

**Statement of *W. Thomas McGough, Jr.*
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Before the Pennsylvania House Committee on Health
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I am Tom McGough, Senior Vice-President and Chief Legal Officer of UPMC. Thank you for this opportunity to speak to House Bills 1621 and 1622.

I'll begin with the opening paragraph of a statement issued by UPMC's Board of Directors on June 12, 2013:¹

UPMC's Mission is to serve our communities by providing outstanding patient care and to shape tomorrow's health system through clinical and technological innovation, research, and education. Within the comparatively short life of UPMC, this critical Mission has been advanced with levels of effectiveness and impact that probably are unsurpassed in the history of modern American medicine. Today, UPMC is widely recognized as one of the top academic medical centers in the world. The beneficiaries of UPMC's success include the patients we serve, the communities in which we work and the health of human kind.

Today, UPMC provides health care to millions of patients annually. In Western Pennsylvania we are the clear provider-of-choice, and draw our patients from all over the world. UPMC currently cares for 40 percent of the patients in our region, and provides nearly 62 percent of the hospital charity care there.² In the last fiscal year, UPMC provided \$887 million in IRS-defined "Community Benefits," made up of \$268 million in charity care and unreimbursed amounts for programs for the poor, \$238 million devoted to improving health and quality of life in our region's communities, and \$381 million spent on research and education.³

To put that total number of \$887 million in perspective, it is nearly twice the \$470 million budget of the City of Pittsburgh,⁴ and roughly three times the total federal, state, and local taxes that UPMC estimates it would pay were it a for-profit company.

Most of the credit for these accomplishments goes to the 60-some thousand people who earn their livings at UPMC. But a significant portion of that credit goes to our Board of Directors, 24 civic leaders⁵ who volunteer their time and represent a broad cross-section of the communities and constituencies we serve. Although the Board's membership has changed over time, that body has consistently defined UPMC's mission and provided the strategic vision to fulfill that mission.

That Board also shoulders a fiduciary responsibility to ensure that UPMC's charitable mission is pursued relentlessly and that its charitable assets are guarded zealously. That responsibility has never been taken lightly. If you read none of the other materials we have submitted, I would ask you to read the Background Statement to the Resolution adopted unanimously by the Board on June 12, 2013. It contains a fascinating, and sobering, review of the last 20 tumultuous years of health care in Western Pennsylvania.

That history reminds us that during those two decades Western Pennsylvania has seen the rise and ultimate failure of two major health systems, AHERF and West Penn Allegheny Health System. The AHERF implosion in particular had seismic effects across the Commonwealth, especially in Philadelphia, and remains the largest bankruptcy in the history of health care.

During that same time period numerous community hospitals failed or have found themselves on the brink of failure. Add to those examples the massive changes and challenges that are now confronting every hospital and every physician across the country and the message to our Board is clear: Providing world-class health care, academic excellence, and economic energy to a region is a complicated and challenging endeavor.

Fifteen years ago the UPMC Board made one of its wisest and most far-sighted decisions: creating the UPMC Health Plan. At the time that insurance arm was formed, numerous critics, including Highmark, publicly stated that UPMC's integrated payor/provider model could not and would not work—that UPMC was destined to be another AHERF. Those critics, especially Highmark, have been proven wrong. As you have heard today, UPMC's integrated model is widely recognized as a highly effective way to deliver medical value, and is now being imitated by organizations across the country, including Highmark.

For 15 years, however, the UPMC Health Plan has been a competitive thorn in Highmark's side, the principal threat to its insurance dominance in Western Pennsylvania. Highmark has responded to that threat aggressively and relentlessly, deploying one strategy after another to drive UPMC out of the health insurance market.⁶ So far, none of those strategies has succeeded.

Instead, as Diane Holder has pointed out, the UPMC Health Plan has grown and Western Pennsylvania now has an "ideal" competitive environment for health care.⁷ In three short years the region has moved from one of the least competitive markets—with one dominant insurer and one increasingly preferred provider—to one of the most competitive—with Highmark and UPMC each offering narrow network plans featuring their respective health systems and several national insurers competing to offer networks with the best of both systems. It is no wonder that media outlets are reporting on the "price war" for health insurance in Western Pennsylvania.⁸

For the region's hospitals, however, this has been a mixed blessing. When Highmark acquired West Penn Allegheny it touched off what the Pennsylvania Insurance Department has called a "zero sum game" for hospital admissions.⁹ To put it bluntly, Western Pennsylvania simply has too many hospital beds, and any gain in admissions at one hospital must come at the expense of other hospitals.

According to plans Highmark filed with the Insurance Department earlier this year, it must increase annual admissions at West Penn Allegheny by more than 41,000 patients if it is going to save that now-struggling system.¹⁰ Note that it must do that whether or not UPMC gives it a contract.¹¹

Highmark has even specified the hospitals from which it intends to take those admissions. Unfortunately, the chart made public by the Insurance Department was and remains redacted as to the number of admissions Highmark plans to steer away from each targeted hospital, but the total of 41,135 is crystal clear.¹²

Table 24
Projected Source of WPAHS Incremental FY17 Admissions

Hospital	Grant Thornton Estimate		Harris Alternative Estimate	
	Admissions	% of Total	Admissions	% of Total
Total	41,135		41,135	
UPMC	[REDACTED]			
Butler				
St. Clair				
Excelsa Westmoreland				
HV Sewickley				
Excelsa Latrobe				
Uniontown				
Washington				
Other				
Undetermined				

As unsettling as this chart is for the region’s hospitals, including UPMC, employers and consumers are quickly adapting to this newly competitive environment. As has been widely reported, major employers like Westinghouse, American Eagle Outfitters, Dick’s Sporting Goods, PNC, BNY Mellon, Education Management (EDMC), and even the City of Pittsburgh are offering their employees attractive alternatives to Highmark insurance,¹³ and while the enrollment data won’t be complete until after the first of the year, it appears that employees are taking full advantage of these new options. Meanwhile, UPMC’s conversations with employers around the region confirm that virtually all of them will be offering their employees an insurance option that includes in-network access to UPMC by the time the existing contracts between Highmark and UPMC expire at the end of next year.

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Other witnesses have described or will describe how an integrated model for delivering health care can improve outcomes, both economically and medically. In fact, the nation has now had more than a decade of favorable experiences with hospitals getting involved in the insurance business—Kaiser Permanente, Intermountain Health, UPMC, and Geisinger come to mind. But only when a powerful Pennsylvania insurance company, Highmark, began to get involved in the hospital business did HB 1621/1622 appear. And when they did appear, it turned out that the sponsors saw a problem with, of all things, hospitals getting involved in the insurance business.

Rather than reiterate points made by others about how HB 1621/1622 aren’t the right prescription for whatever supposedly ails IDFSs, I’ll turn to some other justifications that have been offered for the legislation and point out that it is a bit like snake oil: heavily promoted as a cure for a host of supposed market ailments but in fact curing none of them.

A. "Access"

In perhaps the most widely disseminated justification for HB 1621/1622, proponents have argued that it would guarantee various forms of access ("affordable" access, "open" access) for various populations (Highmark subscribers, holders of any insurance card, everyone) to UPMC facilities and services.¹⁴ Before examining that argument, it is important to understand what the exact state of "access" to UPMC facilities and services will be when the Highmark contracts expire at the end of 2014. In overview, by January 1, 2015, virtually every insurable resident of Western Pennsylvania will have the option of choosing affordable, full, in-network access to UPMC, and the small fraction that can't or don't want to choose in-network access for a particular UPMC facility will have full out-of-network access.

The arithmetic is straightforward: Medicare and Medicaid subscribers, who represent approximately 50 percent of the insurable residents, are already guaranteed in-network access to UPMC after the contracts expire. Add the individual policyholders who will shop on the exchanges and the group plans that now offer or soon will offer insurance alternatives to Highmark, and the number of residents who won't be able to choose in-network access to UPMC will be rapidly receding toward zero. Under the terms of the contract extension brokered by the Governor in 2012, moreover, even those subscribers who choose or are required by their employers to keep Highmark insurance after 2014 will have in-network access to Children's Hospital of Pittsburgh, Western Psychiatric Institute & Clinic, UPMC Northwest, UPMC Bedford Memorial, and any cancer services unique to UPMC. UPMC is also committed to ensuring that Highmark members have in-network access to UPMC Altoona, UPMC Hamot, and UPMC Horizon for all Highmark insurance products. And, of course, Highmark subscribers will have full out-of-network access to all other UPMC facilities and services. As can be seen, everyone in Western Pennsylvania will be able to access UPMC if they choose, with almost all of that access being in-network.

Turn then to the argument that HB 1621/1622 will somehow improve on this situation by guaranteeing "affordable" access to UPMC for Highmark's remaining subscribers. In fact, with or without this legislation, Highmark will never again allow its subscribers to use UPMC affordably.¹⁵ On the contrary, now that it must shift tens of thousands of patients per year from UPMC to West Penn Allegheny or lose its \$2+ billion investment, it has no choice but to steer its subscribers away from UPMC by making UPMC too expensive for them to choose. It could do this by network design, by "tiering and steering," or by deploying innumerable other techniques like increased co-pays, deductibles, co-insurance and out-of-pocket maximums. The only certainty is that Highmark will, in fact, render UPMC unaffordable for those who have Highmark insurance.

A variation on this theme is that the bills would somehow guarantee some undefined class of people access to UPMC's "charitable assets." In recent weeks Highmark has been running an increasingly aggressive, even disturbing, series of advertisements attacking UPMC's stewardship of those charitable assets, including its hospitals, and suggesting that HB 1621 and 1622 will impose additional obligations on nonprofit institutions like UPMC.¹⁶ In fact, those bills do not deal with—or even acknowledge—the complex fiduciary responsibilities borne by nonprofit hospitals and instead treat nonprofits identically to for-profits, requiring both to enter into contracts with insurance companies at regulated rates regardless of whether those contracts will preserve or dissipate the provider's assets.

A final species of the “access” argument attempts to leverage off the plight of a group of subscribers to Highmark’s “Community Blue” health plan who found themselves unable to get treatment at UPMC because of Highmark’s limitations on that plan. According to several of the bills’ promoters, UPMC has denied those patients access to its doctors and facilities, supposedly because they have the “wrong” insurance carrier, “even if they are willing to pay cash.”¹⁷ Pointing to this caricature of UPMC’s well-publicized decision not to offer non-emergent, out-of-network services to Highmark’s Community Blue subscribers because of the unique features of that plan—including its prohibition on “balance billing”—those promoters then state or imply that HB 1621/1622 would somehow force UPMC to treat those subscribers out of network.¹⁸

In fact, HB 1621/1622 would not change anything about that situation, which hinges on the narrowness of the Community Blue network. Highmark specifically designed that network to exclude certain UPMC hospitals and services so that the plan’s subscribers would use West Penn Allegheny or other parts of Highmark’s captive health system, Allegheny Health Network. The underlying contracts also placed an additional obstacle in the path of Community Blue subscribers who wanted to use UPMC facilities or services: a prohibition on balance billing.¹⁹

HB 1621/1622 would alter none of this; those bills leave insurers completely free to exclude providers from their networks as they see fit. Nor do those bills deal at all with services that aren’t included in the contracts between the insurer and the provider, i.e., “out of network.” So even with HB 1621/1622 Highmark could still structure its contracts and construct its networks any way it pleased, and UPMC could still decide whether and on what terms it would treat non-emergent patients out of network.

There is, however, an important and happy coda to the Community Blue controversy: On December 31, 2014, that plan’s prohibition on balance billing will expire, and thereafter its subscribers will have full, out-of-network access to UPMC.

B. Consolidation of Health Care Systems

A different reason offered for enacting HB 1621/1622 is the perceived need to deter a supposed wave of provider consolidations. One of the bills’ sponsors asserted at a recent press conference that “dominant providers are buying up community hospitals it seems every week, buying up doctors’ offices every week.” Another proponent argued in a letter to House members that “Large healthcare systems are consolidating at unprecedented rates . . . buying out countless physicians’ offices, satellite hospitals, outpatient care facilities and urgent care centers[,] . . . Acting almost as local healthcare monopolies . . .”²⁰ Highmark, meanwhile, asserts through its thinly disguised Coalition for Healthcare Choice that HB 1621 and 1622 “will ensure that any dominant hospital will not be able to demand unreasonable rates from insurers, which raises the overall cost of care.”²¹

In fact, HB 1621/1622 say nothing at all about provider consolidation, large healthcare systems, or dominant hospitals. Instead, they impose their onerous regulations, including governmentally set rates, on any hospital—of whatever size—that offers a health insurance program—of whatever size—in competition with established insurers—like, say, Highmark. As Diane Holder and others have pointed out, this transparent attack on a health system’s opportunity to offer its services directly to patients is not only a very bad idea, but bad public policy benefitting no one, except, of course, Highmark.

C. Lowering the Cost of Health Care

According to one of the bills' sponsors, HB 1621/1622 are intended "to bend the curve on cost" in the market for health care. It would supposedly do this by capping the rates paid to hospitals and physicians by health insurers like Highmark at levels far below what those insurers could obtain through arms-length negotiation. Diane Holder and others have explained why this sort of rate regulation has failed everywhere it's been tried. But even if such governmental intrusion into the market actually kept the rates paid to hospitals low, the proposed legislation says nothing at all about how much of those savings the insurer must pass on to the consumer through lower premiums, which would presumably be set at whatever level the insurer thinks the market will bear.

If there is one lesson that Western Pennsylvania has learned over the last decade, however, it is that a dominant insurer like Highmark can force very low rates on doctors and hospitals and then raise premiums to consumers without any real restraint, thereby earning tremendous profits and amassing billions of dollars in reserves. Indeed, in a provision only a dominant insurer could have dreamed up, section 806(j)(2)(iii) of HB 1621 actually prohibits an integrated system from using any operating margin made on the provider side to "subsidize" the premiums charged on the insurance side. Apparently, if the hospital side of the system actually thrives, the organization would actually be forbidden from passing the efficiencies along to consumers.

D. The Law of Unintended Consequences

To the extent that some believe that HB 1621/1622 merit consideration as a lever to force UPMC to give Highmark the long-term contract it so clearly covets, I would suggest consideration of the law of unintended consequences. The Insurance Federation of Pennsylvania pointed out in its presentation that a contract between Highmark and UPMC would combine into a collaborative relationship the region's dominant insurer, its second-most dominant insurer, its dominant provider, and its second-most dominant provider. That combination would control virtually all of health insurance and virtually all of health care in Western Pennsylvania, a result with profound antitrust implications, and would likely do damage to other hospitals and other insurers. As the IFP argues, the region would be far better served by keeping Highmark and UPMC at arm's length than by demanding that they collaborate.²²

Another unintended consequence of a contract between Highmark and UPMC would be the likely demise of the former West Penn Allegheny Health System. While it was seeking the Insurance Department's approval to acquire that health system, Highmark generated projections showing that, in the event it extended its relationship with UPMC, it could not move enough volume into West Penn Allegheny to turn that system around.²³ That reality explains why the Insurance Department's order approving the acquisition specifically prohibited Highmark from entering into a new contract with UPMC unless it produced:

*updated information, based on reasonable assumptions and credible projections on the impact of any New UPMC Contract on the financial performance of WPAHS, as well as an independent analysis of an expert on the impact of the New UPMC Contract on both the insurance and provider markets in the region including but not limited to any effects on competition.*²⁴

The introduction and promotion of HB 1621/1622 is merely the latest chapter in a long-running effort by Highmark to lure or force UPMC into a destructive contract, one that would either compel UPMC to exit the insurance market or to surrender the future of its providers to the vagaries of a rate-setting process guaranteed to ruin a world-class academic medical center and the principal engine of Western Pennsylvania's economy.

In its super-heated pursuit of this unwise and unattainable contractual relationship, Highmark has in recent weeks ratcheted its advertising in support of HB 1621/1622 up to new heights. Its television attacks on UPMC have now reached saturation levels in Western Pennsylvania and have ranged in tone from pleading²⁵ to insulting²⁶ to vaguely threatening.²⁷

Highmark, like UPMC, is a 501(c)(3) public charity operating tax-exempt hospitals that have been built with contributions from the community. Yet it is pouring millions of dollars in charitable assets into this tone-deaf campaign to achieve an unworthy goal.

Regrettably, UPMC has had to waste far too much time and expend far too much money dealing with this political nonsense, resources that could be better spent on providing the highest quality health care to those who need it most.

I want to thank the Committee for this rare opportunity to address HB 1621/1622 in a thorough and temperate fashion and along with Diane Holder would be happy to answer any questions you might have.

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References

- 1 Background Statement and Resolution of June 12, 2013, Tab A.
- 2 UPMC Community Benefits Report, Fiscal Year 2013, Tab B, p. 9.
- 3 Id., at 6-7.
- 4 See "Ravenstahl's proposed budget has not cuts in taxes, services," Pittsburgh Post-Gazette, September 24, 2013 (available at <http://www.post-gazette.com/neighborhoods-city/2013/09/24/Ravenstahl-s-proposed-budget-has-no-cuts-in-taxes-services/stories/201309240061>).
- 5 A list of the current Board of Directors is at Tab C.
- 6 See Amended Complaint, UPMC v. Highmark, Inc., et al., Case No. 2:12-cv-00692-JFC (W.D. Pa), Tab D.
- 7 See "Where you live determines how much you pay for health insurance," Kaiser Health News, September 29, 2013. <http://www.kaiserhealthnews.org/stories/2013/september/30/premium-variation-intrastate-obamacare-marketplaces-exchanges.aspx>.
- 8 Id.; "Aetna wants Highmark to know it's not an interloper," Pittsburgh Post-Gazette, November 24, 2013 (available at <http://www.post-gazette.com/business/2013/11/24/Aetna-wants-Highmark-to-know-it-s-not-an-interloper/stories/201311240114>);
 "Westinghouse drops Highmark; Aetna to handle all health insurance," Pittsburgh Post-Gazette, September 25, 2013 (available at <http://www.post-gazette.com/businessnews/2013/09/25/Westinghouse-drops-Highmark-Aetna-to-handle-all-health-insurance/stories/201309250083>);
 "Highmark-UPMC battle brings competitive pricing to region as new health care law dawns," Pittsburgh Tribune-Review, September 25, 2013;
 "Pittsburgh employees to see 2 health suitors," Pittsburgh Post-Gazette, August 29, 2013 (available at <http://www.post-gazette.com/businessnews/2013/08/29/Pittsburgh-employees-to-see-2-health-suitors/stories/201308290372>);
 "Highmark, Aetna, HealthAmerica among health insurers battling for business," Pittsburgh Business Times, September 2, 2011 (available at http://www.bizjournals.com/pittsburgh/print-edition/2011/09/02/highmark-aetna-healthamerica-business.html?ana=e_ph&page=all);
 "Insurers see opportunity in UPMC-Highmark split," Pittsburgh Post-Gazette (July 29, 2011)(available at <http://www.post-gazette.com/businessnews/2011/07/29/Insurers-see-opportunity-in-UPMC-Highmark-split/stories/201107290144>).
- 9 Economic Analysis of Highmark's Affiliation with WPAHS and Implementation of Integrated Healthcare Delivery System, Compass Lexecon Submission to Pennsylvania Insurance Department dated April 24, 2013 ("Compass Lexecon Report") (PID Docket No. 1401) at 147. The zero-sum game is actually a negative-sum game because, as Highmark itself concedes, hospital admissions are projected to continue to decline, aggravating the already troubling oversupply of hospital beds in the region.
 Id. at 136 ("Highmark recognizes that [western Pennsylvania] has a declining population that will result in fewer inpatient discharges"); id. at 158 (Western Pennsylvania "has a declining and aging population and industry participants consider the Pittsburgh area to be over-bedded relative to other areas of the United States"); id. at 117 ("Overall inpatient volumes in the southwestern PA area have been flat or declining.").
- 10 Compass Lexecon Report at 148.
- 11 The PID's economist, Compass Lexecon, explained in its Final Report that Highmark's PID submissions reveal that "a continuing Highmark/UPMC contract would not materially affect WPAHS's FY13 through FY17 incremental discharge projections."
 Id. WPAHS's discharges under Highmark's Base Case (no UPMC contract) scenario were 89,624 for FY17 with UPMC being the "primary source of WPAHS' incremental discharges."
 Id. at 126. Under Highmark's "New UPMC Contract" projections, Highmark assumed that it would secure a new contract from UPMC allowing Highmark to tier and steer patients away from UPMC and into the Allegheny Health Network. Under this scenario, Highmark projected that WPAHS would only have 6,800 fewer incremental discharges in FY17 than under Highmark's Base Case/ No Contract scenario. Id. at 159-60. The 6,800 difference "in discharges derives from eliminating one source of discharges - discharges from enrolled that decide to stay with Highmark who otherwise would have switched to UPMC."
 Id. Incremental discharges "through all other sources remain the same as in the case where UPMC is out of network."
 Id. at 160. In other words, Highmark's own projections demonstrate that its plan is take most of the 41,135 admissions it needs from UPMC under both the no-contract and new-contract scenarios it submitted to the PID.
- 12 Id. at 148.
- 13 "Westinghouse drops Highmark; Aetna to handle all health insurance," Pittsburgh Post-Gazette, September 25, 2013;
 "Pittsburgh employees to see 2 health suitors," Pittsburgh Post-Gazette, August 29, 2013;
 "Aetna's inroads into the market," Pittsburgh Post-Gazette, March 1, 2012 (available at <http://www.post-gazette.com/business/businessnews/2012/03/01/Aetna-s-inroads-into-the-market.html>);
 "National carriers' membership rates jump as access to UPMC expands," Pittsburgh Tribune-Review, Dec. 18, 2011 (available at http://triblive.com/x/pittsburghtrib/news/s_772588.html#axzz2nHgHGoul).

- 14 See Press Release, Rep. Dan B. Frankel (announcing introduction of “legislative package aimed at protecting patient access and choice in the health care marketplace”)(available at <http://www.pahouse.com/frankel/PAHouseNews.asp?doc=30322>);
- “Pa house bills aimed at protecting consumer health care access, lawmakers say,” Pittsburgh Tribune-Review, Oct. 2, 2013 (“Hundreds of thousands of people are on the verge of being forced to find a new doctor or hospital because of the logo on their insurance card,” Christiana said.”)(available at <http://triblive.com/news/adminpage/4807594-74/care-legislation-health#>).
- 15 See Compass Lexecon Report at 119 (“the overall success of [Highmark’s] proposed IDN rests with the assumption that UPMC and Highmark will not extend their present contract beyond 2014 and UPMC would become a more expensive out-of-network option for Highmark policyholders.”)(emphasis added).
- 16 http://www.youtube.com/watch?v=V_kfTX02yDA; <http://www.youtube.com/watch?v=FDOvnqG1Fmg&feature=youtu.be&noredirect=1>; http://www.youtube.com/watch?v=V_kfTX02yDA
- 17 See, e.g., Letter of October 17, 2013, from Michael Brunelle, Executive Director, SEIU PA State Council; see also Letter of November 15, 2013 from T. McGough, Tab E.
- 18 “Pa house bills aimed at protecting consumer health care access, lawmakers say,” Pittsburgh Tribune-Review, Oct. 2, 2013 (available at <http://triblive.com/news/adminpage/4807594-74/care-legislation-health#>); <http://www.youtube.com/watch?v=Kz71HlbfkAU>; <http://www.pahouse.com/frankel/PAHouseNews.asp?doc=30322>;
- 19 Although UPMC has made repeated requests over the last several months that Highmark waive this prohibition, Highmark refuses. Indeed, Highmark’s most recent emphatic “no” to UPMC’s request for this simple fix came December 6, 2013.
- 20 See, e.g., Letter of October 17, 2013, from Michael Brunelle, Executive Director, SEIU PA State Council; see also Letter of November 15, 2013 from T. McGough, Tab E.
- 21 <http://www.coalitionforhealthcarechoice.org/>
- 22 Statement of The Insurance Federation of Pennsylvania to the House Health Committee.
- 23 *Highmark Inc. v. WPAHS*, No. GD-12-018361 (Allegheny Cty. Ct. Com. Pl.), Hr’g Tr., Nov. 1, 2012 at 641, 658 (Dr. Keith Ghezzi, former Highmark consultant and interim WPAHS CEO, testifying that Highmark had projections before filing its November 2011 Form A with PID that keeping UPMC in its network would “not return [WPAHS] to profitability” or “financial stability”);
- See also id. Hr’g Tr., Oct. 26, 2012 at 251 (Nanette DeTurk, Chief Financial Officer and Executive Vice President and Treasurer of Highmark, testifying that she knew the Mediated Agreement would result in “fewer patients” and “less money” for WPAHS);
- Id. at 317-19 (Dr. Kenneth Melani, former Highmark CEO, testifying that the Mediated Agreement “compromised” WPAHS’ ability to compete with UPMC); Id. at 456, 462 and Hr’g Tr., Nov. 1, 2012 at 641, 658; WPAHS Ex. 230 (internal Highmark email dated May 1, 2012 and revealed in November 2012) (executing the Mediated Agreement would make “the turn[-] around of WPAHS much more difficult if not improbable”);
- Highmark v. WPAHS*, WPAHS Ex. 24 (Highmark PID Projections dated July 2012) at 1, 6 (Mediated Agreement would “extend the turnaround time for WPAHS,” reduce its revenue by \$400 million and net income by \$200 million);
- Highmark’s Addendum No. 1 to Amendment No. 1 to Form A, Aug. 24, 2012 (PID Docket No. 866) at 4 (Mediated Agreement would “negatively impact[]” the “projected volumes at WPAHS”).
- 24 Approving Determination and Order of the Pennsylvania Insurance Department dated April 29, 2013 at 15-16.
- 25 <http://www.youtube.com/watch?v=FDOvnqG1Fmg&feature=youtu.be&noredirect=1>
- 26 <http://www.youtube.com/watch?v=ZQ-wM9DNwM4&feature=youtu.be>
- 27 http://www.youtube.com/watch?v=V_kfTX02yDA