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EXAMINING HEALTH CARE MERGERS IN PENNSYLVANIA

HEARING

BEFORE THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

APRIL 9, 2007

PHILADELPHIA, PENNSYLVANIA

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THE HIGHMARK/INDEPENDENCE BLUE CROSS MERGER: EXAMINING COMPETITION AND CHOICE IN PENNSYLVANIA'S HEALTH INSURANCE MARKETS

MONDAY, APRIL 9, 2007

UNITED STATES SENATE,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Committee met, Pursuant to notice, at 9:30 a.m., in the Kirby Auditorium, The Constitution Center, Philadelphia, Pennsylvania, Hon. Arlen Specter, presiding.

Present: Senators Specter and Casey.

OPENING STATEMENT OF HON. ARLEN SPECTER, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Senator SPECTER. Good morning, ladies and gentlemen. The hearing of the Senate Judiciary Committee will now convene. We will be considering today the proposed merger of Independence Blue Cross and Highmark, two very large companies which provide health care insurance for Pennsylvania—Independence Blue Cross in the eastern part of the State and Highmark in the west.

We all know the importance of health care. Health is our No. 1 capital asset. Without good health, there is nothing any of us can do. And I am Exhibit A on that proposition and thankfully enjoying good health because of excellent medical care. But we need to provide that medical care for all Americans, and this proposed merger has very major implications for people in the Commonwealth of Pennsylvania.

These two companies are enormous in their importance in the State. Independence Blue Cross has 64,000 employees, serves about 3.4 million Pennsylvanians, has arrangements with more than 16,000 physicians and more than 70 hospitals. Highmark, similarly, had a dominant share of the market in western Pennsylvania, covering 4.6 million Pennsylvanians, 30,000 physicians, and takes care of approximately—or has arrangements with approximately 100 hospitals.

There are real concerns, which have been expressed from time to time, about the financial undertakings of these two companies, especially with respect to the surpluses. Highmark has a surplus of some $2.6 billion, Independence Blue Cross a surplus of $1.2 billion. There is a recognition that surpluses are necessary for unanticipated costs, but there is a real question as to whether that is excessive.

When you take a look at executive compensation—and all of this on the public table—compensation for the CEO of Highmark is $896,000, $2 million in bonuses, and another $315,000. And when you are looking at nonprofits, candidly, there is a question as to whether it really is nonprofit.

There is a projection that there will be a saving of some $1 billion in consolidation and efficiencies. Well, that raises the question as to where that $1 billion is going to go. And to move the hearings along, I wrote to the CEOs of these two companies asking them for the specifics as to where the $1 billion would go. They talk about covering the uninsured. If that were to be the case, that would be very salutary. We have many Pennsylvanians, in accordance with the national picture, who do not have health insurance.

We have a real concern about the bargaining power and dealing with the hospitals and dealing with doctors. Last year I presided at a hearing in the Judiciary Committee where the doctors are looking for an antitrust exemption so that they have more bargaining power in dealing with Independence Blue Cross and Highmark. So these are all major, major issues.

We are joined today by the distinguished Governor of Pennsylvania, Edward Rendell, and the distinguished Senator—maybe both Senators are distinguished, but I will certainly say Senator Casey is distinguished. Senator Casey has been in the Senate only a short time, but he is already on the Judiciary Committee, at least on occasion.

We have eight witnesses. Many people wanted to testify. We do not expect to be able to answer all of the questions today, but today is a start. To give the key players a chance to express themselves, we are going to ask everybody to observe the time limits very closely. I am at 4½ minutes on an opening and will close in less than 30 seconds. We have allocated an hour and a half, and we are going to have to move right along and focus on the issues to stay within the time limits.

All prepared statements will be made a part of the record, and now I am pleased to yield to my distinguished colleague and friend, Governor Rendell.

STATEMENT OF HON. EDWARD G. RENDELL, GOVERNOR, STATE OF PENNSYLVANIA

Governor RENDELL. Well, thank you, Senator, and I will be very brief. As most of you know, Senate bill 550, sponsored by Senator White, who is with us today, passed the Senate and is in the House, and it will give the Insurance Commissioner the broad power to approve or disapprove mergers for nonprofits, a power that the Insurance Commissioner has for for-profits at this time. You never can predict what happens in the legislature, but whether that bill passes or not, the Insurance Commissioner has the power to conduct hearings around the State, and we will conduct hearings in four or five different locations, fairly exhaustive hearings, over the next several months.

Of course, the law allows for and requires public comment to go on the record, and there will be ample opportunity for that as well. So both through the public comment process and through the hear-

ing process, we hope to get exhaustive input before any final decisions are made on this issue.

However, I do want to compliment Senator Specter and Senator Casey for taking the lead here and bringing some of these issues to light early, because I think it is important that the public understand what is at stake and what the intent of the parties is in this merger.

I, too, share—and I am sure Senator Casey does as well—two great concerns: what this merger will do to competitiveness in terms of the consumer, the businesses who buy and provide health care for their employees, the employees who pay premiums, those who are self-insured as well. That is of great concern to me. Pennsylvania presently does not have enough competition, and the question of a price point, we have tried to do things to engender that competition. But our competition is limited, and we want to determine what, if any, effect this has on the competitive process from that angle.

But, second, as the Senator said, we very much care about our physicians and our hospitals. Physicians have been squeezed on pricing because in many areas there is a dominant carrier and that carrier sets the price for a procedure, and it is essentially take it or leave it for that physician. We want there to be greater flexibility and greater competition from that standpoint as well.

Having said that, I would be remiss if I did not also say, however, that the two companies who come before us today are, in my judgment, superb corporate citizens of the State of Pennsylvania. They contribute in so many different ways, and when we sought 2 years ago, Senator, to expand our adult basic care program, which is the existing program for working Pennsylvanians, these companies took the lead in reaching an agreement with the head of the Office of Health Care Reform, Rosemarie Greco, to put significant dollars—significant dollars—into the very significant expansion of the ABC program. When we outlined this year our prescription for Pennsylvania, which will cover over the course of the next 5 years, the remaining 757,000 Pennsylvanians that do not have health care, these companies stood forthright and supported those efforts.

When we pushed a bill to cover all of our children in Pennsylvania, a bill that I signed in October of 2006, both companies were very supportive of those efforts. We appreciate that, and they are good corporate citizens. They are excellent employers. So they start off with, in my book, a solid presumption. However, the issues that Senator Specter has raised and the issues that I have highlighted are very significant and must be resolved in a satisfactory way.

Senator SPECTER. Thank you, Governor Rendell.

Senator Casey?

STATEMENT OF HON. ROBERT P. CASEY, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Senator CASEY. Senator, thank you very much.

I first of all want to thank Senator Specter for bringing us together today for a lot of reasons. One is because of the nature of this question for the people of Pennsylvania, but also I want to commend his leadership on so many aspects of health care, which is such a critical issue for the State and for the country. And we

are honored by the presence of the Governor and his work to expand health insurance in Pennsylvania.

We face, I think, in the country a real challenge on obviously a lot of aspects of health care—cost being principal among them—but I think there is an opportunity this year in the Congress. Senator Specter and I have worked very hard to make sure that at the Federal level the Children's Health Insurance Program is expanded, so-called SCHIP. Governor Rendell is an example of someone who is trying to expand health care coverage in Pennsylvania by a significant number. At the same time, the Federal Government, at least the Bush administration, wants to go in the opposite direction if their budget proposal is any indication—which it is.

So it is a critical issue for the State, and I think when it comes to this question of Independence Blue Cross and Highmark, obviously we have some real concerns about the potential anti-competitive nature of this arrangement. We are concerned about, as Senator Specter said, the level of surplus that both companies have right now. And we are also concerned in a broader way about the impact that this merger would have on health care and jobs in Pennsylvania.

We will not reach conclusions today necessarily. We will not be able to ask and answer every question. But it is a very good start, and I think this hearing and others like it, in conjunction with the State, the hearings that Governor Rendell referred to at the State level, I think will inform and enlighten the people of Pennsylvania about this. And I join Governor Rendell in commending a lot of the work that has already been done by these two firms to expand the number of Pennsylvanians who are covered and to provide quality health care for the people of the State.

But I think we have real opportunities this year in terms of the Federal budget and legislation, and also we want to make sure that we get this right when it comes to the impact of this merger on the people of Pennsylvania.

Senator, thank you again.

Senator SPECTER. Thank you very much, Senator Casey.

We turn now to our first witness, Mr. Joe Frick, President and CEO of Independence Blue Cross. Thank you very much for joining us today, Mr. Frick, and we look forward to your testimony. I might just say that each witness will be allowed 5 minutes, and then there will be rounds of questioning at 5 minutes each.

STATEMENT OF JOSEPH A. FRICK, PRESIDENT AND CHIEF EXECUTIVE OFFICER, INDEPENDENCE BLUE CROSS, PHILADELPHIA, PENNSYLVANIA

Mr. FRICK. Well, thank you again, Senator Specter and Senator Casey and Governor Rendell, for the opportunity to speak to you today about why the combination of Highmark and Independence Blue Cross into a new company is good for Pennsylvania and how it will create value for our customers, for health care providers, the communities we serve, and, most of all, for the people of our great Commonwealth.

I am very pleased to be here today on a panel with recognized leaders in our community and hear their perspectives on this important matter.

The unanimous vote 10 days ago by the boards of Highmark and IBC to combine our two companies begins an extensive review process. We look forward to working cooperatively with State and Federal regulatory agencies and with public officials who want to understand the impact of this combination on the people of Pennsylvania. Today we will continue the open dialogue we have already begun with key stakeholders in health care about how this combination will enable us to better serve their needs. We welcome your participation.

You know, every major national and local survey in the last year has shown that the No. 1 issue on people's minds is the availability of affordable health care coverage. It is no wonder. Every year employees shoulder more of the cost of health insurance, fewer employers offer health coverage, and there are more uninsured. Our mission at Independence Blue Cross and at Highmark is to provide access to quality, affordable health care.

We strongly believe this combination is mission driven and will not reduce competition or choice in the health insurance marketplace in the Commonwealth. First and foremost, the combined companies will generate more than $1 billion in additional resources over 6 years for health care in Pennsylvania. This is new money, and it goes beyond any commitments we have today. These additional resources will come largely through savings from business efficiencies that the two companies cannot produce individually. The savings will enable us to invest in new market-leading capabilities that are increasingly important to consumers and providers.

The combined company will avoid duplicating future investments in costly technology and administrative requirements. These savings will fund and allow us to more quickly take advantage of cutting-edge technology to improve the quality of care, such providing electronic personal health records or e-prescribing tools.

We will also achieve significant savings by consolidating computer systems used for claims processing, enrollment, medical management, and provider transactions. One new capability this will allow us to pursue is real-time claims adjudication, a major benefit for both patient and physician.

By using the best practices of Highmark and IBC to perform more efficiently, the combined company will have the resources to expand wellness initiatives that keep people healthy and disease management programs that help the chronically ill lead healthier lives.

We also listened to our customers' concern about ever-increasing pharmacy costs. The combined company will reduce prescription drug costs by launching initiatives that capture higher rebates, pharmacy discounts, and lower the cost of administration—economies possible only with a larger membership base—and these savings of approximately $285 million will go directly to our customers.

Since we do not have shareholders or investors like our publicly traded competitors, the combined company will be able to reinvest this $1 billion in savings into the health care needs of our customers and community. Our first priority is to direct more than $650 million to expand access to health insurance for Pennsylvania's uninsured and underinsured—$650 million over and above

our current commitments. The increasing number of uninsured in the Commonwealth drives up health care costs for all of us. We will spend roughly $350 million to extend for 3 years the Community Health Reinvestment agreement we have with the Commonwealth. Another $300 million will fund other programs or newly developed products to expand health care coverage in Pennsylvania.

Most of our customers' premium dollar, more than 85 cents of every dollar, pays for the medical care our members receive. Less than 10 cents of each premium dollar goes to administrative fees. The combined company will not increase administrative fees for 2 years—direct savings to our customers' premiums of almost $300 million that would not be possible without an IBC/Highmark combination.

There has been much speculation about what our ultimate plans are. I assure you both our boards and executive teams are committed to our Pennsylvania-based, not-for-profit status as one of the key factors that differentiates us. In 2006, Highmark and IBC contributed over $200 million to support community health and education programs, such as those focused on fighting hospital-acquired infections, providing clinics for the uninsured, increasing the supply of nurses through scholarships, and preventing childhood obesity. These efforts are increasingly important and will continue.

The proposed combination will not reduce competition. First, Highmark and IBC do not compete and never have—

Senator SPECTER. Mr. Frick, how much more time will you need?

Mr. FRICK. Less than a minute, Senator.

Senator SPECTER. Proceed.

Mr. FRICK. Thank you. We are both licensees of the Blue Cross Blue Shield Association, a brand that is second to none and proudly insures one out of every three Americans. We have worked closely together for more than 50 years. However, we have virtually no geographic or customer overlap. So, by combining, we are not reducing competition. It is worth noting that today Pennsylvania is one of only five States in America with more than one Blue plan. With the Federal Government developing regions for Medicare PPOs and the Commonwealth exploring statewide risk pools, it is important for us to offer seamless statewide products, networks, and services.

Highmark and IBC have major competition: national, publicly traded, highly capitalized companies—Aetna, Cigna, Coventry, United. All have access to capital to buy companies and add capabilities. Sierra Health Plan was recently purchased for $2.6 billion by United, one of our top competitors, with more than 33 million members and $71.5 billion in annual revenue. In 2005, Aetna spent $400 million to acquire ActiveHealth, a clinical data analytics company.

When we began talking with Highmark almost 2 years ago about the possibility of working together, we had one goal in mind: access to quality, affordable health care. Today we are very energized by the possibilities we see ahead.

Thank you.

[The prepared statement of Mr. Frick appears as a submission for the record.]

Senator SPECTER. Thank you, Mr. Frick.

We turn now to the President and CEO of Highmark, Dr. Kenneth Melani. Prior to joining Highmark, he was President of West Penn Cares, certified in internal medicine, summa cum laude from Washington and Jefferson, and medical degree from Wake Forest.

Thank you for being with us today, Dr. Melani, and the floor is yours.

STATEMENT OF KENNETH R. MELANI, M.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, HIGHMARK, INC., PITTSBURGH, PENNSYLVANIA

Dr. MELANI. Thank you, Senator Specter, Senator Casey, and Governor Rendell, for the opportunity to speak to you today about why the proposed combination of Highmark and Independence Blue Cross into a new company is good for Pennsylvania and how it will create value for the communities in which we operate, for our customers, for health care providers, and, most of all, for the people of Pennsylvania.

We recognize that this hearing is the start of what may be an extended review process involving State and Federal regulatory agencies with input from the Pennsylvania General Assembly and the U.S. Congress, and we welcome the opportunity to discuss the proposed combination of Highmark and Independence Blue Cross and are committed to working cooperatively to help ensure that this process is open.

Before the announcement of this agreement to combine the two companies, we had been regularly briefing key stakeholders in Pennsylvania on the status of the discussions between the two companies, and we will continue this open dialogue as we move forward.

We expect some individuals and organizations may have some apprehension and some pointed questions about the potential impact of this agreement. Because there are still many details that have to be decided about how to integrate the two companies, we may not be able to answer all of your questions today. I assure you that we will provide you with updates about the new company as important business issues are decided.

We ask that members of this Committee, other people here today, and all Pennsylvanians keep an open mind and look at the big picture in weighing the merits of this agreement. The boards of directors of the two companies took this approach during their thorough review of this transaction and concluded that the combination of the two companies is good for Pennsylvania. In fact, both the Highmark and Independence Blue Cross boards unanimously approved the agreement to combine the two companies.

Why will this new company be good for Pennsylvania? Joe Frick addressed many of the reasons in his remarks, but in addition to helping improve access to affordable, high-quality health care, the new company will serve as an engine for the Pennsylvania economy for years to come. Currently the two companies have a total annual business impact of $4.2 billion on the State's economy, representing monies generated in Pennsylvania because of Highmark and Independence Blue Cross. We employ more than 18,000 Pennsylvanians, and we help produce jobs for another 54,000 people in businesses that provides goods and services to the two companies.

Although we are both nonprofit corporations, we provide substantial tax revenue for the State with our subsidiaries paying $113.6 million in State taxes in 2006.

In the future, the new company has the potential to become an even larger contributor to the State's economy. I believe we will be able to grow our business to meet the shifting needs of our current customers and new customers, not only in the area of health insurance but also in our dental and vision businesses and other related services through partnerships with other Blue Cross Blue Shield companies throughout the country. The additional revenues generated through the business growth means we can bring back more money to Pennsylvania, create more jobs in the State, and stimulate additional business opportunities for Pennsylvania-based companies.

Equally important, while we anticipate gaining operating efficiencies as a result of the combination, we expect that any potential impact on employment will be managed through attrition and business growth. In other words, we plan to use our collective workforces to meet the changing needs of our customers and provide employees with opportunities for professional growth.

Now, as Joe has discussed, the new company will generate $1 billion in economic benefits that will be used to achieve savings for our customers and to expand access to health insurance for Pennsylvania's uninsured population. What I would like to talk about is why this combination is a plus for health care providers, including physicians.

As a physician, I, too, am concerned about the changes taking place in the financing and delivery of health care and how they may be affecting the physician-patient relationship and the quality of patient care. For a number of reasons, however, I believe the new company will have a positive effect on physicians, primarily because it will allow them to spend more time with patient care versus administrative tasks of a medical practice. The new company will work to identify best practices to help simplify administrative transactions with physicians and hospitals, using the most effective means of electronic connectivity, and at the same time, we will continue to approach health care on a region-by-region basis. Because the delivery of health services is a local issue, we will concentrate on maintaining our well-established relationships with physicians to address unique medical needs of our customers—their patients—in each region.

The new company's commitment of $650 million to expand access to health insurance for Pennsylvania's uninsured will also benefit hospitals, physicians, and other health care professionals by providing more revenue for the medical services they provide. Physicians have been a valued partner in both Highmark's and IBC's longstanding missions, and we want to continue that spirit of collaboration, especially with the development of an electronic personal health record to help address quality, patient safety, and cost issues.

I would also like to take a moment to address a question in your recent letter relating to concerns raised by physicians, hospitals, and other health care providers about reimbursements to health care providers.

Physicians and hospitals will be important to the new company's success as they have been for decades to the success and long-standing missions of Highmark and Independence Blue Cross. One of the principal ways that we have met our customers' expectations in the marketplace is by offering health benefit programs that include access to the broadest networks of physicians, hospitals, and other providers. To help achieve broad provider networks, we have strived to fairly reimburse providers for medical care provided to our customers.

I want to be very clear on one other point. The new company will continue to maintain fair and reasonable provider payment levels. The $1 billion in economic benefits that Joe has discussed and I have been discussing today will not result from changes in physician and hospital reimbursement levels.

All of us must recognize that the rising cost of health care is straining the country's system of employer-sponsored health insurance. For this reason, the new company will strive to balance fair and reasonable provider payment levels—

Senator SPECTER. Dr. Melani, how much more time will you need?

Dr. MELANI. Ten seconds.—with the need to maintain comprehensive and affordable health benefit programs for consumers.

In closing, the two companies are coming together to be better able to serve the people of Pennsylvania with a focus on providing access to affordable, high-quality health care coverage. The new company will achieve operating efficiencies, freeing resources to invest in programs and services that will benefit our group customers, individual customers, physicians, hospitals, and the communities in which we operate.

For these reasons, Highmark and Independence Blue Cross have agreed to combine to build a better company for Pennsylvania, and I welcome the opportunity to respond to any questions you may have.

[The prepared statement of Dr. Melani appears as a submission for the record.]

Senator SPECTER. Thank you very much, Dr. Melani.

Our next witness is Senator Don White. We very much appreciate his joining us here. He represents the 41st District of Pennsylvania and has since 2000. He serves as Chairman of the Senate Committee on Banking and Insurance. Bachelor's degree from Juniata College in 1972 and a real leader in this field.

Thank you for being with us today, Senator, and the floor is yours.

STATEMENT OF HON. DON WHITE, STATE SENATOR, 41ST DISTRICT, INDIANA, PENNSYLVANIA

Senator WHITE. Thank you, Senator Specter. Senator Casey, always a pleasure. Governor, good to see you here. It is an honor to be invited by Senator Specter to testify at this important public hearing, and I want to applaud him for scheduling this event.

I appreciate the opportunity to provide the Judiciary Committee with a perspective of the Highmark/Independence Blue Cross merger from the State government level and discuss the concerns I—and others—have regarding this proposal. The potential effect on the

availability and quality of health care coverage in Pennsylvania could be profound.

You have already heard from the principal players in the merger, as well as from officials from the health care industry, and are fully aware of the magnitude of this proposal. The questions Senator Specter posed to Highmark and IBC prior to this hearing are most appropriate and accurately summarize the concerns we all should have.

The State legislature is moving rapidly to ensure maximum review and oversight over this proposed merger when it occurs. Currently, under the Commonwealth's GAA Amendments Act and the Insurance Holding Companies Act, the Pennsylvania Department of Insurance is empowered to review proposed mergers of for-profit health care providers. Such review is intended to protect the interest of both policyholders in the marketplace by directing the Department of Insurance to protect the integrity of the insurance market through a review of corporate transactions for anticompetitive effect.

Unfortunately, under current law the Highmark IBC deal, because it involves two Blues organizations, is not subject to the same scrutiny.

In response, I introduced Senate bill 550, which as the Governor mentioned has passed the Senate, and it would provide the Pennsylvania Insurance Department with oversight power over mergers involving nonprofit health care insurers, such as Blue Cross Blue Shield. Senate bill 550 will ensure this proposal comes under the same scrutiny as if they were for-profit corporate transactions.

If the existing gap in the department's regulatory authority is allowed to persist, the department will remain unable to protect the interest of the Blue plans' policyholders in ruling on corporate transactions or a review of any pending transaction involving the parent Blue plans for anticompetitive effect. However, I am confident we will correct this gap in a very timely manner. The State Attorney General must have authority necessary to review this proposed merger, and I am working with his office to ensure that is the case.

I am encouraged by this Committee's concern about the quality and availability of health care coverage in Pennsylvania. From what I understand, there is a potential for a review of this merger at the Federal level under the Hart-Scott-Rodino Antitrust Improvements Act. I would assume Highmark and IBC will file an advanced notice of this merger with both the FTC and the Department of Justice since its value greatly exceeds the thresholds that trigger this Federal requirement.

I strongly urge this Committee to recommend to those Federal agencies that they scrutinize this merger for its impact on competition in the health insurance market and share their work with the State legislature, the Insurance Department, and our Attorney General. While Pennsylvania does not have a State antitrust law, our Attorney General can take action under the Federal law. Therefore, coordination between State and Federal review is essential.

While economies of scale and efficiencies might be achieved by this merger and result in positive short-term benefits, there must

be some concern over its long-term effects. Creating the third larger insurer in the Nation with specifically defined geographic territory is not, I believe, in the best interest of competition, and the reality is competition is in the best interest of the consumers. There is no better regulator than a competitive marketplace in terms of bringing better service, better products, and better prices to consumers and in terms of giving consumers and providers real and fair choices.

In my own district, I have seen the problems providers and consumers face from a lack of competition in health insurance. I spent 27 years in the industry. It can lead to some real predatory practices. We need to make sure practices are not spread across the Commonwealth through this merger.

Highmark and IBC contend the merger should be approved based on the premise that it will result in savings. If so, then there needs to be ironclad assurances that those savings will occur not only in the short term, but also in the long term. Further, any savings should not be used to support growing operations in other States or in lines of business outside of insurance. Moreover, we need to make sure those savings do not come at the cost of consumers' accessibility to needed health care and to the doctors, hospitals, pharmacists, and others who provide that care. Finally, this merger must not undercut the social mission obligation that Highmark and IBC have—an obligation that is part of their being excused from premium taxes and affords them other statutory advantages under Pennsylvania law.

Again, thank you, Senator Specter, Governor Rendell, and Senator Casey, for your interest in this critical issue, and I look forward to working with you on this matter in the months ahead.

[The prepared statement of Mr. White appears as a submission for the record.]

Senator SPECTER. Thank you very much, Senator White.

Our next witness is Professor Lawton Burns, Professor of Health Care Systems at the University of Pennsylvania Wharton School, a graduate of Haverford, a doctorate and MBA from the University of Chicago.

We appreciate your coming in today, Professor Burns, and we look forward to your testimony.

STATEMENT OF LAWTON R. BURNS, JAMES JOO-JIN KIM PROFESSOR, PROFESSOR OF HEALTH CARE SYSTEMS AND MANAGEMENT, AND DIRECTOR, WHARTON CENTER FOR HEALTH MANAGEMENT AND ECONOMICS, WHARTON SCHOOL, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PENNSYLVANIA

Mr. BURNS. Thank you, Senator. In the interest of transparency, I should say that I have been a happy enrollee of Independence Blue Cross for the last 12 years. However, last week they sent me an Explanation of Benefits form that overcharged me $100 in deductibles, so I think I can present a balanced viewpoint here today.

I have reviewed the statement issued by Highmark and Independence Blue Cross about the benefits of the merger. I think what is missing is any sort of explication or a road map as to how those

benefits are to be achieved. And, frankly, as I look at it, most of these benefits may not be attainable for the following sets of reasons:

First, the merger is characterized as a "combination," and there is nothing in the statement that talks about the actual integration or consolidation of the infrastructure of these two health plans. And as a result, it is hard to envision where any savings or efficiencies are going to spring from, from this combination and, in fact, there may be duplication. Most mergers achieve savings, at least in the short run, by combining administrative functions or reducing administrative head counts. That does not seem to be the case here because one of the goals of the mergers is to create jobs.

Second, the most efficiencies and synergies that result from corporate mergers result from defined pre- and post-merger integration efforts, and there is no detail here in the statement regarding how these efforts are going to be conducted, both pre- and post-merger integration. Also, to the extent that these benefits and synergies exist at all, they may already be attainable by two very large-size independent corporations right now.

Third, even in the presence of such efforts and defined post-integration strategies, scale economies and merger efficiencies are difficult to achieve. The econometric literature shows that scale economies among health plans are reached at a much smaller size than these two plans currently exist at. As a result, there may be minimal economies of scale for these two plans to reap. In addition, the econometric evidence also shows that there is very little economies of scope in health plans. And so combining operations to serve a diverse population may not result in any additional savings either.

Another reason why these benefits may not be attainable is that the recent historical experience with mergers of managed health care plans and other types of enterprises does not reveal any long-term efficiencies. Indeed, a recent Wall Street analysis of the mergers of investor-owned health plans in the last few years shows that the majority of these mergers underperform the market within 2 years after the merger. More broadly, the literature and corporate strategy shows that the majority of corporate mergers, 60 to 70 percent of them, fail. What explains the low success rate for corporate mergers? One major problem is the failure to deliver on the sources of value, which is extremely difficult to do. And, in fact, the literature shows that mergers of two evenly sized larger firms are perhaps the most difficult to pull off altogether.

So, if all of this is true, why then do mergers continue to occur? Well, there are a number of reasons, but I think the one reason that we ought to consider here is the fact that a merger reduces the number of competitors or potential competitors in the market by at least one. What is so important about the sheer number of competitors? Well, econometric evidence shows that in the managed care field, an increase in the number of competitors is associated with both lower costs and lower premiums. Conversely, a decrease in the number of competitors is associated with an increase in costs and an increase in premiums.

The evidence also shows that the sheer number of competitors exerts a stronger influence on these outcomes than does the penetration levels of managed care in a local market. The most signifi-

cant effect of the Highmark/IBC proposed merger is the removal of one potential competitor from the Pennsylvania health plan landscape. One might then wonder what this landscape looks like statewide, and, in fact, the Commonwealth has four Blue Cross plans. If you look at the respective market shares of these four Blue Cross plans, Highmark dominates the western part of the State, Independence Blue Cross dominates the southeastern part of the State, and Highmark has a significant presence in terms of joint operating agreements with the Northeast Pennsylvania Blue Cross plan up in the northeast sector of the State.

In effect, Highmark controls not only the western portion of the State, but also a solid piece of the northeast, and with the pending merger with Independence Blue Cross, Highmark would control not only the western portion but most of the eastern portion as well.

Now, as noted, this would not lead to any further concentration in any of the specific regions within the State, and one reason is because they have historically operated in their own separate territories. Another reason why is that most of these regions are already concentrated. It is already not very competitive in each of these regions.

So the net effect of a Highmark/Independence Blue Cross merger might then be a nearly statewide confederation of Blue Cross plans controlled by Highmark with strong domination in each region. What has changed is not so much the local market-level concentration but, rather, the common ownership and control of the plans that enjoy this concentrated market power.

Is this a cause for concern? Well, one would think that this might have a potentially deleterious effect on the health care plans in the center of the State that would—

Senator SPECTER. Professor Burns, how much more time will you need?

Mr. BURNS. I will be done in 30 seconds, Senator.

Senator SPECTER. Thank you.

Mr. BURNS. This might have a deleterious effect on the plans that operate in the central part of the State. It might also have a deleterious effect on potential entry into the State by investor-owned health care plans from outside of the State. And it is widely believed that the Blue Cross plans fear entry into the Pennsylvania market by these States because of their access to capital, as has been mentioned here.

At present, there is little econometric evidence to support the presumed benefits and synergies of the merger. To date, the two firms have failed to provide a convincing rationale and game plan for extracting the value from this combination.

Thank you, Senator.

[The prepared statement of Mr. Burns appears as a submission for the record.]

Senator SPECTER. Thank you, Professor Burns.

Our next witness is the Vice Chairman of the Pennsylvania Medical Society, Dr. C. Richard Schott. Board-certified in cardiovascular disease, Clinical Assistant Professor of Medicine at both Hahnemann and Temple, medical degree from Hahnemann.

We appreciate your being here, and the floor is yours, Dr. Schott.

STATEMENT OF C. RICHARD SCHOTT, M.D., VICE CHAIR, BOARD OF TRUSTEES, PENNSYLVANIA MEDICAL SOCIETY, HARRISBURG, PENNSYLVANIA

Dr. SCHOTT. Good morning. I am C. Richard Schott, Vice Chair of the Pennsylvania Medical Society Board of Trustees. Let me begin by thanking Senator Specter, Senator Casey, and Governor Rendell for inviting the Pennsylvania Medical Society to speak at today's hearing on the proposed merger of IBC and Highmark.

As you already know from the news reports, the proposed IBC/Highmark merger is a mega-merger. It would form the third largest health insurance company in the country. The new company would control 53 percent of the Pennsylvania health delivery market. Based on the enrollee figures, the combined IBC/Highmark company is estimated to have 8 million enrollees. The majority would be Pennsylvanians. This new company would ensure the majority of our State's residents. Prior to announcing their intentions, the Pennsylvania Medical Society was able to meet with the CEOs of both companies, and we continue our dialogue with them.

Historically, the Pennsylvania Medical Society has expressed concerns when mergers are announced. We are not rushing to judgment until we have all the questions answered. Similarly, we hope that regulators and others will not push this marriage down the aisle until we can ensure it does no harm to the public.

Some believe the growing trend at consolidation within the health insurance market has the potential to imperil competition, which threatens both health care quality and patients' access to care. Highmark and IBC currently do not compete in the same areas of the State, but that does not mean that their proposed merger could not do harm. There are patients, employers, and physicians who live along those non-compete Blue lines that define their territories, who presently do have some choice and do, to some extent, drive pricing. A merger of this size could deter new competition in these markets.

Will the size of this merger stop other health insurers from entering the Pennsylvania market? In theory, the new IBC/Highmark company should gain economies of scale. Will those economies of scale benefit the public? And after those economies of scale are initially realized, then what happens?

Highmark and IBC stated that the new combined company will have the resources to hold administrative fees flat for 2 years. Then what? Published studies show that health insurers exhaust their economies of scale at 100,000 to 150,000 enrollees. Insurers with 1 million, 2 million, 5 million, or 8 million enrollees are not any more efficient and may, in fact, lose efficiency as they become larger.

After 2 years, can we expect a big jump in the merged companies' operating costs? Will any competition still exist in Pennsylvania to keep their costs in check, or will competition in Pennsylvania be stifled?

Competition generally improves pricing, consumer choice, clinical quality, and service quality. Reduction in competition could negatively impact everyone—patients, hospitals, health care professionals, and the Government. With an expanded insurance monopoly, the new company could exclusively control the insurance mar-

ket that now allows for premium competition. Similarly, this could create a huge monopsony in which there is only one buyer of health care goods and services in the market. This would negatively impact health care professionals and hospitals, giving them little opportunity to play on a level playing field.

Let me say that again: A level playing field.

This concern leads us to our most important question. If this merger goes there, will there ever be a level playing field between health insurers and health care professionals who already are not able to collectively negotiate the terms of their contracts? Will we be able to select insurance products we accept, or will the single mega-company dictate that providers participate in all their products? The all-products clause. Will there be fair contracts, or will the current standard of "take it or leave it" become "take it or leave"?

All this comes at a time when we are already not competitive in the national market to attract and retain high-quality young physicians here in Pennsylvania. Will insurers focus even more on cost-cutting mechanisms with less regard to patients' needs? Who will be here to speak for their needs?

The lack of competition among health insurers, as well as the consolidation of health insurers across the Nation, raises very serious concerns for the provision of quality patient care. As a patient advocate, physicians are often undermined by dominant insurers who prevent them from ordering necessary or the most appropriate testing. We feel we have already a dysfunctional market with annual double-digit health insurance premiums, unilateral decisions about hospital payments, below-market hospital fees, below-market physician fees schedules that are unilaterally imposed, and yet substantial profit levels for insurers.

Based on the 1997 Federal Trade Commission/Department of Justice Horizontal Merger Guidelines, Pennsylvania would already be categorized as "concentrated."

Senator SPECTER. Dr. Schott, how much more time do you need?

Dr. SCHOTT. Thirty seconds, please.

Senator SPECTER. Thank you.

Dr. SCHOTT. Under the guidelines, a merger of markets that raises the HHI index, which is what the Government uses to measure the effects of competition, Pennsylvania already has an HHI that is over 1,500, which is concentrated. We feel this number is even distorted because of the regionalization at the present time, that it looks at Pennsylvania as if the competition were uniform across the State. We feel strongly that this will exceed the FTC guidelines, and we would emphasize that, quoting from the guidelines, "As the HHI market concentration increases, competition and efficiency decreases. The chances of collusion and monopoly increases."

In conclusion, I ask: Will the proposed IBC/Highmark merger be good for Pennsylvania? At first glance, maybe. But below the surface, there are some serious questions that need to be investigated. That is why something this immense needs the attention of the Federal Government through the Department of Justice and the Federal Trade Commission.

Thank you for your concerns.

[The prepared statement of Dr. Schott appears as a submission for the record.]

Senator SPECTER. Thank you, Dr. Schott.

We now turn to Mr. James Buckley, President of the Delaware Valley Health Care Coalition. A graduate of St. Joseph's University, previously served in various positions as managing the pension and health and welfare fund for Plumbers Local 690.

Thank you for being with us, Mr. Buckley, and we look forward to your testimony.

STATEMENT OF JAMES R. BUCKLEY, PRESIDENT, DELAWARE VALLEY HEALTH CARE COALITION, INC., PHILADELPHIA, PENNSYLVANIA

Mr. BUCKLEY. Senator Specter, Senator Casey, Governor Rendell, thank you very much for allowing us to be here. The Delaware Valley Health Care Coalition is a group of

union health and welfare funds that have joined together to take advantage of discount pricing. Currently, we represent 91 funds in the Commonwealth of Pennsylvania, 190,000 members, and over 400,000 lives. In 2006, a very conservative estimate of our total spent was $1.5 billion.

At this point in time, the Delaware Valley Health Care Coalition has no position regarding the planned merger between Highmark Blue Cross—Highmark—and Independence Blue Cross—IBC. This is simply due to the fact that there is very little information concerning the potential effects of this merger available to health care consumers and providers.

We have learned some information from the various press organizations and speaking to representatives of the Blues, and what we understand is this merger is going to take from 3 to 5 years to complete. There will be an infusion or an allocation of $650 million to the State government, bringing the total amount given to the State government of $1.1 billion. There will be a 2-year cap on the administrative fees by both Highmark and IBC. There is going to be a $285,000 infusion of cash into the Blue Cross prescription drug program in fee reductions and drug cost reductions.

The new corporation will be nonprofit. It will be headquartered in Camp Hill, Pennsylvania, and there will be no layoffs. All employee reductions will be achieved through attrition. Also, there will be no buyouts or golden parachutes.

Although at this time the DVHCC has no official position, I am here on behalf of our directors to express our profound concern and hope that certain questions regarding this merger will be answered through the Committee's review process. Our concerns and questions focus on whether the resulting entity will foster greater competition in the Commonwealth to the benefit of health care consumers, payers, and providers, or stifle competition to the detriment of these groups.

Both organizations have a tremendous amount of money in reserves, both being owed in part to their nonprofit status, to be used for the uninsured in our Commonwealth. In 2005, it was reported that the reserves of Highmark Blue Cross and Independence Blue Cross were $2.8 billion and $1.43 billion, respectively.

By combining the Blues organizations and the hopeful efficiencies created, our directors are concerned with how excess reserves will be utilized. Will these reserves be used to create better and more affordable health care systems for the citizens of our Commonwealth? Or will they be used to finance predatory pricing practices of the new merged company? Will the excess reserves and economies of scale created by the unified insurer be used to smooth rates from year to year? Will there be guidelines that control what reserves may be used for? And if so, who will be charged with the oversight of these reserves? Will the anticipated reduction of 9,000 jobs through attrition eventually resulting in approximately $450 million per year upon completion of the workforce reductions pay for runouts for employees' health care whose employer becomes insolvent or disease management for all insured? Further, will the reductions in the workforce affect service provided and, consequently, the quality of care provided in the Commonwealth?

Of great concern to our member directors is whether or not the new entity, with its integrated systems, will provide a greater flow of information concerning quality of care providing by hospitals and physicians in the Commonwealth and payment information? It is our sincere hope that there will be a mandate for transparency with regard to information on hospitals and physicians and, further, and more importantly, that this information will be shared with the Pennsylvania Health Care Cost Containment Council, an organization that has compiled an invaluable knowledge base on health care quality in the Commonwealth, and who, I might add, without renewed enabling legislation will cease to exist in 2008.

It is our sincere hope that these questions will be answered and the issues be addressed when this merger is scrutinized by the Committee and the Department of Justice, as well as the Insurance Department of the Commonwealth of Pennsylvania.

Thank you again for allowing me to be here. I will take any questions when the time comes.

[The prepared statement of Mr. Buckley appears as a submission for the record.]

Senator SPECTER. Thank you, Mr. Buckley.

We now have our next witness the Executive Director of the Action Alliance of Senior Citizens of Greater Philadelphia, Mr. Pedro Rodriguez. He had been Legislative Director for Philadelphia City Council. Bachelor's degree from the State University of New York in Economics.

We appreciate your being here, Mr. Rodriguez, and we look forward to your testimony.

STATEMENT OF PEDRO RODRIGUEZ, EXECUTIVE DIRECTOR, ACTION ALLIANCE OF SENIOR CITIZENS, PHILADELPHIA, PENNSYLVANIA

Mr. RODRIGUEZ. Thank you, Senator Specter. Good morning, Senator Casey, Governor Rendell. Thank you for this opportunity to add a consumer perspective to the pending merger of Independence Blue Cross of Southeastern Pennsylvania and Highmark of Western PA.

The planned Blue Cross merger in Pennsylvania is a potential disaster for Pennsylvania consumers. It is a mega-corporate reshuf-

fling of the deck chairs on our sinking Titanic health care system. It demonstrates once and for why all Americans need a program like Medicare or a single-payer health care insurance system.

This proposed merger poses more questions than answers. It also, in a very tragic way, points to the failure in Pennsylvania for government and consumers to have a place to ask those questions and try to get some answers and clarity, questions such as: Is this the first step toward a for-profit conversion? According to a report by Community Catalyst of Boston, the Blues' charitable commitment, such as the provision of coverage to children and other low-income individuals, has been decreasing since 2000. Will the merger reverse the trend or make it worse?

Already, Independence Blue Cross is a de facto for-profit corporation, having transferred most of its assets to its for-profit subsidiaries. IBC admitted that 90 percent of its revenues come from the for-profit companies it owns.

There are no clear and substantial benefits to the public from this merger. The Blues will not commit to premium reductions or pledge to put a ceiling on premiums. Rising Blue Cross premiums will contribute significantly to the increasing rate of those without insurance, particularly older people who are not yet eligible for Medicare. There are no guarantees that individuals with flat incomes, who are dropping coverage, or "buying down" to coverage with reduced benefits or increased deductibles will realize a better deal with this merger.

The Blues' statutorily mandated charitable obligations will not be expanded under this merger. The Blues have cleverly misrepresented in their press release that $650 million will go to expanded coverage for the uninsured. This is a bald-faced misrepresentation to the public because they did not clarify that most of this money had already been obligated under a binding agreement with Governor Rendell signed in the fall of 2004 requiring annual charitable payments beginning in 2005 under the Annual Community Health Reinvestment (ACHR) program. There appears to be no substantial expansion of charitable payments coming from this proposed merger.

In addition, no one can say the proposed merger is in the public interest unless there are guarantees that the new entities pay fairly for services. It is not in consumers' interests if as result of the merger the Blues are able to low-ball payments to doctors and hospitals, causing them to end up closing their medical practices or hospital doors. No matter how low the cost of health insurance, if services are unavailable, the savings are worthless.

To determine whether the proposed merger is in the public interest, we need to know how it will lower health care costs, and whether it will allow more people to afford health care and make it easier for the State to grow jobs and eliminate unnecessary bureaucracies. The merger is not in the public interest if all it does is free up more money for the Blues to start more for-profit subsidiaries. I don't think anyone can say it is in the public interest unless we see how much savings are being projected and to whom the savings flow. Will those savings go to huge salaries for top executives or to provide increased access to health care for working people in Pennsylvania?

What is also of grave concern is the appalling absence of any decent consumer protection law or enforcement within the State and Federal Governments. The catch-up bills of Senator Don White and Representatives Todd Eachus and Phyllis Mundy would finally amend the State's Insurance Holding Company Act to include the Blues with other insurance companies so that a planned merger would now need Insurance Department approval. The Department for the first time would be able to determine if the Blues merger would "substantially lessen competition," but this, again, is grossly inadequate.

We should have a body of laws that require the Blues, and other insurance companies, to first demonstrate a substantial benefit to the public before any merger is approved—a standard that has been effectively used for utility companies in Pennsylvania for a long time.

Because the Pennsylvania Insurance Department has always been a paper tiger or a captive of the insurance and Blues industry, consumers need much more in protections. Consumers need a right to have standing to intervene in Insurance Department proceedings, have rights to discovery, and have their fees and costs paid by the insurance company if they make a "substantial contribution" to the result—as provided for in California law.

To conclude, Pennsylvania has 2.8 million people without health insurance or underinsured. That is a whopping 27 percent of the non-elderly population. The proposed merger does not promise to solve this crisis. We appeal to Washington to lend the consumers of Pennsylvania a hand and to come and ask the tough questions about this proposed merger.

Thank you.

[The prepared statement of Mr. Rodriguez appears as a submission for the record.]

Senator SPECTER. Thank you, Mr. Rodriguez.

Our final witness is Joseph "Chip" Marshall, Chairman and CEO of Temple University Health System. Bachelor's degree and law degree from Temple University.

Thank you for coming in today, Mr. Marshall, and the floor is yours.

STATEMENT OF JOSEPH W. "CHIP" MARSHALL III, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, TEMPLE UNIVERSITY HEALTH SYSTEM, PHILADELPHIA, PENNSYLVANIA

Mr. MARSHALL. Thank you. Good morning, Senator Specter, Senator Casey, and Governor Rendell. I am Chip Marshall, Chairman and CEO of the Temple University Health System. On behalf of all of our employees, physicians, and patients, thank you for the opportunity to testify today on the Highmark/Independence Blue Cross Merger—a matter of significance to the Temple University Health System, the southeast Pennsylvania region, and the entire Commonwealth.

At the outset, let me share with you some background on the Temple University Health System, whose hospitals have steadfastly provided their communities with compassionate, high-quality care for more than 150 years. The Temple University Health System is comprised of five hospitals, including Temple University

Hospital, Temple University Children's Medical Center, the Temple-Episcopal Campus, Jeanes Hospital, and Northeastern Hospital.

Last year, we handled a quarter-million emergency department visits, admitted approximately 60,000 inpatients, provided over a half-million outpatient visits, and delivered more than 6,000 babies.

Temple University Hospital and Temple Children's serve as the chief clinical training sites for the Temple University School of Medicine. Together, these hospitals are the region's only Level I Trauma Center for adults, children, and burn victims.

Our Health System family also includes the Temple Transport Team, our state-of-the-art ground transport unit that provides rapid transport from central Pennsylvania to the New Jersey coast. Temple Physicians, Inc., our network of community-based doctors' offices, serves Philadelphia, Bucks, and Montgomery counties.

When I joined the Health System as CEO, I established a goal for the health system to become a high-quality, regional health care provider. We are entirely committed to excellence, as evidenced by our continued investment in our professional workforce, facility improvements, and advanced medical technologies.

It is with this background that I offer my views on the proposed merger of Highmark and Independence Blue Cross. As both an IBC network provider and as a purchaser of its insurance product for an 8,000-employee health system, thank you for bringing national focus to this important matter affecting competition and choice in the Pennsylvania insurance market.

I realize that at this early stage, we do not have sufficient information to make firm declarations or recommendations. Over the next several months, however, hospitals, physicians, consumers, employers, and other stakeholders will closely monitor merger developments. As they do, it will become clear that the benefits promised by Highmark and IBC will not be self-executing simply as a result of this merger. Benefits of a consolidated plan will be achieved only with strong efforts of all stakeholders in the health care industry. Only if done right could the combination of Highmark and IBC offer opportunities for efficiencies in the insurance market and a deeper commitment to the social missions of these plans.

Ultimately, the issue is whether stakeholders in the health care delivery system will benefit from or be disadvantaged by the combination of Highmark and IBC. To help resolve this, I believe it is imperative that several questions be explored.

First and foremost, how would a consolidation of Highmark and IBC affect access to care? If hospitals and physicians are not compensated fairly for their services, or they are closed out of provider networks, then the supply of vital services will be restricted at the expense of those who need care.

Second, would a consolidation of Highmark and IBC damage or destroy the social missions of these plans? In eastern Pennsylvania, IBC is an important part of the community and is highly valued for its corporate leadership and financial support of many worthy causes. Temple Health System, for example, has collaborate with IBC in our joint roles with the Philadelphia Chamber of Commerce,

Select Greater Philadelphia, and the CEO Council for Growth, as well as many outreach activities designed to improve the health status of our communities. We hope this civic partnership will be preserved. In western Pennsylvania, stakeholders will have their own questions as to how a merger would be managed with high expectations from a strong Philadelphia area market.

Third, how do we balance the benefits of price competition with the financial and social burdens imposed on hospitals, which are required to provide 24-hour access to all who present to their emergency rooms?

Fourth, how will financial benefits that accrue to a combined Highmark/IBC plan be shared with patients, hospitals, physicians, and the communities they serve? Will employers and consumers benefit from lower premium costs and improved products that might be offered by a stronger, more efficient, and effective company?

Finally, what impact would a consolidation have on an already fragile health care system? As we consider this issue, we must be vigilant in balancing the competing interests of hospitals, physicians, insurers, employers, consumers, and patients. A market change of this magnitude must fortify, not weaken, Pennsylvania's health care delivery system. A consolidated company must be steadfastly dedicated to working with providers to ensure their continued ability to offer quality care to our patients, for it is the patients around whom we are all centered.

In closing, let me emphasize that the standard economic competitive analysis might not be entirely sufficient in considering the impact of a consolidated Highmark and IBC. The dominant IBC market share in the region, the overall complexity of the health care market, including the virtual inability of providers to sell their services directly to consumers, thus necessitating that insurers be an efficient and effective component of the delivery system are all factors that have to be carefully considered in evaluating a possible consolidation.

On that note, we must keep in mind that with time, Pennsylvania's health care system requirements will change. What is efficient and effective today did not exist 10 years ago and will change over the next 10 years. Pennsylvania—

Senator SPECTER. Mr. Marshall, how much more time will you need?

Mr. MARSHALL. Just 30 seconds, Senator. Again, it is too early to take a position for or against the proposed consolidation. We would not want to oppose a merger simply because of possible downsides. If carefully executed, with constructive involvement from hospitals, physicians, employers, consumers, and other stakeholders, a consolidation could provide an opportunity to stabilize Pennsylvania's health care system, preserve the economic stability of its businesses, and ensure access to care for all its citizens. We at Temple Health System are committed to working with all stakeholders on this important issue.

Again, thank you, Senators and Governor Rendell, for your leadership on this issue and for allowing me to testify today.

[The prepared statement of Mr. Marshall appears as a submission for the record.]

Senator SPECTER. Thank you, Mr. Marshall, and thank you all.

We now turn to 5-minute rounds from the panel, and I would begin with you, Dr. Melani. When we talk about nonprofits, there is a real question as to exactly what that means. Right now Congress is wrestling with a pay increase for Federal judges, who earn $165,000 a year. When we look at executive compensation at Highmark in excess of $3 million, and when we look at a surplus of $2.6 million, would there be savings potentially to premium payers if that surplus was not maintained or the level of executive compensation if nonprofit really has to have some significance in terms of not being for-profit?

Dr. MELANI. Yes, Senator, let me address your question. The number of lives that Highmark covers across the Nation is actually 28 million, not 4.6 million. It is 4.6 million in the State of Pennsylvania who have health insurance. We service 28 million individuals around the United States. So if you were to charge our customers for my compensation, it is about 50 cents per customer per year—I should say 10 cents per customer per year, is what it comes out to be. So that would be the savings to the customer. I guess that was part of your question, what would the savings be if I received zero income. It would be about 10 cents per customer per year.

Senator SPECTER. Well, Dr. Melani, whatever the saving would be, there would be a saving. But what I am sort of groping for is really what does "nonprofit" mean. We have had some concerns expressed that this might be a precursor to having Highmark and go profit, as WellPoint did, the second biggest health carrier in the United States. And I am not sure that being for-profit would necessarily be more profitable than nonprofit. But can you assure us that that is not in the offing to go for-profit?

Dr. MELANI. We have no intent to go for-profit. Not-for-profit for us is two things: One is a corporate structure, and it is a corporate structure that exists for purposes of taxing and other things. And, frankly, our not-for-profit status is a bit of a misnomer because we pay just about every corporate tax there is—property taxes, all of those things. So we get very little in the way of tax forgiveness as a not-for-profit in the State of Pennsylvania.

What it really means for us is a philosophy in the way we manage. It is the corporate mission. It is a community-focused mission. It is the ability to actually look at the community as a whole and work on initiatives for the community for the long term, without concern about shareholders, without returning value to shareholders other than the people of the Commonwealth of Pennsylvania. Our shareholders are the people we serve in Pennsylvania, the people in Pennsylvania. So everything we do as a not-for-profit is geared around trying to make health care more affordable, more accessible for the people of Pennsylvania, and that is our not-for-profit mission. That is our not-for-profit status.

We do not intend to veer from that. Corporately, we enjoy that structure. We enjoy the purpose for which we exist. Our employees are engaged. I as the chief executive am engaged in that. We do not have any intent to convert to a for-profit organization.

Senator SPECTER. I am going to have to move on to Mr. Frick. We do not have a whole lot of time here.

Mr. Frick, Dr. Melani testifies about you have fair and reasonable premiums, but is it better to rely upon competition to hold down premium costs? And would you favor an antitrust exemption for doctors and hospitals to negotiate with Independence Blue Cross?

Mr. FRICK. Well, the first question about our provider reimbursements and competition, as I mentioned in our testimony, over 85 cents of every dollar that we take in in revenue from our customer goes directly out the door to pay for health care services to the hospital community and the physician community on behalf of our members. We are proud of that. That is a number that is much higher than the publicly traded competitors that we referenced earlier.

Senator SPECTER. Well, if you have this kind of a merger, would you say that it would be fair to give a little more bargaining power to doctors and hospitals not to be restrained by antitrust in negotiating with Independence Blue Cross and Highmark? That is my last question. I only have a few seconds left.

Mr. FRICK. Well, Senator Specter, I think the leverage is joint today. We need quality providers to render care, and we look every year at fair and reasonable compensation. We had a 30-percent increase in the last 5 years in our payments to providers, and actually, the number of participating providers in our network has increased 11 percent. So I think all of us are aligned more today than ever in terms of fair and reasonable compensation, and also to make sure that the fees we pay reflect quality and performance and the health status of all of our members. I think that is the priority.

Senator SPECTER. Thank you, Mr. Frick.

Senator—Governor Rendell? I almost demoted you.

Governor RENDELL. That is all right. I am sorry to the other panelists to address these questions almost exclusively to Mr. Frick and Dr. Melani, but it is the nature of where we are, and I did have one question for Senator White, which I cannot resist since I have got him here.

To Dr. Melani or Mr. Frick, there has been a lot of talk about what the increases in level, the $1 billion increase, but I think it is very important that we start from understanding what the baseline is. And I know we do not have a lot of time, but can you give us an understanding of the baseline of the charitable commitments that IBC and Highmark make right now? And it is my understanding—Mr. Rodriguez said that this would just be money going to fulfill the commitment you made to us on the adult basic care program. It is my clear understanding that that is not the case; this is above and beyond the existing commitment. But can you both give us an idea of your baseline?

Mr. FRICK. Well, our obligation in 2006, Governor, was a total of $52.4 million, and $29 million of that was directed specifically to adult basic. And as you know as the architect of that agreement, the Community Health Reinvestment Agreement is scheduled to expire in 2010. So the $350 million that I alluded to is to extend that agreement for an additional 3 years, but through operational and technology savings, we believe we can also generate an additional $300 million in savings that we believe is most appropriate

to direct to access and reducing the uninsured, because every stakeholder we talk to, that is the single most important issue in Pennsylvania, although Pennsylvania, I think, because of the historic partnerships between our government and the Blues, the rate of uninsured in Pennsylvania is much lower than the national average. And while I do feel good about that, because I believe it reflects the history of the Blues and our progressive leadership, I think with the additional commitent we would make as part of the consolidation, we can do better.

Governor RENDELL. We are the seventh lowest in the Nation in terms of percentage of uninsured. That is correct.

Dr. Melani, do you want to comment on that? Give us an idea of your baseline.

Dr. MELANI. I agree with what Joe says, that the Community Health Reinvestment initiative sunsets in 2010, so a portion of this is the extension of the Community Health Reinvestment initiative. But there is $300 million of additional funds over 6 years that will be applied to the uninsured. That is in addition to continuing our community commitments. Last year, combined, we committed over $250 million back to the community. Without the merger, those funds will not be available.

Governor RENDELL. And just so I am clear, as you know, the Commonwealth, at least the administration, is asking the legislature to adopt something called "Prescription for Pennsylvania" that would ensure health care for all the uninsured. Adult basic care would phase out under that, and the money that is currently programmed for adult basic care would go into the pot that would pay for the increase in covering all the uninsured. It goes without saying that those payments would go to that program as well, the ABC payments.

Mr. FRICK. And the additional funding that I spoke about, $300 million, would go to whatever new programs or products we jointly believe the administration, the legislature, and us as Blues would best provide increased access to small employers and reduce the uninsured rate. Absolutely.

Governor RENDELL. And I have one question for Senator White. Senator White deserves a great deal of credit for taking this issue head on and Senate bill 550 would remedy, I think, something that needed to be remedied by giving the Insurance Commissioner the right to approve or reject mergers between nonprofits.

But as you know, Senator, we also have a proposal in Prescription for Pennsylvania to allow the Insurance Commissioner to rate-set for health care, both for-profits and nonprofits. I hope you would be supportive of that because one of the things that has been expressed here is the concern by Senator Specter, Mr. Rodriguez, and others is what is going to happen to premiums and rates. Certainly we will be in a better position if the Insurance Commissioner has the ability to reject rate increases.

Senator WHITE. Governor, you are absolutely right, and I think everybody—you are to be commended and lauded for Prescription for Pennsylvania, and you are getting a lot of support in the legislature for all parts of it. But I am sitting between these two giants here, and I feel a little squeezed.

[Laughter.]

Senator WHITE. But, you know, the community mission part of this is wonderful, and it is a great concept. And while it is helping the Commonwealth with the uninsured, which is, you know, a pretty staggering figure, 800,000 people, let's not forget that we have 11.2 million people that do have insurance, and they want to know where the benefits are coming from, too.

Also, sometimes I have a problem—the reserve part of this I guess is something that I need to be better educated on because, Governor, as far as I am concerned, in my own mind I classify these as basically excess premiums. And we all pay into that.

Governor RENDELL. Well, just to follow up, the legislature should understand the reserve issue as it is ruled on by Pennsylvania, and other States as well, and I agree. And we should do that as part of this process.

But don't you agree that in terms of protecting those 11.2 million who do have health care, it is important to give the Insurance Commissioner the ability to set rates?

Senator WHITE. Absolutely, Governor.

Governor RENDELL. Thank you.

Senator SPECTER. Senator Casey?

Senator CASEY. Thank you, Senator.

I think my first question is directed to both Mr. Frick and Dr. Melani, and it is a question, I think, that a number of speakers today, a number of people in their testimony, as well as in the questions, spoke to either directly or indirectly, and that is the standard, the basic standard, which may not be required of both companies in this merger situation, but I think is a good standard for us to follow here in the State. So whether it is the mandatory legal standard or not, I think it is important to answer this question. And it is the basic overarching question of the so-called affirmative showing of substantial public benefits from this merger.

I would ask both of you to answer that as best you can in the short period of time we have today, but also to supplement or amplify your answer in writing as part of the record of this Committee, and I would ask Senator Specter's permission to do that, because I think that is one of the overarching questions: What are the substantial public benefits of this merger? If you could both answer, maybe Mr. Frick first.

Mr. FRICK. Senator Casey, sure. I guess one of the reasons for the 2-year process between IBC and Highmark to come to this day today is because we both recognize our standing and importance—not just in health care in Pennsylvania, but for the local communities. Our local communities want to make sure we preserve jobs. Our employer communities want to make sure that we keep rates affordable. Our partners in Government want to make sure we can continue to insure as many people as possible. Our provider partners want to make sure that reimbursement is aligned and fair and reasonable.

So we have multiple stakeholders, and what Highmark and IBC believe is that by avoiding duplicative investments, cutting down on unnecessary administrative spending, every dollar that we can achieve from this consolidation, Senator, will go directly to make health care work better in Pennsylvania. That is our primary objective. We are not out-of-State companies. We are looking to be more

efficient so we can reinvest whatever dollars we can accrue to make health care work better for all of our stakeholders—employers, the uninsured, our provider partners. That is our objective, and I believe that we do have to prove that to you or this combination should not happen. But that is how committed we are.

Senator CASEY. Doctor?

Dr. MELANI. Yes, Senator Casey, I think Joe articulated the answer quite well, but I will just restate that there are definitely economic benefits that will be derived, both direct and indirect. Direct benefits we talked about, which is the $1 billion that we will get back to the community over the first 6 years of operations, and those will continue in perpetuity from that point forward. But in the first 6 years, that is $1 billion of economic benefit that otherwise would not have been received, about half of which will go back directly to customers in savings through health care cost or administrative cost savings, and the other half will go toward the uninsured to help get them access to health care services that they need.

The indirect is really the benefit we talked about which our companies bring to Pennsylvania every day. It is the employment that we have, the 18,000 employees we have located here in Pennsylvania. Unlike other companies that compete in Pennsylvania, you know, our employees are based here servicing the people of Pennsylvania and those nationwide, and we intend to continue that.

In addition, the way we operate, we purchase in Pennsylvania. Over 85 percent of all of our services are purchased here in Pennsylvania from Pennsylvania-based companies who employ people here, another 54,000 jobs created by way of that.

Also, our surplus, the way we use our surplus to generate economic benefit to the Commonwealth through procurement of services and companies that we have put in place servicing others across the Nation, those jobs are back here in Pennsylvania. Again, no cost to the Commonwealth, done by us. A great benefit to the Commonwealth.

I do not want to also understate, though, the quality value, working with the providers in the community. We have historically had a 70-year relationship with providers in the community. We were started by providers, started by the Hospital Association, started by the Pennsylvania Medical Society. We have a rich tradition of working closely with the provider community in our markets.

Yes, today things are tough. There is a tension because of health care costs. But we will continue that rich tradition of working face to face to improve quality of care and to try to make health care more affordable by advancing technologies, the personal health record, by looking at ways to increase our passthrough in our claims, by doing real-time claims adjudication, improving cash flow for physicians and hospitals. We will continue to look at initiatives on transparency, pay for performance—all those things that are critically important, that we will not be duplicating and confusing to the provider community or customers. One time, one place.

Senator CASEY. I would just urge you in the future, as you did today but I think we need more detail, to be very specific about the benefits and remember that part of that standard has the word "substantial," and that means something that is going to have a

phenomenal effect, a substantial effect on everyone's life, and that means both health care coverage and I think it also means the question of cost.

So I think when you are making your list and you are submitting for the record, not just for this hearing but for any filing, that you think about it in very specific and in broad terms what the word "substantial" actually means. I think that is what people are looking for.

We are out of time.

Senator SPECTER. Thank you, Senator Casey. We have time for one more round of 4 minutes and still make our 11 o'clock termination time.

Senator White, there have been some rumors that if this merger goes through, some current competitors will withdraw from the State; other potential competitors will not enter the State. How would you evaluate that? Would there be a significant impact on competition for similar competitors?

Senator WHITE. The best way I can answer that, Senator, is to say that, you know, there are so many—whether this merger goes through or not, we are still in a state where, when you combine all the Blues coverage in Pennsylvania, they have—this did not happen overnight. This happened and developed over a 20-, 25-year period. And a lot of it had to do with broken unions and the fact that the unions always wanted the Blues. The Blues were always the No. 1 choice, and that has helped to generate this growth.

I think right now what you have is the entry barriers for commercial businesses coming into Pennsylvania with the environment that we have today is not real positive. There are just so many barriers. They are going to continue to dominate the market, and I think this is something—this is a good step. I think something should have been done maybe along these lines in 1996, which we sort of just let it slip under our nose.

But the point is that from a commercial end, when I was in the business, a lot of the times in the rural parts of Pennsylvania, Senator, you had—if I had my little companies that I represented, I actually did not want to handle health care. I handled the property/casualty or life or disability or annuities and pensions. I did not want to handle health care because if my client was unhappy and then the next year I came back with a 20-percent increase in his premium, and I could not explain it to him, I had to go back to the same company, Highmark, and just get a cheaper plan. And that is the extent. There is no network in the area that I represent in Pennsylvania for—

Senator SPECTER. Dr. Schott, if this merger goes through, what impact will there be on the bargaining power of doctors and hospitals? How does this affect your interest in having an antitrust exemption for doctors and hospitals to join together to negotiate with Independence Blue Cross and Highmark?

Dr. SCHOTT. Physicians find themselves at this point clearly at the bottom of the economic power structure in dealing with third-party payers and even at times in dealing with hospital systems. The reimbursement market for physicians is an important issue, not so much that I can take home salaries that some of our CEOs enjoy, but to retain and attract people to this market. And we have

been progressively unable to do that because of both the economic and to a large extent the tort climate that we face in Pennsylvania, especially in southeastern Pennsylvania.

The national average for third-party payer reimbursement for evaluation and management services, which is what most internists spend their life doing, is substantially above Medicare, while in southeastern Pennsylvania we have expected our doctors to work here at substantially below Medicare.

Senator SPECTER. I am going to ask for a show of hands, with only 20 seconds left, of those on the panel who think there should be an antitrust exemption for doctors and hospitals to negotiate. You do not have to be yes or no if you have not had time to think about it. I would understand an abstention. But everybody on the panel who thinks that if this merger goes through, it would be appropriate to have an antitrust exemption for doctors and hospitals. If you favor that, raise your hand. Opposed?

[Four in favor.]

Governor RENDELL. Can I ask one question? Basically a yes or no answer.

Senator SPECTER. No, no. You can ask several.

Governor RENDELL. I thought we were out of time.

Senator SPECTER. You have got 4 minutes.

Governor RENDELL. Doctor, I hear what you say. Mr. Frick just told us that the increase in physician reimbursement has been 30 percent over the last 5 years. Correct or incorrect?

Dr. SCHOTT. I do not know that that number is absolutely true. I cannot substantiate that number. There are different issues that play into that number, and I know we are time-limited, but the ability of any given physician to be able to survive in this environment has been very marginal.

The fact that southeastern Pennsylvania has high demands on service is an issue that we share the concern with IBC. When we are taking care of a patient, they frequently are probably sicker than the average and require a lot more services, and the system, as it has evolved, including the system where primary care physicians now are not given any advantage to go to the hospital to see their patients because their only revenue comes from what they do in their office.

So there are a lot of factors here. I realize time is very limited, and I would be happy to spend as much time as any of you want to spend at any time to further discuss this.

Governor RENDELL. Could the objective that Senator Specter is trying to reach with antitrust, would that not have been reached had the legislature approved the legislation on provider groups? Maybe you want to explain that to the Senator, the legislation that failed.

Dr. SCHOTT. Well, the Senator is well aware of the Campbell bill, which was the national bill after which both the Texas bill and the Pennsylvania bill were patterned. That would have the ability for physicians to collectively bargain under the oversight of the Department of Health or the Insurance Commissioner or some State-based agency.

It is cumbersome. The process for doing that we would certainly like to address and tweak, but we would certainly be in favor of

moving forward with that as a trade-off for the bargaining power that we are not going to have when we have one monopsonistic corporation.

Governor RENDELL. And there were efforts in the Pennsylvania legislature to achieve that, and they failed.

Dr. SCHOTT. Absolutely.

Governor RENDELL. I will not say "miserably," but they failed.

Senator SPECTER. Senator Casey?

Senator CASEY. I have one question for Professor Burns with regard to duplication. You were making assertions about what may happen to both economies of scale and efficiency and duplication. I was curious to have you explain at least the duplication assertion as to how this merger would, in fact, lessen the possibility that we could reduce duplication.

Mr. BURNS. Well, Senator, the insurance business is a labor-intensive industry. It is not a capital-intensive industry. And so when you put together two firms that are located 300 miles apart, you are not going to really be generating job savings or efficiencies by combining those two companies because you will still have the same number of people doing the same number of things in both locations.

I think we have some historical experience we can draw on here, and I do not mean to bring up some unpleasant memories, but 10 years ago we tried to pull together a huge hospital system here in Pennsylvania that had one part of it in Pittsburgh and the other part of it here in Philadelphia, and that was the Allegheny system. And they made many of the same claims here, and they had the same difficulties that I have outlined in my report on trying to achieve these kinds of efficiencies.

You have two labor-intensive markets—hospitals and health plans—operating 300 miles apart. It is hard to pull those together and automate them.

Senator CASEY. One last question. As the Governor apologized, I will, too, to direct these to the two principals for today, but it is important. Children's health insurance, we have 9 million kids in the country with no health insurance at all. This State does a much better job than most States. The Governor is trying to expand it. But how do you see this merger impacting the question of children's health insurance, meaning how many are covered? And do you see it as having a positive impact on the number of children who are covered?

Mr. FRICK. I do not think there is any greater priority than health insurance for children, and Highmark and IBC were pioneers with the administration in the CHIP program that has now become a national model. And I think why we are allocating a large percentage of the savings is for two things: one, no one in America should be without health insurance; and, No. 2, those who are are increasing costs for everyone else.

So no matter what stakeholder we talk to, creating more access to health insurance is good for everyone, and there is no single greater priority for us.

Senator CASEY. Thank you, Senator.

Senator SPECTER. Well, thank you all for the testimony today. The record will be held open for 1 week in accordance with Judici-

ary Committee rules for the submission of written questions. I think the hearing has been very fruitful in exploring quite a number of issues—oh, Mr. Rodriguez, you had your hand up a few moments ago and wanted to say something in addition?

Mr. RODRIGUEZ. Thank you, Senator. I just want to emphasize some of the comments made by some of the principals of the Blues about the commitment that they were not going to turn into for-profit corporations in the near future. I think if that is the case—and they are very nice people, and I think we can take them at their word—they will have no problem in signing some binding agreement that they would not do so for 10 years.

In addition to that, I believe that it would be in the best interest of consumers in Pennsylvania if part of the surplus is used to up the ante in terms of the $650 million that we have on the table, to increase that to about $1.2 or $1.5 billion to provide health insurance for Pennsylvanians.

Senator SPECTER. Thank you very much, Mr. Rodriguez, and I thank—I see a hand in the audience. We would like to take questions, but we are at 10:59.

Governor RENDELL. Fifteen seconds.

Senator SPECTER. Go ahead.

Audience MEMBER. Mental health coverage, separate, not equal. Magellan in Georgia, bean counters handling Blue Cross' covering of—

Senator SPECTER. And your question is?

Audience MEMBER. My question is, if we are going to have more Magellans with this big thing, or are we going to take a look at what—

Senator SPECTER. Okay. We have your question.

Mr. Frick?

Mr. FRICK. Well, as she alluded to, Magellan is our third-party provider for mental health and behavioral health services for Independence Blue Cross. Highmark does not use them now.

Our comprehensive integration plan over the next 12 months will look at every aspect of our company to understand what is the best practice in that particular care area administration, and what we will deliver to the marketplace is what we believe is the best.

Senator SPECTER. If anybody else has any questions, see Mike Oster, my executive director in Philadelphia, and we will be glad to ask them for the record. And if you have any questions generally, just communicate with my office, and I am sure Senator Casey would say the same, as would Governor Rendell.

Governor RENDELL. Can I just say one thing on that?

On that quick question, Prescription for Pennsylvania does require, unlike ABC, Adult Basic Care, mental health coverage, behavioral health coverage, and substance abuse coverage. So it is an improvement. The product in Prescription for Pennsylvania is a step up because it includes generic brand prescription coverage, which ABC does not, and it includes behavioral health, which ABC does not.

Senator SPECTER. Gentlemen, thank you all very much for coming in today. As I said, this is just the beginning. There will be more questions.

I want to thank the National Constitution Center for opening up this beautiful auditorium, and thank especially Joe Torsella, the President.

That concludes our hearing.

[Whereupon, at 11:01 a.m., the Committee was adjourned.]

[Questions and answers and submissions for the record follow.]

QUESTIONS AND ANSWERS

Independence Blue Cross

www.ibx.com

1901 MARKET STREET
PHILADELPHIA, PA 19103-1480

May 17, 2007

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

Attn: Jennifer Leathers, Hearing Clerk

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

Dear Mr. Chairman and Committee Members:

Please accept the following response to the supplemental written questions from members of the United States Senate Judiciary Committee on behalf of Independence Blue Cross ("IBC"). Because the same questions were addressed to both IBC and Highmark, and because certain of those questions concern plans for the new, consolidated company, IBC has worked together with Highmark on preparing certain responses where appropriate.

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

Response: IBC believes that criticism over the size of its reserves (*i.e.*, surplus)[1] is misplaced. These critics lack an appreciation for both the level of regulatory scrutiny that IBC and the other Pennsylvania Blue Plans are subjected to regarding their surplus levels, and the vital roles that surplus plays. As a not-for-profit insurer, IBC's surplus is

1 As a matter of insurance terminology, "reserves" typically refer to monies that have been set aside to pay for claims that have been incurred or are expected, but which have not yet been paid; whereas "surplus" refers to the accumulated amount of capital that remains after all liabilities have been deducted from the company's assets. See, e.g., Determination of the Insurance Department of the Commonwealth of Pennsylvania, Misc. Dckt. No. MS 05-02-006, February 9, 2005. An accumulated surplus, therefore represents the net results of both underwriting profits and investment gains. Id. at 17. We believe that the Committee's questions relate to IBC's surplus, and have responded accordingly.

Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Ins. Co., and with Highmark Blue Shield, Independent Licensees of the Blue Cross and Blue Shield Association.

used to ensure the payment of medical claims in the event of unforeseen contingencies (*e.g.*, contingencies that may range from terrorism events and pandemics, to new government mandates, changes in utilization patterns and sustained underwriting losses), and to fund the new growth and investment opportunities necessary to bring new products and services to its members. Thus, as the Insurance Department of the Commonwealth of Pennsylvania ("PID") summarized in its Determination and Order regarding the Pennsylvania Blues Plans Surplus Levels (the "Determination"):

> [T]he maintenance of appropriate levels of surplus is important for many reasons. Some are specific to each Blue Plan, but the most important reason is applicable to all, and that is to remain adequately solvent. Protection of these companies' financial health is paramount for the millions of citizens in the Commonwealth who receive health insurance and other services from the Blue Plans.

Id. at 9.

The PID's Determination was the culmination of a multi-year investigation and analysis of the Pennsylvania Blue Plans' respective surplus levels conducted under the PID's statutory authority, 40 Pa. C.S.A. Sections 6101, 6301, *et seq.* That review and investigation included extensive public comments, an independent review of the Plans' financial reporting practices, and the employment of independent actuarial and financial experts. At the conclusion of that review and investigation, the PID determined that for IBC, a "sufficient surplus operating range" would be between 550-750% of its Risk Based Capital ("RBC"). In its Determination, the PID rejected any notion that IBC's surplus was excessive, and found, instead, that IBC was operating within an "efficient" range of surplus.

Contemporaneous with the PID surplus investigation, the Pennsylvania House of Representatives passed a resolution that tasked the Legislative Budget and Finance Committee ("LBFC") to "examine options and alternatives available to the Commonwealth with respect to the regulation, oversight and disposition of reserves and surpluses of health insurers." The LBFC, in turn, retained the health care research and consulting firm, the Lewin Group, to conduct that study. After reviewing the PID's analysis and conducting its own, independent study, the Lewin Group reached the conclusion that an RBC ratio of 887% would be needed to have a 95% confidence of maintaining reserves above the BCBSA minimum level in a seven year insurance down cycle. Based on that determination they found that surplus levels producing "RBC ratios in the range of 500% to 900% can be justified to protect against underwriting swings that could jeopardize a Blue plan's standing with state insurance regulators and the Blue Cross Blue Shield Association." (Lewin Report at iv). Accordingly, the Legislature's commissioned study concluded, in summary, that;

> [PID] Commissioner Koken's February 2005 [Determination] set reasonable bounds on the Pennsylvania Blue Plans' accumulation of surplus. Further, it is not likely that the ruling will disrupt the Pennsylvania insurance market, as the process set forth for managing surplus offers both the Blues and the Commissioner sufficient latitude to act prudently.

See, Considerations for Regulating Surplus Accumulation and Community Benefit Activities of Pennsylvania's Blue Cross and Blue Shield Plans, Legislative Budget and Finance Committee, June 2005.

In summary, the surplus levels of IBC, Highmark and the other Pennsylvania Blue Plans have been and continue to be actively scrutinized and regulated by the Pennsylvania Insurance Department. The PID's Determination not only rejected the notion that IBC's surplus was "excessive," but found it to be at an "efficient" level. Every year, the surplus levels of IBC and the other Pennsylvania Blue Plans are reviewed by the PID, and those surplus levels are a factor considered by the PID as part of their approval of new rate requests. In March 2007, the PID published its statement regarding the 2006 surplus levels, and again, found that IBC's surplus remains at an "efficient" and appropriate level.

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

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

Response: At the outset, IBC does not accept any characterization of its surplus as either "excessive" or "tremendous" relative to the risk it is underwriting for the reasons set forth in response to Question 1, above. Indeed, after extensive study and analysis, the PID concluded that IBC's surplus was at and remains at an "efficient" level based on its RBC.

It should also be noted that IBC's surplus was accumulated over more than a sixty (60) year period of continuous operations and service to Pennsylvania. Thus, as the reference to Dr. Burns' testimony implies, IBC's surplus is the accumulated result of both its net operating margins, and the successful investment and management of its

surplus over time. The investment income that IBC earns on its surplus does allow IBC to hold down the level of its premiums, as well as to fund investments in new products, technologies or services to better serve IBC's members, as well as to fund its social mission. Because a surplus is used to guarantee the payment of claims and to fund investments for the benefit of both IBC's members and the community, it is not appropriate to equate a surplus with "profits" that constitute a return to shareholders.

With respect to the suggested correlation between IBC's accumulation of surplus over time and the level of competition in the marketplace, IBC believes that the markets it participates in are sufficiently competitive. To the extent that operating margins may be deemed a useful indicator of the intensity of that competition, IBC's profit margins are modest and range from 2% to 3%. By contrast, while it is difficult to isolate particular geographic areas or lines of business, it is important to note that United, Aetna, Cigna and Coventry have all reported considerably higher profit margins than IBC, ranging from 5% to more than 7%.[2]

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

Response: Highmark and IBC have engaged in extensive study and analysis of their cost-saving opportunities, and concluded that the consolidation will result in over $1 billion in net economic benefits over the first six years of the new company's operations. These benefits are made up of a combination of certain revenue growth opportunities and cost savings that will flow directly from the consolidation.

With respect to the cost-saving aspects, the consolidation will enable the new company to generate over $820 million in scale-based economies over a six year period. These savings opportunities include cost reductions in information technology spending on claims management, medical management, informatics, enrollment, and corporate systems; consolidation of IT and desktop infrastructure; and consolidation of data

2 As the LBFC concluded in its June 2005 report, it is difficult to make an accurate comparison of the surplus levels of a not for profit Blue Plan, like IBC, and a publicly-traded for-profit insurer. "For-profit insurers tend to retain surplus at lower levels than non-for-profit Blue plans because they find it less advantageous in having big surpluses. First, these insurers must show investors highest possible return on equity [so surplus can be used] to buy[] back shares – [to] lower the denominator in the return on equity formula and raise the result. For-profit insurers also can sell shares to raise cash, something that not-for-profit insurers cannot do. Further, [in the case of] for-profit insurers . . .. the entities holding state licenses are wholly-owned subsidiaries that usually pass their profits up the line quickly. This action creates the impression of low surplus by the entity that files reports with state regulators." Lewin Group Report at iii.

centers (with avoided costs in new data center investments and upgrades).[3] Additional material savings will be realized through the consolidation of back-office and corporate management and administration functions. In addition, the parties have estimated that the consolidation should produce approximately $285 million in pharmacy cost savings over the first six years of operations. These savings will be a function of increased scale which should enable the new company to secure higher rebates and pharmacy discounts, and lower PBM administration and dispensing fees as compared to their stand-alone operations.

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

Response: As referenced in my earlier testimony at the April 9 hearing, IBC and Highmark have proposed to use the more than $1 billion in anticipated savings from the consolidation to hold down the cost of and increase access to health care for Pennsylvanians. First, the new company will extend and expand upon IBC's and Highmark's current commitments to the Community Health Reinvestment Agreement (CHRA) through 2013. That Agreement was designed to target the expansion of health insurance coverage for Pennsylvania's low income and uninsured through programs such as adultBasic coverage. By extending that agreement through 2013, the new company will contribute an additional $350 million to the CHRA. Second, the new company will contribute an additional $300 million over six years to existing programs targeting the uninsured (*e.g.*, Children's Health Insurance Program ("CHIP")) or to new initiatives aimed at expanding healthcare coverage by providing uninsured and small business employees with affordable coverage.

In addition to specific programs to assist the low income and uninsured, the savings generated by the consolidation will be used to help control the cost of health care for our members. In particular, we have committed to keeping our per-member per-month administrative fees for our employer group customers flat for two years after the new company is formed. We anticipate that this initiative will save our customers approximately $300 million in premiums. By passing along the savings achieved in the pharmaceutical area, we expect to save our customers an additional $285 million over

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3 By way of example, the proposed consolidation will avoid the need for duplicative investments in new tools to serve Highmark and IBC subscribers and providers. At present, both companies are investing in new automated capabilities to meet customer demands, and in many cases these investments are, or would be, redundant. For example, both of the Plans are investing tens of millions of dollars in building parallel and largely overlapping capabilities in informatics, medical management programs, investments in consumer driven health plans, electronic health records, personal health records, and other similar initiatives.

six years in reduced prescription drug costs. Finally, the consolidation will eliminate the certain fees related to the costs of claims processed between Highmark and IBC, generating savings of another $36 million.

Question 5: Physicians, hospitals and other health care providers have repeatedly complained that health insurers in Pennsylvania have so much market power that they can dictate reimbursement rates for providers. After the merger, what safeguards will exist to ensure that the combined company does not exercise too much market power when dealing with providers? Can you explain why you think an antitrust exemption for doctors and other health care providers (for purposes of negotiating reimbursement rates with insurance companies) would be a good idea, or not?

Response: Although IBC appreciates the fact that hospitals and other health care providers may comment that IBC and/or other health insurers can effectively dictate their reimbursement rates, that assertion is unfounded. Provider reimbursement rates are determined in a competitive market and by a process of negotiations that results in fair and reasonable compensation of providers. Indeed, as Dr. Mark Piasio, M.D., President of PMS recently noted in his recent May 2007 interview with Physicians News Digest, IBC does negotiate reimbursement rates with providers.

As noted in our prior testimony, IBC's business practice of negotiating with its provider community reflects the market realities that the interests of providers and insurers are more often aligned than opposed. IBC has focused on making available to its members the broadest possible physician and hospital network – a feat that could not be achieved without the participation of almost all providers in a given service area. This focus on accessibility (which will remain a central pillar of the future consolidated entity) creates a delicate interdependency between IBC and health-service providers that must be carefully balanced and maintained. Ultimately, this interdependency serves as the most effective "safeguard" of the providers' interests, and that relationship between IBC and its provider network will be unaffected by the consolidation.[4] In addition, hospitals and other providers have gained negotiating power as a result of the backlash against restrictive managed care organizations, as well their own consolidations and new business models (e.g., integrated delivery systems). Beyond these market "safeguards," both the Department of Justice and the Pennsylvania Insurance Department will have the opportunity to analyze all aspects of this transaction for its impact on competition *before* the transaction is approved, including considering any impact on providers. The antitrust laws will continue to apply

4 IBC, like any other health insurer or managed care entity, is able to negotiate better rates with providers because of its ability to deliver its members to those providers who are willing to participate in its provider networks. Here, because of the different geographies covered by Highmark and IBC and their respective memberships, there will be relatively little impact on providers in any particular part of the state, and thus, little change in the negotiating dynamics.

to the conduct of the parties *after* the consolidation is complete.

Finally, with respect to any proposed legislation to allow physicians or other providers to bargain collectively, IBC would need to see the specific proposal, including any limitations designed to protect consumers, before it could comment in full. As an entity committed to delivering broad access to health insurance benefits at the lowest costs to the greatest number of people, however, IBC would be concerned with the impact such an exemption for collective bargaining could have on prices for health care services and the quality of medical care provided to our members.

IBC generally supports proposals, legislative or otherwise, that are designed to promote the more efficient provision of quality health care services in Pennsylvania. A blanket collective-bargaining proposal for one group of professionals, however, appears to do little on the surface to help promote this goal or advance the interests of consumers of health care. A fundamental purpose of any such proposal would be to raise reimbursement rates, and thus, would necessarily raise costs to health care consumers. Such a cost increase, in turn, threatens to decrease access to health care, either because insurers will simply not be able to meet all of the provider demands, or because the increased cost of care will further reduce the number of employers offering health care coverage. Lastly, while IBC strongly supports measures designed to align higher quality of care with reimbursement rates, a general antitrust exemption does nothing to raise quality or decrease utilization in a manner that may help offset any anticipated rate increase.

Based on the same concerns outlined above with respect to the impact such legislation would likely have on affordability, access and quality of health care, we also point out that the federal antitrust agencies strongly oppose provider collective bargaining, most notably in the joint DOJ/FTC Report, "Improving Health Care: A Dose of Competition":

> Some physicians have lobbied heavily for an antitrust exemption to allow independent physicians to bargain collectively. They argue that payors have market power, and that collective bargaining will enable physicians to exercise countervailing market power. The Agencies have consistently opposed these exemptions, because they are likely to harm consumers by increasing costs without improving quality of care. The Congressional Budget Office estimated that proposed federal legislation to exempt physicians from antitrust scrutiny would increase expenditures on private health insurance by 2.6 percent and increase direct federal spending on health care programs such as Medicaid by $11.3 billion.[5]

5 A Dose of Competition at p. 14 of Executive Summary.

For these reasons, the DOJ and FTC recommended that: "Governments should not enact legislation to permit independent physicians to bargain collectively. Physician collective bargaining will harm consumers financially and is unlikely to result in quality improvements."[6]

As a mission-based company dedicated to increasing access to affordable, high quality health care for the citizens of Pennsylvania, IBC would have the same concerns as expressed by the DOJ and FTC regarding any such proposed legislation that fundamentally impacts the health care delivery system – how would it affect cost, accessibility and the quality of care provided.

Question 6: You have publicly committed $650 million in savings from the merger to help fund health insurance for uninsured Pennsylvanians. Is this commitment in excess of the combined amount that both of your companies have previously committed to contribute toward health insurance for uninsured Pennsylvanians under the Community Health Reinvestment Agreement (CHRA) – which provides funding to the "adult basic" program – through 2010?

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

Response: Yes. As I testified at the April 9 hearing, the $650 million that we have proposed to commit to help cover uninsured Pennsylvanians as a result of the consolidation is above and beyond either companies' existing commitments to the Community Health Reinvestment Agreement. Those existing commitments expire in 2010. As a result of the savings over six years achieved through consolidation, the new company will extend that commitment by an additional $350 million through 2013. In addition, the remaining $300 million will be spent on other programs to help the uninsured and low income families of Pennsylvania enjoy access to health care. Although these funds have not been specifically earmarked at this time, the companies anticipate further contributions to existing programs such as non-profit health clinics and funding for CHIP, as well as other new programs. The new company anticipates working cooperatively with government and community stakeholders on how best to address the needs of this segment of the population.

Question 7: At the hearing, Professor Burns questioned your ability to extract additional savings from your pharmaceutical costs. Given the market power that your companies already wield, do you believe that it is realistic to expect that you will be able to extract additional savings from your drug spending?

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6 Id. at 23, "Recommendation 4" (emphasis in the original)

Response: Yes. The companies believe that their pharmaceutical savings estimates are realistic and achievable. The estimated savings were the result of a careful and detailed study of all of the potential cost saving opportunities that could be achieved in a consolidation, including the impact on each company's respective pharmaceutical purchases. The estimated annual savings represents only 2% of the combined companies' annual spending on pharmaceuticals, and most of the estimated savings are based upon a direct comparison of each company's actual purchase prices and rebate levels.

As to the anticipated sources of pharmaceutical savings, the companies anticipate the savings to result from the following changes: use of best pricing across the newly consolidated organization to provide enrollees with better discounts; cost reductions by lowering pharmacy benefit management administrative fees (prescription claims processing expenses); cost reductions achieved by negotiating lower dispensing fees; cost reductions by routing specialty drugs through their pharmacy (as opposed to treating as medical costs); and rebate increases by virtue of comparing rebate per claim by formulary.

Finally, it should be noted that while Highmark and IBC may each be relatively significant purchasers of pharmaceuticals in terms of the dollars spent, their separate purchases represent at most a small fraction of the total sales by the pharmaceutical manufacturers who sell nationwide (and, indeed worldwide). Thus, the companies do not possess significant "market power" as purchasers of pharmaceuticals.

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

Response: In analyzing the opportunities for synergies and cost savings that could be achieved as a result of the consolidation of Highmark and IBC, both companies were cognizant of trying to balance the interests of their various stakeholders, including their employees, customers, and community leaders, and both companies were adamant about preserving their core values, which include their not-for-profit status, their respective social missions, and their strong focus and commitment to their respective local communities. Accordingly, the plan for a consolidation with Highmark presents many opportunities for strategic growth and cost savings, but not at the expense of sacrificing either company's core values. One reflection of the companies' commitment to those core values was their decision to maintain a significant local presence, in terms of the new company's leadership, employment, board membership, and direct community involvement in each of the Pittsburgh, Camp Hill and Philadelphia regions.

In addition, as set forth above in responses to Questions 3 and 7, and in Mr. Frick's original testimony, the $1 billion in savings anticipated over six years as a result of the consolidation comes primarily from scale-based efficiencies (e.g., consolidated IT spending, elimination of duplicative investments, reduced administrative expenses, and pharmacy cost savings). These savings are not based upon, and are not contingent on significant job losses or an overall consolidation of the new company's work force.

Question 9: You have argued that IBC and Highmark are not competitors. However, there is no reason why IBC and Highmark could not compete with one another. As the two largest insurance companies in Pennsylvania, IBC and Highmark must each look over their shoulders at each other to some extent. Doesn't the fact that IBC and Highmark are each other's biggest potential competitive threat help keep prices down? If the companies merge, those competitive pressures will dissipate, correct?

Response: Given their respective geographic focus, IBC and Highmark are not competitors. Since its inception, IBC has focused on serving the Philadelphia area, consistent with the scope of its license from the Blue Cross and Blue Shield Association (BCBSA). IBC's targeted expansion efforts outside of its BCBSA service area (i.e., without using its Blue Cross trademark) have been limited, and have enjoyed their greatest success by serving the Philadelphia commuter suburbs in New Jersey. In contrast with those commuter suburbs to Philadelphia, there is little in common between the Philadelphia and Pittsburgh areas in terms of their economic base, employer groups, provider networks, demographics or media markets. IBC has never seriously considered an expansion into the Pittsburgh area or Western Pennsylvania. In addition, IBC does not regard Highmark a likely entrant into IBC's service area in southeastern Pennsylvania, and thus, IBC's product pricing is not influenced by any perceived competition from Highmark. More fundamentally, as set forth below in response to Request No. 10, IBC's prices are restrained by the many actual competitors actively participating in its market area, and not by the theoretical possibility of future entry by any other insurer.

Question 10: Why have the "major, national, publicly traded, highly capitalized companies" that you compete with had such a difficult time gaining a foothold in the Pennsylvania health insurance markets?

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

Response: With respect to IBC's core service area in the greater Philadelphia region, IBC sees no shortage of major, national, publicly-traded competitors. These competitors include United Healthcare (the largest health insurer in the U.S.), Aetna,

Cigna and Coventry. Cigna and Aetna (including through its acquisition of U.S. Healthcare) have been major competitors in the Philadelphia area for many years; whereas United and Coventry are relatively recent entrants. United's entry, in particular, we believe is illustrative of the mistaken premise of the question.

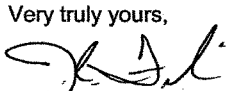
According to a story published by HeathLeaders-Interstudy in May 2006: "national insurance giant UnitedHealthCare has tagged Pennsylvania as a major growth market, and is moving aggressively to establish a greater presence there. According to the latest issue of Pennsylvania Health Plan Analysis, United regards Pennsylvania as among its best growth opportunities nationally." Pursuant to that strategy, United purchased the Fidelity Insurance Group for approximately $20 million in 2004, established a joint venture with the Jefferson Health System for consumer directed health plans in 2006, and has quickly emerged as a major competitor for commercial business in the Philadelphia area, evidenced, in part, by its active pursuit of the state employees' contract. As the United experience demonstrates, there are no structural impediments to competition in the Philadelphia region. Accordingly, IBC believes that any alleged difficulties that these firms may claim to encounter in growing their presence can be attributed to the highly competitive markets in which IBC participates, and their own internal strategies and profitability levels demanded by their shareholders.

Finally, IBC has no independent information regarding allegations concerning the Highmark-UPMC relationship on competition in Allegheny County, and thus, defers to Highmark for its response.

* * * * *

In conclusion, we appreciate the opportunity to address and respond to this Committee's questions and to help convey the opportunities that this consolidation offers to improve the state of health care in Pennsylvania.

Very truly yours,



Joseph A. Frick
President & CEO

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

May 17, 2007

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

Attn: Jennifer Leathers, Hearing Clerk

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

Dear Chairman and Committee Members:

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

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

Response 1:

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

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

Fifth Avenue Place • 120 Fifth Avenue • Suite 3111 • Pittsburgh PA 15222-3099 • Telephone: (412) 544-7245 • Fax: (412) 544-8240

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

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

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

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

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

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

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

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

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

Response 2:

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

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

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

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

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

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

Response 3:

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

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

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

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

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

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

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

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

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

Response 4:

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

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

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

Question 5:

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

Response 5:

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

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

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

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

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

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

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

Question 6:

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

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

Response 6:

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

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

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

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

Question 7:

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

Response 7:

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

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

Response 8:

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

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

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

Question 9:

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

Response 9:

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

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

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

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

Question 10:

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

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

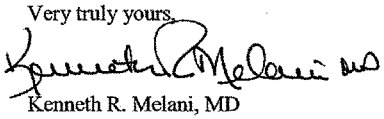
Response 10:

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

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

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

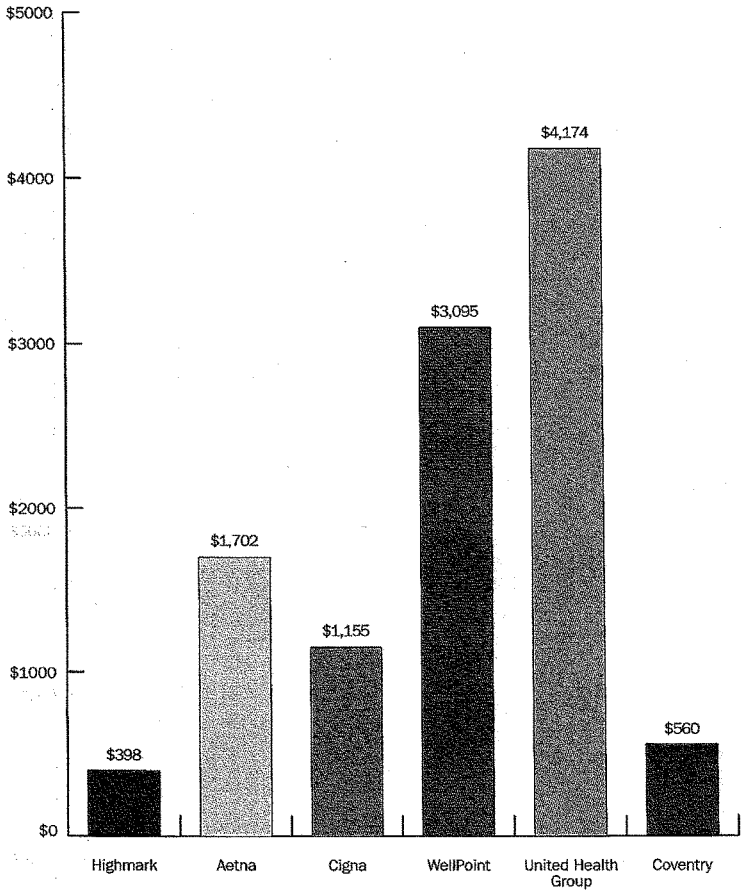
Very truly yours,



Kenneth R. Melani, MD
President and Chief Executive Officer

2006 Net Income of Health Insurers

In millions



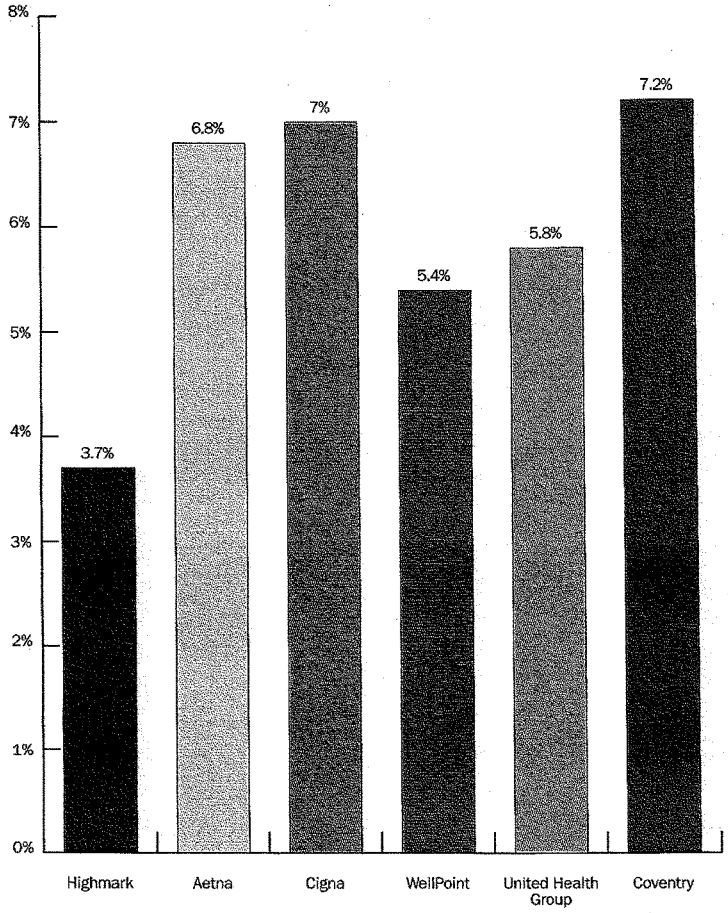
HIGHMARK®

Source: Company financial reports

Exhibit 2A

2006 Net Income Margins of Health Insurers

Includes all lines of business

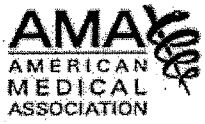


HIGHMARK®

Source: Company financial reports

Exhibit 2B

SUBMISSIONS FOR THE RECORD



Statement

of the

American Medical Association

to the

Senate Committee on the Judiciary
United States Senate

RE: Proposed Merger of Independence Blue Cross and Highmark, Inc.

April 12, 2007

The American Medical Association (AMA) appreciates the Senate Judiciary Committee's ongoing concern about the conditions of health insurance markets in the United States. The AMA commends the Committee for conducting field hearings in Pennsylvania on April 9, 2007 regarding the recently announced proposed merger between Highmark, Inc., and Independence Blue Cross (IBC). There is no debate about the magnitude of this merger, which would result in a single company controlling more than 53% of the Pennsylvania commercial insurance market. We wholeheartedly agree with the testimony of the Pennsylvania Medical Society (PaMS) and others that this calls for a thorough investigation by state and federal regulators to ensure that the proposed merger, if approved, will truly benefit patients and that it will not result in business practices that make it more difficult for physicians to practice medicine in Pennsylvania.

In September 2006, the AMA testified before the Committee about the range of concerns that we have about the growing consolidation of health insurance markets and the potential harm to America's patients. We are pleased that at this week's hearing, the Committee asked senior executives of IBC and Highmark, Inc. tough questions about their financial operations. In the course of their investigations, state and federal regulators must find the answers to these and many other questions, and determine what these answers mean for the patients of Pennsylvania.

At the April 9 hearing, PaMS very effectively set forth the specific concerns that patients and physicians have about the proposed Highmark/IBC merger. We agree with these concerns. Rather than repeat those points, we would like to focus our comments on the issue of the threat that the merged company could exercise monopsony power over the purchase of physician services. As has been noted, if this merger is approved, it will dominate the statewide market and also dominate Pennsylvania's two largest urban markets- Philadelphia and Pittsburgh. The U.S. Department of Justice (DOJ) has recognized that a health plans' ability to exercise monopsony power over physicians can harm patients.

We want to focus specifically on contracting provisions and practice, which, if not prohibited, could dramatically increase the risk that the combined company could exercise monopsony power. These provisions may also operate as barriers to new entry into a market, thus further undermining the goal of competitive markets. The AMA urges, at a minimum, that the following contracting provisions and practices be prohibited as a condition of any approval of this merger:

- **All products provisions:** These provisions require a physician to participate in all products offered by a health insurer. In its 1999 challenge to the Aetna/Prudential merger, the DOJ specifically acknowledged the potentially harmful impact to patients of the "all products" provisions/policies. The DOJ noted that where a health insurer has a large market share, an "all products" policy further limits a physician's ability to walk away from a contract. The DOJ went on to observe that when a physician cannot walk away from a contract, the health insurer can potentially exercise monopsony power over physicians and that the exercise of monopsony power harms consumers—in this case patients.

  Moreover, all products provisions are tying arrangements that can also hurt competition by allowing a dominant health insurer to insulate a particular product from competition, thereby hindering market entry by making it difficult to introduce a product that could otherwise compete on the merits. We also think that a health insurer could have such a large market share that an all products policy could reduce the capacity of physician practices to a point where they cannot accept new business from a competitor trying to

enter the market.

- **Most favored nations provisions;** In a series of cases and enforcement actions, the federal antitrust agencies have prohibited the use of most favored nations provisions in the presence of market power because they deter entry into the market and thus eliminate or reduce competition among insurers. If a merged IBC/ Highmark, Inc were to require "most favored nation" status, this would constitute an additional and very significant barrier to entry in Pennsylvania.

- **Refusal to accept valid assignment of benefits for non-participating providers**: A number of health insurers, including Blue Cross Blue Shield plans, have adopted a policy of not accepting valid assignment of benefits executed by patients on behalf of non-participating providers. Instead of paying the physician who provided the service, the health insurer pays the patient. Consequently, the patient is required to assume financial responsibility to the provider that should be assumed by the plan. The health insurers are clear that the strategy is designed to pressure physicians to contract with the health plan. For this reason, a number of states already require health insurers to honor valid patient assignments. If an anti-assignment policy were implemented by a combined IBC/Highmark, Inc., it would make it nearly impossible for physicians not to contract with the merged company which would create or exacerbate existing monopsony power over physicians.

We anticipate that there are many issues that will arise during the course of the merger investigation and that other conditions will be necessary to protect patients and to protect competition in Pennsylvania's health insurance market. The AMA is very concerned about the adverse impact that the IBC/Highmark, Inc., merger may have on the ability of Pennsylvania physicians to practice medicine in a manner which patients have come to expect and deserve. Patient care must not be sacrificed on the altar of "market power."

The AMA appreciates the Committee's ongoing concerns about the issues of competition in health insurance markets. We look forward to working with Senator Specter and the Committee to address these issues and others that arise as a result of these mergers and consolidation of health insurance markets.

Delaware Valley Health Care Coalition, Inc.

2980 Southampton Road, Philadelphia, PA 19154

1-215-676-7940 • FAX 1-215-676-7941

James R. Buckley
President

Matthew B. Kearney
Secretary

Boe Gillespie
Treasurer

Randall DiPalo
Executive Director

David Daino
Executive Director

Dennis Sarnowski
Chairperson

TESTIMONY OF JAMES R. BUCKLEY, PRESIDENT OF THE DELAWARE VALLEY HEALTH CARE COALITION, INC.

on April 9, 2007

United States Senate on the Judiciary

"The Highmark/Independence Blue Cross Merger: Examining Competition and Choice in Pennsylvania's Health Insurance Markets"

Senator Specter, Members of the Committee:

My name is James R. Buckley and I am President of the Delaware Valley Health Care Coalition, Inc. The Delaware Valley Health Care Coalition, Inc. ("DVHCC") is a group of Union Health and Welfare Funds who have joined together to improve each Fund's individual purchasing power. At the present time, we represent ninety-one (91) Union Funds located in the Commonwealth of Pennsylvania representing one-hundred ninety thousand (190,000) Members; and, when one includes Member dependents, the health insurance provided easily covers in excess of four hundred thousand (400,000) lives.

An extremely conservative estimate of the DVHCC overall annual hospital/doctor spend for calendar year 2006 in our Commonwealth, is approximately one billion, five hundred million dollars ($1,500,000,000). The DVHCC Member Funds are located across our Commonwealth from Pittsburgh to Philadelphia, as well as seven other states and the District of Columbia. Part of our mission is to monitor legislative initiatives and the healthcare marketplace for matters that may impact our membership as well as to research, evaluate and creatively develop programs that improve the quality and efficiency of health care and various health care delivery systems.

At this point, the Delaware Valley Health Care Coalition, Inc. has no position regarding the planned merger between Highmark Blue Cross ("Highmark") and Independence Blue Cross, Inc. ("IBC"). This is simply due to the fact that there is very little information concerning the potential effects of this merger available to healthcare consumers and providers. We have learned the following from various press releases and other sources that may or may not be accurate:

- The merger will be completed over a three to five year period.
- There will be a contribution to the Rendell Administration of SIX-HUNDRED-FIFTY MILLION DOLLARS to cover the uninsured, bringing the total contribution amount to 1.1 BILLION DOLLARS.
- There will be a two-year financial cap on Administration fees by Highmark and IBC.
- There will be an additional TWO-HUNDRED-EIGHTY-FIVE MILLION DOLLAR infusion of cash into the Blue Cross Prescription drug product in fee and drug cost reductions.
- The new corporation will be non-profit.
- The new corporation headquarters will be in Camp Hill, Pennsylvania.
- There will be no lay-offs, all employee reductions will be achieved through attrition.
- There will be no employee buy-outs or golden parachutes.

Although at this time, the DVHCC has no official position, I am here on behalf of our Directors to express our profound concern and hope that certain questions regarding this merger will be answered through this Committee's review process. Our concerns and questions focus on whether the resulting entity will foster greater competition in the Commonwealth to the benefit of healthcare consumers, payers and providers, or stifle competition to the detriment of those groups.

Both organizations have a tremendous amount of money in reserve that, in part, owing to their non-profit status are to be used to afford health coverage to the uninsured in our Commonwealth. In 2005, it was reported that the reserves of Highmark Blue Cross and Independence Blue Cross were $2.8 billion and $1.43 billion, respectively. By combining the Blues organizations and the hopeful efficiencies created, our Directors are concerned with how excess reserves will be utilized. Will excess reserves be used to create a better and more affordable healthcare system for citizens of the Commonwealth, or will they be used to finance "predatory pricing" practices of the newly merged company? Will the excess reserves and economies of scale created by the unified insurer be used to "smooth rates" from year to year. Will there be guidelines that will control what reserves may be used for and if so, who will be charged will the oversight of these reserves. Will the anticipated reduction of 9,000 jobs through attrition, eventually resulting in savings of approximately $450 million dollars per year upon completion of the workforce reductions, pay for run-out for employees' healthcare whose employer becomes insolvent or disease management for all insured? Further, will the reductions in workforce affect the services provided, and consequently the quality of care provided in the Commonwealth.

Of great concern to our Member Directors, is whether or not the new entity with its integrated systems will provide for a greater flow of information concerning quality of care provided by hospitals and physicians in the Commonwealth and payment

information. It is our sincere hope that there be a mandate for transparency with regard to information on hospitals and physicians; and, further, more importantly, that this information be shared with the Pennsylvania Healthcare Cost Containment Council, an organization that has compiled an invaluable knowledge base on healthcare quality in the Commonwealth, and who, I might add, without renewed enabling legislation will cease to exist in 2008.

It is our sincere hope that these questions will be answered and issues be addressed when this merger is scrutinized by this Committee and the Department of Justice as well as the Insurance Department of the Commonwealth of Pennsylvania.

Thank you for giving me the opportunity to express the concerns of the Delaware Valley Health Care Coalition, Inc.'s Directors regarding the proposed merger of Highmark Blue Cross and Independence Blue Cross.

U.S. Senate

Committee on the Judiciary

Hearings on the Highmark/Independence Blue Cross Merger

Sen. Arlen Specter

Testimony of Lawton R. Burns, Ph.D., MBA
The James Joo-Jin Kim Professor
Professor of Health Care Systems and Management
The Wharton School
University of Pennsylvania
PH: 215-898-3711
burnsL@wharton.upenn.edu

April 9, 2007

Testimony of Lawton R. Burns re. the Highmark/Independence Blue Cross Merger

1. Introduction

Good morning. My name is Lawton Robert Burns. I am the James Joo-Jin Kim Professor, Professor of Health Care Systems and Management, and Director of the Wharton Center for Health Management and Economics - - all at the Wharton School at the University of Pennsylvania. I appreciate the opportunity to present testimony about the Highmark/Independence Blue Cross Merger.

My remarks are drawn from research I have conducted on the history of the Pennsylvania insurer and hospital markets since the 1980s, and national research on the relationship between insurer and hospital market structures. They are also based on my understanding of the field of industrial organization economics, which examines (in part) the causes and consequences of mergers. I have taught the graduate-level course in industrial organization as applied to healthcare at The Wharton School for the past ten years.

2. The Highmark/Independence Blue Cross Merger

On March 28, 2007, Highmark and Independence Blue Cross (IBC) announced their merger. The press statement mentions several benefits of their combination:

1. Generate $1 Billion in economic benefits via:
   a) $650 Million to expand health insurance access to the uninsured
   b) $280 Million savings from better management of prescription drug costs
   c) $300 Million savings from holding administrative fees flat for two years

2. Better serve customers and providers

3. Improve health care quality and the health of communities served

4. Generate new business, create jobs, and stimulate business opportunities for Penna firms

5. Meet shifting customer demands for new products

6. Combine the best practices, talents, and resources of the two firms

7. Fund essential technological and infrastructure improvements to deal with external, competing, investor-owned health plans

The aims of the merger are lofty. Unfortunately, there is no detail provided regarding how these benefits are to be achieved. My personal view is that most of these benefits are probably not attainable for several reasons.

3. Why the Merger Won't Produce the Anticipated & Espoused Benefits

First, the merger is labeled by both companies as a "combination". The two firms will maintain their respective headquarters in Pittsburgh and Philadelphia. There thus seems to be little integration or consolidation of the infrastructure of the health plans. As a consequence, it is difficult to envision where any savings and efficiencies will spring from. In fact, there may be duplication due to the use of a combination rather than an integrative merger. There may also be higher costs of operations, simply due to the need to coordinate two giant operations located 300 miles apart. The Allegheny Health Education & Research Foundation (AHERF) discovered this sad fact prior to its bankruptcy nine years ago. Many mergers achieve at least short-term savings by combining administrative functions and reducing administrative headcounts. That does not seem to be the aim here, since one goal of the merger is to create jobs.

Second, the literature on corporate mergers and acquisitions is quite clear in showing that efficiencies and synergies result from defined pre- and post-integration efforts. There is no detail regarding these efforts in this pre-merger phase. Specifically, the economic literature on scale economies outlines the different areas in which efficiencies can be reaped: spreading of fixed costs over larger volume, increased specialization of labor, enhanced ability to raise capital, lower costs of carrying inventory, learning curve effects, marketing economies (e.g., branding, advertising), promotion economies (e.g., lower consumer transaction and search costs), and purchasing economies (greater leverage over suppliers). One of the espoused rationales for the merger is better management of drug costs. It is hard to see how the combined firm would have any more leverage over pharmaceutical suppliers than the individual firms already enjoy. Suppliers grant discounts based on local market penetration; Highmark and IBC already have achieved this, and their combination will not increase it. Indeed, to the extent they exist at all, many of the proposed benefits of the merger may already be attainable by the separate organizations. Highmark and IBC should be explicit in outlining where the efficiencies and synergies are to come from, and how they will be achieved. Simply combining two firms without integrating them does not yield operating efficiencies.

Third, even in the presence of such efforts and defined post-integration strategies, scale economies and merger efficiencies are difficult to achieve. The econometric literature shows that scale economies in HMO health plans are reached at roughly 100,000 enrollees. Enrollment levels at the HMO plans operated by Highmark and IBC far exceed the minimum efficient scale. Moreover, the provision of health insurance (e.g., front-office and back-office functions) is a labor-intensive rather than capital-intensive industry. As a result, there are minimal economies to reap as scale increases. Moreover, there is little econometric evidence for scale economies in multi-plant firms - - e.g., firms that have multiple sites or plants of operation scattered geographically. This seems to be the case with this merger. Finally, there is little econometric evidence for economies of scope in these health plans - - e.g., serving both the commercial and Medicare populations. Serving these different patient populations requires different types of infrastructure. Hence, few efficiencies may be reaped from serving large and diverse client populations. Indeed, really large firms may suffer from diseconomies of scale.

Fourth, the recent historical experience with mergers of managed care plans and other types of enterprises does not reveal any long-term efficiencies. Indeed, a recent Wall Street analysis shows that the mergers of investor-owned health insurers under-perform the market two years after the merger. More broadly, the strategy literature shows that the majority of corporate mergers (60-70%) fail. What explains the low success rate? A major problem is the failure to deliver on the sources of value, which is extraordinarily difficult to do. Mergers are complex situations; mergers of large companies are even more complex. In fact, the literature shows that mergers of two evenly-sized firms are the most complex and difficult to extract value from, given the convoluted politics of integration between firms that consider themselves equal.

4. So Why Do Mergers Continue to Occur?

If all of the above is true, when then do mergers (and mergers of health plans) continue to occur? One reason is "managerial hubris": the feeling of firm executives that they can do what others have not done to extract value from existing operations. Another reason is "empire building": executives of larger firms derive monetary and psychic rewards from administering a bigger enterprise. A third reason, and one the Senate should consider, is that mergers serve to reduce the number of competitors in a market by at least one.

What is so important about the sheer number of competitors? Econometric evidence shows that in the managed care field, an increase in the number of competitors is associated with lower health plan costs and premiums; conversely, a decrease in the number of competitors is associated with increases in plan costs and premiums. The evidence also shows that the sheer number of competitors exerts a stronger influence on these outcomes than does the penetration level achieved by plans in the market. Perhaps the most significant effect of the Highmark/IBC merger is the removal of one competitor from the Pennsylvania health plan landscape.

One might then wonder what this landscape looks like statewide? The Commonwealth has four Blue Cross plans and one statewide Blue Shield plan. The four Blue Cross plans are: Highmark, Capital Blue Cross (CBC), Blue Cross of Northeastern Pennsylvania (BC-NEPA), and Independence Blue Cross (IBC). Highmark operates the one Blue Shield plan. The Blue Cross plans operate in various regions in the state. For purposes of discussing the Pennsylvania market today, I have identified eight regions as defined by the Hospital and Healthsystem Association of Pennsylvania (HAP). In HAP's report on HMO managed care, these regions and their dominant HMO health plans include:

Northwest Penna	Highmark – Keystone Health Plan West
Southwest Penna	Highmark – Keystone Health Plan West
Altoona/Johnstown	Highmark – Keystone Health Plan West
North Central Penna	Geisinger Health Plan
South Central Penna	HealthAmerica
Northeast Penna	Blue Cross of Northeast Penna – First Priority
Lehigh Valley	Capital Blue Cross – Keystone Health Plan Central

Southeast Penna Independence Blue Cross – Keystone Health Plan East

This initial list suggests that the four Blues plans dominate the Western and Eastern portions of the state, with the Central region controlled by two non-Blues plans. The situation is a bit more concentrated than this, however. Highmark has 40 percent ownership of the Blues plan operations in Northeast Pennsylvania, and has joint operating agreements with BC-NEPA to market its traditional, comprehensive, senior, and PPO products. In effect, Highmark controls not only the Western portion of the state but also a solid piece of the Northeast. With the pending merger with IBC, Highmark would control not only the Western portion but most of the Eastern portion as well. One might surmise from this that Highmark's strategy, beginning with its formation in 1996 with the merger between Western Blue Cross and Pennsylvania Blue Shield, has been and continues to be its desire to be the only Blue Cross plan in the Commonwealth.

This would not necessarily lead to any further concentration[1] in any of these eight regions. This is because the Blues plans have typically operated in their own regions and not poached on the territories of other Blues plans. One exception has been in South Central Pennsylvania, where Highmark ended its joint operating agreement with CBC around 2001 and has since competed with them for market share. Another reason why there would probably not be more concentration is because the various markets are already concentrated. Data published by the American Medical Association on both HMO and PPO enrollments in Pennsylvania's metropolitan statistical areas (MSAs) reveals that the vast majority of these markets are already highly concentrated with respect to HMO products, and most are concentrated with respect to their PPO markets as well. That is, there is relatively little competition within these markets. Philadelphia and Pittsburgh, in particular, are two of the most concentrated markets in the US.

The net effect of the Highmark-IBC merger might then be a nearly-statewide confederation of Blue Cross plans controlled by Highmark with strong domination in each region. What has changed is not so much the local market-level concentration but rather the common ownership and control of the plans that enjoy this concentrated market power. Is this a cause for concern? One might surmise that a powerful Highmark, with control over the Eastern and Western portions of the Commonwealth, might then set its sights on seeking to enter or combine operations with the Blues and other plans operating in the Central regions of the Commonwealth. This would have the effect of reducing what little competition already exists between rival Blues plans in South Central Pennsylvania and the LeHigh Valley. Indeed, given that Highmark and IBC are the two most powerful Blue Cross plans in the Commonwealth, one wonders whether the

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[1] For purposes of definition, I define "concentrated market structure" in terms of the number of competitors and their relative share of the market. These two components are often summarized as the Herfindahl-Hirschman Index (HHI). This index measures how much market share is concentrated in one or a few large health plans. The HHI is measured as the sum of the squared shares of each firm in the market. Thus, a market with three firms whose shares are 25%, 25%, and 50% would be equal to: $25^2 + 25^2 + 50^2 = 3{,}850$. The higher the HHI, the more concentrated the market, and the more powerful are one or a few plans. According to the Department of Justice's Horizontal Merger Guidelines, markets with HHI greater than 1,800 are highly concentrated.

proposed merger eliminates any possible future competition between them as they eye one another's regions for market entry and expansion.

Are there other possible rationales for the Highmark/IBC merger? I think that one of the rationales for the merger espoused by Highmark may in fact be legitimate: the desire to confront the growing competition from out-of-state, investor-owned health plans such as UnitedHealthcare and Aetna. United has declared a major commitment to expand into Pennsylvania, which would serve to link up its more extensive operations to the East (Maryland, Virginia, New Jersey) and to the West (Ohio). United's strategy has been to contract with national employers with whom it does business elsewhere and which have operations here in the Commonwealth (e.g., Boeing).

The Blues plans in Pennsylvania are worried about the entry of these national plans into their marketplace for several reasons. First, the investor-owned plans have lower medical loss ratios and administrative costs. Second, they are less restricted in medical underwriting practices than the Blue Cross plans. Third, they have begun to take market share away from the Blue Cross plans in certain portions of the state (e.g., Southeast Pennsylvania). The Blues plans are worried that large national firms have the financial ability to under-price the market and sustain losses over several years in order to gain market share. A merger of Highmark and IBC might enable the combined firm to pool their reserves and stave off the threat of market entry and growth by these firms. Blue Cross plans commonly use their reserves to generate investment income that helps to moderate premium increases.

Alternatively, the national firms might competitively price their premiums but use their financial resources to pay providers in the Commonwealth more than the Blues plans currently pay. This strategy would enable them to develop contracts with hospitals more readily than in the past, and would surmount the historical tendency among providers to retard new market entry (and thereby shoot themselves in the foot) by asking for higher levels of reimbursement from the new insurer on the block. Most insurers could not afford to do this for long, and quickly exited the market - - leaving the market less competitive and more concentrated.

5. Conclusion

At present, there is little econometric evidence for the merger of large health plans like Highmark and IBC. To date, the two firms have failed to provide a convincing rationale and game plan for extracting the value and efficiencies from their proposed combination. There is some legitimate concern that the proposed merger has potential anti-competitive effects on existing Blue Cross plans in other regions of the Commonwealth as well as market entry and expansion by national investor-owned firms.

The Highmark/Independence Blue Cross Merger:

Examining Competition and Choice

in Pennsylvania's Health Insurance Markets

A U. S. Senate Judiciary Committee Hearing

April 9, 2007

Testimony by

Joseph A. Frick

President and Chief Executive Officer

Independence Blue Cross

My name is Joe Frick, and I am president and chief executive officer for Independence Blue Cross. I want to thank Senator Specter, Senator Casey and Governor Rendell for the opportunity to speak to you today about why the combination of Highmark and Independence Blue Cross into a new company is good for Pennsylvania and how it will create value for our customers, for health care providers, the communities we serve, and, most of all, for the people of our great Commonwealth.

I am very pleased to be here today and to appear on a panel with recognized leaders in our community and hear their perspectives on this important matter.

The unanimous vote 10 days ago by the boards of Highmark and Independence Blue Cross to approve an agreement to combine our two companies begins an extensive review process. We look forward to working cooperatively with state and federal regulatory agencies and with public officials who want to better understand the impact of the combination on the people of Pennsylvania. Today we will continue the open dialogue we have begun with key stakeholders in health care about how this combination will enable us to better serve their needs. We welcome your participation.

Every major national and local survey in the last year has shown that the No.1 issue on people's minds is the availability of affordable health care. It is no wonder. Every year employees shoulder more of the cost of health insurance, fewer employers offer health coverage, and there are more uninsured in Pennsylvania.

This troubles us deeply. Our mission at Independence Blue Cross and at Highmark – and we are passionate about it – is to provide access to quality, affordable health care, enabling people to live longer, healthier lives and strengthening the wellbeing of our communities. After almost two years of thorough data-driven analysis, we concluded that the best way for each of us to fulfill that mission was to join our two progressive Pennsylvania companies. We strongly believe this combination will not reduce competition or choice in the health insurance marketplace in the Commonwealth.

This morning, we want to demonstrate why. First and foremost, the combined companies will generate more than $1 billion in *additional* resources to provide access to affordable, quality health care coverage for Pennsylvanians. Let me be completely clear: this is new money and goes beyond any commitments we have today. By combining together, we will generate savings and revenue growth over six years that total more than $1 billion.

The savings will come from business efficiencies that the two companies could not produce individually. The savings will enable us to invest in new market-leading capabilities that are increasingly important to consumers and providers.

The combined company will generate savings by avoiding duplicating future investments in costly technology and administrative requirements. These savings will fund our moving more quickly than we could independently to take advantage of

cutting-edge technology to improve the quality of care – such as providing electronic Personal Health Records.

We will also achieve significant savings by consolidating computer systems used for claims processing, enrollment, medical management, and provider transactions. One new capability this will allow us to pursue is real-time claims adjudication – a major convenience and time-saver for both patient and physician.

By using the best practices of Highmark and IBC to perform more efficiently, the combined company will have the resources to expand wellness initiatives that keep people health and disease management programs that help the chronically ill lead healthier lives.

We listened to our customers' concern about ever-increasing pharmacy costs. To save our customers $285 million, the combined company will reduce prescription drug costs by launching initiatives to capture higher rebates and pharmacy discounts and lower the cost of administration – economies possible only with a larger membership base. These savings will go directly to our customers.

In addition to generating savings, the combined companies will be able to increase revenue by strengthening sales of ancillary health products (vision, dental, workers' compensation, and pharmacy) and leveraging our combined expertise (TPA services, national accounts, and Medicare)..

Together these savings and new revenue will generate $1 billion in additional resources. Since we do not have shareholders or investors like our publicly traded competitors, the combined company will be able to reinvest this $1 billion in the health care needs of our customers and community. Our first priority is to direct more than $650 million to expand access to health insurance for Pennsylvania's uninsured and underinsured – $650 million over and above our current commitments to help the uninsured. The increasing number of uninsured in the Commonwealth drives up health care costs, for which each of us ultimately pays. We will spend roughly $350 million to extend for three years the commitment in the Community Health Reinvestment agreement we have with the Commonwealth. Approximately $300 million will fund other programs or newly developed products to expand health care coverage in Pennsylvania.

In addition, the new company has pledged to hold administrative fees flat for two years, resulting in direct savings to customers of almost $300 million. Most of a customer's premium dollar – more than 85 cents – pays for the medical care the member receives. Less than 10 cents of each premium dollar goes to administrative fees. The combined company will not increase the administrative fees portion of customers' health care premium for two years – direct savings to our customers' premiums of almost $300 million that would not be possible without an IBC-Highmark combination.

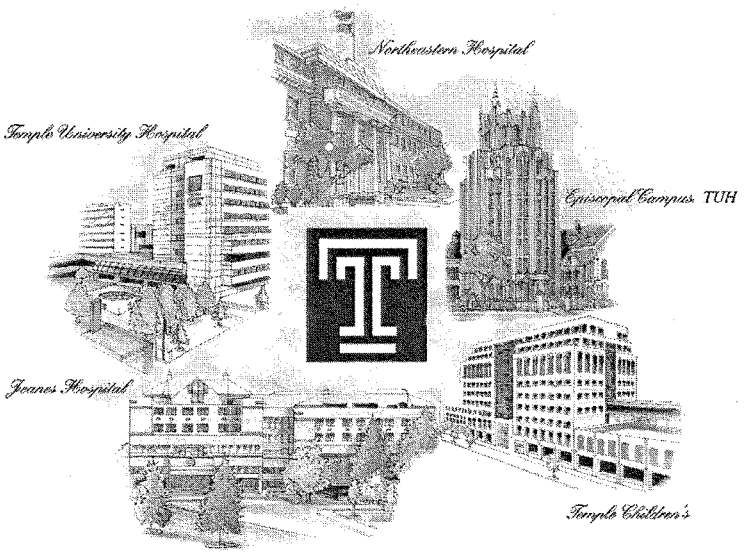
There has been much speculation about what our ultimate plans are. I assure you that both of our boards and executive teams are committed to our not-for-profit status as one of the key factors that differentiates us in our local communities and distinguishes us from our publicly traded competitors. In 2006, Highmark and IBC contributed over $200 million to support community health and education programs such as fighting hospital-acquired infections, funding clinics for the uninsured, increasing the supply of nurses through scholarships, and preventing childhood obesity.

I said earlier that I am convinced that this proposed combination will not reduce competition or choice in the health insurance marketplace. There are two compelling reasons. First, Highmark and Independence Blue Cross do not compete and never have. We are both licensees of the Blue Cross Blue Shield Association – a brand that is second to none in health care and proudly insures one out of three Americans. IBC and Highmark have worked closely together for more than 50 years on projects and products. However, Highmark and Independence have virtually no geographic or customer overlap. So by combining we are not reducing competition because there is no competition between us. It is worth noting that today Pennsylvania is one of only five states in America with more than one Blue plan. We are the only state with four Blues. With the federal government developing expansive regions for Medicare PPOs and state governments exploring establishing statewide risk pools, it is important for us competitively to offer seamless statewide products, networks, and services.

Second, both Highmark and IBC have major competition. Who are our competitors? Major national, publicly traded, highly capitalized companies, including Aetna, Cigna, Coventry, and United. These are not small Mom and Pop insurance companies whom we would overshadow. Most are larger than IBC or Highmark. All have access to capital to buy companies and capabilities. For example, Sierra Health Plan was recently purchased for $2.6 billion by United, one of our top competitors with more than 33 million members and $71.5 billion in annual revenue – almost quadruple our combined revenue. In 2005, Aetna spent $200 million to acquire ActiveHealth, a clinical data analytics company

When we began talking with Highmark almost two years ago about the possibility of working together, we had one goal in mind – improving access to quality, affordable health care. Today we are enormously energized by the possibilities we see ahead when we combine the talents of our two organizations into one great team that will continue to make affordable access to quality health care in Pennsylvania its top priority. I look forward to answering any questions you may have.

TEMPLE UNIVERSITY HEALTH SYSTEM



Statement of

Joseph W. "Chip" Marshall, III

Chairman and CEO, Temple University Health System

Before the

United States Senate

Committee on the Judiciary

April 9, 2007

At

The National Constitution Center

Philadelphia, Pennsylvania

Good morning Senator Specter, Senator Casey and Members of the Judiciary Committee. I am Chip Marshall, Chairman and CEO of the Temple University Health System. On behalf of all of our employees, physicians and patients, thank you for the opportunity to testify today on the Highmark/Independence Blue Cross Merger - a matter of significance to the Temple University Health System, the southeast Pennsylvania region and the entire Commonwealth.

At the outset, let me share with you some background on the Temple University Health System, whose hospitals have steadfastly provided their communities with compassionate, high-quality care for more than 150 years. The Temple University Health System is comprised of five hospitals, including Temple University Hospital, Temple University Children's Medical Center, the Temple- Episcopal Campus, Jeanes Hospital and Northeastern Hospital.

Last year, we handled more than a quarter-million emergency department visits; 60 thousand inpatient visits; a half-million outpatient visits; and 6 thousand births.

Temple University Hospital and Temple Children's serve as the chief clinical training sites for the Temple University School of Medicine. Together, these hospitals are the region's only Level I Trauma Center for adults, children and burn victims.

Our Health System family also includes the Temple Transport Team, our state-of-the-art ground transport unit that provides rapid transport from central Pennsylvania to the New Jersey coast. Temple Physicians, our network of community based doctor's offices, serves Philadelphia, Bucks, and Montgomery counties.

When I joined the Health System as CEO, I set forth the goal to become a high quality, regional healthcare provider. We are entirely committed to excellence, as evidenced by our continued investment in our professional workforce, facility improvements and advanced medical technologies.

It is with this background that I offer my views on the proposed merger of Highmark and Independence Blue Cross. As both an IBC network provider and as a purchaser

of its insurance product for an eight thousand-employee health system, thank you for bringing national focus to this important matter affecting competition and choice in the Pennsylvania insurance market.

I realize that at this early stage, we do not have sufficient information to make firm declarations or recommendations. Over the next several months, however, hospitals, physicians, consumers, employers and other stakeholders will closely monitor merger developments. As they do, it will become clear that the benefits promised by Highmark and IBC will not be self-executing by these plans. Benefits of a consolidated plan will be achieved only with strong efforts of all stakeholders in the healthcare industry. If done right, the combination of Highmark and IBC could offer opportunities for efficiencies in the insurance market and a deeper commitment to the social mission of these plans.

Ultimately, the issue is whether stakeholders in the healthcare delivery system will benefit from or be disadvantaged by a combination of Highmark and IBC. To help resolve this, I believe it imperative that several questions be explored.

First and foremost, how would a consolidation of Highmark and IBC affect access to care? If hospitals and physicians are not compensated fairly for their services, or they are closed out of provider networks, then the supply of vital services will be restricted at the expense of those who need care.

Second, would a consolidation of Highmark and IBC damage or destroy the social missions of these plans? In eastern Pennsylvania, IBC is an important part of the community, and is highly valued for its corporate leadership and financial support of many worthy causes. Temple Health System, for example, has enjoyed working with IBC in our joint roles with the Philadelphia Chamber, Select Philadelphia, and the CEO Council for Growth, as well as many outreach activities designed to improve the health status of our communities. We hope this civic partnership will be preserved. In western Pennsylvania, stakeholders will have their own questions as to how a merger would be managed with high expectations from a strong Philadelphia area market.

Third, how do we balance the benefits of price competition with the financial and social burdens imposed on hospitals, which are required to provide 24-hour access to all who present to their emergency rooms?

Fourth, how will financial benefits that accrue to a combined Highmark/IBC plan be shared with patients, hospitals, physicians and the communities they serve? Will employers and consumers benefit from lower costs and improved products that might be offered by a stronger, more efficient and effective company?

Finally, what impact would a consolidation have on an already fragile healthcare system? As we consider this issue, we must be vigilant in balancing the competing interests of hospitals, physicians, insurers, employers, consumers and patients. A market change of this magnitude must fortify, not weaken, Pennsylvania's healthcare delivery system. A consolidated company must be steadfastly dedicated to working with providers to ensure their continued ability to offer quality care to our patients: for it is the patients around whom we are all centered.

In closing, let me emphasize that the standard economic competitive analysis might not be entirely sufficient in considering the impact of a consolidated Highmark and IBC. In southeast Pennsylvania, IBC has sizeable market share. However, our complex healthcare market virtually precludes the ability of providers to sell their services directly to consumers. Because insurers are a necessary component of the delivery system, we want them to be efficient and effective.

On that note, we must keep in mind that with time, Pennsylvania's health system requirements will change. What is efficient and effective today, did not apply 10 years ago, and will change over the next 10 years. Pennsylvania's population is aging, and cutting-edge technologies are creating new opportunities to live at both ends of the human life cycle. As consumer demand for advanced care increases, profit margins are threatened by the increased cost of providing that care. Rather than fight change, stakeholders must work together to ensure that change is geared toward stabilizing our healthcare delivery system.

Again, it appears too early to take a position for or against the proposed consolidation. We would not want to oppose a merger simply because of possible downsides. If carefully executed, with constructive involvement from hospitals, physicians, employers, consumers, and other stakeholders, a consolidation could provide opportunity to stabilize Pennsylvania's healthcare system, preserve the economic stability of its businesses, and ensure access to care for all its citizens. We at Temple Health System are committed to working with all stakeholders on this important issue.

Again, thank you Senators for your leadership on this issue and for allowing me to testify today.

Testimony at Hearing on Highmark/Independence Blue Cross Merger

United States Senate Committee on the Judiciary

April 9, 2007

Kenneth R. Melani, M.D.

President and Chief Executive Officer

Highmark Inc.

My name is Dr. Ken Melani, and I am president and chief executive officer for Highmark. I want to thank Senator Specter, Senator Casey and Governor Rendell for the opportunity to speak to you today about why the proposed combination of Highmark and Independence Blue Cross into a new company is good for Pennsylvania and how it will create value for the communities in which we operate, for our customers, for health care providers and, most of all, for the people of Pennsylvania.

We recognize that this hearing is the start of what may be an extended review process involving state and federal regulatory agencies, with input from the Pennsylvania General Assembly and the United States Congress. We welcome the opportunity to discuss the proposed combination of Highmark and Independence Blue Cross and are committed to working cooperatively to help ensure that this process is open. Before the announcement of the agreement to combine the two companies, we had been regularly briefing key stakeholders in Pennsylvania on the status of the discussions between the two companies. We will continue this open dialogue as we move forward.

We expect some individuals and organizations may have some apprehension and some pointed questions about the potential impact of this agreement. Because there are still many details that have to be decided about how to integrate the two companies, we may not be able to answer all of your questions today. I assure you, however, that we will provide you with updates about the new company as important business issues are decided.

We ask that members of this Committee, other people here today and all Pennsylvanians keep an open mind and look at the big picture in weighing the merits of this agreement. The boards of directors of the two companies took this approach during their thorough review of this transaction and concluded that the combination of the two companies is good for Pennsylvania. In fact, both the Highmark and Independence Blue Cross boards unanimously approved the agreement to combine the two companies.

Why will this new company be good for Pennsylvania? Joe Frick addressed many of the reasons in his remarks. In addition to helping improve access to affordable, high-quality health care, the new company will serve as an engine for the Pennsylvania economy for years to come. Currently, the two companies have a total annual business impact of $4.2 billion on the state's economy, representing monies generated in Pennsylvania because of Highmark and Independence Blue Cross.

We employ more than 18,000 Pennsylvanians and help produce jobs for another 54,000 people in businesses that provide goods and services to the two companies.

Although we are both non-profit corporations, we provide substantial tax revenue for the state, with our subsidiaries paying $247.8 million in state taxes in 2006.

In the future, the new company has the potential to become an even larger contributor to the state's economy. I believe we will be able to grow our business to meet the shifting needs of our current customers and new customers not only in the area of health insurance, but also in our dental and vision businesses and other related services through partnerships with other Blue Cross and Blue Shield companies in the country. The additional revenues generated through business growth means we can bring back more money to Pennsylvania, create more jobs in the state and stimulate additional business opportunities for Pennsylvania-based companies.

Equally important, while we anticipate gaining operating efficiencies as a result of the combination, we expect that any potential impact on employment will be managed through attrition and business growth. In other words, we plan to use our collective workforces to meet the changing needs of our customers and provide employees with opportunities for professional growth.

As Joe Frick has discussed, the new company will generate $1 billion in economic benefits that will be used to achieve savings for our customers and to expand access to health insurance for Pennsylvania's uninsured population. I would like to talk about why this combination is a plus for health care providers, including physicians.

As a physician, I, too, am concerned that the changes taking place in the financing and delivery of health care may be affecting the physician-patient relationship and the quality of patient care. For a number of reasons, however, I believe the new company will have a positive effect on physicians, primarily because they will have more time to spend on patient care versus the administrative tasks of a medical practice.

The new company will work to identify the best practices to help simplify administrative transactions with physicians and hospitals, using the most effective means of electronic connectivity. At the same time, we will continue to approach health care on a region-by-region basis. Because the delivery of health services is a local issue, we will concentrate on maintaining our well-established relationships with physicians to address unique medical needs of our customers – their patients – in each region.

The new company's commitment of $650 million to expand access to health insurance for Pennsylvania's uninsured will also benefit hospitals, physicians and other health care professionals by providing more revenue for the medical services they provide.

Physicians have been a valued partner in both Highmark's and IBC's long-standing missions. We want to continue that spirit of collaboration, especially with the development of an electronic personal health record to help address quality, patient safety and cost issues.

I also would like a moment to address a question in your recent letter relating to concerns raised by physicians, hospitals and other health care providers about reimbursements to health care providers.

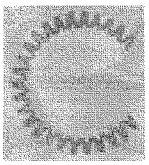
Physicians and hospitals will be important to the new company's success, as they have been for decades to the success and long-standing missions of Highmark and Independence Blue Cross. One of the principal ways that we have met our customers' expectations in the marketplace is by offering health benefit programs that include access to the broadest networks of hospitals, physicians and other providers. To help achieve broad provider networks, we have strived to fairly reimburse providers for the medical care provided to our customers.

I want to be very clear on one point: the new company will continue to maintain fair and reasonable provider payment levels. The $1 billion in economic benefits that Joe Frick and I have been discussing today will not result from changes in physician and hospital reimbursement levels.

All of us must recognize that the rising cost of health care is straining the country's system of employer-sponsored health insurance. For this reason, the new company will strive to balance fair and reasonable provider payment levels with the need to maintain comprehensive and affordable health benefit programs for consumers.

In closing, the two companies are coming together to be better able to serve the people of Pennsylvania, with a focus on providing access to affordable, high-quality health care coverage. The new company will achieve operating efficiencies – freeing resources to invest in programs and services that will benefit our group customers, individual customers, physicians, hospitals and the communities in which we operate.

For these reasons, Highmark and Independence Blue Cross have agreed to combine to build a better company for Pennsylvania. I welcome the opportunity to respond to any questions you may have.



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TESTIMONY OF PEDRO RODRIGUEZ, ACTION ALLIANCE OF SENIOR CITIZENS APRIL 9 HEARING on BLUES MERGER, BEFORE THE US SENATE COMMITTEE ON THE JUDICIARY

Good Morning, Members of the Committee. Thank you for the opportunity to add a consumer perspective on the issues surrounding the pending merger of Independence Blue Cross of Southeastern Pennsylvania and Highmark of Western and Central PA.

My name is Pedro Rodriguez. I am the Executive Director of the Action Alliance of Senior Citizens. The Action Alliance is a grass roots organization of retirees and seniors working to improve conditions for retirement and for those who have already retired. Our members range in age from 50 years old to 100 years old in Pennsylvania. Our strength is in Southeastern Pennsylvania but in the last two years we have been slowly organizing in other parts of the state, including Allegheny, Washington, Berks, Luzerne, Lehigh and Dauphin counties. As you can imagine, part of our work revolves around issues of health care: questions of access and navigation, affordability and quality.

The planned Blue Cross merger in Pennsylvania is a potential disaster for Pennsylvania consumers. It is a mega-corporate reshuffling of the deck chairs on our sinking Titanic health care system. It demonstrates why all Americans need a program like Medicare or single payer health insurance system.

This proposed merger, to create the nation's third largest health insurance company, poses more questions than answers. It also, in a very tragic way, points to the failure in Pennsylvania for government and consumers to have a place to ask those questions and try to get some answers and clarity. Questions such as: is this the first step toward a for-profit conversion? According to a report by Community Catalyst, the Blues' charitable commitment, such as the provision of coverage to children and other low-income individuals, has been decreasing since 2000. Will the merger reverse the trend or make it worse?

Already, Independence Blue Cross is a de facto for-profit corporation, having transferred most of its assets to its for-profit subsidiaries. IBC admitted that 90 percent of its revenues come from the for-profit companies it owns.

There are no clear and substantial benefits to the public from this merger. The Blues will not commit to premium reductions or pledge to put a ceiling on premiums.

Rising Blue Cross premiums will contribute significantly to the increasing rate of those without insurance, particularly older people who are not yet eligible for Medicare. There are no guarantees that individuals with flat incomes, who are dropping coverage or "buying down" to coverage with reduced benefits or increased deductibles, will realize a better deal with this merger.

The Blues' statutorily mandated charitable obligations will not be expanded under this merger. The Blues have cleverly misrepresented in their press release that $650 million will go to expanded coverage for the uninsured. This is a bold faced misrepresentation to the public because they didn't clarify that most of this money had already been obligated under a binding agreement with Governor Rendell signed in the fall of 2004 requiring annual charitable payments beginning in 2005 under the Annual Community Health Reinvestment (ACHR) program. There appears to be no substantial expansion of charitable payments coming from this merger.

In addition, no one can say the proposed merger is in the public interest unless there are guarantees that the new entities pay fairly for services. It is not in consumers' interests if as result of the merger the Blues are able to low ball payments to doctors and hospitals, causing them to end up closing their medical practices or hospital doors. No matter how low the cost of health insurance, if services are unavailable, the savings are worthless.

To determine whether the proposed merger is in the public interest, we need to know how it will *lower* health care costs, and whether it will allow more people to afford health care and make it easier for the state to grow jobs and eliminate unnecessary bureaucracies. The merger is not in the public interest if all it does is free up more money for the Blues to start more for profit subsidiaries. I don't think anyone can say it is in the public interest unless we see how much savings is being projected and to whom the savings flow. Will those savings go to huge salaries for top executives or to provide increased access to health care for working people in Pennsylvania?

What is also of grave concern is the appalling absence of any decent consumer protection law or enforcement within state and federal governments. The catch-up bills of State Senator Don White (SB 550) and Reps. Todd Eachus and Phyllis Mundy (HB 112) would finally amend the state's Insurance Holding Company Act to include the Blues with other insurance companies so that a planned merger would now need Insurance Department approval. The Department for the first time would be able to determine if the Blues merger would "substantially lessen competition", but this is grossly inadequate.

We should have a body of laws that require the Blues, and other insurance companies, to first demonstrate a substantial benefit to the public before any merger is approved—a standard that has been effectively used for utility company mergers.

Because the PA Insurance Department has always been a paper tiger or a captive of the insurance and Blues industry, consumers need much more in protections. Consumers need a right to have standing to intervene in insurance department

proceedings; have rights to discovery; and have their fees and costs paid by the insurance company if they make a "substantial contribution" to the result—as provided for in California law.

Consumers also need an Insurance Public Advocate, similar to the one that has existed in Pennsylvania for three decades for public utilities. The Insurance Department has always acted as a lapdog of the industry, and the public needs an Advocate with the resources and expertise to ensure a level playing field—one that has never existed in Pennsylvania.

The existing state Insurance Holding Company Act, even with Senator White's proposed amendments, do not mandate hearings (they are discretionary). They also do not require hearings with teeth: for example, having an Administrative Law Judge or independent fact finder; discovery rights; and ability to cross-examine witnesses.

Today, we don't have a transparent process in place to scrutinize this merger and get at the truth behind the Blue Cross press releases. There is no process for determining whether there is any public benefit or savings that will come from a merger, and where these savings will be going.

As for the serious anti-trust concerns that are present here, we simply do not trust the PA Insurance Department to address these complex matters. And although this merger has been reported for some time, we have not heard a single word from the Pennsylvania Attorney General nor the United Sates Department of Justice about any plans to seriously investigate the merger and invest sufficient resources in the process. We have not seen vigorous anti-trust enforcement from either agency to give consumers confidence.

Members of the Committee, it pains me to say that at times, Pennsylvania is unable to do the right thing by its people and safeguard its interests even if policy makers want to do so. There seems to be a political paralysis that prevents well-intentioned people from standing up to ask questions and probe. As an example, a recent series in the *Philadelphia Inquirer* exposed the state's failure to properly exercise regulatory oversight over our assisted living and personal care home industry, resulting in failures of care that have led to the death of seniors and people with disabilities. And just as when the Commonwealth of Pennsylvania had to intervene because the City of Philadelphia was unable to properly manage its public school system, we need the federal government to step in and fill the vacuum here by protecting the interests of Blues members and other health insurance consumers.

Pennsylvania has 2.8 million people without health insurance. That is a whopping 27 percent of the non-elderly population. The proposed merger does not promise to solve this crisis. We appeal to Washington to lend the consumers of Pennsylvania a hand, and to come and ask the tough questions about this proposed merger.

Testimony: IBC / Highmark Merger

Presented to
U.S. Senate
Committee on the Judiciary

On
April 9, 2007

By
C. Richard Schott, MD
Vice Chair

Pennsylvania
MEDICAL SOCIETY®
Doctors and Patients. Preserve the Relationship.®

Good morning. I'm C. Richard Schott, MD, vice chair of the Pennsylvania Medical Society's Board of Trustees.

Let me begin by thanking Senator Specter and this committee for inviting the Pennsylvania Medical Society to speak today on the proposed merger of Independence Blue Cross and Highmark Blue Cross and Blue Shield. It is truly an honor.

As you already now, according to news reports, the proposed IBC-Highmark merger is a mega-merger. It would form the third largest health insurance company in the country. By far, it would be the largest in Pennsylvania. And, the new company would control 53 percent of the Pennsylvania health delivery market. Based upon the enrollee figures from both companies that were mentioned in the merger news release, the new IBC-Highmark company is estimated to have 8 million enrollees. Some of these would be out-of-state residents, but the majority would be Pennsylvanians. Census numbers suggest that there are roughly 12 million Pennsylvanians; so needless to say, this new company would insure the majority of our state's residents.

Rumors of this merger have been floating around for quite some time. So, in all reality, it didn't surprise the Pennsylvania Medical Society when it was officially announced. And, prior to IBC and Highmark formally announcing their intentions, the Pennsylvania Medical Society was able to meet with the chief executive officers of both companies at which time we began a dialogue as part of our investigation to determine if this merger will be a good one for patient care. We are continuing our dialogue with the two companies as we further our review.

Even though historically the Pennsylvania Medical Society has expressed concerns when mergers are announced, we are not rushing to judgment until we have all of our questions answered. Similarly, we hope that regulators and others will not rush this merger marriage down the aisle until we can ensure it will do no harm to the public.

The Pennsylvania Medical Society believes that no merger should move forward until the benefits to patients and health care professionals are well defined. Until that is determined, the Pennsylvania Medical Society will closely monitor the proposed merger and articulate our concerns. Some believe the growing trend of consolidation within the health insurance market has the potential to imperil competition and threatens health care quality and patient access to care.

Highmark and IBC currently do not compete in the same areas of the state. But that doesn't mean it couldn't do harm. It's possible that a merger of this size could deter new competition in those markets, causing insurance premiums to increase at a more rapid rate than we are already experiencing. So, our first question is "will the size of this merger stop other health insurers from entering the Pennsylvania market?"

In theory, the new IBC-Highmark company should gain economies of scale that very favorably could impact the cost of health insurance. And, that leads us to our second and

third questions. How long will those economies of scale benefit the public? And, when those economies of scale end, what happens?

The joint news release from Highmark and IBC on March 28, 2007, stated that "the new, combined company will have the resources to hold administrative fees flat for two years."

Published studies show that health insurers exhaust their economies of scale at 100,000 to 150,000 enrollees. Our own work confirms this conclusion, albeit at a slightly higher number. Insurers with one million, two million, four million, or five million enrollees are not any more efficient and may, in fact, be more inefficient than smaller ones. As stated earlier, based upon adding enrollee figures from both companies that were mentioned in the merger news release, the new IBC-Highmark company is estimated to have 8 million enrollees.

But, based upon the IBC-Highmark promise to hold administrative fees flat for two years, does that mean that after two years, we can expect a big jump in the merged companies operating costs? And, during those two years, will competition in Pennsylvania be stifled? When the IBC-Highmark promise to hold fees flat for two years ends will competition exist to keep their costs in check? Competition generally improves price, service quality, consumer choice, and clinical quality. Will the reduction in competition negatively impact those considerations?

If so, this could negatively impact everyone from patients to hospitals to health care professionals to government. With an insurance monopoly, the new company could exclusively control the insurance market that allows for premium competition. That could negatively impact employers, patients, and government. Similarly, could this create a monopsony in which there is only one buyer in the market? If so, this would negatively impact health care professionals and hospitals, giving them little opportunity to play on a balanced field.

A balanced playing field. Let me say that again. A balanced playing field. Ultimately, that leads us to our most important question.

If this merger goes through, will there ever be a balanced playing field between health insurers and health care professionals? Will those who contract to do work for health insurers be able to select which insurance products they accept, or will the single mega-company dictate providers accept all of their products or none. Will there be fair contracts? Or will the standard "take it or leave it" approach and insurer imposed cost-cutting mechanisms be used?

The lack of competition among health insurers in health delivery markets throughout the country and in Pennsylvania, as well as the consolidation of health insurers across the nation, raises serious concerns for the provision of quality patient care. As patient advocates, physicians are often undermined by market dominant insurers and prevented from providing necessary care. As a result, dysfunctional markets have produced:

- annual double-digit health insurance premium increases going back to the early 1990s
- unilateral decisions about hospital payment
- physician fee schedules that are unilaterally imposed and have provided stagnant or declining compensation
- substantial profit levels for health insurers

Insurer market consolidation alone can be detrimental to consumers from a financial perspective. While many large Pennsylvania insurers are posting huge profits and surplus reserves, premiums continue to skyrocket (Pennsylvania has some of the highest premiums in the nation), and patient cost sharing continues to increase without any increased benefit.

Furthermore, based on a 2005 update by the American Medical Association, the Pennsylvania statewide Herfindahl-Hirschman Index (HHI) for all HMO and PPO products is 1513. This would make the Pennsylvania market "concentrated" based on the 1997 Federal Trade Commission / Department of Justice Horizontal Merger Guidelines (FTC/DOJ guidelines). This number is probably low since it is very difficult to obtain accurate PPO numbers. Under the guidelines, a merger in these markets that raises the HHI by more than 100 points may raise significant competitive concerns. If the market has an HHI above 1800, which the Pennsylvania statewide market probably is if accurate PPO numbers were known, the market is considered "highly concentrated" under the guidelines. A merger in these markets that raises the HHI more than 50 points may raise significant competitive concerns and mergers that raise the HHI more than 100 points are presumed to be anti-competitive. It is therefore imperative that the FTC / Justice Department collects accurate HMO / PPO numbers to determine the correct HHI for the Pennsylvania market. If the HHI were found to be above 1900, a combination of Highmark and IBC would not be permitted under existing FTC/DOJ merger guidelines.

In conclusion, I ask, "Will the proposed IBC-Highmark merger be good for Pennsylvania?" At first glance, maybe. But below the surface … well, there are questions that need to be investigated.

And that's why something this big needs the attention of the federal government, either through the Department of Justice or the Federal Trade Commission.

Thank you.

Testimony of
Senator Don White
Before the US Senate Judiciary Committee
April 9, 2007

Good Morning Senator Specter and members of the Senate Judiciary Committee, I am Pennsylvania State Senator Don White and I serve as Chairman of the Senate Committee on Banking and Insurance.

It is an honor to be invited by Senator Specter to testify at this important public hearing and I would like to applaud him for scheduling this event. I appreciate the opportunity to provide the Judiciary Committee with a perspective of the Highmark/ Independence Blue Cross (IBC) merger from the state government level and to discuss the concerns that I, and others, have regarding this proposal. The potential affect on the availability and quality of health care coverage in Pennsylvania could be profound.

You have already heard from the principal players in the merger, as well as from officials from the health care industry and are fully aware of the magnitude of this proposal. The questions Senator Specter posed to Highmark and IBC prior to this hearing are most appropriate and accurately summarize the concerns we all should have.

The state legislature is moving rapidly to ensure maximum review and oversight over this proposed merger occurs. Currently, under the Commonwealth's GAA Amendments Act and the Insurance Holding Companies Act, the Pennsylvania Department of Insurance is empowered to review proposed mergers of for-profit health insurance providers. Such review is intended to protect the interests of both policyholders and the marketplace by directing the Department of Insurance to protect the integrity of the insurance market through review of corporate transactions for anti-competitive effect.

Unfortunately, under current law, the Highmark-IBC deal, because it involves two 'Blues' organizations, is not subject to the same scrutiny.

In response, I introduced Senate Bill 550 which would provide the Pennsylvania Department of Insurance oversight power over mergers involving non-profit health care insurers such as Blue Cross/Blue Shield. SB 550 will ensure this proposal comes under the same scrutiny as if they were for-profit corporate transactions.

If the existing gap in the Department's regulatory authority is allowed to persist, the Department will remain unable to protect the interests of the Blue plans' policyholders in ruling on corporate transactions, or review any pending transaction involving the parent Blue plans for anti-competitive effect. However, I am confident we will correct this gap in a very timely manner. The state Attorney General must also have the authority necessary to review this proposed merger and I am working with his office to ensure that is the case.

I am encouraged by this committee's concern about the quality and availability of health care coverage in Pennsylvania. From what I understand there is potential for review of this merger at the Federal level under the Hart-Scott-Rodino Antitrust Improvements Act. I would assume Highmark and IBC will file an advance notice of this merger with both the Federal Trade Commission and the Department of Justice, since its value greatly exceeds the thresholds that trigger this federal requirement. I strongly urge this committee to recommend to those federal agencies that they scrutinize this merger for its impact on competition in the health insurance market and share their work with the state legislature, the Insurance Department and our Attorney General. While Pennsylvania does not have a state antitrust law, our Attorney General can take action under the federal law. Therefore coordination between the state and federal review is essential.

While economies of scale and efficiencies may be achieved by this merger and result in positive short-term benefits, there must be concern over its long-term affects. Creating the third largest insurer in the nation with a specifically defined geographic territory is not, I believe, in the best interests of competition and the reality is competition is in the best interests of the consumer. There is no better regulator than a competitive marketplace – in terms of bringing better service, better products and better prices to consumers, and in terms of giving consumers and providers real and fair choices. In my own district, I've seen the problems providers and consumers face from a lack of competition in health insurance – it can lead to some real predatory practices. We need to make sure such practices are not spread across the Commonwealth through this merger.

Highmark and IBC contend the merger should be approved based on the premise that it will result in savings. If so, then there needs to be iron clad assurances that those savings will occur not only in the short term but also the long term. Further, any savings should not be used

to support growing operations in other states or in lines of business outside of insurance. Moreover, we need to make sure those savings do not come at the cost of consumers' accessibility to needed health care – and to the doctors, hospitals, pharmacists and other who provide that care. Finally this merger must not undercut the social mission obligation that Highmark and IBC have – an obligation that is part of their being excused from premium taxes and affords them other statutory advantages under Pennsylvania law.

Again, thank you Senator Specter and members of the Judiciary Committee for your interest in this critical issue and I look forward to working with you on this matter in the months ahead.

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