BlueCross BlueShield of Delaware

BCBSD 2008 Capabilities Assessment

Final Deliverable

June 6, 2008

EXHIBIT
JOINT-4.1

Deloitte.

Contents

Executive Summary

This section summarizes Deloitte's overall findings and conclusions.

Background and Objectives

- As part of the strategic planning process, Blue Cross Blue Shield of Delaware (BCBSD) asked Deloitte to assist with refreshing a 2004 assessment of operational capabilities.

- The objectives of this assessment are to:
  - Understand how BCBSD compares against future market requirements
  - Analyze how BCBSD compares against local and national competitors
  - Determine future capital requirements, priorities and high-level investment costs

- These objectives were achieved through a series of analyses, including an operational and technology capabilities assessment and a review of local and national best practices.

- The BCBSD team played an integral part in the assessment providing primary and secondary data for the capabilities assessment. Interviews and working sessions with the BCBSD executive team and department level managers were critical in understanding the current state baseline for BCBSD.

- What follows is a review of the changes since 2004, an executive summary outlining key strengths, areas of opportunity, high-level recommendations, and a summary of gaps and cost estimates.

Summary of Findings: Key Strengths

Since 2004, BCBSD continues to be the dominant player with strong brand recognition in the Delaware market. Key accomplishments over the past four years include:

- Established the company as an independent Blues plan from CareFirst
- Increased market share 11%*
- Grew total membership 19%*
- Increased revenues 57%*
- Contributed a total of $5.5 M in corporate charitable giving and community investments between 2005-2007
- Developed a consumer-driven health (CDH) product and experienced membership growth in the individual, large group, and CDH product segments
- Implemented several new technologies including:
  - An imaging / optical character recognition (OCR) solution
  - BenefitFocus for the employer and broker portal
  - An integrated care management application (MEDecision's CarePlanner)

Source: BCBSD 2004 and 2007 Financial Statements; Market Segments 2003 and 2007; Membership - Data Collection Tab; 2003-2007 Administrative Expense Analysis; Deloitte analysis
Note: * Data is for 2003-2007 unless otherwise stated

Summary of Findings: Areas of Opportunity

As part of the assessment, we identified several high priority areas of opportunity for BCBSD.

- The following topical areas were identified as critical to address so that BCBSD begins to lay the groundwork for the future:
  - Enterprise executive management dashboard and management reporting strategy
  - Financial systems upgrade
  - Product development process and benefit plan designs
  - Rating technology
  - Marketing resource management, campaign management and lead/opportunity management
  - Commission tracking and payment system
  - Online billing and payment capabilities
  - Core administration system
  - BlueCard process and BCBSA move to common ITS platform
  - Associate tenure and organization succession planning
  - Web capabilities development/enhancement for all stakeholders
  - Data management and reporting
- Address administrative cost structure
- Information technology has the potential to play a significant role in increasing the efficiency of operations.
- Alignment of the leadership team around the organization's strategic goals and objectives will be important. Decision-making processes and consensus-building will require the appropriate level of balance to avoid missed opportunities to innovate in the marketplace.

Summary of Findings: Recommendations

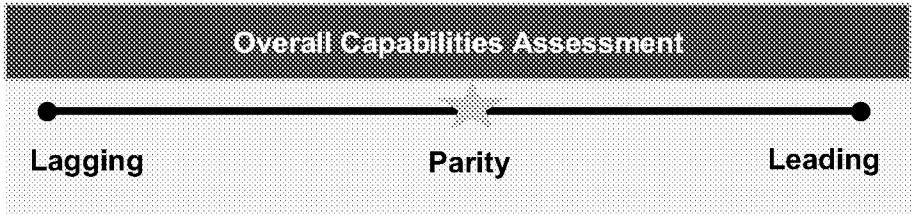
BCBSD should assess all the current gaps estimated at an investment of $100M to $129M. Our recommendations to address those gaps are below.

- Implement an **enterprise executive management dashboard and management reporting strategy** to provide leadership with a dashboard view of profitability, membership, growth trends and operational performance and help to manage and plan towards strategic goals and objectives.
- Formalize a **product development process** to incorporate the consumer 'voice' into product offerings and balance flexibility and customization with ease of administration.
- Implement a **rating technology** to automate pricing and underwriting processes that could be used with existing systems.
- Establish more sophisticated **Marketing and Sales capabilities** such as Marketing Resource Management, Campaign Management and Lead/Opportunity Management.
- Implement a **commission tracking and payment system** and re-evaluate the **broker commission structure**.
- Prepare for growth of CDH and **improve CDH administration** by offering improved member tools and better integration with other claims and customer service system and operations.
- Establish **online billing and payment capabilities**, specifically reconciliation and payment, to decrease administrative costs.
- Modernize/replace the **core administration system** because the current system is antiquated and cumbersome to code.
- Streamline or outsource the **BlueCard process** in order to meet BCBSA mandates.
- Focus on **succession planning** to address retirement eligible employees and establish the appropriate level of cross-training and knowledge transfer.
- Enhance **web portal capabilities** for members, accounts, providers and brokers.
- Establish an **enterprise data warehouse** to increase the rigor of data management, reporting, and profitability and trend analyses.

2008 Capabilities Assessment Approach

- Company performance was evaluated across two external and seven internal dimensions.
- External dimensions were assessed on favorability relative to current position and future outlook.

  Unfavorable Neutral Favorable
- Internal dimension evaluations included two components:
  - BCBSD performance relative to current industry standard capabilities
  - BCBSD strategy and planned investments/initiatives relative to future market requirements
- Each internal dimension was provided an overall rating:



- Within each internal dimension, individual capabilities were given a rating based on the market.

Key Evaluation Factors

External Dimensions		
Marketplace		▪ Competitive, employer, demographic, legislative and regulatory dynamics
Public/Community Relations		▪ Degree of emphasis on and commitment to community mission and investments ▪ Brand awareness and strength/value in the local marketplace ▪ Public image and relations
Internal Dimensions		
Financial	**Performance**	▪ Ability to make future investments ▪ Performance relative to strategic corporate targets as well as competitor/industry performance
	Processes	▪ Assessment of growth and profitability over time ▪ Ability to plan, forecast and conduct profitability analyses
Product, Pricing and Distribution		▪ Content and structure of product offerings within core business relative to market/competitors ▪ Distribution strategy and performance across products/market segments ▪ Member account satisfaction with product portfolio and product development process
Network Management and Medical Management		▪ Size and composition of facility, physician and pharmacy networks ▪ Competitiveness of reimbursement for facility, physician and pharmacy networks ▪ Breadth/depth of medical management programs
Operational Performance		▪ Performance and capability levels of core plan operations including claims, customer service, enrollment and billing relative to market requirements and industry standards
Human Resources		▪ Overall headcount, tenure, turnover, leverage ratio, employee satisfaction results ▪ Quality and magnitude of learning and development process
Information Technology		▪ Level of functional and technical adequacy of the existing platforms ▪ Strategic alignment of major IT initiatives and investments
Informatics: Data Management and Reporting		▪ Data warehouse, data analysis and internal and external reporting capabilities

2008 Strategic Assessment: External Dimensions

External Dimensions	Overall Favorability Rating	Rationale
Marketplace		
Public/Community Relations		

2008 Strategic Assessment: Internal Dimensions

Internal Dimensions		Overall Capability Rating	Rationale
Financial	Performance	[redacted]	[redacted]
	Processes		
Product, Pricing and Distribution	Product		
	Pricing/ Underwriting		
	Sales and Marketing		
Network Management and Medical Management			

2008 Strategic Assessment: Internal Dimensions

Internal Dimensions		Overall Capability Rating	Rationale
Operational Performance	Membership and Billing	[redacted]	[redacted]
	Claims		
	Customer and Provider Service		
	BlueCard		
Human Resources			
Information Technology			
Informatics: Data Management and Reporting			

Gaps and High-Level Cost Estimates

BCBSD has a number of capability needs that will require significant investment over the next several years.

Internal Dimension	Area	Recommended Action	Cost Range	Duration
Financial	**Financial Processes**	Implement an executive management information system (Dashboard)	$3M - $5M	12 months
Product, Pricing and Distribution	**Product**	Formalize a product development process	~$250K	3 months
	Pricing/Underwriting	Implement rating technology to automate pricing and underwriting processes	$2M - $5M	9-15 months
	Sales and Marketing	Establish more sophisticated Marketing (Marketing Resource Management, Campaign Management) and Sales (Lead / Opportunity Management) capabilities	$4M - $8M	12-30 months
	Commissions	Implement a commission tracking and payment system	$300K - $500K	6 months
Network and Medical Management	**Network and Medical Management**	• Fully integrate iExchange with a new core admin system to more fully automate pre-authorizations • Implement a provider profiling system and pay-for-performance	$5M - $10M	18-24 months
Operational Performance	**Membership and Billing**	Establish an online bill presentment and payment capability (group and individual)	$1.5M - $3M	12-18 months
	BlueCard	Outsource BlueCard Host claims	$3M - $5M*	12-14 months
Human Resources	**Human Resources**	Build and execute succession plan	$2M - $3M	6 months

Note: * Based off of benchmarks from other plans; would require negotiation with NASCO

Gaps and High-Level Cost Estimates (cont'd)

Internal Dimension	Area	Recommended Action	Cost Range	Duration
Information Technology	**Core Administration – TBS (Claims, Enrollment, Billing, Provider)**	Perform assessment of core administration landscape to begin to formulate short list of possible vendor (assessment cost would be $250K-750K) This exercise will help in documenting specific capabilities that BCBSD should prioritize in any affiliation arrangement	$35M - $50M (for full replacement)	24-48 months
	CDH	Migrate CDH products to the future core administration system and build more advanced CDH tools.	$3M - $5M	12 months
	Web Portals	Once BCBSD has established a formal IT Strategy including portal rationalization, enhance online capabilities (e.g., CDH member tools, transactional capabilities)	$8M - $10M	18-24 months
	Service Oriented Architecture (SOA) / Enterprise Service Bus (ESB)	Select vendor and establish architecture for integration	$3M - $5M	12-24 months
	Electronic Data Interchange (EDI) / Business to Business (B2B) Services	Determine longer term business requirements for functions such as Claims Pre-adjudication, in order to incorporate into SOA/ESB vendor selection	N/A	N/A
Informatics: Data Management and Reporting	**Document Management**	Enhance workflow and OCR capabilities	$500K - $2M	12-18 months
	Informatics	Establish an enterprise data warehouse (EDW) and enhance data management and security	$9M - $15M	24-36 months
	External Client Reporting	Implement interactive account reporting capabilities	$3-5M	6-12 months

IT Gaps and High-Level Cost Estimates

There are a mix of "quick-hit" and longer term initiatives BCBSD can undertake to improve IT operations and delivery.

Capability	Recommended Action	Cost Range	Duration	Comments
IT Strategy and Planning	Develop IT Strategy	$500-$750K	3 Months	
Program and Delivery Management	Perform Capability Maturity Model Integration (CMMI)-like maturity assessment and develop maturity roadmap	$250-$500K	3 months	
Resource Management	Formalize skill set cross-training / SME development program	$250-$500K	4-6 months	• As a pre-requisite to the SME program, performing a review of internal/external staffing mix and targets would be advisable
Vendor and Alliance Management	Formalize and centralize the vendor management function	~$250K	3 months	• In progress; cost may be minimal
Value Management	Introduce more formal ROI / business case model to major corporate initiatives	~$100K	6-12 months	

Next Steps

- Develop an overall information technology strategy
- Develop a strategic plan to determine priorities given the recommendations from the capabilities assessment
- Determine whether BCBSD will make investments to meet the market requirements or affiliate with another health plan to meet the needs

Overview of Deloitte Engagement

This section provides the background and objectives, scope and approach, and methodology for the Deloitte engagement.

Background and Objectives

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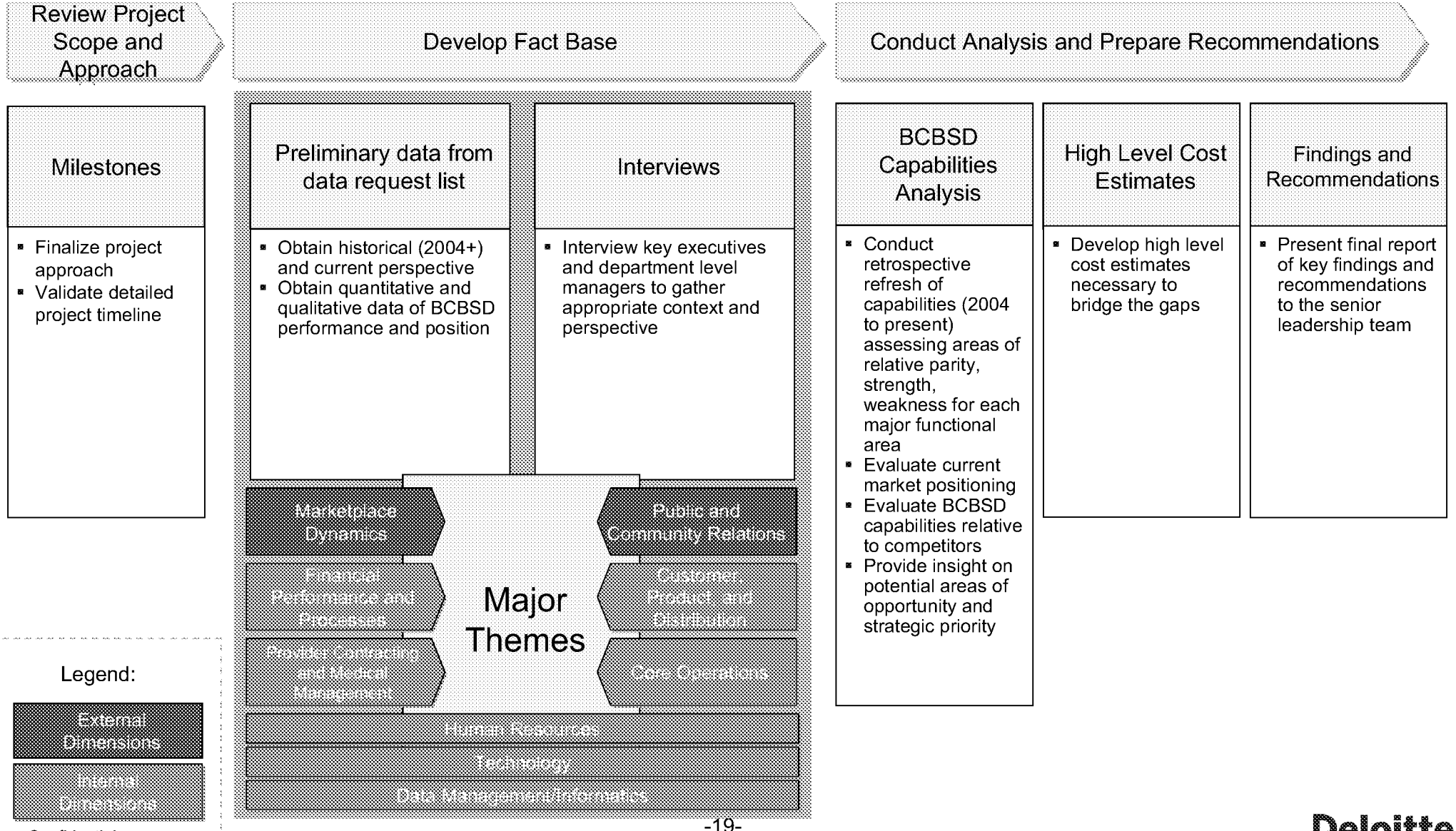
- The objectives of this are assessment are to:
  - Understand how BCBSD compares against future market requirements
  - Analyze how BCBSD compares against local and national competitors
  - Determine future capital requirements, priorities and high-level investment costs
- These objectives were achieved through a series of analyses, including an operational and technology capabilities assessment and a review of local and national best practices.
- The BCBSD team played an integral part in the assessment providing primary and secondary data for the capabilities assessment. Interviews and working sessions with the BCBSD executive team and department level managers were critical in understanding the current state baseline for BCBSD.

Project Scope and Approach

Our project approach focused on developing a fact base, conducting strategic analyses and identifying potential areas of opportunity and strategic priority.



Key Evaluation Factors

External Dimensions		
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Internal Dimensions		
Financial	**Performance**	▪ Ability to make future investments ▪ Performance relative to strategic corporate targets as well as competitor/industry performance
	Processes	▪ Assessment of growth and profitability over time ▪ Ability to plan, forecast and conduct profitability analyses
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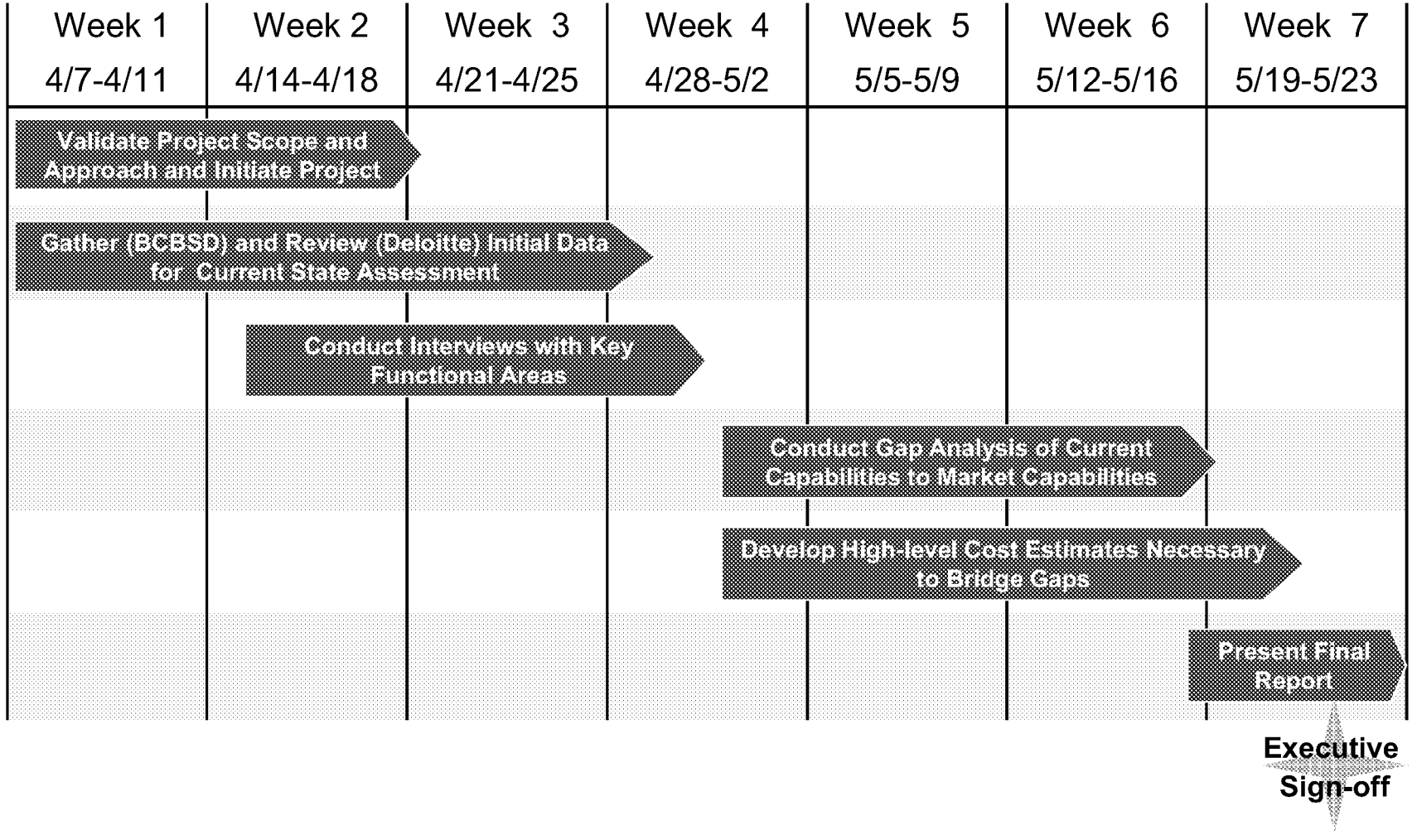
Operational Performance		▪ Performance and capability levels of core plan operations including claims, customer service, enrollment and billing relative to market requirements and industry standards
Human Resources		▪ Overall headcount, tenure, turnover, leverage ratio, employee satisfaction results ▪ Quality and magnitude of learning and development process
Information Technology		▪ Level of functional and technical adequacy of the existing platforms ▪ Strategic alignment of major IT initiatives and investments
Informatics: Data Management and Reporting		▪ Data warehouse, data analysis and internal and external reporting capabilities

Timeline

Below is an overview of the high-level steps that were followed to complete the project.



Data Collection: Interview List

Interviews were conducted with over 40 participants across every major functional area within the company.

Account Retention
- Jay Reed
- John Savage

Actuarial Services
- Joe Klimchak

Agency
- Sue Dahms

Audit and Assurance Services
- John Ross

Behavioral Health
- Tim Toole

Claims*
- Esther Dill
- Jenifer Fioravanti
- Mickey Matthews
- Keith Richard
- Roy Underwood

Corporate Communications
- Darelle Riabov

Corporate Compliance / HIPAA
- George English
- Karen Kane
- Maureen Marshall

Corporate Controller and Treasurer
- Phillip Carter
- David Goins
- Gwen Olmstead
- Stuart Oser
- John Van Nostran

Corporate Marketing
- Chris Alrich

Corporate Planning
- Scott Fad
- Donna Gunkel

Customer Service
- Frank Savage
- Paula Simpson

Enrollment and Billing
- Frank Savage
- Tony Zambino

Finance
- Lauren O'Brien

General Counsel
- Bill Kirk

HSA / Flex
- Scott Fad
- Jeff Kitchen

Human Resources
- Susan Slaysman

Information Technology
- Richard Foley
- Bill Jones
- Sally Retzko

Network and Medical Management
- Dr. Paul Kaplan
- Mark Meddings

Operations
- George English

Provider Relations and Contracting
- Judy Charles
- Eileen Masterson-Carr

Provider Service
- Wendy Norman
- Diana Ortiz

Quality Improvement
- Debbie Sweeney

Sales / Product Development`
- Carl Fink

Statistical Services
- Jill Macconi

Underwriting
- Iris Carr
- Melisse Tonge

Note: * Claims include individuals from BlueCard

Data Collection: Other Sources

Key data elements and deliverables* were reviewed to conduct a preliminary assessment of BCBSD's past, present and future position.

Mission and Corporate Strategy	Financial	Operations
▪ Mission and vision statements ▪ Annual reports ▪ Relevant marketing collateral ▪ Business, financial and incentive plan	▪ Financial statements ▪ Operating/Administrative expense ▪ Loss ratio, expense ratio ▪ Top accounts ▪ Operating results by product line	▪ MTM, FEP and BlueCard scores ▪ Electronic claims % ▪ BlueCard claims % ▪ First call resolution ▪ ID card production volume ▪ Claims first pass rate, financial and processing accuracy
Market	**Sales, Product and Distribution**	**Network and Medical Management**
▪ Market share ▪ Membership ▪ Key account wins/losses ▪ Retention rates ▪ Competitor profiles ▪ Average price changes ▪ Market environment	▪ Sales target and performance ▪ Incentive plans ▪ Broker, member, provider and employer survey results ▪ Brand performance survey results ▪ Current product listing	▪ Number of providers/hospitals contracted and coverage ▪ Pharmacy utilization and trend ▪ Inpatient utilization trends ▪ Average reimbursement increases
Employees	**Technology**	**Public Image**
▪ Organizational structure ▪ Employee survey results ▪ Employee demographics ▪ Employee turnover rate ▪ Employee to member ratio	▪ IT investment budget / capital investments ▪ Corporate initiatives ▪ Technological improvements ▪ Web strategy ▪ Application listing	▪ Newspaper headlines and articles ▪ National accreditation ▪ Community initiatives ▪ Budget for corporate donations ▪ Working Well Report

Note: *The list provided is not exhaustive but is intended to provide an overview of key data elements

2008 Capabilities Assessment

This section explores BCBSD's competitive strengths and gaps today relative to current market demands and competitor offerings. In addition, this section provides Deloitte's perspective on BCBSD's positioning and plans relative to emerging future requirements and industry trends.

BCBSD Fast Facts

Since 2004, major investments (e.g. a new building) and the disaffiliation from CareFirst created increased expenses resulting in declining operating income. At the same time, both membership and revenue increased.

		2003	2007	% Change	Compound Annual Growth Rate (CAGR) 2003 – 2007
Total Contracts [1]		[redacted]			
Total Membership [2]					
Market Share					
Revenue					
Operating Income					
Operating Margin					
Net Income					
Profit Margin					
Reserves					
Risk-Based Capital (RBC) Level					
Admin. Expense	General and Admin.				
	Broker Commission				
	Community Related				
Administrative Expense Ratio[3]					
General and Admin. Expense Ratio[4]					
Medical Loss Ratio (MLR)					
Employees					
Management					
Non-Management					

[redacted]

[redacted]

Marketplace

Marketplace Perspectives

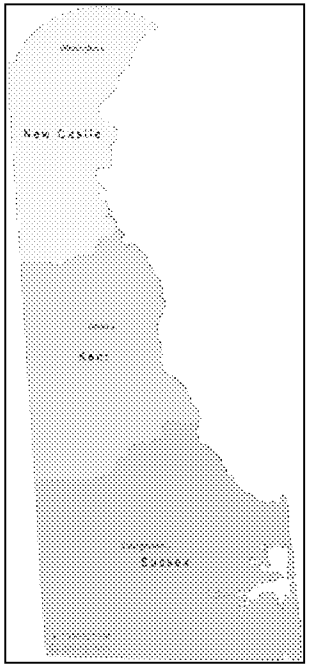
BCBSD continues to be the dominant player in the Delaware market even when national competitors have increased focus on the local marketplace.

- From a demographic perspective, the Delaware population grew 8.9% from 2000 to 2006 and is expected to continue to grow, particularly the senior population (age 65+).
  - The senior population is expected to grow 36% nationally between 2010-2020. Within Delaware, the senior population is projected to grow 37% within the same time frame compared to an overall 9% state population growth.
- BCBSD maintains the position of market leader even though competitors are making a play for market share.
  - Over the past 4 years, Aetna and United have increased market share through acquisitions.
  - Coventry decreased market share with the loss of the State of Delaware account but has a renewed focus and success in the small group market.
- The top two employers in the state of Delaware are customers of BCBSD.
- The regulatory environment within the state has become more challenging since 2003.

Source: U.S. Census Bureau; Delaware Population Consortium; BCBSD Interviews

Service Area Demographics and Population Growth

The population of the counties which comprise BCBSD's service area is expected to surpass 1 million by 2025, which is a 17% growth.



Population Growth

- BCBSD services 3 counties: New Castle, Kent and Sussex. Sussex County is projected to have the largest population growth by 2025 at 31%, compared to Delaware state's 17% growth.
- Delaware's population is expected to grow 9.8% over the next 10 years and 22% by 2030.
- Delaware's senior population, age 65 and older, is expected to increase by 22% by 2015 and by 61% by 2025.
- More Delaware residents commute to another state for work than those residents who commute within the state of Delaware. Individuals who commute out of state are not part of BCBSD's potential market which is confined to the three counties in Delaware.
  - In 2006, 87% of the Delaware labor force worked within the state and 13% (approximately 56,000) worked outside of their state of residency.
  - Today, an estimated 31,000 people commute into Delaware from other states. It is expected that 51,000 will commute outside of Delaware for work in 2020.
- The uninsured population comprises 12% of the state population, which is below the national average of 15.8% in 2006.

	2000	2006	% Change[1]	Comments
Population	**783,600**	**853,476**	**8.9%**	▪ **The U.S. population grew at 6.2% between 2000-2006.** ▪ **The insurable population (age 18-64) in Delaware has experienced a 9.8% growth between 2000-2006 with a significant increase in the senior population ages 60-64.**
# of Firms	**20,167**	**21,069 [2]**	**4.5%**	▪ **Approximately 45% of Delaware companies have 1-4 employees, which is very close to the U.S. statistic of 47% of companies.**
# of Delaware Residents in the Labor Force	**401,152**	**434,952**	**8.4%**	▪ **This includes individuals ages 16 and over who are in the labor force.** ▪ **The U.S. labor force has increased 4.7% between 2000-2006.**

Source: U.S. Census Bureau; State of Delaware website; BCBSD 2007 Environmental Assessment with Implications for 2008; University of Delaware Population Study; Deloitte Analysis
Note: [1] Data only available for years 2000 and 2006 for Delaware; [2] Number of firms is from 2005 data

BCBSD Competitors and Market Share

BCBSD has increased market share despite the emergence of several national competitors attempting to gain market share through acquisitions. Most of BCBSD's membership growth has been through existing groups rather than acquisition of new groups.

	Market Share (2003)	Market Share (2007)	Comments
BCBSD	[redacted]		
Aetna			
Coventry			
United			
Other			

[redacted]

Top 10 Accounts[1]

Top 20 Accounts vs. Top 20 Employers

BCBSD insures 8 of the top 20 employers in the state of Delaware. Of the top 20 employers not currently insured by BCBSD, only one has potential for becoming a new BCBSD account.

[redacted]

Top Employers in Delaware (No. 21-50)

Expanding the view to the top 50 employers in state reveals that only an additional 14 are headquartered in Delaware and of those, some are covered by the State of Delaware contract, leaving limited opportunity for growth in the largest of the large group segment.

Stakeholder Relationships

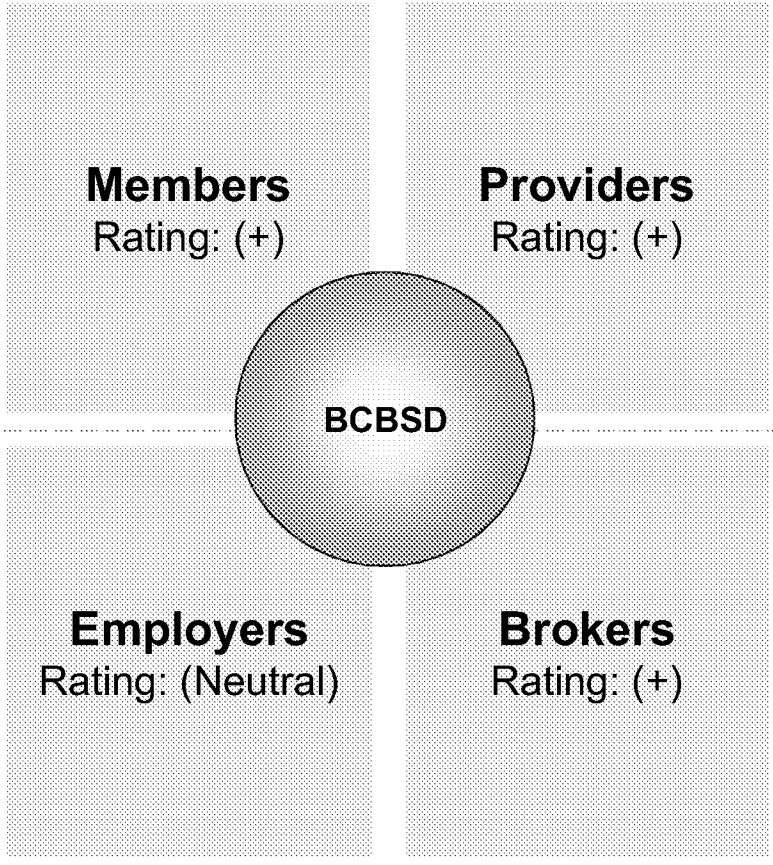
BCBSD has maintained strong stakeholder relationships by addressing the evolving needs of each constituent. Today strong stakeholder relationships appear to be an area of competitive advantage.

Overall member satisfaction has decreased since 2004 but competitors had the same experience:

- *Members are satisfied with the network and the ease with which they can obtain good care*
- *Accuracy of ID cards was rated highly*
- *Customer service representatives received high ratings but members would like problems to be resolved in a more timely manner*

Employer satisfaction has trended downward for both BCBSD and its competitors since 2004 but leveled off in 2007:

- *Employers would like increased web capabilities*
- *Overall enrollment process and timeliness of ID cards were not rated highly*
- *Employer groups with 51-199 employees would like additional options for controlling costs*



Provider relationships have been mostly positive since 2004:

- *Voice Response Unit (VRU) was not effective in getting issues resolved*
- *BCBSD has a competitive advantage in written materials and provider seminars*
- *Providers gave high ratings to timeliness in processing provider applications and ease of the referral process*

Broker relationships have remained consistently strong:

- *Brokers are more likely to recommend BCBSD than any other carrier*
- *BCBSD has a competitive advantage in commission rates/bonuses*
- *Support is provided to brokers in sales for Consumer Driven Health Products (CDH)*
- *Sales and Retention representatives have strong product knowledge*

Source: 2007 BCBSD Stakeholder Analysis; 2007 Broker Satisfaction survey; BCBSD Member Real Time Summary 2007; BCBSD New Member Enrollment Satisfaction 2007; BCBSD interviews

Regulatory Environment

BCBSD has experienced some changes in the regulatory environment and will be impacted by the 2008 elections, which include the election of a new insurance commissioner for the state of Delaware.

- There has been an increased focus on health plan regulations within the state of Delaware.
- The passage of Regulation 1310, *Prompt Pay*, has implemented more stringent claims payment timeliness standards.
  - This had an impact on operations and raised administrative costs.
- Changes to the regulatory environment will likely occur with the election of the new commissioner.
- In general, BCBSD does not see significant amount of litigation activity against the company.

Source: BCBSD Interviews

Public/Community Relations

Public/Community Relations Overview

BCBSD has been proactive in sustaining a favorable corporate public image in the community through community programs and charitable giving activities.

- Through the *Working Well Together* initiative, BCBSD:
  - Addresses the concerns of increasing healthcare costs in Delaware as an active participant in healthcare related forums.
  - Makes contributions to organizations that are focused on health-related issues, including increasing health awareness, improving quality and safety of patient care and meeting the healthcare needs of diverse membership.
- The budget for community donations in 2007 was $4 Million. In the same year, BCBSD contributed to 103 community events and programs, based on receiving and processing over 250 requests from local organizations.
  - Contributions to local organizations fall under the purview of Corporate Communications.
  - BCBSD has recently established a donor-advised fund with an advisory council who determines the recipients of donations.
  - In 2007, BCBSD donated $2 M to the donor-advised fund and a one time gift of $1.5 M to St. Francis Foundation.
- BCBSD maintains strong public awareness and is viewed favorably relative to its competitors per the *BCBSD Brand Perception Study* in 2007.

Source: 2006 and 2007 BCBSD Brand Perception Study; Working Well Together 2007 Report; Newspaper clippings; BCBSD interviews; Deloitte Analysis

Financial Performance

Competitor Snapshot

[redacted]

[redacted]

Revenue Growth and Membership

Over the past 5 years, revenue has been growing at a faster rate than membership.

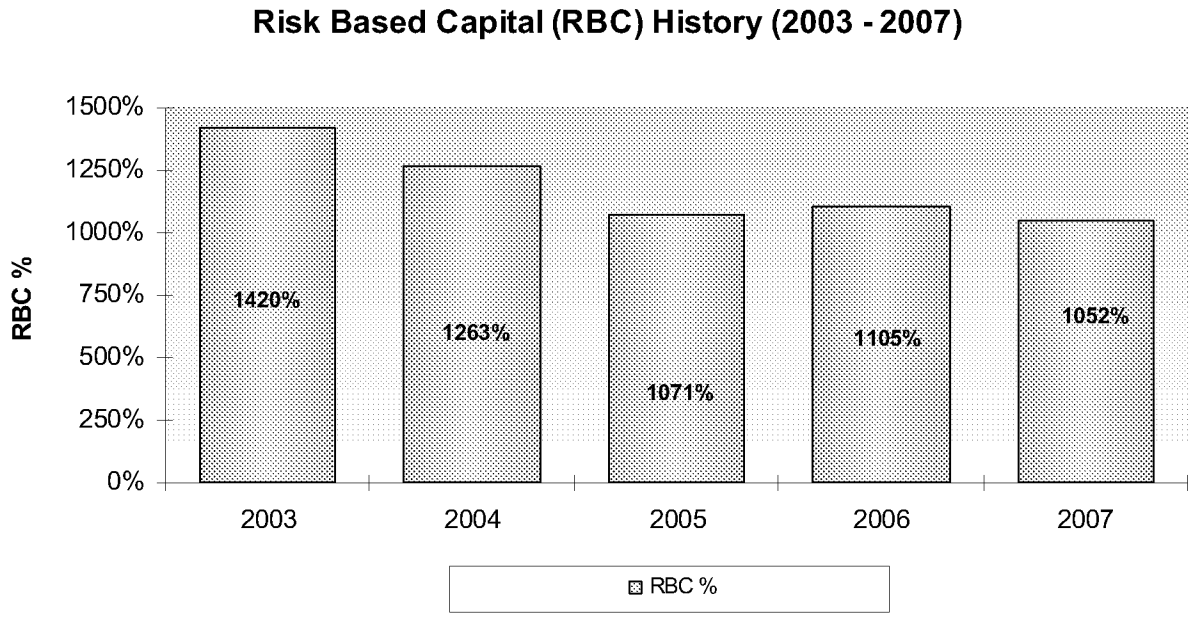
Operating Income and Reserves

Administrative Expense/Ratio

Medical Loss Ratio (MLR)

Risk Based Capital (RBC)

BCBSD's high level of risk based capital is a positive measure of the company's performance.



Key Findings

- BCBSD's RBC level is well above regulatory thresholds for the State of Delaware.
- RBC has decreased by 358 percentage points since 2003 but is still extremely favorable.

Source: HRBC 1999 thru 2007; Deloitte Analysis

Financial Processes

[redacted]

Financial Processes

Capability	BCBSD Capability Assessment	[redacted]
Use an executive management system to provide leadership with a dashboard view of profitability, membership and growth trends	○	
Report monthly comprehensive data by segment that enables executives to make detailed attestation to regulatory authorities	◐	
Provide detailed financial reports by segment, product and account	○	
Use systematic, cross-functional decision making for capital allocation decisions in order to manage return on equity	◐	
Coordinate with overall strategy and objectives	◐	
Use capital allocation methodology linked to corporate objectives for growth and profitability	◐	
Manage reinsurance with cross-functional team on design, strategies and approach, with accountability and decision making	N/A	

○ Market Lagging ◐ Market Parity ● Market Leading

Source: BCBSD interviews; BCBSD 2008 Annual Plan

Financial Processes

Since disaffiliating from CareFirst, BCBSD independently manages financial functions and processes.

Key Findings	Opportunities
▪ An executive dashboard is created but it is a manual process to consolidate information from all business areas. ▪ There is lack of key performance indicators (KPIs) that are consistent with the overall corporate strategy. ▪ Business owners feel that BCBSD lacks a data strategy and the skill sets required to conduct in-depth financial analyses. ▪ BCBSD creates an annual plan that has a business, financial and incentive component. ▪ BCBSD does not have dedicated skilled resources (i.e. medical economist) to analyze and predict medical costs. ▪ BCBSD does not have standard reports that provide actionable medical cost data to management.	▪ Dedicate more time to forecasting administrative and medical costs to improve accuracy in forecasting and budgeting activities. ▪ Consider opportunities to collaborate budgeting and strategic planning activities with financial monitoring activities. ▪ Create a centralized data repository. Multiple sources of data and manual processes involved in preparing reports create opportunities for error and require a significant amount of time for creating the reports. ▪ Increase rigor of profitability analysis. Track profitability by segment, product and account. ▪ Develop an overall strategy for the organization by determining whether the goal is to increase profitable growth or increase membership count.

Product, Pricing and Distribution

BCBSD Customer and Products

[redacted]

Product, Pricing and Distribution: Product

Capability	BCBSD Capability Assessment	[redacted]
Offer multiple types of healthcare products, including:	◐	
• HMO / POS	◐	
• PPO	◐	
• EPO	◐	
• Indemnity	◐	
• Medicare/Medicaid	○	
• Consumer directed	◐	
Get new products to market (new product launch cycle time from concept to launch) within competitive timeframe for new product development /product enhancements and for responding to marketplace changes	●	
Support modular/componentized product set-up/configuration process for benefit coding	○	

○ Market Lagging ◐ Market Parity ● Market Leading

Source: BCBSD interviews

[redacted]

Product, Pricing and Distribution: Product (cont'd)

Capability	BCBSD Capability Assessment	Rationale
Offer modular product portfolio where employers can pick and choose benefit plan components	◐	[redacted]
Provide members with online access to decision support tools for plan selection, utilization and cost estimates	○	
Have a well defined product development process, including governance	○	
Have comprehensive understanding of the customer and integrate the customer voice into products and services	○	
Manage operational complexity well (e.g. sales force works with operations to manage the level of complexity/custom features in a product sold)	○	
Administer products with defined product managers to easily load products into the system	○	

○ Market Lagging ◐ Market Parity ● Market Leading

Source: BCBSD interviews

Product, Pricing and Distribution: Product

BCBSD is able to offer highly customized products which must be balanced with managing administrative complexity and product profitability.

Key Findings	Opportunities
▪ Speed to market in new product roll out is 2-9 months. ▪ There is a demand in the marketplace for senior products. Currently Medicare supplement is the only offering. ▪ A consumer-direct health (CDH) product was recently implemented. Educating a broader group of BCBSD employees on the details of the product is ongoing. The TBS system cannot administer CDH products which is a key challenge. ▪ The ability to customize plans can be both a strength and a weakness. Highly customizable benefit plans are a market differentiator, however, they are more difficult and expensive to administer and may not be priced accordingly.	▪ Focus on development of an overall product strategy. Groups are moving to the lower cost alternatives reducing overall premium revenue. ▪ Focus on reducing medical cost through benefit plan designs. For example, BCBSD could charge a triage fee and/or actively discourage accounts from going to the emergency room (ER) by charging a higher co-pay for ER than an urgent care center to reduce ER utilization rates. ▪ Integrate member touch points with other functional areas (e.g. marketing and medical management) to enhance the member experience, improve medical management outcomes and identify cross-selling opportunities. ▪ Build consumer voice into products by conducting an appropriate level of consumer research and using it to develop innovative product designs.

Source: BCBSD interviews

BlueCross BlueShield of Delaware

[redacted]

Product, Pricing and Distribution: Pricing/Underwriting

Capability	BCBSD Capability Assessment	Rationale
Provide access to data for developing base rates and group specific pricing	○	[redacted]
Offer pricing for non-standard product designs that require manual workarounds	◐	
Involve Underwriting in field sales efforts for new groups and renewals	◐	
Involve cross-functional participants in the product development process	◐	
Offer competitive CDH pricing	◐	
Utilize CDH forecasting model	○	
Utilize predictive modeling	○	

○ Market Lagging ◐ Market Parity ● Market Leading

Source: BCBSD interviews

Deloitte.

BlueCross BlueShield of Delaware

[redacted]

Product, Pricing and Distribution: Pricing/Underwriting (cont'd)

Capability	BCBSD Capability Assessment	Rationale
Have automated quoting and underwriting capability for small groups of (1-50)	◐	[redacted]
Have automated quoting and underwriting capability for individual market	○	
Has a competitive quote turnaround time (TAT) for groups of 1-50	◐	
Has a competitive quoting turnaround time (TAT) for 51+ groups	◐	
Have automated renewal capability for groups of 1-50	○	
Involve pricing/underwriting in the provider contracting process	◐	
Utilize underwriting assistants in absence of automation	◐	
Utilize monitoring reports	○	

○ Market Lagging ◐ Market Parity ● Market Leading

Source: BCBSD interviews

Deloitte.

Product, Pricing and Distribution: Pricing/Underwriting

Pricing is a collaborative effort between the marketing, actuarial and underwriting departments. With respect to some segments, specifically individual and ASO, more emphasis has been placed on membership growth rather than profitability in recent years which has impacted pricing decisions.

Source: BCBSD interviews

BlueCross BlueShield of Delaware

[redacted]

Product, Pricing and Distribution: Sales and Marketing

Capability	BCBSD Capability Assessment	[redacted]
Possess a strong channel management strategy	○	
Have a comprehensive understanding of external legal and regulatory environment	●	
Actively manage the brand	◐	
Conduct research on external market	◐	
Manage broker performance	○	
Segment customers by common attributes	◐	
Possess effective sales skills	○	
Integrate marketing communications with sales	◐	

○ Market Lagging ◐ Market Parity ● Market Leading

Source: BCBSD interviews

Deloitte.

BlueCross BlueShield of Delaware

Product, Pricing and Distribution: Sales and Marketing (cont'd)

[redacted]

Capability	BCBSD Capability Assessment	Rationale
Possess an established relationship with broker network, including a formal commissions program	◐	[redacted]
Provide basic web capabilities (e.g. download forms, view contact information)	◐	
Support underwriting functions for community rated business	◐	
Support underwriting functions for experience rated business	●	
Possess lead generation and tracking system	○	
Utilize automated renewal triggers to alert sales force	○	
Utilize automated underwriting capability/rating engine which is integrated with sales process	◐	

○ Market Lagging ◐ Market Parity ● Market Leading

Source: BCBSD interviews

Product, Pricing and Distribution: Sales and Marketing (cont'd)

[redacted]

Capability	BCBSD Capability Assessment	Rationale
Possess ability to capture and trend key sales data, including close rates, product profitability, and segment profitability	◐	[redacted]
Provide additional online and/or remote self-service capabilities (to support new business and renewals, view commission reports, view reports)	○	
Offer basic shop and/or buy online capabilities for specific products or market segments	◐	

○ Market Lagging ◐ Market Parity ● Market Leading

Source: BCBSD interviews

Product, Pricing and Distribution: Sales and Marketing

The BCBSD brand and broker relationships are a key strength relative to competitors but there are opportunities to evaluate broker commission structure and incentives.

Key Findings	Opportunities
▪ BCBSD is a dominant player in Delaware in the 51+ market and is doing well in the 1-9 market. ▪ Broker relationships are a key strength. ▪ Market research is supported by pre-established relationships through CareFirst, which provides overall trends but Delaware market specific research is somewhat limited. ▪ Online tools for brokers were piloted but not working optimally. Modifications are in process to enable e-quoting. ▪ BCBSD brand remains a key strength. ▪ BCBSD's image campaign continues to be well aligned with its objectives of regional, community-oriented positioning. Community giving aligns with BCBSD's role as a healthcare company focused on improving the health of members of the community. ▪ State of Delaware, as the largest client, has significant leverage and is provided additional services at no cost.	▪ Consider offering internal sales skills training which is currently somewhat limited. ▪ Explore whether an internal captive sales force could handle sales leads for individual products more efficiently in lieu of the current practice of referring them to a broker. ▪ Actively manage broker performance. ▪ Explore opportunities to automate sales functionality for key functions such as lead management, call documentation, sales forecasting and management reporting. ▪ Consider opportunities to streamline review of internal and external communications to improve timeliness. ▪ Focus on profitability for the individual market. ▪ Increase focus on the fully insured market, a key success for BCBSD. A reduction in administrative costs may be necessary in order to price competitively in the fully insured market segment. ▪ Evaluate broker commission structure and incentives to be consistent with the market.

Network Management and Medical Management

Network Management

[redacted]

Capability	BCBSD Capability Assessment	Rationale
Establish comprehensive network coverage within service area	●	[redacted]
Maintain accurate record of provider demographics and credentialing	◐	
Support various industry standard pricing methodologies	○	
Accommodate multiple pricing arrangements for each provider	◐	
Support sharing of contract and demographic information to reduce set-up and maintenance	○	
Use standard contract/fee schedule templates to ease administration	◐	
Support web portal for provider self-service to update demographic information	○	
Profile physicians and hospitals to measure and report on cost and quality metrics	○	
Offer pay-for-performance (P4P) pricing based on utilization and quality data	○	
Provide strong provider relations capabilities, enabling technology and provider satisfaction	●	

○ Market Lagging ◐ Market Parity ● Market Leading

Source: BCBSD Interviews

Network Management

BCBSD has the most comprehensive network in Delaware, but opportunities exist to increase automation of network management functions.

Key Findings	Opportunities
Contracting and Reimbursement: ▪ TBS is a flexible system that supports provider contract administration and multiple reimbursement arrangements. ▪ BCBSD has a comprehensive hospital network with 100% network access. ▪ BCBSD has a 95% participation rate from providers within the state of Delaware. ▪ Average reimbursement increases for hospitals and physicians have remained at 5% and 2% respectively since 2003. ▪ Less than 20% of providers receive direct deposit reimbursements. ▪ Nearly 99% of groups contract for the pharmacy benefit. **Credentialing** ▪ Credentialing and re-credentialing are handled via paper. Primary source verification is outsourced to Credentialing Connection, Inc. (CCI). **Provider Relations** • Provider relations are a key strength for the company. Provider satisfaction scores are strong.	▪ Explore opportunities to automate current network management functions: – Eliminate monthly mailing of paper provider directories. – Eliminate mailing paper member lists to PCPs. – Focus on opportunities to increase electronic provider reimbursement . – Explore opportunities to automate credentialing. – Explore opportunities to support web portal for provider self-service to update demographic information. ▪ Explore opportunities to analyze provider inquiry trends within Provider Service. ▪ Continue efforts to identify and implement a provider profiling system to have the option of exploring tiered networks. ▪ There is an opportunity to consolidate multiple provider databases. ▪ Explore future opportunities to pursue pay-for-performance and quality initiatives, perhaps with a strategic partner. (Method to rate physicians on service has been initiated.)

Source: BCBSD Interviews

BlueCross BlueShield of Delaware

[redacted]

Medical Management

Capability	BCBSD Capability Assessment	Rationale
Offer wellness/health promotion programs for members		[redacted]
Possess quality management programs and accreditation standards		
Offer utilization management programs for inpatient and outpatient services		
Offer case and disease management (CM and DM) programs for members		
Provide access to a health coach or 24-hour nurse line		
Offer online member access to best provider information, disease content, and treatment alternatives		
Possess an integrated medical management desktop		
Offer an automated auth submission process for providers		
Utilize predictive modeling to identify and stratify members for care management programs		
Utilize triggers from claims or authorization data to identify high-risk members		
Provide employers with reporting to quantify ROI from medical management programs		

Source: BCBSD Interviews

Deloitte.

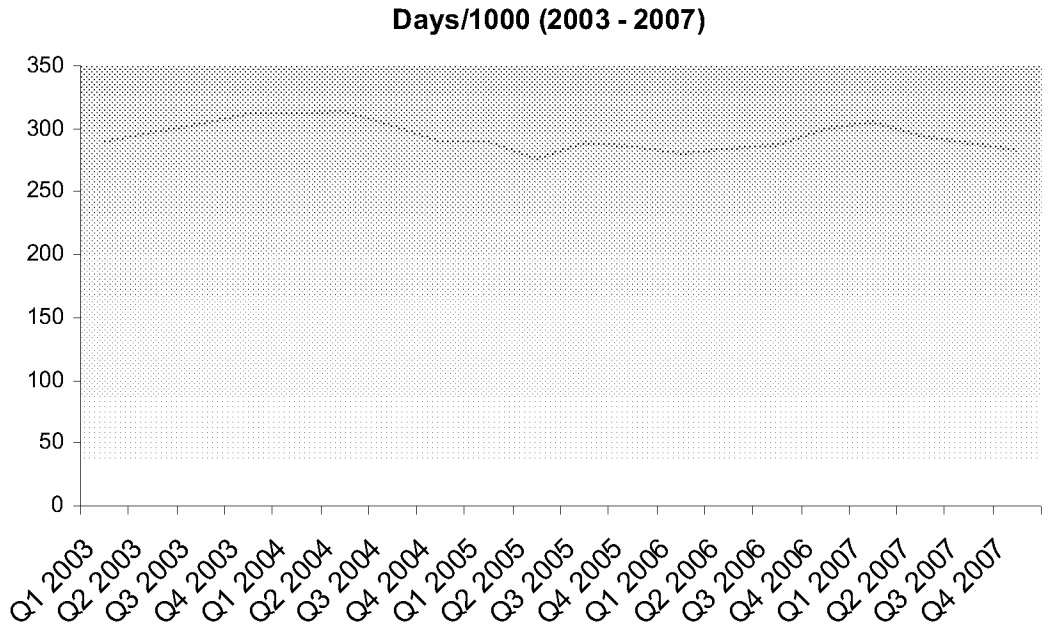
Medical Management

Since 2004, BCBSD has invested in an integrated care management system.

Key Findings	Opportunities
▪ Relative to competitors, BCBSD has a solid member outreach and overall medical management offering and is the market leader in the state of DE for clinical guidelines. ▪ BCBSD lags in Informatics relative to Aetna who is the forerunner in the market. ▪ A key success since 2004 is the implementation of MEDecision's CarePlanner product with minimal customization (v3.4, upgrading to v5.1). ▪ The TBS system cannot keep up with CarePlanner because it is antiquated. ▪ BCBSD tracks both inpatient and outpatient utilization through a comprehensive dashboard. ▪ CareFirst serves as BCBSD's PBM and Argus handles pharmacy claims. There are issues with Argus (no test system, issues with CDH claims). The pharmacy trend rate is at about 4-5%. ▪ There are many requests to do more employer group and community activities (e.g. health fairs) but Medical Management is not staffed to meet the volume of requests. ▪ BCBSD has their own medical policy committee but also works with CareFirst to review and update medical policy. ▪ Quality Compass is used for external benchmarking. ▪ BCBSD is in the RFP process to identify a radiology vendor for implementation in October 2008. ▪ There is an internal effort to identify cost savings through medical management activities. Healthways is able to provide ROI on DM programs for large accounts. Other vendors (e.g. Accordant) can provide aggregate ROI data. ▪ BCBSD is well integrated with Healthways on DM. Biweekly calls are set up to discuss issues coupled along with an issues log. ▪ BCBSD can view utilization and enrollment on individual member charts online.	▪ Focus on greater integration of pharmacy and behavioral health into other medical management disciplines. ▪ Explore next generation health and wellness opportunities. Staffing would be critical for it. ▪ Explore opportunities to rebalance case management activities (e.g. moving prescreening activities to mid-level clerical personnel). ▪ Need to educate providers to use iExchange for automated preauthorization functionality. However, there is a system limitation that hinders use. ▪ Across Marketing, Customer Service and Medical Management, focus on (1) integrating member touch points and (2) leveraging a longitudinal view of member data to enhance care management programs (as well as cross-selling opportunities). ▪ Continue efforts to explore cost reduction strategies for high dollar services and pharmaceuticals (e.g. radiology, chemotherapy drugs). ▪ Identify opportunities to streamline decision-making processes to avoid missed opportunities for care management innovation (e.g. Clipboard Methodology). ▪ Assess whether CareFirst and Argus are meeting PBM/Pharmacy claims needs.

Medical Management Landscape

Since the year 2003, days/1000 have remained relatively flat, which is consistent with industry trend. The average length of stay has stayed constant.



	2005 Adjusted [1]	2006	2007 Projected [2]
Average Length of Stay	4.6	4.6	4.6

Key Findings

- BCBSD is able to hold utilization relatively flat, consistent with industry trend.
- All admissions used to require pre-authorization but it has been slimmed down to focus on procedures that really warrant preauthorization.
- iExchange is used to do some automatic pre-authorizations but capabilities are limited because the system cannot integrate with TBS to read specific plan design limitations (e.g. pre-existing conditions).

Source: Manage Care Tracking Q1 2003 – Q4 2007; Inpatient Utilization Dashboard Report 2007; BCBSD interviews; Deloitte analysis

Note: [1] 2005 is adjusted data because data was first entered into CarePlanner January 26, 2005; [2] 2007 data is projected because of data availability

Operational Performance

[redacted]

Operational Performance: Membership and Billing

Capability	BCBSD Capability Assessment	Rationale
Ability to accept electronic enrollment information via multiple formats	◐	[redacted]
Possess ability to complete case installation in a reasonable timeframe	◐	
Ability to produce member ID cards and enrollment materials timely and accurately	◐	
Support application of benefits at both subscriber and member level	○	
Support scheduled and/or on-demand bill generation	◐	
Support online member maintenance for life-event changes, coverage changes, and ID card requests	◐	
Support automated bill payment options, including automated clearing house (ACH) transactions	○	
Integrate data captured during the sales process into case installation process	◐	
Support web-based online enrollment process	◐	
Support web-based online bill presentation, reconciliation, and payment	○	

○ Market Lagging ◐ Market Parity ● Market Leading

Source: BCBSD Interviews

Operational Performance: Membership and Billing

Since 2004, BCBSD has focused on increasing automation by adding electronic enrollment functionality through BenefitFocus and a homegrown system called Blue Express.

Key Findings	Opportunities
[redacted]	[redacted]

Source: BCBSD Interviews

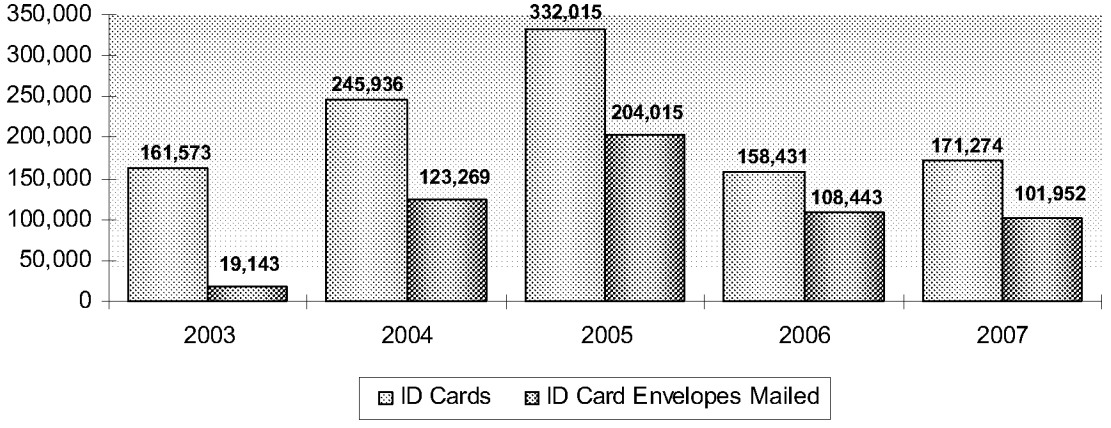
BCBSD Operating Performance (2003 – 2007): Membership and Billing

ID card production hit a peak in 2005 because of new membership from the purchase of Mid-Atlantic Health Plan. Electronic enrollment was at 49% in 2007 but is tracking significantly lower in 2008.

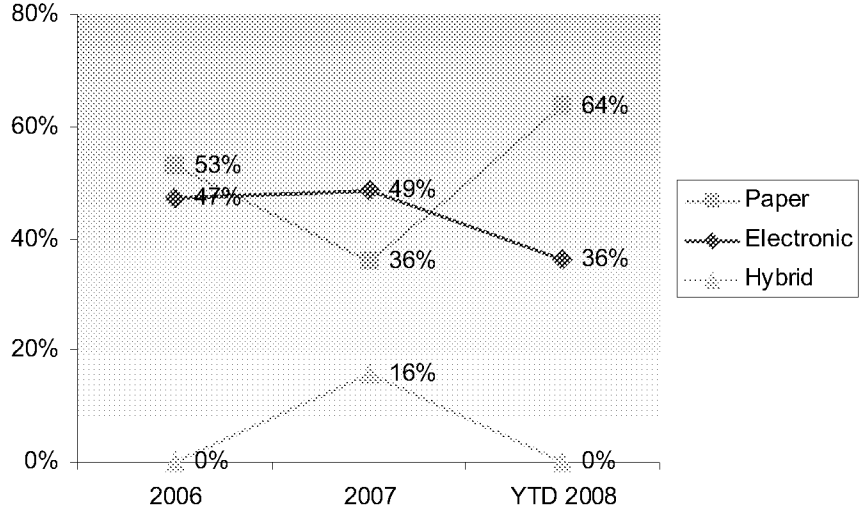
Key Findings

- The acquisition of Mid-Atlantic Health Plan created a significant number of new members that required high ID card production in 2005.
- BCBSD provides employers with the option to send ID cards directly to the members or in bulk to the employer. Distribution has increased significantly between 2003-2004.
- Electronic enrollment was the dominant method in 2007 but paper enrollment has been extremely high for YTD 2008. This is normal for this time of the year as renewals have not yet occurred for the bigger accounts.
- Hybrid enrollment format is unique to BCBSD. It has been immaterial in 2008.

ID Card Production and Distribution (2003 - 2007)



Enrollment by Method (2006 - YTD 2008)



Source: ID Card and Distribution; 2006-YTD 2008 Enrollment Timeliness; Deloitte Analysis

[redacted]

Operational Performance: Claims

Capability	BCBSD Capability Assessment	Rationale
Support multiple claims intake methods including electronic and paper submission	◐	[redacted]
Possess front-end imaging and Optical Character Recognition (OCR) functionality to file and enter paper claims data	◐	
Pay claims promptly and accurately	◐	
Pay claims through a consistent and standard process	◐	
Adjudicate claims for all product lines including HMO, PPO, and Indemnity	◐	
Produce Explanation of Benefits (EOBs) and remittance notices for members and providers	◐	
Demonstrate competitive metrics including auto-adjudication rate and percent of electronic claims	◐	
Possess a single gateway (front-end) for claims submission	○	
Use workflow software to manage claims exceptions and queues	◐	
OCR and imaging are available	◐	

○ Market Lagging ◐ Market Parity ● Market Leading

Source: BCBSD Interviews

Operational Performance: Claims

TBS is a flexible system but can be cumbersome and inefficient for core administration activities, including claims processing.

Key Findings	Opportunities
▪ The core system is flexible but cumbersome and inefficient (e.g. requires multiple screens/files to approve a service; requires a lot of special notes). TBS cannot do gradation of payment (e.g. urgent care vs. ER) or a front end batch reconciliation process. ▪ There is no front-end batch reconciliation system to track and reconcile claims which has resulted in issues with auditing processes. ▪ A Performance Improvement Committee (PIC) reports inventory, performance tracking and operations issues. ▪ There are two trainers in the claims area but they are frequently pulled into other activities (e.g. claims audits) that detract from their intended roles and responsibilities. ▪ Level of rework is high. BCBSD denies many claims intentionally because of policy reasons which require reprocessing. (e.g. emergency room claims are denied intentionally because medical records are required). ▪ Complex product and provider contracting increases inefficiency. ▪ Staff in the operations areas tend to be very tenured with many employees approaching retirement age. Knowledge transfer and bench strength is a concern.	▪ Stabilize imaging system to maximize the potential efficiency and then explore opportunities to add additional auto-workflow capabilities. ▪ Assess overall operations training and quality needs to determine an appropriate course of action to maintain service levels. ▪ Focus on succession planning and building bench strength across operations areas. ▪ Assess the long-term viability of TBS because it is antiquated and it is difficult to integrate with systems with newer technologies.

Source: BCBSD Interviews

BCBSD Operating Performance (2003 – 2007): Claims

Claims processing accuracy and timeliness have decreased somewhat in recent years.

[redacted]

Operational Performance: Customer and Provider Servic

Capability	BCBSD Capability Assessment	Rationale
Support service access through multiple channels (web, phone, e-mail, fax, or mail)	◐	[redacted]
Provide self-service to customers and providers through Voice Response Unit (VRU) / Interactive Voice Response (IVR)	○	
Possess integrated customer service desktop for CSRs which integrates data from applicable systems	◐	
Support one and done service philosophy (provide accurate information and satisfy inquiry at point of contact)	●	
Utilize basic workflow and routing functionality to route call to CSR based on phone number, IVR prompt, call history or member ID/product	◐	
Demonstrate acceptable metrics (average speed to answer, blockage rate)	○	
Provide basic member web capabilities, including benefits, eligibility, claims status, physician locator, and/or ID cards	◐	
Maintain a provider portal to support eligibility verification, claims status, authorization / referral submission, and remittance notices	○	
Offer advanced member web capabilities, including treatment cost calculators, and cost/quality data	○	
Allow providers to view quality and/or performance metrics via provider portal	○	

○ Market Lagging ◐ Market Parity ● Market Leading

Source: BCBSD Interviews

Operational Performance: Customer and Provider Service

Customer and provider service continue to be a key strength for BCBSD.

Key Findings	Opportunities
▪ Customer service levels are viewed as a key strength for BCBSD relative to competitors. ▪ The core system is flexible but cumbersome and inefficient (e.g. requires multiple screens/files to approve a service; requires a lot of special notes). TBS cannot do gradation of payment. ▪ Customized benefits results in added complexity in TBS and customer service processes. ▪ The VRU is a source of frustration for customers and discourages self-service. ▪ There is a formal customer service training area but customer service has limited knowledge of BlueCard and ITS processes. Customer service trainers also do quality review and support projects, which can suffer when there are competing priorities ▪ Inquiry accuracy has improved significantly since 2004. All calls are recorded through the NICE system which allows for real-time feedback and training.	▪ With upcoming VRU replacement (2009), consider leveraging hold messages (e.g. to communicate self-service capabilities and direct members to the web). ▪ Provide BlueCard/ITS training opportunities to customer service representatives. Assess overall operations training and quality needs to determine an appropriate course of action to maintain service levels. ▪ Integrate member touch-points with other functional areas (e.g. marketing and medical management) to enhance the member experience, improve medical management outcomes and identify cross-selling opportunities. ▪ Offer an opt in/opt out option for membership communications to reduce administrative expense if aligned properly by line of business. ▪ Enhance web portal capabilities and provider quality and performance data to assist with member decision making. ▪ Assess the long-term viability of TBS because it is antiquated and it is difficult to integrate with systems with newer technologies.

BCBSD Operating Performance (2003 – 2007): Customer and Provider Service

Provider Service experiences a greater call volume than Customer Service.

[redacted]

Operational Performance: BlueCard Operations

The following capabilities pertain to BlueCard Operations specifically.

Capability	BCBSD Capability Assessment	Rationale
Support BlueCard Operations by managing BlueCard inventory.	○	[redacted]
Maintain BlueCard index scores across all key criteria for BlueCard Operations	○	
Able to meet BCBSA BlueCard mandates and complete timely ITS upgrades as required	○	

○ Market Lagging ◐ Market Parity ● Market Leading

Source: BCBSD Interviews

Operational Performance: BlueCard Operations

ITS Host and Home

ITS Host/PAR membership and transactions have increased significantly in the past 4 years. ITS Host transactions grew at a faster rate than ITS Host membership.

Human Resources

BlueCross BlueShield of Delaware

[redacted]

Human Resources

Capability	BCBSD Capability Assessment	Rationale
HR Role		
Aspire to be a "strategic business partner"	◐	[redacted]
Start to actively focus on business challenges, such as talent management and executive development.	○	
Service Delivery		
Include employee and manager self-service as a core foundation of HR service delivery.	◐	
Have performance standards in place for HR service delivery.	○	
Drive employee experience through service delivery.	◐	

○ Market Lagging ◐ Market Parity ● Market Leading

Source: BCBSD interviews; 2007 Associate Survey; 2007 Associate Demographics

Deloitte

[redacted]

Human Resources (cont'd)

Capability	BCBSD Capability Assessment	Rationale
Core Technology and Infrastructure		
Have integrated core systems.	○	[redacted]
People		
Begin to identify skills and competencies required for future roles.	○	
Performance Measurement and Reporting		
Focus on HR operations metrics and use these metrics to drive service improvement.	○	
Report significant data.	◐	

○ Market Lagging ◐ Market Parity ● Market Leading

Source: BCBSD interviews; 2007 Associate Survey; 2007 Associate Demographics

Human Resources

With a highly tenured workforce, succession planning is critical to address the issue of associate retirement so that the appropriate knowledge transfer and training occurs.

Key Findings	Opportunities
[redacted]	[redacted]

Human Resources Profile

Since 2004, overall employee satisfaction has improved and employee turnover has decreased.

Information Technology

Information Technology

[redacted]

Capability	BCBSD Capability Assessment	Rationale
IT Strategy and Planning: ▪ Employ effective decision-making and strategy development ▪ Prioritize investments and project timing	◯	[redacted]
Program and Delivery Management: ▪ Manage the design, development, testing and deployment of projects or applications ▪ Effectively deliver business capabilities and services ▪ Ensure that projects are delivered on time and on budget ▪ Ensure that projects deliver results as promised and are managed to acceptable levels of risk	◐	

● Market Leading ◐ Market Parity ◯ Market Lagging

Source: BCBSD interviews

[redacted]

Information Technology (cont'd)

Capability	BCBSD Capability Assessment	Rationale
Operations Management: ▪ Maintain systems, manage operations and provide support/services to end users ▪ Maintain hardware to support operational infrastructure	●	[redacted]
Resource Management: ▪ Provide the right resources with necessary skill sets to support initiatives ▪ Manage resource availability to support initiatives and timelines	◐	
Vendor and Alliance Management: ▪ Establish and maintain flexible, reliable vendor relationships to deliver effective enterprise systems and capabilities	○	
Value Management: ▪ Evaluate and balance project investment portfolio to create maximum return, value and customer satisfaction	◐	
Applications and Infrastructure: ▪ Maintain updated technology assets to include modern and flexible programming languages, data base management systems and user interfaces	○	

● Market Leading ◐ Market Parity ○ Market Lagging

Source: BCBSD interviews

Information Technology

IT investments have been made to keep stride with competitors but the benefits have not been fully realized. A more structured approach to identify and prioritize investments and a more robust program and delivery management function would improve returns and efficiencies.

Key Findings	Opportunities
[redacted]	[redacted]

BlueCross BlueShield of Delaware

IT Investments

BCBSD's Application Landscape

Applications and Infrastructure Details

Over the past 3-4 years, BCBSD has focused significant effort on meeting BCBSA mandates, implementing select new technologies and enhancing TBS.

- **Core Administration –** Performed limited Enrollment, Billing and Claims enhancements on the TBS core system
- **Enrollment and Billing –** Implemented BenefitFocus (BF) for electronic enrollment for a select market segment; Developed a home-grown system (Blue Express) that is also for electronic enrollment; Developing Automated Eligibility (AE)
- **Claims** – Implemented the first phase of imaging and Optical Character Recognition (OCR) but additional investments are required to realize full functionality; Implemented one workflow to track suspended claims
- **Customer Service** – Implemented NICE phone system that records 100% of the calls; Implemented BlueChip that is a Windows-based application for users to access information stored in TBS; Replacing Voice Response Unit (VRU) system
- **Provider Service** – Launched iEXCHANGE to automate pre-authorizations on select procedures
- **Network and Medical Management** – Launched an integrated care management application (MEDecision's CarePlanner)
- **Informatics/Analytics** – Limited analytics and no data warehouse exists; Reports are created manually by pulling data from multiple sources
- **Web Portals** – Portals are delivered through BCBSD and CareFirst; Developed standard web portal capabilities for members; Provider directory is very robust; Provider portal, via CareFirst, allows physicians to check claim status, obtain information and download forms; Broker portal capabilities are limited.
- **Infrastructure** – Established new facilities (including Data Center), computers, printers and phone system

Source: 2004 - 2008 IT Capital Project Activity; BCBSD Interviews

Informatics: Data Management and Reporting

[redacted]

Informatics: Data Management and Reporting

Capability	BCBSD Capability Assessment	Rationale
Provide basic operational reports to support day-to-day business for all functional areas	◐	[redacted]
Provide access to analytical resources to produce ad-hoc reports and perform analysis	◐	
Provide employer groups with standard or custom reports/data	○	
Produce automated executive dashboard	○	
Provide employer groups with online access to data and reporting	○	
Possess a consolidated data warehouse across all lines of business	○	
Possess data mining capability to support root cause analysis in specific areas	○	
Utilize provider profiling to identify cost and quality patterns	○	
Utilize predictive modeling and risk stratification to identify future utilization trends	◐	

● Market Leading ◐ Market Parity ○ Market Lagging

Source: BCBSD interviews

Informatics: Data Management and Reporting

BCBSD has started the process to acquire many of the tools that are used for reporting and analytics but it would require a significant amount of time and investment to reach market parity.

Key Findings	Opportunities
▪ Many business owners would like to make more data-driven decisions but BCBSD lacks the tools to do so. ▪ Many reports are generated using Statistical Analysis Software (SAS) but few associates know how to use the tool to generate reports themselves. ▪ The business has expressed the need for various technologies and investments such as provider profiling capabilities but the underlying infrastructure to support that is unavailable.	▪ Establish an Enterprise Data Warehouse so that all data is stored in a single repository that supports ad hoc and structured analytics and reporting. ▪ Automate the creation/extraction of standard reports that are used on an ongoing basis. ▪ Enhance web capabilities to allow automated transactions and interactive reporting. Enhancements are in the plans for employer groups. ▪ Increase rigor of informatics to forecast and identify areas of challenges: – A provider profiling system would provide greater ease in managing and monitoring health care delivery. – Increase self-service for commonly used reports so that associates' time is freed up to focus on customized reports and to conduct in-depth data analysis. Develop a code library to support self-service. – Report profitability by account.

Appendix

Supporting slides that outline foundational and emerging capabilities by functional area.

Foundational and Emerging Capabilities – Financial Processes

Capability	Foundational Capabilities	Emerging Capabilities
Financial Processes	[redacted]	

Foundational and Emerging Capabilities – Product, Pricing and Distribution

Capability	Foundational Capabilities	Emerging Capabilities
Product	[redacted]	

Foundational and Emerging Capabilities – Product, Pricing and Distribution

Capability	Foundational Capabilities	Emerging Capabilities
Pricing/ Underwriting	[redacted]	
Sales and Marketing		

Foundational and Emerging Capabilities – Network and Medical Management

Capability	Foundational Capabilities	Emerging Capabilities
Network Management	[redacted]	
Medical Management		

Foundational and Emerging Capabilities – Operational Performance

Capability	Foundational Capabilities	Emerging Capabilities
Membership and Billing	[redacted]	
Claims		

Foundational and Emerging Capabilities – Operational Performance

Capability	Foundational Capabilities	Emerging Capabilities
Customer/ Provider Service	[redacted]	

Foundational and Emerging Capabilities – Human Resources

Capability	Foundational Capabilities	Emerging Capabilities
Human Resources	[redacted]	

Foundational and Emerging Capabilities – Information Technology*

Capability	Foundational Capabilities	Emerging Capabilities
Web-based Services for Members	[redacted]	

[redacted]

Foundational and Emerging Capabilities – Information Technology*

Capability	Foundational Capabilities	Emerging Capabilities
Web-based Services for Employers	[redacted]	
Web-based Services for Providers		

[redacted]

Foundational and Emerging Capabilities – Information Technology*

Capability	Foundational Capabilities	Emerging Capabilities
Web-based Services for Brokers and Individuals	[redacted]	

[redacted]

Foundational and Emerging Capabilities – Informatics: Data Management and Reporting

Capability	Foundational Capabilities	Emerging Capabilities
Data Management and Reporting	[redacted]	

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BlueCross BlueShield of Delaware

BCBSD Affiliation Overview

Proudly serving our customers for 75 years

EXHIBIT
JOINT-5.1

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Affiliation Considerations

1) Environmental Drivers:

Market demands in the health care system are driving consolidation; carriers are aggressively pursuing quantum improvements in technologies and capabilities through strategic acquisitions. BCBSD's competitors are now all large, national conglomerates with significant resources, which pose a real threat to small, unaffiliated companies.

2) Capabilities Gaps:

With the support of industry experts, BCBSD performed a comprehensive assessment of the capabilities required to remain competitive. The study concluded that gaps in BCBSD capabilities will require a bold new strategic direction for the company to continue to be successful.

3) Experience:

Direct experience as an affiliate of the CareFirst organization has provided real evidence of the value to our constituents of being part of a larger Blue organization. In addition, our current experience in the Delaware marketplace clearly demonstrates the challenges associated with operating as a small, independent health plan.

4) Health Care Reform:

The passage of the Patient Protection and Affordable Care Act in March of this year has fundamentally altered the health care industry and imposes unprecedented new requirements on health care plans. Small, independent plans are unlikely to have the breadth and depth of human and financial capital to engineer the make-over required to survive in this new environment.

1) Environmental Drivers

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Environmental Drivers

- There has been significant consolidation of health plans throughout the industry, resulting in a few very large companies dominating the marketplace.
- Although BCBSD remains the local market leader, these large, consolidated health plans have a number of advantages that could potentially erode BCBSD's position:
  - Ability to conduct business with lower administrative cost ratios (economies of scale)
  - Resources needed to acquire and develop new products and services demanded by the marketplace
  - Resources needed to acquire leading edge technologies
  - Resources to acquire specialty companies to bring added value to the marketplace
  - Financial depth and breadth to withstand market and economic volatility
  - Resources required to meet HIPAA 5010, ICD-10 and other federal mandates
  - Human and financial capital needed to respond to health care reform
- This shift in the competitive landscape is putting mounting pressure on small, independent health plans.

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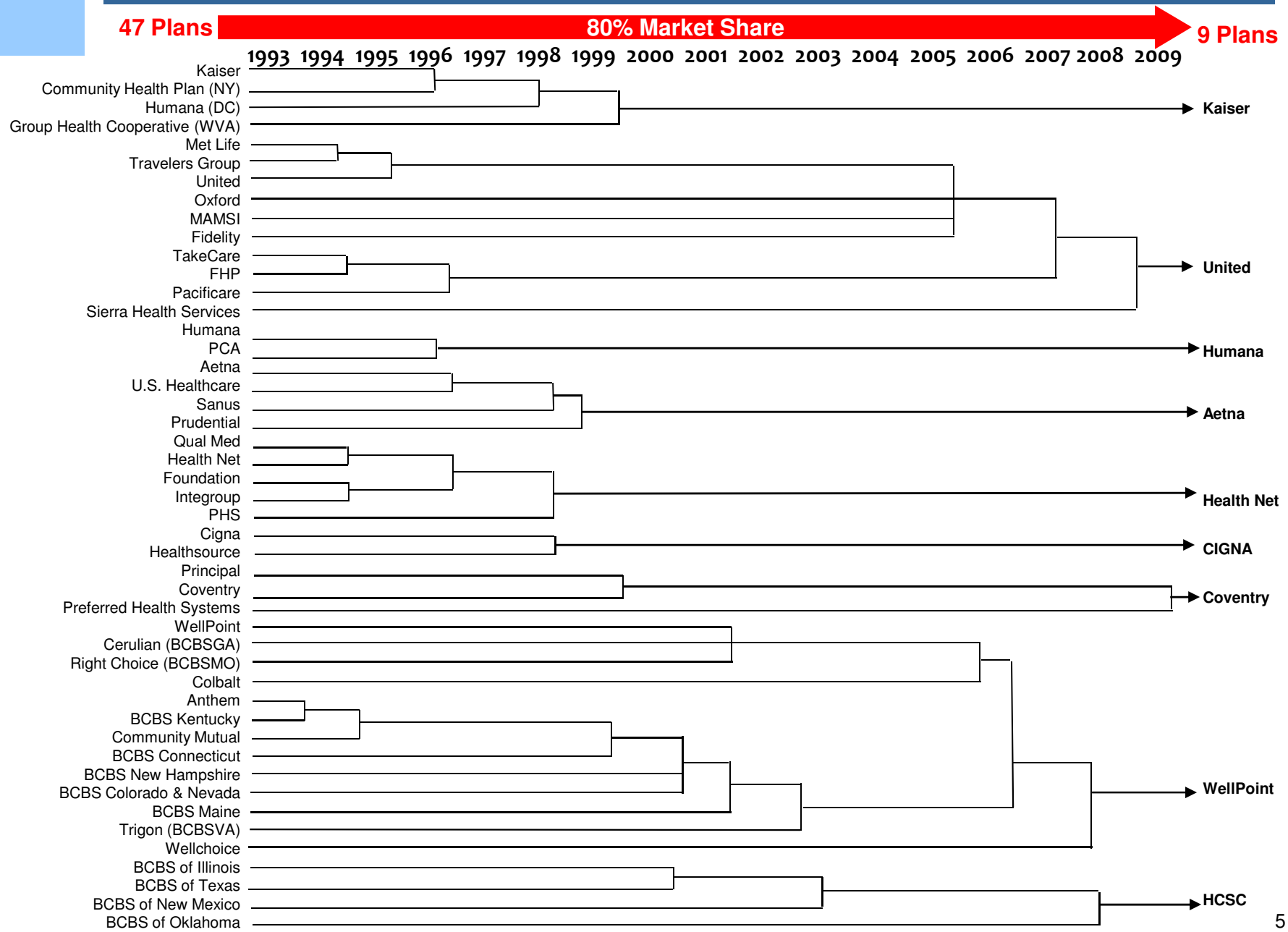
Health Plan Consolidations



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Specialty Company Acquisitions

- In addition to consolidating through acquisition, the large commercial carriers are expanding capabilities through the acquisition of specialty companies.
- Carriers are integrating these specialized capabilities (technology, informatics, clinical expertise, ancillary programs, etc.) into their core programs to create a greater value proposition for clients. Examples include:
  - Aetna: Active Health Management (wellness programs), Broadspire (disability carrier), Strategic Resources Co. (specialty products for part-time and hourly employees)
  - United: Ingenix (informatics and technology), Definity Health (consumer products and services), Golden Rule (senior products)
  - Cigna: Star HRG (specialty products for part-time and hourly employees), ChoiceLinx (consumer products and services)
  - Coventry: First Health (third-party administrator and workers compensation), Concentra (workers compensation)
- Given its size, BCBSD is not in a position to expand or enhance its capabilities through acquisitions.

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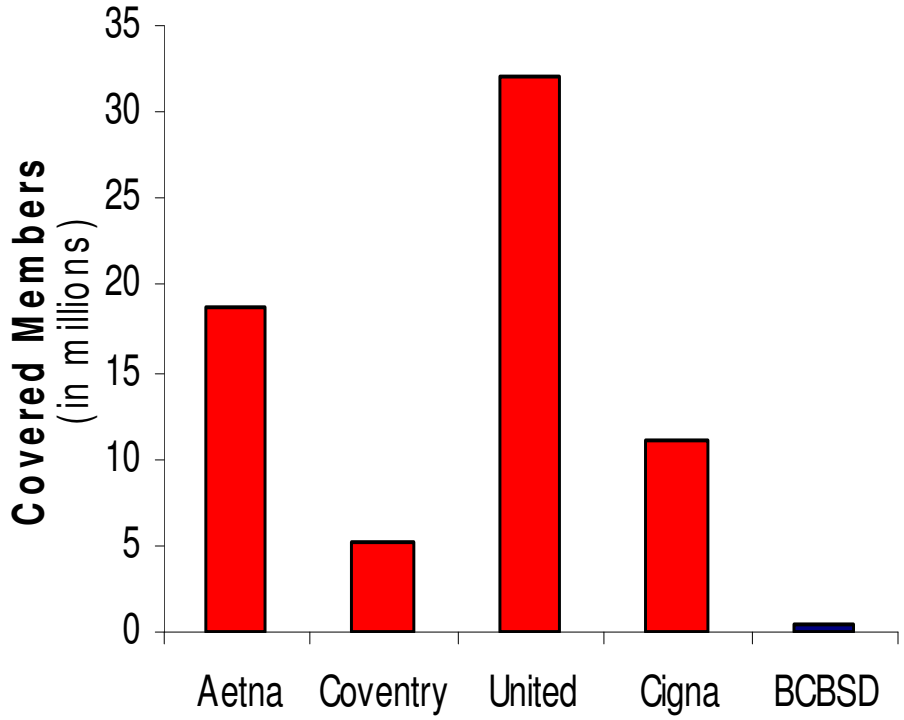
Competitive Landscape



- BCBSD's local competitors are all large, national companies that have grown through acquisition and consolidation.
- Coventry, the smallest of these competitors, is still more than 12 times larger than BCBSD.
- United Health Care, the largest of these competitors, is nearly 80 times larger than BCBSD.
- These companies have access to considerably more resources to invest in technology, products and services.
- Given the size of our market (Delaware), BCBSD cannot realize the economies of scale on its own.

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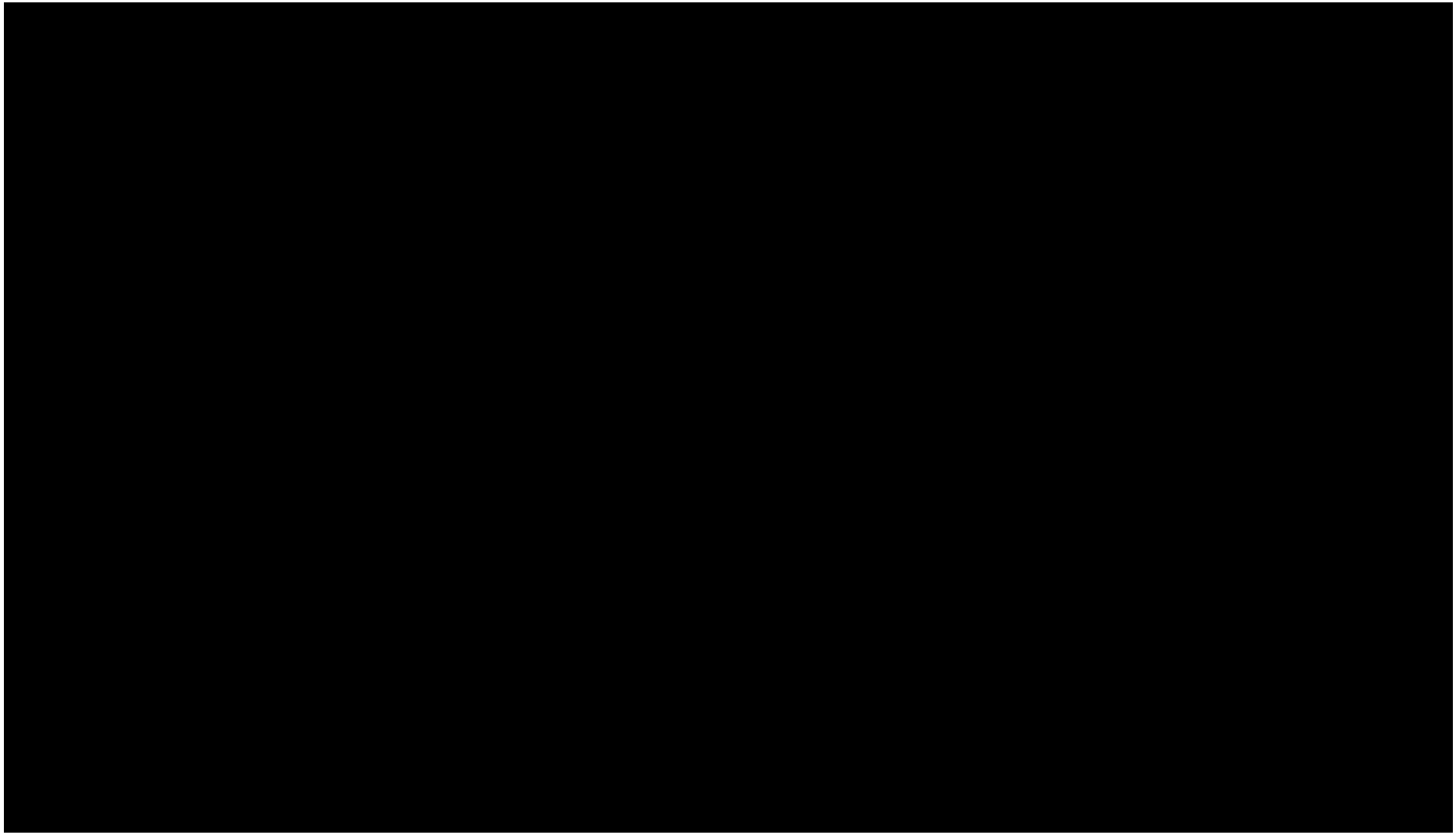
Scale Impact on Administrative Costs



2) Capabilities Gaps

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Capabilities Gaps

- In 2003, while an affiliate of CareFirst, BCBSD engaged industry consultant, Deloitte, to assess the company's business capabilities in the context of current and future market needs:
  - BCBSD invested in many capabilities improvements recommended by the study; however, the disaffiliation from CareFirst limited our ability to make further improvements.
- In 2008, BCBSD engaged Deloitte to update its assessment of the company's capabilities:
  - The study concluded BCBSD, as an independent company, would need to invest up to $130 million in capabilities improvements over the next 3 - 5 years to maintain its leading market position.
  - Most of the capabilities gaps are in technology and other modernization of information systems.
- In 2010, BCBSD engaged Deloitte to update their assessment to consider Health Care Reform and the HIPAA 5010 and ICD-10 federal mandates:
  - The study concluded that BCBSD, as an independent company, would need to invest $90 to $140 million over the next 3 – 5 years to remain competitive and to meet government mandates.
  - Making the investments to meet the requirements of Health Care Reform and ICD-10 is particularly urgent as deadlines are approaching quickly.

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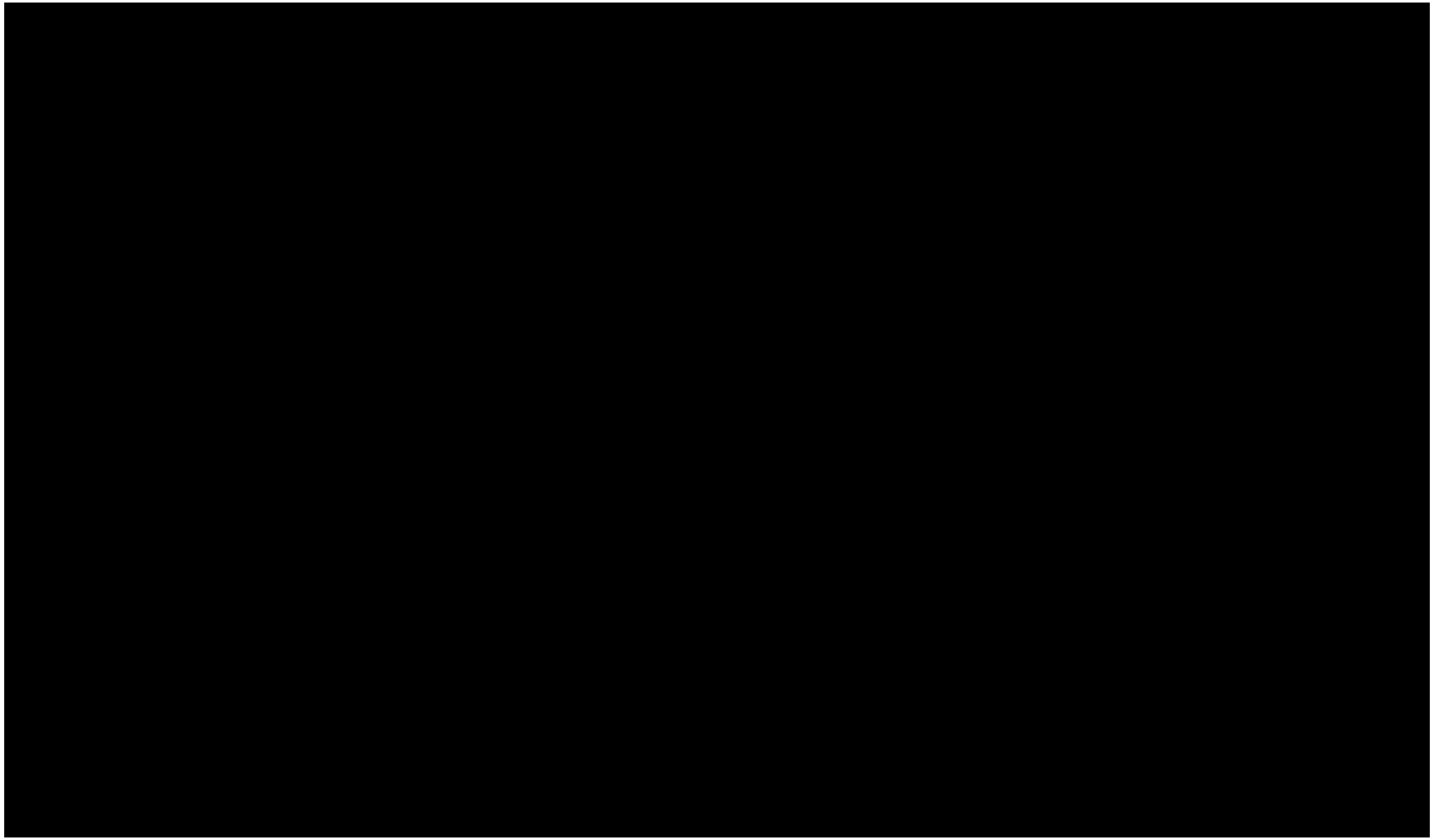
Impact of Capabilities Gaps

Key gaps in capabilities include:



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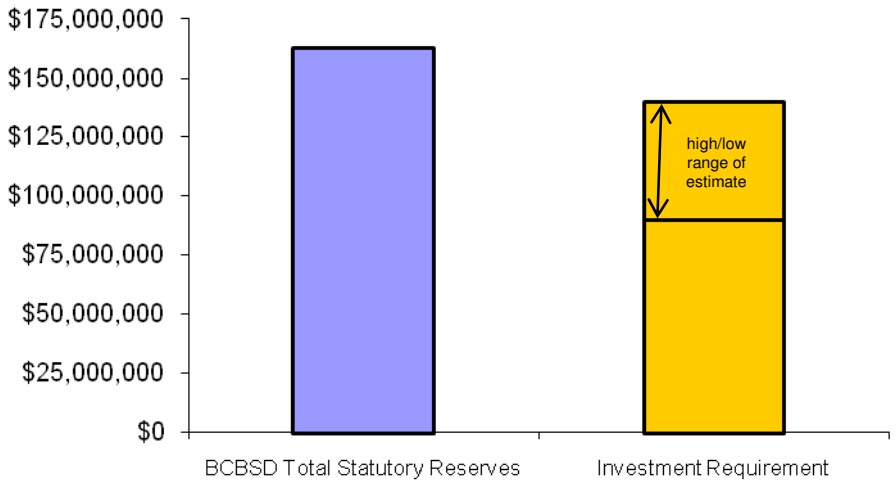
Summary of Capabilities Challenges

- Investments in the range of $90 to $140 million over the next 3 - 5 years would be required to address these capabilities gaps; however,
- Even given BCBSD's relatively strong capital reserve position, the amount of the required investment exceeds the company's means.



The investment required to meet capabilities needs would substantially consume BCBSD claims reserves.

- Further, BCBSD lacks the human capital that larger companies possess to implement a massive upgrade in capabilities over a short period of time.

3) Experience

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Experience

- BCBSD was in an affiliation with CareFirst from 2000 through 2006. During that time, the company achieved significant improvements in:
  - Enrollment growth
  - Administrative costs
  - Underwriting gain / loss
  - Claims reserves
- Following disaffiliation, BCBSD performance has declined:
  - Enrollment has declined [redacted] over the last [redacted] alone.
  - Administrative costs are increasing (see slide 16).
  - Financial performance has declined (see slide 17).
  - Overall reserves have fallen. BCBSD's Risk Based Capital (RBC) ratio was over 1100% at the end of its affiliation with CareFirst. By 2008, the RBC declined to 730%. Although BCBSD's RBC is projected to increase to 950% as of 12/31/2010, it is subject to volatility due to changes in investment markets and BCBSD's small size. Investments BCBSD would need to make as a stand-alone company in required upgrades would substantially consume the company's reserves.

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Administrative Costs

- Prior to the affiliation with CareFirst, BCBSD's administrative costs consistently exceeded [redacted]
- During the affiliation, administrative costs dropped substantially to an average of [redacted]
- Following the disaffiliation, administrative costs are rising again as BCBSD has lost economies of scale and has had to replace administrative structure that was provided by CareFirst.

  Administrative costs are projected to be [redacted] in 2010 and will increase further in 2011.

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Underwriting Gain / Loss

- A steady string of years with underwriting losses, prior to affiliation with CareFirst, were replaced by years of strong underwriting gains.
- Following the disaffiliation, financial performance has declined significantly, with underwriting losses in 2008 and 2009. The projection for 2011 is for breakeven.

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Pressures Impacting BCBSD and the Community

The examples below illustrate the real-world consequences and challenges BCBSD faces as a small, independent carrier competing in an industry dominated by much larger companies:

- BCBSD does not have the resources to develop and deliver Medicaid, Medicare Advantage or Medicare Part D programs for Delaware citizens.

  Example: In the past two State Medicaid RFP bids, BCBSD has brought in third parties to provide proposals. In both cases, the bids were not accepted.

- To retain existing business, BCBSD has been forced to lower its administrative fees. While BCBSD's administrative fees cover its variable costs, they are not adequate to absorb all of BCBSD's fixed costs.

- BCBSD is vulnerable to losing accounts to large competitors able to invest hundreds of millions of dollars in consumer directed health care and other new products and services.

4) Health Care Reform

Health Care Reform

In March, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). The new law has profound effects on the health care industry, including:

- Complete redesign of all products to become compliant with the law; some of these changes take effect immediately, while others are phased-in over the next four years
- Strict limits on medical loss ratios, new rate filings and approval requirements, and greatly expanded regulatory oversight at both the state and federal levels
- Major pricing implications, including guaranteed issue, elimination of pre-existing condition exclusions, coverage of adult children to age 26, and mandated community rating with significant rate compression
- New taxes and fees on carriers and others within the industry
- Complete overhaul in product distribution, with the creation of state-based insurance purchasing exchanges
- New individual subsidies and penalties, and new small employer tax credits and large employer coverage mandates
- Massive expansion of Medicaid, major changes in Medicare
- And others

Reform Impact on Carriers

To become compliant with the new law, and to successfully compete under these new rules, carriers will be required to invest in a major re-engineering of their business, including:

- All new products
- All new rating and underwriting methodologies
- Expanded regulatory compliance capabilities (new reporting and oversight mandates)
- All new sales and marketing strategies and capabilities
- Significant system enhancements to meet federal requirements

The quantification of these investment costs is yet to be established but will be significant:

- Detailed regulations are still forthcoming from the Administration; final investment projections will be made once all regulations are published
- The depth and breadth of changes clearly indicate that the investment required will be of a considerable magnitude

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Reform Impact on BCBSD

As one of the smallest health carriers in the nation, BCBSD is particularly vulnerable to this major and immediate shift in the health care business:

- BCBSD does not posses the human capital required to quickly re-engineer its core business to meet the immediate requirements and opportunities that health care reform presents.
- BCBSD does not possess the financial resources required to overhaul major business systems and strategies to meet these new requirements and opportunities.
- The passage of health care reform, with its immediate and sweeping implications, heightens the urgency for BCBSD to affiliate swiftly with a larger Blue plan that can provide the human and financial resources required to assure BCBSD's continued position as the leading carrier serving the citizens and businesses of Delaware.

Conclusions

Conclusions

- Competitor consolidation has changed the landscape of the health care industry, resulting in a few very large and dominant carriers that are driving a new standard in administrative cost efficiency and sophistication of products and services.
- As an affiliated company, BCBSD enjoyed significant advantages in its cost structure and financial stability. As a small, independent company, however, BCBSD has seen its ability to compete and continue to thrive diminish.
- The passage of health care reform and the HIPAA 5010 and ICD-10 mandates require a comprehensive overhaul of current systems and capabilities that is beyond the scope of BCBSD's resources.

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Process for Assessing Options

Upon disaffiliation from CareFirst, BCBSD's management and Board of Directors established the following process for addressing the challenge of maintaining BCBSD's strength and stability over the long-term:

- Redefined BCBSD's Mission and Vision as an independent company
- Conducted an assessment of the global societal and business trends affecting the industry and their impact on BCBSD
- Established requirements for success, including the attributes necessary for a successful affiliation
- Conducted a thorough evaluation of potential partners

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Key Partner Attributes Required

- Proven history of successful affiliations and systems migrations
- Low-cost structure/economies of scale; access to capital/strong financial position
- Strong data analytics to advance strategies that lower health care costs
- Good cultural fit (ethics, integrity, customer service, business strategy, operating philosophy)
- Excellent service metrics
- Track record of success in meeting constituent needs:
  - Strong customer satisfaction, and advanced wellness and medical management programs
  - Excellent broker and account relationships
  - Streamlined benefits administration
  - Commitment to local community support and government relations
  - Superior provider satisfaction, real-time processing and leading-edge provider efficiencies
  - Commitment to strong local presence, with local workforce, competitive employee benefits and other employee opportunities

Key Partner Attributes Required (cont'd)

- A demonstrated local market orientation and ability to understand and be responsive to Delaware-specific needs
- Positive BCBSA relationship, with the ability to favorably influence Association policy and proactively participate in national health care reform initiatives
- Strong regulatory compliance and reporting
- Ability to fill key BCBSD capabilities gaps:
  - State-of-the-art administrative infrastructure and technology, including web-based tools for employers, members, providers and brokers
  - Exceptional health care cost management systems
  - Broad and flexible product offerings for all segments, including programs to meet the needs of Delaware's underserved populations (Medicaid and future potential initiatives for the uninsured)
  - Provides the experience and human capital necessary to implement ongoing improvements
  - Provides these improvements at a lower cost than BCBSD could do on its own

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Selecting Highmark

BCBSD selected Highmark as the company best qualified to meet the key partner attributes and needs of BCBSD stakeholders

- The affiliation will allow BCBSD to continue to operate as a not-for-profit company, headquartered in Delaware
- With Highmark, BCBSD can achieve the capabilities improvements required for ongoing success while maintaining adequate and independent capital reserves
  - The cost for required capabilities upgrades to BCBSD under Highmark is projected to be $35M, this is a substantial savings from the $90M to $140M BCBSD would otherwise need to invest as a stand-alone company
  - This relieves BCBSD from depleting plan reserves and helps secure the company's ongoing viability
  - The agreement requires that BCBSD reserves remain with the BCBSD company and cannot be used or drawn upon for use other than support of the BCBSD company
  - The agreement requires Highmark to guarantee that BCBSD's reserves meet statutory and BCBSA minimums, and Highmark must subsidize BCBSD reserves if needed
  - In addition, the agreement includes a Line of Credit available to BCBSD from Highmark of up to $45M to help fund, if needed, these capital improvements
  - These arrangements were crafted to assure BCBSD remains strong while protecting and enhancing the company's value to our constituents

Selecting Highmark (cont'd)

- Highmark is an experienced and successful partner and will provide leading edge technology and capabilities to BCBSD stakeholders:
  - Highmark is the product of the successful merger between BCBS of Western Pennsylvania and Pennsylvania Blue Shield
  - Mountain State (West Virginia) BCBS successfully affiliated with Highmark under an arrangement comparable to the proposed BCBSD affiliation
  - With its advanced technology and capabilities, Highmark has contracts with several other Blue organizations to handle various operations functions
  - Highmark consistently scores very high on operational performance metrics and has achieved exceptional satisfaction among members, employers, brokers and providers
- BCBSD can continue to focus on being a good corporate citizen in Delaware:
  - During the five years preceding its affiliation with CareFirst, BCBSD's annual community contributions averaged about $70,000; during the CareFirst affiliation annual community contributions increased to over $330,000 and are even higher now
  - Highmark and its affiliates have a strong record of community giving:
    - In West Virginia the Mountain State BCBS plan was able to expand its community giving to $3M in 2007-2009, driven by its improved financial strength as a Highmark affiliate
    - Highmark's community giving in Pennsylvania was $130M in 2009

Selecting Highmark (cont'd)

- The Highmark affiliation was designed to preserve BCBSD as a Delaware-focused company, staffed and managed by Delawareans
  - BCBSD will remain headquartered in Delaware with a Delaware President and Board of Directors; BCBSD will continue to be regulated by the Delaware Department of Insurance.
  - Market-facing functions (Community Relations, Government Relations, Sales & Account Relations, Provider Relations & Contracting) will be staffed in Delaware and report directly to the Delaware President.
  - Most back-room functions (Customer Service, Claims Processing, Enrollment and Billing) will be staffed and conducted in Delaware with local management reporting to Highmark senior operations leadership.
  - The affiliation requires Highmark to apply commercially reasonable efforts to maintain staffing levels in Delaware proportionate to health care enrollment as is maintained in its other geographies, and requires Highmark to make good faith efforts to create new employment opportunities in Delaware:
    - In West Virginia, Mountain State BCBS employment grew from 670 employees in 2000 to nearly 900 following its affiliation with Highmark, driven by strong growth in enrollment and consolidation of certain core business functions in West Virginia
    - In BCBSD's own experience with CareFirst, growth as an affiliate of a larger plan allowed BCBSD to increase employment from 530 employees in 2000 to 675 by 2006; since the disaffiliation, employment has declined to 630 employees

CERTIFICATE OF INCORPORATION

GROUP HOSPITAL SERVICE, INCORPORATED

FIRST: The name of this corporation is GROUP HOSPITAL SERVICE, INCORPORATED.

SECOND: Its principal office in the State of Delaware is to be located at 1501 Van Buren Street, in the City of Wilmington, County of New Castle, State of Delaware, and the name and address of its Resident Agent is James S. Stirling, 1501 Van Buren Street, Wilmington, New Castle County, Delaware.

THIRD: The objects and purposes of said corporation shall be to inaugurate, operate and maintain in the City of Wilmington and State of Delaware, and in such other parts of the State of Delaware as may be approved by the three-fourths vote of the entire Board of Trustees, a hospital service plan by which hospitals subscribing to the plan shall furnish hospitalization to individuals, who are also subscribers and contributors to the plan, when they may be in need of hospital care; to collect in connection with the operation of the plan, statistics and data and to compile reports which may be deemed of value to the community, other hospitals and to the furtherance of the plan; to be of assistance in the promotion of such activities as are considered to be for the best interests of the community in relation to its hospitals; to assist in defraying the cost of hospital care to such subscribers and contributors when such care is rendered in hospitals not within the State of Delaware or not members of the plan.

FOURTH: The said corporation is not a corporation organized for profit and shall not have authority to issue capital stock.

The members of this corporation shall consist of The Delaware Hospital, Homeopathic Hospital Association of Delaware, St. Francis Hospital, Incorporated, and Wilmington General Hospital Association, and such other hospitals situated within the State of Delaware as may from time to time be selected by a majority of the members hereof. The corporation shall have power in its By-Laws to provide for other classes of membership and attach conditions and limitations thereto, but the voting power of the members of this corporation shall reside solely in the members which are hospitals associated with this corporation in its group hospital service. In the event that any member hospital shall withdraw from participation in the plan of group hospital service conducted by this corporation its membership herein shall immediately cease and determine.

FIFTH: The names and places of residence of each of the incorporators are as follows:

Clarence A. Hume	Wilmington, Delaware	James F. McCloskey	Wilmington, Del.
James S. Stirling	Wilmington, Delaware	Theodore A. Weth	Wilmington, Del.

EXHIBIT
JOINT-6

SIXTH: The existence of this corporation shall be perpetual.

SEVENTH: Private property of the members shall not be subject to the payment of the corporate debts to any extent whatsoever.

EIGHTH: The business and affairs of the corporation shall be carried on by a governing body which shall be called the "Board of Trustees", which shall consist of three Trustees selected by each of the hospital members and four additional members to be selected by the Board of Trustees. The Trustees so selected shall hold office for a period of one year or until their successors are duly elected and qualified. Any vacancy occurring among the Trustees selected by the hospital members shall be filled for the unexpired term by the hospital member which theretofore elected to the office in which the vacancy occurred; any vacancy occurring among the four Trustees elected at large shall be filled for the unexpired term by the remaining Trustees. Of the three Trustees selected by each of said hospital members one shall be selected from the medical staff of the hospital. The Board of Trustees shall have the right to oust any Trustee, whether with or without cause shown therefor, by a three-fourths vote of the entire Board of Trustees.

NINTH: The Board of Trustees shall have the whole and sole control of the property and business of the corporation, except as shall be otherwise provided by the laws of the State of Delaware and except that none of the property of the corporation shall be used for any purpose other than the purposes herein set forth. The Trustees shall have no power to borrow money, except for the purpose of meeting the initial organization and promotion expenses and the current operating expenses of the corporation.

TENTH: The Board of Trustees shall keep a record of all donations, moneys, securities or other property received by the corporation for its corporate purposes and, in the event of the dissolution or liquidation of the corporation, the assets of the corporation, after the payment of all debts, shall be prorated to and distributed among such donors, their heirs, executors or administrators, in the proportion which their total donations shall bear to the entire donations made to the corporation; provided, however, that the amount of such distribution shall not exceed the amount of any donation.

ELEVENTH: This corporation shall have power to receive, by deed, assignment, gift, bequest, or otherwise, and to purchase, hold, sell, assign, transfer, mortgage, pledge or otherwise dispose of, real and personal property of whatever kind or nature, including the shares of the capital stock of, or bonds, securities or other evidences of indebtedness issued or created by the United States, any State, political subdivision of any State, or by any other corporation of the State of Delaware or elsewhere, and, while the owner of any such stock or securities, may exercise all the rights, powers and privileges of ownership, including the right to vote thereon, to the same extent as natural persons might or could do, subject to the limitations of the powers of the Board of Trustees herein set forth.

TWELFTH: This corporation shall have power to enter into, make and perform, contracts of every kind with any person, firm, association or corporation, governmental agency or body and, without limit as to amount,

to draw, make, acknowledge, endorse, discount, execute and issue promissory notes, drafts, bills of exchange, warrants, bonds, debentures or other negotiable or transferable instruments and evidences of indebtedness, whether secured by mortgage or otherwise, so far as may be permitted by the laws of the State of Delaware, in so far as the same may be necessary or incidental to the exercise of the powers of the corporation and subject to the limitations upon the powers of the Board of Trustees, as herein set forth.

THIRTEENTH: This corporation reserves the right to amend, alter, change or repeal any provision contained in the Certificate of Incorporation in the manner now or hereafter prescribed by the Statutes of the State of Delaware, upon the affirmative vote of three-fourths of the entire Board of Trustees, and all of the rights conferred upon officers, Trustees and members are granted subject to this reservation.

We, the undersigned, being the incorporators hereinbefore named, for the purposes of forming a corporation in pursuance of the Act of the Legislature of the State of Delaware entitled "An Act Providing a General Corporation Law," approved March 10, 1899, and the Acts amendatory thereof and supplemental thereto, do make and file this Certificate, and declare that the facts herein stated are true, and we have accordingly hereunto set our respective hands and seals, this 13th day of August, A. D. 1935.

CLARENCE A. HUME (SEAL)

JAMES S. STIRLING (SEAL)

JAMES F. McCLOSKEY (SEAL)

THEODORE A. WETH (SEAL)

MEETING OF THE BOARD OF DIRECTORS
BLUE CROSS & BLUE SHIELD OF DELAWARE, INCORPORATED

JUNE 25, 1980

AGENDA

I. Announcements

II. Review of Minutes

: Board of Trustees - March 26, 1980
: Special Meeting of the Board of Trustees - May 14, 1980

III. Corporate Bylaws - Confirmation of Approval

IV. Certificate of Incorporation - Adoption of Amendments

V. Committee Reports

: Medical Advisory Committee
: Audit Committee
: Health Care Costs Committee
: Personnel Committee
: Investment Committee
: Executive Committee

VI. Financial Report

VII. Management Report

VIII. Other Business

MEETING OF THE BOARD OF DIRECTORS
BLUE CROSS & BLUE SHIELD OF DELAWARE, INCORPORATED

JUNE 25, 1980

A regular meeting of the Board of Directors of Blue Cross & Blue Shield of Delaware, Inc., was held on Wednesday, June 25, 1980 at 3:00 p.m. in the Corporate offices. The following members of the Board, constituting a quorum were present:

Gene Derrickson, Presiding
Robert H. Bolling, Jr.
Robert C. Cole, Jr.
Ben Corballis, M.D.
L. Vincent Croze, Jr.
Bernard J. Daney
Edward K. Hannigan
Alfred Lazarus, M.D.
John M. Levinson, M.D.
Harry W. Lynch, Jr.
C. Raeford Minix
Howard W. Papen
Frances M. West
Morris E. Williams

The following members of staff were also in attendance: Messrs. Charles R. Richards, W. Michael Ireland, Ms. Patricia Nolan and Ms. Brenda Betty. Distributed to each member prior to the meeting was a kit containing:

- A Corporate Bylaws Resolution - Confirmation of Approval
- A Certificate of Incorporation Resolution - Adoption of Amendments
- Financial Report of May, 1980
- A Board of Directors and a Committee Roster

I. Announcements

Mr. Derrickson noted:

- The resignations of Dr. Dobson and Mr. Wiley from the Board though Dr. Dobson will continue to serve on the Board of the Blue Shield Association.
- Mr. Dugan's letter expressing his appreciation for his retirement party, and his years of employment with the Company.

EXHIBIT
JOINT-7

II. Minutes of the Meetings of the Board, March 26, 1980 and May 14, 1980

The minutes of March 26, 1980 meeting and the actions therein were approved as mailed.

The minutes of the special meeting of May 14, 1980 and the actions therein were approved with a correction to reflect the attendance of Mr. Bolling at the meeting.

III. Bylaws and Certificate of Incorporation Amendments

A. Based upon the discussions and vote of the Board at its May 14, 1980 special meeting, Mr. Ireland read to the Board the following resolution:

RESOLUTION

WHEREAS, The Board of Trustees of Blue Cross & Blue Shield of Delaware, Incorporated adopted new Bylaws for the Corporation on May 14, 1980 at a special meeting of said Board which was convened upon proper notice; and

WHEREAS, the Board of Trustees did make certain changes to said Bylaws at the May 14, 1980 special meeting which were not part of the Bylaws described in the notice for the special meeting:

NOW THEREFORE BE IT RESOLVED That the Board of Trustees of Blue Cross & Blue Shield of Delaware, Incorporated reaffirms its adoption of the attached Bylaws which are identical to the Bylaws presented for adoption at the May 14, 1980 special meeting except for the incorporation of certain changes made at said May 14, 1980 special meeting and for the correction of certain typographical errors.

The resolution was made, seconded and unanimously adopted.

B. Mr. Ireland then read the following resolution in regard to the Corporation's Certificate of Incorporation:

WHEREAS, the Board of Trustees of Blue Cross & Blue Shield of Delaware, Incorporated did, at a special meeting of said Board held upon proper notice, on May 14, 1980, declare the advisability of the following amendments to the Certificate of Incorporation of said Corporation;

RESOLVED That the Board of Trustees of Blue Cross & Blue Shield of Delaware, Incorporated hereby adopts the following amendments to the Certificate of Incorporation of said Corporation:

a) Amend the Second Article of Incorporation by deleting the word "resident" and inserting in lieu thereof the word "registered".

b) Amend the Third Article of Incorporation by deleting it in its entirety and insert in lieu thereof the following:

Third: The purposes of this Corporation shall be: to develop, market and underwrite all types of health insurance and other employee benefit programs at reasonable cost: to promote policies and programs which foster effective health care cost containment; to act as underwriter or administrator for the administration of governmental health care programs; to provide all types of health services; to assist individuals in defraying the costs of all types of health services; to do all things in any way related to or connected with these purposes and to engage in any lawful act for which corporations may be organized under the General Corporation Law of the State of Delaware.

c) Amend the Fourth Article of Incorporation by deleting the phrase "is not a Corporation organized for profit and shall not have the authority to issue capital stock" and inserting in lieu thereof the phrase "shall be operated as a private not-for-profit Corporation and shall not have the authority to issue capital stock".

d) Amend the Eighth Article of Incorporation by changing the name of the Corporation's governing body from "Board of Trustees" to "Board of Directors" and effectuate such a change by deleting the words "carried on by a Board of Trustees" and inserting in lieu thereof the words "managed under the direction of a Board of Directors" and by deleting the word "Trustees" as it last appears in such article and inserting in lieu thereof the word "Directors". Aside from the change in title of the incumbent members of the governing body, their status shall not otherwise be impacted.

e) Amend the Ninth, Tenth, Twelfth and Thirteenth Articles of Incorporation by deleting the word "Trustees" wherever it appears and inserting in lieu thereof the word "Directors".

FURTHER RESOLVED That the President and Secretary of the Corporation are hereby authorized to integrate these amendments into the existing Certificate of Incorporation to form a single instrument to be known as the "Restated Certificate of Incorporation" and to execute, acknowledge, file and record such Restatement as required by law and to take such other actions as may be required to implement and effectuate such Restatement

The resolution was moved, seconded and unanimously adopted.

IV. Committee Reports:

Medical Advisory Committee - Dr. Lazarus, Committee Chairman, reported that at its last meeting the Committee had dealt with a number of issues. Specifically, he noted that the Committee had:

- Reviewed a request from the Urology Department of the Wilmington Medical Center for the reimbursement of urological surgical assistants and then determined that such request should be denied.

- Reviewed the Corporation's reimbursement policy in regard to assistants at surgery in the downstate Delaware hospitals and a report from a subcommittee of the State Medical Society's Medical Review Committee. The Medical Advisoty Committee reaffirmed the policy of reimbursement based upon an hourly rate of reimbursement and agreed with management's recommendation that the current hourly rate be revised to a more reasonable amount related to the services being rendered with the provision that the reimbursement allow for individual review of exceptional cases.

- Reviewed the issue of whether a new procedure code should be established for the day of discharge for medical visits and determined that such a code should not be established, since routine, intermediate and extended Blue Shield codes for medical visits already exist, and physicians have ample Blue Shield codes to identify the level of care rendered.

- Reviewed the issue of whether a separate code should be established for flexible sigmoidoscopy and agreed to the establishment of a separate code and allowance for the procedure, since a flexible sigmoidoscopy is a procedure that is distinctly different (both professional and technical component) from a rigid sigmoidoscopy.

Further, Dr. Lazarus reported that the Committee had received information status reports in regard to the physician lecture series, the annual recomputation of fees and the Corporation's new footcare guidelines.

The report was adopted as presented.

Nominating Committee - Dr. Levinson, Committee Chairman, noted that he had held a meeting with Mr. Cole and Mr. Derrickson to discuss the role of the Committee. He stated that there are opportunities for three new members on the Board. He noted that the Corporation needs individuals on the board which represent a variety of interests, skills and experience rather than only representing a segment of the population. For example, a needed skill is in the area of dentistry, because of our growing dental

IV. Committee Reports: (Cont'd)

program. Dr. Levinson indicated that if any Board member had individuals in mind for the vacant board position, he or she should report the name to Mr. Cole or Dr. Levinson so that the Nominating Committee can consider such suggestions at a future meeting. It was noted that the Nominating Committee will be meeting within the next several months to work on these nominations.

Audit Committee - Mr. Bolling, Committee Chairman, noted that at the last meeting of the Committee, it had:

- Recommended to the Executive Committee the continued retention of Arthur Anderson and Company as the Corporations auditors, and
- Reviewed the progress of the Corporation's Internal Auditors.

The report was accepted as presented.

Health Care Costs Committee - Chairman Frances West reported that at its meeting of May 21, 1980, no issues were raised that would require Board approval; however, the Committee had received an informational presentation on the HMO project. The Committee was advised that Corporate management, in order to thoroughly assess the nature and extent of Corporate possible involvement in HMOs, five to six months of further analysis would be required prior to making a recommendation to the Board. However, the Corporation is prepared to move more quickly if competition threatens. In addition, it was reported that the Corporation has responded to the DuPont Company's position on competition and is working through the issue with officials of that organization.

In addition to the above, the Committee received a report on hospital contract negotiations, which compared the principles the Corporation had sought in negotiations and what has been agreed to in principle with the hospitals. Further, it was reported that a new hospital contract is expected to be effective July 1, 1980 and will embody virtually all of the principles sought by the Corporation.

The report was accepted as presented.

Executive Committee - Mr. Derrickson reviewed with the Board the activities of the Executive Committee at its April, May and June, 1980 meetings. In summarizing the activities, he noted that among other items the Committee had:

IV. Committee Reports: (Cont'd)

- reviewed reports from Management in regard to the financial position of the Corporation and its relations with the State Insurance Commissioner;
- reviewed the Corporation's decision as to the Brandywine Gateway Project;
- reviewed routine reports on legislative matters, the HMO and litigation with Milford Hospital under the Medicare Part A subcontractor;
- reviewed reports and discussed the Customer Service Improvement Project;
- approved W. Michael Ireland as Vice President Corporate Relations, Peter Sparber as Vice President Public Affairs and Brenda Betty as Assistant Corporate Secretary (replacing Patricia Nolan who had been promoted).
- reviewed the Corporation's additional office space. He noted that Management is reviewing the Corporation's future growth and the Corporation's space needs on a long-term basis (five to fifteen years).

The report was accepted as presented.

Personnel Committee – In the absence of the Committee Chairman, Mr. Cole reported that at the Committee's June 4, 1980 meeting, the Personnel Committee had reviewed the thrift plan study prepared by Management. Included in this review was:

- introduction of the concept of a thrift plan;
- advantages of a thrift plan both to the employer and to the employee;
- thrift plan provisions;
- implementation process;
- costs;
- COWPS considerations.

Management had asked that the Committee approve the concept of the program design and the implementation process. These steps would allow further work to proceed but without a firm commitment to implement the plan. Following discussion, the Committee approved the concept of a thrift plan and asked Management to come back with firmer details on its administration including fiduciary accountabilities and greater detail as to implementation.

After a discussion, during which it was noted that the Board would continue to receive reports on this subject, the report was adopted.

V. Financial Report

Mr. Crouch reviewed with the Board the May, 1980 Financial Report noting specifically:

- On page 2, that the year-to-date operating loss of $1.9 million was due primarily to a postponement of the Corporation's rate increases, while a new rate making and implementation process was being effected.
- On page 3, that the majority of the operating loss had occurred in the Medical/Surgical area where utilization was on the upswing for the first time in a number of years.
- On page 4, that the Corporation was overbudget on a year-to-date basis due primarily to unexpected overtime costs associated with the claim backlogs during the first part of the year.
- On page 5, that the difference in the Corporation's investment portfolio between market value and carrying value had been reduced from $7.5 million to $3.3 million.
- On page 7, that the Corporation's reserves were now at 2.2 months and decreasing. He indicated that the situation was not yet critical and will be reversed as the required rate increases are put into effect.

VI. Management Report

Mr. Cole reviewed the May 1980 Management Report. He noted that the Medicare Part B contract negotiations with the Federal Government had resulted in a move to combine this Corporation's Medicare Part B functions with those of Blue Shield of Pennsylvania. He indicated that this action was consistent with the Health Care Financing Administration's (HCFA) objectives of integrating Medicare Parts A & B and Medicaid contracts and reducing the number of Medicare contractors. He pointed out that this action in Delaware has been a long term goal of HCFA having tried to cancel the contract in 1976 or 1977. However, the Corporation had been able to convince them to reverse that decision at that time.

The HCFA direction could be considered logical since this Corporation processes only 350,000 claims per year compared to Pennsylvania Blue Shield's 8 million claims per year. Recognizing that one of HCFA's goals was to improve performance, the Corporation previously negotiated with HCFA to install a new computer system called Model B System, which was a federally financed program. The new Model B

VI. Management Report (Cont'd)

System was installed in October 1979 and is now running smoothly. On June 12, 1980, HCFA called a meeting at which time they indicated that the government was not going to renew the Corporation's Medicare Part B contract and that they would give the Corporation a written notice on June 30 of such non renewal. Government representatives, however, stated that their real desire was to encourage this Corporation to become a subcontractor under Pennsylvania Blue Shield with Delaware performing certain functions locally. Management agreed to explore this opinion and given a configuration which would be in the best interests of the Corporation, Delaware Medicare beneficiaries and providers, and the tax payers, the Corporation would participate.

Under the initial HCFA proposal, the Medicare claims would go directly to Pennslyvania Blue Shield in Camp Hill. Management proposed a more significant subcontracting role for this Corporation which would still save administrative costs for the Medicare Program while maintaining local provider and beneficiary service. While no decisions had been made as of this date, Mr. Cole indicated that it would be a long and difficult process and that he would keep the Board advised on this topic.

VII. Other Business

Mr. Cole then asked Mr. Richards to review with the Board the Corporation's progress against its cost containment program.

Mr. Richards reviewed the cost containment program started in 1977 which was to be carried out over time and which would directly and indirectly impact increases in health care costs. Further, he noted the program was divided into two distinct elements - price and utilization.

1) On the price side he reported the following activities:

Hospital Contract Negotiations -

- 6 of the 7 state hospitals are in agreement in principle as to a new hospital contract. There will probably be a meeting in July to see if the outstanding concerns can be resolved.

- Rockford Center and Kent General Hospital - The Corporation actively opposed the purchase of the Rockford Center by another party because the sale would increase the center's costs without any corresponding benefit. In the Kent General matter, the Corporation had opposed a part of that Hospital's expansion project on a cost basis.

VII. Other Business

- Cat Scanner – The Corporation is active in health planning process in regard to decisions for additional CAT Scanners in Delaware.

- Physician Charges - The Corporation negotiated annual prevailing fee limitation agreements and is presently working with Medical Society to resolve inequities with U&C System.

2) On the Utilization or volume side of the equation Mr. Richards reported that:

- The Hospital Contract – A new utilization review provision under which each Hospital agrees to undertake a utilization review program for Blue Cross subscribers with ability on the part of the Corporation to monitor and evaluate the effectiveness of each Hospital and meet to resolve any ineffectiveness.

- Physician Utilization Review – The Corporation has worked with the physicians on a number of issues including the National Medical Necessity project, the utilization of Ultra Sound Devices, Second Opinion Program and the Pre-Admission Program.

- Alternative Systems – The Board was reminded of the Corporation's HMO project and its progress to date. Further, it was reported that competition from one of the Philadelphia HMOs was possible in Northern Delaware.

- Benefit Administration – Progress has been made in updating the Corporation's Surgical/Medical and Dental Claims policies and tightening up the administration of noncovered services contractual provisions.

- Subscriber Education – The Corporation has made significant strides in this regard in the establishment of Governor's Health Week; participation and sponsorship of various fitness activity - Fitness days and Marathons; and Lifecourse in State and County parks; and in the creation and continued publication of SNOOPER.

- Employee Health Education – The Corporation has begun to test its Employee Health Education program with its own employees. As the experiment continues, it will be expanded into other employers' work sites.

VII. Other Business (Cont'd)

He summarized that the programs that the Corporation had offered have helped cut down on our hospital in-patient care. The admission rate dropped 4% in 1979. This is the lowest drop since 1969. He noted that many of the Corporation's initiatives can not be quantitatively measured as to their effectiveness and thus a need exists to develop more significant effectiveness measures.

Dr. Lazarus reminded the Board that there was another side to the CAT Scanner issue. He commented that rather than limiting the growth of the diagnostic tools, the Corporation should be encouraging more both upstate and downstate. His opinion was based upon the fact that the Scanners are valuable improvements in the diagnostic techniques and also that they are used in lieu of additional hospital utilization and surgical explorations; thus, they have a positive impact on cost containment.

Dr. Levinson suggested that in developing measurement means that the Corporation consider working with DELRO. Management indicated that exploration of this was already underway.

Mr. Derrickson complemented Management on its efforts and requested that the subject of the alcoholism and drug abuse be addressed at a future meeting.

VIII. Adjournment

The meeting adjourned at 4:50 p.m.

Respectfully submitted,

W. Michael Ireland
Secretary

Delaware Healthcare Association

Wayne A. Smith
President & CEO

June 1, 2011

RECEIVED BY
JUN 10 2011
Timothy J. Constantine

Linda Sizemore
Director of Company Regulation
Delaware Department of Insurance
841 Silver Lake Boulevard
Dover, DE 19904-2465

Dear Ms. Sizemore,

On behalf of the Board of Directors of the Delaware Healthcare Association, I am pleased to submit this letter of support for the proposed affiliation between Blue Cross Blue Shield of Delaware and Highmark.

Following investigation of the transaction, interaction with Highmark executives and discussions with counterparts in West Virginia whose Blue Cross Blue Shield underwent a similar affiliation with Highmark, our Board has the opinion that the affiliation is in the best interests of the citizens of Delaware. Among the reasons are:

1. Discussions with the West Virginia Hospital Association indicate the affiliation with Highmark in that state was invisible to providers in terms of transactional interface between hospitals and Blue Cross Blue Shield of West Virginia and the technology improvements wrought by the affiliation were positive for healthcare delivery;
2. Blue Cross Blue Shield of Delaware is in need of significant investment in technology to deliver to providers and their insured state of the art services and products. We are persuaded that absent an affiliation, Blue Cross Blue Shield of Delaware will have to pursue upgrades on their own at a cost factor several times that available to them via affiliation with Highmark;
3. Blue Cross Blue Shield of Delaware is likely to pursue affiliation with some party if not Highmark. This introduces risk that another party may not be as advantageous a partner for Delaware insured or providers;
4. Safeguards in terms of post-affiliation board membership as well as protection of local reserves are adequate to provide on-going financial stability for Blue Cross Blue Shield of Delaware as well the ability of decisions to be influenced locally.
5. The affiliation is neither a merger nor acquisition. Rather, this affiliation represents an avenue for Blue Cross Blue Shield of Delaware to avail themselves to very reasonably priced technological upgrades while preserving the structure, assets, and locus of decision making that make it a Delaware institution.

Blue Cross Blue Shield of Delaware's small size relative to other insurance companies, the dramatically changing landscape due to national healthcare reform, and the need for Blue Cross Blue Shield of Delaware to upgrade technology to remain competitive present a challenging environment for Delaware's largest health insurer. A substantial investment is required of Blue Cross Blue Shield of Delaware to

1280 South Governors Avenue Dover, Delaware 19904-4802
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www.deha.org

EXHIBIT
JOINT-8

remain competitive and offer efficient health insurance products and coverage options. Without such an investment, Blue Cross Blue Shield of Delaware risks obsolescence in terms of service and product offerings on a relative basis. In order to meet the investment challenge, Blue Cross Blue Shield of Delaware has a dramatically lower cost option via affiliation with Highmark that would be available to it on a stand-alone basis.

Our association is confident that this affiliation is in the best interests of Delaware as proposed. It has been my pleasure to offer this letter of support on behalf of the Delaware Healthcare Association.

Sincerely,

Wayne A. Smith
President & CEO

Highmark WV

Staffing and Financial Metrics

Years	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
FTE Staffing	673	671	737	815	824	866	869	891	980	990	949	869
TPA Staffing	-	-	-	62	70	71	121	236	360	322	316	295
Membership												
U/W	126,494	141,407	148,872	158,210	164,725	173,110	171,064	176,243	170,223	183,092	182,349	175,977
Non-Risk	52,470	58,685	59,981	54,529	64,404	74,560	74,474	76,399	93,415	87,866	82,606	98,598
National	42,391	35,075	32,794	30,003	25,175							
ITS/BlueCard	30,450	26,611	22,876	120,413	159,895	175,820	187,514	212,478	235,452	254,919	275,615	273,526
Total	251,805	261,778	264,523	363,155	414,199	423,490	433,052	465,120	499,090	525,877	540,570	548,101
Financial Reporting ***(in thousands)***												
MSR from Highmark	-	-	-	1,216	2,510	3,217	7,313	7,308	14,459	19,161	21,016	27,393
Highmark Charges	328	1,831	4,994	6,290	5,408	6,697	9,301	10,675	14,129	15,391	16,836	31,132
BluePrint Project	-	-	-	-	-	10,109	13,823	-	-	-	-	-
BluePrint Project MA	-	-	-	-	-	-	1,367	-	-	-	-	-
Stat Net Income	3,666	6,341	9,595	12,337	31,273	25,774	24,385	21,181	41,802	49,623	5,344	30,553
STAT Surplus Note	4,180	3,740	3,300	2,860	2,420	-	-	-	-	-	-	-
Reserves	14,469	20,930	28,279	36,996	75,658	87,348	99,149	122,011	164,082	205,315	212,779	241,702
Total Surplus	18,649	24,670	31,579	39,856	78,078	87,348	99,149	122,011	164,082	205,315	212,779	241,702
RBC	276	258	284	312	562	529	562	583	795	1004	879	1013

Note:

In 2007-08, the Antares contract expired resulting in some of the staff members being transferred to the Highmark FEP account in late 2007 with the remaining staff being transferred in 2008. The initial training cost was assumed by Highmark WV which is why reimbursement from Highmark does not correspond to the TPA member count at 12/31/2007.

EXHIBIT
JOINT-12

DEPARTMENT OF JUSTICE
820 NORTH FRENCH STREET
WILMINGTON, DELAWARE 19801

JOSEPH R. BIDEN, III
ATTORNEY GENERAL

PHONE (302) 577-8338
FAX (302) 577-2610

May 31, 2011

Via Email and U.S. Mail

David S. Swayze, Esquire
Parkowski, Guerke & Swayze, P.A.
800 King Street, Suite 203
Wilmington, De 19801

RE: Proposed Affiliation of BCBSD, Inc. ("BCBSD") with Highmark, Inc. ("Highmark")

Dear David:

I write in regards to the Department of Justice's review of the proposed affiliation (the "Affiliation") of BCBSD and Highmark pursuant to 29 *Del. C.* §§ 2531 *et seq.* (the "Conversion Act").

The Department of Justice has concluded that the Affiliation constitutes a not-for-profit healthcare conversion transaction under 29 *Del. C.* § 2531(1)(c). Accordingly, a tax-exempt public benefit or charitable organization or foundation must be established, pursuant to 29 *Del. C.* § 2533, for "proceeds or reserves" of the conversion transaction that constitute "public benefit assets."

The Department of Justice, with the assistance of our financial expert, intends to continue to perform a valuation analysis to determine the amount of "proceeds or reserves" of the conversion transaction that constitute "public benefit assets", as defined in *29 Del. C.* § 2531(5). We will also continue our review pursuant to 29 *Del. C.* §§ 2530 *et seq.*, including § 2533(k) and our common law authority, and as a party to the review by the Insurance Commissioner.

Very truly yours,

Joseph R. Biden, III

Joseph R. Biden, III

c.c. (via email):
Charles E. Butler, Esquire

EXHIBIT
JOINT-14

Timothy E. Mullaney, Sr., Esquire
Ian R. McConnel, Esquire
Meredith S. Tweedie, Esquire
Michael Houghton, Esquire
Leslie Polizoti, Esquire
Rick Campbell, Esquire
Doak Foster, Esquire
Michael W. Teichman, Esquire
William Kirk, Esquire
Cynthia Shoss, Esquire
Grace Vandecruze

SPONSOR: Sen. Blevins & Rep. B. Short
Sen. Simpson; Reps. Gilligan, Hocker & D. Short

DELAWARE STATE SENATE
146th GENERAL ASSEMBLY

SENATE BILL NO. 146

AN ACT TO AMEND TITLES 18 AND 29 RELATING TO NOT FOR PROFIT HEALTH CARE CONVERSIONS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend §2531(1)c., Title 29 of the Delaware Code by striking §2531(1)c. in its entirety and replacing it with the following:

"c. A substantial change or amendment to a certificate of incorporation which materially affects a not-for-profit healthcare entity's charitable or public benefit intent, or the disposition of reserves or control of a not-for-profit healthcare entity to an entity or a person other than a charity or not-for-profit entity."

Section 2. Amend Subchapter III, Chapter 25, Title 29 of the Delaware Code by adding a new §2534 to read as follows:

"§2534. Annual Report to Secretary of State.

In the event of a Not-for-profit healthcare conversion transaction, the new owner shall submit an annual report to the Delaware Secretary of State providing the status of reserves, the amount and source of funding received, and the amount and purpose of expenditures."

Section 3. Amend Chapter 63, Title 18 of the Delaware Code by adding a new §6310 to read as follows:

"§ 6310. Acquisitions of Control.

In the event that a health service corporation proposes to enter into a transaction through which it will become controlled by another entity, which transaction is not a not-for-profit healthcare conversion transaction under Subchapter III of Chapter 25 of Title 29, any approval of the change of control shall be conditioned upon appropriate measures designed to preserve the surplus or reserves of the health service corporation for the use of said health service corporation for the benefit of said health service corporation's subscribers."

Section 4. This legislation shall be applicable to all transactions that shall close on and after the effective date.

SYNOPSIS

This bill corrects certain flaws in Delaware's Not-for-profit Healthcare Conversion Act (the "Act") enacted in 2004. The bill clarifies the General Assembly's intent that the Act does not consider a Delaware not-for-profit healthcare entity affiliation with another not-for-profit entity to be a "not for profit healthcare conversion." The Act has recently been interpreted by the Delaware Attorney General as requiring that result in a specific transaction involving a not-for-profit

SD : TGW : vls
0781460166

Jun 21, 2011

EXHIBIT
JOINT-15

Delaware health service corporation seeking to affiliate with another not-for-profit company, where both entities will retain their not-for-profit status post affiliation. The bill corrects language in the Act that on its face requires the same result for any not-for-profit entity or charity that decides to dispose of its reserves or control by charter change or otherwise, even if it is not a health care-related entity, and even if the change involves another not-for-profit entity.

In the event of a Not-for-profit conversion, the bill requires an annual financial report to the Secretary of State. Also, this bill adds a new §6310 to Title 18 that ensures that change of control transactions involving Delaware health service corporations do not result in the dissipation or improper use of the reserves or surplus of such health service corporation.

Author: Senator Blevins

SD : TGW : vls
0781460166

Jun 21, 2011

Draft
Confidential Pursuant to 18 Del. C. 321(g)

Blue Cross Blue Shield of Delaware
Stand Alone Basis - Five Year Forecast (2011 Through 2015) - Current Version
August 3, 2011

Stand Alone Basis	2010	2011	2012	2013	2014	2015
Member months	4,779	4,752	4,660	4,537	4,408	4,272
Premium revenue	$ 498,655	$ 518,409	$ 540,293	$ 543,700	$ 540,373	$ 546,335
Self funded fees	38,277	36,840	36,360	36,170	36,034	35,347
Other	13,160	15,905	15,942	15,942	15,942	15,942
Total revenue	550,091	571,153	592,594	595,812	592,350	597,624
Cost of care	424,007	441,867	458,796	461,687	459,167	464,155
SG&A expenses	117,784	124,737	124,776	125,655	128,220	130,965
Capability enhancement expense	-	700	2,327	5,368	12,880	31,625
Total operating expenses	541,791	567,305	585,899	592,710	600,267	626,745
Gain (loss) from operations	8,300	3,848	6,695	3,102	(7,918)	(29,122)
Investment income, net	11,635	8,792	8,048	7,182	6,406	5,761
Income (loss) before income taxes	19,935	12,640	14,744	10,284	(1,512)	(23,360)
Income taxes	4,084	2,651	2,949	2,057	(302)	(4,672)
Net income (loss)	$ 15,851	$ 9,989	$ 11,795	$ 8,227	$ (1,210)	$ (18,688)

(Amounts in Thousands)

Stand Alone Basis	2010	2011	2012	2013	2014	2015
Cash & short-term Investments	$ 33,727	$ 23,977	$ 25,095	$ 25,395	$ 25,795	$ 27,395
Investments	231,243	236,982	205,917	187,509	161,535	150,685
Uncollected premiums	11,351	16,500	17,112	16,990	16,580	16,522
Amounts receivable from uninsured plans	11,719	12,059	12,662	13,295	13,960	14,658
Property and equipment, net	4,785	5,386	4,561	4,052	3,310	2,890
Other	13,893	13,893	13,893	13,893	13,893	13,893
Total admitted assets	$ 306,718	$ 308,798	$ 279,241	$ 261,134	$ 235,073	$ 226,044
Unpaid claims & claim adjustment expense	$ 37,914	$ 36,675	$ 38,080	$ 38,320	$ 38,111	$ 38,525
Accounts payable	44,931	43,836	44,158	44,654	45,939	46,983
Premiums received in advance	13,794	10,313	10,695	10,619	10,363	10,327
Other liabilities	38,948	38,379	34,273	32,475	30,316	33,882
Capital & surplus	171,131	179,596	152,034	135,066	110,344	96,328
Total liabilities, capital & surplus	$ 306,718	$ 308,798	$ 279,241	$ 261,134	$ 235,073	$ 226,044
Risk-Based Capital %	1,056	1,082	886	784	646	556
SAP Member Months	1,333,092	1,325,946	1,313,075	1,252,165	1,181,241	1,131,213
SAP Member Months / 1000	1,333	1,326	1,313	1,252	1,181	1,131

Capability enhancements							
2011 capital expenditures	$ 5,800	$ -	$ -	$ -	$ -	$ -	$ 5,800
Highmark supported capability enhancements	-	39,245	35,317	31,538	7,900		114,000
Total capability enhancements	5,800	39,245	35,317	31,538	7,900		119,800
Routine capital expenditures	2,200	2,000	2,000	2,000	2,000		10,200
Total capital expenditures	$ 8,000	$ 41,245	$ 37,317	$ 33,538	$ 9,900		$ 130,000

EXHIBIT
JOINT-16

Blue Cross Blue Shield of Delaware
Affiliation Basis - Five Year Forecast (2011 Through 2015) - Current Version
August 10, 2011

	Forecast					
	2010	2011	2012	2013	2014	2015
Contract Months						
Individual < 65	70,970	62,507	60,990	65,038	100,480	131,516
Individual > 65	42,232	41,002	42,373	50,400	64,800	81,150
Small Group	198,509	192,504	193,995	200,716	192,248	186,221
Large Group	303,278	306,242	315,670	317,483	324,153	341,550
Self-Funded	1,189,430	1,151,264	1,124,760	1,124,560	1,168,060	1,228,060
FEP	116,946	118,491	119,544	121,313	123,763	126,261
Medicaid	-	-	-	-	-	-
Ancillary Products - Incremental Impact	-	-	-	-	-	-
Non-Risk Par	622,484	648,540	650,232	650,232	650,232	650,232
Total	2,543,849	2,520,550	2,507,564	2,529,741	2,623,736	2,744,990
Member Months						
Individual < 65	111,427	99,459	97,165	103,612	165,792	217,001
Individual > 65	42,232	41,002	42,373	50,400	64,800	81,150
Small Group	375,731	365,471	368,069	380,822	364,755	353,319
Large Group	587,291	595,628	615,513	619,046	632,052	665,974
Self-Funded	2,274,108	2,201,381	2,150,874	2,150,494	2,233,679	2,348,417
FEP	216,411	224,386	227,023	230,379	235,032	239,776
Medicaid	-	-	-	-	-	-
Ancillary Products - Incremental Impact	-	-	-	-	-	-
Non-Risk Par	1,171,616	1,224,418	1,227,324	1,227,320	1,227,320	1,227,320
Total	4,778,816	4,751,745	4,728,341	4,762,073	4,923,430	5,132,957
Revenue						
Individual < 65	30,179,497	27,357,738	29,265,778	34,172,315	59,874,518	85,813,243
Individual > 65	9,605,173	9,034,940	9,803,897	12,244,170	16,529,630	21,735,315
Small Group	146,860,999	149,186,953	157,008,605	168,621,752	168,775,387	170,840,621
Large Group	210,837,860	227,389,310	245,554,818	257,336,784	274,566,817	302,321,340
Self-Funded	38,276,829	36,839,567	36,894,203	37,809,877	40,254,242	43,380,043
FEP	93,363,351	98,601,288	104,748,060	111,611,339	119,558,849	128,070,687
Medicaid	-	-	-	-	-	-
Ancillary Products - Incremental Impact	-	-	21,375	119,839	259,314	423,950
Stop Loss	7,807,843	7,301,951	-	-	-	-
Non-Risk Par	13,159,674	12,917,804	12,886,902	12,886,860	12,886,860	12,886,860
Total	550,091,226	568,629,552	596,183,638	634,802,937	692,705,617	765,472,059

EXHIBIT
JOINT-17

Blue Cross Blue Shield of Delaware
Affiliation Basis - Five Year Forecast (2011 Through 2015) - Current Version
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	Forecast					
	2010	2011	2012	2013	2014	2015
Incurred Care						
Individual < 65	24,824,225	22,352,422	23,780,349	27,615,080	48,120,231	68,588,886
Individual > 65	6,554,938	7,334,563	7,958,802	9,939,816	13,418,752	17,644,727
Small Group	117,578,327	118,754,901	124,981,045	134,225,272	134,347,567	135,991,523
Large Group	180,007,464	190,297,052	206,482,611	216,597,522	232,205,590	256,901,378
Self-Funded	-	-	-	-	-	-
FEP	89,282,889	94,667,954	100,569,524	107,159,017	114,789,491	122,961,780
Medicaid			-	-	-	-
Ancillary Products - Incremental Impact	-	-	-	-	-	-
Stop Loss	5,759,312	7,557,010	-	-	-	-
Non-Risk Par	-	-	-	-	-	-
Total	424,007,155	440,963,901	463,772,331	495,536,707	542,881,631	602,088,294
Contribution Margin						
Individual < 65	5,355,272	5,005,317	5,485,429	6,557,234	11,754,287	17,224,357
Individual > 65	3,050,235	1,700,377	1,845,094	2,304,354	3,110,878	4,090,589
Small Group	29,282,672	30,432,053	32,027,560	34,396,480	34,427,819	34,849,098
Large Group	30,830,396	37,092,259	39,072,207	40,739,263	42,361,227	45,419,962
Self-Funded	38,276,829	36,839,567	36,894,203	37,809,877	40,254,242	43,380,043
FEP	4,080,462	3,933,334	4,178,537	4,452,322	4,769,358	5,108,907
Medicaid	-	-	-	-	-	-
Ancillary Products - Incremental Impact			21,375	119,839	259,314	423,950
Stop Loss	2,048,531	(255,059)	-	-	-	-
Non-Risk Par	13,159,674	12,917,804	12,886,902	12,886,860	12,886,860	12,886,860
Total	126,084,071	127,665,650	132,411,307	139,266,229	149,823,986	163,383,765
Broker Fees	17,497,338	17,773,946	18,790,344	19,647,301	20,948,551	22,539,116
General & Administrative - Fixed	92,868,452	47,940,000	49,378,200	50,859,546	52,385,332	53,956,892
General & Administrative - Variable Ex. Medicaid		50,812,909	52,079,517	54,024,584	57,530,795	61,778,514
General & Administrative - Variable - Medicaid		-	-	-	-	-
General & Administrative - Affiliation						
General & Administrative - Other		500,000				
General & Administrative - ITS AEA Reclass	5,000,000	-				
Corporate Initiatives - Health Care Reform	-	400,000	400,000	400,000	400,000	400,000
Corporate Initiatives - Affiliation / Integration	-	1,000,000	-	-	-	-

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Corporate Initiatives - Medicaid Implemnetation	-	-	-	-	-	-
Corporate Initiatives - Other	-	-	-	-	-	-
Disease Management	-	2,402,095	2,474,158	2,548,382	2,624,834	2,703,579
2011 Capital Expenditures - Depreciation	-	700,000	2,326,667	2,326,667	1,630,000	-
Capability Enhancements - Depreciation	-	-	-	2,916,667	11,666,667	11,666,667
Capability Enhancements - Support Expense	-	-	-	-	-	-
Integration Planning Consulting (See Note a)	-		150,000	-	-	-
Highmark Support Charges (See Note b)			3,447,000	7,722,000	20,702,000	21,659,000
Affiliation Synergies (See Note c)	-	-	(3,430,000)	(9,166,000)	(23,421,000)	(23,421,000)
Marketing / Communication / Branding	-		1,500,000	750,000	-	-
Community Related Expense - Part 1	787,468	750,000	750,000	750,000	750,000	750,000
Non Recurring Carveout, Net	-	-	-	-	-	-
Total Operating Expenses	116,153,258	122,278,950	127,865,885	132,779,147	145,217,178	152,032,768
Underwriting Gain/(Loss)	**9,930,813**	**5,386,701**	**4,545,423**	**6,487,083**	**4,606,808**	**11,350,997**
Investment Income	11,635,000	8,791,568	8,234,836	8,345,701	8,876,910	9,851,746
FAS 115	-	-	-	-	-	-
Income Before Taxes	21,565,813	14,178,269	12,780,259	14,832,783	13,483,717	21,202,743
Provision for Income Tax	4,084,000	2,735,381	2,333,931	2,708,763	2,462,396	3,872,045
Community Related Expense - Part 2	1,631,080	1,233,509	1,111,883	1,290,452	1,173,083	1,844,639
Net Income/(Loss) from Operations	15,850,733	10,209,378	9,334,445	10,833,568	9,848,237	15,486,060
Non Recurring Carveout, Net	-	-	-	-	-	-
Net Income/(Loss)	15,850,733	10,209,378	9,334,445	10,833,568	9,848,237	15,486,060
SG&A expenses	117,784,338	122,812,459	126,651,100	128,826,265	133,093,595	142,210,740
Capability enhancements	-	700,000	2,326,667	5,243,333	13,296,667	11,666,667
Total operating expenses	117,784,338	123,512,459	128,977,767	134,069,599	146,390,262	153,877,406
Gain (loss) from operations	8,299,733	4,153,191	3,433,540	5,196,630	3,433,724	9,506,359
Investment income, net	11,635,000	8,791,568	8,234,836	8,345,701	8,876,910	9,851,746
Income (loss) before income taxes	19,934,733	12,944,759	11,668,376	13,542,331	12,310,634	19,358,105
Income taxes	4,084,000	2,735,381	2,333,931	2,708,763	2,462,396	3,872,045
Net income (loss)	15,850,733	10,209,378	9,334,445	10,833,568	9,848,237	15,486,060

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	Forecast					
	2010	**2011**	**2012**	**2013**	**2014**	**2015**
Revenue PMPM						
Individual < 65	270.85	275.07	301.20	329.81	361.14	395.45
Individual > 65	227.44	220.35	231.37	242.94	255.09	267.84
Small Group	390.87	408.20	426.57	442.78	462.71	483.53
Large Group	359.00	381.76	398.94	415.70	434.41	453.95
Self-Funded	16.83	16.73	17.15	17.58	18.02	18.47
FEP	431.42	439.43	461.40	484.47	508.69	534.13
Medicaid	-	-	-	-	-	-
Stop Loss	NA	NA	NA	NA	NA	NA
Non-Risk Par	11.23	10.55	10.50	10.50	10.50	10.50
Commercial Risk	**355.95**	**374.89**	**393.22**	**409.38**	**423.45**	**440.79**
Incurred Care PMPM						
Individual < 65	222.78	224.74	244.74	266.52	290.24	316.08
Individual > 65	155.21	178.88	187.83	197.22	207.08	217.43
Small Group	312.93	324.94	339.56	352.46	368.32	384.90
Large Group	306.50	319.49	335.46	349.89	367.38	385.75
Self-Funded	NA	NA	NA	NA	NA	NA
FEP	412.56	421.90	442.99	465.14	488.40	512.82
Medicaid	-	-	-	-	-	-
Stop Loss	NA	NA	NA	NA	NA	NA
Non-Risk Par	NA	NA	NA	NA	NA	NA
Loss Ratio						
Individual < 65	82.3%	81.7%	81.3%	80.8%	80.4%	79.9%
Individual > 65	68.2%	81.2%	81.2%	81.2%	81.2%	81.2%
Small Group	80.1%	79.6%	79.6%	79.6%	79.6%	79.6%
Large Group	85.4%	83.7%	84.1%	84.2%	84.6%	85.0%
Self-Funded	NA	NA	NA	NA	NA	NA
FEP	95.6%	96.0%	96.0%	96.0%	96.0%	96.0%
Medicaid	NA	NA	NA	NA	NA	NA
Stop Loss	73.8%	103.5%	NA	NA	NA	NA
Non-Risk Par	NA	NA	NA	NA	NA	NA
833(b) MLR Calculation	85.5%	84.8%	84.9%	84.9%	85.0%	85.1%
Risk MLR	85.0%	85.0%	84.9%	84.9%	84.9%	84.9%

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	2010	**2011**	**2012**	**2013**	**2014**	**2015**
General & Administrative - pMpm						
General & Administrative - Fixed		10.09	10.39	10.70	11.02	11.36
General & Administrative - Variable Ex. Medicaid		10.69	11.01	11.34	11.69	12.04
General & Administrative - Variable - Medicaid		16.04	16.52	17.02	17.53	18.05
General & Administrative - Other						
General & Administrative - Total	**24.31**	**25.73**	**27.04**	**27.88**	**29.50**	**29.62**
Broker Commissions						
Individual < 65			6.20%	5.78%	5.19%	4.84%
Individual > 65			1.40%	1.36%	1.32%	1.28%
Small Group			5.50%	5.40%	5.28%	5.15%
Large Group			2.90%	2.84%	2.77%	2.70%
Self-Funded			0.90%	0.90%	0.89%	0.89%
Broker Commissions						
Individual < 65			1,814,478	1,973,591	3,110,091	4,152,142
Individual > 65			137,255	166,521	218,380	278,950
Small Group			8,635,473	9,113,344	8,903,439	8,796,778
Large Group			7,121,090	7,305,217	7,607,878	8,176,510
Self-Funded			332,048	338,629	358,762	384,734
New Sales / Retention Programs			750,000	750,000	750,001	750,002
Total			18,790,344	19,647,301	20,948,551	22,539,116
Broker Commissions - Per Contract						
Individual < 65			29.75	30.35	30.95	31.57
Individual > 65			3.24	3.30	3.37	3.44
Small Group			44.51	45.40	46.31	47.24
Large Group			22.56	23.01	23.47	23.94
Self-Funded			0.30	0.30	0.31	0.31
Community Related Expense Detail						
State Tax Proxy	787,468	750,000	750,000	750,000	750,000	750,000
Community Contributions	1,631,080	1,233,509	1,111,883	1,290,452	1,173,083	1,844,639
Total	2,418,548	1,983,509	1,861,883	2,040,452	1,923,083	2,594,639

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		Forecast				
	2010	2011	2012	2013	2014	2015
Expected Net Income		10,209,378	9,334,445	10,833,568	9,848,237	15,486,060
True Up Section		10,209,378	9,318,836	10,833,578	9,848,251	15,486,061
Cash & Short Term Investments - % of Expenses	6.5%	6.8%	6.4%	6.1%	5.8%	5.6%
Balance Sheet (GAAP Basis)						
Cash & Short Term Investments	35,056,000	35,056,000	35,056,000	35,056,000	35,056,000	35,056,000
Cash & Short Term Investments		3,000,000	3,000,000	3,000,000	5,000,000	7,000,000
Investments	239,664,000	237,488,582	233,073,476	243,823,716	263,428,265	299,528,645
Uncollected Premiums	12,169,000	12,389,068	13,248,993	14,171,251	15,592,391	17,421,316
Amounts Receivable from Uninsured Plans	11,485,000	12,059,250	12,662,213	13,295,323	13,960,089	14,658,094
Property & Equipment, (Net)	18,962,000	26,087,333	42,625,667	46,734,000	38,163,667	21,540,000
Other	31,346,000	33,346,000	35,346,000	37,346,000	39,346,000	41,346,000
Total Assets	348,682,000	359,426,233	375,012,348	393,426,290	410,546,412	436,550,054
Short-term Borrowing	9,930,000	9,930,000	9,930,000	9,930,000	9,930,000	9,930,000
Unpaid Claims & Claim Adjustment Expense	35,286,000	36,600,004	38,493,103	41,129,547	45,059,175	49,973,328
Accounts Payable	42,941,000	44,024,628	45,552,203	46,310,909	47,915,534	51,124,858
Premiums Received in Advance	10,737,000	10,324,224	11,040,827	11,809,376	12,993,659	14,517,763
Other Liabilities	63,334,000	63,334,000	63,334,000	63,334,000	63,334,000	63,334,000
Other Liabilities		(1,450,000)	664,391	4,081,066	4,634,414	5,504,415
Capital & Surplus	186,454,000	196,663,378	205,997,824	216,831,392	226,679,630	242,165,689
Total Liabilities, Capital & Surplus	348,682,000	359,426,233	375,012,348	393,426,290	410,546,412	436,550,054
Edit Check (Must Be Zero)		-	-	-	-	-
Balance Sheet (GAAP/SAP Adjustments & Non-Admitted Asset Impact)						
Cash & Short Term Investments	(1,329,000)	(1,329,000)	(1,329,000)	(1,329,000)	(1,329,000)	(1,329,000)
Investments	(8,421,000)	(8,500,000)	(8,500,000)	(8,500,000)	(8,500,000)	(8,500,000)
Uncollected Premiums	(818,000)					
Amounts Receivable from Uninsured Plans	234,000					
Property & Equipment, (Net)	(14,177,000)	(20,847,235)	(37,608,853)	(41,509,190)	(32,369,211)	(14,752,462)
Other	(17,453,000)	(19,453,000)	(21,453,000)	(23,453,000)	(25,453,000)	(27,453,000)
Total Assets	(41,964,000)	(50,129,235)	(68,890,853)	(74,791,190)	(67,651,211)	(52,034,462)

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	2010	2011	2012	2013	2014	2015
Balance Sheet (GAAP/SAP Adjustments & Non-Admitted Asset Impact)						
Short-term Borrowing	(9,930,000)	(9,930,000)	(9,930,000)	(9,930,000)	(9,930,000)	(9,930,000)
Unpaid Claims & Claim Adjustment Expense	2,628,000					
Accounts Payable	1,990,000					
Premiums Received in Advance	3,057,000					
Other Liabilities	(24,386,000)	(18,205,775)	(20,205,775)	(22,205,775)	(24,205,775)	(26,205,775)
Capital & Surplus	(15,323,000)	(21,993,460)	(38,755,078)	(42,655,415)	(33,515,436)	(15,898,687)
Total Liabilities, Capital & Surplus	(41,964,000)	(50,129,235)	(68,890,853)	(74,791,190)	(67,651,211)	(52,034,462)
Edit Check (Must Be Zero)	-	-	-	-	-	-
Balance Sheet (SAP Basis)						
	-	-	-	-	-	-
Cash & Short Term Investments	33,727,000	36,727,000	36,727,000	36,727,000	38,727,000	40,727,000
Investments	231,243,000	228,988,582	224,573,476	235,323,716	254,928,265	291,028,645
Uncollected Premiums	11,351,000	12,389,068	13,248,993	14,171,251	15,592,391	17,421,316
Amounts Receivable from Uninsured Plans	11,719,000	12,059,250	12,662,213	13,295,323	13,960,089	14,658,094
Property & Equipment, (Net)	4,785,000	5,240,098	5,016,814	5,224,810	5,794,455	6,787,538
Other	13,893,000	13,893,000	13,893,000	13,893,000	13,893,000	13,893,000
Total Assets	306,718,000	309,296,998	306,121,496	318,635,100	342,895,200	384,515,592
Edit Check (Must Be Zero)	-	-	-	-	-	-
Short-term Borrowing	-	-	-	-	-	-
Unpaid Claims & Claim Adjustment Expense	37,914,000	36,600,004	38,493,103	41,129,547	45,059,175	49,973,328
Accounts Payable	44,931,000	44,024,628	45,552,203	46,310,909	47,915,534	51,124,858
Premiums Received in Advance	13,794,000	10,324,224	11,040,827	11,809,376	12,993,659	14,517,763
Other Liabilities	38,948,000	43,678,225	43,792,616	45,209,291	43,762,639	42,632,640
Capital & Surplus	171,131,000	174,669,918	167,242,746	174,175,977	193,164,193	226,267,002
Total Liabilities, Capital & Surplus	306,718,000	309,296,998	306,121,496	318,635,100	342,895,200	384,515,592
True Up Section		174,669,918	167,227,134	174,160,365	193,148,581	226,251,390
Risk-Based Capital Ratio	1,056	1,054	1,014	994	1,007	1,063
Authorized Control Level (Dollars in Thousands)	16,206,344	16,577,194	16,488,696	17,525,283	19,180,972	21,291,706
	-	-	-	-	-	-
ACL Source	Actual	DH - HMK	DH - HMK	DH - HMK	DH - HMK	DH - HMK
			128,027,134			
			776.5%			

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Statement of Cash Flows - Indirect Method (GAAP Basis)						
Operating Activities						
Net Income/(Loss)		10,209,378	9,318,836	10,833,578	9,848,251	15,486,061
Depreciation		6,424,667	7,991,667	10,908,333	19,123,667	17,493,667
Decrease/(Increase) in Certain Assets		(2,794,318)	(3,462,887)	(3,555,368)	(4,085,906)	(4,526,929)
Increase/(Decrease) in Liabilities		1,984,855	4,137,279	4,163,698	6,718,537	9,647,581
Investing Activities						
Purchase of Property & Equipment		(13,000,000)	(22,400,000)	(11,600,000)	(2,000,000)	(2,000,000)
Other		(5,000,000)			(10,000,000)	
Financing Activities						
Not Applicable		-	-	-	-	-
Net Increase/(Decrease) in Cash		(2,175,418)	(4,415,106)	10,750,240	19,604,549	36,100,379
Investments		237,488,582	233,073,476	243,823,716	263,428,265	299,528,645
Investment Income Yield		4.0%	4.0%	4.0%	4.0%	4.0%
Investment Income		9,543,052	9,411,241	9,537,944	10,145,040	11,259,138
Investment Management Fee		0.5%	0.5%	0.5%	0.5%	0.5%
Investment Management Expense		1,192,881	1,176,405	1,192,243	1,268,130	1,407,392
Investment Income, Net		8,350,170	8,234,836	8,345,701	8,876,910	9,851,746
		441,398	-	-	-	-
Statement of Cash Flows - Indirect Method (GAAP Basis) - Supporting Documentation						
Capital Expenditures						
Routine		2,200,000	2,000,000	2,000,000	2,000,000	2,000,000
Capability Enhancement		10,800,000	20,400,000	9,600,000	-	-
Total		13,000,000	22,400,000	11,600,000	2,000,000	2,000,000
Depreciation						
Routine		550,000	500,000	500,000	500,000	500,000
Capability Enhancement		696,667	2,326,667	5,243,333	13,296,667	11,666,667
Total		1,246,667	2,826,667	5,743,333	13,796,667	12,166,667
		3,333	-	-	-	-
Depreciation (Built into G&A Expense)	3,814,000	3,800,000	3,800,000	3,800,000	3,962,000	3,962,000

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Enhanced Depreciation		1,378,000	1,365,000	1,365,000	1,365,000	1,365,000
	3,814,000	5,178,000	5,165,000	5,165,000	5,327,000	5,327,000
Property & Equipment GAAP / SAP						
Property & Equipment - Routine						
Property & Equipment at 12/31/10	47,288,000	47,288,000	47,288,000	47,288,000	47,288,000	47,288,000
Property & Equipment - Post 12/31/10		2,200,000	4,200,000	6,200,000	8,200,000	10,200,000
Accumulated Depreciation	(28,326,000)	(33,504,000)	(38,669,000)	(43,834,000)	(49,161,000)	(54,488,000)
Net	18,962,000	15,984,000	12,819,000	9,654,000	6,327,000	3,000,000
Capability Enhancement						
Property & Equipment		10,800,000	31,200,000	40,800,000	40,800,000	40,800,000
Accumulated Depreciation		(696,667)	(1,393,333)	(3,720,000)	(8,963,333)	(22,260,000)
Net	-	10,103,333	29,806,667	37,080,000	31,836,667	18,540,000
Property & Equipment - Total						
Property & Equipment	47,288,000	58,088,000	78,488,000	88,088,000	88,088,000	88,088,000
Accumulated Depreciation	(28,326,000)	(32,000,667)	(35,862,333)	(41,354,000)	(49,924,333)	(66,548,000)
Net	18,962,000	26,087,333	42,625,667	46,734,000	38,163,667	21,540,000
SAP Admitted Property & Equipmnet		5,240,098	5,016,814	5,224,810	5,794,455	6,787,538
Non-Admitted Property & Equipment	(14,176,775)	(20,847,235)	(37,608,853)	(41,509,190)	(32,369,211)	(14,752,462)
Calculated Capital & Surplus	171,131,000	174,669,918	167,242,746	174,175,977	193,164,193	226,267,002
True Up Section	**171,131,000**	**174,669,942**	**167,227,138**	**174,160,338**	**193,148,508**	**226,251,260**

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		Forecast				
	2010	2011	2012	2013	2014	2015
Capability Enhancement						
Asset Cost		11,980,000	32,380,000	41,980,000	41,980,000	41,980,000
Accumulated Depreciation		(696,667)	(3,023,333)	(8,266,667)	(21,563,333)	(33,230,000)
Net		11,283,333	29,356,667	33,713,333	20,416,667	8,750,000
Routine						
EDP Equipment, Net (Admitted)		3,000,000	2,000,000	2,000,000	2,000,000	2,000,000
EDP Equipment, Net (Non-Admitted)		2,240,098	3,016,814	3,224,811	3,794,457	-
Routine						
Non-EDP Equipment, Net (Admitted)		-	-	-	-	
Non-EDP Equipment, Net (Non-Admitted)		-	-	-	-	-
Capability Enhancement						
EDP Equipment, Net (Admitted)		11,283,333	29,356,667	33,713,333	20,416,667	8,750,000
EDP Equipment, Net (Non-Admitted)		(11,283,333)	(29,356,667)	(33,713,333)	(20,416,667)	(8,750,000)
Capital Assets, Net (SAP)		5,240,098	5,016,814	5,224,811	5,794,457	2,000,000
Non-Admitted Portion		9,043,236	26,339,853	30,488,522	16,622,209	8,750,000
Capital Assets, Net (GAAP)		14,283,333	31,356,667	35,713,333	22,416,667	10,750,000
Capital & Surplus - 12/31/09						
Net Income						
Change in Non-Admitted Assets						
Capital & Surplus 12/31/10						

Notes

Blue Cross Blue Shield of Delaware
Affiliation Basis - Five Year Forecast (2011 Through 2015) - Current Version
August 10, 2011

		Forecast			
	2010	2011	2012	2013	2014	2015
a. Integration Consulting:						
Planning and Implementation		227,000	150,000	50,000	-	-
Resource Supplements - Planning		643,000	-	-	-	
Specialty Consulting					-	-
Total Integration Consulting		870,000	150,000	50,000	-	-
Marketing / Communication / Branding			1,500,000	750,000		
b. Highmark Charges to BCBSD:						
Home Office/Governance		-	3,447,000	3,476,000	3,090,000	3,233,000
IT Platform (Net)		-	-	4,246,000	17,612,000	18,426,000
Total Highmark Charges		-	3,447,000	7,722,000	20,702,000	21,659,000
c. Synergies:						
Corporate Function Integrations		-	-	-	-	-
Operational Efficiencies (Best Practices, Integrations)			(1,805,000)	(5,917,000)	(17,949,000)	(17,949,000)
Disease Management		-	(513,000)	(1,025,000)	(1,025,000)	(1,025,000)
Procurement savings		-	(1,112,000)	(2,224,000)	(4,447,000)	(4,447,000)
Total Synergies		-	(3,430,000)	(9,166,000)	(23,421,000)	(23,421,000)
Net (Savings) / Cost		-	17,000	(1,444,000)	(2,719,000)	(1,762,000)