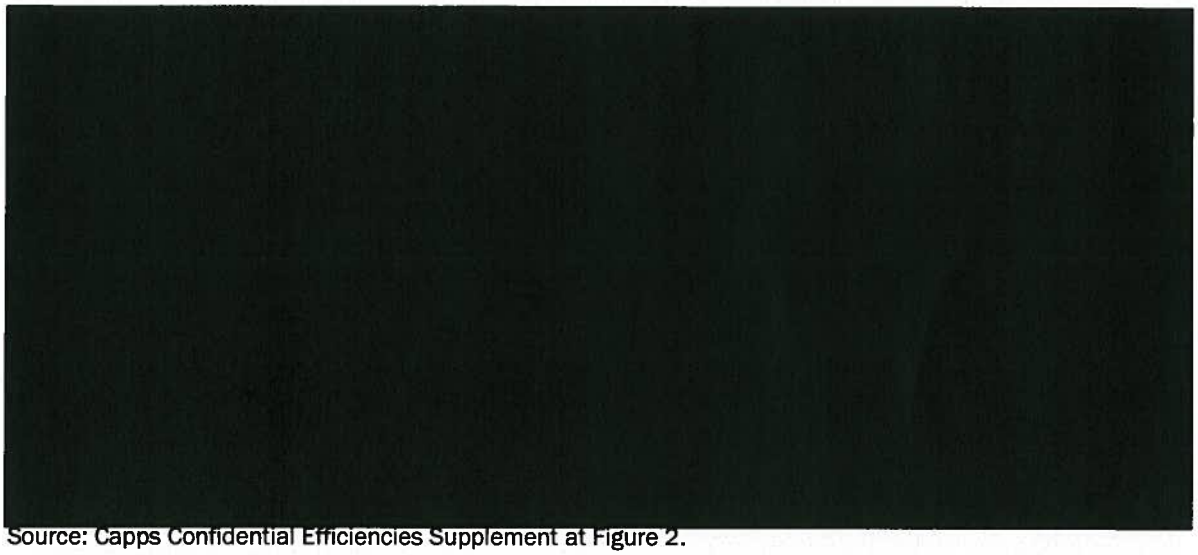
[230] Capps Confidential Report at Figure 2.

Table C-2
Stop Loss Data Provided by Highmark

Stop Loss Data Request - 2012			
Summary	**Premium $**	**# Customers (employer groups)**	**# Covered employees[3]**
Stop loss products/policies -- all customers[1]	[redacted]		
Stop loss products/policies -- PA domiciled customers only[2]			
Detail	**Premium $**	**# Customers (employer groups)**	**# Covered employees[3]**
Stop loss products/policies -- all customers[1]	[redacted]		
Stop loss products/policies -- Customers who also purchase health insurance coverage from Company			
Stop loss products/policies -- Customers who do not purchase health insurance coverage from Company			
Stop loss products/policies -- PA domiciled customers only[2]			
Stop loss products/policies -- PA customers who also purchase health insurance coverage from Company			
Stop loss products/policies -- PA customers who do not purchase health insurance coverage from Company			

[1] This item requests all premiums received by Company for the sale of stop loss coverage to customers located in the United States
[2] This item requests all premiums received by Company for the sale of stop loss coverage to customers located in Pennsylvania
[3] This item requests the number of employees covered by stop loss policies, separately for the entire US and Pennsylvania only.

Table C-3
Drug spending under alternative discounts (all <34 day supply) from Capps Confidential Efficiencies Supplement



Source: Capps Confidential Efficiencies Supplement at Figure 2.

Table C-4[231]
Timeline of Merger Synergies

Synergies	2014	2015	2016	Run-Rate
Admin, net of related costs				
Pharmacy Synergies				
Tax Benefits (One-Time)				
Total Synergies				

[231] Highmark's Form A Regarding the Acquisition of Control of BCNEPA and Subsidiaries, Confidential Supplement, Tab 6: Highmark Board of Directors Presentation and Resolution at 14.