WILCOX & FETZER LTD.

In The Matter Of:

Before the Insurance Commissioner of the State of Delaware

Proposed Affiliation of BCBSD, Inc with Highmark, Inc

Volume # 2

Docket No. 1509-10

October 6, 2011

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BEFORE THE INSURANCE COMMISSIONER
FOR THE STATE OF DELAWARE

IN RE: THE PROPOSED) VOLUME TWO
AFFILIATION OF BCBSD,)
INC., DOING BUSINESS) Docket No. 1509-10
AS BLUE CROSS BLUE)
SHIELD OF DELAWARE,)
WITH HIGHMARK INC.)

Delaware Department of Insurance
841 Silver Lake Boulevard
Dover, Delaware

Thursday, October 6, 2011
9:00 a.m.

BEFORE: THE HONORABLE BATTLE R. ROBINSON,
Hearing Officer

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THE HEARING OFFICER: Good morning, everyone. I hope everybody had a good night last night and is ready for another day of this.

Does anyone have anything they want to bring to my attention before we proceed with the testimony?

MR. HOUGHTON: I do, Your Honor, but I think Mr. McConnell, as well.

THE HEARING OFFICER: Mr. McConnell?

MR. McCONNELL: Just a few housekeeping items, Your Honor.

The DOJ would like to reserve its right to do posthearing briefing if it would be helpful for Your Honor on the issue of the DOJ condition.

THE HEARING OFFICER: Okay. Let me wait and rule on that at the end.

MR. McCONNELL: The other administrative item, Your Honor, is just a question about closing statements and whether or not Your Honor wants to have closing statements, or at this point you don't think that's necessary.

THE HEARING OFFICER: Yes,

Mr. Houghton?

MR. HOUGHTON: The Department of Insurance had no intention of making closing statements.

THE HEARING OFFICER: That does help. I started to say I would wait until I heard the witnesses today. At the present time I feel no need of any closing statements.

MR. McCONNELL: Thank you, Your Honor.

THE HEARING OFFICER: Three primary, but if that should change during the course of the testimony today, I will let you know.

MR. HOUGHTON: Your Honor, as a preliminary matter, we have two additional communications from members of the public, and consistent with Your Honor's earlier request, we are putting on the record and seek to put as Exhibit 117 and Exhibit 118 two communications that we received within the last day. I believe everybody has seen them and is aware of them.

Everybody got copies?

THE HEARING OFFICER: Yes. That's the Trost and the Marquez letters?

MR. HOUGHTON: That is correct, Your Honor.

THE HEARING OFFICER: Mr. Houghton, do you want to proceed?

MR. HOUGHTON: Your Honor, we are ready to proceed. Your Honor, we would like to call to testify at this time Mr. Martin Alderson-Smith of Blackstone.

MARTIN ALDERSON-SMITH

the witness herein, having first been duly sworn on oath, was examined and testified as follows:

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DIRECT EXAMINATION

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BY MR. HOUGHTON:

Q. Good morning, Mr. Smith. Mr. Smith, could you please introduce yourself?

A. Good morning, ladies and gentlemen. My name is Martin Alderson-Smith and I'm employed by The Blackstone Group, which is a leading investment banking firm engaged primarily in financial advisory services and principal investments. I work in Blackstone's mergers and

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acquisitions advisory group, and my title is senior managing director.

Q. Please give us a brief overview of your educational and professional background.

A. I have a Bachelor's degree and a Master's degree from Oxford University and a Master of Business Administration, or M.B.A., from the Harvard Business School.

I have worked for over 25 years in the fields of corporate finance and mergers and acquisitions advisory services. I have been employed by Blackstone since 1991.

Q. Please give us a brief overview of Blackstone and its experience relevant to the proposed affiliation.

A. Blackstone has been retained by the Delaware Department of Insurance to conduct an independent review of specific financial aspects of the Form A application that was submitted in connection with the proposed affiliation between Highmark, Inc., and BCBSD, Inc., which is more commonly known as Blue Cross Blue Shield of Delaware. For the remainder of my testimony I will generally refer to Blue Cross Blue Shield of

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Delaware simply as "Blue Cross" or "the company."

Blackstone has significant experience advising state insurance regulators on various life insurance and health insurance transactions. During the last several years, Blackstone has advised the Pennsylvania Insurance Department on the proposed consolidation of Highmark and Independence Blue Cross, the New Jersey Department of Banking and Insurance and the New Jersey Attorney General on the proposed conversion and subsequent IPO of Horizon Blue Cross Blue Shield, and the Maryland Insurance Administration on the proposed conversion and subsequent acquisition of CareFirst Blue Cross Blue Shield by WellPoint.

Blackstone has also advised the New York Public Asset Fund which owned 62 percent of WellChoice on the sale of WellChoice to WellPoint.

Further, Blackstone has advised the Office of the Insurance Commissioner of Washington State on the proposed conversion and subsequent IPO of Premera Blue Cross.

Over the course of our work advising

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insurance state regulators, Blackstone has in some instances recommended approving proposed transactions and in other instances has recommended denying proposed transactions. Our recommendations are always based on our review of the circumstances of the particular transaction.

Q. When was Blackstone retained by the Delaware Department of Insurance in this matter?

A. Blackstone executed an engagement letter on 31st March 2011, and began work immediately thereafter.

Q. Has Blackstone done any prior work for Blue Cross Blue Shield of Delaware?

A. No.

Q. Has Blackstone done any prior work for Highmark?

A. No, Blackstone has never been retained by Highmark, nor done any prior work for Highmark; however, as previously referenced, Blackstone has assisted and may assist in the future, the Pennsylvania Insurance Department in its review of other transactions involving Highmark.

Q. Has Blackstone done any prior work for the Delaware Department of Insurance?

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A. No.

Q. Is your analysis in connection with the department's review of the proposed affiliation unbiased and independent?

A. Yes. We are independent and formed our own view on the proposed affiliation.

Q. Could you please describe in detail the purpose of your retention by the Department in this proceeding?

A. The DOI has asked Blackstone to analyze several aspects of the proposed affiliation as part of the DOI's process of determining whether the affiliation meets certain of the standards contained in Title 18, Chapter 50 of the Delaware Insurance Code that are required in order for the affiliation to be approved.

Specifically, Section 5003(d)(1) contains six standards that have been deemed to be applicable to this transaction that must be assessed as part of the department's review.

The Department has asked Blackstone to assist in analyzing five of these six standards.

Q. Please tell us which standards the

Department has asked Blackstone to review.
A. The Department has asked Blackstone to assist in its review of standards A, B, C, D, and F. The Department has not asked Blackstone to assist in its review of standard E, which deals with the assessment of the competence, experience, and integrity of the persons who would control Blue Cross. That standard is being handled directly by the Department.
Q. Can you please provide a brief description of each standard in Section 5003(d)(1) and that the Department asked Blackstone to review?
A. Standard A involves an assessment of whether, after the proposed transaction is completed, Highmark and Blue Cross would still be able to satisfy the requirements for the issuance of a license to write the lines of insurance in Delaware for which they are presently licensed.
Standard B involves an assessment of whether the effect of the affiliation would be to substantially lessen competition or tend to create a monopoly in Delaware.
Standard C involves an assessment of

whether Highmark, as the proposed controlling affiliate, might jeopardize the financial stability of Blue Cross or prejudice the interests of Blue Cross's policyholders.
Standard D involves an assessment of whether the plans or proposals that Highmark has to liquidate Blue Cross, sell Blue Cross's assets, or consolidate or merge it with any person, or to make any other material change in Blue Cross's business or corporate structure or management are unfair and unreasonable to Blue Cross policyholders and not in the public interest.
And standard F involves an assessment of whether the affiliation is likely to be hazardous or prejudicial to the insurance-buying public in Delaware.
Q. Before we start discussing the standards, can you please describe the structure of the affiliation?
A. Yes. According to the Affiliation Agreement and related documents, Blue Cross will remain a separate, not-for-profit, nonstock Delaware corporation, and Highmark will control

Blue Cross and become the sole member of Blue Cross.
Blue Cross will become a controlled affiliate of Highmark which will become the primary Blue Cross Blue Shield Association licensee in Delaware.
Q. Can you explain what it means for Blue Cross to become a controlled affiliate of Highmark and for Highmark to become the primary Blue Cross Blue Shield Association licensee in Delaware?
A. The Blue Cross and Blue Shield service marks are the intellectual property of the Blue Cross Blue Shield Association which I will refer to during the remainder of my testimony as "National Blue Cross."
The right to exclusively use the Blue Cross and Blue Shield brand, including the name and the logos within certain geographic areas is granted by National Blue Cross to certain insurers under licensing agreements.
National Blue Cross licensees in particular geographic areas are often said to have the mark for that area.

Blue Cross Blue Shield of Delaware is currently the National Blue Cross licensee in the service area of the state of Delaware.
Upon completion of the proposed affiliation, Blue Cross will relinquish its National Blue Cross license and Highmark will become the National Blue Cross licensee for the Delaware service area.
Blue Cross Blue Shield of Delaware will retain the ability to use the marks within the Delaware service area, however, as a controlled affiliate of Highmark.
The term "controlled affiliate" is used by the National Blue Cross for purposes of establishing criteria for the relationship between the licensee in a particular area, in this case Highmark, and the affiliated organizations that seek to use the service marks in that same area, in this case Blue Cross.
Among the criteria for Blue Cross Delaware to be a controlled affiliate of Highmark and, therefore, able to use the marks, are that Highmark must have certain control over Blue Cross Delaware and provide a guarantee of

Delaware Blue Cross's claims.
Q. Is the proposed transaction a merger or an acquisition?
A. No. It's only an affiliation, not a merger or an acquisition. Although affiliations share similarities with mergers and acquisitions, there are significant differences that influence the analysis of the proposed transaction pursuant to the applicable standards of the Delaware Insurance Code.
Q. What are the key differences between a merger and acquisition on the one hand and an affiliation on the other?
A. In an accusation the buyer typically pays consideration, typically a combination of cash and stock, to the seller's owners in exchange for ownership of the current equity or unassigned surplus, which we hereafter will refer to as "reserves" of the seller, as well as for ownership of the rights to the seller's future profits and economic interests.
Usually, once an acquisition is closed, it is typically not subject to being unwound. The key issue for the seller is whether

the total consideration that the seller receives is sufficient because the seller is selling ownership or control of current equity and future economic interests.
In this proposed affiliation, Highmark will assume control of Blue Cross in exchange for providing administrative services at cost, a guarantee of Blue Cross's claims, and overall corporate and strategic support.
As mentioned before, Highmark will become the primary licensee of the National Blue Cross service marks, though Delaware Blue Cross will be able to use the marks as a controlled affiliate.
Highmark is also providing Blue Cross the opportunity to draw upon a $45 million line of credit to facilitate Blue Cross's IT systems conversion. Highmark is not paying Blue Cross any amount of consideration and will have no right to benefit from either Blue Cross's current reserves or future profits.
Blue Cross will retain the right to disaffiliate in the future under certain circumstances which preserves the company's

ability to sell its equity and economic interests to a third party in exchange for consideration at a future date.
Among other items, the key issues for the controlled affiliate in an affiliation of this type, of the type proposed by Blue Cross and Highmark, including insuring that the reserves and future profits of the controlled affiliate are not indirectly transferred to the controlling party and carefully assessing the impact of the change of control on the target and on its customers.
Q. Given the particular aspects of the proposed transaction noted in the scope you were assigned by the DOI, could you please describe your overall approach to assessing the five standards?
A. In evaluating standard A, Blackstone analyzed the relevant capital and surplus requirements per DOI guidance for each of the domestic insurers involved for issuance of a license.
In evaluating standard B, Blackstone performed mathematical tests of market share and

market concentration per the Delaware Insurance Code, and analyzed potential mitigating factors for reasonableness where prima facie evidence of an anticompetitive impact existed.
In evaluating standard C, Blackstone analyzed Highmark's current and expected financial condition, as well as the current condition of Blue Cross's reserves.
In evaluating standard D, Blackstone analyzed the nonfinancial benefits to Blue Cross policyholders in this transaction and the potential risks of the affiliation from a policyholder perspective.
In evaluating standard F, Blackstone analyzed the manner in which the affiliation may affect the insurance market in Delaware.
Q. What steps did you specifically take in enacting the approach you just described?
A. Blackstone's work on behalf of the DOI was extensive. The complete list of work that we did is set forth on pages 13 and 14 of our report, but it includes the following highlights: We reviewed the Form A filing submitted by Highmark in connection with the proposed

affiliation. We reviewed Blue Cross's and Highmark's financial statements and financial projections. We attended public information sessions in three locations in Delaware during May of this year and reviewed the responses provided by Blue Cross and Highmark to questions posed by the public.

We reviewed materials related to the proposed affiliation produced by the applicants, including more than 1,500 documents.

We held over 15 discussions with executives and senior management of both Blue Cross and Highmark.

And we held discussions with 14 third-party industry participants who provided their perspectives on the proposed affiliation and its potential impact on the health insurance market in Delaware.

We held discussions with Highmark's affiliate, Highmark West Virginia, Inc., as well as the West Virginia Department of Insurance for purposes of discussing Highmark West Virginia's experience affiliating with Highmark.

Q. Are there any limitations to the scope of

the work that Blackstone has performed?

A. Yes. Blackstone has not independently verified the accuracy and completeness of financial and other information that is available from public sources or was provided to us by Blue Cross, Highmark, or their representatives or otherwise reviewed by us.

We did not make an independent appraisal of Blue Cross's and Highmark's reserves or assets, or express any opinion as to whether either the value of such reserves or such assets or the value of the projected income and cash flow expected to be derived therefrom.

We did not perform due diligence on Blue Cross's and Highmark's physical properties, sales, marketing, distribution, or service organizations or product markets.

And we did not express any formal opinion regarding the fair value of Blue Cross, Highmark, or the affiliated entity, or consider either the relative merits of the proposed affiliation as compared to other transactions that might be available to Blue Cross, or the effect of any other arrangement in which Highmark

and Blue Cross might engage.

Q. Now that we understand the background of your engagement and the specific approach used in your review, please describe your analysis of standard A.

A. Standard A requires that after the change of control, Blue Cross would be able to satisfy the requirements for the issuance of a license to write lines of insurance for which it's presently licensed.

As set forth on page 48 of our report, Blue Cross is a health service corporation governed by the licensing and other requirements of Title 18. Based on its original Certificate of Incorporation, which has been entered into the record as a joint exhibit, and on information from the Department following the closing of the affiliation, Blue Cross will remain a health service corporation and, according to the Department, will be able to continue to write the same lines of insurance after the affiliation as prior to the affiliation without acquiring a certificate of authority with the Department.

Also set forth on page 48 of our report, Blackstone also verified that Highmark's Delaware-based subsidiaries will meet the capital balance requirements for the satisfaction of their licensing requirements as domestic insurers in the state of Delaware.

Specifically, there are three subsidiaries of Highmark's that are currently licensed in Delaware and are expected to continue operating subsequent to the affiliation.

The subsidiaries are HM Life Insurance Company, HM Health Insurance Company, and United Concordia Life and Health Insurance Company. Highmark provided information to support the conclusion that each of its three current Delaware subsidiaries holds capital balances in excess of the minimum required in Delaware.

Q. What information did Blackstone rely on in its analysis of standard A?

A. Blackstone received a memorandum regarding Blue Cross's licensing status from Blue Cross management on July the 7th, 2011, and received information regarding Highmark's subsidiaries operating in Delaware from the Department in a discussion on August 9th, 2011.

Q. What are your conclusions regarding standard A?

A. Both Blue Cross and Highmark's Delaware subsidiaries would continue to be able to write the lines of insurance for which they are presently licensed. As such, Blackstone believes that the proposed affiliation would not violate standard A.

Q. Please describe your analysis of standard B.

A. Standard B requires that the effect of the affiliation would not substantially lessen competition in insurance in Delaware or tend to create a monopoly.

In the course of its examination under this standard, Blackstone applied specific quantitative standards relating to the respective market shares of Blue Cross and Highmark and to recent trends towards increased concentration in the market as set forth in Title 18, Chapter 50 Section 5003A(d)(2) of the Delaware Insurance Code.

If certain quantitative criteria are met, then there is prima facie evidence that the competitive standard has been violated. Even if the standard has been violated, however, the affiliation may, nonetheless, satisfy the overall standard if there are -- if there is some other substantial evidence that suggests that the affiliation will have an anticompetitive effect.

The DOI compiled reports from data from the National Association of Insurance Commissioners, or NAIC, concerning the market shares of insurers in Delaware. Based on this data, Blackstone determined that Highmark, through various subsidiaries, and Blue Cross earned 2010 premium revenue in Delaware in two overlapping product lines: stop loss and dental insurance. This means that Blue Cross and Highmark effectively compete in the stop loss and dental segments of the Delaware health insurance market.

In order to assess potential anticompetitive impacts of the transaction in these two product lines, Blackstone applied the mathematical tests per standard B, but Blackstone

was only able to do so in the dental market.

Q. What prevented you from applying the mathematical test to the stop loss market?

A. According to the Department, complete and consistent data with respect to the Delaware health insurance stop loss market is not available because individual insurers report stop loss premiums to the NAIC using different and inconsistent categories that are not exclusive to stop loss premiums.

Q. Given the data limitations in the stop loss market, are there secondary measurements that may indicate whether there would be evidence of a prima facie violation of the competitive standard for the stop loss market?

A. Yes. Highmark reports total 2010 health insurance premiums written in Delaware, including all categories of health insurance, such as stop loss and dental, in two NAIC categories: "comprehensive health" and "life, accident and health." Blue Cross and several of its primary competitors in Delaware report all of their health insurance premiums in the comprehensive health category. Although not an

apples-to-apples comparison, comparing Highmark's total insurance premium to the total premiums reported in the comprehensive health category indicates that Highmark would have a 0.8 percent market share of the NAIC category that is most closely aligned with the overall market for health insurance in Delaware.

Because the threshold for evidence of a prima facie violation in the competitive standard requires Highmark to have a 1 percent or more market share, Highmark market shares in this category would not vital the mathematical competitive standards.

Blackstone believes that this is a conservative calculation because it compares all of Highmark's activities in the Delaware market, including health insurance, life insurance, and accident insurance, against the total premiums written within the comprehensive health category only, even though it is likely that other insurers in addition to Highmark report health insurance premiums in categories other than comprehensive health.

If Highmark's total insurance

premiums in comprehensive health and life, accident, and health were compared to the total Delaware premiums in these two categories, Highmark's market share would be less than 0.8 percent.

Blackstone does not view the effect of the affiliation on the stop loss market as having any sort of anticompetitive effect in Delaware.

Q. Was the necessary data available to conduct the statutory mathematical test in the dental market?

A. Yes. Unlike health insurance stop loss premiums, the NAIC maintains a specific dental category which the Department believes captures most of the dental premiums written in the state.

Q. Did you find evidence of a prima facie violation of the competitive standard for the dental market?

A. Because the market share of the four largest dental insurers in Delaware is 97.9 percent, the market is considered to be highly concentrated. Therefore, there would be a prima facie evidence of violation of the

competitive standards if one of the insurers involved in the affiliation holds 10 percent or more of the market while the other holds 2 percent or more of the market.

According to NAIC data provided by the DOI, Blue Cross and Highmark have 11.1 percent and 5.8 percent shares of the dental insurance market in Delaware, respectively.

Consequently, there is prima facie violation.

Q. Is it possible to establish the absence of any anticompetitive effect through other factors?

A. Yes. Although Highmark, via United Concordia subsidiary, accounts for nearly 6 percent of the dental insurance premiums in Delaware, over 81 percent of United Concordia's Delaware dental customers obtain their insurance through their employment with companies that are not located within Delaware.

Blue Cross is not a potential provider of dental insurance for these employees, and we believe that pricing actions taken by Blue Cross for dental products in Delaware have little

impact, if any, on the pricing of dental insurance for United Concordia customers outside of Delaware. Therefore, United Concordia is effectively not participating in the same market as Blue Cross.

Blackstone performed two calculations for the purpose of estimating United Concordia's market share after excluding customers employed by out-of-state employers.

The first calculation applied the percentage of United Concordia customers located in Delaware to United Concordia's market share percentage based on total premiums in the Delaware market. This calculation resulted in an estimated adjusted market share of 1.2 percent for United Concordia.

The second calculation applied the number of United Concordia members located in Delaware as a percentage of the total number of Delaware residents enrolled in a private dental insurance plan. This calculation resulted in an estimated adjusted market share of 0.8 percent for United Concordia. Both estimates are below the statutory 2 percent threshold.

Additionally, Blackstone also considered that Highmark's potential increased presence in the Delaware market, in the Delaware dental market, resulting from the affiliation may increase competition by providing more of a counterweight to the current market leader, Delta Dental. Delta Dental's market share exceeds 73 percent compared to 15 percent to Dominion and 11 percent for Blue Cross, the next two largest competitors.

Blue Cross also currently offers only standard reimbursement plans that do not utilize provider networks, but Highmark, via United Concordia, plans to offer dental plans in Delaware which would compare more favorably to the product offerings of Delta.

Blackstone believes that these factors, taken together, may lead to increases in competitive pressures in the Delaware dental market.

Q. Did you have any other concerns or findings related to the impact of the proposed affiliation on competition in the Delaware market?

A. Despite the fact there does not appear to be evidence of the affiliation having an anticompetitive impact on the Delaware health insurance market, a potential negative impact to customers could result from the bundling of ancillary Highmark products, such as dental and vision insurance, with Blue Cross's core health products.

Q. What does bundling mean and why might it be a concern?

A. Bundling would occur if Blue Cross were to condition the sale of their core health products on the simultaneous purchase by the same customer of ancillary products. The risk to customers stems from the ability of Blue Cross to use the sale of core health products for which they may already have some level of market power before the affiliation as a means of forcing customers to purchase ancillary products for which neither Highmark nor Blue Cross currently enjoy a strong market presence in Delaware.

In doing so, Blue Cross could potentially extend existing market power in core health products to newly introduced ancillary

products with the potential consequence of limiting competition in ancillary products markets over the long term.

Prohibiting the bundling of ancillary products with core health products could limit the ability of Highmark and Blue Cross to engage in activities that may lessen competitive competition in ancillary product markets.

Q. What are your conclusions regarding standard B?

A. In summary, based on our analysis and the imposition of a condition by the Department related to anti-bundling, Blackstone does not believe the proposed affiliation is likely to lessen competition in any of the markets in Delaware in which Blue Cross and Highmark compete.

Q. What information did Blackstone rely on in its analysis of standard B?

A. Blackstone received NAIC market share data from the Department on September the 12th, 2011, and reviewed information provided by Highmark regarding United Concordia's Delaware market activity.

Q. Please describe your analysis of standard C.

A. Standard C requires that the financial condition of Highmark does not jeopardize the financial stability of Blue Cross or prejudice the interest of Blue Cross policyholders.

Blue Cross and Highmark will remain separate legal entities under the terms of the proposed affiliation, and Blue Cross will not be responsible for the paying any of Highmark's liabilities. Highmark's financial condition affects whether Highmark has the ability to fulfill its obligations under the terms of the Affiliation Agreement and the Administrative Services Agreement, including a provision of administrative and corporate services to Blue Cross. Blackstone's analysis, therefore, is focused on three issues.

One, Highmark's financial condition, in part, as evidenced by its risk-based capital ratio, and the likelihood that Highmark will remain a dependable source of services for Blue Cross.

Two, Blue Cross's reserves and the

likelihood that Blue Cross will need to rely upon Highmark for support of payment of Blue Cross's claims.

And three, Highmark's proposed affiliation with the West Penn Allegheny Health System and the potential impact that that transaction could have on Highmark's overall financial stability.

Q. You mentioned that your analysis involved consideration of Highmark's risk-based capital ratio. What is that?

A. In this context, risk-based capital, sometimes called RBC, represents an insurer's capital base for paying customer claims. In other words, the amount of money needed for an insurer to pay its claims.

RBC is calculated according to a particular formula. An insurer's RBC ratio is a frequently used metric in the insurance industry to indicate financial strength of an insurer and is intended to capture the risks posed to the insurer. The RBC ratio is equal to the total capital of the insurer divided by the insurer's risk-based capital.

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For example, an insurer with a 300 percent RBC ratio has capital equal to three times the insurer's risk-based capital. Although the RBC ratio is not a perfect measure of an insurer's ability to pay customer claims, generally speaking, the higher an insurer's RBC ratio, the stronger an insurer's financial position.
Q. What information did Blackstone rely on in its analysis of standard C?
A. Blackstone reviewed industry data compiled by CapitalIQ and SNL as of September 2011 as well as pro forma financial information provided by both Highmark and Blue Cross.
Q. Please discuss your assessment of Highmark's financial condition.
A. Highmark's risk-based capital ratio is approximately 692 percent, which exceeds the median ratio of 487 percent among a sample of large publicly traded health insurers.
This figure indicates the above average strength of Highmark's financial condition as it relates to the ability to satisfy

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liabilities even the face of a market downturn or adverse development.
Further, Highmark anticipates steady growth in the coming years resulting from the company's strong market position and an emphasis on cost containment, which is expected to result in growth of the company's investment portfolio and reserves.
Q. How did you arrive at those numbers for Highmark's risk-based capital ratio and its steady growth?
A. As of September 31st, 2010, Highmark's total adjusted capital was approximately $3.7 billion and its authorized control level, which is a measure of the risks that is determined and calculated based on statutory guidelines, was approximately $535 million. Highmark's RBC ratio as of that date is calculated by dividing total adjusted capital by the authorized control level which yields an RBC ratio of 692 percent. These numbers are found on Highmark's RBC statement.
Highmark's growth trajectory is observable in the financial projections provided

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by Highmark to the DOI on August 26, 2011.
Q. Can we go back for a second?
Was the reference to the total adjusted capital of 3.7 billion, was that as of December 31st, 2010? I thought I heard you say September.
A. Yes, it was. I'm sorry. As of December 31st, 2010.
Q. Thank you.
Why are Blue Cross's current reserves important in your analysis of this standard?
A. Although we reviewed the overall projected pro forma financial condition of Blue Cross in detail as part of our review of standard D, we reviewed the current strength of the company's reserves as part of our review of standard C in order to assess the likelihood that Blue Cross may become dependent upon Highmark for financial stability after the affiliation.
Blue Cross's maintenance of strong reserve levels is important for two reasons: First, given that Highmark has agreed to guarantee Blue Cross's claims, Highmark will be incented to closely monitor Blue Cross's

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operating and financial condition. Having strong reserves may, therefore, comparatively strengthen Blue Cross's relative ability to maintain local operational decision-making as a result of decreased potential dependence on Highmark for financial stability.
Second, Blue Cross's maintenance of strong reserves will be an important element in retaining flexibility in the event of a disaffiliation from Highmark as the company is likely to have fewer strategic options available if its reserves are insufficient for it to operate on a stand-alone basis.
Q. What is the potential impact of the proposed affiliation between Highmark and West Penn Allegheny Health System?
A. The proposed relationship between West Penn Allegheny Health System and Highmark involves a financial commitment from Highmark as well as a change to Highmark's corporate structure and business functions.
As a result, Highmark will file Form A application with the state insurance regulators in numerous jurisdictions, including

Pennsylvania and Delaware.

The final details of the transactions are not yet finalized, and Highmark has not yet filed a Form A with the Pennsylvania Insurance Department, but preliminary financial terms indicate an initial commitment from Highmark in the amount of $475 million to West Penn, including a mixture of grants and loans.

Q. On what information did you base your analysis of the potential affiliation with West Penn?

A. Because the terms of the potential transaction involving Highmark and West Penn have not yet been memorialized in definitive documents, our analysis of the West Penn affiliation was based on verbal statements made by Highmark management during a series of phone interviews held in August 2011.

Highmark management noted during each conversation that the details discussed was subject to change pending ongoing negotiation of definitive documents with West Penn.

Q. Will Blue Cross have financial exposure to the West Penn situation?

A. Blue Cross will not have direct exposure to any liabilities or potential operating losses, and Highmark has stated, and the Department seeks to make this statement a condition, that it will not pass operating costs from the West Penn transaction to Blue Cross.

In a worst-case scenario, if Highmark were to lose its total potential financial commitment to West Penn, Highmark estimates that its risk-based capital ratio could fall approximately 60 to 115 percentage points.

We note that this would keep Highmark's risk-based capital ratio above the 375 percent association's monitoring threshold, and above the median ratio of 487 percent among a sample of large publicly traded health insurers.

Q. What are your conclusions regarding standard C?

A. In summary, Blackstone concludes that, one, Blue Cross will not have direct exposure to any liabilities of Highmark and the stand-alone financial condition of Highmark does not appear to be such that Blue Cross's reliance on Highmark for the provision of administrative services

would jeopardize Blue Cross's ability to effectively serve its policyholders in the foreseeable future.

Two, Blue Cross's current reserve levels are such that it is unlikely that Blue Cross would need to rely upon Highmark to honor Blue Cross's claims in the near future.

And three, Highmark's potential transaction with West Penn is not likely to interfere with Highmark's provision of services to Blue Cross or Highmark's claims guarantee to Blue Cross in the near future.

Because of the above analysis, and subject to certain conditions to be determined by the Department, Blackstone does not believe that the financial condition of Highmark is such as might jeopardize the financial stability of Blue Cross or prejudice the interests of its policyholders.

Q. Please describe your analysis of standard D.

A. Under Blackstone's analysis, standard D is one of the most critical standards by which to evaluate the affiliation.

Standard D requires that the plans or proposals which the controlling affiliate, in this case Highmark, has to liquidate the insurer, in this case Blue Cross, 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 fair and reasonable to policyholders of the insurer and in the public interest.

Highmark has represented that it has no present plans or proposals to liquidate Blue Cross or sell Blue Cross's assets or consolidate or merge it with any person, and the Department seeks to make this a condition.

Blackstone notes that the change of control resulting from the proposed affiliation entails risks to Blue Cross and its policyholders. Those risks, however, must be weighed against the benefits that may accrue to the policyholders as a result of Blue Cross gaining access to enhanced capabilities and overall corporate support services.

The affiliation would result in several different and important changes to Blue

Cross's business, corporate structure, and management. Blackstone examined these plans and agreements to assess whether the changes would be fair and reasonable to Blue Cross policyholders, and to determine whether the changes would be against the public interest.

Blackstone focused on four general categories: one, changes to Blue Cross's corporate structure, governance structure, and market presence; two, the anticipated impact of the affiliation on Blue Cross's financial condition; three, the anticipated impact of the affiliation on Blue Cross's corporate capabilities and provision of services to Blue Cross customers; and four, the outcome of Highmark's past affiliation with Highmark West Virginia.

Q. How will the compensation of Blue Cross's executives be affected by the affiliation?

A. Blackstone first reviewed potential changes to Blue Cross management roles and compensation. Subsequent to the affiliation, Blue Cross's CEO and six vice presidents will be incorporated into Highmark's organizational

hierarchy. These executives have employment agreements with provisions that are materially unchanged from agreements that predate the proposed affiliation. These agreements include provisions for payments of severance benefits under certain conditions. Full payment of severance benefits based on termination of all seven executives who have such agreements after the closing of the proposed affiliation would involve an approximate $6 million payout.

The latest revisions to executive compensation agreements, however, did not include provisions for compensation that was specifically tied to the proposed affiliation.

Further, a change of control alone, including the proposed affiliation, does not allow an executive to collect severance benefits. Instead, there must be an additional trigger such as involuntary termination of the executive's employment, a substantial reduction of duties or compensation, or a significant geographic relocation.

Q. Are there any bonuses or financial incentives to Blue Cross's executives to enter

into the affiliation?

A. No.

Q. Are there any separate side agreements or understandings between Highmark and Blue Cross executives which would give those executives a personal financial incentive to form the affiliation?

A. Blackstone has not discovered and is not aware of any such agreement. The Department seeks a condition which precludes any such arrangements.

Q. What is Blackstone's conclusion about the issue of executive compensation?

A. It is unlikely that Blue Cross management will gain direct financial benefit from the affiliation at the expense of the company's policyholders.

Q. What information did Blackstone rely on in its executive compensation analysis?

A. Blackstone reviewed an executive compensation analysis prepared for the Blue Cross board of directors on May 18th, 2011.

Q. Are there any bonuses to any of Blue Cross's nonexecutives as a result of the

affiliation?

A. Yes. Bonuses tied directly to the transaction itself are limited to nonexecutive employees and are projected to be approximately $300,000 in total. These bonuses were approved by the Blue Cross board of directors after consultation with an industry advisor in June of 2010, and range between 25 percent and 30 percent of the recipient's annual salaries.

These bonuses were structured as stay bonuses for nonexecutive employees only and were deemed by the Blue Cross board to be critical to the success of the proposed affiliation.

Q. What's a stay bonus?

A. A stay bonus means that if you remain in employment past a certain date, you will receive this bonus automatically. So it is to incent you to stay during a transition period in a merger or an acquisition.

Q. Thank you.

What information did Blackstone rely on in connection with its analysis of the nonexecutive bonuses?

A. Blackstone held a discussion on this

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topic with Blue Cross management on August 30th, 2010, and received written information from Blue Cross, as well.

Q. How will Blue Cross's governance structure be affected by the affiliation?

A. The composition of Blue Cross's board will change as a result of the affiliation if approved. The Blue Cross board will consist of four Class A directors, four Class B directors, and one president director.

The Class A directors cannot be officers or employees of Highmark or Blue Cross. The initial four Class A directors will be chosen by Blue Cross prior to the closing of the affiliation and will serve staggered terms of one, two, three, and four years, and such time thereafter until their successors are elected and qualified.

Thereafter, new Class A directors will be nominated by the current Class A directors and are subject to election by Highmark.

The new Class A directors will serve three-year terms, and such time thereafter until

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their successors are elected and qualified.

The four Class B directors are chosen by Highmark and serve one-year terms. For the first three years, Class B directors will include the Highmark CEO and two Highmark CEO direct reports.

The president director is the president of Blue Cross who will serve as a director for as long as he or she is president of Blue Cross and whose election is subject to the approval of Highmark.

The president director may serve terms not to exceed five years and may be removed at any time for any reason or no reason at all by the Class B directors. A majority of the Blue Cross board of directors must be residents of Delaware.

The Class A directors will have the right to cause Blue Cross to disaffiliate from Highmark upon certain triggering events.

Q. What information did Blackstone rely on in connection with its analysis of the postaffiliation governance structure of Blue Cross?

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A. Blackstone reviewed the statement affiliation filed with the Department by Highmark on October the 7th, 2010, and the business Affiliation Agreement dated August 19th, 2010.

Q. How will Blue Cross's management structure be affected by the affiliation?

A. Blue Cross will retain autonomy as a Delaware-based entity with regard to market-facing functions. Key market-facing decisions such as how to price products and how to decide which products to offer in the Delaware market, however, will be subject to both input from the Blue Cross board and approval by Highmark through the annual budgeting progression.

In addition to the changes in board structure discussed above, the affiliation will result in some Blue Cross corporate departments and professionals reporting to their corresponding Highmark departments and professionals such as in the areas of operations and finance. The Blue Cross president will, however, retain relative autonomy when making decisions relating to interactions with Blue

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Cross customers and the Delaware public.

Corporate budgets will be determined at Highmark, but the Blue Cross president and certain Blue Cross personnel will have input into Highmark's budget-planning process, so that they can help to address any extraordinary cost issues impacting Blue Cross, or to introduce strategic changes in such areas as pricing and product development.

Q. What is Blackstone's conclusion about the issue of Blue Cross's management structure?

A. The affiliation is structured such that there is a high likelihood that Blue Cross's market-facing functions will remain locally managed in the foreseeable future.

Q. How did the changes to Blue Cross's governance and management structures that you have discussed impact a potential disaffiliation?

A. These changes to Blue Cross's management and governance structures involve a level of integration with Highmark that is more complex than Blue Cross's previous affiliation with CareFirst. In light of the CareFirst disaffiliation, Blackstone analyzed the proposed affiliation in terms of how it addresses any potential disaffiliation between Blue Cross and Highmark.

It is noteworthy that Blue Cross's Class A directors have the option to disaffiliate with Highmark under certain conditions. If there is a disaffiliation, Blue Cross likely would have to disassociate its core administrative and IT functions from those of Highmark. Blue Cross would then have to either find an alternative provider of IT services, as well as a provider of other services, or build its own capabilities to provide those services.

Blue Cross would have to navigate this capability-building process while faced with having to repay the funds borrowed on the line of credit agreement, if any amounts are outstanding, and to fulfill the national Blue Cross Blue Shield Association's requirements related to Blue Cross reestablishing itself as the primary licensee in Delaware.

Q. What is Blackstone's conclusion about the impact of the affiliation on Blue Cross's ability to disaffiliate?

A. Blue Cross's contractual option to disaffiliate under certain adverse circumstances will help to protect the company and its policyholders from potentially unfair and unreasonable outcomes in the context of certain potential Highmark actions, including conversion to for-profit status or insolvency.

Although Blue Cross's ability to disaffiliate from Highmark in the future is a key component of the Affiliation Agreement, Blackstone believes that additional conditions proposed by the Department regarding Blue Cross's ability to disaffiliate in the future, which addresses, among other things, Highmark providing sufficient time and support to Blue Cross during this process, are appropriate.

Q. How does a disaffiliation impact Blue Cross's ability to obtain the marks?

A. In the event of a disaffiliation, Blue Cross will have to reapply to the National Blue Cross and meet certain requirements of the association in order to reestablish its status as the sole association licensee in Delaware.

As the association ultimately governs

the process and outcomes for the application progression, neither Blue Cross nor Highmark can guarantee that the marks will be returned to Blue Cross after a disaffiliation.

However, Blackstone believes that a condition proposed by the DOI requiring Highmark's use of all reasonable best efforts, acting with diligence, and in good faith, and providing active assistance in Blue Cross regaining its status as the primary licensee of the marks in Delaware, are appropriate for the protection of Blue Cross's policyholders and the public interest of Delaware.

Q. Now, sir, let's turn to the anticipated impact of the affiliation on Blue Cross's financial condition.

Can you tell us what economic transfer between Blue Cross and Highmark are contemplated by the affiliation agreements?

A. The affiliation would impact Blue Cross's financial condition via certain economic transfers to Highmark, including payments made for IT systems upgrades and ongoing administrative services, and the pro forma impact

of the affiliation on Blue Cross's financial results and reserves as compared to a stand-alone scenario.

If the affiliation is approved, there can be three types of economic transfers from Blue Cross to Highmark: first, Blue Cross will pay Highmark for upgrades to Blue Cross's IT systems; second, Blue Cross will make payments to Highmark for the ongoing administrative and technology services -- pardon me -- second, Blue Cross will make payments to Highmark for the ongoing administrative and technology services Highmark will provide to Blue Cross; third, Blue Cross will make interest payments to Highmark on any funds Blue Cross opts to obtain under the line of credit agreement.

The affiliation does not otherwise provide for any mechanism for Blue Cross to transfer funds to Highmark.

In addition, the Department has proposed a condition which would limit the transfers that Blue Cross can make to Highmark to the three transfers I just discussed, thereby prohibiting Highmark from accessing Blue Cross's

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funds in any other manner.
Q. Let's discuss the first type of economic transfer of payments from Blue Cross to Highmark for upgrades to Blue Cross's IT systems.
Can you explain what those payments are and how Blackstone evaluated them?
A. Blue Cross has agreed to make payments to Highmark for Blue Cross's migration to Highmark systems.
As noted by KPMG in its report and testimony, the largest financial impact of the affiliation can be measured by comparing the costs Blue Cross expects to incur upgrading its IT systems as a stand-alone entity with the costs Blue Cross expects to incur to transition to Highmark's IT platforms.
The total cost of Blue Cross's systems upgrade may reach $37 million as an affiliate of Highmark compared to as much as $150 million if Blue Cross were to achieve the same level of upgrades as a stand-alone entity.
Highmark and Blue Cross have been working cooperatively since December 2010 on a detailed plan of integration which the applicants

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believe fully sports the estimated costs and planned functionality.
Q. What is Blackstone's conclusion about the reasonableness of the cost for Blue Cross to migrate to Highmark systems?
A. Consistent with the KPMG report and testimony, the 2008 Deloitte report and 2010 update, as well as information received during interviews with Highmark West Virginia, the costs of the IT systems upgrades to be provided by Highmark are not unreasonable.
It is especially true given the level of functionality and service to be obtained and the fact that the cost to Blue Cross of upgrading via Highmark's IT platform does not appear to be higher than the cost to Blue Cross of achieving the same level of functionality on a stand-alone basis.
I understand that the Department has proposed, and the applicants have agreed, to a cap on this integration cost.
Q. Let's discuss the second type of economic transfer: payments from Blue Cross to Highmark for ongoing administrative services.

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Can you explain the parameters behind these payments?
A. Blue Cross will pay Highmark for ongoing administrative services. The provision of these services is to be governed by an Administrative Services Agreement included in the Form A filing by Highmark.
The Administrative Services Agreement contemplates that Blue Cross will compensate Highmark for services in an amount equal to Blue Cross's fair and reasonable allocable share of the total actual cost without provision for profit to Highmark of providing the services.
Q. What's the method by which Highmark will charge Blue Cross for services under the Administrative Services Agreement?
A. Blue Cross will reimburse Highmark for the fair and reasonable allocable share of the total actual cost to Highmark of providing these administrative services, but without provision for profit. This share shall be determined in accordance with Highmark's established cost accounting practices as in effect from time to time.

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Q. What are the current estimates for the annual amounts of payments that Blue Cross will make to Highmark for administrative charges?
A. Administrative charges from Highmark to Blue Cross are anticipated to reach an annual amount of $21.7 million by 2015. However, these charges will be offset by projected synergies that are forecasted to amount to $23.4 million in 2015, and are forecasted to fully offset the administrative charges.
Q. What happens if there are disputes about the amount of payments?
A. Although either Blue Cross management or Highmark management will both have the ability to dispute any extraordinary or unfair charges and disputes will be resolved, if necessary, through the Blue Cross board of directors and, if still unresolved, through the Highmark board of directors. Prohibiting the Highmark board's involvement and making the Department the final arbiter of any cost-related disputes would be beneficial. And we understand the Department is offering a condition to this effect.
Q. What is Blackstone's conclusion about the

reasonableness of the cost allocation methodology for Blue Cross to migrate to Highmark's systems?

A. Highmark's methodology for allocating ongoing operational and administrative charges to Blue Cross is not unreasonable, subject to appropriate monitoring, authorization, and dispute controls being implemented as planned.

Blackstone believes that additional conditions proposed by the Department regarding the Department's oversight of cost allocations are appropriate.

Q. What is Blackstone's conclusion about whether the affiliation provides Highmark with a way to access or control the current or future reserves of Blue Cross?

A. With the additional conditions advanced by the Department, the affiliation does not provide Highmark with the means of accessing or controlling the current or future reserves of Blue Cross.

Q. Has Blackstone reviewed the terms and conditions of the line of credit agreement, and what is Blackstone's view as to the reasonableness of that agreement?

A. Yes. Highmark will provide Blue Cross with a $45 million line of credit for the purpose of financing Blue Cross's costs associated with converting its IT systems onto Highmark's platform. Borrowing under the line of credit is at Blue Cross's option and there are no unused capacity fees or early repayment penalties.

At present, Blue Cross does not anticipate drawing on the line of credit. If Blue Cross were to draw on the line of credit, the rate of interest would be the lesser of prime rate or the one-month Libor plus 350 bases points.

The balance would be payable on the seventh anniversary of the signing of the Business Affiliation Agreement. Blackstone has reviewed these terms of the proposed line of credit and believes that the pricing and payback period are not unreasonable to Blue Cross.

The terms and interest rate of Blue Cross's line of credit agreement with Highmark considered as a whole are not unreasonable. Blackstone believes that conditions proposed by the DOI regarding the terms of the termination

and repayment of the line of credit are appropriate.

Q. What is Blackstone's conclusion about the overall financial impact of the affiliation on Blue Cross?

A. The overall financial impact of the affiliation is reflected in two sets of financial projections prepared by Blue Cross management: one set for the situation in which Blue Cross remains a stand-alone entity, and another set for Blue Cross affiliating with Highmark.

In general, the stand-alone projections assume that Blue Cross will bear the full cost of the IT upgrades on its own which will necessitate raising premiums in order to help recoup a portion of the cost of the upgrades, and that Blue Cross's membership will suffer due to these price increases.

In the affiliation scenario, Blue Cross assumes that it will be able to keep its premium rates lower than possible in the stand-alone scenario, and that membership will increase as a result of the company's projected operational benefits of affiliating with Highmark

and the ability to introduce new products to the market.

In order to capture the impact of the proposed affiliation on Blue Cross's claims-paying resources, Blackstone assessed the difference in projected levels of reserves between the two scenarios in 2015, and then assessed the differences in projected levels of cash and investments in 2015.

Blue Cross projects that its reserves will be $53 million lower by 2015 if the company remains a stand-alone entity, which is largely due to IT-related depreciation and support expense.

Blue Cross projects that its cash and investments will be $147 million lower by 2015 if the company remains a stand-alone entity, which is also due to IT-related expenses that have not yet been depreciated by that time and are, therefore, reflected as capital assets on the company's balance sheet.

As cash and investments are generally significantly more liquid than assets related to IT systems, the affiliation scenario implies a significantly greater amount of claims-paying resources than the stand-alone scenario.

Q. Will the affiliation impact employment in Delaware?

A. Yes. Another anticipated impact of the affiliation relates to employment levels in Delaware. Although Highmark is contractually obliged to use commercially reasonable efforts to maintain employment levels in Delaware that are proportionate to those employment levels in other Highmark health insurance service areas, Blue Cross employment levels could decline as a result of the affiliation.

This is ultimately a tension between Highmark's goal of enhancing Blue Cross's competitiveness by promoting greater efficiency with Blue Cross and efforts to preserve employment levels.

Should there be a significant decrease in Blue Cross's enrollment or market share during the implementation period, for example, from the loss of a large customer, that results in any lost positions, Highmark will not be responsible to replace those lost positions

and doing so could potentially hurt Blue Cross's profitability.

Q. What is Blackstone's conclusion about the likely postaffiliation financial condition of Blue Cross?

A. It is unlikely that the financial condition of Blue Cross will be materially worse in the foreseeable future as a result of an affiliation with Highmark than it would otherwise be if Blue Cross were to -- were to remain a stand-alone entity, and it may well improve as a consequence of the affiliation.

Q. Has Blackstone reviewed the potential impact and cost to the IT systems upgrades that are planned as part of the affiliation?

A. We have participated in discussions with management from both Highmark and Blue Cross concerning the level of IT enhancements that are expected to result from the affiliation, and we have reviewed the report dated September 6, 2011, by KPMG.

Q. What are Blackstone's conclusions about the cost and functionality of the IT systems upgrades that are planned as part of the

affiliation?

A. Neither an outsourcing relationship with a business process provider, nor investing in additional capabilities as a stand-alone entity would be expected to provide Blue Cross with capabilities that exceed those anticipated in the affiliation.

Furthermore, such arrangements would likely entail greater costs to Blue Cross and would not address Blue Cross's lack of scale and resources in areas such as strategic development, product innovation, and regulatory planning.

Q. How will the affiliation affect Blue Cross's corporate capabilities and provision of services to Blue Cross customers?

A. Blue Cross currently faces several challenges as a result of small -- as a result as a small nonprofit corporation, including limited technology resources and a limited ability to adapt to regulatory change.

Blue Cross's lean operating model also means that Blue Cross has difficulty innovating in the areas of product development and pricing structures. Faced with much larger

national competitors, these pressure points are particularly sensitive for Blue Cross.

The affiliation is anticipated to address many of these capability gaps, particularly given the breadth of experience of Highmark has with various affiliations and administrative services agreements.

The functionality that Blue Cross anticipates gaining via the affiliation should address many of the company's current gaps in capabilities as compared to industry norms and expectations of customers and providers.

Q. How does the proposed affiliation compare to Highmark's previous affiliation with Highmark West Virginia?

A. Highmark's affiliation with Highmark West Virginia involved a transaction similar, though not identical to, the proposed affiliation.

Since 2008, Highmark West Virginia has operated with an IT and back-office system that is fully integrated with Highmark's platform, yet has continued to exercise market-focused decision-making authority.

Since 1999, Highmark West Virginia has seen significant increases in its reserves, risk-based capital ratio, and membership levels. Specifically, Highmark West Virginia's reserves have increased from $19 million to $242 million between 1999 and 2010, and risk-based capital has increased from $276 percent to 1,013 percent.

The president of Highmark West Virginia also remains locally autonomous with regard to market-facing decisions, and Highmark West Virginia's customers appear to have benefitted from Highmark's operational best practices, national account services, and overall scale.

Additionally, no significant complaints related to loss of local autonomy have been received by the West Virginia Department of Insurance from market participants or customers since the completion of the full integration between Highmark and Highmark West Virginia.

Q. What are Blackstone's conclusions about the effects on the West Virginia Blue Cross Blue Shield as a result of the affiliation with Highmark?

A. Based on the views of Highmark West Virginia's local president and the West Virginia Department of Insurance, Highmark's affiliation with Highmark West Virginia has resulted in that company having significant capabilities and corporate support and has not been detrimental to Highmark West Virginia's policyholders.

Q. What are your conclusions, therefore, for standard D?

A. Based on these analyses, Blackstone believes that conditions addressing Blue Cross's corporate governance structure, the terms of Blue Cross's contractual option to disaffiliate under certain events, certain terms of the Administrative Services Agreement, and the line of credit agreement, and the terms of any proposed rate increases or any changes to benefits or products would be appropriate to bring the affiliation into compliance with the statutory criteria. The specifics of those conditions are within the purview of the Department of Insurance.

Based on Blackstone's analysis in the

above conditions, plans and proposals related to the affiliation do not appear unfair and unreasonable to Blue Cross's policyholders, and do not appear to be against the public interest of Delaware.

Q. Could you describe your analysis, please, of standard F?

A. Standard F requires an analysis of whether the affiliation is likely to be hazardous or prejudicial to the insurance-buying public. Given Blue Cross's unique position as the largest locally based not-for-profit insurer in the Delaware health insurance market, the proposed affiliation could have a significant impact on the insurance-buying public.

In order to identify potential hazards or prejudices, Blackstone examined Blue Cross's current market position, reviewed Blue Cross's search for a strategic partner, and assessed the feedback received in public information sessions and private interviews with interested parties.

Q. Could you describe Blue Cross's current position in the Delaware insurance market?

A. Blue Cross provides services to a significant portion of the Delaware population and, as a result, has many stakeholders. Many of these stakeholders in the Delaware market, including customers, providers, employers, brokers, and community members, are generally satisfied with Blue Cross's performance.

Blue Cross faces significant challenges, however, including the limited growth potential of the Delaware market broadly, anticipated capital costs to modernized and remain competitive, and the uncertainty proposed by federal health care reform.

Finally, Blue Cross's small size and lean business model limit the resources Blue Cross is able to devote to developing new products, improving its data management, and addressing other capability enhancements necessary for Blue Cross to continue its successful performance in service.

Q. What other options did Blue Cross explore before deciding to pursue an affiliation with Highmark?

A. Blue Cross began its search in December of 2006 and considered various types of transactions, including affiliations, mergers, conversions, and asset sales.

Blue Cross assessed various potential partners, including multi-state Blue Cross Blue Shield plans, regional Blue Cross Blue Shield plans, and single-state Blue Cross Blue Shield plans.

The board decided to pursue a transaction with either multi-state or regional Blue Cross Blue Shield plans. The board determined that single-state Blue Cross Blue Shield plans were determined not to be an acceptable solution for Blue Cross's long-term strategic needs. The board preferred an affiliation to maintain local identity and control.

In the spring of 2008, the board received interest from Highmark and four other health insurers. And after further diligence, the board chose a national for-profit insurer as an exclusive negotiating partner for a potential acquisition transaction.

The board negotiated with the

national for-profit insurer for several months, but the for-profit health insurer's evaluation of Blue Cross declined significantly from its initial indication, in our view, in part, due to the deterioration of Blue Cross's financial outlook and investment portfolio during the U.S. credit and dislocation and subsequent recession.

The parties remained relatively far apart on other terms of an agreement. In the fall of 2009, the Blue Cross board reached out to Highmark, and on December 3rd, 2009, chose to pursue an affiliation with Highmark on an exclusive basis over an affiliation with another nonprofit Blue Cross Blue Shield plan due, in part, to the perceived strength of Highmark as a long-term partner and Highmark's operating model, which would provide more local control than other potential partners.

Q. On what basis did Blackstone reach that conclusion?

A. We reviewed documents produced by the applicants, including numerous summaries of Blue Cross board meetings held between December 2006 and July 2010, during which the company's search

for an assessment of strategic options were discussed, Highmark's response to Blue Cross's request for information, a Deloitte report prepared for Blue Cross in 2008 and updated in 2010, as well as proposals prepared for Blue Cross by other potential strategic partners.

Q. What feedback was received during the public information sessions and private interviews that were held?

A. Blackstone both participated in public information sessions and conducted private diligence meetings in order to identify public and private concerns regarding the proposed affiliation.

Of highest priority were the stakeholders' views on Blue Cross's performance and capabilities relative to its competitors, the importance of having a large nonprofit provider in Delaware, the importance of Blue Cross being locally managed, experiences with any prior interactions with Highmark, and the affiliation's potential impact on competition in the Delaware health insurance market.

From these sessions and meetings,

Blackstone gauged the reactions of various Delaware stakeholders to the proposed affiliation.

Q. What was the greatest concern conveyed to you by interested parties?

A. The greatest concern conveyed was generally related to Blue Cross's ability to retain a strong local presence and local decision-making authority. Even with these concerns, however, nearly all of the interested parties contacted voiced their support on balance for the proposed affiliation due to Blue Cross's perceived lack of cutting-edge products and capabilities when compared to larger competitors.

Q. What are your conclusion goes for standard F?

A. In summary, Blackstone concludes that, one, Blue Cross maintains a leading position in the Delaware health insurance market and offers a unique preference as the only locally controlled, nonprofit health insurance carrier in Delaware.

Two, the board's determination of Blue Cross's strategic position was jeopardized subsequent to the CareFirst disaffiliation was reasonable given industry trends that included consolidation among competitors, cost pressure from providers, increasing need for significant IT investments, and the increasing scope and uncertainty of federal and state healthcare regulation goes.

Three, the board's review of strategic alternatives and search for a partner was reasonable.

Four, the primary concern of Blue Cross's customers in the insurance-buying public relate to Blue Cross's maintenance of a strong local presence and decision-making ability in key market-facing functions.

And five, given the company's current strategic position and options available to remain a viable health insurance carrier as identified during the board's strategic review process, the board's option that an affiliation with Highmark will balance the company's achievement of long-term strategic goals with the company's ability to maintain an appropriate local presence is reasonable.

Based on the above analysis,

Blackstone believes that conditions designed to preserve Blue Cross's local presence and autonomy, and to ensure local decision-making and local customer service and account management, would be appropriate to bring the affiliation into compliance with the statutory criteria.

The specifics of these conditions are within the purview of the Department of Insurance. With such conditions in place, the affiliation is not likely to be hazardous or prejudicial to the insurance-buying public of Delaware and would, thus, not vital standard F.

Q. In summary, did your analysis of the proposed affiliation indicate that any of the five standards that Blackstone examined -- A, B, C, D or F -- would be violated?

A. Based on our analysis, and subject to certain conditions which are properly within the discretion of the Department to impose, the proposed affiliation does not violate standards A, B, C, D or F.

Q. Do you have any further testimony?

A. I do not.

MR. HOUGHTON: Thank you.

THE HEARING OFFICER: Thank you. I think at this point we will take a brief break before we begin cross-examination.

(A recess was taken.)

THE HEARING OFFICER: I think we will go ahead and proceed with cross-examination.

Mr. McConnell?

MR. McCONNELL: Your Honor, I'm going to ask that Ms. Shoss, our cocounsel, conduct the cross-examination.

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CROSS-EXAMINATION

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BY MS. SHOSS:

Q. Good morning, Mr. Alderson-Smith. You testified and I know that you worked on conversions of Blue Cross's and representing attorneys general and departments of insurance in conversions and proposed conversions.

The Delaware Conversion Act does recognize that if Blue Cross were ever to convert, the public benefit asset would have to be placed into a foundation. Is that consistent with your experience in conversions of Blue

Cross?

A. Yes, it is.

Q. In considering the public interest here, did you consider at all the interest of the public in the preservation of that asset, in the event of a subsequent conversion down the road?

A. We did not specifically focus on preserving that public asset for any potential conversion down the road.

What we did focus on was ensuring that the reserves in the organization in Blue Cross remained intact, that there were different ways to disaffiliate if it was appropriate to do so, so that we had appropriate escape hatches if certain conditions were triggered.

So to the extent that we wished to preserve flexibility, and to the extent that we wished to ensure that the reserves of the company were being appropriately protected, to that extent we did look at those elements.

Q. But not to the extent of the interest in the public, the public benefit asset be preserved --

A. That is correct, not to the extent that

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the public asset -- the public benefit asset be preserved to the extent of, for example, looking at a snapshot or various other methods that have been attempted and looked at in other affiliation transactions.

Q. In your report, on page 111, which is the conclusions page about standard D, you say that: "Based on the above analysis, conditions addressing, among many other things, changes to benefits" -- let's see -- "Blue Cross's employment and community initiative commitments in Delaware. The conditions addressing those would bring the affiliation into compliance with the statutory criteria and would be within the purview of the Department of Insurance."

Were there any conditions in the 37 that were ultimately proposed that addressed community initiative commitments which I gather must have gone to your public benefit or public interest analysis?

A. No. Of the 37 conditions that we have in front of us, none of those specifically deal with that issue. There is some history to that because we had some conversations or some

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thinking about that, but we did not ultimately propose that to be one of the conditions at this time.

Q. Could you talk a little about the history that that?

A. Yes. We did actually look at potential that there should be some form of methodology examined whereby potentially some monies could go from the company on an annual basis if there was available money over and above what was needed for the company to protect the company, to protect the policyholders of Delaware.

If there was some money over and above that, that it was sensible and safe to then allocate for various charitable endeavors or other public interest benefit, that was something that we examined.

Q. Did you consider at all what that might be, how you might derive --

A. We did bat around some amounts. I don't think we came out with a final amount, because I think there was no negotiation that took place with Blue Cross of Delaware on that, but we did consider that there would be a potential to look

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at a percentage of net profits that could be contributed on an annual basis if there was appropriate safeguards to ensure that they would only be paid out after policyholders had been protected.

Q. Only on an annual basis?

A. Only on an annual basis. We did not consider, and we felt that it was not advisable to consider, that there be monies taken out of reserves, out of policyholders' reserves at this time because we did not consider this being an affiliation, that that was appropriate which could potentially weaken this company and not give it the sort of flexibility that we think that it will still require.

Q. I listened to your testimony about this being an affiliation and not an acquisition, but it is a change of control?

A. Absolutely it is a change of control.

Q. Right. Okay. And governance will change?

A. Absolutely governance will change.

Q. And direction of policies will change?

A. And direction of policies will change.

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But the things that won't change will be the reserves and the future profitability of this company is not available for Highmark. This is only available for the policyholders in the Delaware company.

Q. But with respect to community initiatives, for example, we did hear Mr. Constantine testify yesterday that he would be unable even to commit to continuing the $750,000 that's discretionary spending for community initiatives without checking with Highmark. So clearly that sort of decision-making will change, as well.

A. And I think that the way that we would visualize monies being able to go out on some form of annual basis subject to there being appropriate monies for the protection and the ongoing viability of Blue Cross, I think that would be something that, clearly, the board of directors of the Blue Cross of Delaware board will ultimately make a decision on.

Obviously, as I heard quite an amount of the testimony yesterday afternoon discussing the possibility of there being either Blue Cross

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potential donations on an annual basis, or even being linked into the Highmark foundation. Those are, I think, interesting avenues to pursue. But ultimately, our job is to make sure that the policyholders in this company are fully protected as our sort of primary objective here.
Q. Let's talk about that for a minute.
What's the RBC ratio today of Blue Cross?
MR. TEICHMAN: Your Honor, I'm going to raise an objection again, and it's following my objection from yesterday morning.
Based upon your order of last week, we came here expecting some cross-examination and discussion about whether a foundation was needed and whether some reserves might have to be taken from Blue Cross, etcetera. But what we did not come here expecting to talk about was specific amounts.
It's my understanding of your order that those issues would be dealt with at a later day. I think where the cross-examination is now going is into how much, and --
THE HEARING OFFICER: Is that where

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you're going?
MS. SHOSS: No, ma'am. No, Your Honor, it is not where I'm going. I'm going to feasibility, not to amount.
THE HEARING OFFICER: Specific amounts?
MR. TEICHMAN: But I think that's the same question. Is $1 feasible? Is $100 million feasible? That's the kind of issue, Your Honor, that we would expect to get into at the subsequent hearing, if it's even needed.
THE HEARING OFFICER: I'm going to permit her to proceed and see where we go. Thank you.
BY MS. SHOSS:
Q. So what is the RBC ratio of Blue Cross?
A. Approximately -- it varies, but it's approximately 1,050 to 1,070 depending on the period.
Q. Okay. And I think on page 59 of your report you list a number of Blue Cross's competitors and their RBC ratios. Where does the Blue Cross RBC ratio fit in comparing with those other companies?

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A. It compares favorably. It's well-capitalized company.
Q. Isn't it, in fact, the highest of the RBC ratios on that page?
A. It is certainly a well-capitalized company.
Q. I know you have represented the Pennsylvania Department of Insurance on some matters in the past, and the Pennsylvania Department of Insurance, as you're probably aware, has looked in the past at efficient use of capital by the Blue Cross plans, and has determined that beyond a certain range, there's excess capital that's no longer is required to support policyholder obligations, and that when a Blue Cross plan hits that level, I think for Highmark it would be 750 or the range of 550 to 750. For a smaller plan, it would be a higher range. When a Blue Cross plan hits that range, the Blue Cross plan has to come up with a use for that capital to reinvest it in the community or come up with a plan. Certainly Blue Cross of Delaware is well beyond the highest range there.
Does the Department of Insurance

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consider any of those issues, particularly in light of the new guarantee that Blue Cross will also have as a result of affiliating with Highmark?
A. Okay. Let me try and -- there's a bunch of stuff there.
Q. Yes. Sorry.
A. So let's -- we will kick off with -- let's just kick off with Pennsylvania and the sufficient range of 550 to 750. We will just start with that. And obviously I think Pennsylvania also said, by the way, for smaller companies, it would be 750 to 950.
And the sort of first major caveat I have to say is I am not an actuary and I'm very nervous about getting into a discussion of RBC ratios because ultimately I think this is something that would have to be examined by the company's actuary or by a special study commissioned by the company to be able to understand what the appropriate levels of RBC are.
I think that it is -- it's a little dangerous, in my opinion, that we should be

deciding, an investment banker and a lawyer and some other excellent people, but none of us are actuaries, deciding what the right level, what the appropriate level, what is the difference between an abundance of reserves and an overabundance of reserves, what those numbers are.

To be able to do that without having a proper actuarial study gives me great cause for concern.

And I think if Delaware, for example, was to decide to implement similar standards to those that are in force in the Commonwealth of Pennsylvania, which would indicate for a company of this size that the sufficient level of reserves would be 750 to 950, I think we would have to look at all of the details and a proper study would have to be conducted by an actuary.

Interestingly enough, five, six years ago Blue Cross did commission a study by Milliman. That Milliman study indicated that the -- by the way, we think, we had a look at the study, it's a pretty good, not -- I sort of I didn't understand it all, but I did understand a

lot of the scenario testing that they did. I did understand that there was an enormous amount of different shocks that they applied to the system in terms of epidemics, in terms of market dislocations of the type that we had in 2008. They did a lot of scenario planning. And coming out of that study, Milliman recommended that this company should have an RBC ratio of something in the region of 950 to 1,200.

We took a look at that and we said that's kind of a useful benchmark. It's six years old, so it may not be all that useful, but it's at least a starting point to think about the appropriate reserves of this company.

And so it's sort of our opinion that the Milliman study, the Pennsylvania views on the 750 to 950, and then, in addition, just thinking about this company now going into this affiliation with Highmark, yes, there was a claims guarantee.

I talk about the next portion of your question. Yes, there is a claims guarantee, but ultimately we, sitting in Delaware, are -- if something bad happens to the company in Delaware,

ultimately the Department of Insurance needs -- and we need to act, the Department of Insurance needs to act to go and seize assets. It's a lot easier to seize assets, seize RBC, seize reserves located in this Delaware that have been ring-fenced for the people of Delaware than trying to chase down a guarantee from some distant organization in Pittsburgh.

It is a lot easier for us to know that we have got a regulatory authority over a ring-fenced company with it's own reserves which we think are appropriate for running this business.

And then, in addition, yes, we have a claims guarantee, but if there was to be another disaffiliation, and again, we have been already been there, done that once with this company, we have already been through a wrenching dislocation through a disaffiliation. It's our view that we will need to ensure that there are appropriate and sufficient reserves to be able to claw back the information systems that we need to be able to stand alone or do an outsourcing deal with another party. All of those things are very

expensive.

And, therefore, as a result of this, as a result of the Milliman study, as a result of the Pennsylvania standards, as a result of the claims guarantee which is nice to have, but I'm not going to put a whole hell of a lot -- I'm sorry -- a whole lot of scope and faith in that, the result is that we do not think that there is necessarily an overabundance of reserves. We think this is a well-capitalized company, but it's a little company operating in a small market.

And, therefore, you know, getting into the details of what the appropriate RBC, I am not the right person to ask. I think we would have to have an actuarial study to refresh that Milliman work that's been done.

But I do believe that there is -- you know, it is very important to protect the policyholders here in Delaware and to have an appropriately capitalized -- perhaps even a well-capitalized company sitting here representing Delaware.

Q. We talked some about disaffiliation and

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what would be involved, and we have heard some testimony, read some testimony about how difficult this would be to unscramble some years hence.

Would a stand-alone option even be feasible if this company were to have to disaffiliate five or ten years out?

A. We believe that a stand-alone, pure stand-alone option would be very hard. We think that if there was -- if Highmark decided to seek for-profit status, if Highmark became insolvent, if there was a need for us to disassociate or disaffiliate from Highmark, it would be very hard -- other than maybe on a very temporary basis -- to be a stand-alone company in this marketplace. It's a market that is continuing to consolidate.

It would be, I think, our view that it would be more likely that this company would then need to find another partner to be able to affiliate with or perhaps go even to a for-profit status or convert. But we think that it would be very hard to see this as a stand-alone, not-for-profit, completely separate in the way

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that it now is.

Q. So saving for that contingency is maybe not necessarily something -- continuing to have an inefficient capital structure, just adding on and adding on to that when it's not even actually an option?

A. I know, but even in the instance of even disaffiliating and reaffiliating with another party, that will be an expensive option. And we think we have been there, done that with this company once before. It is a real possibility that in the future there may be the necessity for a disaffiliation and we wouldn't want to make that a nonoption by pulling reserves out and, thereby, potentially weakening this company, and weakening what is effectively reserves, paying ability and to allow this company to thrive and prosper in this market.

Q. Let's turn to cost allocation methodology, because we have heard a fair amount of testimony from you and others that that is one way that funds would leave Blue Cross and go to Highmark.

A. Correct.

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Q. Do you have a sense of what percentage of overhead at Highmark gets allocated down to the companies among which it gets allocated which will include Blue Cross if this is approved?

A. No, I do not of an exact number for that, but I've -- I do not have a number for that.

Q. Okay. Do you have a sense of how many cost pools exist at Highmark, and how many of those will be allocated to Blue Cross?

A. I think there will be a large number of cost pools that will be potentially allocated to Blue Cross.

Q. Do you have an idea of what percent of the entire Highmark enterprise Blue Cross will be by any of several metrics?

A. By any of several metrics, Blue Cross will be a very small part of the overall Highmark enterprise on the basis of revenues, on the basis of reserves. In almost all instances, it will represent less than 10 percent and in many instances less than 5 percent of the overall Highmark enterprise.

Q. Okay. Can we walk through a couple of cost allocation scenarios? Suppose there are

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these conditions that we had read to us a couple times yesterday and you talked to us about.

Let's just imagine for a moment that there's a determination by Mr. Fad or Mr. Constantine that a cost allocation is unreasonable, clearly unreasonable in their view. So they take it up the chain the way they testified yesterday.

Will the DOI ever know that there was a view that it was unreasonable, it was taken to the people to whom they report on whom their jobs depend, that it was taken to the board of which Highmark has control and was ultimately resolved against them, if they don't take it, then, to the DOI in spite of going to the people to whom they report and the board controlled by Highmark, if they don't then take it to the DOI, will the DOI have any idea that there was a dispute?

A. I think that the way that we see the cost allocation methodology working, and as I say, we have in the Administrative Services Agreement we have the standard of fair and reasonable, we have the cost allocation methodology which is going to be used consistently across the Highmark

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enterprises.

We also see that there are going to be both internal and external reviews for many different organizations within the Highmark sort of family of companies, West Virginia, NEPA, other Highmark subsidiaries.

And we also see that external parties, including the federal government, will be watching and happily monitoring all of these different -- these different allocation methodologies.

If, on the other hand, just to go directly to your question, if there is a significant variance from a budget, in other words, the Department will be looking at the budget, the Department will be reviewing that budget, if, then, there is a variance from that budget, the Department will -- and that variance is material, the Department will automatically see that variance from the budget and will be checking, if the Department is actually doing its job, they're going to be checking those variances to the budget.

So, therefore, there will be sort of

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an independent look at whether these methodologies are being applied consistently and appropriately and in line with the budgets that have been approved, again, by the Department of Insurance using the fair and reasonable standard.

There is a possibility, however -- just to go straight to your question, there is a possibility, I think it is a low possibility, but there is a possibility that on occasion some of these potential variances, which I would suspect will be of a less-than-material nature, may not be caught by Mr. Constantine and his management team flagging them directly for the Department's review.

Q. And did the Department consider at all requesting that it be notified even if something didn't rise to the level of a dispute that the Department to arbitrate?

A. Not if it was a relatively nonmaterial item because there has to be a little bit of a -- there has to be, ultimately, a set of review standards that are appropriate for, A, allowing this company to continue to run effectively, but also, B, ensuring that the reserves and the

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interests of this company are protected in Delaware. There is a balance between those two. We think that the set of conditions that have been laid out by the Department gets that balance about right.

Q. We heard yesterday from Mr. Earley about the caps on increases in costs that can be allocated. And when you talked about the comparison between the two transactions, I'm not aware of any caps like that in the Blue Cross transaction.

Is that something that the DOI looked at or considered might be appropriate in this situation?

A. Yes. We had a chat with the Department of Insurance of West Virginia, and in that conversation we talked about two types of caps. We talked about the upfront integration caps. And we actually thought that the department of West Virginia's caps in that example were actually a rather good idea and so we decided to basically plagiarize their condition, because it was a useful and appropriate tool to manage the initial upfront costs. And so we have a proposal

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of a cap in that instance.

With regards to the caps that West Virginia imposed as a condition on annual charges, we decided that our package -- we felt that was a little bit of a blunt instrument. We were a little worried by those caps because it almost allowed the Highmark company underneath those caps to more or less do whatever they wanted to do.

So what we instead went for is a much more -- we had a little bit more time in West Virginia. We had a little bit more time to examine this. What we decided to do instead of imposing those CPI plus 2 percent, or whatever those caps were, we felt along with the Department of Insurance, that it was more appropriate to have a more flexible but more comprehensive series of conditions that did many of the things that a cap would do, but, in our view, were more flexible and more comprehensive and allowed us, actually, to manage, and for the Department of Insurance in future years to manage, what will be many changes, many unforeseen circumstances that will be able to

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manage around through the package of conditions that we put in terms of their line of credit.
Q. Were they mutually exclusive?
A. Effectively Virginia used -- West Virginia, I'm sorry, used the caps as their sort of primary tool to manage the overall set of relationships on the annual charges.
Our belief is that if we had an annual cap, they almost become a little more exclusive. A cap, in our view, wouldn't really have done much, done much that all of our other conditions actually go to resolving and effectively securing annual charges in a way that the review is much more comprehensive and much more appropriate, in our view, than a simple cap.
Q. In the midst of your review process there were changes in the law we heard testimony about yesterday, and one of those changes was the enactment of Section 6311 of the Health Service Corporation Act.
And part of that act tells -- requires the Insurance Commissioner to -- it says that the review is subject to the Holding Company Act, which is what you analyzed, what your report

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goes to, and that also a review will be subject to conditions that ensure compliance with this new Section 6311, part of which goes to preservation of the amount that constitutes the surplus or reserves of the health service corporation, and there are notification provisions to the Attorney General and so on in that section.
Did your review change at all? Did you do anything in addition to what you were doing under the Holding Company Act to report to the DOI or to ensure compliance with 6311?
A. Quite a lot of our review, and certainly a lot of the work that we did in terms of formulating these conditions, actually occurred after that act had come into force. So obviously we got a series of conditions as part of that act, but then we used the time after the enactment of that act to really work with the DOI to craft all of these conditions.
So I can't necessarily tell you whether, in fact, we changed course. We actually baked that into our evaluation of the appropriate conditions and the appropriate ways to safeguard

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the reserves and the ongoing economic interests of this company for the people of Delaware.
Q. Okay. And when you talk about for the people of Delaware or your review in the public interest, how are you defining that?
A. Well, the most important element of what we are trying to do is make sure that this company remains a viable, vibrant competitor. It is able to pay its claims, it's able to continue in business, it's able to service both current policyholders and future policyholders, and by it being an important player in the marketplace, it's also able to drive competition and also able to ensure that the overall market remains vibrant, competitive, the lowest cost for maximum service that we can achieve.
So in all of those instances, both for the insurance-buying public and for the policyholders within this organization, those are probably the two primary goals that we're looking for: all insurance-buying people in the state plus all of the policyholders in BCBSD, and then to the broader extent, to the public interest.
But I think those are probably the

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primary two; namely, the current policyholders, the future policyholders, and the insurance-buying public.
Q. And is your analysis of whether a transaction is or is not in the public interest the analysis that you went through for standard D any different when the company is a not-for-profit corporation than when the company is a for-profit corporation?
A. We believe that being a not-for-profit company effectively should not dramatically change whether this company is viable and whether it's able to service its current policyholders and its policyholders.
So I'm not convinced that necessarily just because it is a not-for-profit versus it is a for-profit, the thing that we need to ensure is that it has the reserves and the capabilities to effectively look after current policyholders, its future policyholders, the insurance-buying public, and that it is operating at least in the public interest in a more general sense.
But I do not think that there are many market differences between it being a

not-for-profit versus a for-profit. Obviously there is, however, separate legislation for this company being a not-for-profit organization.

Q. And its members only represent about 30 percent of the population of Delaware we were told yesterday, 30 percent market share or something like that. So the public actually is quite a larger body.

A. Absolutely. And I think it would be fair to say that we tend to look not just at current policyholders, but we also look at future policyholders.

And we also look at the overall all the insurance-buying public, which is a very large chunk of the population here in Delaware, because we believe that it is very important for this company to be operating -- and by the way, we received a lot of feedback through our interviews and conversations with market participants, that for them it is important that we have a not-for-profit organization here in Delaware serving alongside national for-profit players and regional for-profit players so that we can ensure that there is a vibrant market

which allows all of the insurance-buying public to benefit, not just the 30 percent who are specifically and currently policyholders inside BCBSD.

Q. And what about the public the public with unmet health needs, medically uninsured and underserved populations?

MR. HOUGHTON: Your Honor, can I ask a question?

THE HEARING OFFICER: Yes, you may.

MR. HOUGHTON: It might the witness if he's being asked to construe a piece of legislation or what work he did concerning it to have it in front of him. Is it possible --

MS. SHOSS: I'm not asking to construe. I'm asking him if he considered --

MR. HOUGHTON: Your Honor, I believe he's being asked to construe and to determine how he applied, if he did in his review, Sections 6311 and 5003. It might be helpful if the witness could have it in front of him. That's all I'm suggesting. If Ms. Shoss would prefer for him not to have in front of him, I guess he doesn't have to.

THE HEARING OFFICER: I haven't heard him ask to have that in front of him, but why don't we give it to him in case he needs to review that.

BY MS. SHOSS:

Q. When you considered the interests of the public, did you consider the interests of medically uninsured and underserved populations?

A. The way that we looked at the public interest is we came to the conclusion that if this transaction did not trip up any of the standards that we laid out in Chapter 50 of the insurance law, if it did not trip up any of those standards, then it should be approved under the insurance law.

The standards indicate that this -- if this transaction is not in the public interest, then it -- then there should be study made of that and it could potentially be blocked.

However, we did not find that this transaction is not in the public interest and, therefore, on each and every one of the standards we reviewed, we felt that it met all of those quite carefully defined standards.

And if there are other elements now being thrown into the mix effectively in terms of the underinsured or the poor, the poor and the needy within the state of Delaware, those are entirely worthy causes, but we're not sure that those are really the elements that we should actually be looking at in terms of a determination as to whether this particular deal with all the conditions that we have laid out is effectively appropriate and meets the standards laid out in Chapter 50.

So that would be the sort of way that I would tend to answer that. We fully appreciate these are worthy goals, but we do not consider these are appropriate elements for us to look at in this hearing for the simple reason that the insurance law sort of lays out a set of standards that we have to decide whether this affiliation meets, and it's our opinion that it does meet those standards.

Q. Although I would come back to the conclusion in your report about the Department of Insurance imposing conditions that address community initiative commitments which --

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A. Right. And I should note that we did --
at that time we were thinking of putting some form of annual payment which we had begun to draft, that there would be some form of annual payment which would be based on net profits, would not be overly burdensome to the company, would be paid out if the company had already made sure that its reserves were entirely appropriate to deal with all of the uncertainties in the health insurance markets that we're facing, and that those potential benefits would then be paid out into a charitable endeavors at the discretion of the Delaware-based likely-to-be-the-A directors within Delaware.

When this report was written, that was one of the things we were thinking about. We were then superceded by the Department of Justice with a rather more substantial task in terms of potentially attacking the reserves of the company, which, in our view, would not be to the benefit of the current policyholders, nor to the benefit of future policyholders, and nor, actually, to the benefit of the insurance-buying public, which is the vast bulk of the people of

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this state.

So, therefore, we felt that it was appropriate to put into this report the potential for those charitable endeavors being considered, but then to some extent events superseded where we were to come out.

Q. Mr. Smith, can I just clarify? When you say "we," you're talking about Blackstone? Are you talking about Blackstone and the Department of Insurance?

THE WITNESS: I apologize, Your Honor. I sometimes maybe get a little bit too associated with my client. I apologize.

So when I say "we," what I mean, I would define "we" as the Department of Insurance and its legal and financial advisors.

THE HEARING OFFICER: Thank you.

MS. SHOSS: No further questions, Your Honor.

THE HEARING OFFICER: Let me see. I see Mr. Campbell has something.

MR. CAMPBELL: Yes, ma'am.

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CROSS-EXAMINATION

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BY MR. CAMPBELL:

Q. Mr. Smith, I'm Rick Campbell. We've met before. I'm one of the counsel for Highmark. I have just one question for you.

I want to go back to the line of questioning that Ms. Shoss started with which related to the Delaware conversion statute and resulting foundation.

Based upon your knowledge and experience and your review of the Form A filing submitted by Highmark and by Blue Cross Blue Shield Delaware, is the proposed transaction a conversion?

A. The proposed transaction, in my opinion, is not a conversion.

MR. CAMPBELL: Thank you.

MR. TEICHMAN: Your Honor, I have just a few questions.

THE HEARING OFFICER: Okay, Mr. Teichman.

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CROSS-EXAMINATION

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BY MR. TEICHMAN:

Q. Mr. Smith, are you familiar with the triggering events to a disaffiliation?

A. Yes, I am familiar with those triggering events.

Q. Let me go through a couple of those with you.

One of them in the Affiliation Agreement is the insolvency of Highmark, correct?

A. That is correct.

Q. And then the Department has added a number of them as conditions, proposed conditions, correct? One of those would be if Highmark is the subject of delinquency proceedings, correct?

A. That is correct.

Q. And a delinquency proceeding is triggered typically when a company is financially impaired. Is that fair to say?

A. That is fair to say.

Q. Another triggering event is if Highmark's risk-based capital drops to 425, correct?

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A. That is correct.
Q. So is it fair to say that a number of the triggering events that might cause a disaffiliation are centered around a deteriorating financial condition of Highmark?
A. Yes, that is correct.
Q. Now, all else being equal, is a deterioration in Highmark's financial results more or less likely in times of economic downturn, economic distress, bad economic times?
A. It is more likely that we would see Highmark potentially falling into distress in those times.
Q. So, therefore, it's more likely that if BCBSD were forced to disaffiliate, that disaffiliation might occur in bad economic times?
A. That is quite possible, yes.
Q. I think you testified earlier, I think you used the term "credit dislocation," but are you familiar with what happened to BCBSD's surplus in 2008?
A. I am familiar with what happened.
Q. Tell us what happened.
A. BCBSD in 2008, the general reserves of

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BCBSD fell by approximately $40 million as a result of a number of its fixed-income and its equity holdings declining in value.
Q. You heard Mr. Constantine testify that was not 30 percent?
A. I was actually not present for Mr. Constantine's testimony, but that is approximately the right reduction.
Q. Are you familiar with the KPMG report?
A. I am familiar with the report.
Q. Did KPMG do an analysis of the costs that might be involved in a disaffiliation?
A. They did do some work around the costs of a disaffiliation.
Q. I think their range was 35 to 55 million potential costs?
A. Yes. There is some -- I have some debate over the exact numbers of the KPMG disaffiliation costs, and obviously I'd like KPMG to talk about that when they're on the stand.
But I think it's fair to say that there are significant costs in terms of disaffiliation. KPMG identified those as somewhere between 35 and 55 million. I think a

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portion of that cost may actually be on a sort of close reading of that report, a portion of that cost may be reduced by the fact that you don't have to pay Highmark the $21.5 million or so.
But the critical element of that disaffiliation is -- of that disaffiliation cost, be it 35 to 55 million, or be it more like 20 to 30 million, that, effectively, allows BCBSD to remove itself from the Highmark information systems, the Highmark systems, the Highmark management, etcetera, but it does not allow BCBSD to then reaffiliate or get onto another organization's platform or to outsource onto another platform.
Therefore, our view is that that 35 to 55 million, it may be a relatively optimistic number in terms of the total costs of a disaffiliation and, as I testified earlier, we think it would be unlikely, then, that BCBSD would be able to remain independent, and then a reaffiliation or another outsourcing contract with another provider.
Q. So given that this disaffiliation, if it were to occur, of course we hope it never does,

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but if it does occur, it would be more likely to occur in times of severe economic distress. Do you have a sense or can you give us a sense of what kind of stress that would put on BCBSD's surplus when you combine a significant economic downturn like you had in 2008 along with these additional costs that BCBSD is going to have to incur during and after that disaffiliation?
A. Yes. And I have to give some really major caveats because I am -- as I pointed out before, I'm not an actuary and I'm not a systems expert.
But simply doing the math on a potential where the reserves of Blue Cross right now are in the order of $180 million, if we were then to see a similar credit dislocation of the type that we experienced in 2008, this could potentially reduce the reserves of Blue Cross by $40 million, just to use the same dollar number, not the percentage number, but the same dollar number, that result frequented the dislocation in 2008, that would bring one down to reserves of something in the order of $140 million.
If then we see and we take sort of a

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midpoint case of the costs of disaffiliation which KPMG laid out in their report of $45 million, that would take one down to a reserve number of around $95 million.

And, obviously, that is before any consideration has been made of the potential costs of then reaffiliating or outsourcing with a new party, again, which KPMG has at least done some preliminary thinking on those numbers as well.

So the combination in what would be a bad situation, a bad situation, but the only point I would make about bad situations is we had a credit dislocation, it occurred in 2008, just recently. We had a disaffiliation. It occurred in 2002 to 2005. We have had it recently.

So these are not totally unexpected, totally academic outcomes. These are outcomes that we have experienced over the course of the past decade, specifically with regards to Blue Cross Blue Shield of Delaware.

Q. So what I hear you saying is that it's two bad events, disaffiliation during a bad economic downturn. If that happens, BCBSD's

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surplus could be cut in half?

A. That is correct.

MR. TEICHMAN: Thank you. Nothing further.

MR. HOUGHTON: Your Honor, a few questions on redirect.

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REDIRECT EXAMINATION

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BY MR. HOUGHTON:

Q. I'd like to go back for a minute to touch upon the Milliman report, which is, for purposes of the record, Joint Exhibit No. 74, and just ask you again, you made it clear you're not an actuary. I think we all understand that. We sympathize with your lack of actuarial acumen.

But that report is how old?

A. That report was commissioned in 2005.

Q. And your recollection is that it defined the appropriate RBC range as between 950 and 1,200?

A. That is correct.

Q. Next I wanted to touch upon the claims guarantee issue. There was testimony that you

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have given regarding the interface, in your view, between a claims guarantee and risk-based capital issue.

I just wanted to ask you: What happens in the event of a disaffiliation to the use of or the existence of a claims guarantee by Highmark?

A. The claims guarantee would go away at the time of the disaffiliation.

Q. So if there is a circumstance that is a triggering event or some unforeseen basis for undoing the transaction if it is approved, is it fair to assume at that point in time the company's going to be under significant financial pressure as a consequence of disentangling all these arrangements just as we have discussed here this morning?

A. I think it is fair to assume that there could well be some financial pressure on the company.

Q. And at the time when the company would be under possibly significant financial pressure, there is no guarantee to look to, as a basis to support because, as you just testified, it goes

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away in the context of a disaffiliation?

A. That is correct.

Q. I want to touch briefly on cost allocation methodology.

In your experience, and in the examination of information in connection with this particular transaction, is it fair to say that your belief is that the allocation methodology remains appropriate and satisfies the statutory criteria to the extent it's implicated in this hearing?

A. I do believe that allocation methodology is appropriate.

Q. I wanted to go back just for a minute to talk about the West Virginia CPI plus 2 percent.

A. Yes.

Q. If I heard you correctly, you said there were two caps that had been reviewed and considered in connection with the work that was done and examination of the West Virginia situation.

The first cap, did I understand correctly, was the $42 million IT transition cost cap?

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A. Yes. West Virginia obviously had a different dollar number, but that is correct. In other words, there was an IT integration cap and then there was an annual services cap that West Virginia and the Department of Insurance imposed on this transaction between Mountain State and Highmark.
Q. Now, the Consumer Price Index plus 2 on allocation cost, the cap in West Virginia is something, if I heard you correctly, was a number that was considered but not accepted as a course to follow in this particular track, correct?
A. The concept of an annual cap was considered, yes.
Q. And is it your testimony that the tools that are in the toolbox, so to speak, for the Department in this transaction give more detail and a better mechanism for the Department to drill down on anticipated increased costs than just a flat cap might otherwise provide?
A. We believe that the tools that the Department of Insurance has under the proposed affiliation allows them a better set of tools to look at the annual costs, be they rising or, in

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fact, be they falling, whereas, the West Virginia caps allows for -- it's a rather blunter instrument in terms of managing those cost relationships between Highmark and Highmark West Virginia.
Q. To go back for a minute to the calculation of -- which Mr. Teichman, I think, just walked you through, the potential cost of a disaffiliation to BCBSD and the impact on its reserves.
If I heard you correctly, you discussed the technology-related cost of disentangling the affiliation, correct?
A. That is correct.
Q. We talked about what could be the impact of a market shock and the impact on the portfolio of the company.
And I think we talked, also, about the cost of connecting with a new IT provider of some sort because the disentanglement cost did not include the cost of essentially getting back into an IT model that would work. So there's a cost attendant to that last point I just referenced, correct?

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A. That is correct.
Q. Could you go over that again with me as to what the anticipated cost or range of cost might be related to that expense?
A. Yes. So just to review where we were, we talked about the current reserves being approximately $180 million. We talked about a market shock being potentially as much as $40 million if we were just to look at what happened peak to trough in 2008 which would give us revised reserves of $140 million.
We then look at potential disaffiliation, and again, in the KPMG report the numbers were given as 35 to $55 million. We believe that perhaps a portion of that actually is already accounted for in the annual amounts of money that you would not otherwise have to pay to Highmark, of perhaps, 20 or so million dollars.
And therefore, it would be reasonable to say that stripping $20 million out of the 35 to 55 would potentially give you something in the order of 15 to -- 15 to 25 or $30 million. So that would be the potential cost of disaffiliation.

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And then in addition to that cost, there would be a link-up or a reaffiliation cost either with a Blue Cross -- another Blue Cross provider, another provider not in the Blue Cross system, or an outsourcing contract with an information services technology firm, and that could be an additional amount of money over and above the disaffiliation cost that's identified in the KPMG report.
Q. So what is your net range, taking all that into consideration?
A. If we were to look at the after-shock balance sheet reserves of $140 million, if we were to strip out an additional $30 million of disaffiliation cost, in other words, I'm taking a slightly smaller number than the KPMG number, that would give us, after disaffiliation, reserves of $110 million.
And then if we were to link up with a new player, either a Blue Cross Blue Shield provider or a non-Blue Cross Blue Shield health insurance company or an outsourcing contract, this could potentially cost between 30 and $45 million to reaffiliate, very similar to the

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numbers that KPMG and we reviewed in terms of the current affiliation with Highmark.

So we take a rather more cautious approach than Mr. Teichman in terms of a cost of all of those things could lead to a net balance sheet reserve for this company under those three very bad sets of circumstances of 65 to $80 million for Blue Cross Blue Shield of Delaware.

Q. Now, this is, again, a company that has a history of a disaffiliation.

A. Correct.

Q. And in light of that particular history, do you think there should be more attention and concern about these sorts of issues and the cost of disentangling or disaffiliating than you might think would be applicable in other circumstances?

A. I think in any circumstance where we have a -- in the contract there is a potential to disaffiliate and the conditions being laid out where there is a potential to disaffiliate, we are in a most extraordinary environment at the moment, and the shocks that can be delivered both in terms of shocks on the balance sheet of this

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company and on Highmark, the shocks that can be -- that can occur as a result of changes in legislation and healthcare legislation and other legislation would indicate that there is a risk. There is a risk. I cannot quantify that risk, but there is a risk that this company, who was already disaffiliated once, may find it expedient and necessary to disaffiliate in the future.

And, therefore, we want to make sure -- pardon me -- the Department of Insurance and its advisors would want to make sure that there is an appropriate level of cushion inside the reserves of this company to deal with these potential, hopefully low probability, but nevertheless potential risks which could be quite damaging to Blue Cross of Delaware.

Q. Let's apply one more shock mathematically to the process, and that would be to remove $45 million from the reserves of the company. Again, what is the mathematical consequence of removing an additional $45 million at this point?

A. So if we were to look at the net reserves of the company that I just alluded to after the two shocks that we have just talked about of

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65 to 80 million dollars, removing $45 million from the reserves would give a net reserve total of 20 to 35 million dollars.

Q. Would this company be a viable company with reserves of that amount at that point?

A. We think that it would be very difficult to see this as a viable company with reserves as that low. And certainly the possibility or the likelihood of the national Blue Cross Blue Shield Association regranting the Blue Cross Blue Shield marks to a company that was in this financial condition would be questionable.

Q. So in the event that the mark was not granted by the national association, do you have an understanding of mechanically how the mark would be disposed of by the national?

A. No, I don't have a specific understanding of how that mark would be disposed of, but the mark is -- likely that the mark would be granted to another potential holder, another potential franchisee who would then potentially come into the market and begin to build a presence based on the Blue Cross Blue Shield mark.

Q. Presumably an out-of-state qualified

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entity?

A. Which would likely be an out-of-state entity. Likely be an out-of-state entity.

Q. I just had one more brief series of questions which are premised on a quick review of 6311. So I appreciate everyone's indulgence in my getting 6311 up to the witness.

I wanted you to take a look, please, at 6311(b) and read for me the first sentence of 6311(b).

A. "If a health service corporation regulated under this chapter proposes to enter into a transaction in which it will become controlled by another entity, the Insurance Commissioner shall place conditions upon any approval of the change of control intended to preserve that amount determined in accordance with Delaware law that constitutes the surplus or reserves of the health service corporation. Such conditions shall include, without limitation, requiring, 1, the review and approval by the Department of Insurance of any change in the Certificate of Incorporation of the health service corporation; 2, review and approval by

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the Department of Insurance of any individual expenditure or transfer of funds or coordinated series of expenditures or transfers of funds by the health service corporation in excess of $500,000 to the controlling entity or any affiliate of such controlling entity, which review and approval shall assess the commercial reasonableness of the proposed expenditure or transfer."

Q. Let me stop you there, if I can, because I really didn't mean to take you through 1 through 4 at least now.

To the extent that you have read this already and you have an understanding of this provision, is it, like the provisions in Chapter 5003 that you have reviewed, designed to preserve the surplus or reserves of the entity?

A. Yes, I believe that it is designed to do that.

Q. Is there any language that you have read here that relates to a broader public benefit beyond just addressing the preservation of the surplus or reserves?

A. Not in my reading up till the end of

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part 2.

Q. Let me ask you to just go down to part 4 which relates to the ability of the Insurance Commissioner to seek appropriate relief from the Court of Chancery or other courts and ask you to just read from the third line which begins with the words "to prevent" and read the rest of section 4. So it says, "Other courts of appropriate jurisdiction to prevent."

A. -- "to prevent the entity controlling the health service corporation from improperly using the assets of the health service corporation for the benefit of the controlling entity rather than the benefit of the health service corporation and its subscribers or otherwise violating the terms of this section, Chapter 50 of this title, or any agreement between the health service corporation and the controlling entity or affiliate thereof."

Q. So is it fair to say that this language as you've read it and as you construe it is a recognition of the ability of the Insurance Commissioner to attempt to use whatever steps it can appropriately to preserve assets for the benefit of Blue Cross Blue Shield and its

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subscribers?

A. Yes, that is my understanding.

Q. And is that consistent with your earlier testimony about the analysis that was undertaken by Blackstone to do a review of Section 5003 to examine preserving assets for subscribers and for those purchasing insurance?

A. Yes, I believe that it is.

Q. Is there anything that you've seen in Section 6311 as we have read it, and if you care to peruse it further, you can, that relates to a preservation of reserves or assets to meet the state's unmet healthcare needs?

A. I do not believe so, on my reading.

Q. Now you've been involved in a variety of transactions around the country that relate to the sale or disposition or conversion of a not-for-profit to a for-profit; is that correct?

A. That is correct.

Q. And in those contexts have regulators and/or attorneys general been involved in attempting to extract the value of the not-for-profit from the not-for-profit and preserve it for the public when there is a sale

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to a for-profit enterprise?

A. Yes, that is the case.

Q. What is your understanding generally as to why in conversions and sales, when there is a conversion from a not-for-profit to a for-profit that occurs, how does it work? What is the rationale behind it?

A. Effectively, in a change of control including a merger or an acquisition, there is consideration paid by one company, in this instance a for-profit entity, for the operations and the reserves of another company. And that payment, which is the payment made, is then frequently taken by the state or by a public benefit trust or by a public asset fund, that payment is then used for the public benefit as a public benefit asset.

Q. Is that because the not-for-profit is no longer a not-for-profit, large amounts of cash have been exchanged so that an accrued benefit for the public generally is now converted into cash and used for the public good?

A. Yes, that is correct.

Q. You've been through these transactions

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before in other states, New York and elsewhere, and that's the standard -- that's the standard mechanism at the time that there's a conversion from a not-for-profit to a for-profit?

A. Yes, that is correct.

Q. Have you ever in your experience seen a circumstance where, if there is a change of control of a not-for-profit and it is controlled by another not-for-profit, that there has been this sort of extraction of value or conversion of value then used for the public benefit or transferred to some public fund?

A. And I have not -- I am not aware of such an example.

MR. HOUGHTON: No further questions, Your Honor.

MS. SHOSS: I have a few.

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RECROSS-EXAMINATION

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BY MS. SHOSS:

Q. Are you aware of -- just following up on Mr. Houghton's question, are you aware of a change of control of a not-for-profit Blue Cross

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that has the sort of RBC ratio and the sort of surplus, relative surplus, as we are looking at here with Blue Cross of Delaware?

A. The answer is no, I'm not aware of such an affiliation or a transaction of that type involving a not-for-profit with a substantial well-capitalized party.

Q. Turning to the disaster scenarios that we have been walking through. Are you aware of whether Blue Cross has adjusted its investment portfolio strategy to reduce the impact of future market shocks?

A. I think that Blue Cross has noted what happened with the market shocks. One of the problems with market shocks is quite frequently they're different. Each type of shock is a different shock. I think that Blue Cross has probably -- has made -- taken steps to ensure that a complete rerun of the 2008 type of shock, they are better immunized against such a shock in the future. But unfortunately I'm not sure if they are able to ensure that any market shock is one that they could be immune from.

Q. In the event of a disaffiliation, we have

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talked about the unlikelihood of Blue Cross being able to actually go into a stand-alone mode. Do you believe that Blue Cross would have strategic options to align with another partner in this consolidating market?

A. Based on the search process that Blue Cross went through in this last round which ended up with Highmark being the partner, I do believe that there are other potential options for Blue Cross to tie up with another Blue Cross Blue Shield affiliate or potentially another -- go into an outsourcing contract after disaffiliation.

Q. And even considering all these disaster scenarios, and every company has its own set of disaster scenarios I dare say, and I know you're not an actuary, but you are an investment banker, you invest and advise investors, you testified that Blue Cross has the highest RBC of any of the companies that you put on your chart. Are all of the other Blue Cross and other companies severely underreserved given all the catastrophes in our world?

A. No. I think that, again, based on the

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Milliman study and based on the detailed work that they did on this company, I would sort of tend to go back to looking at the suggested RBC ratios that they presented to the Blue Cross board. And I believe that, certainly, under the affiliation case that Highmark and Blue Cross have worked on in terms of projections, the company remains inside those Milliman bands today and will remain inside those Milliman bands under the affiliation case going forward.

So we believe that based on a sort of professional organization of specialists having produced a study that would indicate a range of appropriate RBC ratios, I think that that is clearly the right set of ratios for this company operating in this state.

I'm not able to really comment on whether all of those other organizations who may be more geographically diverse, they may have different market segments that they are serving, whether those RBC ratios are appropriate and whether they also have had an actuarial study to actually recommend the appropriate level of RBC for each of those.

Q. Just to be clear, the Milliman study envisioned a lot of scenarios, but it didn't envision a scenario with a guarantee such as the guarantee that is part of this transaction. Is that correct?
A. That is correct.
Q. Then, in addition, you said you considered community investment but -- reinvestment as a condition, you and your client, but stopped as a result of the AG's entering the process with a different perspective on the community reinvestment.
So your response to you and your client in response to the AG's proposal didn't resolve that there was no community reinvestment proposal that was appropriate anymore?
A. No. I think it was just that we didn't want to have sort of a battle of conditions between conditions that the DOI might have put forward, which would have been very much flexed to the ability of Blue Cross of Delaware to pay any potential monies into a charitable organization for the discretion of the A directors, as opposed to -- so we really didn't

want to get into sort of a competing conditions scenario.
So I think our position was we were going to wait until all the dust settles on all of these conversations and then allow Blue Cross of Delaware to think about the right steps forward. But we have not -- we have not advanced those conversations with regards to potential alternatives to what we had initially been thinking about.
MS. SHOSS: No further questions.
MR. TEICHMAN: I have a couple.
THE HEARING OFFICER: Mr. Teichman?
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RECROSS-EXAMINATION
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BY MR. TEICHMAN:
Q. Mr. Smith, Mr. Houghton asked you about Section 6311, and in one place in 6311, and I'm going to read this to you, it requires that "the Insurance Commissioner shall place conditions on any approval of a change of control intended to preserve that amount determined in accordance with Delaware law that constitutes the surplus or

reserves of the health service corporation." That's Section 6311(b).
So simple question for you, Mr. Smith. If we take whether it be $45 million or $1 from the surplus of BCBSD and put that into a foundation that is intended to serve the unmet healthcare needs of Delawareans so that it's no longer available to pay claims or otherwise be available for the obligations of BCBSD, can we consider that amount still to be part of the surplus or reserves of the company?
A. We could not consider that amount to then be part of the reserves or surplus of the company.
Q. Now, Ms. Shoss asked you a little bit about the company affiliation options or reaffiliation options in the event that what Ms. Shoss described as the disaster scenario. Coming out of that disaster scenario where we have a shock to BCBSD's surplus, we have a significant amount of money having to be expended to disentangle from Highmark, it is fair to say, and I think you testified, that the company will be under at least some financial stress at that

point? Is that fair?
A. I think the company will certainly be under more financial stress than it would be without these shocks, yes.
Q. Is it also fair to say that in that condition the company would not have the same negotiating leverage with another affiliation partner as it does, for instance, today when the company is well-capitalized?
A. It is possible that the company will have less negotiating leverage both with respective partners, as well as with the national Blue Cross Blue Shield Association.
Q. So that being the case, it's possible the company would not be able to get a deal with the same terms it has now?
A. That is possible.
Q. One other question. When we talk about -- when we compare risk-based capital of this company or that company, risk-based capital is influenced by a number of things, right? Asset mix and business mix principally, right?
A. That is correct.
Q. So is it always an apples-to-apples

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comparison when you take one Blue plan's risk-based capital and you compare it to another Blue plan's risk-based capital?

A. No. The risk-based capital calculations are, to some extent, a summary, a very quick and brief summary, of a company's standing and its ability to pay claims based on its business mix, its geography, and its asset mix.

So it is sort of a shorthand method of being able to at least begin to compare Blue Cross Blue Shield or other insurance companies across different states or different geographies.

Having said that, it is only one metric and it is not a fail-safe metric, and, therefore, it's not always the case that you can look at a risk-based capital ratio for one company and immediately be able to compare it on a pure apples-to-apples basis. It is an attempt to do that, but it is not fail-safe.

MR. TEICHMAN: Thank you. One minute, Your Honor.

Nothing further, Your Honor. Thank you.

THE HEARING OFFICER: Thank you.

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Sorry. Did you indicate you had a question?

MR. HOUGHTON: I do. And I promise to be quick, but I want to refer the witness to the Blackstone report on page 59 and then I'm going to ask you to turn to page 62.

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REDIRECT EXAMINATION

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BY MR. HOUGHTON:

Q. On page 59 of your report there is, in fact, a listing at the bottom of page 59 of Blue Cross Blue Shield and its risk-based capital ratio at the very bottom. You see that there?

A. I do.

Q. Can you read the caption of the column at the very far left? There's a series of columns. And BCBSD is listed at the bottom, but what's the caption at the top beneath which there are a series of companies listed?

A. "Publicly traded companies."

Q. Publicly traded companies. Is BCBSD a publicly traded company?

A. It is not.

Q. So this is a comparison -- well, it is a

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listing of BCBSD at the bottom as a point of information compared to a variety of publicly traded companies who have risk-based capital levels which are significantly lower. Correct?

A. That is correct.

Q. But these are much larger companies?

A. There are two observations, actually. One is these are generally larger companies and, in fact, they're all larger companies. And secondly, they are publicly traded companies. As publicly traded companies, they have at least, as a general rule, access to the capital markets to be able to raise additional equity or additional debt to be able to fund their operations and to pay claims. Obviously those are elements which are not available to all or less available, I would say, to privately owned or not-for-profit companies.

Q. I think I have it correct. This is the page the Department of Justice referred to before, I believe. It was page 59.

I'd like you -- so you would not view this as an apples-to-apples comparison between these publicly traded companies with access to

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the capital markets and the listing of BCBSD and their RBC to the extent it is a comparison?

A. I would indicate that this is a comparison based on publicly available information. It is often very much easier to be able to obtain RBC ratios of public companies because those are more readily available. It is often more difficult to receive and to obtain RBC ratios for privately owned companies.

So this is a -- not a perfect -- in fact, it's a little imperfect as an apples-to-apples comparison.

Q. Let's turn to page 62 where I think the apples look more like apples and compare better.

If we look at the bottom of page 62, there is a caption, correct, that says "Nonpublicly Traded Comparable Companies"?

A. That is correct.

Q. Those are a series of -- it looks to me like nonpublic Blue's plans; is that correct?

A. That is correct.

Q. Can we go to the far right-hand column which has a listing of the RBC ratios of various companies? Now, Blue Cross Blue Shield is the

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last listed company with 1,056, correct?
A. That is correct.
Q. How many other companies in this listing of companies have RBC levels that are higher than Blue Cross Blue Shield?
A. There are three other companies on the list.
Q. Could you read for those three that are higher what their RBC numbers are?
A. Yes. Capital Health Plan has an RBC of 1,307 percent; HMO Louisiana, Inc., has a RBC ratio of 1,393 percent; and Health Options, Inc., has a RBC ratio of 1,284 percent.
Just to clarify, these are not all Blue Cross Blue Shield affiliates.
Q. I see.
A. They're a lot smaller companies. But they are nonpublicly traded.
Q. Nonpublicly traded?
A. They do not have the same access to the capital markets.
MS. POLIZOTI: One second, Your Honor, please.
BY MR. HOUGHTON:

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Q. Let's look quickly at the column which is captioned "Total Assets" within that grouping. Do you see that column?
A. I do.
Q. Now, under total assets it ranks, if I read this correctly, BCBSD is 349 million. And it has an RBC of 1,056. Could you tell me what the total assets are of both Capital Health Plan and HMO Louisiana, Inc., as well as their RBC ratios?
A. So Capital Health Plan has total assets of 352 million, RBC of 1,307. And the second company -- would you like me to mention the one from HMO Louisiana, Inc.?
Q. Yes?
A. That's 342 million of assets, total assets, and an RBC ratio of 1,393 percent.
Q. So both of those have RBC ratios that are somewhere between 250 and 300 percentage points higher with comparable total assets, correct, that is higher than BCBSD with comparable total assets?
A. That is correct.
MR. HOUGHTON: Thank you. No further

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questions.
THE HEARING OFFICER: Anything further?
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EXAMINATION
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BY THE HEARING OFFICER:
Q. Mr. Smith, could I just ask you a couple of questions?
Have you had experience with a disaffiliation in the healthcare area other than what you know about the disaffiliation with Blue Cross and CareFirst?
A. No, other than the fact that Blackstone and I, personally, represented CareFirst of Maryland in the WellPoint -- the failed WellPoint acquisition of the CareFirst group. And so we had some understanding of Blue Cross Blue Shield of Delaware being an affiliate of that -- of CareFirst of Maryland.
But other than that, I have not had experience of a disaffiliation in the Blue Cross Blue Shield context in my experience.
Q. From your general experience and

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knowledge of this area, would you say that a disaffiliation is more likely to occur during the first few years of the affiliation?
A. Not necessarily, because I think that a disaffiliation may often occur because of a change in direction of the -- of the controlling party, and that may occur for a whole host of reasons, not necessarily to do with the controlled party and its own strategic directions.
So in other words, a disaffiliation won't necessarily occur because the controlled affiliate has decided they don't want to be an affiliate anymore. It is more likely to occur because the controlling party, in this instance Highmark, may decide to go down a different path, may decide to convert itself, or may, in fact, become insolvent or have troubles of its own.
Q. And you also testified that Blue Cross had taken steps to be sure it's better immunized in case of a disaffiliation.
Do you know whether that would have included setting aside in an escrow account or a special account any sum of money to tide it

through a disaffiliation?
A. No, I'm not aware of any establishment of any sort of separate account to be able to -- that has been set up in any way to tide it through a potential disaffiliation.
THE HEARING OFFICER: Thank you. I have no further questions. You're excused.
It's nice to have someone else with an accent speaking, speaking in the hearing room.
I think we best break for lunch now.
MR. HOUGHTON: I think that makes sense.
THE HEARING OFFICER: Do you think if we come back at 1:30 that would give you time, Mr. Houghton?
MR. HOUGHTON: I think if we come back at 1:30, that should give me time through the rest of the day. That's three and a half hours. I think so.
THE HEARING OFFICER: Just to be sure everybody has time to eat today. I'm not sure they had time yesterday. Thank you.
(Lunch recess taken at 12:10 p.m.)
(Hearing resumed at 1:30 p.m.)

THE HEARING OFFICER:
MS. POLIZOTI: Your Honor, the Department of Insurance would like to call Mr. Kenneth Jackson, please.
THE HEARING OFFICER: Mr. Jackson, would you step forward, please, and be sworn in?
KENNETH JACKSON,
the witness herein, having first been duly sworn on oath, was examined and testified as follows:
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DIRECT EXAMINATION
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BY MS. POLIZOTI:
Q. Good afternoon, Mr. Jackson.
A. Good afternoon.
Q. Could you please introduce yourself?
A. My name is Kenneth Jackson. I'm a senior director at KPMG LLP in the transactions and restructuring advisory practice, and a member of the strategic services group where I focus on information technology due diligence, merger integration and divestitures as part of the mergers and acquisition information technology

team. I will refer to information technology as "IT."
Q. Please give us a brief overview of your educational and professional background.
A. I have a Bachelor's degree in electrical engineering from Cornell University and a Master's in Business Administration from Columbia University.
Previously I have held IT management consulting and professional services positions at leading consultancies, hardware and software companies, and outsourcing firms, such as Oracle Corporation, Hewlett-Packard Company and Cognizant Technology Solutions.
Q. Please describe the circumstances that led up to KPMG's retention in this matter.
A. KPMG was approached by the Delaware Department of Insurance earlier this year to assist in the Department's review of the proposed affiliation between BCBSD, which I will refer to as "Blue Cross," and Highmark.
Q. When was KPMG retained?
A. June 2011.
Q. Has KPMG done any prior work for Blue

Cross?
A. No. The conflict check KPMG ran in June before the engagement was accepted did not identify KPMG as having provided any prior work for Blue Cross.
Q. Has KPMG done any prior work for Highmark?
A. Yes. We have performed several state and local tax engagements, plus one or more pharmaceutical benefits manager or PBM audits. This work does not substantially -- or substantively relate to any of the issues in the present matter.
Q. Has KPMG done any prior work for the Delaware Department of Insurance?
A. Yes. KPMG serves as the external auditor for the State of Delaware and the Department of Insurance does fall within the audit.
Q. Is KPMG's analysis in connection with the Department's review of the proposed affiliation unbiased and independent?
A. Yes.
Q. What was the scope of your work?
A. As part of the rationale for the proposed

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affiliation between Blue Cross and Highmark, Blue Cross stated that there are certain aspects of its information technology capabilities that must be addressed if Blue Cross is to meet government mandates and remain competitive in the Delaware market. We were retained to do four things.

First, to assess Blue Cross's information technology needs by reading and commenting on a report prepared by Deloitte for Blue Cross concerning Blue Cross's information technology needs, which is Joint Exhibit 47. And the 2011 supplement to which is Joint Exhibit 48.

Second, to consider Blue Cross's potential options in addressing these needs.

Third, to consider and comment on costs or other issues that may arise in the event that Highmark and Blue Cross were to affiliate and then later disaffiliate.

Finally, KPMG also considered and commented on Blue Cross's assertions that the affiliation needed to be approved by December 2011 or else Blue Cross would have difficulty meeting the government mandates that I referenced a moment ago.

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Q. You mentioned information technology capabilities. Can you explain what that means?

A. Information technology goes to the heart of what Blue Cross does. Almost all of the services provided by Blue Cross run off of Blue Cross's IT platform. Blue Cross's IT capabilities can, therefore, affect the company's ability to perform current processes more efficiently and to address new services required to compete with other providers in its market.

In addition, IT upgrades may substantively improve the quality of service Blue Cross is able to provide. For example, by implementing a CRM, or customer relationship management system, Blue Cross may be able to better understand its customer segments and their specific needs.

This may help Blue Cross create higher-value products that are more attractive to various types of customers, thereby supporting an increase in or retention of its policyholders.

Another example where Blue Cross might be able to add value to its policyholders is by implementing a provider profiling system

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with paid-for performance capabilities.

This system could allow customers to identify and compare the high-performing and cost-effective providers in the marketplace and, thus, allow for potentially reduced medical costs for both Blue Cross and its customers.

Q. You had also mentioned that there are certain governmental mandates that Blue Cross must address. What are those governmental mandates?

A. I'll speak to two in particular on which we focus as part of our engagement.

The first is known as ICD-10. ICD-10, or ICD, rather, stands for International Classification of Diseases. The ICD system is a coding system developed by the World Health Organization and is a system to classify diseases that is used in more than 100 countries.

The standardized codes are used by, among others, healthcare providers and payors in connection with insurance claims, reimbursements. For example, a health insurance provider would use ICD codes to standardize the way it bills for its services and to help ensure the accuracy of

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payments made by the insurance companies.

The United States is presently the only developed country that operates under ICD-9, the coding scheme that predates ICD-10. The U.S. government has required a move to ICD-10 which must be completed by October 1st, 2013.

For a health insurance company, a switch from ICD-9 to ICD-10 can be both costly and time-consuming. The goal is to improve healthcare and to help the U.S. healthcare system gather and share data more accurately in diagnosing and treating diseases.

The second government mandate is known as HIPAA 5010. HIPAA is the Health Insurance Portability and Accountability Act which regulates the electronic exchange of health data. The intent of HIPAA is to protect health insurance clients, reduce fraud, and set standards regarding the transmittal of private information.

The current HIPAA standard is HIPAA 4010. The U.S. government has required a move to HIPAA 5010 with a compliance deadline of January 1st, 2012. All health insurance companies must comply with both the ICD-10 and HIPAA 5010 mandates. Many companies have been preparing for quite sometime, in some cases for years, to implement this transition.

Q. What happens if Blue Cross does not become ICD-10 compliant by the deadline?

A. Codes from ICD-9 will no longer be accepted for claims reimbursement as of October 1st, 2013, so any company that is not ICD-10 compliant by then will likely lose the ability to, for example, bill for their services or submit claims.

The conversion to ICD-10 codes affects most of Blue Cross's existing IT applications, including those for adjudicating claims, managing medical cases, contracting with providers, billing customers, and paying providers. Thus, timely ICD-10 compliance is very important for Blue Cross to ensure smooth business operations.

Q. Can you please give a brief summary of the work you performed in this matter?

A. In short, we considered Blue Cross's information technology needs and potential

options for Blue Cross to address those needs.

First, we considered the stand-alone option whereby Blue Cross will address its IT needs as a separate, nonaffiliated entity through investment in its IT infrastructure. In this analysis, we considered the feasibility of a report that was created by Deloitte at the request of Blue Cross to estimate the needs and costs of a stand-alone upgrade.

We also provided options to consider in addition to Deloitte's recommendations regarding Blue Cross's stand-alone operations.

Second, we considered an option involving Blue Cross's entrance into a long-term outsourcing agreement whereby Blue Cross might be able to address its IT needs on a contractual basis through outsourcing with a third party.

Third, we considered the proposed affiliation with Highmark.

Finally, in addition to our own analysis of the proposed affiliation from an IT perspective, we also considered potential impact if the affiliation is not approved by December 31st, 2011, as well as the potential

cost if Blue Cross disaffiliates from Highmark in the future.

Q. Before we go through these specific scenarios, can you describe the approach that you took in considering these scenarios?

A. We took a hands-on approach within the scope of our engagements as an IT advisor. We interviewed key Blue Cross executives and managers, we met with Deloitte, the company that performed a prior assessment of Blue Cross's IT needs, and we met with Highmark to understand its capabilities and plans.

We also collected and considered data from Blue Cross and Highmark on their current IT systems and their IT strategies, plans, and estimates going forward, including how Highmark plans to achieve compliance with the ICD-10 and HIPAA 5010 mandates, in addition to considering the ongoing affiliation plans, roadmaps and models created by Blue Cross and Highmark.

Q. There's a binder in front of you that's titled "Advisors' Reports." Can you just turn to tab 2 of that binder and identify that document?

A. This is the Project Delaware report

developed by KPMG.

Q. Does this report contain KPMG's analyses and conclusions regarding the matters it was asked to consider?

A. Yes.

Q. If you could turn to slides 11 and 12 of this report, can you please describe what's shown on slides 11 and 12?

A. Slides 11 and 12 contain a summary of the business strategy options that I outlined previously.

Q. Let's turn to the first scenario, the stand-alone scenario. What were KPMG's conclusions with respect to the stand-alone scenario starting with the potential costs of such a scenario?

A. We began by considering the conclusions of Deloitte. Deloitte was hired by Blue Cross in 2008 to assess Blue Cross's IT capabilities and recommend solutions to close what we call capabilities gaps which are areas that Blue Cross needs to upgrade in order to remain competitive in the marketplace and compliant with government mandates.

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We also considered Deloitte's updated analysis from late 2010. At that time it was important for Blue Cross to have an understanding of its capabilities gaps and the potential costs of closing those gaps as Blue Cross was evaluating its strategic options going forward.

Q. Did KPMG agree with Deloitte's capabilities gaps and cost estimates?

A. Yes, we generally agreed with the capability gaps and solutions set forth by Deloitte, as well as the costs to address Blue Cross's capability gaps which were estimated by Deloitte to cost between 88 million to $140 million for Blue Cross to upgrade its IT systems on its own.

Deloitte also estimated annual costs of over $21 million in 2012 which would increase each year to over $34 million per year beginning in 2016.

Q. On what did KPMG base its conclusions regarding Deloitte's findings?

A. We reviewed documents created by Deloitte, including the 2008 Deloitte report, which is Joint Exhibit 47, and its 2010 update to

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that report, which is Joint Exhibit 48.

Q. Did KPMG offer additional recommendations based on its review of Blue Cross's IT needs and potential solutions?

A. Yes. Based on the procedures we performed and assumptions regarding market trends and the impact of healthcare reform and other government mandates, we believe there are some things that Blue Cross must do to remain competitive in Delaware if Blue Cross remains a stand-alone entity.

These additional potential capabilities may include the development of private exchanges that provide a defined contribution arrangement for their customers and retail initiatives that can allow Blue Cross to understand, attract, and retain individual customers through various channels, such as online marketing and member letters.

Q. Did KPMG reach some conclusions that were different from Deloitte's findings?

A. Yes. Deloitte recommended that Blue Cross perform full remediation which involves a complete upgrade and/or replacement of all

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impacted IT applications to meet the new ICD-10 coding structure.

This approach may also require a significant reengineering of the existing business processes supported by these applications in order to meet the October 2013 ICD-10 deadline.

In KPMG's view, however, because Blue Cross has not yet begun any substantial ICD-10 remediation work, it may be very difficult for Blue Cross to perform full ICD-10 remediation within the remaining time to meet published deadlines. Therefore, KPMG outlined an option whereby Blue Cross would consider an ICD-10 neutralization approach.

This involves adding conversion maps, ICD-9 to ICD-10, and vice versa, around existing ICD-9 systems to help insulate them from the need to address ICD-10 code formats. This approach may allow existing systems and business processes to remain largely unchanged.

Neutralization may be a less expensive and quicker option for Blue Cross to become ICD-10 compliant. Given facts and

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circumstances associated with time constraints for compliance, this may be the only realistic alternative. However, neutralization may prevent Blue Cross from realizing certain benefits of ICD-10. These include the potential for a greater specificity in clinical documentation, more precise business intelligence to measure and improve resource utilization and patient safety, and the ability to reduce the number of miscoded claims that result from the ambiguity of the ICD-9 codes.

In addition, there are other IT areas that KPMG believes Blue Cross may need to address in order to remain competitive in the Delaware market.

For example, Blue Cross may wish to consider hiring a team to lead the execution of its IT upgrades. Blue Cross may also wish to consider offering certain services such as a private exchange whereby employers allow employees to choose how to allocate healthcare dollars among a variety of health plans and services. Private exchanges are becoming increasingly popular in the marketplace.

Q. Did these different recommendations that KPMG had increase or decrease the cost of the stand-alone option?

A. One of the options outlined for Blue Cross's consideration decreased the cost, but overall the estimated cost range decreased.

Specifically ICD-10 neutralization may be approximately one-third the cost of full remediation. The remaining recommendations for maintaining Blue Cross's competitive position in the marketplace, however, were not addressed by Deloitte and, therefore, may add costs above and beyond those estimated by Deloitte.

Q. What is the estimated overall impact on the one-time cost range in KPMG's report?

A. We estimated that the one-time cost would be $93 million to $150 million compared to the $88 million to $140 million estimated by Deloitte. Due to the scope of our engagement, we did not estimate the increased annual costs. We do believe, however, that Deloitte's estimated annual costs -- which rise from $20 million annually to more than $34 million annually -- appear reasonable.

Q. What are the potential benefits of the stand-alone option to Blue Cross?

A. The main benefit is that Blue Cross would remain self-reliant. The stand-alone option would allow Blue Cross to upgrade its IT systems to become compliant with government mandates, while at the same time improving it's IT capabilities to remain competitive in the Delaware market, all without affiliating or entering into complex contractual relationships with another entity.

An additional benefit, at least as compared to the affiliation and outsourcing options, is that the stand-alone option eliminates any concerns about the future disentanglement or disaffiliation from another company.

Q. What are the potential risks for the stand-alone option?

A. There are a number of potential risks. First, in addition to what may be substantial costs of the stand-alone option, this type of IT upgrade can be highly complex and it's inherently risky. These risks could materially increase the

level of costs of the transformation to the new technology, as well as delay the expected implementation of the overall project.

To complicate matters, the current Blue Cross IT organization has not had experience in delivering such a complex multi-year transformation project.

In addition, although the stand-alone option would allow Blue Cross to become compliant with government mandates and remain competitive from a purely IT perspective, it still would not fully address the other areas of weakness identified in Deloitte's assessments, including IT strategy and planning capabilities, program and process management, and resource management capabilities.

Similarly, the stand-alone option may also prevent Blue Cross from realizing the economies of scale it may realize through affiliating with a larger entity, which may increase Blue Cross's ability to compete with much larger competitors.

I also understand that the stand-alone plan may not be consistent with the

strategic priorities of Blue Cross as explained further in the Blackstone report.

Q. Let's move from scenario one, the stand-alone option, to scenario two, the long-term outsourcing arrangement.

What are KPMG's conclusions regarding the option of Blue Cross to enter into a long-term outsourcing arrangement? And let's start with the cost of such an arrangement.

A. Based on the level of preliminary analysis we were able to perform within the scope of our engagement, the results of our work suggests that such a long-term contractual arrangement would cost between 30 and $45 million up-front, with estimated annual costs of between 30 and $60 million. We believe that there could be additional one-time setup costs, although we were unable to obtain precise estimates.

Q. How did KPMG derive its estimated annual costs for the outsourcing option?

A. Our estimates were based on information that KPMG obtained through conversations with IT representatives from several health plans that have contracted for outsourcing services of the

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type needed by Blue Cross.
Q. Your report describes this as the business process and information technology outsourcing option. Can you describe those two components?
A. Business process outsourcing involves the outsourcing of various back-office and administrative functions or processes such as enrollment in claims adjudication to a third party who typically represents themselves as capable of performing the work more efficiently and at a lower cost.
IT outsourcing involves contacting with a third party to provide day-to-day operation support such as IT operation program management, examples being development, maintenance and support, and IT computer services, examples being data center operations, telecom, server and storage hosting and management support.
Lower costs can be achieved through economies of scale, typically, as well as benefits from labor arbitrage benefits, and improved processes and/or technology capabilities

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and solutions can be achieved.
The outsourcing option can also allow companies to realize cost savings and can provide access to new technology and other benefits.
Q. What are some of the other potential benefits of the outsourcing option?
A. This option may allow Blue Cross to outsource certain of its functions and business processes to vendors who may be able to perform them better, faster, and cheaper. These vendors may possess more comprehensive subject matter expertise and may be more current on leading practices in the industry, thus allowing them to potentially provide access to improved business processes and support capabilities.
In addition, as compared to the affiliation option, potential future disentanglement could be less complex and less costly because of a lesser degree of integration between Blue Cross and a third party.
Q. What are the risks to Blue Cross of the outsourcing option?
A. There is a risk that Blue Cross might have difficulty finding an appropriate

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outsourcing provider. With the upcoming government deadline, demand for outsourcing providers may increase as other companies seek outsourcing to meet government mandates. This increased demand could decrease Blue Cross's leverage to negotiate favorable pricing terms. It may also be difficult for Blue Cross to find a good cultural match with a third-party outsourcer.
Further, similar to the stand-alone option, Blue Cross also appears to currently lack the experience and expertise in managing a such a long term contractual relationship, particularly if the outsourcing option requires Blue Cross to outsource with multiple companies to get all of the services it needs.
Finally, even if Blue Cross found a suitable outsourcing partner, given the upcoming ICD-10 compliance deadline, Blue Cross may have to incur $3 million to $5 million in throw-away costs, meaning costs it would have to incur for no other purpose than meeting a deadline and costs that will not otherwise benefit Blue Cross in the long-term to become compliant before it is

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able to migrate to the systems of the outsourcer that it would partner with.
In addition, many of the business processes that Deloitte identified are not necessarily good candidates for outsourcing. For example, we looked at the 70 affiliation integration projects currently underway between Highmark and Blue Cross, and our experience suggests that over half of the projects may not best be delivered through outsourcing.
Many of the projects that address corporate communications and strategic planning, examples being branding strategy and market launch initiatives, may not represent good options for outsourcing since they are short-term initiatives that involve strategic decision-making by key business stakeholders. Conversely, back office projects that involve more tactically oriented work, such as programming, an example being the customer service application system changes, or the membership enrollment application system changes, can often be good candidates for outsourcing since they involve long-term implementation that

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can be staffed with lower cost resources.
Q. What are KPMG's overall views of the outsourcing option as it relates to Blue Cross's goals and ability to implement that arrangement?
A. As with the stand-alone option, it is my understanding that the outsourcing option does not meet the strategic goals of the Blue Cross board of directors.
In addition, while the outsourcing arrangement may improve access to process and technology expertise, Blue Cross may not be able to benefit from the full range of other capabilities from its partner, including economies of scale and back-end or centralized support.
In addition, Blue Cross may have difficulty implementing the outsourcing option given the time constraints imposed by government mandates and Blue Cross's potential need to manage a complex process with one or more vendors to handle all of its outsourcing needs.
Q. Now let's move to the third scenario that you had initially identified, the affiliation between Blue Cross and Highmark.

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What are KPMG's conclusions regarding the proposed affiliation between Blue Cross and Highmark? Again, let's start with the costs of such an affiliation.
A. From a cost perspective, Blue Cross and Highmark estimate that Blue Cross's transition to Highmark's systems would cost between 35 and $37 million as a one-time cost, with annual costs with services that Highmark would provide under the Administrative Services Agreement estimated at between 21 million and $23 million.
Q. Does KPMG have a view as to the reasonableness of these estimated costs, and if so, what is that view?
A. Yes. Based on our review of affiliation planning documentation, and based on our experience in working on integration projects of similar scope and complexity, we believe that the estimated range of costs is reasonable.
In addition, I understand that the Department of Insurance has proposed a condition of placing a cap of $42 million on the costs of the integration, which is reflected is proposed condition 17. The estimated annual charges of

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$23 million also appear reasonable.
Q. Let's talk about those annual charges for a moment. Where do they come from, and what do they represent?
A. These charges represent both business-as-usual charges, which includes the costs of the day-to-day operations based generally on Blue Cross's transaction volumes. The charges will also include Blue Cross's share of the expense of Highmark's legacy modernization project. Blue Cross may derive substantial benefits from Highmark's upgrade, such as new systems capabilities, and Blue Cross will, in turn, pay for its share of the cost of the upgrade.
Pursuant to the Administrative Services Agreement, these charges are allocated by Highmark at cost. In other words, under the agreement, Blue Cross will pay for its fair and reasonable share of the total cost of services being provided without provision for profit to Highmark in providing the services.
Q. Is such an arrangement, meaning the provision of IT integration at cost without

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profit -- common in the industry.
A. Yes. Where there is an affiliation, like the one proposed with Highmark and Blue Cross, it is not unusual for the entity in Highmark's position to charge costs only, with no markup.
Q. Did KPMG review the manner in which Highmark has agreed that it will allocate costs to Blue Cross and whether there's the potential for Highmark to overcharge Blue Cross?
A. Highmark states that it will charge Blue Cross for its allocable share of resources and services consumed based on transaction volumes, project-related costs, and other factors.
In an affiliation, it should be in the interest of both parties for Blue Cross to maintain its ability to compete in the marketplace with competitive administration fees in addition to consumer-directed healthcare products and services.
This alignment of interest should hopefully decrease any motivation for Highmark to enrich itself to the detriment of Blue Cross, but our engagement did not include a review of any process system or governance controls associated

with avoiding this scenario.

Further, I understand that the Department of Insurance has proposed a number of conditions related to cost allocation, and that such companies are memorialized as proposed conditions 9 through 14. These conditions as drafted appear reasonable and should provide the Department of Insurance the opportunity to identify issues relating to cost allocation and a mechanism to address these concerns.

Q. What documents did KPMG review in reviewing the cost of the affiliation?

A. A number of documents, including the Administrative Services Agreement, plus a number of affiliation documents from Blue Cross and Highmark such as the Blue Cross/Highmark Planning Overview, which is Joint Exhibit 8.

Q. What are KPMG's views as to the feasibility of the proposed affiliation with Highmark?

A. Based on our review of the affiliation planning process and the work completed to date, the integration effort appears to be on strong footing and the affiliation appears to be a

feasible solution for Blue Cross's needs, including allowing Blue Cross to meet the ICD-10 and HIPAA 5010 guidelines.

The affiliation plan also appears well suited to address the needs of Blue Cross. The current plan will address each capability concern raised in the 2008 Deloitte report, and will also provide an additional 42 capabilities to Blue Cross. These capabilities include, for example, market leading actuarial, pricing and direct marketing processes, product offerings for dental and vision, consumerism and retail marketing capabilities, and informatics capabilities in data management, reporting and analytics.

Q. What are the potential benefits from a technology perspective to Blue Cross affiliating with Highmark?

A. Blue Cross will be able to benefit from the economies of scale including lower costs that should be realized through the affiliation.

In addition, Highmark is offering a low-cost structure for Blue Cross to migrate on to its IT systems.

For example, as I discussed earlier, the administrative services will be provided by Highmark at cost with no provision for profit to Highmark.

In addition, Highmark has made a material commitment to its IT capabilities and, as a result, Blue Cross may gain significant benefits in all areas of its operations. Highmark was ranked third in the nation's top 500 innovators of IT, and has invested approximately $400 million in IT capabilities in the past three years. Highmark's commitment to IT allows it to offer state-of-the-art technology and systems to meet the evolving needs of its customers, including Blue Cross's customer base.

Further, Highmark appears to already be well on track to meet government mandates. For example, Highmark has indicated that it is already 5010-compliant and is scheduled to be ICD-10 compliant well before the 2013 deadline in October.

Because Blue Cross is currently contracting with Highmark for its small subset of services that Highmark would provide under the

Administrative Services Agreement such as electronic data, exchange services, Blue Cross is already HIPAA 5010 compliant through its use of Highmark's platform, and Blue Cross should be better positioned to be ICD-10 compliant by the government deadline.

Q. Did KPMG consider the likelihood of success of the affiliation effort?

A. Yes. The experience Highmark has gained through a history of what appears to be successful affiliations and system migrations should help mitigate the risk of an unsuccessful affiliation.

We also considered the in-depth affiliation integration planning approach undertaken by the Blue Cross and Highmark affiliation planning teams which evolved over ten months of effort to identify and scope required projects, and continually assess and re-assess assumptions and cost estimates throughout the planning process.

In addition, Highmark has up to 18 arrangements with other health plans whereby Highmark offers a variety of services, including

back-office functions. This gives Highmark experience in running multiple businesses on a single technology platform, which may result in significant cost savings. This experience in cost savings may improve the chances of a successful affiliation with Blue Cross.
Q. What are the risks from a technology perspective of the proposed affiliation with Highmark?
A. A potential risk is the cost allocation that I mentioned previously, although, as I stated, the Department has proposed reasonable conditions that should allow the Department the opportunity and mechanism to address any cost allocation issues.
In addition, one risk is that, as a relatively small affiliating company, Blue Cross may not receive adequate support for its service requests along the integration of the two companies or during the integration of the two companies.
Throughout the affiliation, Blue Cross will need to work with Highmark and its other affiliates and partners to ensure that its

strategies in other projects are funded and executed.
One potential way to mitigate the risk is for Highmark and Blue Cross to execute a service level agreement which establish the target service levels and standards of performance by which Highmark will be measured during the affiliation.
Further, ongoing reporting of service level performance to a regulatory agency could help performance targets to be met and avoid other problems with performance. I understand that the Department of Insurance has proposed a condition, memorialized as proposed condition No. 16, that relates to service levels and reporting.
Q. Did KPMG analyze the risks of a delayed affiliation? In other words, what are the risks if the affiliation is not approved before December 31st, 2011?
A. Yes. The work we performed suggests that delays in affiliation approval may increase the risk and costs for Blue Cross to ensure that it's systems are ICD-10 compliant by the government

deadline. Delay may mean that outsourcing is not a feasible option because Blue Cross may not have sufficient time to migrate to a new software platform prior to the government deadlines. Delay may leave ICD-10 neutralization as the only option and could also mean that Blue Cross may have to incur throw-away costs just to ensure its systems are compliant. These costs would range from three million to $5 million.
Q. Did KPMG analyze the implication of Blue Cross disaffiliating from Highmark at some point in the future? And if so, what was KPMG's conclusion?
A. We did. Much of the analysis depends on how long Blue Cross and Highmark have been affiliated at the time they disaffiliate, and on the operational breadth and depth of that affiliation.
In other words, the greater the business processes and data of the two companies are integrated and dependent on one another, the greater the complexity of IT separation.
Q. I'm sorry. Can I interrupt you one second? Can you just repeat that last answer?

Maybe start at the beginning.
A. We did. Much of the analysis depends on how long Blue Cross and Highmark had been affiliated at the time they disaffiliate and on the operational breadth and depth of that affiliation.
In other words, the greater the business processes and data of the two companies are integrated and dependent on one another, the greater the complexity of IT separation. We estimate that disaffiliation effort will mirror the affiliation effort, and that disaffiliation could require two to three years.
Disaffiliation costs will exceed the affiliation integration costs. Based on current estimated -- based on the current estimated $17 million annual cost that Highmark plans to charge Blue Cross for use of its technology platform, a two- to three-year disaffiliation period will involve costs ranging from 38 million to $55 million.
This cost range reflects the current terms of the administration --- or Administrative Services Agreement which provides that upon

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disaffiliation, Highmark will provide transition services to Blue Cross for a period of two years at cost plus 8 percent.

Because of the expected length of time it will take for Blue Cross to disaffiliate, and the potential complexity of such an affiliation, it may be appropriate for these terms to be modified such as providing for a longer period of transition services at a different cost structure.

I understand that the Department of Insurance has proposed conditions relating to these terms which are reflected as proposed condition No. 18.

MS. POLIZOTI: Thank you, Mr. Jackson. No further questions.

MR. CAMPBELL: No questions, Your Honor.

MR. TEICHMAN: No questions.

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CROSS-EXAMINATION

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BY MS. SHOSS:

Q. Mr. Jackson, I'd like your perspective on

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the question that we asked Mr. Alderson-Smith this morning.

Is stand-alone after a disaffiliation that occurs, say, five years or more after affiliation really likely to be an option for this company?

A. It is probably the most costly and riskiest option of those available, and would probably be the least feasible. There are a number of reasons for that.

One, it would take significant resources, time and investment, of course, to reach stand-alone capabilities, and the Delaware IT resource pool is small at this point, 22 people or so, part of that team, and there's going to be a lot of work that would need to be done in order to make that migration to stand-alone operation.

So it would be very complex, very risky, and probably the least likely scenario.

Q. And would outsourcing really be an option at that point, five years, ten years out? Because you do talk about how much more complicated disaffiliation becomes.

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A. Outsourcing would be a reasonable option to pursue. The current situation with many of the smaller plans is they're increasingly looking for outsourcing as an option to maintaining their systems internally. The outsourcing option would be a feasible approach that could offer a number of benefits as I discussed in the testimony, and I think it would be something that should be strongly considered.

Q. Is there ever a point at which disaffiliation just becomes virtually impossible?

A. No, not really. I mean, the key here is that the main -- the main issue around disaffiliation in this scenario is extracting Delaware or Blue Cross's data out of Highmark's systems and storage devices.

In other words, data is the main asset that you're extracting. That data has to be provided in a form that can be imported into a new systems platform. But there are not a lot of physical IT assets that will be involved in disaffiliation. It's largely going to be data.

Q. You talked about the alignment of interests created by both parties' desire for

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Blue Cross Blue Shield to maintain its ability to compete in the marketplace with fees, competitive fees, and better products and services. You said that that should decrease any motivation for Highmark to enrich itself to the detriment of Blue Cross Blue Shield. I note that you added "hopefully should" when you gave your testimony which wasn't written in the written testimony, and there was also a disclaimer.

Are there scenarios where that might not be the case?

A. I can't think of any.

Q. At some point, notwithstanding all the catastrophes that we talked about this morning, notwithstanding or maybe because of the catastrophe scenario analyses, Blue Cross could conceivably reach a capital level that more people would agree is excessive.

Does your statement still make sense in that context?

A. Well, the discussion centered around the idea that there would be a number of costs to be considered in the event of a disaffiliation. There would be the actual cost to separate Blue

Cross's data from Highmark's technology platform, and then there was the cost to basically migrate to a new platform either through the use of another affiliation partner or through an outsourcing arrangement, or through the set up of stand-alone IT environment.

So I think given those different scenarios, there are significant cost implications that needed to be considered, and I think that that is something that is important in looking at the issue you described.

Q. Do you think Highmark has the ability to enrich itself to the detriment of Blue Cross Blue Shield?

MS. POLIZOTI: Objection to the extent that you know the answer to that question as it asks for what Highmark is from Highmark's perspective. You can go ahead and answer.

THE WITNESS: I think the cost allocation methodology is set up in a way that allows for transparency in terms of how costs are captured and how they are allocated based on various allocations bases.

There are conditions that allow for

ongoing review of these costs and the supporting assumptions behind them, the algorithms behind them will be made available.

So I think given that type of transparency, there will be plenty of opportunity for there to be an audit of these specific allocation costs on an annual basis or on an as-needed basis, and that can ensure that the allocation of costs is fair and equitable.

Q. About those conditions, did KPMG analyze those conditions in the way they would be implemented and the way they will operate, how those audits will take place?

A. We did review the conditions.

Q. And you have such that you can conclude that the way that they will be implemented will substantially diminish the risk?

A. Yes, I believe so. I believe they provide good safeguards, and I believe that based on the testimony of Highmark representatives, that they will be providing sufficient information and sufficient detail, including detail supporting invoices, as well as detail supporting their cost allocation methodology,

that will give a fair level of assurance that the allocation methodology will be implemented appropriately and fairly.

Q. And they can be audited appropriately?

A. And can be audited, absolutely.

MS. SHOSS: I think that's it.

MS. POLIZOTI: No further questions.

THE HEARING OFFICER: Mr. Jackson, thank you for your testimony.

THE WITNESS: Thank you.

MR. HOUGHTON: Your Honor, if everyone is prepared to proceed, we would like to call Linda Sizemore, the director of company regulation for the Delaware Department of Insurance.

THE HEARING OFFICER: Ms. Sizemore, would you step forward, please, and be sworn in?

LINDA SIZEMORE,

the witness herein, having first been duly sworn on oath, was examined and testified as follows:

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DIRECT EXAMINATION

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BY MR. HOUGHTON:

Q. Good afternoon, Ms. Sizemore.

A. Good afternoon.

Q. Would you please introduce yourself?

A. Yes. My name is Linda Sizemore. I am the director of company regulation at the Delaware Department of Insurance. My position is also called director of BERG, the Bureau of Examination, Rehabilitation and Guaranty. This section of the Department of Insurance examines and regulates the solvency of insurance companies licensed and domiciled in the state of Delaware.

Q. Could you please give a brief overview of your professional and educational background?

A. I have a Bachelor's degree in international relations from the University of Delaware and an associate's degree in accounting from Delaware Technical & Community College.

I have been a certified public accountant in Delaware since 1982. And since 2005 I have been a certified financial examiner with the Society of Financial Examiners. I worked for the Department since May 2001. Initially I served as a financial analyst. In September 2007, I became chief financial examiner and in August 2010 I became director of company regulation.

Immediately before my service in the Department, I worked for 17 years as a CPA and principal of my own public accounting firm in Georgetown, Delaware.

Q. What was the name of your accounting firm?

A. Linda Swaine Sizemore, CPA.

Q. Very impressive, Ms. Sizemore. Thank you.

I'll refer to BCBSD as "Blue Cross" and Highmark, Inc., and its affiliates as "Highmark."

Can you please describe the Department of Insurance's role with respect to the proposed affiliation between Blue Cross and Highmark?

A. The Delaware Department is charged with regulating the insurance industry in the State of Delaware for the protection of all policyholders

and the Delaware insurance-buying public. The decision of Blue Cross, a nonprofit, Delaware health service corporation to enter into an affiliation with Highmark requires the Department to evaluate the proposed affiliation.

Q. How has the Department evaluated the proposed affiliation?

A. The Department has examined the proposed affiliation according to statutory criteria found in Section 5003(d)(1) of the Delaware Insurance Code. Where we have determined that additional elements are needed to ensure that the affiliation meets the statutory criteria, we have recommended that certain conditions be imposed before the Commissioner would approve the affiliation.

Q. Has the Department of Insurance reviewed proposed affiliations involving Delaware health service corporations before?

A. Yes. In fact, the Department was involved in reviewing the affiliation and later disaffiliation of Blue Cross and CareFirst, a Maryland corporation. In 1998, Blue Cross entered into an affiliation with CareFirst which

the Department approved in 2000.

Ultimately in 2006, as a result of legislation passed in Maryland, it impacted the governance of CareFirst and the Department's ability to regulate Blue Cross. The Department required that the affiliation between Blue Cross and CareFirst be terminated.

Q. Does the Department believe that the disaffiliation between Blue Cross and CareFirst has relevance to this proposed affiliation between Blue Cross and Highmark?

A. Yes. The disaffiliation between Blue Cross and CareFirst demonstrated that affiliations sometimes need to be unwound and that planning for a potential disaffiliation is essential to ensuring that policyholders are protected.

The Department's exercise with the Blue Cross disaffiliation from CareFirst colored how the Department reviewed the proposed affiliation between Blue Cross and Highmark and served as the basis for some of the conditions the Department seeks to impose here.

Q. Would you please describe how the

Department conducted its review of the proposed affiliation of Blue Cross and Highmark?

A. The Department conducted a comprehensive review of the proposed affiliation and its potential impact on Delaware consumers and the Delaware public. We engaged several advisors, including our outside legal counsel, Morris Nichols Arsht & Tunnel; our financial advisor, Blackstone Advisory Partners; and our information technology advisor, KPMG.

With the assistance of our advisors, the thousands of pages of documents that were produced by Blue Cross and Highmark were reviewed.

We also solicited input from the Delaware public, including three public information sessions and from various Delaware stakeholders including healthcare providers, employers, and customers.

We met extensively with executives and management from both Blue Cross and Highmark. We spoke with our peers at the Pennsylvania Insurance Department because Highmark is based in Pennsylvania.

We also spoke with our peers at the West Virginia Department of Insurance because Highmark was involved in a similar affiliation with the West Virginia Blue Cross Blue Shield.

Q. Why did the Department hire these advisors?

A. We hired Morris Nichols to provide legal advice and assistance to us during our review. Morris Nichols had also advised the Department in connection with the CareFirst affiliation and so we wanted to draw on that experience.

We hired Blackstone as our financial advisor to assist with our review of the statutory criteria set forth in Section 5003.

And we hired KPMG as our technology advisor to address and analyze the assertions made by Blue Cross concerning the technology-related reasons why they sought the proposed affiliation.

Q. Before we get into the specifics of the Department's review, can you give a brief overview of the conclusion that the Department has reached?

A. This transaction involves an out-of-state

company assuming control of Delaware's largest not-for-profit health insurer. The Department wants to ensure that Blue Cross's reserves are protected, that Blue Cross maintains a meaningful level of local control, is not unfairly charged for services, and is in a strong-enough position to protect the interests of its policyholders should a disaffiliation occur.

The Department has determined that there are certain conditions that need to be imposed in order for the proposed affiliation to fully comply with the statutory criteria and protect Blue Cross's policyholders.

Subject to the conditions recommended by the Department, we recommend that the Commissioner approve the proposed affiliation.

Q. I'd like to show you a document titled "Department of Insurance Conditions." I think you may have a copy with you which is Joint Exhibit 13. Do you have it?

A. Yes.

Q. 113. I'm sorry.

A. Yes, I do.

Q. Can you please identify the document?

A. This is a document titled -- that lists the specific language of each of the Department's proposed conditions to the affiliation, as well as provides the rationale and statutory citation for each condition.

During my testimony, in the interest of time and efficiency, I will refer generally to the conditions that the Department seeks to impose, but this document contains the actual language of the proposed conditions.

Q. Thank you.

Let's now begin with the discussion of the statutory standards within 5003(d)(1) of the Delaware Insurance Code and the Department's conclusions and conditions related to each.

Would you please describe and confirm for us the Department's conclusions regarding standard A which requires that after the affiliation Blue Cross be able to satisfy the requirements for the issuance of a license to write the lines of insurance for which it is presently licensed?

A. Certainly. The proposed affiliation does not involve a change to Blue Cross's corporate

identity, its status as a health service corporation under Chapter 63 of the Delaware Insurance Code, or its ability to satisfy all applicable licensing standards.

After the affiliation, all relevant entities will still continue to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which they are presently authorized. Therefore, the affiliation meets standard A.

Q. Can you please discuss the Department's conclusions regarding standard B relating to the effects of the affiliation on competition in Delaware?

A. The Department worked with Blackstone to complete an analysis based on the quantitative standards of Sections 5003 and 5003A of the Delaware Insurance Code.

The purpose of these standards is to determine whether the affiliation will result in any anticompetitive effect. We determined that there was one area of potential lessening of competition, judging solely by the raw data on market share numbers.

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In the dental category, based on the respective market shares of Blue Cross and of a Highmark subsidiary that offers dental services, there was what is called prima facie evidence of a competitive violation, because the dental market is highly concentrated and Blue Cross and Highmark have more than the statutory minimum of the dental market.

However, as Mr. Alderson-Smith described, the statute directs the Department to analyze whether there is any substantial evidence that will show that the affiliation will have no anticompetitive effect.

We ultimately concluded that the affiliation would not have an improper anticompetitive effect on the dental market.

Q. Notwithstanding, does the Department have any concerns about the potential competitive effect of the affiliation?

A. Yes. The Department does have concerns about the potential or different kind of anticompetitive effect which relates to the issue of bundling two or more insurance products together.

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The Department is concerned about the possibility that Blue Cross might be able to leverage a strong position in core health products to require consumers to also buy secondary products that Blue Cross would have the ability to offer as a result of the affiliation.

Accordingly, as noted in proposed condition No. 30, the Department seeks conditions that would prohibit Blue Cross and Highmark from engaging in any type of improper bundling of products or services.

Therefore, with the addition of such conditions, the Department determines that the effect of the affiliation would not be to substantially lessen competition in insurance in this state or tend to create a monopoly therein.

Q. Please describe the Department's conclusions regarding standard C involving the strength of Highmark's financial condition.

A. In evaluating standard C, the Department, in consultation with Blackstone, examined Highmark's financial condition, including the potential impact of a recently announced large transaction with another Pennsylvania company.

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We also analyzed Blue Cross's financial strength apart from Highmark, as well as its ability to successfully emerge from a future disaffiliation, if necessary.

Q. What conclusions did the Department reach regarding the financial strength of Highmark?

A. After reviewing the company's financial data generated over the last five years, the Department has concluded that Highmark is in a strong financial position. On a GAAP, Generally Accepted Accounting Principles, basis, Highmark had total assets of $9.4 billion and total reserves of $4.6 billion as of September 31st, 2010.

Also at year end 2010, Highmark had a risk-based capital ratio of 692 percent, and recent trends indicate steady growth moving forward.

Therefore, standard C is satisfied in that the financial condition of Highmark is not such as might jeopardize the financial stability of Blue Cross or prejudice the interests of its policyholders.

Q. You mentioned another transaction

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involving Highmark. What is that transaction and what did the Department conclude with respect to that transaction?

A. Earlier this year Highmark announced an intention to affiliate with West Penn Allegheny Health System, a large hospital system in western Pennsylvania.

As a part of that transaction, Highmark is expected to provide at least $475 million in financing to West Penn Allegheny and possibly more. Even if that transaction fails entirely, Highmark's risk-based capital levels would still remain above the levels for many large insurers and well above the requirements of Blue Cross Blue Shield Association.

Nonetheless, in order to prevent any direct or indirect cost of the West Penn Allegheny transaction from impacting Blue Cross, the Department has proposed the condition preventing Highmark from directly or indirectly passing any losses associated with the West Penn transaction on to Blue Cross as discussed in proposed condition No. 35.

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In addition, in the event that the West Penn transaction impacts Highmark's RBC, the Department has also proposed condition No. 23 that would allow Blue Cross the ability to disaffiliate if Highmark's RBC ratio dropped below a certain level.

Q. What conclusions did the Department reach regarding Blue Cross's financial strength?

A. We concluded that Blue Cross's current financial position is also strong with a risk-based capital ratio of 1,056 percent. Under the affiliation, Blue Cross's risk-based capital ratio will be significantly higher than the level projected if Blue Cross remains a stand-alone entity. The affiliation will allow Blue Cross's risk-based capital ratio to remain within or above the recommended ranges. This is another reason why the affiliation would not jeopardize Blue Cross's financial stability or prejudice the interests of Blue Cross policyholders.

Q. Turning to standard D, could you please describe the Department's conclusions regarding the fairness, reasonableness, and public interest of Highmark's plans for Blue Cross?

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A. Yes. Many of the Department's concerns about the affiliation are implicated by standard D. This standard requires an analysis of the plans or proposals that Highmark has to make any material changes in Blue Cross's business, corporate structure, or management.

The statute requires that the Department determine whether any of these plans or proposals are unfair or unreasonable to Blue Cross's policyholders and not in the public interest.

The Department focused on five key areas -- I'm sorry -- six. Let me count again.

The structure of Blue Cross after the affiliation.

No. 2, protecting Blue Cross's reserves, including an analysis of how money could be transferred from Blue Cross to Highmark.

No. 3, the affiliation's impact on Blue Cross's IT capabilities.

No. 4, ensuring Blue Cross's ability to disaffiliate, if necessary.

No. 5, ensuring that Blue Cross executives did not receive personal financial

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benefits from the transaction.

And No. 6, the effect on employment levels in the Delaware community.

I will discuss these six specific areas further. Before I do that, I would like to note that the Department also concluded that Highmark does not have any plans for proposals to liquidate Blue Cross, sell its assets, or consolidate or merge Blue Cross, which is another part of the required evaluation under standard D.

The Department based its conclusion, in part, on representations made by Highmark which have been made as condition of this transaction as reflected in proposed condition 37.

Q. Did the Department have any concerns about the corporate structure of the proposed affiliation to Blue Cross?

A. Yes. As part of the affiliation, and as required for Blue Cross to retain use of the Blue marks as a controlled affiliate of Highmark and receive Highmark's full guarantee of its claims, Blue Cross must give Highmark a certain level of corporate control.

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The Department is concerned that the degree to which Highmark will exercise control over Blue Cross could cause Blue Cross to, for example, lose its local control and not make decisions effectively considering the interests of Delaware policyholders.

From a corporate governance perspective, there will be four independent Class A directors on the postaffiliation Blue Cross board who will serve an important role for Blue Cross policyholders and the interest of Delaware.

By statute, a majority of the Blue Cross board must consist of individuals not currently employed by Blue Cross or its affiliates and who are residents of Delaware and have been so for at least five years.

However, the Department believes that certain additional corporate governance conditions reflected as proposed conditions 20, 21, and 22 which require at least one independent director to be present before the board can act and which extends service of the initial independent directors are necessary to ensure that the corporate governance structure appropriately protects the interests of policyholders and of the Delaware public.

Q. Ms. Sizemore, what is the Department's view about the extent Blue Cross's reserves are protected under the insurance code?

A. One of the department's primary concerns is to prevent Highmark from causing any inappropriate transfer of funds from Blue Cross to Highmark or any improper assessment of expenses against Blue Cross, which, if not kept in check, could drain Blue Cross's reserves to the detriment of policyholders.

I believe that this concern was also the same as the legislature's concern when they amended Section 6311 of the Delaware Insurance Code to require that the Insurance Commissioner shall place conditions upon any approval of the change of control, which conditions are intended to prevent Highmark from improperly using Blue Cross's reserves.

The statutorily mandated conditions, including Department approval of any individual or coordinated series of transfers from Blue

Cross to Highmark or its affiliates, along with others discussed below prevent, in the department's opinion, the threat of improper movement of money from Blue Cross to Highmark and the erosion of Blue Cross's reserves as a result.

With the help of its legal advisors, the Department evaluated the statutory provisions that protect Blue Cross's reserves. The July 2011 legislation requires that a condition be imposed on the proposed affiliation that mandates review and approval by the Department of any transfer of funds, individual or in the aggregate by Blue Cross, in excess of $500,000 to Highmark or any Highmark affiliate.

Under the new law, the Department must review and access the commercial reasonableness of the proposed expenditure or transfer, and the applicants must consent to the Commissioner's standing to seeking relief in the Delaware Court of Chancery to enforce this condition.

The statutory requirements are memorialized in proposed conditions 1 through 6. This law is strong protection against any attempt

by Highmark to use Blue Cross's reserves for itself or its affiliates.

As for profits and dividends, Blue Cross is a not-for-profit, nonstock membership corporation. After the affiliation, Blue Cross will remain a not-for-profit, nonstock membership corporation, with Highmark as its sole member.

As such, Blue Cross has no stock or membership interest or anything similar to give to Highmark. Highmark simply does not share in Blue Cross's profits and losses and has no right to receive distributions of profits.

In addition, the applicants have agreed to proposed condition No. 31, which requires that Blue Cross will be subject to Delaware's Holding Company Act, which is Chapter 50 of the Delaware Insurance Code after the affiliation.

Under the Holding Company Act, all transactions between Blue Cross and Highmark must be fair and reasonable. This standard applies to fees that Highmark will charge to Blue Cross for various services rendered under the Administrative Services Agreement, the Department

may order Blue Cross and/or Highmark to produce books, records or other information to determine whether the applicants have complied with, among other things, the fair and reasonable standard.

The Department believes that these statutory provisions and conditions will effectively prevent Highmark from taking any of Blue Cross's reserves to the detriment of Delaware's policyholders.

Q. Has the Department analyzed how Highmark may transfer monies from Blue Cross pursuant to the Affiliation Agreement?

A. Yes. The Department also reviewed the ways that Highmark can receive money from Blue Cross pursuant to the various contracts between Highmark and Blue Cross to evaluate if there are ways to unfairly charge Blue Cross and inappropriately move money to Highmark.

Specifically, Highmark will charge Blue Cross for the expense of migrating onto Highmark's technology system, and for the future expense of operating on that system. Our advisors have evaluated the migration expenses and indicated that they are reasonable.

To ensure that those expenses remain reasonable, the Department seeks a cap discussed as proposed condition No. 17 on the costs of the integration process in the amount of $42 million, which is approximately 15 percent more than the current estimate of costs.

The Department also seeks an oversight role with respect to the manner in which Highmark charges Blue Cross for future services.

The Department has, therefore, proposed the comprehensive set of conditions, some of which are now mandated by statute, which enhance its existing statutory powers.

These conditions as paraphrased consist of the following: No. 1, review an approval by the Department of any transfers of funds, individually or in the aggregate, in excess of $500,000 to Highmark.

No. 22, Highmark shall not improperly use the assets of Blue Cross for the benefit of Highmark rather than the benefit of Blue Cross and its subscribers without DOI approval and without limitations on any statutory requirements

or other conditions on this affiliation.

The only economic transfers that Blue Cross is permitted to make to Highmark are payments for Blue Cross's integration to Highmark's IT systems, ongoing payments for administrative services Highmark will provide to Blue Cross under the Administrative Services Agreement, and payments pursuant to the line of credit agreement.

No. 3, there shall be a $42 million cap on integration costs.

No. 4, prior to closing, Blue Cross and Highmark shall file with the Department the cost allocation methodology and formula, and will file an annual budget describing the plan charges which the Department will review and approve under a fair and reasonable standard.

No. 5, Blue Cross and Highmark shall agree on a service level agreement and Blue Cross shall provide quarterly reporting to the Department concerning whether the standards in such agreement are met.

No. 6, Blue Cross agrees that it is subject to the general supervisory authority of

the Delaware Department of Insurance.

No. 7, Highmark agrees that it is an affiliate of Blue Cross such that Highmark is governed by the relevant provisions of Chapter 50 and agrees that it will provide information to the Department to assure compliance with and enforcing conditions imposed on or commitments made by Highmark in this application.

No. 8, the Department has also proposed a condition relating to any disputes about costs charged to Blue Cross.

In general, the president of Blue Cross and the chief executive officer of Highmark will first attempt to resolve any dispute, after which the dispute will be referred to the Blue Cross board.

If the dispute is still not resolved, it will be submitted to the Department which will have final decision-making authority with respect to whether the disputed charge is fair and reasonable to be allocated to Blue Cross.

Q. Does the Department have concerns concerning the line of credit agreement?

A. Yes. The line of credit agreement as

currently written requires that after a disaffiliation, there is an immediate repayment of any outstanding funds under the line of credit. To ensure that disaffiliation is a viable option, the Department recommends that Blue Cross be given a longer period of time -- three years -- to repay its obligations should disaffiliation occur.

Also, as written now, the line of credit agreement would allow Highmark to terminate the agreement for any reason without giving Blue Cross the opportunity to resolve whatever concerns Highmark has.

The Department believes that there should be some limit on Highmark's ability to terminate the line of credit agreement and these are noted as proposed conditions 27, 28, and 29.

Q. We have been talking about the amount of money that Blue Cross will spend to migrate on to Highmark's technology platform. Can you please describe the Department's analysis regarding the affiliation's impact on Blue Cross's IT capabilities?

A. Yes. One rationale for the proposed

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affiliation is Blue Cross's stated concern that it needs significant technology and systems upgrades to remain competitive in Delaware and meet government mandates. The Department and its advisors reviewed whether these concerns are legitimate and whether the affiliation will address them.

We concluded that Blue Cross does, in fact, face significant challenges, including those posed by upcoming government mandates and by Blue Cross's outdated technology and systems.

The Department and its advisors reviewed the potential solutions to the challenges faced by Blue Cross, including reviewing the cost of the proposed affiliation and comparing those costs to certain alternatives, which include Blue Cross entering into a long-term contractual outsourcing relationship, or remaining a stand-alone company and upgrading its IT systems on its own.

Of these choices, the Department determined that the proposed affiliation is fair and reasonable and, quite frankly, the best option.

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The upfront costs of the proposed affiliation is approximately $37 million, compared to the 95 to $150 million cost range of the stand-alone option, and the 30 to 45 million cost range of the outsourcing option.

Blue Cross will pay approximately $20 million per year during the affiliation to Highmark, compared to an approximately 30 to 60 million annual range in the outsourcing option.

In sum, the proposed affiliation is the least expensive option, but it also allows Blue Cross to address its IT capability needs and gain access to overall corporate support services as described by Mr. Alderson-Smith and Mr. Jackson.

Q. Does the Department have concerns about the Administrative Services Agreement?

A. Yes. In addition to seeking conditions to ensure that Highmark does not unfairly allocate costs to Blue Cross pursuant to the Administrative Services Agreement, the Department also seeks conditions to ensure that the terms of the ASA are in the best interest of Blue Cross's

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policyholders and the public.

The Administrative Services Agreement can currently be terminated by Highmark after the first year for any reason Highmark chooses. One of the conditions proposed by the Department requires the Department to approve a voluntary termination of this agreement to protect the interests of Blue Cross policyholders. This is proposed condition No. 15.

Q. Does the Department have concerns about the ability of Blue Cross to disaffiliate in the future?

A. Yes, we do. Particularly given the disaffiliation between Blue Cross and CareFirst, the Department carefully analyzed the potential for disaffiliation here. The Department believes that to protect Blue Cross policyholders, certain conditions should be imposed that allow Blue Cross to disaffiliate and successfully transition away from Highmark, if necessary.

Presently the independent Class A directors have the option to disaffiliate in only a limited number of circumstances. These do not include situations that may potentially harm Blue

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Cross policyholders, such as if Highmark's financial condition deteriorates or Highmark undergoes certain changes of control.

The Department believes that the Class A directors should have the option to disaffiliate if Highmark experiences these kinds of important changes as noted in proposed condition No. 23.

In addition, under the current structure of the affiliation, the decision to disaffiliate must be made on a very short time frame with limited opportunity for the Class A directors to fully evaluate alternatives for Blue Cross.

For Blue Cross to have a meaningful chance of a successful transition from the disaffiliation, the Department believes it is important that Highmark provides sufficient time, at least 180 days, and adequate support to Blue Cross to allow the Class A directors to evaluate alternatives for Blue Cross.

In addition, during any transition period, the Department believes that Highmark should be required to continue providing services to Blue Cross on terms that protect the interests of Blue Cross's policyholders. This is addressed by proposed condition No. 25.

Finally, the Department recommends that Highmark also be required to make all best efforts to help Blue Cross reacquire the Blue Cross Blue Shield marks if Blue Cross and Highmark disaffiliate. The marks are important to Blue Cross being able to serve its policyholders after a disaffiliation from Highmark. This is addressed by proposed condition No. 26.

Q. Can you describe the Department's analysis of Blue Cross's management executive compensation as it relates to the affiliation?

A. The Department and its advisors first determined that neither Highmark nor Blue Cross has made any agreements with Blue Cross executives to give them personal financial incentives to go forward with the affiliation.

We then analyzed the employment agreements of the Blue Cross executives and the findings of a Blue Cross executive compensation consultant.

In 2011, a compensation consultant concluded that the compensation of Blue Cross's executives is generally below competitive median levels in the industry.

The Department also analyzed whether any executives would receive golden parachutes or other compensation as a result of the affiliation. The Department examined the employment agreements of Blue Cross's executives and determined that the executives will not receive any financial compensation as a result of the consummation of the affiliation.

Although certain Blue Cross executives have employment agreements that include severance payments under certain conditions, those rights were in place before the affiliation was negotiated and will not be automatically triggered by the affiliation.

To further ensure that there are no inappropriate side agreements between Highmark and any Blue Cross executive that could influence the decisions of the executives in favor -- to favor this affiliation, the Department has proposed condition No. 36 which precludes any

such arrangement.

Q. In evaluating the impact of the proposed affiliation, did the Department assess the potential impacts on employment?

A. Yes. The Department noted that Highmark is contractually obligated under the Affiliation Agreement to use reasonable efforts to keep employment levels in Delaware consistent with levels in Highmark's other service areas.

Nonetheless, it is likely that the affiliation will result in employment changes at Blue Cross, including a decrease in employment. This is an unfortunate effect of Blue Cross becoming more efficient as a result of the affiliation.

To help mitigate this impact, Blue Cross and Highmark have voluntarily made a number of commitments regarding postaffiliation employment levels including, No. 1, committing to maintaining Blue Cross's corporate headquarters in Delaware.

No. 2, assuring that the total number of full-time equivalent positions in Delaware will be maintained during the 18-month

integration period at the same level, assuming no significant decrease in enrollment or market share.

However, if there is a significant decrease in Blue Cross's enrollment or market share during the integration period, for example, from the loss of a large customer that results in any lost positions, Highmark will not be responsible to replace those lost positions in order to maintain existing levels of employment.

No. 3, allowing any Blue Cross employees who lose their jobs the first opportunity to fill in the new jobs in Delaware.

And No. 4, ensuring that the quality of service provided by Delaware-based client service employees does not materially decline.

The exact terms of these commitments have been agreed upon by the applicants and the Department proposes them as conditions to the affiliation as reflected in proposed conditions 7 and 8.

Q. Can you please describe the Department's conclusions regarding standard E which evaluates the competence, experience, and integrity of

those persons that will control Blue Cross?
A. The Department has reviewed the biographies, credentials, and records of the 21 board members and 11 executive officers of Highmark.
The Department has focused on the education, employment history, experience, and professional licensing of these individuals, as well as answers to questions relating to any fraud, dishonesty, civil actions, and bankruptcy associated with companies for which these individuals have worked or served as directors.
This review by the Department included the individual's proposed by Highmark to serve as Class B directors on the Blue Cross board. Highmark has identified three of the four individuals who will serve as Class B directors on the postaffiliation Blue Cross board of directors: Dr. Kenneth Melani, Deborah G. Rice and Nanette P. DeTurk.
Our review found that these three individuals are executives in a highly regulated industry whose qualifications have also been reviewed and accepted by other state departments

of insurance. They collectively have 43 years of executive experience at healthcare entities.
Prior to the final approval of the affiliation by the Commissioner, the Department will conduct the same thorough review of the fourth person Highmark proposes to appoint as a Class B director, and will complete its follow-up analysis with Highmark in order to make a final determination as to whether the affiliation satisfies the criteria of standard E.
The president director will be Blue Cross's current president and CEO, Tim Constantine, and the initial four Class A directors will be chosen from the existing Blue Cross board of directors.
The Department is familiar with Mr. Constantine and the current Blue Cross board of directors and has no concerns about their competence, experience, or integrity.
Based on this review, the Department has no reason to question the competence, experience, or integrity of these individuals such that their control of Blue Cross postaffiliation would be contrary to the

interests of Blue Cross's policyholders or to the public interest.
Q. Can you describe the Department's conclusions regarding whether the affiliation would be hazardous or prejudicial to the insurance-buying public under standard F?
A. In order to determine the affiliation's impact on the insurance-buying public, the Department reached out to many different stakeholders in the Delaware community.
Blue Cross clearly plays a significant role as one of the largest health insurers in Delaware as a not-for-profit, and as the only locally controlled insurer. Blue Cross is generally highly regarded by its customers and stakeholders.
The Department reviewed Blue Cross's search for a strategic partner following Blue Cross's disaffiliation from CareFirst in 2006. It is clear that Blue Cross has identified many of the challenges it faces, particularly in terms of IT modernization, product development, and remaining compliant with federal guidelines, and has undertaken a long and extensive process to

address these challenges.
Another important consideration is that Blue Cross is a local Delaware health insurer that faces competition from health insurance companies with much larger networks nationwide, including more financial resources to make important changes and remain in compliance with rapidly changing laws and regulations.
The Department has concluded that Blue Cross affiliating with Highmark as a strategic partner is not hazardous or prejudicial to the insurance-buying public given the prospects and challenges for Blue Cross and the risks to its local identity that it faces as a stand-alone entity in the coming years.
Q. Has the Department proposed any conditions relating to standard F?
A. Yes. Many of the conditions I described earlier in connection with standard D also apply to standard F. For example, conditions regarding Highmark's ability to access Blue Cross assets and Blue Cross's ability to disaffiliate are essential to ensuring that the affiliation is not hazardous to the insurance-buying public.

With these conditions, the Department does not believe that the proposed affiliation would be hazardous or prejudicial to the insurance-buying public.

Q. Finally, does the Department have any conditions relating to its oversight of Highmark and Blue Cross relating to this affiliation?

A. Yes. The Department sought, and the applicants have agreed to, certain conditions relating to the jurisdiction of the Department over Blue Cross and Highmark for the purposes of implementing the conditions of the affiliation, as well as the Department's ability to seek information and exercise its examination authority to assure compliance with the conditions of the affiliation.

These are found at proposed conditions 31 through 34.

Q. Ms. Sizemore, based on the Department's nearly year-long review of the proposed affiliation, the statutory criteria we have discussed today, what recommendations has the Department developed regarding the proposed affiliation?

A. The Department has conducted a very lengthy and thorough review of the proposed affiliation. The Department has a number of concerns, particularly related to ensuring that the postaffiliation operations of Highmark and Blue Cross under this affiliation are fair to and in the best interest of Delaware policyholders and the public.

These concerns are addressed by the conditions I have discussed today. Accordingly, the Department recommends that the Commissioner approve the affiliation subject to the conditions recommended by the Department.

Q. Ms. Sizemore and those following along, we do have some additional items that we would like to discuss.

MR. HOUGHTON: Your Honor, earlier today, I did circulate to all the parties a series of additional exhibits which we would like to hand up. My understanding is there is no objection to these exhibits. They would be Joint Exhibits 119, 120 -- there's two versions of 120 -- and 121. And let me explain what these are.

These are, taken together, a series of documents which were provided to Ms. Sizemore and to our consultant, Blackstone, by Highmark in connection with a discussion about cost allocation issues.

And in discussing the matter last evening, it became clear that there was, in fact, some additional information that we thought would be illustrative and useful to the entire process. We wanted to just walk Ms. Sizemore through some testimony relating to this.

We note that with respect to Exhibit 120, which does include, as I understand it, various categories and specific subcategories of cost allocation units or information, that there is a redacted two pages of the request to Highmark because that information is confidential and proprietary.

I hope -- I don't intend to get into any particular discussion of the numbers, and the parties, I think, are sensitized to the confidential nature of that information.

BY MR. HOUGHTON:

Q. Ms. Sizemore, do you have those exhibits

in front of you?

A. Yes, I do.

MR. HOUGHTON: Your Honor, I'd like to ask Ms. Sizemore to first identify these to confirm that she has seen these documents previously in connection with the circumstances we discussed.

BY MR. HOUGHTON:

Q. Are these familiar to you?

A. Yes, they are. They were -- they were sent to us by Highmark in early June as a result of us asking to find out more information on the cost allocation methodology.

MR. HOUGHTON: So, Your Honor, if there's no objection, I'd like to have these moved in as exhibits 119 to 121.

MR. TEICHMAN: No objection.

MR. CAMPBELL: No objection.

MR. McCONNELL: No objection, Your Honor.

THE HEARING OFFICER: Hearing no objection, you may proceed.

MR. HOUGHTON: Thank you, Your Honor.

BY MR. HOUGHTON:

Q. Ms. Sizemore, let's pick up where you just left off. As part of the Department's review, did you learn about Highmark's cost allocation process and methodology?
A. Well, I haven't learned it to the extent of the 300 pages that I'm promised --
Q. I'm sure you're looking forward to that.
A. But we got a very high-level overview on the cost allocation methodology from these exhibits and in our conversation.
I can tell you I was impressed because this is one of the worries I have about this affiliation, and I take very seriously our commitment to enforce the statutory law on this to make sure it's fair and reasonable.
Q. Can we go for a minute just piece by piece through these and let you give me a brief description of what your understanding is as to what these documents are?
The first document, 119, is captioned, "Highmark Cost Allocation Overview." This is a document that was forwarded to you by Highmark?
A. Yes, it was. They all came together.

And I was going to mention on cross-examination, but it's right here on the second page about the number of cost centers and cost pools. There are over 600 cost centers and more than 140 cost pools.
As we ran through this description, I was impressed by how rigorous and complex their cost allocation methodology is, although I won't profess to understand it all as yet. I was impressed. There are numerous allocation factors. They described a lot of those to us, a number of claims that might determine how the allocation will go or number of full-time employees who worked on in a certain cost area by premium, by number of computers.
There are so many of them and I'm sure this is part of the 300 pages that we're going to get and study and come to understand.
Q. Several pages in there is a caption of an allocation illustration April 2011 year-to-date. That was, I guess, an example offered up as to how expenses are allocated in various categories, correct?
A. Yes. Once we got beyond the general

overview of the Highmark allocation methodology, they offered up several exhibits of what they actually provide to Highmark West Virginia. These are actual, I guess, forms I can examine and get a comfort level with.
Actually, I'll trace it back from the invoice. I can understand it better.
Q. The invoice, Exhibit 121?
A. All right. Exhibit 121. This is what would come, I suppose, monthly to Highmark, Blue Cross of West Virginia summarizing the direct charges which are direct costs, centralized services, product allocations. And then you see several pages of very detailed costs that have been allocated to Highmark West Virginia.
The comfort level I get from that, and once I saw these schedules, I determined that should we have questions and want to go further with this analysis, besides kind of examining the monthly invoices, I wanted to have examination authority to be able to go in, if we saw variances, to actually track these down invoice by invoice if we have to to be able to see the whole Highmark cost allocation methodology

amongst the system, not just a narrow silo pinpointing Blue Cross's portion of this.
That led to a condition.
Q. Can I ask you about Exhibit No. 120? On the second page there are a series of captions. The document is captioned "Administrative Expense Analysis." In the first series of three columns to the left am I correct that this reads: "Actual Budget and Variance"? In fact, that runs across all nine columns reflected here on the page.
What is your understanding of what information is contained here and what this would tell you as a regulator reviewing on a periodic basis or a regular basis information relating to cost allocations submitted by Highmark?
A. I interpreted this as a monthly statement that is sent to Highmark West Virginia. It's for the month of April 2011. It's the administrative expense analysis. They show April -- the month of April, they will show the actual cost, the budgeted cost, and they will show a variance. They will do that for year-to-date as well.
When I saw this schedule, and I

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actually saw it at the end of the conference call, I think my face lit up because this is the one thing that I can get from, I guess, Blue Cross Blue Shield of Delaware, they will be receiving this, that I can get monthly and pinpoint the variations -- variances.
Q. It's the variances between the actual and the budget, it's those particular variances that would be of interest to you because it gives you a sense of the difference and the materiality of the difference between what had been forecasted and what is the actual experience of the company under the allocations, correct?
A. Correct. And this would be a month-to-month schedule. We do have and have asked for the annual review and approval of the budget and the cost allocation methodology at that time, but this is a month-to-month check.
Q. We talked about this in your testimony earlier, but if you could just review quickly, from your perspective, what you think are what I will call the tools in the toolbox for the Department with respect to the review of cost allocation issues, both in terms of your regular

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process and the conditions that have been imposed in this particular transaction, or that are proposed to be imposed?
A. Well, we start out with what we're normally accustomed to, which is a Chapter 50 review of the affiliated agreements. That would be the Administrative Services Agreement.

That will happen just prior to the closing or, perhaps, at closing we will review and approve that updated Administrative Services Agreement.

We also now have, as a result of 6311, the charge to look at cost or transfers of monies that are $500,000 or greater or a series.
Q. Condition 12. If you go back and look at the list of conditions.

MR. HOUGHTON: And, Your Honor, I won't belabor the point, but essentially the conditions that I think you're talking about are 10 through 13 that we have discussed at length here about prior to closing, information relating to cost allocations, the annual review, and approval of Highmark charges, and the one you just mentioned about review and approval of

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overages of in excess of $500,000.
A. So my understanding and what we wanted to see was that annual review and approval process, that condition. And then I think -- we will look at the budget. We will then approve any variances over that approved budget by $500,000 going forward. And I look at this administrative expense analysis as an integral part of how I'm going to keep track of that, or how the analysts will keep track of far month to month.
Q. You also have under a condition that's been agreed to in condition No. 32, don't you, access not only to Blue Cross's information, but Highmark.

Would you like to discuss for a minute the importance of access to Highmark's information to assess, confirm, or review any of this cost allocation information?
A. Well, as I explained, it's not enough to pull these from Blue Cross on a monthly basis. If we have questions further than this, or maybe if we just want to check, pull a sample, whatever, to determine that there's compliance in the way we think there should be, we need the

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ability to go on-site, visit Highmark with respect to enforcing these conditions, and pull a sample of invoices to track -- to understand those 300 pages that we're going to get.

I feel there needs to be some on-site authority and I think that condition gives us that ability.
Q. I'd like to now shift to what was some additional direct that we put together this afternoon on our lunch break.

This afternoon, while everybody was eating their sandwiches, let the record reflect we were working diligently.

This is just a series of questions really designed to flush out quickly some issues that I think are of importance expressed earlier today, particularly to the Department of Justice.

I'd like to ask -- there was a question about a Department of Insurance proposed condition relating to community contributions. Do you remember that discussion?
A. Yes.
Q. Do you recall the condition that was offered by the Department of Insurance to Blue

Cross Blue Shield?
A. There are actually a couple of conditions that we put into the conditions document which do not fit exactly within our statutory standards. We put them in because Highmark -- Highmark had voluntarily, or Blue Cross, has voluntarily made these commitments.
And the one I'm thinking of first is the one on jobs. We don't normally mandate these conditions. We did pick up from the administrative -- the Affiliation Agreement from the information sessions that Highmark was making the commitment on jobs and Blue Cross. And we wanted to memorialize these in a condition, so we put them in. They are voluntary and Highmark and Blue Cross had no reason to take exception.
We refined a few of those job conditions, but the other condition that I would say does not exactly fit our statutory mandate is the one on community contributions.
Now, we had seen this in the pro formas and in the financial statements --
Q. When you say you had seen this, you had seen an historical plus a projected level of

contribution to the community that was in their financial statements, the projected financials?
A. Correct. I think it's a note to the financial statements that instead of paying state income tax, they donate those monies to the Delaware community fund.
Q. Which is approximately $1.6 million a year?
A. Well, it's going to vary -- I think it's going to vary based on the net profits for that year because state taxes is a percentage. But one of the years there was $1.6 million, yes.
Q. Now, is your understanding that that commitment on the part of, if it is that, or that practice on the part of Blue Cross Blue Shield is based on some representation they have made to the Delaware Community Foundation? I think there was testimony yesterday that there had been a letter or some commitment that they had made --
A. Task force.
Q. -- to a task force or somebody.
But so you're saying that was one aspect of what the Department discussed with Blue Cross Blue Shield. Was there another component

to that?
A. Well, within the pro formas there was a mention of a $750,000 charitable contribution. We added that in as part of a condition. We changed it a little bit. It was the greater of $750,000 or 5 percent, I think, of net profits.
Q. And those two components, the payment -- what I will call the payment in lieu of taxes of approximately $1.6 million, plus the other that you just described, the greater of $750,000 or 5 percent of net profits, was offered to Blue Cross as a condition that they might consider making voluntarily just as there had been commitments with respect to jobs?
A. Just like in the job example, yes. We thought we would flesh that out. Blue Cross informed us that they believed that to be a board of directors decision and did not think that that should be memorialized in conditions where it would be mandated from here on after.
Q. So Blue Cross, in light of their position, would not agree to that as a condition, correct?
A. Correct.

Q. And what was the Department's position subsequent to that?
A. Well, just as with jobs, we have no right to require that, so we accepted that. And we hope that in the future that they will consider it their privilege to make certain contributions.
Q. Were you here yesterday for both Mr. Constantine and Mr. Hynek's testimony regarding the stated intention of Blue Cross to continue levels of charitable contribution in the community?
A. Yes. There was a discussion of, perhaps, joining the Highmark foundation. Is that what you're referring to?
Q. There was discussion about the possibility, but there was also a discussion about the possibility of them going forward continuing with the level or the tradition of community contributions.
A. There was some discussion, yes.
Q. But again, when we approached regarding that being reduced to a condition, for the reasons you stated, they elected not to make it a condition, and it's the position of the

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Department that that condition is not a prerequisite to satisfying the statutory standards of Chapter 50?
A. No, it is not.
Q. You're aware of the Department of Justice's proposed condition?
A. Yes.
Q. And that condition is, as I understand it, is that there be some mechanism, perhaps a fund that would be created and into which there would be $45 million placed to meet the state's unmet health needs and that that money would be money coming from Blue Cross Blue Shield. Is that correct?
A. That's my understanding.
Q. What is the Department of Insurance's view of that particular proposed condition from the Department of Justice?
A. Well, there are many thoughts on that proposed condition. I'll come out with the first thing I thought of as a regulator, and that was I'm here to protect policyholder benefits, protect the interests of the policyholders.
I personally could not sanction

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moving the $45 million lump sum from surplus held by Blue Cross, but it's for the solvency margin they might need to protect their obligation to pay policyholder claims, to move that from the policyholders over into a charitable foundation, which is the public, but we can't get that back. Everyone's referring to the list of catastrophes that were talked about earlier, but should bad things happen, and I have to be concerned about that as a regulator, I would not want to see that being done.
Q. From a regulatory perspective, is it fair to say that more reserves and more surplus are better things rather than worse things?
A. Yes. That's always a regulator's point of view.
Q. You heard the testimony earlier today regarding just the mathematical exercise of the $180 million, approximately, in reserves, and then as you characterized the list of catastrophes and the effect that it had on those reserves.
I don't want to run everyone through that math again, but do you disagree with that

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math and how it would work and where it would leave Blue Cross Blue Shield at the end of the day in addition to all of those events, if there was an additional $45 million that was taken out? I think the calculation from Mr. Alderson-Smith was something we had gone through earlier.
A. Yes. I would actually like to run through the numbers --
Q. Please do.
A. -- as a financial solvency regulator. Sorry.
Q. Apparently your counsel can't do the math because we had five conditions and you had six. So we should leave the math to you.
A. I want to preface that this is the remarks of a financial solvency regulator, which I am.
When I look at RBC and Blue Cross, I don't look at the large number by itself. RBC is one tool that we use to regulate companies. Actually, it's a tool that is a minimum solvency tool. That is what it was designed for. We set up formulas. We change those formulas from time to time to get a more granular result. But I

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know out in the industry it is used to determine solvency, financial health.
Q. And those formulas, to the extent they're modified from time to time, are not done unilaterally by the Delaware Department. These are developed by the National Association of Insurance Commissioners?
A. Yes. They're meant to be uniform amongst the 50 states. So we can't go in and alter one of those.
Q. Thank you.
A. But as I mentioned, there are other things we need to consider. Let me go down this list of catastrophes because I do need to consider it.
As Mr. Alderson-Smith pointed out, he started at 180 million in surplus. That's the six-month figure, June 30th, 2011. The economic downturn I absolutely agree with. We saw it happen in 2008. I put a preliminary number there of 40 as an estimate. But you listen to the news and you have that possible -- that possibility. I can't rule it out. And could that be prolonged? We don't know.

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So when you reduce the $180 million surplus by the $40 million possible economic downturn, you get $140 million. That's 865 percent RBC.

Coupled with that, something I really can't put a number on, and that's the federal healthcare reform. I know in the pro formas Mr. Hynek worked in the medical loss ratios that are going to be a feature of the new federal law.

But I feel there are still unknown costs to certain programs that are going to come about as a result of that healthcare reform that we don't know right now. Maybe the companies don't know right now. I can't quantify it. But we will leave that as a catastrophe -- not a catastrophe, but a change. It's something that you have to plan for.

There are also always state regulatory changes. I'm on a committee at the NAIC. We're constantly changing principles of accounting that may -- that do impact insurers in the 50 states. That's something going forward, some things have to realize that have adequate surplus reserve against that.

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So we're down to $140 million. Now, the catastrophe or the disaffiliation scenario, yes, I know we're putting together what sounds like doom's day scenarios, but we have been through it. This company is batting a thousand when it comes to -- if that's the right metaphor. They have had an affiliation. They have been disaffiliated.

We have planned for that, the consequences of that all the way through this. In fact, Mr. Jackson can remember when we were first starting to hire them, I requested that, specifically: What does it take to back out of this if we have to?

So to put a number on that, migration of IT functions, actually it's kind of conservative, $30 million. Let's take $30 million out of the $140. That brings us down to $110 million in surplus. 678 RBC.

Let's go further. Once you have migrated those IT functions, KPMG tells us, well, you build a new IT platform. That could be 93 to $150 million plus annual costs. I don't know that they could get that up and running quickly

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enough. I'm not even going to run that through the catastrophe scenario. I'm going to say that my best guess would be that they would try to link up to another partner or outsource at that point in time.

And KPMG has given a cost of 30 to 45 million. Being a regulator, I'm going to take the most conservative amount there. So we take the 110 million less 45 million and you get down to 65 million in surplus. That's 401 percent RBC.

Then you make the assumption that before any of this happened, the $45 million that the AG is requesting has already come out of surplus. Can't come back. That means we're down to $20 million in surplus. That's 124 percent RBC. Very close to authorized control level where we would want to take over the company. I don't think that's a good place to be in.

Q. Ms. Sizemore, let me ask you a question. In light of that calculation, and maybe I'm asking it because I think the Department of Justice may ask it, why would we ever approve an affiliation if the consequence of unravelling the

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affiliation could be so dramatically negative for the company? In other words, is it -- is the more prudent course to do nothing for this company in this environment?

A. Absolutely not. With the benefits that will come to Blue Cross from this affiliation, the benefits to policyholders, it is worth that risk.

I have every hope and confidence that this is going to be a good partnership, but there's always the possibility that we need to maintain Blue Cross's reserves in a strong-enough position that should the unknown happen, they're ready to go on their own for a while.

Q. Do you think that the Department could be criticized for being imprudent in light of the history of this company with disaffiliation if it didn't plan for and access the worst-case scenarios in this particular proposed transaction?

A. Given the history, yes, I think it would be imprudent if we did not plan for a disaffiliation scenario.

MR. HOUGHTON: Your Honor, we have no

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further questions.
THE HEARING OFFICER: Thank you.
MR. CAMPBELL: Your Honor, it's not often that a company lawyer gets an opportunity to cross-examine a Department employee.
THE WITNESS: Watch it.
MR. CAMPBELL: I will be back. So Highmark has no questions.
MR. HOUGHTON: Just to make clear.
THE HEARING OFFICER: Mr. Teichman?
MR. TEICHMAN: No questions.
THE HEARING OFFICER: Are you undaunted?
MS. SHOSS: Undaunted I think.
THE HEARING OFFICER: You may proceed.

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CROSS-EXAMINATION

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BY MS. SHOSS:
Q. Bearing in mind Mr. Campbell's comments, I'm in the same position here.
First of all, I'd like to talk a little about your disaster scenario. For one

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thing, the mechanism that the AG, I would just like to clarify, the mechanism that the AG has proposed says that Highmark and Blue Cross Blue Shield would come up with a mechanism for protecting the public benefit asset. Doesn't presume that it would all come from Blue Cross Blue Shield of Delaware. I just want to clarify that. That's not what the AG has requested.
A. How would it come out of -- I'm sorry. I'm going to cross-examine you. How would it come out of Highmark? They're not a parent -- is that a grant?
Q. They're taking control of this company. It is an acquisition of control of a company. Normally companies pay something to take control of a company.
A. There is a change in control, but they get no distribution of profits. They get no ownership interest if they sell it later. I don't know that they have any obligation to fund that. That's really nice if they do and I know they have talked about a Highmark foundation. But I don't believe that they have an obligation to do that.

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Q. Let's look at what that surplus consists of that we want to keep preserved for the possibility that all of these catastrophes would happen in precisely the same time frame.
That surplus -- this is a not-for-profit. It's not that that surplus was built up entirely by policyholder premium. There's a fairly significant component of that surplus that is undoubtedly attributable to the not-for-profit status of this particular company, the taxes that it didn't pay for years, no federal taxes. For more years than that, no state taxes. So we're not talking about the traditional kind of policyholder surplus in a for-profit company, which is where the Attorney General's perspective is.
So given that, do you view the Pennsylvania Insurance Commissioner as a financial solvency regulator?
A. Absolutely.
Q. Because that regulator, Highmark's regulator, conducted hearings and came out with a mandate about the Blues in that state, recognizing that they're not-for-profits and

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recognizing the unique status, and at some point capital is not necessarily excessive, but there are more efficient uses of capital, and mandated that Blues come up with a plan --
MR. SWAYZE: Your Honor, objection. This is more testimony than cross-examination.
THE HEARING OFFICER: I believe it is, Ms. Shoss.
BY MS. SHOSS:
Q. Is that not something that the Delaware Insurance Department would consider?
A. I'm glad you asked that question because --
MR. SWAYZE: I take my objection back.
MR. HOUGHTON: Perhaps counsel now understands why counsel did not object.
THE WITNESS: I stayed up late last night going through Pennsylvania's department's Web site on this issue because I wanted to get an understanding of what they had done. I've heard you mention that Highmark has to remain within an RBC level of 550 percent to 750 percent, and it is not something that we have considered.

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So I wanted to get my arms around what happened there so that I could explain it a little bit better to myself.

When I read -- as I understand it, Pennsylvania has four Blue plans, and early in 2000, I'm thinking it was for the year end 2003 where they actually studied -- I think the commissioner's ruling was maybe 2005, but I think there were these very concerns about excess reserves. And so they commissioned studies. They commissioned public comment. And there's a lot of good discussion on RBC in there. And I copied it and I was going to read it to you guys, but I'm already going long. So what I just want to talk about are the findings.

The four companies -- of the four companies there were two that were in that 550 percent-750 percent range. That range is regarded by Pennsylvania as sufficient surplus. Anything over top is maybe inefficient surplus by their terms.

So I copied down the numbers because you can't compare RBC just raw numbers without looking at the underlying financial data, and

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Pennsylvania did the same. Total adjusted surplus, Highmark was at the very top, the very biggest. They had $2.2 billion in surplus at the end of 2003; health premiums written, $7.7 billion; 3,800,000 members.

Let's compare that to Blue Cross Blue Shield. Just today, 2010, Blue Cross Blue Shield of Delaware has $171 million -- that's the end of 2010, sorry -- total adjusted surplus. They had health premiums written of almost $500 million, 400,000 members. Substantially smaller than Highmark.

Pennsylvania then -- but Pennsylvania is not looking at Blue Cross Blue Shield of Delaware. I just want you to understand the comparison. You work through -- the other companies in that 550-to-750 range of sufficient surplus was Independence Blue Cross. Another big company. $840 million in surplus, $7.9 billion in premium written, 3,500,000 members.

Then we get to another range which I hadn't heard the Department of Justice speak about and that's the 750 percent to 950 percent, and what they have done, to summarize, is they

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have put smaller companies there because they realize Blue companies do not have the access to capital market. They can be more volatile.

So they put a sufficient range around two companies, Capital Blue Cross which has $515 million in surplus, $1.7 billion in health premium written, one million members. Again, think back to Blue Cross's numbers, $171 million in surplus, 400,000 members. The smallest company of the Pennsylvania Blues was Blue Cross of Northeastern Pennsylvania. Their surplus was $404 million, health premium written of almost $600,000, 600,000 -- no, sorry. $600 million in health premium, 600,000 members.

Again, compare that to Blue Cross Blue Shield, $171 million just in surplus, health premium written $500 million, 400,000 members. Blue Cross is arguably much smaller.

Just in trending this, I don't know that Pennsylvania back then, if they had Blue Cross Blue Shield of Delaware in their state, whether they would have put them in this even the 750-to-950 percent range because we're smaller.

Then it hit me that this actually all

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falls in together because Blue Cross had a Milliman study. Pennsylvania didn't do these ranges without actuaries. They brought actuaries in. They did the studies to come up with those ranges. Milliman has been into Blue Cross Blue Shield of Delaware. They came up in an independent actuarial study. Their recommendation is that the RBC range should be 950 percent to 1,200 percent. That was in 2005.

To me that seems appropriate. There's not been another one done, but when I look at what Pennsylvania did, this sort of follows along with the trend given the size of the company.

That would be my explanation. I'm sorry, I don't have that study as an exhibit. It's on the Pennsylvania department's website. Very interesting reading. Late at night. But that will be my answer on the Pennsylvania study. I think our Milliman study or Blue Cross's Milliman study flows into that and kind of falls in that range.

Q. How does the Department of Insurance view this company as a not-for-profit and the tax

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revenues that have -- the revenues, the surplus that has built up from the company's not having to pay taxes over the years?

A. I think that's the point of for-profit conversion, right, because if you have a nonprofit Blue whose nonprofit mission is to take care of the policyholders within the state of Delaware and the insurance-buying public, I can't recall your mission statement off the top of my head, but that's what I would peg it at.

I have lost my train of thought.

What was the question?

THE HEARING OFFICER: She asked how the Department views not-for-profits and the fact that this is a not-for-profit.

THE WITNESS: Right. Well, I view a not-for-profit, in this case, insurance company as being there to protect -- offer the benefits to insurance-buying public of Delaware and make sure you're around to pay the claims of the insurance-buying public in Delaware. Of the policyholders. That's the mission.

BY MS. SHOSS:

Q. I received an early copy of your

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testimony and I notice that as you were talking through your testimony you changed in a number of places where you said Delaware Department's duty is to protect the policyholders and the public, and you changed it to the insurance-buying public.

Why do you draw that distinction or where do you draw that distinction?

A. Well, that comes from there's one standard which references the policyholders and the insurance-buying public. I think it's F. And then there's one standard, D, which says we have to look at the plans that the controlling entity coming in would have to liquidate assets to merge with another company. Any material plans that may not be in the best interest of the policyholders and -- let me get the exact wording because I think the wording is informative.

The statute requires the Department to determine whether any of these plans or proposals are unfair or unreasonable to Blue Cross's policyholders and not in the public interest.

So when they described their plans to

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the Department, we have to look at those one by one and decide if they're not in the public interest. We have listened to their plans and proposals. There's nothing there that I can pull out and say, oh, my gosh, this is going to wreck the market and harm -- I guess harm the public. There's nothing there that would harm the public. So there's nothing there that would not be in the public interest. As opposed to saying, well, in a Form A I need -- I need to consider everyone gets a contribution from the requiring party. I don't consider that my duty or part of the standard.

Q. Can we talk a little bit about the allocation methodology, shifting over to there? You were getting this 300 pages of methodology and formulae before closing, not before the order?

A. Before closing, not before the order, yes.

Q. Will you have an opportunity to review it before closing?

A. I don't look at it -- well, hopefully. It sounded like it was promised before closing.

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But it also sounded like per Mr. Gebhard that initially maybe for the first couple years what we're going to see mostly are Blue Cross Blue Shield of Delaware paying their own direct costs and then gradually, as they get integrated, they would move on to more and more of this cost allocation methodology. I'm hoping that that is happening gradually enough where we build into it. They work with us and we get the understanding so that we can review it, approve it annually, and then examine it if we need to on site. But I don't look for us needing to see that before we would do an order. I don't think it would figure in as we're just not going to do this under these conditions. At least what I have seen so far.

Q. The methodology doesn't represent the guiding principles as compared to the budgets that you do review?

A. I think what's important to me is that there is an Administrative Services Agreement that says there will be services provided at cost, no profit margin at cost. That's a good deal. And we have to approve that probably

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simultaneous to the closing. And I know we're going to -- because of the conditions, we're going to amend it and get those conditions in. And we feel the conditions are rigorous enough that, if we find out later this cost methodology is not what it's cracked up to be, I believe we have relief in the Court of Chancery. The lawyers can tell me if I'm wrong. It can go that far.

I feel protected -- I feel fine as we are now.

Q. Do you feel that -- are the parties going to pay for advisors to assist you in reviewing all this? Is this typical of what you review, these budgets?

A. Examinations will be at -- how did we arrange it? Any type of review in a Chapter 50 proceeding, there is a section that we already have where the company requesting this approval has to pay. It's at their own expense. This is the way that we use it. I think I already have all kinds of consultants already volunteering for the job, so I'm not worried about that.

Q. And that will apply as well to your

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review of methodology formula, budgets, etcetera. Those are all under the financial examination review?

A. We're going to have to look at what comes in under the 300 pages to see if it looks reasonable to us. I realize we're not cost accountant whizzes, but we are able to look at things. We're analysts. We look at things and determine, well, does this make sense? Cost allocation is not rocket science. It has to make sense.

Now, yes, it's kind of inexact. The formulas are based on, well, maybe there's two and a half full-time employees that are going to handle this. There's ways that -- there are ways that Blue Cross Blue Shield could benefit because maybe it's not as precise as you would like it, but when we examine the variances, I think we should be able to pick up on things that we want to question and examine.

Q. And are you convinced that you will get the information you need about variances or disputes, characterized as disputes in the condition I think that Blue Cross has if you only

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get what comes to you? Have you gone all up the chain? What comes to you as an arbitrator?

A. The variances, I know from having this phone call that that is a slip of paper that Blue Cross Blue Shield will get monthly. It's a simple thing for them to scan it in and send it to the Department.

The dispute resolution, you're right, we're not going to know at the -- where the cost processors are, where they have to have that discussion about what's fair and what's not. You're right, we don't get that granular. And it sounded like from testimony if there are already big issues, that's where we resolve those issues. We're the ultimate arbiter. If I'm concerned about something along the line, there is a way that we can check Blue Cross Blue Shield's minutes. The Blue Cross Blue Shield board will be one of those steps upon exam. We look at the corporate minutes. So we can see that.

That's about the best I can answer.

Q. Do you feel you nailed as much of this down preaffiliation as you can?

A. We have tried to nail as much as we can

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prior to the affiliation because, yeah, frankly, we have the leverage now, and it's good to put it in writing. All the parties know going forward this is how it's going to be, but I look upon the cost allocation methodology and the reviews and the approvals as an ongoing challenge. It's a learning opportunity for us, but I think that the Department is up to it. It's an analysis chore at the end of the day. We have analysts who look at Blue Cross and analysts like Anna who looks at it on a quarterly basis. They're used to doing this type of thing.

Cost allocation is a little bit different, I grant you. We will work with the company and have what we need.

Q. In the closing line or two of your testimony you talked about "plus any further conditions that the Commissioner might impose." Do you have any in mind? Are you aware of any?

A. I'm not aware of any, but this is a process where the Hearing Officer will consider what's been spoken of here and may have some conditions of her own to recommend to the Commissioner. At the end of the day, the

Commissioner has to feel free to also review this process and say, now, look, guys, I want this one more condition and I'll feel that the Delaware policyholders are protected. I can't guarantee what she will do.
Q. All of the conditions, at least so far as I'm aware, that the Department is putting forward have been agreed by Highmark and Blue Cross; is that correct?
A. Thirty-seven conditions are agreed to.
Q. And are there any others that you're putting forward that aren't agreed?
A. Not to my knowledge, no.
Q. So all the ones, all the conditions the Department is putting forward are conditions that the companies are willing to live with?
A. Yes. They're in this exhibit -- I forget the number of the exhibit.
MR. HOUGHTON: 113.
BY MS. SHOSS:
Q. One other question I think.
If there are overcharges by Highmark, what happens? Are there penalty provisions? What are the teeth in that?

A. No, I don't believe we set up penalty provisions. There would be -- there would have to be a settling up. If there's an unfair or improper allocation, No. 1, the company is going to want to get into it with Highmark and they would be the first line of defense and ask for that. I suppose at the end of the day for the arbiter we would also ask for it back.
If you're asking for interest charges, I'm thinking that this is a fairly rapid process. The dispute resolution mechanism in the ASA, it's 30 days at the process owner level. Then it moves to Tim Constantine and the CEO of Highmark. Then for 30 days. Then in the next 30 days, if they don't resolve it, it goes to the Blue Cross board, 30 days, then it would come to us.
I guess if it's large enough, I guess the interest charges on that would be harmful and maybe we will discuss it. Ordinarily, from what I heard from Highmark West Virginia, it doesn't reach that level. I would hope to catch most of this hopefully in the annual budgeting process. But like I said, we will check the variances.

Q. Yeah, because there can be overcharges or allocations that are disputed. But there might be some that come up in the course of your review as well that perhaps aren't raised and disputed by Blue Cross. What sort of teeth are you -- what sort of --
A. If Blue Cross Blue Shield of Delaware has not disputed these things, and I'm hoping that the analysts would pick it up in the variance process, but if it gets missed there, we also have an examination, a full-scope examination done. I believe for health service companies in the law it's three years.
So we have examiners that will go on-site. It's their normal duty to pull out all these documents and look at the cost allocations. If we hear at the Department that the analyst level missed it and Blue Cross hasn't told us about it, like I said, there's the minutes, Blue Cross Blue Shield board minutes, and then there's the examination on-site that we do as a regular process here as a requirement to pick it up.
Q. You haven't really thought about whether there would be penalties or interest or anything

like that if there were a pattern?
A. No, we haven't, but I think -- if you're worried about that, the Commissioner has discretionary authority and there are fines and penalties. In the conditions I know of nothing that have been built in as interest charges.
Q. One other -- I'm sorry. I said one more. But there is one more. One more one more.
We had some discussions this morning with Mr. Alderson-Smith about the cap in the West Virginia deal, and he said that the Department and advisors talked about that and opted for what he described as a more flexible arrangement.
Is there any reason why you wouldn't do both?
A. Why we wouldn't do both.
Q. Sorts of belts and braces as they would say in Mr. Alderson-Smith's plan?
A. I guess that's possible to do both, but why would you? I think I would rather have this very admittedly granular process to understand it. Caps. Is that an appropriate cap? Did West Virginia put on an appropriate cap? We

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really haven't done a study on whether that was even an appropriate thing to do. I think West Virginia put it on as a precaution. I think it makes analysis that much easier because it's a cap that can go all the way up. We're not going to examine until we get all the way up until plus 2 percent. That may be a big number. Why wouldn't we examine it through the processes that we have set up and cap it at less than plus 2 percent? That would be my explanation.

Q. Yeah, I don't see it as mutually exclusive. That's why I asked why wouldn't you do both. Why wouldn't you examine and have a cap?

A. I can't honestly answer other than that we were satisfied with what we had set up and feel strong enough.

MS. SHOSS: That was the last one. Unless there's any redirect.

THE HEARING OFFICER: Any further questions?

MR. TEICHMAN: I have a couple.

THE HEARING OFFICER: You may proceed.

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CROSS-EXAMINATION

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BY MR. TEICHMAN:

Q. Ms. Sizemore, as first an analyst for the Department and chief examiner and now director of company regulation, is it fair to say that over the years you've become familiar with the financial reporting and the financial results for BCBSD?

A. Yes. In 2006 I was the analyst for Blue Cross Blue Shield of Delaware and I was that analyst until I became chief financial examiner sometime in 2007. So I got to know them on a quarterly basis for about a year after that.

Q. With that background, I have just a couple of questions.

Ms. Shoss asked you a couple of questions about the source of BCBSD's surplus. Let me ask that question a different way.

What are the sources of revenue for BCBSD, generally speaking?

A. Health insurance premiums in a variety of lines coming from the policyholders in the state.

Q. Investment income, too?

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A. Certainly.

THE HEARING OFFICER: I didn't understand your question.

MR. TEICHMAN: I'm sorry, Your Honor. I said, "Investment income, too."

THE WITNESS: Absolutely. Investment income, realized capital gains, premium revenues. I'm sure there's some miscellaneous categories.

BY MR. TEICHMAN:

Q. Just to be clear, no charitable contributions or anything like that, correct?

A. No. As revenue, no.

Q. Now, there was a question or two actually posed to Mr. Smith earlier in the day, and the questions related to whether BCBSD is taking appropriate safeguards with respect to its surplus as a result of the economic downturn a few years ago. In fact, I think even the Judge had a question about maybe was there an escrow or something like that.

Were you in the audience when those questions were being asked?

A. Yes.

Q. My question is from a statutory

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accounting principle standpoint, is there anything that these principles require with respect to protecting surplus from economic downturns that BCBSD is not doing now?

A. No. I knew BCBSD as a compliant company when it comes to safeguarding its assets and complying with the statutory accounting principles.

Q. One other question. I think you started to talk a little bit about the examination process, the tri-annual examination process. It might be helpful for the Judge if you could spend a few minutes describing that process and describing what the Department's examiners look at.

A. Well, the examiners will come on-site, as I said. According to the statutory law and for health service corporations it is every three years, not every five years. They will test assets. They will look at custodial agreements. They will interview the -- we're now involved in risk-focused examinations. So we will look at all the risks that reside within Blue Cross Blue Shield of Delaware and then they will form a

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matrix and decide if Blue Cross Blue Shield of Delaware has mitigated those risks, if they have internal controls in place that will mitigate those risks.

So they're pretty much confirming the assets, going through the balance sheets, not so much to tick and tie anymore. You're moving from that. It used to be where all the assets and all the liabilities had to be fully ticked and tied I guess on the financial statement. But it's gone more to a risk-focused process where we're trying to understand the dangers and the risks to Blue Cross Blue Shield and its policyholders and put some substance, some examination around that. We bring in actuaries who will test the reserves.

Q. Let me ask you this. Some of the controls that you mentioned that your examiners will be looking at, will some of those controls include internal controls on the allocation process?

A. Yes. Absolutely. I mean, normally they would look at the cost allocation process because it is a way that expenses could be improperly allocated. So it is one thing that they would

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examine, yes.

MR. TEICHMAN: Nothing further.

THE HEARING OFFICER: Thank you, Mr. Teichman.

Mr. Houghton?

MR. HOUGHTON: Unfortunately, Your Honor, quickly.

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REDIRECT EXAMINATION

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BY MR. HOUGHTON:

Q. Ms. Sizemore, I'd like you to look at the list of conditions that we have been working from, and I want to try to address the issues that have been raised regarding perhaps the lack of a clear enforcement mechanism in the event that there has not been appropriate compliance by Highmark with cost allocation, fair and reasonable allocation of expenses.

I wanted you to look at condition No. 32. Condition 32 is a condition under which Highmark agrees to be governed by Chapter 50, which is the holding company registration chapter; is that correct?

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A. That's correct.

Q. And condition No. 11 provides that there will be Department annual review and approval of plan charges which shall be fair and reasonable under 18 Delaware Code 5005, correct?

A. That's correct.

Q. Under Chapter 50 are you aware of the sanction and enforcement mechanisms that exist in Section 5010 pursuant to which there can be a variety of charges, fines, and a variety of other enforcement mechanisms leveled against directors or officers not only of insurers but of members of the insurance holding company system, which would include an affiliate, for failure to comply with the provisions of Chapter 50? Have you ever had occasion to look at those sanctions or enforcement mechanisms?

A. I have read through them. I don't know that I have used the sanctions.

Q. Is it fair to think that as we together move forward with an affiliation, if an affiliation is approved, that you will review the relevant provisions of Title 18, including Section 5010 relating to sanctions for failure to

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satisfy the provisions of Chapter 50, to determine whether or not you have tools to enforce both conditions that have been made and other provisions of Chapter 50?

A. I feel confident that we do have the tools to enforce Chapter 50. Whether it's 5010 -- that would be the ultimate authority if we do an examination leading up to any enforcement action.

Q. And Highmark has also agreed pursuant to Chapter 32 to -- I'm sorry, condition 32 to provide information in accordance with sections 318, 320, and 322 of the Code, correct?

A. Correct.

Q. Those are general examination authority. Is it fair to say the Department would carefully examine the remainder of Chapter 3 to see the connection between those examination provisions and any enforcement provisions elsewhere in Chapter 3 that could be applicable?

A. Certainly.

MR. HOUGHTON: No further questions, Your Honor.

THE HEARING OFFICER: Thank you.

Ms. Sizemore, thank you for your testimony.

THE WITNESS: Thank you.

THE HEARING OFFICER: You are excused.

I think that completes the testimony for today?

MR. HOUGHTON: Your Honor, the Department of Insurance has no further testimony in connection with the application, and the Department of Insurance has no appetite or inclination for closing statements.

THE HEARING OFFICER: Nor does the Hearing Officer. However, two things.

First of all, after we're all excused, I would like to meet with counsel for just a few minutes sort of to get our -- partly to get our ducks in a row for tomorrow about what's going to happen tomorrow. If you all don't mind staying just a few minutes.

Earlier today Mr. Swayze asked me if he could have a moment to place on the record a response to the Attorney General's statement that he made at the outset of these proceedings, and I

indicated that I would grant him the permission to do that, just to respond to that, because he was not -- no one was able to cross-examine the Attorney General and seemed only fair to give him a chance to respond to that.

So you may proceed, Mr. Swayze, briefly.

MR. SWAYZE: Thank you, Your Honor. Always briefly.

As you know, the Attorney General submitted on the 4th of September a refined condition regarding the Blue Cross reserves that spoke to the creation of a mechanism by which the two companies, Blue Cross and Highmark, could address a public interest of undefined proportions. We understand, of course, from previous statements that the Attorney General is, in making that condition or opposing that position, asserting in the context of this hearing his parens patriae authority which we don't dispute except in the context of this hearing.

Our concern in the first instance, Your Honor, is that this hearing is convened

pursuant to paragraph 8 of the prehearing order to determine whether or not the proposed affiliation of Highmark and Blue Cross Delaware meets the six criteria under Chapter 50, and we have, I think, arduously pursued that process over the past year. And this hearing has been, I think, a very fine reiteration of all the work that's gone before with respect to, again, compliance with the Chapter 50 process.

The condition which the Department of Justice would impose is not consistent or it hasn't any particular nexus with the criteria that are set out in Section 5003 of Chapter 50. Indeed, in the prehearing memorandum, if you look at page 12 of that memorandum, the Department of Justice admits as much. It says, "Therefore, the DOJ's role extends beyond the impact of a change of control on the insurance-buying public or policyholders to matters beyond the purview of the DOI, including the impact on the public as a whole as to matters that would not trigger the DOI's protection, e.g., protection of the assets accumulated through the public subsidy."

The Attorney General's basically

saying even though it's in the context of this hearing, I'm asking the Department of Insurance to do something that is not dictated by or indeed even cognizable under the provisions of Chapter 50. We think for that reason that the condition is not appropriately before this body.

I point out in that connection, Your Honor, that it's not as if the Attorney General doesn't have recourse with respect to the exercise of his parens patriae powers. Historically they're exercised in our courts of general jurisdiction, either Superior Court or perhaps, in this instance, Chancery Court. But he does not have to rely on this process to exercise his common law or statutory authorities as he sees it.

In this particular case, Your Honor, we have a new provision, 6311(b), which I think informs the Chapter 50 process, and it has been, I think, addressed in some detail here today and very effectively by Mr. Alderson-Smith and indeed by Ms. Sizemore.

But basically the provisions of 6311(b) make clear that the purpose of the conditions, the additional conditions which the Commissioner is asked to impose on a transaction of this sort protect, protect the reserves and surplus of the company. I think it is not very much of a deductive process to realize that what was referred to by Mr. Alderson-Smith as an attack on the reserves and surplus of Blue Cross Blue Shield Delaware is at the antithesis of the protection of the surplus and reserves. You cannot characterize the removal of 25 percent of Blue Cross's surplus as a protection. I think that any condition which does other than protect those reserves is not consistent with 6311(b) and, therefore, not consistent with Chapter 50.

I'd ask for that reason that no condition be considered which has the effect basically making the Blue Cross reserves sort of a piñata and asking the Department or the Commissioner of Insurance to swing the stick in hopes of raining down a portion of that reserve on some purpose or for some purpose that does not relate to the protection of the company and its policyholders as is found at 6311(b)(4), which is the standard, I think, that is imposed by that

statute.

For those reasons, Your Honor, we would request that there be no consideration of a condition such as that interposed by the Department of Justice with respect to the withdrawal of reserves of Blue Cross Blue Shield Delaware for a purpose other than the protection of the policyholders and the company.

Thank you.

THE HEARING OFFICER: Thank you, Mr. Swayze. I will keep your argument under advisement.

MR. SWAYZE: I appreciate that.

THE HEARING OFFICER: And I have a huge task ahead, as you can all tell, reviewing all these documents and all the testimony we have heard and getting a recommendation to the Commissioner very quickly.

We did say there is a deadline of October the 24th to get in, if the parties wish to, file proposed findings. You may have until that date to do so.

MR. HOUGHTON: Thank you, Your Honor.

THE HEARING OFFICER: Thank you. And

that concludes this portion of the hearing. We will be back at 9 o'clock tomorrow to allow members of the public to participate. Thank you, all, for your attention.

(Hearing adjourned at 4:20 p.m.)

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T E S T I M O N Y

C E R T I F I C A T E

STATE OF DELAWARE)
)
NEW CASTLE COUNTY)

I, Kimberly A. Hurley, Registered Merit Reporter and Notary Public, do hereby certify that the foregoing record, pages 326 to 611 inclusive, is a true and accurate transcript of my stenographic notes taken on Thursday, October 6, 2011, in the above-captioned matter.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this 6th day of October, 2011, at Wilmington.

Kimberly A. Hurley