UPMC ANALYSIS OF HIGHMARK'S AMENDMENT NO. 2 TO FORM A

(AFFILIATION WITH WEST PENN ALLEGHENY HEALTH SYSTEM)

Background

On June 28, 2011, Highmark, Inc., and West Penn Allegheny Health System ("WPAHS") announced that they intended to negotiate an affiliation to establish "a new integrated health system." Under the terms announced at that time, and ultimately reflected in a definitive agreement, Highmark would provide WPAHS with a total of $475 million consisting of a $100 million grant, $75 million for a medical education endowment, and $300 million in loans. The "Form A" asking the Pennsylvania Insurance Department to approve this transaction was filed on November 7, 2011.

UPMC has never opposed Highmark's effort to convert itself into an integrated health system, but consistently made two points regarding that proposal.

- First, $475 million was not nearly enough money to accomplish what Highmark said it wanted to do.
- Second, because Highmark's integrated health system would be competing directly with UPMC's hospitals and physicians, the contracts that have since 2002 allowed Highmark to include UPMC hospitals and physicians in its provider network would not be renewed at the end of their terms.

This second point—UPMC's decision not to renew its contracts if Highmark converted itself into a competing health system—was hotly and publicly debated for nearly one year. Then, on May 1, 2012, a mediation convened by Governor Tom Corbett resulted in an agreement to extend the existing contracts, with certain revisions, until December 31, 2014.

On January 18, 2013, Highmark filed a second amendment to its Form A and seeks approval of a plan very different from what it proposed in its original filing. Most notably, and predictably, Highmark has assigned a new price tag to the deal—a minimum of $2.4 billion, more than five times the original cost of $475 million. In addition, and unpredictably, Highmark has now predicated the future viability of WPAHS entirely on the absence of a contract with UPMC after 2014.

Given the radical transformation of Highmark's proposal, UPMC offers ***five observations*** about the proposed transaction.

1. The Success Of Highmark's Proposed Integrated Health System Now Depends On Highmark Not Having A Contract With UPMC

Until very recently, Highmark had argued that its continued ability to have access to UPMC facilities and physicians in its provider network was not only in Highmark's best interest, but also absolutely essential to the well-being of the community. To cite but one example, in a letter dated September 20, 2011, to Senator Donald White, Chairman of the Banking and Insurance Committee of the Pennsylvania Senate, Highmark's then-CEO Kenneth Melani outlined in great detail what supposedly would be the "immediate and profound" adverse effects of a non-renewal on "consumers, employers, doctors, West Penn, and Highmark." Included in that dire recitation were:

- Increases in premiums for health insurance,
- Consumer confusion about "their access to UPMC doctors and facilities",
- "Substantial reduction in choice" for both employers and consumers,
- Loss of treatment options for physicians, and
- A "decrease in . . . utilization and revenues" at WPAHS.

Now Highmark has completely reversed its field. According to the recently filed "Supplement" to its "Strategic Vision" and the accompanying financial projections, the economic viability of the proposed integrated health system is completely dependent on Highmark not having access to UPMC in its network after December 31, 2014.

The reason for this surprising turnabout is actually very straightforward—Highmark's own financial modeling demonstrated that the only way to get enough of its subscribers to use WPAHS is to deny them access to UPMC. Dr. Keith Ghezzi, the Highmark consultant who built those financial models for Highmark before he became CEO of WPAHS, explained their import during a hearing on October 26, 2012:

> *Q. So, you did prepare a set of projections while you were at Alvarez & Marsal, correct?*
> *A. We actually prepared two sets of projections.*
> *Q. What is the difference between the two sets?*
> *A. We were asked by Highmark to do projections with UPMC in and out of network.*
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> *Q. When you were asked to provide projections for the Pennsylvania Insurance Department filing, which projections were used?*
> *A. Only UPMC out-of-network.*
> *Q. Why did you decide to put UPMC out-of-network in the Pennsylvania Insurance Department's filing?*
> *A. We didn't decide that. We presented our projections to the Highmark senior leadership. . . . The UPMC in-network projections did not work. They did not return [WPAHS] to profitability. So, management made the decision to not include them in the Pennsylvania Insurance filing.*

As a result of those projections, Highmark has been grappling for at least the past year with the inconvenient truth that it cannot save WPAHS unless it denies its subscribers the choice of UPMC. On May 1, 2012, the very day that Highmark was deciding whether to sign the mediated agreement that would extend UPMC's in-network status until the end of 2014, an internal Highmark email exchange captured this dilemma perfectly—while the mediated agreement would give Highmark "more time to build out our provider organization assets" it would "make the turnaround of WPAHS much more difficult if not improbable."

Highmark did sign the mediated agreement, buying more time to "build out [its] provider organization assets." But it now is heading in the opposite direction, pursuing its vision of an integrated health organization whose only chance of success rests on UPMC being out-of-network and out-of-reach for its subscribers. Highmark's plan requires 25,000 additional admissions to WPAHS annually—representing a 45% increase over its current volume—and cannot permit referrals to UPMC. UPMC agrees that there must be no further contract extension.

2. Highmark Will Spend A Minimum Of $2.4 Billion—And As Much As $4 Billion—To Convert From An Insurance Company To An Integrated Delivery And Finance System

This is a remarkable and extremely high-risk commitment by Highmark, equivalent to at least 50% of their premium reserves, which supposedly had been set aside to cover subscribers' health care in the event of unanticipated contingencies. The $2.4 billion commitment is at least five times more than Highmark originally proposed and could seriously compromise Highmark's financial integrity. Further, necessary additional support to make WPAHS viable could raise the cost to $4 billion. Many will view this as an extraordinary waste of vital community assets, an amount also equivalent to 15% of the annual budget of the Commonwealth of Pennsylvania.

3. Highmark's Latest Proposal Does Not Address WPAHS's Operating Losses, Provide Funds For Programs, Upgrade The Facilities With Capital Improvements, Guarantee Its Pensions, Or Protect Its Jobs, And Will Result In A WPAHS Bankruptcy

Two other financial features of Highmark's current filing are particularly noteworthy: its proposal to borrow approximately $600 million to satisfy WPAHS's bondholders and its assertion that within three years WPAHS will have turned its operations around to such a degree that—on its own—WPAHS will be able to show net operating income, fully fund its now-distressed pensions which Highmark does not guarantee, and borrow $900 million to pay off the credit Highmark will have extended to it. What Highmark does not say—but is perfectly obvious—is what happens to WPAHS if that miraculous financial turnaround doesn't happen: bankruptcy.

Nor does the filing offer any credible plan to bring about this financial transformation:

- There are no promised funds to make badly needed capital improvements or to cover any ongoing operating losses,
- There is no plan to eliminate the surplus capacity that has long plagued WPAHS,
- There are no pension guarantees or job protections, but rather only unrealistic projections that WPAHS will be able to cover those obligations on its own within three years,
- There is no recognition that Medicare and Medicaid, which generally account for 55%-65% of a health system's revenues, are about to slash reimbursement levels, and
- There is no consideration of the need to spend as much as $4 billion to make WPAHS viable.

If Highmark cannot engineer this miraculous turnaround of WPAHS within the next three years, then WPAHS's slim chances of borrowing the $900 million called for in Highmark's proposal would be reduced to nothing, and bankruptcy would be inevitable.

4. Highmark's Plan Will Decimate The Community Hospitals

The potential for a financial turnaround at WPAHS appears to depend entirely on Highmark's ability to increase admissions there by approximately 25,000 patients each year. Where will Highmark find those additional admissions in the significantly over-bedded western Pennsylvania market?

Hospital admissions in southwestern Pennsylvania are declining about 3% each year (approximately 20,000 fewer admissions per year) and are expected to continue to decline into the foreseeable future. The 25,000 admissions needed by WPAHS represent a 45% increase over their current level of admissions, and would be the equivalent of a 30% decrease in total admissions at the largest independent community hospitals. Yet the entire viability of Highmark's plan to turn WPAHS around depends on its ability to steer huge numbers of admissions into a distressed, severely under-capitalized system in the face of a contracting marketplace.

In an attempt to achieve this, Highmark's plan is to force its subscribers to use WPAHS by denying them in-network access to UPMC. UPMC will not be in the Highmark network but will be available in-network to the four national insurers—Aetna, Cigna, HealthAmerica, and United Healthcare—and the UPMC Health Plan. But since patients generally prefer to keep the doctors and services available at UPMC to holding a "Blue" card, solely attracting subscribers from UPMC into WPAHS is improbable and will not be enough.

By necessity, Highmark will need to steer patients away from the community hospitals in its network—hospitals already struggling to survive, which will no doubt result in the failures of many. There is simply no way for Highmark to acquire the 25,000 admissions per year to revive WPAHS without taking them from the community hospitals.

5. Highmark's Plan Ignores The Competition It's Now Facing In The Insurance Market

For decades, Highmark has maintained a monopolistic hold on the market for health insurance, but over the last two years that hold has been slipping. National insurers, armed with contracts for in-network access to UPMC, have joined the UPMC Health Plan in chipping away at the Highmark monopoly. Premium increases have moderated or even disappeared as insurers have battled for market share. Yet Highmark's latest filing betrays no awareness that its subscribers have an increasing number of options when choosing a health insurer.

According to Highmark, if its application is denied, "annual premiums for a family of four will be $3,000 higher than they would be with an affiliation between Highmark and WPAHS." Missing entirely from Highmark's projections, of course, is how much it would have to raise an average family's premiums to recover the $2.4 billion to $4 billion it wants to sink into its new integrated delivery and finance system.

More significantly, however, Highmark's threat that without an affiliation it would raise premiums for a family of four by an average of $3,000 a year ignores an important reality—were it to hike up premiums like that, it would lose those families of four to its competitors, who are already gaining market share against the premiums Highmark is now charging. Moreover, these national insurers are already paying market rates to UPMC and the community hospitals and are competing favorably.

With similar competitive blindness, the financial projections in Highmark's proposal assume that after 2014 it will see no significant decline in its subscriber base even though it will no longer have UPMC in its network. In other words, all of Highmark's past rhetoric about the importance of keeping UPMC doctors and hospitals in its network was wrong—Highmark subscribers will, almost to a person, move to WPAHS rather than switch to an insurer that offers in-network access to UPMC.

Conclusion

Many of the assumptions Highmark has made are not realistic, nor is its latest proposal to the Pennsylvania Insurance Department. In sum, while UPMC fully supports choice and competition in the insurance and provider marketplace, the Highmark proposal will likely limit both. Provider competition is diminished as Highmark's latest proposal fails to address the real needs of WPAHS, which, when unmet, will result in bankruptcy and decimate the community hospitals. Insurance competition is reduced as it will seriously compromise the financial integrity of Highmark itself, diminishing its role as a competitive insurer and the only "Blue" franchise in western Pennsylvania.

Competition and choice are too important to the vitality of the healthcare marketplace to be trusted to Highmark and its second woefully inadequate proposal.

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