HIGHMARK.

Kenneth R. Melani, M.D.
President and
Chief Executive Officer

May 17, 2007

The Honorable Patrick Leahy, Chairman
United States Senate Judiciary Committee
224 Dirksen Senate Office Building
Washington, D.C. 20510

Attn: Jennifer Leathers, Hearing Clerk

Re: Responses to Supplemental Written Questions of the United States Senate Judiciary Committee Regarding "Examining Health Care Mergers in Pennsylvania"

Dear Chairman and Committee Members:

Please accept this letter as our response to the supplemental written questions from members of the United States Senate Judiciary Committee included in your letter dated April 25, 2007. For ease of reference, we have repeated each question below followed by Highmark Inc.'s ("Highmark") response to such question. In that the identical questions were posed to Mr. Joseph Frick of Independence Blue Cross ("IBC"), you will note that, to some extent, the responses to the questions which focused on our plans for the new company are very similar or even identical to those of IBC. For questions where it was not appropriate for our responses to be similar, they are not.

Question 1: According to publicly available information, Highmark has around $3.1 billion in reserves and Independence has around $1.4 billion in reserves. At the same time, policy holders have complained about skyrocketing rates and doctors and hospitals have complained about declining reimbursement rates. How do you respond to critics that claim your reserves are too high?

Response 1:

The issue raised in Question 1 in your letter has been thoroughly reviewed and decided by the Pennsylvania Insurance Commissioner ("Commissioner").[1]

[1] To address the Committee members' questions, a clarification should be made between the term "reserves" and the term "surplus." These terms, as used in the healthcare insurance industry, have distinct meanings. "Reserves" refers to the estimate of liability for medical services rendered but not yet paid. As an insurer, Highmark is required to set aside "reserves" to meet this liability. "Surplus," by contrast, is the company's statutory net worth which is a statement of the company's capital that remains after all liabilities have been deducted from the company's assets. It

In brief, after a comprehensive review period lasting nearly 2½ years, the Commissioner issued a Determination and Order in February 2005 ("Determination"), approving the surplus levels of the four nonprofit "Blue" health plans in Pennsylvania, including Highmark. In the Determination, the Commissioner concluded that Highmark's surplus at the conclusion of calendar year 2003 was not excessive. To the contrary, Highmark's surplus fell within an acceptable, or "sufficient operating surplus range." A surplus level above this range is "presumed" to be "inefficient". Any "Blue" plan operating within the "sufficient operating surplus range" is barred from including risk and contingency factors in its filed premium rates (thus limiting premiums charged to customers). Any "Blue" plan which exceeds the "sufficient operating surplus range" must file a report with the Commissioner justifying its surplus level or explaining how it will divest itself of surplus to return to a sufficient range.

Because surplus is a function of ongoing operations, the Commissioner's conclusion that Highmark's year-end 2003 surplus was "sufficient," and not excessive, effectively addressed any questions about Highmark's surplus levels in prior years as well. Since the Determination, the Commissioner has reviewed annually the surplus levels of the Pennsylvania "Blue" plans based on the considerations and standards set forth in the Determination. To date, the Commissioner has not found that Highmark's surplus level is excessive, or "inefficient," under those standards. As recently as March 2007, the Pennsylvania Insurance Department ("Department") issued a statement indicating that on the basis of its review of Highmark's 2006 annual statement, the company's surplus level remains in the "sufficient" range and is consequently not excessive.

The Commissioner is the state official in the Commonwealth of Pennsylvania vested with the authority to regulate the insurance industry in the Commonwealth. Her review of the same kind of excessive surplus claims that appear to form the basis of the Committee members' question was thorough. She convened public informational hearings, during which she received testimony from interested parties. She required the "Blue" plans to submit applications to the Department, wherein each plan, including Highmark, was required to justify its surplus level. The Department received 329 public comments on those applications and the "Blue" plans were given an opportunity to respond. In evaluating the applications, the Department reviewed a significant number of factors bearing on the issue, including the public comments, actuarial and accounting analyses, the status of the plans as nonprofit corporations, various means of measuring surplus, solvency requirements, and the Department's technical and regulatory expertise in the areas of insurance and insurance regulation.

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is effectively a statement of the company's financial strength. Because your question appears to deal with "surplus" rather than "reserves," the answer to the question is phrased in terms of "surplus."

While recognizing that questions about the "Blue" plans' surplus levels have arisen in the context of affordability of health care insurance, the Commissioner appropriately concluded that any evaluation of surplus must be based on the short- and long-term financial solvency and overall financial strength of the plans. The Commissioner specifically noted that the maintenance of surplus is important to the solvency of these nonprofit health plans, on which millions of Pennsylvanians depend for health insurance. In undertaking her analysis, the Commissioner evaluated surplus levels by applying "risk-based capital" standards. These standards are a solvency measuring tool created by the National Association of Insurance Commissioners and have been adopted for this purpose in a majority of states, including the Commonwealth of Pennsylvania. ***See*** **40 P.S. §§ 221.1-B to.15-B.**

Highmark must maintain surplus to finance the substantial infrastructure improvements and investments in technologies required to meet shifting customer demands for new health benefit products and services, to withstand fluctuations in the health business cycle, and to protect its customers against the potentially high costs of unexpected events, such as public health outbreaks. As a nonprofit company, Highmark is not able to raise capital by issuing stock like its for-profit competitors.

Accordingly, the Commissioner has conducted what may well be the most thorough review of surplus for a "Blue" plan undertaken anywhere in the country. Her conclusion, which was based on a wide variety of considerations directly rebuts any claim that Highmark's surplus is too high.

Question 2: In a competitive market, profit margins are constantly being pushed down. Yet, IBC and Highmark have accumulated reserves that many have characterized as excessive. Given your assertion that you have significant competition from major national insurers, how do you explain the tremendous reserves that the two companies have accumulated?

- Dr. Burns has indicated in his written testimony that your companies use your reserves to generate investment income, which helps to keep premiums down. However, in a sufficiently competitive market, IBC and Highmark would have been under competitive pressure to keep premiums down in the first instance, making the accumulation of large reserves difficult. Given the significant reserves that your companies have accumulated, do you believe the markets in which you compete are sufficiently competitive?

Response 2:

As discussed above, Highmark's surplus is not excessive. Nor is it a result of non-competitive "profit" margins.

It is incorrect to think of surplus as an indication of profitability. Surplus is required to assure the soundness, stability and reliability of an insurer. It is not used, as are profits, to fund payouts to investors. Surplus serves the business purpose of assuring continued

coverage of health services to Highmark insureds in case of events such as a major public health outbreak or severe reversals in Highmark's business. It also is used to develop and implement infrastructure improvements and investments in technologies required to meet shifting customer demands for new health benefit products and services. The Department regulates the financial soundness of all Pennsylvania Blue plans, and it regards the level of Highmark's surplus as sufficient and not excessive. See Highmark's Response to Question 1.

In addition, Highmark's net income and net income margins in 2006 are both well below the levels of major national health insurers. Attached as Exhibits 2A and 2B are charts, based on published financial reports, comparing the net income and margins of Highmark against the profit and margin of national health insurers.

Furthermore, Highmark's surplus was not accumulated by charging higher than competitive premiums. Increases in premiums in recent years have tracked increases in health care costs because the principal driver of premium levels is payments to providers. Almost ninety percent of the premiums charged by Highmark are used to pay health care providers. For many health insurers, less than eighty percent of the premium dollar is used to pay providers.

Question 3: Highmark and Independence Blue Cross claim that the proposed merger will result in over $1 billion in cost savings to the combined company. The companies have asserted that some cost savings will come from the combined company's ability to bargain for better prices with drug companies and to eliminate duplicative administrative costs. Please provide the Committee with a detailed, written explanation of how the merger will produce savings of over $1 billion.

Response 3:

The $1 billion in economic benefits includes administrative efficiencies, pharmacy savings and operating gains from new growth opportunities that the new company expects to realize over its first six years. [2]

Scale-based Economies. **Highmark and IBC expect the consolidation will enable the new company to generate $822 million in "scale-based economies" that the two companies could not generate on their own. Most of the cost savings will be related to information systems and technology. The new company can achieve savings by consolidating systems for processing claims, medical management, transactions with health care providers, informatics and enrollment files. In addition, savings will be achieved by consolidating the**

[2] The $1 billion in economic benefit is net of required investments of $269 million.

data centers of the two companies and avoiding duplicate future investments in data facilities and information technologies.

Additionally, savings will be achieved by identifying and using the best practices of Highmark and IBC to more efficiently perform a wide range of administrative functions. These functions include managing the company's information system networks, improving the rate of processing medical claims without manual handling and better purchasing of facilities services, office equipment and office furniture.

Scale-based Pharmacy Savings. **The consolidation should produce approximately $285 million in pharmacy cost savings for the first six years of operations. By being a larger volume purchaser of prescription drugs, the new company will be better able to obtain lower prices and higher rebates on pharmaceuticals on behalf of its customers. The new company will also achieve pharmacy savings by using the best practices in benefit designs of both companies relating to generic, brand and mail-order drugs.**

New Growth Opportunities. **The new company expects to generate additional operating gains of about $178 million over the first six years of its operations through growth in three main areas:**

- **Increased sales of ancillary health products;**
- **Expanded sales of health-related products and services on a national scale, including (i) increased sales of third party administration services in states adjacent to Pennsylvania and (ii) growth in the new company's pharmacy benefit management services to other Blue Cross and Blue Shield companies and other health insurers; and**
- **Expanded sales of administrative support services to other organizations in connection with their Medicare Advantage and Medicare Part D offerings.**

Question 4: Highmark and Independence Blue Cross have stated that they plan to use the cost savings to keep insurance premiums stable, keep drug costs down and to help expand access to health insurance for Pennsylvania's uninsured population. Please provide the Committee with a detailed, written explanation of how the combined company would allocate the cost savings resulting from the merger.

Response 4:

Highmark and IBC plan to use the $1 billion in anticipated savings from the consolidation to hold down the cost of, and increase access to, health care for Pennsylvanians. First, the new company will contribute $300 million over six years to existing programs targeting the uninsured and/or to new initiatives aimed at expanding health care coverage by providing the uninsured and small business employees with affordable coverage. The savings generated by the consolidation will also be used to keep the new company's per-member per-month administrative fees for its employer group customers flat for two

years after the new company is formed. We anticipate that this initiative will save customers $295 million in premiums. The new company also will pass along the pharmacy cost savings, expected to be about $285 million over six years, resulting from the company's ability to reduce prescription drug costs. Finally, approximately $100 million of the savings will be used to fund health care quality initiatives, including continuation and expansion of each company's current ePrescribing initiatives, incentives to retain health care professionals in Pennsylvania and mechanisms to encourage implementation of standardized personal health records and electronic medical records.

In addition to the allocation of the consolidation savings, Highmark and IBC intend to extend their current commitments with respect to the Community Health Reinvestment Agreement through 2013, by the new company. See Highmark's Response to Question 6.

Question 5:

Physicians, hospitals and other health care providers have repeatedly complained that health insurers in Pennsylvania have so much market power that they can dictate reimbursement rates for providers. After the merger, what safeguards will exist to ensure that the combined company does not exercise too much market power when dealing with providers? Can you explain why you think an antitrust exemption for doctors and other health care providers (for purposes of negotiating reimbursement rates with insurance companies) would be a good idea, or not?

Response 5:

Long-standing business practices and traditions in the health care marketplace in Pennsylvania provide substantial safeguards that the new combined company will continue to deal with physicians and other health care providers in a fair and reasonable manner. Physicians and hospitals will be important to the new company's success, as they have been for decades to the success and missions of Highmark and IBC.

One of the principal ways that the companies have met their customers' expectations in the marketplace is by offering health benefit programs that include access to the broadest networks of hospitals, physicians and other providers. To help achieve broad provider networks, the companies have strived to fairly reimburse providers for the medical care provided to their customers. Moving forward, the new company intends to continue the same business model based on offering health benefit programs supported by broad provider networks. In fact, the success of the new company is heavily dependent on this business model.

Another factor that helps provide a series of checks and balances among stakeholders in the health care coverage industry is the increased scale of health care providers. Over the past decade, large provider organizations and health systems, as well as national chain pharmacies, have grown in size and scale through consolidations and acquisitions to

enhance their market power when dealing with health plans. Examples include large health systems which control a number of hospitals in markets across Pennsylvania, the emergence of for-profit, single-specialty hospitals owned by physicians and the growth of large multi-specialty and single-specialty hospitals. These marketplace forces all underscore the point that safeguards currently exist in the health care system to help ensure that the new company will deal fairly and reasonably with health care providers.

Beyond these market "safeguards," both the Department of Justice and the Pennsylvania Insurance Department will have the opportunity to analyze all aspects of this transaction for its impact on competition *before* the transaction is effective, including any impact on providers, and the antitrust laws will continue to apply to the conduct of the parties *after* the consolidation is complete.

Finally, with respect to any proposed legislation to allow physicians or other providers to bargain collectively, Highmark would need to see the specific proposal before it could provide a responsive comment. As a mission based company dedicated to increasing access to affordable, high quality health care for the citizens of Pennsylvania, however, Highmark would have concerns regarding any such proposed legislation that fundamentally impacts the health care delivery system. For example, how would it affect cost, accessibility and the quality of care provided?

Highmark believes that a collective-bargaining proposal for health care professionals would likely do little to help promote the goal of providing high quality health care coverage in an efficient manner. A fundamental purpose of any such proposal would be to raise reimbursement rates, and thus, raise costs to health care consumers. Such a cost increase, in turn, threatens to decrease access to health care, either because insurers will simply not be able to meet all of the provider demands, or because the increased cost of care will further reduce the number of employers offering health care coverage. Lastly, while Highmark strongly supports measures designed to align higher quality of care with reimbursement rates, a general legislative antitrust exemption would likely do nothing to raise quality or decrease utilization in a manner that would help offset any rate increase that would almost certainly result from such an exemption.

Question 6:

You have publicly committed $650 million in savings from the merger to help fund health insurance for uninsured Pennsylvanians. Is this commitment in excess of the combined amount that both of your companies have previously committed to contribute toward health insurance for uninsured Pennsylvanians under the Community Health Reinvestment Agreement – which provides funding to the "adult basic" program – through 2010?

- Mr. Frick's written testimony indicates that only $350 million of the $650 million will go toward extending your commitment to the CHRA; what will the other $300 million go toward?

Response 6:

The new company will provide over $650 million in monies to help expand access to health insurance for Pennsylvania's uninsured and underinsured population. This financial commitment is in addition to the current commitment of the two companies under the Community Health Reinvestment ("CHR") agreement with the Commonwealth.

The CHR agreement expires in 2010. A portion of the $650 million (approximately $350 million) will be used to extend for three years the commitments that Highmark and IBC currently have under the CHR agreement.

The balance of the $650 million (approximately $300 million) will be used for other programs targeted to expand health care coverage for the uninsured and small businesses. The new company expects to work with other stakeholders in the health care industry, as well as government officials, to identify the most appropriate uses of these monies to help uninsured individuals and small business employees obtain health insurance.

This additional commitment of $650 million underscores that the new company will build and expand upon the long-standing missions of the two companies to look for new ways of meeting the changing health care needs of Pennsylvanians.

Question 7:

At the hearing, Professor Burns questioned your ability to extract additional savings from your pharmaceutical costs. Given the market power that your companies already wield, do you believe that it is realistic to expect that you will be able to extract additional savings from your drug spending?

Response 7:

The companies believe that their pharmaceutical savings estimates are realistic and achievable. The estimated annual savings represents only 2% of the combined companies' annual spending on pharmaceuticals. Highmark and IBC have based their estimated savings on a careful analysis of the potential cost saving opportunities that could be achieved in a consolidation, including the impact on their respective pharmaceutical purchases. The companies anticipate the pharmaceutical savings to result from the following: better discounts, lower pharmacy benefit administrative fees and lower dispensing fees resulting from the new company's increased size; reimbursement of more specialty drugs under a pharmacy benefit, rather than the medical benefit; and adoption by the new company of the best practices of each company, such as to increase generic utilization and mail order usage.

Question 8: You have stated that you expect to achieve around $1 billion in savings, but that you do not plan to integrate the company's headquarters and other administrative functions. Given that, how do you expect to achieve the savings you have promised?

Response 8:

As set forth above in response to Question 3, $1 billion in economic benefit is expected to be realized by combining the two companies. Most of the economic benefit will be generated by savings from scale-based economies achieved by consolidating administrative functions and avoiding future duplicate investments in data facilities and information technologies.

In analyzing the opportunities for savings that could be achieved as a result of the consolidation of Highmark and IBC, both companies also sought to balance the interests and concerns of their various stakeholders, including their employees, customers, public officials and community leaders. The goal of the new company will be to hold down premium increases for its customers, while also helping to expand access to health insurance coverage for more Pennsylvanians, continuing to serve as an economic engine for the state and continuing to serve the communities in which the new company will operate. As a reflection of this community-based commitment, the new company plans to maintain dual headquarters in Pittsburgh and Philadelphia and a regional presence and operating locations throughout the Commonwealth.

While it is possible that greater savings could be achieved at the expense of more significant and immediate job losses, the companies struck a different balance in their plan for consolidation. The two companies anticipate that savings generated by streamlining duplicative administrative functions and scale-based economies could be achieved more gradually through attrition and redeployment of employees to new positions as the new company grows its business.

Question 9:

You have argued that IBC and Highmark are not competitors. However, there is no reason why IBC and Highmark could not compete with one another. As the two largest insurance companies in Pennsylvania, IBC and Highmark must each look over their shoulders at each other to some extent. Doesn't the fact that IBC and Highmark are each other's biggest potential competitive threat help keep prices down? If the companies merge, those competitive pressures will dissipate, correct?

Response 9:

No. Highmark does not view IBC as a likely potential competitor; thus the premise that perceived potential competition from IBC has any effect on Highmark's premiums is simply not true. Rather, Highmark's premiums are affected by many other factors,

including actual competitors in its market, such as several of the national health insurers mentioned in Exhibits 2A and 2B.

Nor does Highmark have any intention to enter the service area of IBC, because it sees little value in doing so. Highmark would face obstacles in trying to enter the Philadelphia market. In Philadelphia and surrounding areas, Highmark has no staff or employees, no hospital or ancillary facility contracts and no existing managed care business. Highmark likely would need to negotiate more competitive contracts with physicians so it could more effectively compete with other insurers in the area.

Highmark believes, in short, that there is no factual basis for the view that the level of premiums in any part of Pennsylvania is affected by perceived potential competition between Highmark and IBC.

Question 10:

Why have the "major, national, publicly traded, highly capitalized companies" that you compete with had such a difficult time gaining a foothold in the Pennsylvania health insurance markets?

- Do you think there is any truth to the allegations that Highmark's close relationship with the University of Pittsburgh Medical Center (UPMC) has prevented competing insurers from gaining a foothold in Alleghany County and other parts of Western Pennsylvania?

Response 10:

Most national health insurers do have a foothold in Pennsylvania. Highmark suspects they have not penetrated further because they have not earned in Pennsylvania the level of profits that they are able to earn in other markets. We have no information as to whether they see a prospect for additional business in Pennsylvania.

Specifically with respect to the second question under "10," the answer is "No." UPMC is both an aggressive, arms-length negotiator of hospital and physician services provided to Highmark insureds (as we have experienced most recently in 2002) and a vigorous competitor of Highmark in the health insurance business, through its subsidiary health plan.

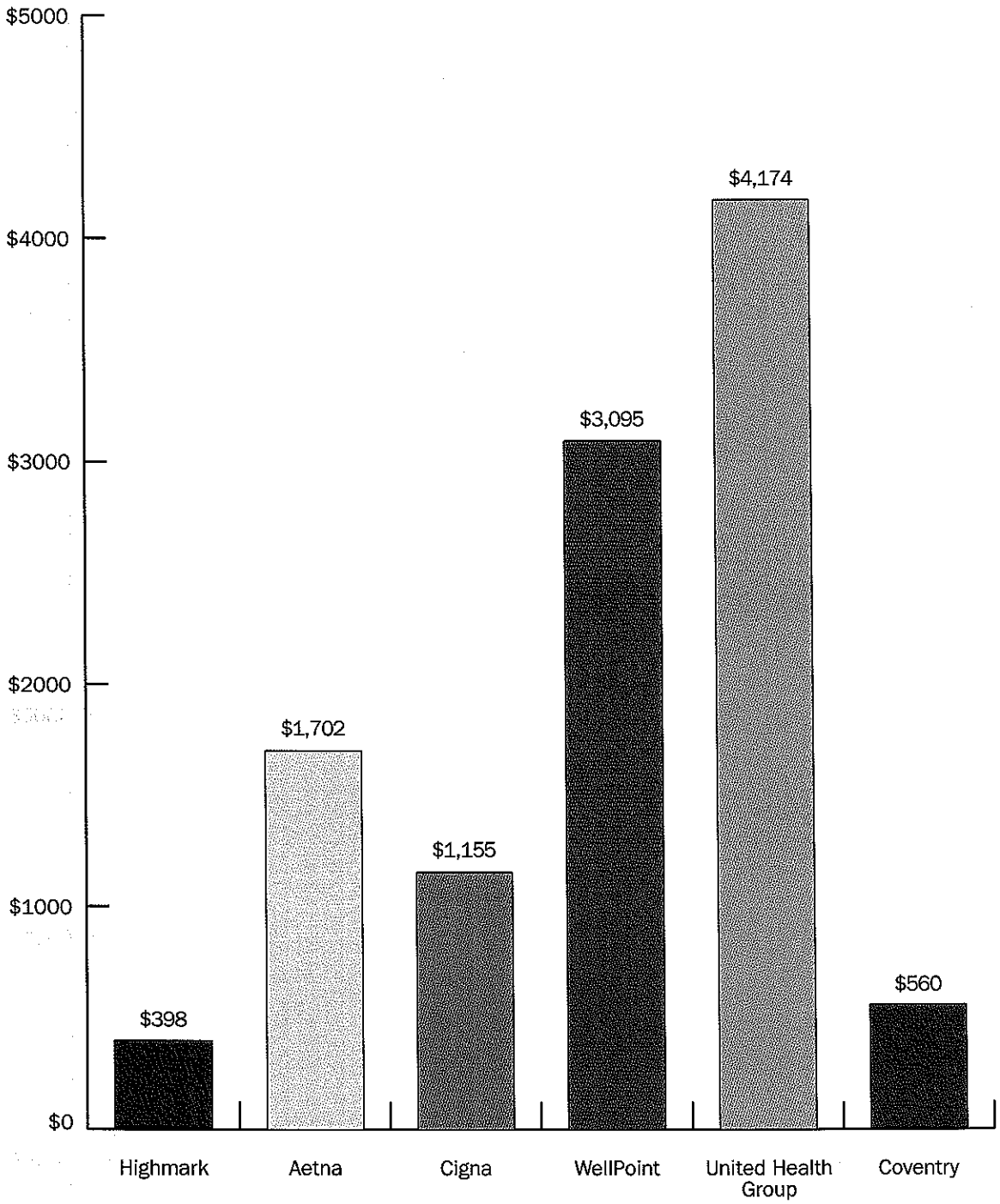
I hope that this letter has adequately addressed your questions and also helped to explain how this combination will result in a strong Pennsylvania company that can expand access to health care coverage and make health insurance more affordable for the communities we serve.

Very truly yours,

Kenneth R. Melani, MD
President and Chief Executive Officer

2006 Net Income of Health Insurers

In millions



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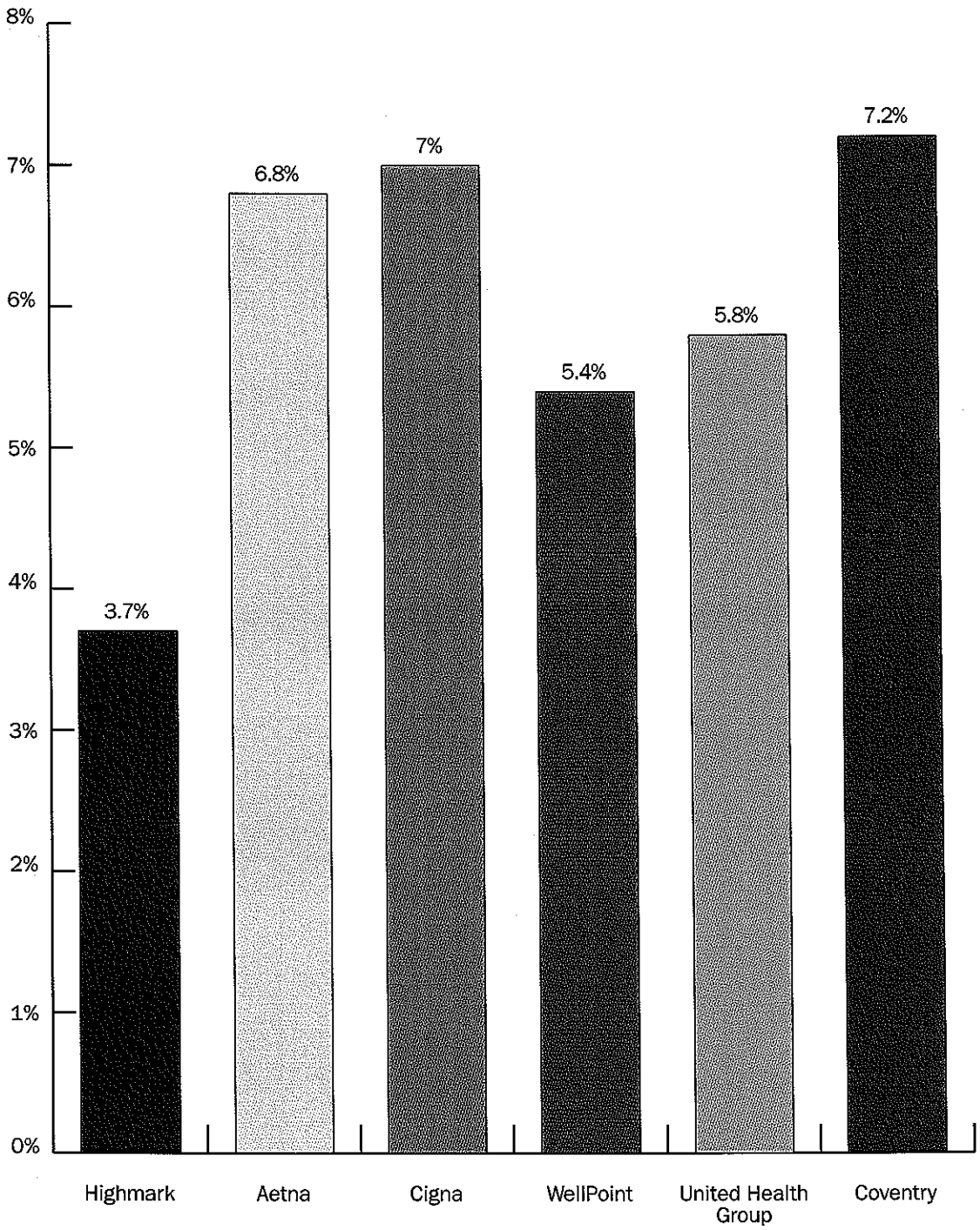
Source: Company financial reports

Exhibit 2A

2006 Net Income Margins of Health Insurers

Includes all lines of business



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Source: Company financial reports

Exhibit 2B