

Blue Cross and Blue Shield **A Historical Compilation**

Table of Contents:

1. Blue Cross and Blue Shield: A History of Charitable and Benevolent Health Insurance Plans.....2-15
2. Blue Cross/Blue Shield State Histories.....16-49
3. Blue Cross/Blue Shield Insurer Histories.....50-52
4. Blue Cross/Blue Shield Stories: Community Participation Makes a Difference.....53-58
5. Chart: Blue Cross/Blue Shield Affiliation and Status.....59-62
6. Chart: Blue Cross/Blue Shield Assets Set Aside.....63

Blue Cross and Blue Shield A History of Charitable and Benevolent Health Insurance Plans

Blue Cross and Blue Shield plans across the country were created with the intention of providing affordable health care coverage in the nonprofit context with a community focus. The plans were established to fill significant holes in the health care system. They were created and promoted by the community, acting in the public benefit. Their history and involvement in creating an alternative health care coverage source—the voluntary, nonprofit prepaid health plan—and their subsequent participation in the development of the Medicare and Medicaid programs have helped ensure that more Americans obtain access to health care coverage.

Since the Blue Cross and Blue Shield Association voted to allow its nonprofit members to become for-profit corporations in 1994, some Blues plans have attempted to deny that they are charitable organizations, claiming they are thus not obligated, under charitable trust law, to set aside their assets to continue their missions when they convert to for-profit entities. But nonprofit Blue Cross and Blue Shield plans were clearly established as charitable and benevolent entities, and should therefore be subject to charitable trust requirements. This paper discusses the history of Blue Cross and Blue Shield plans, with a particular emphasis on the Texas plan, and outlines the many pieces of evidence showing that Blue Cross and Blue Shield plans are charitable and benevolent organizations.

I. The Texas Experiment

What we know of today as Blue Cross and Blue Shield plans were started by an experiment in Texas to provide increased hospital coverage to members of the community at an affordable rate. The first effort to confront the problems of access to health care through a nonprofit prepaid mechanism began in Dallas in 1929. That year, Baylor University hired Justin Ford Kimball, formerly a superintendent of schools in Dallas, to provide oversight of the University's medical education and to "shore up the shaky finances of University Hospital."¹ With occupancy rates falling and patients unable to pay their own bills, Mr. Kimball set out to establish a plan that would help hospital patients pay their bills and keep the hospital alive.²

Having previously established a sick benefit for the Dallas teachers ten years earlier, Mr. Kimball used this same teacher organization to initially explore prepaid hospital coverage. Kimball's proposal virtually coincided with the October 1929 stock market crash, which "added urgency to the teachers' worries about economic security and increased their interest in the hospitalization fund."³ With the teachers' enthusiasm,

¹ Robert Cunningham III and Robert M. Cunningham Jr., *The Blues: History of the Blue Cross and Blue Shield System*, (1997) page 3. This book, written by a father and son team, is a comprehensive study of the history of BCBS plans. It was sponsored by the Blue Cross Blue Shield Association. The authors had access to internal documents from the national Association and conducted interviews with numerous former and current Blues officials. Robert Cunningham, Jr. served as a consultant to the BCBS Association in the 70's and 80's during which he was instrumental in organizing their archives and creating the BOBS Plan History Project. This book was a major outcome of the Project.

² *Id.* at 4.

³ *Id.* at 5.

Kimball proceeded forward with the experiment.

The Baylor prepaid hospital plan was created to be distinct from traditional commercial insurance.⁴ As a nonprofit plan, one of its earliest brochures boasted that, "Baylor uses no sales agency or middlemen, but prefers to deal directly with each group so that all group hospitalization fees paid may be used only for hospital care of members and not for any personal profit."⁵ The original Baylor plan gave Dallas teachers twenty-one days of hospital care for \$6 per year.⁶ The Texas Department of Insurance determined that the Baylor plan was not in the business of providing insurance. Instead, the Department viewed the plan as a "group contract for the sale of services."⁷ Deemed by Kimball's assistant Brice Twitty as a "godsend to thousands," more than 1,300 teachers initially signed up for the Baylor plan, and within five years more than 408 employee groups with more than twenty-three thousand members were covered by this new type of plan.⁸

II. Blue Cross Plans Flourish Across the Country

It did not take long for the concept of prepaid, nonprofit health care coverage as envisioned in Texas to take root in other parts of the country. As the 1930s began, gaps in health care coverage were widening. Families and individuals were faced with hard choices and hospitals were increasingly facing financial difficulties. As a hospital executive and fixture Blue Cross executive stated,

"I could remember the difficulties we had then, trying to keep our doors open... People brought chickens in and meat to pay their bills. They would paint or do work around the hospital of some kind.... Nurses would come in and beg us to give them a job without pay, for room and board, because they were starving."⁹

It became clear that, for communities to survive, something drastic had to happen in the health care system. Kimball's Baylor Plan provided a new and creative opportunity for improving access to care. The embrace of Kimball's experiment was a,

"recognition and pulling together of some of the most promising tools then available for dealing with the problems of cost and access to care, thereby setting the table for a generation of social engineers who were determined to make care available to anyone who needed it."¹⁰

As plans developed in other states, improvements were made to the Baylor model, the most important being an expansion of coverage to hospital networks rather than one individual

⁴ *Id.* at 4.

⁵ *Id.* at 6 (quoting Blue Cross and Blue Shield, *Advance*, June 1989 at page 6)

⁶ Paul Starr, *The Social Transformation of American Medicine*, (1984), page 295.

⁷ C. Rufus Rorem, *Enabling Legislation for Non-Profit Hospital Plans*, 6 *Law and Contemporary Problems* 528, 529 (1939).

⁸ *Cunninghams*, at 6-7.

⁹ *Cunninghams*, at 9 -10 (quoting Fritz Lattner, interview with Odin Anderson, page 4).

¹⁰ *Id.* at 7.

hospital.¹¹ The first multi-hospital plan began in New Jersey in 1931. Frank Van Dyk was hired as the executive director of the Essex County Hospital Council to collect overdue bills from patients at the seventeen hospitals affiliated with the council. In the early 1930s, Mr. Van Dyk's job was difficult because,

“families needed every penny to keep warm, dry and fed. They did not have the money to pay hospital bills. ‘It occurred to me what a wonderful thing it would be if you could remove the cashier's window from the hospital...There ought to be a better method of doing things...Everywhere in the state people had to put off going to the hospital because of inability to pay.’”¹²

Like his counterpart in Texas, Van Dyk sought to create a nonprofit plan which put health care before profits. The New Jersey plan offered up to twenty-one days of semiprivate hospitalization for \$10 a year, not including maternity or dependent care. Soon after, the plan added dependent care, and within a year six thousand people were covered and thirty hospitals were participating.¹³

Support from leaders in the community and community engagement were two of the primary reasons for success of the Blue Cross plans. The Cleveland Plan was started with a special city welfare federation grant of \$7,500. By the mid 1930's the Cleveland plan had engaged people and organizations from throughout the area to assist in promotion. Because of this high level of community involvement, the plan was able to pay back the federation and boasted,

“wherever the Plan secured and kept such public identification, the membership growth was rapid and beyond the dreams of the most optimistic manager. In these areas, governors and mayors proclaimed Blue Cross enrollment periods, service clubs took part in promotion, Boy Scouts delivered enrollment material to prospects, and clergymen from the pulpit urged people to enroll in this community enterprise. Such promotion could not be bought at any price.”¹⁴

There was active community participation from all sectors in promoting and supporting Blue Cross plans as a means to protect people from the high costs of health care. The foundations of Blues plans across the country were unquestionably built with the help of this strong community support.

By 1933, the American Hospital Association's (AHA) Council on Community Relations and Administrative Practice adopted its own approach for developing hospital insurance, rejecting the single hospital plan modeled in Baylor, which limited consumer choice to only one hospital. As one of the early leaders in the Blue Cross organization stated, it "soon became obvious . . . that a general community need could not be met through single-

¹¹*Id.* at 10.

¹²*Id.* at 11 (quoting Frank Van Dyk, interview with Odin Anderson, page 2).

¹³*Id.* at 12.

¹⁴*Cunninghams*, at 15 (quoting James E. Stuart, "Blue Cross Story: An Informal Biography of the Voluntary Nonprofit Prepayment Plan for Hospital Care").

hospital service Plan."¹⁵ The AHA sought to create insurance plans that "were to be nonprofit, to emphasize the public welfare, and to limit themselves to dignified promotion."¹⁶ C. Rufus Rorem, the leader of the AHA movement, stated that the,

“pioneers in the voluntary hospitalization movement were not philosophers. They were not social reformers. They were social organizers. The voluntary Plans were an attempt to organize the public buying power on a voluntary basis, without the disadvantage of political control, a means by which an employed group of people could finance medical care for itself. They were dealing with a practical problem in a practical way.”¹⁷

From the very beginning, the Board of Trustees of the AHA resolved to approve the principle of "hospital insurance" and developed a brochure, issued later that year, entitled "Essential of an Acceptable Plan for Group Hospitalization." The essentials included an "emphasis on public welfare" by being organized as a public service and "nonprofit organization" in which "no individual or group should be allowed to enjoy any financial gain from a plan, other than a reasonable and proper return for necessary services."¹⁸

Under the leadership of C. Rufus Rorem, head of the AHA's Commission on Hospital Service, the AHA drafted Model legislation that served as the basis for most state enabling statutes. The Model law proposed a special class of nonprofit voluntary hospital insurance plans, exempt from state general insurance laws and conferred with "charitable and benevolent status."¹⁹ Like their nonprofit hospital counterparts, prepaid hospital insurance plans',

“voluntary spirit was reflected not only in terms of nonprofit incorporation and the ideal of community service frequently invoked by early leaders, but also in the fundamental differences between the Plans' approach to paying for care and conventional underwriting practice. The keys to this approach were the concepts of the service benefit and of a single, community wide premium rate.”²⁰

Virtually all the Blue Cross plans were established with "community rating"²¹ instead of rates based on an individual's health status to price their products."²² Throughout the country, these charitable corporations offered "the same rates to all subscriber groups regardless of age, sex, occupation, or other characteristics that might affect the frequency with which members of the

¹⁵*Id.* at 20 (quoting James E. Stuart, "The Blue Cross Story: An Informal Biography of the Voluntary Nonprofit Prepayment Plan for Hospital Care").

¹⁶ *Starr*; at 296.

¹⁷ *Cunninghams*, at 19 (quoting C. Rufus Rorem as cited in Odin Anderson, *Blue Cross Since 1929: Accountability and the Public Trust*).

¹⁸ Report by Louis Reed of the Federal Security Agency, U.S. Public Health Service (1947). The *Cunninghams* describe this report as the "definitive 1947 study" of BCBS. *Cunninghams*, at xiii (Acknowledgments).

¹⁹ *Rorem*, at 531 and 543.

²⁰ *Cunninghams*, at 31.

²¹ The concept of creating rates for a large pool of subscribers is known as "community rating," which is distinct from experience rating. "Experience rating" is the practice of setting insurance premiums on the basis of the actual loss experience of a given employee group. *Cunninghams*, at 258 (glossary).

²² Cathy Tokarski, *Mergers, Conversions: Blues' Survival Strategies*, *American Medical News*, May 20, 1996, at page 17.

group would require hospitalization."²³ It was not until the for-profit commercial insurers began to move into the health insurance market that the Blues' Plans began to question whether their efforts to provide community rating should continue.²⁴

As more local communities initiated plans, the AHA's Special Commission on Hospital Service, created in 1937, determined that it would offer "associate institutional membership" to any nonprofit organization that met specific standards.²⁵ The Commission's initial role involved issuing approval certificates for nonprofit plans which met the standards.²⁶

Among the standards first instituted in 1937 were the requirements that: membership plans be nonprofit; the board of each plan include representatives from local hospitals, the medical profession, and the general public; all hospitals in a community be given the opportunity to participate in the plan; plan employees receive salaries rather than commissions; and hospitals be reimbursed based on costs in order to get the best possible coverage to the largest possible number of people at the lowest possible costs.²⁷ In their history of the Blue Cross and Blue Shield system, the Cunninghams write that the standard requiring reimbursement based on costs would have been a difficult one to resolve between all the plans and their network of hospitals. Until the standards were created, there had never been a uniform position regarding payment rates in prepaid coverage plans. The AHA was confronted with the tensions between meeting the needs of hospitals and the needs of the plans.

“It was plain that too low a price would beggar the hospitals and too high a price would beggar the Plan...The payment rate had to be decided by negotiation, in good faith on both sides, with the kind of trust made possible by common purpose and no thought that either could profit from the result. It is remarkable that there were apparently no deadlocks, no broken negotiations, and no recriminations during the first decade after the creation of these standards. In the nonprofit environment, payment rate negotiation was not seen solely as a game of winners and losers.”²⁸

A formal approval process by the Blue Cross Commission of the AHA began in 1938, and only those approved could use the Blue Cross symbol and name. The process set the stage for a long history of publicly promoting these nonprofit hospital-sponsored plans as different than those sold by other insurance companies.

By the end of the 1930s, approximately half of the states had passed enabling legislation for hospital care service plans like Blue Cross.²⁹ Many incorporated several of the important features proposed by the AHA including a declaration that the plans be organized as charitable

²³ *Cunninghams*, at 31.

²⁴ *Id.*

²⁵ *Cunninghams*, at 28.

²⁶ *Rorem*, at 541.

²⁷ *Cunninghams*, at 29-30.

²⁸ *Cunninghams*, at 30.

²⁹ *Starr*, at 298.

organizations.³⁰

The statute that enabled the original Baylor plan to provide the public prepaid hospital coverage for more than one hospital was created in 1939.³¹ The Texas statute gave charitable and benevolent status to its Blue Cross plan. Additionally, the state of Texas enacted strong measures for state involvement and oversight of BCBST. The Texas statute restricted the amount that could be used for administrative services to 15% of dues. Moreover, the plan had to obtain state approval even before the 15% could be used for administration.³² The statute also prohibited the Texas plan from compensating its employees more than \$6,000 per year, again requiring that the state approve all salaries before they could be implemented.³³

The enabling statute in Texas specifically distinguished a health service corporation from traditional insurance: "hospital service corporations shall be governed by this act, *and shall not be construed as being engaged in the business of insurance* under the laws of this state."³⁴ As a leader in the AHA movement in support of charitable and benevolent hospital service plans, C. Rufus Rorem asserted that the Blues Plans were clearly distinct from traditional insurance:

"From the economic point of view, hospital service plans are a form of insurance. From the provisions of the various state regulations and the enabling acts, it appears that they constitute *a special type of insurance* differing from the stock and mutual companies."³⁵

Blues plans were created with "fundamental system(s) of values, in the tradition of the private voluntary, not-for-profit hospital that dominated the American scene."³⁶ By 1940 the ranks of the Blue Cross plans supported by the AHA grew to include over 6 million enrollees.³⁷ Of the 39 plans surveyed, virtually all were begun with the seed of nonprofit, publicly-supported sources among which: 22 were started with capital contributed by hospitals (virtually all of which were nonprofit); six received funds from a local "Community Chest" or foundation; and three received all initial funding from civic leaders. But for the nonprofit resources from Baylor, a charitable hospital, the entire Blues movement might never have been created.

III. Blue Shield Plans Not Far Behind

With the growing public reliance on prepaid hospital plans, there also rose a demand for coverage for medical services. Physicians, however, were more resistant than hospitals to the concept of prepaid plans, fearing among other things, a violation of the physician and patient relationship.³⁸ Yet the public continued to feel the financial burdens of paying for medical care that they otherwise could not afford. In response to growing public pressure throughout

³⁰ *Id.*

³¹ *Rorem*, at 531.

³² *Rorem*, at 538.

³³ *Id.* at 541.

³⁴ *Rorem*, at 534 [emphasis added].

³⁵ *Id.* [emphasis added].

³⁶ *Cunninghams*, at 30.

³⁷ *Starr*, at 298.

³⁸ *Cunninghams*, at 38.

the country, select physicians and medical groups began to develop special contracts with employers and employees to cover medical services.³⁹

The first successful prepaid medical plan began in California in an effort to cover five thousand workers building an aqueduct. Soon thereafter, under the guidance of Henry J. Kaiser, whose construction company was involved in the aqueduct project, a similar program began that was open to other employee groups—today known as Kaiser Permanente Health Plan.⁴⁰ Not far behind Kaiser, the California Medical Association ("CMA") launched its own voluntary prepayment plan and the American Medical Association ("AMA") began to seriously consider, rather than outright resist, the concept of prepaid medical care.⁴¹

Simultaneously, President Roosevelt, in conjunction with his effort at social welfare reform, established a committee to investigate the establishment of a national health insurance plan. While these early efforts at national health insurance by the Roosevelt administration were abandoned, the medical establishment's steadfast resistance to prepaid health care coverage began to wane.⁴² In California, the California Medical Association (CMA) offered a nonprofit service-oriented prepayment plan for voluntary private coverage in an effort to hold back the governor's attempt to institute compulsory insurance.⁴³ The governor objected to the categorization of the CMA plan as a "nonprofit" instead of an insurance company and argued that the plan violated California law.⁴⁴ The court held that the plan was appropriately categorized as "nonprofit" and should be exempt from state insurance laws.⁴⁵ As the California Blue Shield plan developed, it was committed to its identity as a nonprofit organization, like its sister hospital plans. Soon thereafter, physician plans quickly flourished in other states and became substantially similar to the Blue Cross plans.⁴⁶

IV. Blue Cross and Blue Shield Plans Evolve

As Blues plans developed and became an integral part of the health care system, local autonomy remained one of their "cardinal rules."⁴⁷ The plans became more financially independent and they remained committed to strong public representation on their boards of trustees.⁴⁸ The Blues plans saw themselves as the "intermediary" between the needs of the community and the needs of the hospital networks.⁴⁹ A 1947 report by Louis Reed of the Federal Security Agency, U.S. Public Health Service discusses the evolution of public involvement in the Blue Cross plans:

“A new Plan which the hospitals have started and which they underwrite is in a

³⁹ *Id.* at 35-36.

⁴⁰ *Id.* at 39.

⁴¹ *Id.* at 41.

⁴² *Id.* at 42-44.

⁴³ *Id.* at 45.

⁴⁴ *California Physicians' Services v. Garrison*, 28 Cal. 2nd 790 (1946).

⁴⁵ *Cummings*, at 46.

⁴⁶ *Id.* at 309.

⁴⁷ *Cummings*, at 62.

⁴⁸ *Id.* at 63.

⁴⁹ *Id.* at 64.

very real sense a creature of the hospitals. However, as the Plan grows it stands more and more on its own feet.... After a certain stage it would seem that dominant control should shift to the public.... When the children have grown, when they support themselves, then parental control is no longer desirable or possible.”⁵⁰

The report further asks the question "Who controls the plans?" and describes a realistic picture of the varying types of control from state to state. However, ultimately the report concludes that to be successful, plans must be true to their promotion of themselves as "civic organizations," and thus "must give the general public the feeling that the plan belongs to the public, that it is in truth a civic organization, of, by and for the public."⁵¹

During the 1940s, there was a growing movement to ensure that all Blue Cross plans offer direct enrollment to individuals as well as groups, recognizing "that their social purpose and public relations require that the opportunity of enrollment should be available to all."⁵² Plans began to use a once-a-year community enrollment campaign, providing an enrollment window opened to the general public. This proved to be a successful tactic for increasing enrollment both in the cities and in rural areas. Media and civic organizations promoted the enrollment campaign, categorizing the plans as "public service" options.⁵³ In these campaigns, all possible use was made of publicity, community civic groups, and civic spirit. The techniques varied by state but essentially included a limited period of time during which individuals could sign up for coverage and promotion of the full support of the medical community. In small communities, local civic organizations such as women's clubs and the Red Cross would sponsor and carry out the campaign on behalf of the plan.⁵⁴ The key to successful community enrollment was presentation of the plan as a community service and the use and assistance of every possible civic sponsor.

Until the mid 1940's, plans rarely used advertising to promote their product because of concerns that it would be inconsistent with their nonprofit, civic-service character, and might jeopardize other forms of free promotion that the plans often received. In fact, the first standards established in 1937 to unify the BCBS plans across the country and allow them to use the blue cross symbol included the following: "Promotion and administration policies should be dignified in nature and consistent with the professional standards of the hospitals involved."⁵⁵ Texas advertisements from that era carefully portrayed the state Blues plan as a "public" entity. Advertisements in *Dallas Magazine* by the Texas Blue Cross plan in 1945 identified the plan, not as a private business, but as "Texas' Own Non-Profit Community Plan." A 1943 promotional brochure, "A Message to the People of Texas from over Two Hundred Texas Hospitals on Our Blue Cross Plan," explains, "[t]hrough this plan we bring you a health program by the people and for the people of our state without profit to anyone."

⁵⁰ Report by Louis Reed of the Federal Security Agency, U.S. Public Health Service (1947).

⁵¹ *Id.*

⁵² *Cummings*, at 68.

⁵³ *Id.* at 69.

⁵⁴ One could speculate on the public's perception of the connection between the Red Cross – a high-profile charity serving the public – and Blue Cross – a nonprofit organization helping the community – as being indistinguishable. The "blue cross" first used in Minnesota, was adopted from the Geneva cross, internationally known as a symbol for help for the sick and injured.

⁵⁵ *Cummings*, at 29.

Throughout the 1940s and 1950s, discussion about comprehensive health insurance continued to occur at the national level. There was increased competition between the nonprofit Blue Cross and Blue Shield plans and their for-profit counterparts. At the local and national level, communities were calling for more comprehensive health care coverage.⁵⁶

By the mid 1950s, many of the Blue Cross plans had moved forward with efforts to provide group health care coverage to federal employees. The federal government, unlike many other employers, refused to cooperate in a manner that would ease the burden of administration on the Blues plans. They would not allow payroll deductions nor would they permit premium contributions.⁵⁷ Despite federal resistance, the Group Hospitalization Plan in Washington D.C. managed to insure half the federal employees.⁵⁸ Soon thereafter, the federal government began to ease its resistance for federal employee group life insurance.⁵⁹ Congress approved payroll deductions and a "very substantial" federal contribution for group life. It was not long before federal employee health insurance was enacted.⁶⁰

As the Blue Cross organization moved to strengthen its national presence, the federal government began to recognize the increasing importance of health care coverage for its employees.⁶¹ By the end of 1959, the Federal Employee Health Benefits Program ("FEBHP") was enacted.⁶² Under FEBHP, federal employees were offered the choice between Blue Cross and Blue Shield plan coverage, competing for-profit commercial insurance coverage, and other local prepaid group plans available in the service area.⁶³ FEBHP offered three tiers of coverage, with a lower cost option, a mid-range option, and a high option. The federal government agreed to cover half the premium of the low cost option.⁶⁴

The Blue Cross Association and the National Association of Blue Shield Plans bid directly with the federal government to offer the Blue Cross and Blue Shield options, subcontracting out to local plans.⁶⁵ Together, the two associations were able to create the Federal Employee Program ("FEP") as the primary Blue Cross and Blue Shield choice offered to federal employees across the country.⁶⁶ With involvement from all plans but the Cleveland hospital plan, the national partnership between the Blue Cross and Blue Shield organizations was "a very big moment in the history of [the] Blue Cross and Blue Shield [system]."⁶⁷

⁵⁶ *Id.* at 94.

⁵⁷ *Id.* at 111.

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² *Id.* at 113.

⁶³ *Id.*

⁶⁴ *Id.* at 114.

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ *Id.* at 115 (quoting Edwin Werner interview with author).

V. Serving the Public Need: Responding to the Problems of the Uninsured

Throughout the 1960s, specific populations began to be left out of the health insurance market. Elders, unemployed people, and indigent communities often were unable to obtain health insurance, as the primary source of insurance continued to be through employer group plans. The discussion about whether, and how, to provide comprehensive health care to some of the most vulnerable populations became more heated on the national level. The Blues plans themselves recognized the problem of elderly uninsured but were extremely wary of the government's ability to respond to the problem effectively.⁶⁸ The Blues' leaders recognized that, thus far, they had been unable to meet the growing needs of the elderly population, but believed strongly that the answer to the problem was in local communities, so that "control [could] remain close to the people."⁶⁹

The first federal attempts to deal with the growing elderly uninsured population were not successful, yet the government did not give up. In 1954, Congress turned to the AHA in order to get actuarial data on the costs of providing a prepaid plan to retirees. The AHA and the Blue Cross Commission then established a special Joint Committee to Draft Legislation for the Aged, Indigent, and Unemployed.⁷⁰ The Joint Committee found that the cost of hospital care for the elderly was three to four times higher than the younger population.⁷¹ After collecting actuarial information, the Blue Cross Commission and the AHA drafted a legislative proposal creating a federal program that would provide prepaid coverage to elders and the poor through a federal matching program. While the proposal did not go forward, it is apparent that the Blues Plans' relationship with Congress and the administration became increasingly more intimate and sophisticated.⁷²

Communities continued to face the challenge of providing adequate health care coverage to elders and indigent persons. By the mid 1950s, many of the Blues Plans had established relationships with county and municipal government to work together in an effort to make care more available to these vulnerable groups within communities.⁷³ In Colorado, for example, the state created an "old age pension plan" whereby 85 percent of the state's excise taxes were used to fund a minimum monthly income for Coloradans over sixty five. By 1957 the surplus in the fund had swollen and voters approved a new constitutional amendment to use the surplus to fund a health care program for the aged. In partnership with the state, the Blue Cross and Blue Shield Plans were responsible for administering the new state program, offering benefits that virtually mirrored the Plans' benefit packages.⁷⁴ On their own and in conjunction with state governments, many of the Blues Plans attempted to make coverage more available for elders, but maintaining such coverage became increasingly difficult without oversight and financial intervention from the federal government.

⁶⁸ *Cunninghams*, at 120.

⁶⁹ *Id.* at 121 (quoting Louis Pink letter to Oscar Ewing, October 26, 1951).

⁷⁰ *Id.* at 122.

⁷¹ *Id.* at 123.

⁷² *Id.* at 124.

⁷³ *Id.* at 128.

⁷⁴ *Id.* at 128-129.

In 1959, Congress attempted to fill many gaps in health care coverage by amending the Old Age Assistance (OAA) program. The amendment sought to increase medical assistance for welfare recipients through federal and state matching funds. In addition, Congress added a proposal to create the Medical Assistance for the Aged ("MAA") program which would make health care available to people age 65 and over with low or moderate incomes. The MAA program also required state matching funds. By 1960, both proposals became law.

Because many of the states did not have the resources to provide matching funds, not all states implemented these programs. The need for more comprehensive federal legislation continued to exist throughout the beginning of the 1960s.⁷⁵ The Blue Cross Association achieved consensus among the individual state plans that the private sector should provide the solution to the growing health care problem, but if Congress was to create a "Social Security-type system," then the Association would cooperate.⁷⁶

VI. Texas Blue Cross and OAA: The Precursor to Medicare

Blue Cross and Blue Shield of Texas was one of a handful of Blue Cross plans that began to work with states to administer the MAA portion of the Old Age Assistance program. Ten percent of elders on OAA lived in Texas.⁷⁷ In Texas, the Blue Cross plan worked in unison with physicians, hospitals, and the state welfare department. "Certain that public opinion would not permit them to earn anything for their own reserves, [the Texas Blue Cross and Blue Shield plan] underbid its commercial competitors with a promise to administer the program with overhead costs of no more than three percent."⁷⁸ Despite this tight administrative constraint, within the first two years the plan was so financially sound that it was able to expand benefits and return a surplus of \$100,000 to the state.⁷⁹ The program, funded with 75% federal funds and 25% of Texas state funds, offered comprehensive benefits that met the needs of elder consumers.⁸⁰ As the head of the Texas Blue Cross plan said, "if every state could do what Texas has done, we wouldn't have any problem about the aged."⁸¹ With the success of the Texas Blues' partnership with the state, other state Blues plans increased their efforts across the country to participate in OAA/MAA partnerships.⁸²

With federal concern that the OAA/MAA program was not sufficiently responding to the problems of the uninsured, President Johnson put his efforts into a bill which would offer hospital and nursing home coverage for everyone aged sixty-five and older, financed through a Social Security tax.⁸³ As more legislative proposals were put on the table before Congress, "the expertise of the Blues was in heavy demand."⁸⁴ The final result was a Medicare and Medicaid

⁷⁵ *Id.* at 131.

⁷⁶ *Id.* at 135.

⁷⁷ *Cunninghams*, at 139.

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ *Id.* at 140 (quoting Walter McBee at the BCA annual meeting, 1963).

⁸² *Id.*

⁸³ *Id.* at 141.

⁸⁴ *Id.*

bill that provided "an amalgamation of hospital, medical, and indigent care."⁸⁵ The legislation passed by Congress in 1965 created the Medicaid and Medicare programs, the latter structured with separate hospital and medical benefits. Coincidentally, the Medicare program used the very same structure by which the Blues Plans functioned.

As Medicare evolved, the Blues Plans became more and more integrally involved in the administration and development of this publicly funded program. When the Social Security Administration gave hospitals the opportunity to choose their "intermediaries"-- health plans responsible for administering and reviewing claims under the Medicare Part A program-- the hospitals chose Blue Cross Plans as intermediaries in 31 states, representing 90% of the beds in all participating hospitals.⁸⁶ Out of 49 "carriers" (the administrators for the Medicare Part B plan), the Social Security Administration itself chose Blue Shield to administer 33 plans, covering 60% of eligible beneficiaries.⁸⁷ In the beginning, the Social Security Administration, which was delegated with the responsibility for overseeing the Medicare program, "needed Blue Cross and Blue Shield Plans and other carriers to help teach them the business."⁸⁸ The role of the Blues as intermediaries in the development and administration of the Medicare program became "substantial."⁸⁹ Blues Plans' involvement in the Medicare program "constituted a humanitarian triumph of major proportions."⁹⁰ To most Americans the Blue Cross Blue Shield system was the national health care system of the country, and Medicare and Medicaid intensified this national image.

In Texas, the state Blue Cross Blue Shield plan took on the intermediary role for Medicare from the very beginning in 1966. More than 30 years later, the partnership between Blue Cross Blue Shield of Texas and the federal government continues. The majority of Texas hospitals still choose the Blues plan as their intermediary. All Medicare Part B payments to physicians and other health care providers are handled by Blue Cross Blue Shield Texas, except for home health care and durable medical equipment payments. These two types of payments are handled by one of four regional intermediaries in the U.S. Coincidentally, the southeast region, which includes Texas, is handled by another Blue Cross Blue Shield plan from South Carolina, doing business as Palmetto.

Despite the tension created by the public vs. private debate in the development of Medicare and Medicaid, the culture within BCBS was focused on the public good working with government to solve problems with access to health care. No profit motive existed to create a conflict of interest, and Blues plans were attractive partners for the federal government. The Blue Cross name connected with these government plans implied access to low cost/no profit, publicly responsible coverage and made them more appealing to the public. In turn—even though implementation created a great burden on the plans—access to public money eventually helped BCBS plans to develop expertise and expand their market share.⁹¹

⁸⁵ *Id.* at 142.

⁸⁶ *Id.* at 147.

⁸⁷ *Id.*

⁸⁸ *Id.* at 148.

⁸⁹ *Id.* at 149.

⁹⁰ *Id.* at 153.

⁹¹ Bernard Tresnowski, a future BCBS Association president who joined the Association during this period said the agreement

VII. Special Tax Status: Blues Plans Not Exactly Like Commercial Insurers

For more than forty years, virtually all BCBS plans were organized under federal law as 501(c)(4) "social welfare" organizations. A 501(c)(4) organization is further defined in Treasury Regulations as a corporation primarily,

“engaged in promoting the common good and general welfare of the people of the community. Such an organization is operated primarily for the purpose of bringing about "civil betterments and social improvements.”⁹²

In the early 1980s, many of the commercial insurers began to challenge the fully tax-exempt status of the BCBS plans. They brought their challenge to the IRS and to Congress. The national BCBS Association, a nonprofit organization that holds the BCBS trademark, went to great lengths to distinguish BCBS plans from commercial insurers by stressing their dedication to charitable, community-based health care services. Membership in the national BCBS Association is a prerequisite for any state BCBS plan to use the blue "Cross" and "Shield" service marks. The national BCBS Association representatives argued to Congress that while they might have evolved into business corporations, they still retained the special character of a nonprofit plan, providing "a unique community service."⁹³

The campaign waged by the BCBS plans to defend their nonprofit tax-exempt status resulted in a “split decision.” As of January 1, 1987, the federal government removed the full tax-exempt status of BCBS plans and instead created a special tax class for BCBS organizations, Internal Revenue Code (I.R.C.) §833. The new I.R.C. category subjected BCBS plans to federal taxation but recognized the unique role BCBS plans play. Under I.R.C. §833, the BCBS plans, unlike commercial for-profit insurers, are entitled to special tax benefits. Congress created a special deduction for BCBS plans with reserves worth less than three months of premium income, taxing "net income sheltered by the deduction at 20 percent, rather than at the 34 percent corporate rate."⁹⁴ As the Chairman of the Finance Committee stated when I.R.C. §833 was under consideration, the special deduction was created in "recognition of the community service activities" of these plans.⁹⁵

Due to this continued special consideration, Blue Cross Blue Shield of Texas, for example, paid \$23.9 million less in federal income taxes from 1987-96 than it would have paid without the deduction. Despite the elimination of federal tax-exempt status, most of the BCBS plans at that time continued to remain nonprofit and many often maintained tax exemptions under state and local laws. As Bernard Tresnowski, President of the BCBS Association, stated:

with the federal government allowed the Association to "spread our overhead and attract a lot of new people into the business who might not otherwise have been attracted. Many people . . . came because of the opportunity presented by the government programs. I am one example of that." *Cunninghams*, at 159.

⁹² Treasury Regulation Section 1.501(c)(4) - 1 (a) (2) (i).

⁹³ *Cunninghams*, at 215 (quoting from an interview with the former President of the national BCBS Association, Bernard Tresnowski, December 1992).

⁹⁴ *Id.* at 215.

⁹⁵ *Senator Packwood, Chairman of the Finance Committee, 132 Cong. Rec. 513957* (daily edition September 27, 1986).

“We remain special and thus essentially different from our competitors - as we always have been. The task now becomes one of converting this new circumstance to our competitive advantage by emphasizing the characteristics that distinguish Blue Cross and Blue Shield Plans from all others - community origins, community ties, small group recognition, unique hospital and physician relationships - along with strong name recognition.”⁹⁶

Throughout most of its history, the national BCBS Association's rules prohibited conversion of BCBS plans to for-profit status. The Association actively portrayed itself and its state plan members as public benefit organizations. The 25th Anniversary Report of the Blue Cross Association (1955) states, "Blue Cross belongs to the people...it is an organization operating in the public interest." In 1994, however, one of its largest organizations, Blue Cross of California, ran into controversy over its move to establish a for-profit subsidiary.⁹⁷ In June of that same year, the national BCBS Association changed its policies so that its licensees could convert to for-profit status and distribute earnings to those who exercise control over the company.⁹⁸

The decision by the Association to permit its members to become for-profit entities opened the floodgates to conversions of BCBS plans across the country. As a result, the number of independent Blue plans fell sharply, from 67 in 1995 to 41 in 2003.⁹⁹

⁹⁶ *Cunninghams*, at 216 (quoting Tresnowski, "Report to the Plans, 1986," page 7).

⁹⁷ Milt Freudenheim, *For-Profit Shift at Blue Cross*, *The New York Times*, June 30, 1994, at C1.

⁹⁸ *Id.*

⁹⁹ Carl J. Schramm, "The Diseconomies of Blue Cross Conversion" Alliance for Advancing Nonprofit Healthcare, (2004), at <http://www.nonprofithealthcare.org/documentView.asp?docID=104&sid=>.

Blue Cross/Blue Shield State Histories

(As of November 30, 2007)

ALABAMA

Blue Cross and Blue Shield of Alabama is a nonprofit health insurer with 3.6 million members.

ALASKA

In May 2002, Premera Blue Cross of Washington and Alaska, which covers over 1.6 million people in both states, announced its plan to convert to a for-profit insurance company.

In February 2003, the Washington Insurance Commissioner allowed over two dozen individuals and organizations asserting a “significant interest” to intervene in the conversion proceeding. Several of the intervenors opposed the conversion of Premera and raised questions about whether the full value of the company would be preserved for the public in the event of a conversion.

In granting the motions to intervene, the Insurance Commissioner grouped the intervenors into five categories and required each to appoint a lead attorney. Each group was treated as a single party for purposes of discovery, presentation of evidence, oral and written argument, and cross-examination. The groups included: Washington consumers, Washington hospitals, Washington providers, and a coalition in Alaska. Among the members of the Alaska coalition are the Anchorage Neighborhood Health Center, United Way of Anchorage, and the University of Alaska.

In July 2004, the Washington Insurance Commissioner formally rejected the conversion proposal. Ten days later, the Alaska Director of Insurance echoed the Washington decision by rejecting the company’s effort to convert Premera’s holdings in Alaska. Each regulator thoroughly and critically examined the company’s conversion proposal and concluded that it was not in the best interests of consumers. Premera appealed the decisions in both Alaska and Washington. The Washington decision was upheld on appeal (*see* 133 Wash.App. 23, 131 P.3d 930 (2006)) which prompted Premera to withdraw the appeal in Alaska.

ARKANSAS

Blue Cross and Blue Shield of Arkansas is a mutual health insurer, owned by its policyholders, covering over 425,000 people.

ARIZONA

Blue Cross Blue Shield of Arizona is a nonprofit health insurer with over a million policyholders.

CALIFORNIA

Blue Cross of California (BCC) transferred a majority of its assets to a for-profit subsidiary in 1993. State regulators originally approved the transaction without any formal charitable asset distribution. Subsequently, the Department of Corporations determined that the transaction failed to protect the charitable assets of the former nonprofit corporation. The Commissioner of the Department of Corporations entered into discussions with BCC. The plan initially proposed distributing \$100 million of its assets to a charitable foundation. The Commissioner did not accept this figure. A series of negotiations ensued between the Department and BCC. Ultimately, BCC agreed to distribute all of its assets, over \$3.2 billion, to two grant making health foundations, creating The California Endowment, a 501(c)(3) private foundation, and the California HealthCare Foundation, a 501(c)(4) entity. The Commissioner hired independent consultants for assistance with determining the fair market value of the company and the mission, governance, and structure of the foundations. The charitable assets were distributed in a combination of cash and an equity interest in the new for-profit. The board selection for The California Endowment was extremely thorough and involved an executive search consortium.

The for-profit successor to Blue Cross of California is WellPoint Health Networks, Inc. WellPoint merged with Anthem, Inc. in 2004. The new company, called WellPoint Inc. is the Blue Cross licensee in California, and also a Blue Cross Blue Shield licensee in 13 other states: Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia, and Wisconsin. Wellpoint Inc. provides health insurance to 34 million customers, making it the nation's largest health insurer.

COLORADO

In 1996, BCBS of Colorado (BCBSCO) merged with Nevada BCBS, forgiving \$9.8 million in debt that the Nevada plan owed to the Colorado plan.

In March 1999, Anthem, Inc., a mutual insurer then owned by its policyholders, offered \$155 million for the Colorado and Nevada plans, and promised to preserve at least \$140 million of the purchase price in the Caring for Colorado Foundation.

In November 1999, after a 2-day hearing, the Insurance Commissioner approved BCBSCO's proposed conversion and sale to Anthem. Anthem placed \$155 million in the Caring for Colorado Foundation. The Foundation's by-laws call for a seven-member Community Advisory Committee appointed by the Board of Directors. The CAC is responsible for nominating three people for any Board vacancy. The Governor appoints Board members from the list the CAC provides. The Governor may remove a director he or she appointed for cause only. A vote of the directors can be used to remove any director

with or without cause. The Board of Directors must have at least one public meeting annually, during which the public can address the board.

In February 2001, Anthem announced its intention to convert from a mutual insurance company to a stock corporation (“demutualization”), and filed its demutualization proposal with the Indiana Department of Insurance in June 2001. Although policyholders in Connecticut, Indiana, Kentucky, and Ohio were eligible for Anthem shares, the proposal deprived policyholders in Colorado, Maine, Nevada and New Hampshire of any right to receive shares in the new company. Consumer groups in all Anthem states, concerned about the potential impact of this conversion on health care coverage, encouraged regulators to review the transaction carefully and to impose conditions that would protect current and future policyholders. Despite this request of the multi-state coalition, only the Indiana Department of Insurance conducted a public hearing – as required by state law. The hearing was held in Indianapolis (Anthem’s home base) in October 2001 and was quickly followed by the approval of the Indiana Insurance Commissioner. Subsequently, Anthem launched its IPO to become a publicly traded for-profit company.

Anthem merged with Wellpoint Health Networks in 2004. The new company, called Wellpoint Inc. is the Blue Cross licensee in California, and also a Blue Cross Blue Shield licensee in 13 other states: Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia, and Wisconsin. Wellpoint Inc. provides health insurance to 34 million customers, making it the nation’s largest health insurer.

CONNECTICUT

In July 1997, the Connecticut Department of Insurance approved the merger of BCBSCT with Anthem, Inc., a mutual insurer then owned by its policyholders. The Attorney General recused his office from dealing with the charitable trust issues raised in the merger, citing past assistance BCBSCT provided his office in its tobacco litigation. A Hartford law firm was named Special Attorney General.

During 1997, the state Comptroller and a coalition of advocacy and labor organizations filed separate suits against Anthem to protect policyholder rights and preserve charitable assets now possessed by Anthem. In December 1997, the Special Attorney General filed a suit to prevent Anthem from acquiring and transferring out of Connecticut assets that are rightfully subject to a charitable trust. The Special Attorney General also alleged that Anthem and BCBSCT breached their fiduciary duties by refusing to maintain the assets of the BCBSCT plan for charitable purposes. After the lawsuit was filed, Anthem initiated a public relations campaign against the Attorney General. Consumer groups, legislators and the Attorney General denounced Anthem’s advertising tactics.

In June 1999, the Attorney General, Comptroller and advocacy groups announced that they had reached a settlement with Anthem. As a condition of the settlement, Anthem agreed to transfer approximately \$41 million to a foundation to serve the underserved and uninsured. In order to ensure solid community and consumer representation, the state established the

Connecticut Health Advancement and Research Trust (CHART). This organization proceeded to appoint the board of the Anthem Foundation of Connecticut. The Foundation was incorporated as a supporting organization to CHART.

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DELAWARE

In December 1998, CareFirst, the holding company that owns the District of Columbia and Maryland BCBS plans, announced that it planned to affiliate with BCBS of Delaware. During 1999, the Delaware Department of Insurance and the Solicitor General conducted a review of the proposed combination. The regulators expressed several concerns about the proposed deal, including the transfer of BCBSD assets across state lines, the size of some severance packages for BCBSD executives, and the potential impact of a future CareFirst conversion on policyholders and the community.

In late November 1999, the Delaware Insurance Commissioner conducted two days of hearings on the proposed affiliation. In March of 2000 the Insurance Commissioner approved the affiliation, but in her order, she guaranteed clear regulatory oversight over future activities of the new CareFirst-BCBSD.

In January 2002, CareFirst filed an application with the Insurance Commissioner to convert to a for-profit corporation and merge with WellPoint Health Networks. The application for conversion was filed in Maryland, Delaware and the District of Columbia with the understanding that all three Insurance Commissioners must approve the merger before it would be approved. The Maryland Insurance Commissioner’s decision in March 2003 to

deny the conversion of CareFirst prompted WellPoint to withdraw its application in Delaware. [For more information on the proposed conversion of CareFirst, see Maryland and Washington, D.C.].

The CareFirst companies cover more than 3.3 million members in the Washington, D.C., Maryland, Delaware and Virginia, which is over 45% of the population in the service area.

WASHINGTON, D.C.

In January 1997, Group Hospitalization and Medical Services, Inc. (GHMSI), the Blue Cross and Blue Shield plan for the District of Columbia, announced that it would merge operations with BCBS of Maryland (BCBSMD). GHMSI was created by Congress and is governed by a federal charter. GHMSI sought to repeal its federal charter, and instead allow the nonprofit to be subject to the D.C. nonprofit code and other health insurance laws.

After much public pressure, however, GHMSI halted its efforts to repeal its federal charter. Instead, it began to pursue modifications to the federal charter so that it could merge with BCBSMD and establish a nonprofit holding company. The modifications declare that GHMSI is a “charitable and benevolent” organization. In December 1997, the Insurance Commissioners of D.C. and Maryland issued formal rulings on the proposed merger. Though falling short of calling for a stipulation by the two Plans that their assets are charitable, both rulings include provisions for the protection of assets. The D.C. ruling in particular re-emphasizes the charitable and benevolent status of GHMSI. The Maryland Insurance Commissioner also required that BCBSMD’s public assets be distributed in accordance with Maryland nonprofit law in the event of its dissolution, and required a financial “snapshot” of BCBSMD. In January 1998, the merger of BCBSMD and GHMSI was completed. The Maryland-based nonprofit holding company that governs both Plans is called CareFirst, Inc.. In March 2000, CareFirst “affiliated” with nonprofit Blue Cross and Blue Shield of Delaware.

In January 2002, CareFirst applied to convert to a for-profit corporation and merge with WellPoint Health Networks. The application for conversion was filed in Maryland, Delaware and the District of Columbia with the understanding that all three Insurance Commissioners had to approve the merger in order for it to go forward. A community coalition, CareFirst Watch, monitored the progress of the conversion and reviewed the application. The CareFirst Watch coalition conducted its own valuation and health impact studies to determine what the true value of CareFirst would be if it were sold, and how the proposed transaction would have likely impacted D.C. residents and their ability to access quality affordable health care.

In July 2002, the Council of the District of Columbia enacted emergency legislation regarding conversion, which included a shift in the burden of proof to the applicant to demonstrate that the conversion is in the public interest, expanded opportunities for interested individuals and organizations to participate in the Insurance Commissioner’s

formal hearings, and a 120-day (expanded from 30 days) review period for the Commissioner to decide on an application for conversion.

In March 2003, Maryland's Insurance Commissioner announced his decision to deny the proposed transaction. The D.C. Insurance Commissioner immediately issued a press release stating his plans to similarly deny the proposal in D.C., barring a challenge to Larsen's decision from the Maryland legislature, effectively ending CareFirst's bid to convert.

In May 2005, the D.C. Insurance Commissioner declared that CareFirst should be "engaging in charitable activity significantly beyond its current activities." While the commissioner found that CareFirst was meeting its basic legal obligation, he concluded that CareFirst can and should do more to promote health in the District. [For more information on the proposed conversion of CareFirst, see Maryland].

The CareFirst companies cover more than 3.3 million members in the Washington, D.C., Maryland, Delaware and Virginia, which is over 45% of the population in the service area.

FLORIDA

Blue Cross and Blue Shield of Florida is a mutual health insurer, owned by its policyholders, covering approximately 4 million people.

GEORGIA

In May 1996, Georgia BCBS (BCBSGA) filed for conversion and established itself as a privately held for-profit company called Cerulean Companies, Inc. The transaction was approved without any assessment of the plan's charitable trust obligations. In September 1997, nine consumer organizations filed a class action lawsuit and administrative petition against the Georgia Commissioner of Insurance and Cerulean/BCBSGA, alleging that a statute permitting its conversion was unconstitutional, that the approval must therefore be voided, and that the assets of the plan belong to a charitable foundation.

In July 1998, the consumer plaintiffs and Cerulean/BCBSGA reached a settlement. The settlement called for the transfer of between \$70 million and \$80 million to a new charitable foundation. The new foundation's board included three appointees chosen by the consumer plaintiffs, three chosen by Cerulean/BCBSGA, and three designated by prominent Georgia nonprofit organizations. On the same day, Cerulean/BCBSGA announced that it would be purchased by WellPoint Health Networks, Inc., the for-profit successor to Blue Cross of California. The settlement agreement was approved in August 1998.

When the conversion took place in 1996, shares of stock in Cerulean were issued to BCBSGA policyholders who responded to an offer. Subsequent to the announcement of WellPoint's plan to acquire Cerulean, a lawsuit was filed on behalf of the remaining BCBSGA policyholders who did not obtain Cerulean stock. Although implementation of the settlement was delayed because of the policyholders' litigation, in November 2000, the Cerulean board accepted a higher offer from WellPoint. In March 2001, the Georgia

Insurance Commissioner approved the acquisition. The acquisition increased the new foundation's endowment to \$124 million.

Wellpoint merged with Anthem, Inc. in 2004. The new company, called Wellpoint Inc. is the Blue Cross licensee in California, and also a Blue Cross Blue Shield licensee in 13 other states: Colorado, Connecticut, Georgia Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia, and Wisconsin. Wellpoint Inc. provides health insurance to 34 million customers, making it the nation's largest health insurer.

HAWAII

The Hawaii Medical Service Association, the Blue Cross and Blue Shield licensee in Hawaii, is a mutual health insurer, owned by its policyholders, and covering over 640,000 people.

IDAHO

In March 2001, Regence Blue Cross Blue Shield of Oregon, Regence Blue Shield of Washington, Regence Blue Cross Blue Shield of Utah, and Regence Blue Shield of Idaho, known as The Regence Group, filed an application to "affiliate" with the Blue Cross and Blue Shield plans in Illinois and Texas, which are divisions of the Chicago-based Health Care Service Corporation (HCSC).

Although Regence stated that it intended to remain nonprofit, consumer groups were concerned about the potential loss of charitable assets. Regence and HCSC would have created a separate operating company to handle shared administrative functions. This operating company would have been capitalized by the transfer of assets from HCSC and Regence. Regence is a nonprofit public benefit corporation with obligations to protect charitable assets. HCSC is a mutual company owned by its policyholders. Under the "affiliation," it was not clear how Regence intended to protect the charitable/nonprofit assets it would have transferred into this new operating company.

Although Regence and HCSC denied the deal was a merger, consumer groups argued to regulators that the transaction involved a change of control of the Regence health plans. In May 2001, regulators in Oregon and Washington agreed with consumer groups that the affiliation was indeed a change of control. The affiliation would have created three "interlocking" boards of directors and a single management team; the boards would have had significantly overlapping memberships, giving control over all of three companies to the same group of 17 individuals. All three boards would have had the majority of its members appointed by the Chicago-based HCSC.

Regence announced in August 2001 that it was withdrawing its application to "affiliate" with HCSC. The announcement came one week before public hearings were scheduled to begin on the proposal.

The Regence Group covers nearly 3 million people in four states: the Oregon plan covers 1 million people, about 27% of the state's population; the Washington plan covers 1 million people, about 16% of the population of the state; the Utah plan covers 400,000 people, about 16% of the state's population; and the Idaho plan covers 180,000 people, or 13% of the population.

ILLINOIS

Several years ago, Illinois BCBS, operated by Health Care Service Corporation (HCSC), submitted a proposal to merge with BCBS Texas. HCSC is a mutual insurance company, owned by its policyholders, that can become for-profit by a vote of a majority of its board. BCBSTX, on the other hand, was a nonprofit health insurer whose assets were held in trust to further its nonprofit mission.

The Texas Attorney General filed a lawsuit to block the proposed merger in 1996, arguing that the merger violated Texas law because the Illinois company did not meet the Texas definition of a "nonprofit." In 1998, the trial court issued a letter opinion against the Attorney General and in favor of the merger. The court held, contrary to much of the evidence before it, that BCBSTX is not a charitable corporation and that HCSC meets the Texas definition of a nonprofit corporation.

In 1998, the Texas Attorney General agreed not to appeal the issue of whether HCSC met the Texas definition of a nonprofit corporation and allowed the merger to move forward. In exchange, HCSC agreed to pay \$10 million over five years to Texas Healthy Kids Corporation (for subsidies to low-income families buying insurance for their children). The merger was approved by the Insurance Departments of both Texas and Illinois in late 1998. HCSC remained unwilling to admit that BCBSTX had a charitable asset obligation to the people of Texas. But in December 2002, HCSC entered into a settlement agreement with the Attorney General of Illinois, under which it set aside \$124.6 million in a health care foundation, recognizing its nonprofit status before HCSC became a mutual insurance company in Illinois.

The Texas Attorney General did, however, appeal the trial court ruling that BCBSTX was not a charitable organization. In 2003, the Court of Appeals for the Third Judicial District upheld the trial court's ruling. Weeks later, the Attorney General discovered and shared with the Court of Appeals a written history, which was authorized, underwritten, and published by BCBSTX, entitled *Lone Star Legacy: The Birth of Group Hospitalization and the Story of Blue Cross and Blue Shield of Texas* (1999). In it, the author stated that BCBSTX had, in fact, solicited and received charitable donations over the years. Because of the new evidence, the Attorney General asked the Court of Appeals to reconsider its affirmation of the trial court's ruling, which the Court refused to do. In early 2004, the Attorney General filed a petition for review of this matter with the Supreme Court of Texas. The court rejected the Attorney General's petition. In 2005, the Attorney General filed a Bill of Review with the court asking it to reconsider. Though initially the court denied a

motion by BCBS to dismiss the Bill of Review, the court subsequently denied the Attorney General's request.

HCSC acquired Blue Cross Blue Shield of New Mexico in May 2001. (See New Mexico for more information.) Also in 2001, HCSC filed an application with regulators in six states to "affiliate" with Blues plans in Oregon, Washington, Idaho and Utah. However, one week before public hearings were scheduled to begin on this proposal, and after community groups argued the "affiliation" was really a merger, HCSC announced it was withdrawing its application.

In 2005, HCSC merged with the Blue Cross Blue Shield plan in Oklahoma. HCHS now has more than 11.5 million members in Oklahoma, Illinois, Texas and New Mexico.

In 1998, HCSC pleaded guilty to Medicare fraud charges for the years 1985 through 1994 and agreed to pay \$144 million in fines to the federal government, the largest penalty assessed against a Medicare claims processor for fraud. As a result of its fraudulent activities, HCSC received \$1.29 million in undeserved bonuses.

INDIANA

Indiana Blue Cross and Indiana Blue Shield were created in the 1940's. In 1985, the two plans merged and changed their name to Associated Insurance Companies, Inc. In 1989, Associated created a wholly-owned subsidiary, Accordia, Inc., to handle insurance brokerage, claims administration, underwriting management and employee benefit consulting services. Associated changed its name to Anthem, Inc. in 1996, a mutual insurer owned by its policyholders.

In February 2001, Anthem announced its intention to convert from a mutual insurance company to a stock corporation ("demutualization"), and filed its demutualization proposal with the Indiana Department of Insurance in June 2001. Although policyholders in Connecticut, Indiana, Kentucky, and Ohio were eligible for Anthem shares, the proposal deprived policyholders in Colorado, Maine, Nevada and New Hampshire of any right to receive shares in the new company. Consumer groups in all Anthem states, concerned about the potential impact of this conversion on health care coverage, encouraged regulators to review the transaction carefully and to impose conditions that would protect current and future policyholders. Despite this request of the multi-state coalition, only the Indiana Department of Insurance conducted a public hearing – as required by state law. The hearing was held in Indianapolis (Anthem's home base) in October 2001 and was quickly followed by the approval of the Indiana Insurance Commissioner. Subsequently, Anthem launched its IPO to become a publicly traded for-profit company.

Anthem merged with for-profit Wellpoint Health Networks in 2004. The new company, called Wellpoint Inc. is the Blue Cross licensee in California, and also a Blue Cross Blue Shield licensee in 13 other states: Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia, and Wisconsin.

Wellpoint Inc. provides health insurance to 34 million customers, making it the nation's largest health insurer.

IOWA

Blue Cross Blue Shield of Iowa, Blue Cross of Western Iowa and Blue Cross of South Dakota merged into one nonprofit health service corporation, incorporated in the state of Iowa, in 1989. It then changed its name to IASD. Two years later, IASD applied under special Iowa legislation, to become a mutual insurer, owned by its policyholders and incorporated in Iowa. The legislation permitted conversion from a nonprofit to a mutual so long as the plan declared whether it would organize as a for-profit mutual or as a nonprofit mutual. In the preamble to the new mutual insurer's articles of incorporation, the plan declared that it would be governed under for-profit law and owned by its policyholders.

IASD then merged with South Dakota Blue Shield in July 1996, creating Wellmark BCBS. Regulators approved the transaction without requiring either plan to preserve and protect its charitable assets.

Today, Wellmark BCBS of Iowa covers more than 1.7 million Iowans and Wellmark BCBS of South Dakota covers more than 300,000 South Dakotans.

KANSAS

In May 2001, BCBS of Kansas (BCBSK) and Anthem Insurance Companies, Inc., an Indiana-based mutual insurance company that was in the process of converting to for-profit, jointly announced their intent to affiliate. In this transaction, described as a "sponsored demutualization," Anthem planned to provide \$370 million to BCBSK, of which \$190 million was to cover BCBSK's outstanding expenses and \$180 million would have been paid to eligible policyholders. BCBSK would then become a wholly-owned subsidiary of for-profit Anthem.

During the review process the Insurance Commissioner served as an impartial adjudicator, and a testimonial team, comprised of Insurance Department staff and outside counsel, was created to review the terms of the deal on behalf of the people of Kansas. The Commissioner's role included presiding over the proceedings, examining the information assembled during the review process and then making a determination whether to approve or reject the proposed transaction. The information-gathering process included five public comment meetings held in various locations across the state, and three days of formal public hearings.

Concerned about the impact on health services and access, the Kansas Association for the Medically Underserved, the Kansas State Nurses Association, the Kansas Medical Society and the Kansas Hospital Association petitioned for and were granted intervenor status in the proceedings. Over 1,200 Kansans attended the meetings to question various aspects of the

deal, including whether the conversion would benefit them and to criticize the lack of objective information available on the deal.

The testimonial team and intervenors called on independent financial and economic experts to help analyze the benefits and detriments of the deal. Chief among the detriments was an analysis of the Kansas insurance environment by PricewaterhouseCoopers, which found that imposing a shareholder profit requirement on Kansas's largest insurer would likely result in additional premium increases in the small and individual group markets of \$248 million over five years. In the final hours before the public record was closed, Anthem added to the terms of the deal a \$25 million rate stabilization fund that the state could use to subsidize premiums for small group policies payable to Anthem.

In January 2002, the testimonial team joined the four intervenors in formally opposing the transaction. Citing the additional premium increases, the testimonial team's report recommended rejecting the conversion proposal and took particular exception to Anthem's last minute offer of \$25 million calling it, "an insult to the intelligence of [Kansans] and the Commissioner."

In February 2002, the Insurance Commissioner formally rejected the proposed conversion and became the first industry regulator in the nation to reject a for-profit health insurer's proposal to buy a state's Blue Cross and Blue Shield Plan. The proposal was found to be, "unreasonable to policyholders and not in the public interest, and hazardous and prejudicial to the insurance-buying public." BCBSK announced that it would appeal the Commissioner's final order and formally began the appeals process.

In June 2002, the Shawnee County District Court issued a Memorandum Order and Decision vacating the Order and remanding the case back to the Commissioner for further proceedings consistent with the ruling.

Undeterred, the Commissioner issued a written statement in which she promised "to protect the families and businesses of Kansas from millions of dollars in increased insurance rates." Making good on this vow, the Commissioner filed a Notice of Appeal in June 2002 arguing that it was within her statutorily-granted authority to disapprove the proposal as she did. In August 2003, the Kansas Supreme Court upheld the Commissioner's decision to deny the proposed sale of BCBSK to Anthem Insurance.

KENTUCKY

In 1993, Blue Cross Blue Shield of Kentucky (BCBSKY) merged with Anthem Insurance Companies, Inc., a mutual insurance company owned by its policyholders. The Department of Insurance approved the merger without any consideration of BCBSKY's charitable assets. In 1996, the Department of Insurance requested that the Attorney General's office seek an audit of the 1993 merger because a routine investigation by the Department had raised questions about Anthem's use of reserves. In March 1997, Anthem filed a lawsuit

against the Attorney General and the Department of Insurance, alleging that the merger investigation exceeded the regulators' scope of authority.

In October of 1997, the Attorney General filed a lawsuit against Anthem seeking to recover millions of dollars in charitable assets that Anthem absorbed when it merged with BCBSKY, and to reimburse policyholders for premium increases due to violations of the Consumer Protection Act. Two days later, Anthem initiated a public relations campaign against the Attorney General's lawsuit and consumer groups by sending a mailing to all of its policyholders in Kentucky and taking out advertisements threatening higher premiums and less financial security if the Attorney General prevailed. In March 1998, the Commissioner of Insurance ruled that Anthem conducted a "highly misleading" campaign, but decided to take no action against Anthem.

The court allowed the case to proceed, and gave the Attorney General the opportunity to prove that BCBSKY held charitable assets and to determine the value of those assets.

In December 1999, the Attorney General and Anthem announced a settlement of the charitable trust issue. Anthem agreed to place \$45 million into a newly created 501(c)(3) foundation that would be used to fund unmet health care needs of Kentuckians.

In September 2000, the Governor appointed a 35-member initial advisory committee to create the foundation. The initial advisory committee was diverse both geographically and demographically. It included individuals from universities, provider groups, businesses, and philanthropies, with no single interest appearing to dominate. Among the groups represented on the committee were consumer groups who were deeply concerned about the potential loss of charitable asset dollars when Kentucky Blue Cross merged with Anthem.

The initial advisory committee met in December 2000 to discuss key elements of the structure and composition of the new health foundation, including its articles of incorporation, by-laws, a nomination process and an initial slate of Board members. Among the characteristics of the Foundation is an important role for a continuing Community Advisory Committee that had as its members many of the individuals who served on the initial advisory committee. The new foundation received the \$45 million in charitable assets recovered in the Anthem settlement, plus interest.

In February 2001, Anthem announced its intention to convert from a mutual insurance company to a stock corporation ("demutualization"), and filed its demutualization proposal with the Indiana Department of Insurance in June 2001. Although policyholders in Connecticut, Indiana, Kentucky, and Ohio were eligible for Anthem shares, the proposal deprived policyholders in Colorado, Maine, Nevada and New Hampshire of any right to receive shares in the new company. Consumer groups in all Anthem states, concerned about the potential impact of this conversion on health care coverage, encouraged regulators to review the transaction carefully and to impose conditions that would protect current and future policyholders. Despite this request of the multi-state coalition, only the Indiana Department of Insurance conducted a public hearing – as required by state law. The hearing was held in Indianapolis (Anthem's home base) in October 2001 and was quickly followed

by the approval of the Indiana Insurance Commissioner. Subsequently, Anthem launched its IPO to become a publicly traded for-profit company.

Anthem merged with Wellpoint Health Networks in 2004. The new company, called Wellpoint Inc. is the Blue Cross licensee in California, and also a Blue Cross Blue Shield licensee in 13 other states: Colorado, Connecticut, Georgia, Indiana, Kentucky Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia, and Wisconsin. Wellpoint Inc. provides health insurance to 34 million customers, making it the nation's largest health insurer.

LOUISIANA

Blue Cross and Blue Shield of Louisiana is a mutual health insurer, owned by its policyholders, covering over one million people.

MAINE

In July 1999, BCBSME and Anthem Insurance Companies, a mutual insurer owned by its policyholders, announced plans to "affiliate." The terms of the proposed agreement included a purchase price of \$120 million and a new health conversion foundation founded with an \$82 million endowment.

Over the course of the Attorney General's review of the charitable trust plan, a large community coalition formed to represent individuals and organizations concerned with the proposed sale. The Attorney General held a series of 12 public forums throughout the state in late 1999 to solicit comment on the mission, governance and structure of the proposed foundation. Following these public meetings and discussions with public interest groups, the Attorney General submitted his modifications to the foundation plan prepared by BCBSME. This plan established the mission of the new foundation ("to foster improved access to health care and improved quality of health care to medically uninsured and medically underserved persons within the State of Maine...") and required that at least three members of the foundation's board represent the interests of medically uninsured and underserved populations of the state. The plan also established a Community Advisory Committee that oversees required periodic needs assessments and fills seats on the foundation board.

The Superintendent of Insurance held a public meeting in January 2000 and approved the conversion proposal five months later. The Attorney General then named an 18-member foundation Community Advisory Committee, which submitted nominations for the 15-member Board of Trustees. The Attorney General appointed the members of the initial Board in December 2000.

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with the Indiana Department of Insurance in June 2001. Although policyholders in Connecticut, Indiana, Kentucky, and Ohio were eligible for Anthem shares, the proposal deprived policyholders in Colorado, Maine, Nevada and New Hampshire of any right to receive shares in the new company. Consumer groups in all Anthem states, concerned about the potential impact of this conversion on health care coverage, encouraged regulators to review the transaction carefully and to impose conditions that would protect current and future policyholders. Despite this request of the multi-state coalition, only the Indiana Department of Insurance conducted a public hearing – as required by state law. The hearing was held in Indianapolis (Anthem’s home base) in October 2001 and was quickly followed by the approval of the Indiana Insurance Commissioner. Subsequently, Anthem launched its IPO to become a publicly traded for-profit company.

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MARYLAND

In 1997, BCBS of Maryland (BCBSMD) announced that it would merge with Group Hospitalization and Medical Services, Inc. (GHMSI) of the District of Columbia. The merger was completed on January 16, 1998. The companies are owned by a Maryland-based nonprofit holding company called CareFirst, Inc.

In April 1998, the Governor of Maryland signed conversion legislation giving the Commissioner of Insurance the authority to require a set-aside of all “public or charitable” assets possessed by health service plans such as BCBSMD. The legislation established a conversion foundation, the Maryland Health Care Foundation, to protect the charitable assets.

In March 2000, CareFirst affiliated with nonprofit Blue Cross and Blue Shield of Delaware.

Anticipating a conversion, the Maryland Legislature amended the state’s conversion law in April 2001. This amendment required that the conversion assets be preserved in a trust within the existing foundation to be expended only at the direction of the state legislature.

In January 2002, CareFirst filed an application with the Insurance Commissioners of Delaware, Maryland and the District of Columbia to convert to a for-profit corporation and merge with Well Point Health Networks, a California based for-profit. All three Insurance Commissioners had to approve the merger in order for it to go forward.

In 2002, the Maryland legislature passed two bills that created more-stringent requirements for conversions, including a requirement that the applicant bears the burden to prove that

the conversion is in the public interest, a requirement that the purchase price be provided to the foundation in cash, and restrictions on compensation packages for executives.

The Insurance Commissioner contracted with four experts to assist him in his review of the application. The valuation experts returned their report on the value of CareFirst and advised the Commissioner that CareFirst was worth much more than the \$1.3 billion purchase price. The Commissioner also contracted with experts to study the due diligence aspect of the transaction, foundation issues, the health impact of the conversion and the compensation packages of the executives of CareFirst. In addition to hiring experts, the Insurance Commissioner conducted five public meetings throughout the state and multiple hearings with testimony from CareFirst, Wellpoint, the Commissioner's experts and the public throughout 2002 and early 2003.

There was significant public outcry regarding the compensation arrangements for executives of CareFirst that would have resulted from the conversion. In the compensation provisions, \$27.4 million would have been provided to CareFirst executives as incentive bonuses to stay on after the conversion and \$47.8 million would have been provided to them in change of control payments.

After holding hearings, analyzing the documents, and listening to the concerns expressed by the community, the Insurance Commissioner rejected the application because it was not in the public interest. In his 300-page decision released on March 5, 2003, the Commissioner explained that the Board of CareFirst had failed to uphold its fiduciary duty, the company had abandoned its nonprofit mission, the Board had failed to obtain an appropriate purchase price for the plan, and the Board and management had not considered the impact on the community in deciding to sell the plan. [For more information on the proposed conversion of CareFirst, see Washington, D.C.].

In April 2003, the Maryland legislature passed a bill to make CareFirst a more responsible nonprofit organization by changing the CareFirst Board members, stating its charitable mission in statute and establishing certain requirements for the nonprofit. In January 2005, acceding to pressure about its surplus and its failure to fulfill its charitable obligations, CareFirst Maryland agreed to distribute over \$90 million to help stabilize premium rates and make its health insurance more affordable to consumers.

The CareFirst companies cover more than 3.3 million members in the Washington, D.C., Maryland, Delaware and Virginia, which is over 45% of the population in the service area.

MASSACHUSETTS

Blue Cross and Blue Shield of Massachusetts is a nonprofit health insurer with approximately 3 million members.

MICHIGAN

Blue Cross and Blue Shield of Michigan is a nonprofit health insurer with approximately 4.7 million members.

MINNESOTA

Blue Cross and Blue Shield of Minnesota is a nonprofit health insurer with approximately 2.7 million members.

MISSISSIPPI

Blue Cross and Blue Shield of Mississippi (BCBSMS) changed its business form from a nonprofit to a mutual insurance company, owned by its policyholders, in 1995. A law enacted in 1998 would allow it and other mutual insurers to convert to stock corporations.

MISSOURI

1) BCBS of Kansas City, Missouri (BCBSKC): In March 1997, BCBSKC filed a petition against the Attorney General seeking a declaratory judgment that the plan is a mutual benefit corporation. BCBSKC claimed that it is not, and has never been, a public benefit corporation. In September 1998, a Missouri trial court ruled in favor of the Attorney General and declared that BCBSKC is a public benefit corporation under Missouri's nonprofit code. The Court agreed with the Attorney General that BCBSKC was created for public purposes, and that it consistently held itself out as a public benefit corporation in its articles of incorporation, tax filings, and public pronouncements. The Court noted that for more than 50 years, BCBSKC "took advantage of tax considerations and status in the community based on its pledge to serve a public benefit mission." The decision effectively protects public assets held by BCBSKC in the event that it seeks to convert to for-profit status. BCBSKC appealed the trial court's decision, maintaining that it is a mutual benefit corporation. The Court of Appeals of Missouri upheld this decision, effectively protecting the public assets held by BCBSKC in the event that it seeks to convert to for-profit status in the future.

2) St. Louis: Blue Cross and Blue Shield of Missouri (BCBSMO). BCBSMO "restructured" in 1994, placing approximately 80% of its business into a for-profit subsidiary, Right Choice. The Department of Insurance (DOI) originally approved the transaction without a charitable asset set aside. Subsequently, DOI sought further review, on the ground that the plan failed to protect its charitable assets. BCBSMO sued both DOI and the Attorney General, who each filed counterclaims against the plan. In December 1996, a lower court ruled against BCBSMO, granting summary judgment for the Attorney General and the Department of Insurance. The court held that BCBSMO abused or exceeded its authority as a nonprofit by transferring its assets to a for-profit subsidiary, which was organized to benefit private shareholders. BCBSMO appealed the ruling in early January 1997. In April

1998, while the appeal was pending, BCBSMO and state regulators announced that a tentative settlement agreement had been reached. Under the tentative agreement, BCBSMO would transfer all of its 15 million shares of stock in Right Choice to a new foundation. Four months later, in August 1998, the Court of Appeals denied BCBSMO's appeal. BCBSMO then appealed the denial to the Missouri Supreme Court.

By September 1998, BCBSMO and state regulators finalized their settlement agreement and filed it with the trial court. Under the terms of the agreement, a new charitable health foundation was established and endowed with BCBSMO's 80% interest in Right Choice (approximately 15 million shares). In a final order, the trial court appointed a Special Master to conduct an investigation into the settlement agreement and hold public hearings. During the first public hearing, local and national consumer experts testified about the public interest involved in the conversion of BCBSMO.

In March of 1999, the Special Master issued an order and series of recommendations to the trial court judge. Some of the most important issues identified by the Special Master included recognition that further settlement negotiations should involve consumer groups and a requirement that the proposed settlement must include a fair market valuation.

Pursuant to a January 2000 settlement agreement between Attorney General, the Department of Insurance, and BCBSMO, the company was allowed to convert and a set-aside was made to the Missouri Foundation for Health. In November 2000, the Foundation received almost \$13 million in start-up cash and 15 million shares (80%) of common stock of the new for-profit Right Choice Managed Care, Inc. Those shares were worth approximately \$400 million at the time, making it the largest charitable health foundation in Missouri.

The Governor and Attorney General worked in consultation with representatives from consumer groups to appoint a 13-member Community Advisory Committee (CAC). The consumer groups included the Missouri Consumer Health Care WATCH, League of Women Voters of Missouri, American Association of Retired Persons and Missouri Association for Social Welfare and Reform Organization of Welfare. The CAC screened and named a slate of 35 candidates from which the Attorney General appointed a 15-member Foundation board.

In the fall of 2001, California-based Wellpoint Health Networks agreed to purchase Right Choice for \$1.3 billion, or \$66 per share, more than doubling the estimated value of the Missouri Foundation for Health. As part of the deal, the Foundation reduced its holdings from 80% to 57% of Right Choice shares. At that time, the Foundation was valued at approximately \$880 million.

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MONTANA

For years, Montana consumers and legislators had heard rumors that nonprofit Blue Cross Blue Shield of Montana was planning to convert to a for-profit company. In 2005, Montana enacted comprehensive health care conversion legislation to protect consumers in the event of a conversion. The Montana law establishes a clear application process for nonprofit health plans seeking to become for-profit companies; requires public notice and hearings across the state, gives regulators clear discovery powers, gives unfettered public access to conversion proposals and all accompanying documents; creates a transparent system for distributing the assets to a foundation or another nonprofit organization in the event of a conversion, and requires a company proposing a conversion to pay the reasonable costs of regulatory review of any conversion proposal.

NEBRASKA

Blue Cross and Blue Shield of Nebraska is a mutual health insurer, owned by its policyholders, covering over 600,000 people.

NEVADA

The Insurance Commissioners in Nevada and Colorado approved a merger between BCBS of Nevada and BCBS of Colorado on December 31, 1996. The public learned of the transaction two weeks later, the same day that the now-merged Colorado company filed a proposal to convert to a for-profit corporation. As part of the terms of the merger agreement, the merged company set aside \$1.5 million in Nevada to establish a new foundation focusing on children's health care. No trace of the \$1.5 million set aside has been discovered in Nevada.

In March of 1999, Anthem, Inc, a mutual insurer then owned by its policyholders, offered \$155 million for the Colorado and Nevada plans, and promised to preserve at least \$140 million of the purchase price in the Caring for Colorado Foundation.

In November of 1999, after a 2-day hearing, the Insurance Commissioner approved BCBSCO's proposed conversion and sale to Anthem. Anthem placed \$155 million in the Caring for Colorado Foundation. The Foundation's by-laws call for a seven-member Community Advisory Committee appointed by the Board of Directors. The CAC is responsible for nominating three people for any Board vacancy. The Governor appoints Board members from the list the CAC provides. The Governor may remove a director he or she appointed for cause only. A vote of the directors can be used to remove any director with or without cause. The Board of Directors must have at least one public meeting annually, during which the public can address the board.

In February 2001, Anthem announced its intention to convert from a mutual insurance company to a stock corporation (“demutualization”), and filed its demutualization proposal with the Indiana Department of Insurance in June 2001. Although policyholders in Connecticut, Indiana, Kentucky, and Ohio were eligible for Anthem shares, the proposal deprived policyholders in Colorado, Maine, Nevada and New Hampshire of any right to receive shares in the new company. Consumer groups in all Anthem states, concerned about the potential impact of this conversion on health care coverage, encouraged regulators to review the transaction carefully and to impose conditions that would protect current and future policyholders. Despite this request of the multi-state coalition, only the Indiana Department of Insurance conducted a public hearing – as required by state law. The hearing was held in Indianapolis (Anthem’s home base) in October 2001 and was quickly followed by the approval of the Indiana Insurance Commissioner. Subsequently, Anthem launched its IPO to become a publicly traded for-profit company.

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NEW HAMPSHIRE

On January 28, 1999, Anthem Insurance Companies, Inc. and Blue Cross and Blue Shield of New Hampshire (BCBSNH) announced that Anthem would purchase BCBSNH for \$120 million. Under the terms of the deal, the proceeds of the sale would go to a newly created charitable health foundation.

In 1999, the New Hampshire Attorney General held a series of seven public hearings on the plan for the health foundation and in August signed off on the proposed charitable trust plan. Following this approval, BCBSNH and Anthem filed a *cy pres* petition in Probate Court to obtain court approval of the conversion. Two public interest groups, including New Hampshire Citizens Alliance (NHCA), moved to intervene in the Probate Court review of the *cy pres* petition, opposing the Attorney General’s approval. However, the Court ruled that the two groups could only submit comments related to areas of law which the Attorney General failed to consider in his review. NHCA filed a memorandum, arguing that the Attorney General’s failure to consider the *cy pres* doctrine constituted a material omission, and thus prevented the court from making an informed decision. In October 1999, the court ruled that the Attorney General did not err and approved the charitable trust plan.

Meanwhile, the New Hampshire Department of Insurance conducted a 3-day public hearing on the proposed sale in late August 1999. In addition to New Hampshire consumers, representatives from Connecticut and Rhode Island also testified at the Department of Insurance hearing, speaking about experiences with Anthem in their states. Because the companies were unwilling to release key documents prior to the public hearing, a coalition

of public interest and provider organizations filed discovery requests in formal proceedings before the Insurance Department. In response to these requests, the groups were allowed to review the documents after signing confidentiality agreements.

In October 1999, the Department of Insurance approved the sale of BCBSNH to Anthem and imposed 18 conditions on the new company. The conditions included that Anthem must: 1) create a local advisory board (and that they must consult intervenors when determining membership) which must be consulted before significant changes are made to the NH company such as changes in community benefits, employment levels, and provider contracting; 2) maintain employment levels in New Hampshire that proportionately match Anthem's employment levels in other states; 3) provide community benefits for three years at a rate equal to the average spent by BCBSNH over the past two years (funds should go to a vaccine program, a healthy kids program, and a program called NH Health Link Program); 4) report data on verbal and written complaints to the Department of Insurance for 3 years; 5) offer a nongroup product for the next three years; and 6) maintain a provider network comparable to that of BCBSNH.

According to the charitable trust plan, the net proceeds of the sale of BCBSNH to Anthem Insurance Companies, Inc., would be used to establish the "Endowment for Health, Inc." a 501 (c) (3) foundation whose purpose is to improve the health of the people of New Hampshire. The Endowment for Health Inc was valued at approximately \$83 million in 2000.

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NEW JERSEY

Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) is New Jersey's largest health insurer, providing health coverage to more than 3.4 million members.

Horizon has twice proposed converting to a for-profit company, first in 1996 in an unsuccessful merger with Anthem, Inc. and then later on its own in 2001. In August 2003, Horizon announced that it would not pursue conversion for the time being, after considering its options for two years and watching unsuccessful conversion attempts in other states. However, beginning in early 2005, the New Jersey Governor Richard Codey and legislative leaders initiated discussions with Horizon about possibly reviving its conversion bid. The state is interested in obtaining the proceeds of the conversion to help fund state health care programs such as charity care, and/or non-health care purposes such as property tax rebates.

NEW MEXICO

Blue Cross and Blue Shield of New Mexico (BCBSNM) was, for most of its history, a nonprofit health care plan. Now it is a mutual insurer, owned by its policyholders and affiliated with Health Care Service Corporation (HCSC), the Chicago – based owner of Blues plans in Illinois, Oklahoma and Texas. HCSC has more than 11.5 million members in Oklahoma, Illinois, Texas and New Mexico.

During the 1999 legislative session, the nonprofit BCBSNM sponsored a bill that gave the plan greater authority to enter into transactions, such as mergers, acquisitions, and affiliations, with other health care plans. The legislature passed the bill, but amended it to protect the charitable assets of nonprofit plans. As amended, the legislation requires the Superintendent of Insurance to ensure that, in any transaction, the charitable assets of a nonprofit health care plan, such as BCBSNM, are preserved for the benefit of the people of New Mexico.

In March 2000, BCBSNM announced that it had accepted an acquisition offer from HCSC. In July, BCBSNM submitted a proposal to New Mexico's Superintendent of Insurance to sell the plan to the out-of-state mutual insurer. The terms of the deal included a sale price of \$55 million minus certain liabilities. The company initially estimated that only \$5 million would remain to endow a foundation to carry on the mission of the nonprofit BCBS plan.

In October 2000, a coalition representing New Mexico consumer groups, labor unions and religious groups, called Save Our Health Resources, intervened in the Insurance Division's regulatory hearing reviewing the proposed sale of Blue Cross Blue Shield of New Mexico. This coalition argued that the full fair market value—an amount much higher than \$5 million—had to be set aside for health care needs in New Mexico. The Attorney General, Anthem Insurance Companies, Inc., The University of New Mexico and its foundation, and the New Mexico Public Schools Insurance Authority also intervened in the proceedings.

The parties, including the consumer coalition, announced in April 2001 that they had reached a settlement. Under the agreement, the companies promised to provide approximately \$20 million to endow a foundation devoted to the health of the people of New Mexico. Also, HCSC agreed to continue existing product lines including products offered to individuals, to guarantee New Mexicans representation on the HCSC board of directors, to maintain levels of employment in New Mexico, to maintain local operation of claim processing and other services in New Mexico and to grant New Mexican policy holders the same rights as Illinois policy holders. In May 2001, the Superintendent issued his final order approving the settlement.

After the Superintendent of Insurance approved the final plan, he held another public hearing about what should happen to these nonprofit assets. As a result, the Superintendent and Attorney General convened an eleven-member Advisory and Planning Committee. At the first meeting of the Committee, the regulators recommended that the Committee establish a new, independent health foundation. The Committee, composed of individuals representative of consumer and health care concerns across the state, met several times between August and October 2001 to discuss the mission, structure and governance of the foundation. After its last meeting, the Committee provided its final recommendations to the regulators.

The Superintendent encouraged a thorough and open discussion throughout the Committee meetings. The Attorney General provided staff to help the Committee with its work. With the assistance of both offices, the Committee was able to create the framework for an independent, private 501 (c)(3) charitable foundation with a strong mission to serve the unmet health needs of the people of New Mexico. The Committee proposed the creation of a diverse 12-to-15 member Board of Directors to manage the foundation. The Committee also decided to create a Community Advisory Committee (CAC) of at least 15 members to provide advice and counsel to the foundation Board. The CAC acts as a liaison between health care consumers in New Mexico and the foundation's Board.

NEW YORK

New York has four Blue Cross and Blue Shield (BCBS) plans: BCBS of Western New York (nonprofit); BCBS of Northeastern New York (nonprofit); Excellus (nonprofit); and Empire BCBS (for-profit) a subsidiary of WellPoint.

In January of 2002, at 4:30 in the morning, the governor of New York and the leader of the state's largest labor union (SEIU 1199) persuaded the New York legislature to pass politically self-serving legislation regarding the conversion of Empire Blue Cross and Blue Shield. Under the law, just 5% of the conversion proceeds were set aside in a small foundation dedicated to expanding access to health coverage. The bill required the other 95% of Empire's charitable assets to fund salary increases for hospital workers. To make matters worse, the law imposed a virtual stranglehold by the government on the foundation by giving elected officials the authority to nominate board members and oversee foundation activities.

Although increasing the salaries of deserving hospital employees is a laudable goal, charitable assets should not be squandered for this onetime private purpose. The plan was politically self-serving for both the governor and the union leader. In exchange for his support of the bill, New York's then-governor – George Pataki – got the newfound political support of the union – SEIU 1199. And the union leader, Dennis Rivera, was able to deliver salary increases to 13% of his membership base.

The situation in New York was not always this bleak. Empire originally announced in late 1996 that it would convert to a for-profit corporation. Empire agreed, at that time, to transfer 100% of its charitable assets to a nonprofit foundation. In 1997, Empire filed its conversion documents with the Attorney General and Department of Insurance. At that time, both SEIU 1199 and the Greater New York Hospital Association commenced a campaign of public opposition to the conversion because they believed a for-profit health plan would not protect the health of the poor in New York. In 1999, the New York Insurance Department held a series of three public hearings on the conversion and subsequently approved aspects of Empire's conversion over which the Department had jurisdiction. In May 2000, after a year of negotiations with Empire and the Blue Cross Blue Shield Association, the Attorney General announced his approval of the valuation and foundation aspects of Empire's conversion plan. Unfortunately, to further their own interests, the Governor and the union leader convinced the legislature to take 95% of the funds that otherwise would have gone to a foundation for public health projects.

Outraged that this back room deal diverted approximately two billion dollars from the public, Consumers Union filed a lawsuit. In a major victory for consumer groups, Consumers Union and five individual Empire subscribers were officially granted standing to sue in March of 2003. Later that year, a judge ruled that the plaintiffs had the right to pursue their suit, which argues that the legislation was unconstitutional. In August 2005, the New York Court of Appeals ruled 4-2 that the state had the constitutional authority to take Empire's charitable proceeds, provided they were spent by the state for health care purposes.

In 2005, WellChoice merged with for-profit WellPoint, based in Indiana. WellPoint also operates for-profit Blues plans in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, Ohio, Virginia and Wisconsin.

NORTH CAROLINA

In 1998, North Carolina passed a comprehensive conversion law setting up a process for regulatory review of conversion proposals and requiring the full fair-market value of the assets to be set aside in a foundation.

In 2002, Blue Cross and Blue Shield of North Carolina (BCBSNC) filed with the Insurance Commissioner a proposal to convert to a for-profit corporation. The company proposed that it maintain a virtual stranglehold over the new foundation.

A sophisticated and politically savvy group of consumer advocates, led by the North Carolina Health Access Coalition (NCHAC), urged state regulators to carefully scrutinize the proposal. Active consumer participation was well matched by responsible public officials who became concerned about BCBSNC and the Blue Cross and Blue Shield Association's insistence that the company retain ultimate control of the stock that would have gone to the foundation. Under intense scrutiny, the company's efforts to argue that the conversion was good for consumers fell flat. Instead of suffering a rejection of their proposal by regulators, BCBSNC withdrew its proposal in July 2003.

NORTH DAKOTA

BCBS of North Dakota (BCBSND) filed a proposal to convert from a nonprofit health services corporation to a mutual insurance company, to be owned by its policyholders, in January 1997. The plan asserted that it would remain a nonprofit but would have no charitable trust obligations, despite clear statutory language stating that BCBSND is a "charitable and benevolent institution." Moreover, North Dakota law prohibited nonprofit corporations from being owned by, or distributing income, revenue or dividends to, private interests. The North Dakota Medical Association sponsored legislation that created a new category of mutual insurer – a nonprofit mutual. The proposed legislation also prohibited BCBSND from demutualizing or becoming a for-profit company. The Senate amended the bill to include language that the current BCBS plan is a "charitable and benevolent institution," and that immediately upon conversion; its assets are "impressed with a charitable trust." A final version of the bill passed both houses in the North Dakota legislature and was signed into law in April 1997. This law prohibits BCBSND from converting to for-profit status.

Subsequently, the Department of Insurance held hearings throughout the state on the proposed mutualization of BCBSND. In November 1997, the Insurance Commissioner approved BCBSND's application to become a mutual insurer, and the company is now owned by its policyholders and covers over 440,000 people.

OHIO

1) BCBS Mutual of Ohio/Medical Mutual: In 1996, BCBS Mutual of Ohio submitted a proposal to sell 85% of its assets to Columbia/HCA for \$299.5 million. Columbia/HCA retained the option to buy the rest of the plan for \$1 once it obtained the license to use the "cross" and "shield" service marks. One of the most controversial aspects of the deal was a multi-million dollar payout to top BCBS executives and attorneys who worked on the deal. Moreover, opponents believed the proposal did not protect the charitable assets of the BCBS plan or policyholder rights.

The National BCBS Association refused to permit the Ohio plan to transfer the valuable "cross" and "shield" service marks. In addition, the Ohio Attorney General filed a complaint against the plan, alleging that it breached its fiduciary duty by failing to protect the charitable assets it held in trust. In March 1997 the Ohio Department of Insurance (ODI)

rejected the deal and found that the multi-million dollar payments to insiders were unfair. The Sixth Circuit affirmed the National BCBS Association's revocation of BCBS of Ohio's license, and the Association transferred its license to Anthem Insurance Companies, Inc. In May 1997, legislation passed which gave the Attorney General explicit authority to review these deals and to protect the charitable assets involved.

Upon losing its mark, BCBS of Ohio became Medical Mutual of Ohio. In December 1997, the Attorney General announced a settlement of her complaint against Medical Mutual. The Attorney General said that under a court consent decree and final judgment, the charitable assets of Medical Mutual would be preserved. As part of the judgment, Medical Mutual acknowledged that it holds charitable assets. It also agreed to establish a new foundation to hold its charitable assets if it becomes a for-profit company in the future. The new foundation would be devoted to preventive health care for indigent children and adults.

2) *Community Mutual Insurance – Anthem*: In late 1995, the other BCBS Ohio plan, Community Mutual Insurance, merged with Anthem Insurance Companies, Inc., a mutual insurer owned by its policyholders. The Department of Insurance approved the merger without safeguarding the charitable assets of the plan. In July 1996, the Ohio Attorney General announced that she had initiated an investigation to determine whether there were charitable assets involved in the transaction that should have been protected and preserved. Community groups subsequently pressured the Attorney General to open the investigation for public review and to release documents relating to the merger, but she denied these requests.

In February 1999, the Attorney General's Office and Anthem reached a settlement. Under the terms of the settlement, Anthem contributed \$28 million to a newly created health care foundation called the Anthem Foundation. The Foundation has only five board members, one of whom is appointed by Anthem. Although local community groups were pleased that the Attorney General protected charitable assets, they were not satisfied with many of the terms of the settlement. They had a number of concerns regarding the lack of public process in reaching this agreement, the structure and governance of the foundation, the assumptions made in the valuation process, and the misleading name of the foundation. In valuing the company and reaching the \$28 million figure, the Attorney General's office only took into account the value of the Blue Cross assets and not those associated with the Blue Shield Corporation.

In February 2001, Anthem announced its intention to convert from a mutual insurance company to a stock corporation ("demutualization"), and filed its demutualization proposal with the Indiana Department of Insurance in June 2001. Although policyholders in Connecticut, Indiana, Kentucky, and Ohio were eligible for Anthem shares, the proposal deprived policyholders in Colorado, Maine, Nevada and New Hampshire of any right to receive shares in the new company. Consumer groups in all Anthem states, concerned about the potential impact of this conversion on health care coverage, encouraged regulators to review the transaction carefully and to impose conditions that would protect current and future policyholders. Despite this request of the multi-state coalition, only the Indiana Department of Insurance conducted a public hearing – as required by state law. The hearing

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Anthem merged with Wellpoint Health Networks in 2004. The new company, called Wellpoint Inc. is the Blue Cross licensee in California, and also a Blue Cross Blue Shield licensee in 13 other states: Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, Ohio New Hampshire, New York, Virginia, and Wisconsin. Wellpoint Inc. provides health insurance to 34 million customers, making it the nation's largest health insurer.

OKLAHOMA

In December 2004, Blue Cross and Blue Shield of Oklahoma (BCBSOK), a mutual insurer that covers approximately 600,000 Oklahomans, announced that it was considering a business relationship with Chicago-based Health Care Service Corporation (HCSC), a mutual insurer that controls Blue plans in Illinois, Texas, and New Mexico. In 2005, an independent hearing examiner working on behalf of Oklahoma's insurance commissioner approved the merger. HCSC now has more than 11.5 million members in Oklahoma, Illinois, Texas and New Mexico.

OREGON

In March 2001, Regence Blue Cross Blue Shield of Oregon, Regence Blue Shield of Washington, Regence Blue Cross Blue Shield of Utah, and Regence Blue Shield of Idaho, known as The Regence Group, filed an application to "affiliate" with the Blue Cross and Blue Shield plans in Illinois and Texas, which are divisions of the Chicago-based Health Care Service Corporation (HCSC).

Although Regence stated that it intended to remain nonprofit, consumer groups were concerned about the potential loss of charitable assets. Regence and HCSC would have created a separate operating company to handle shared administrative functions. This operating company would have been capitalized by the transfer of assets from HCSC and Regence. Regence is a nonprofit public benefit corporation with obligations to protect charitable assets. HCSC is a mutual company owned by its policyholders. Under the "affiliation," it was not clear how Regence intended to protect the charitable/nonprofit assets it would have transferred into this new operating company.

Although Regence and HCSC denied the deal was a merger, consumer groups argued to regulators that the transaction involved a change of control of the Regence health plans. In May 2001, regulators in Oregon and Washington agreed with consumer groups that the affiliation was indeed a change of control. The affiliation would have created three "interlocking" boards of directors and a single management team; the boards would have had significantly overlapping memberships, giving control over all of three companies to

the same group of 17 individuals. All three boards would have had the majority of its members appointed by the Chicago-based HCSC.

Regence announced in August 2001 that it was withdrawing its application to “affiliate” with HCSC. The announcement came one week before public hearings were to begin on the proposal.

The Regence Group covers nearly 3 million people in four states: the Oregon plan covers 1 million people, about 27% of the state’s population; the Washington plan covers 1 million people, about 16% of the population of the state; the Utah plan covers 400,000 people, about 16% of the state’s population; and the Idaho plan covers 180,000 people, or 13% of the population.

PENNSYLVANIA

Pennsylvania has four Blue Cross and/or Blue Shield (BCBS) plans, all of which are nonprofit health insurers: Blue Cross of Northeastern Pennsylvania; Highmark; Capital Blue Cross; and Independence Blue Cross.

RHODE ISLAND

In early 1999, it was rumored that both Anthem Insurance Companies, Inc., a mutual insurer owned by its policyholders, and nonprofit Blue Cross Blue Shield of Massachusetts (BCBSMA) were interested in either acquiring or affiliating with nonprofit Blue Cross Blue Shield of Rhode Island (BCBSRI). In April of that year, BCBSMA presented several affiliation options to the Rhode Island plan. In anticipation of any transaction involving BCBSRI, the Rhode Island legislature passed legislation that would govern the sale of the plan. This legislation contains a key provision prohibiting the purchaser of BCBSRI from raising premiums in order to recoup the money transferred to a foundation. Anthem criticized this provision of the law in local papers. BCBSRI announced in September 1999 that it intends to remain an independent, nonprofit firm.

SOUTH CAROLINA

Blue Cross and Blue Shield of South Carolina is a mutual health insurer, owned by its policyholders, covering approximately one million people.

SOUTH DAKOTA

Blue Cross of South Dakota, Blue Cross Blue Shield of Iowa and Blue Cross of Western Iowa merged into one nonprofit health service corporation, incorporated in the state of Iowa, in 1989. It then changed its name to IASD. Two years later, IASD applied under

special Iowa legislation to become a mutual insurer, owned by its policyholders and incorporated in Iowa. The legislation permitted conversion from a nonprofit to a mutual so long as the plan declared whether it would organize as a for-profit mutual or as a nonprofit mutual. In the preamble to the new mutual insurer's articles of incorporation, the plan declared that it would be governed under for-profit law and owned by its policyholders.

IASD then merged with South Dakota Blue Shield in July 1996, creating Wellmark BCBS. Regulators approved the transaction without requiring either plan to preserve and protect its charitable assets.

Today, Wellmark BCBS of Iowa covers more than 1.7 million Iowans and Wellmark BCBS of South Dakota covers more than 300,000 South Dakotans.

TENNESSEE

Blue Cross and Blue Shield of Tennessee is a nonprofit health insurer with approximately two million members.

TEXAS

Texas has the worst record on health insurance among the fifty states; nearly 1 in 4 Texans is without health insurance. Nonprofit health dollars in Texas are vital to the health of the population.

In 1996, BCBS Texas submitted a proposal to merge with Illinois BCBS, operated by Health Care Service Corporation (HCSC). HCSC is a mutual insurance company, owned by its policyholders, that can become for-profit by a vote of a majority of its board. BCBSTX, on the other hand, was a nonprofit health insurer whose assets were held in trust to further its nonprofit mission.

The Texas Attorney General filed a lawsuit to block the proposed merger in 1996, arguing that the merger violated Texas law because the Illinois company did not meet the Texas definition of a "nonprofit." In 1998, the trial court issued a letter opinion against the Attorney General and in favor of the merger. The court held, contrary to much of the evidence before it, that BCBSTX is not a charitable corporation and that HCSC meets the Texas definition of a nonprofit corporation.

In 1998, the Texas Attorney General agreed not to appeal the issue of whether HCSC met the Texas definition of a nonprofit corporation and allowed the merger to move forward. In exchange, HCSC agreed to pay \$10 million over five years to Texas Healthy Kids Corporation (for subsidies to low-income families buying insurance for their children). The merger was approved by the Insurance Departments of both Texas and Illinois in late 1998. HCSC remained unwilling to admit that BCBSTX had a charitable asset obligation to the people of Texas. But in December 2002, HCSC entered into a settlement agreement with

the Attorney General of Illinois, under which it set aside \$124.6 million in a health care foundation, as a result of the transaction in Illinois.

The Texas Attorney General did, however, appeal the trial court ruling that BCBSTX was not a charitable organization. In 2003, the Court of Appeals for the Third Judicial District upheld the trial court's ruling. Weeks later, the Attorney General discovered and shared with the Court of Appeals a written history, which was authorized, underwritten, and published by BCBSTX, entitled *Lone Star Legacy: The Birth of Group Hospitalization and the Story of Blue Cross and Blue Shield of Texas* (1999). In it, the author stated that BCBSTX had, in fact, solicited and received charitable donations over the years. Because of the new evidence, the Attorney General asked the Court of Appeals to reconsider its affirmation of the trial court's ruling, which the Court refused to do. In early 2004, the Attorney General filed a petition for review of this matter with the Supreme Court of Texas. The court rejected the Attorney General's petition. In 2005, the Attorney General filed a Bill of Review with the court asking it to reconsider. Though initially the court denied a motion by BCBS to dismiss the Bill of Review, the court subsequently denied the Attorney General's request.

HCSC acquired Blue Cross Blue Shield of New Mexico in May 2001. Also in 2001, HCSC filed an application with regulators in six states to "affiliate" with Blues plans in Oregon, Washington, Idaho and Utah. However, one week before public hearings were to begin on this proposal, and after community groups argued the "affiliation" was really a merger, HCSC announced it was withdrawing its application.

In 2005, HCSC merged with the Blue Cross Blue Shield plan in Oklahoma. HCSC now has more than 11.5 million members in Oklahoma, Illinois, Texas and New Mexico.

In 1998, HCSC pleaded guilty to Medicare fraud charges for the years 1985 through 1994 and agreed to pay \$144 million in fines to the federal government, the largest penalty assessed against a Medicare claims processor for fraud. As a result of its fraudulent activities, HCSC received \$1.29 million in undeserved bonuses.

UTAH

In March 2001, Regence Blue Cross Blue Shield of Oregon, Regence Blue Shield of Washington, Regence Blue Cross Blue Shield of Utah, and Regence Blue Shield of Idaho, known as The Regence Group, filed an application to "affiliate" with the Blue Cross and Blue Shield plans in Illinois and Texas, which are divisions of the Chicago-based Health Care Service Corporation (HCSC).

Although Regence stated that it intended to remain nonprofit, consumer groups were concerned about the potential loss of charitable assets. Regence and HCSC would have created a separate operating company to handle shared administrative functions. This operating company would have been capitalized by the transfer of assets from HCSC and Regence. Regence is a nonprofit public benefit corporation with obligations to protect

charitable assets. HCSC is a mutual company owned by its policyholders. Under the “affiliation,” it was not clear how Regence intended to protect the charitable/nonprofit assets it would have transferred into this new operating company.

Although Regence and HCSC denied the deal was a merger, consumer groups argued to regulators that the transaction involved a change of control of the Regence health plans. In May 2001, regulators in Oregon and Washington agreed with consumer groups that the affiliation was indeed a change of control. The affiliation would have created three “interlocking” boards of directors and a single management team; the boards would have had significantly overlapping memberships, giving control over all of three companies to the same group of 17 individuals. All three boards would have had the majority of its members appointed by the Chicago-based HCSC.

Regence announced in August 2001 that it was withdrawing its application to “affiliate” with HCSC. The announcement came one week before public hearings were to begin on the proposal.

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VERMONT

In January 2002, nonprofit BCBSVT sought legislation that would have permitted it to “reorganize.” In a complicated proposal, BCBSVT would have converted to for-profit status and created a (non-operational) nonprofit insurance holding company that would own 50.1% of the stock of the new for-profit. Although BCBSVT did not label it as such, consumer advocates believed that this proposal would have resulted in a de facto conversion.

In April 2002, upon invitation, advocates attended meetings held by the Attorney General and testified at hearings held by legislative committees to assess BCBSVT’s proposal. In the end, legislators refused to enact the legislation required to carry out BCBSVT’s plans. In doing so, some of the legislators cited the strong need to maintain BCBSVT’s status as a nonprofit health care insurer.

VIRGINIA

1) Trigon/Wellpoint: Trigon BCBS of Virginia changed from a nonprofit health services corporation to a mutual insurer, owned by its policyholders, in 1987. In 1996, Trigon proposed to convert to a for-profit corporation and denied that it held any charitable assets. The Attorney General became involved and required Trigon to distribute \$175 million to

the state and a small disbursement of stock to policyholders. The State Corporations Commission approved Trigon's proposal without undertaking a fair market valuation of the company's charitable assets or ensuring that the charitable assets were preserved and protected.

In July 2002, the Virginia State Corporations Commission approved the sale of Trigon to Wellpoint Health Networks for \$3.5 billion. Wellpoint merged with Anthem, Inc. in 2004. The new company, called Wellpoint Inc. is the Blue Cross licensee in California, and also a Blue Cross Blue Shield licensee in 13 other states: Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia, and Wisconsin. Wellpoint Inc. provides health insurance to 34 million customers, making it the nation's largest health insurer.

2) *CareFirst*: In January of 2002, CareFirst, a nonprofit holding company that controls the non-profit Blues plans in Maryland, Delaware and the District of Columbia, and that provides insurance coverage to subscribers in Northern Virginia, filed an application with the Insurance Commissioners in the latter three states to convert to a for-profit corporation and merge with WellPoint Health Networks. Wellpoint was then a California based for-profit which owned Blue Cross of California, Blue Cross and Blue Shield of Georgia, and Blue Cross and Blue Shield of Missouri.

After the filing, the Insurance Commissioner of Virginia decided not to review the conversion transaction. However, the Attorney General of Virginia was granted intervenor status in the D.C. Insurance Commissioner's review of the conversion application. In addition, members of the affected Northern Virginia community joined the D.C. community coalition, CareFirst Watch.

After holding hearings, analyzing the documents, and listening to the concerns expressed by the community, the Maryland Insurance Commissioner rejected the application because it was not in the public interest. In his 300-page decision released on March 5, 2003, the Commissioner explained that the Board of CareFirst had failed to uphold its fiduciary duty, the company had abandoned its nonprofit mission, the Board had failed to obtain an appropriate purchase price for the plan, and the Board and management had not considered the impact on the community in deciding to sell the plan. Immediately after the Maryland Insurance Commissioner rejected the application, the D.C. Insurance Commissioner issued a press release stating his plans to similarly deny the proposal in the District.

In May 2005, the D.C. Insurance Commissioner declared that CareFirst should be "engaging in charitable activity significantly beyond its current activities." While the commissioner found that CareFirst was meeting its basic legal obligation, he concluded that CareFirst can and should do more to promote health in the District. [For more information on the proposed conversion of CareFirst, see Maryland and Washington, D.C.].

The CareFirst companies cover more than 3.3 million members in the Washington, D.C., Maryland, Delaware and Virginia, which is over 45% of the population in the service area.

WASHINGTON

Premera Blue Cross: In May 2002, Premera Blue Cross of Washington and Alaska, which covers over one million people in both states, announced its plan to convert to a for-profit insurance company.

In February 2003, the Washington Insurance Commissioner allowed over two dozen individuals and organizations asserting a “significant interest” to intervene in the conversion. Several of the intervenors opposed the conversion of Premera and raised questions about whether the full value of the company would be preserved for the public in the event of a conversion.

In granting the motions to intervene, the Insurance Commissioner grouped the intervenors into five categories and required each to appoint a lead attorney. Each group was treated as a single party for purposes of discovery, presentation of evidence, oral and written argument, and cross-examination. The groups included: Washington consumers, Washington hospitals, Washington providers, and a coalition in Alaska.

In July 2004, the Washington Insurance Commissioner formally rejected the conversion proposal. Ten days later, the Alaska Director of Insurance echoed the Washington decision by rejecting the company’s effort to convert Premera’s holdings in Alaska. Each regulator thoroughly and critically examined the company’s conversion proposal and concluded that it was not in the best interests of consumers. Premera appealed the decisions in both Alaska and Washington. The Washington decision was upheld on appeal (*see* 133 Wash.App. 23, 131 P.3d 930 (2006)) which prompted Premera to withdraw the appeal in Alaska.

Regence Blue Shield of Washington/The Regence Group: In March 2001, Regence Blue Shield of Washington, Regence Blue Cross Blue Shield of Oregon, Regence Blue Cross Blue Shield of Utah, and Regence Blue Shield of Idaho, known as The Regence Group, filed an application to “affiliate” with the Blue Cross and Blue Shield plans in Illinois and Texas, which are divisions of the Chicago-based Health Care Service Corporation (HCSC).

Although Regence stated that it intended to remain nonprofit, consumer groups were concerned about the potential loss of charitable assets. Regence and HCSC would have created a separate operating company to handle shared administrative functions. This operating company would have been capitalized by the transfer of assets from HCSC and Regence. Regence is currently a nonprofit public benefit corporation with obligations to protect charitable assets. HCSC is a mutual company owned by its policyholders. Under the “affiliation,” it was not clear how Regence intended to protect the charitable assets it would have transferred into this new operating company.

Although Regence and HCSC denied the deal was a merger, consumer groups argued to regulators that the transaction involved a change of control of the Regence health plans. In May 2001, regulators in Oregon and Washington agreed with the consumer groups that the affiliation was indeed a change of control. The affiliation would have created three

“interlocking” boards of directors and a single management team. This means the boards would have had significantly overlapping memberships, giving control over all of three companies to the same group of 17 individuals. All three boards would have had the majority of its members appointed by the Chicago-based HCSC.

Regence announced in August 2001 that it was withdrawing its application to “affiliate” with HCSC. The announcement came one week before public hearings were to begin on the proposal.

The Regence Group covers nearly 3 million people in four states: the Oregon plan covers 1 million people, about 27% of the state’s population; the Washington plan covers 1 million people, about 16% of the population of the state; the Utah plan covers 400,000 people, about 16% of the state’s population; and the Idaho plan covers 180,000 people, or 13% of the population.

WEST VIRGINIA

In April 1999, nonprofit Highmark Blue Cross Blue Shield of Pennsylvania completed an affiliation with Mountain State Blue Cross & Blue Shield of West Virginia. Under the terms of the agreement, Highmark loaned Mountain State \$10 million. In exchange, Highmark (a) assumed control of Mountain State's trademark licenses; (b) appointed half of the directors of the Mountain State board; and (c) appointed one of the three directors of Mountain State’s for-profit HMO. The agreement also contained a provision for Highmark and Mountain State to negotiate regarding a further affiliation as well as an acquisition of Mountain State’s for-profit HMO by Highmark.

WISCONSIN

On June 3, 1999 Blue Cross Blue Shield United of Wisconsin (BCBSUW) held a press conference to announce its plans to convert from nonprofit to for-profit status. As part of its plan, BCBSUW proposed to “donate” \$250 million in assets to the Medical College of Wisconsin and the medical school at the University of Wisconsin. The Governor and the Attorney General participated in the BCBSUW press conference and expressed strong support for this plan.

The official proposal was filed with the Office of the Commissioner of Insurance (OCI) shortly after the announcement. After holding hearings, the Insurance Commissioner announced her decision to approve the proposal by BCBSUW to convert to a for-profit company, with certain conditions, in March 2000. In her decision, the Commissioner maintained that BCBSUW had no charitable trust obligation, and approved the plan to turn over the proceeds from the conversion to a new foundation, The Wisconsin United for Health Foundation. But, under the proposal, the foundation was a mere transfer mechanism; its sole purpose would be to review the medical schools’ plans for the funds and then give them the funds.

Consumer groups in Wisconsin filed a petition for judicial review in state court to challenge the Insurance Commissioner's decision. A trial judge heard the case in August 2000 and, in remarks from the bench, upheld the Commissioner's decision. The judge disregarded the great weight of authority from across the country holding that Blue Cross and Blue Shield plans do constitute charitable trusts, reasoning that no other state had a "statutory scheme even remotely similar to Wisconsin." In March 2001, the Insurance Commissioner allowed the conversion of BCBSUW to go through, and the Cobalt Corp., a new publicly-traded Wisconsin Blues plan was created. Consumer groups appealed. In December 2001, the Wisconsin Court of Appeals affirmed the commissioner's ruling, thus upholding the trial judge's decision.

This plan stands in stark contrast to how similar transactions have been resolved in many other states, where converting nonprofits have been required by law to turn over 100 percent of their charitable assets to independent foundations who could ensure the assets would address the community's unmet health needs. However, local consumers were not deterred by this turn of events, and once the Wisconsin United for Health Foundation (WUHF) was created, they continued to advocate that the funds be used to benefit the health of the underserved. The new foundation board was originally proposed as a simple transfer mechanism for exchanging stock and conveying the proceeds to the schools. However, the Commissioner's order included several conditions for the use of the assets, including a requirement that 35% of the funds be used for public health projects and that these funds not supplant expenses the medical schools could fund through other sources. In April 2003 local advocates successfully engaged legislators and the new Governor to block the University of Wisconsin's Medical School's plan to use \$65 million of the assets to construct a new building on campus. Building upon that victory, local advocates have continued to use the conditions placed upon the conversion assets to scrutinize the medical school plans and urge public comment on the use of the assets.

The new for-profit Wisconsin plan, known as Cobalt Corp., was purchased by Wellpoint Health Networks in September of 2003. The assets, which were originally issued as Cobalt Corp. stock, have now grown from \$250 million to over \$600 million with the purchase of Cobalt Corp. by Wellpoint.

Wellpoint merged with Anthem, Inc. in 2004. The new company, called Wellpoint, Inc., is the Blue Cross licensee in California, and also a Blue Cross Blue Shield licensee in 13 other states: Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia and Wisconsin. Wellpoint provides health insurance to 34 million customers, making it the nation's largest health insurer.

WYOMING

Blue Cross and Blue Shield of Wyoming is a nonprofit health insurer with approximately 100,000 members

Blue Cross/Blue Shield Insurer Histories

(As of November 30, 2007)

CareFirst (Washington, D.C., Maryland, Delaware and Virginia)

CareFirst is the nonprofit holding company that operates Blues plans in Maryland, Washington, D.C. and Delaware. CareFirst also provides insurance coverage to subscribers in Northern Virginia. In 2002, CareFirst applied to insurance regulators in Washington D.C., Maryland, and Delaware to convert to a for-profit company and to merge with WellPoint, Inc. which, at the time, operated plans in California, Missouri, and Georgia.

In March of 2003, after holding hearings, analyzing the documents, and listening to the concerns expressed by the community, the Maryland Insurance Commissioner rejected the application because it was not in the public interest. In his 300-page decision, the Commissioner explained that the Board of CareFirst had failed to uphold its fiduciary duty, had abandoned its nonprofit mission, had failed to obtain an appropriate purchase price for the plan, and had not considered the impact on the community in deciding to sell the plan. Immediately after the Maryland Insurance Commissioner rejected the application, the D.C. Insurance Commissioner issued a press release stating that he would also deny the proposal in the District. Shortly thereafter, Wellpoint withdrew its application in Delaware.

The CareFirst companies cover more than 3.3 million members in the Washington, D.C., Maryland, Delaware and Virginia, which is over 45% of the population in the service area.

Health Care Service Corporation (Illinois, Texas, New Mexico and Oklahoma)

Illinois -based Health Care Service Corporation (HCSC) is a mutual legal reserve company, which is owned by its policyholders rather than investors. HCSC operates Blues plans in Illinois, Texas, New Mexico and Oklahoma.

In 2001, HCSC filed an application with regulators in six states to “affiliate” with Blues plans in Oregon, Washington, Idaho and Utah. However, one week before public hearings were to begin on this proposal, and after community groups argued the “affiliation” was really a merger, HCSC announced it was withdrawing its application.

In 2005, HCSC merged with Blue Cross and Blue Shield of Oklahoma, also a mutual insurer owned by its policyholders. HCSC now has more than 11.5 million members in Oklahoma, Illinois, Texas and New Mexico.

Premera Blue Cross (Washington and Alaska)

Premera Blue Cross is a nonprofit health care service contractor domiciled and operating in the state of Washington, which also operates a nonprofit hospital and medical service corporation in Alaska, under the name Premera Blue Cross and Blue Shield of Alaska.

In 2002, Premera filed applications with the insurance commissioners in both states to convert to a for-profit company. Community groups opposed the conversion. After hearing testimony from Premera, insurance commissioners in both states rejected Premera's proposal to convert. Premera appealed the decisions in both states. The Washington decision was upheld on appeal (*see* 133 Wash.App. 23, 131 P.3d 930 (2006)) which prompted Premera to withdraw the appeal in Alaska.

Premera covers approximately 1.2 million people, approximately 19% of the population, in Washington; and 108,000 people, about 16% of the population, in Alaska.

The Regence Group (*Washington, Oregon, Idaho and Utah*)

The Regence Group consists of four Blues plans in the Pacific Northwest: nonprofit Regence Blue Cross Blue Shield of Oregon; nonprofit Regence Blue Shield of Washington; nonprofit Regence Blue Cross Blue Shield of Utah; and Regence Blue Shield of Idaho, which is a mutual insurer owned by its policyholders.

In 2000, The Regence Group submitted an application to affiliate with Illinois-based Health Care Service Corporation (HCSC). Facing difficult questions from community groups and regulators about the Blues plans' charitable asset obligations, The Regence Group withdrew its proposal in 2001.

The Regence Group covers nearly 3 million people in four states: the Oregon plan covers 1 million people, about 27% of the state's population; the Washington plan covers 1 million people, about 16% of the population of the state; the Utah plan covers 400,000 people, about 16% of the state's population; and the Idaho plan covers 180,000 people, or 13% of the population.

Wellpoint/Anthem/WellChoice (*California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia and Wisconsin.*)

Wellpoint, Inc. is the Blue Cross licensee in California, and also a Blue Cross Blue Shield licensee in 13 other states: Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia, and Wisconsin. Wellpoint provides health care benefits to 34 million customers, making it the nation's largest health insurer.

Wellpoint was originally a for-profit subsidiary of Blue Cross of California. In 1993, Blue Cross of California, a nonprofit health maintenance organization (HMO), turned 90% of its assets over to for-profit Wellpoint, making Wellpoint the largest for-profit HMO in California. Wellpoint subsequently acquired Blues plans in Missouri, Georgia, Virginia and Wisconsin.

Wellpoint and Anthem, Inc. merged in 2004. Anthem, formerly Accordia, Inc., was originally created through the merger of Blue Cross of Indiana and Blue Shield of Indiana.

After this merger, Wellpoint acquired Blues plans in Colorado, Connecticut, Kentucky, Maine, Nevada, New Hampshire and Ohio.

In 2005, WellPoint acquired WellChoice, also known as Empire BCBS of New York.

Wellpoint tried to acquire CareFirst, which operates Blues plans in Maryland, Delaware and Washington, D.C., but in 2003 the Maryland Insurance Commissioner rejected the proposed deal.

Anthem tried to acquire Blue Cross Blue Shield of Kansas, but in 2002 the Kansas Insurance Commissioner rejected the proposed deal.

Wellmark (South Dakota and Iowa)

There were once a total of five Blue Cross or Blue Shield plans between the two states of Iowa and South Dakota. They are all now in some way part of the Wellmark system, a for-profit mutual company owned by its policyholders.

Blue Cross of South Dakota, Blue Cross Blue Shield of Iowa and Blue Cross of Western Iowa merged into one nonprofit health service corporation, incorporated in the state of Iowa, in 1989. It then changed its name to IASD. Two years later, IASD became a mutual insurer, governed under for-profit law.

IASD then merged with South Dakota Blue Shield in July 1996, creating a for-profit corporation known as Wellmark BCBS. Regulators approved the transaction without requiring either plan to preserve and protect its charitable assets.

Today, Wellmark BCBS of Iowa covers more than 1.7 million Iowans and Wellmark BCBS of South Dakota covers more than 300,000 South Dakotans.

Blue Cross/Blue Shield Stories **Community Participation Makes a Difference**

Although there are many things Blue Cross and Blue Shield conversions have in common, each conversion has unique issues, requiring unique local advocacy efforts. Take the following examples:

The Regence Deal- A Merger in Sheep's Clothing

When a Chicago Blues plan announced it intended to “affiliate” with four western Blues plans in September of 2000, company executives claimed the move was just a way to “achieve economies of scale” by consolidating “backroom operations” that would not “touch the customer.” But consumer advocates were skeptical. The Blues plans in Washington, Idaho, Utah, and Oregon (known as The Regence Group) were nonprofit, operating in trust for the benefit of the public. The Chicago Blues plan, on the other hand, was a “mutual,” owned by and operated for the benefit of its policyholders alone.

The difference between these two types of health plans is significant: The assets of a nonprofit are held in charitable trust, and must continue to fund health projects if and when the company loses its nonprofit status. The assets of a mutual, on the other hand, are distributed to policyholders if the company changes its corporate status (by, for example, becoming a for-profit). If the Regence “affiliation” was actually a merger, the nonprofit assets of the four western Blues plans would be put at risk because they would be co-mingled with those of the Chicago company.

Advocates poured through the proposal filed with government regulators. One thing became immediately clear – the same 17 people were to serve on all three boards -- Regence, HCSC, and a new joint “operating company.” And, not only did the boards overlap almost completely, but directors from HCSC would have majority control on each of the three boards! Clearly, this was more than a corporate “affiliation.”

Consumer advocates wrote a memorandum to regulators in the four states arguing that the deal was essentially a takeover of the western Blues plans by this Chicago company. Regulators agreed. Three months later, and one week before public hearings were scheduled to begin, the companies announced the deal was off (claiming that their computer systems were incompatible!) Clearly, the advocates’ efforts paid off.

Wisconsin- A Preemptive Strike by Insiders

When Blue Cross and Blue Shield of Wisconsin announced to the public it was going for-profit in 1999, it was clear the company had thoroughly greased the skids for regulatory approval. Standing on the podium with BCBS executives to announce the conversion was a troika of political heavyweights -- the governor, the insurance commissioner, and the attorney general. Consumer advocates knew they had a fight on their hands. Proponents of the conversion, who

wanted all of the money to go to the state's two medical schools, were powerful, mobilized, and interdependent. The Blues plan needed the political types for government approval, the political types wanted funding for the medical schools, and the medical schools were naturally happy to support a proposal that would give them at least \$250 million to fund their efforts to conduct biomedical research and to educate doctors.

Consumer groups, on the other hand, were left out. They thought the money should go to a foundation to fund public health projects in the state, as required by charitable trust law. The proposal to send all of the money to the state's two medical schools – a move without precedent in the history of Blues conversions – would do nothing for public health. Although, at the urging of consumer groups, the insurance commissioner ultimately said that 35% of the money should be spent on public health projects, the medical schools were not legally required to do so.

The consumer groups were denied the opportunity to intervene in the administrative hearings, and once the deal was officially approved by the insurance commissioner, they went to court to appeal the decision. But the insurance commissioner's decision was upheld. Under the law, judges are not allowed to second-guess the decision of an insurance commissioner or other government regulator. Decisions by insurance commissioners can only be reversed by a judge where the commissioner clearly violates the law. The statute in Wisconsin gave the insurance commissioner substantial leeway to approve the plan to use the money, and the judge could not second-guess the insurance commissioner's judgment.

Although the Wisconsin conversion was a disappointment for consumer groups, it did have a silver lining -- the groups were allowed to file their briefs and argue their case in court. It is rare for consumers to be granted "standing" to challenge an administrative decision. Although the Wisconsin judge did not explicitly grant the consumer groups standing to participate, he did not deny it either. He treated the consumers as parties, considered their claims, and ruled on the merits. The high level of participation by consumers in the Wisconsin legal process sets a good example for other groups to follow.

New York – “What’s in it for Me?” – The Ultimate Back Room Deal

Big boss politics are alive and well in New York in the 21st century. Due to a back room deal passed in the dark of night by the New York legislature, two billion dollars in charitable assets were squandered. This story is a living example of a political payoff made at great cost to health care consumers and the public interest.

In January of 2002, at 4:30 in the morning, the governor of New York and the leader of the state's largest labor union persuaded New York legislators to pass politically self-serving legislation regarding the conversion of Empire Blue Cross and Blue Shield. Under the law, just 5% of the conversion proceeds were set aside in a small foundation dedicated to expanding access to health coverage. The bill required the other 95% of Empire's charitable assets to fund salary increases for hospital workers. To make matters worse, the law imposed a virtual stranglehold by the government on the foundation by giving elected officials the authority to nominate board members and oversee foundation activities.

Although increasing the salaries of deserving hospital employees is a laudable goal, charitable assets should not be squandered for this onetime private purpose. In exchange for his support of the bill, New York's then-governor – George Pataki – got the newfound political support of the union – SEIU 1199. And the union leader, Dennis Rivera, was able to deliver salary increases to 13% of his membership base.

Outraged that this back room political payoff diverted approximately two billion dollars from the public, Consumers Union filed a lawsuit. In a major victory for consumer groups, Consumers Union and five individual Empire subscribers were officially granted standing to sue in March of 2003. Later that year, a judge ruled that the plaintiffs had the right to pursue their suit, which argues that the legislation was unconstitutional. Unfortunately, in August of 2005, the New York Court of Appeals ruled 4-2 that the state had the constitutional authority to take Empire's charitable proceeds, provided they were spent by the state for health care purposes.

Nevada – An Unfair Split – the Cost of Regulatory Incompetence

When the nonprofit Colorado and Nevada Blues plans merged in 1996, Nevada regulators approved the deal without preserving the assets, and without even conducting a valuation, of their Blues plan. This decision would prove disastrous for Nevada, which ceded its interests to Colorado with the merger.

The public learned of the transaction two weeks later, the same day that the now-merged Colorado company filed a proposal to convert to a for-profit corporation. If the nonprofit assets were to be set aside for the benefit of the Nevada and Colorado communities that built the plans, this was the last chance.

But Colorado now had jurisdiction over the deal, and Nevada was shut out. Nevada regulators attempted to intervene in the Colorado deal, but were denied intervener status in court. As a result, the Colorado plan received \$155 million, while the Nevada plan got a mere \$1.5 million when the conversion was finally approved in 1999.

North Carolina – Power Brokers Shoot Themselves in the Foot

When the nonprofit North Carolina Blues plan proposed to convert in 2002, consumer advocates were ready. A few years earlier, they had worked hard to enact a very consumer-friendly conversion law. Although the Blues plan claimed the proposal would be good for consumers, experts predicted the conversion would increase insurance premiums, particularly for individuals and small groups. Moreover, there was no guarantee that a foundation would receive the full value of the company, due to a complicated stock plan devised by the Blues.

Fortunately, North Carolina Blues executives did not help their own cause. While regulators were reviewing the conversion, it was revealed that the Blues plan had set up a pro-conversion group masquerading as a grassroots consumer organization called North Carolinians for

Affordable Health Care (NCAHC). The group's initials were almost identical to those of the real grassroots consumer organization – the North Carolina Health Access Coalition (NCHAC).

Ultimately, the company's efforts to argue that the conversion was good for consumers fell flat. Instead of suffering a rejection of their proposal by regulators, BCBSNC withdrew its plan to convert in July of 2003.

New Mexico – A Regulator Feathers His Own Nest

The conversion of New Mexico Blue Cross and Blue Shield is, in general, a good model of community participation and diligent oversight by regulators. But one aspect of the conversion troubled consumer groups. While the New Mexico Superintendent of Insurance was overseeing the creation of the new foundation – the Con Alma Health Foundation – he appointed himself to the board of directors. Not only that, but at the initial board meeting in January of 2002, he got himself elected chairman of the board.

It is inappropriate for a government regulator to influence a health care conversion foundation, especially for his or her own political gain. Such a conflict of interest creates the potential that the funds will be misused. The charitable assets of former Blues plans originated in the private nonprofit sector, and are not government funds. Board membership by government officials creates the impression that private, nonprofit, charitable assets are under governmental control, which could subject the funds to potential use for government projects. It also raises the possibility that a funding proposal may be considered by the foundation's board in light of its political benefits, rather than on the merits of the proposal.

In addition, such a dual role creates the potential that the public official will misuse his government post to benefit the foundation. This is exactly what ultimately happened in New Mexico. In 2006, the Superintendent awarded a contract to a bank that had donated \$124,000 to the foundation. After this was disclosed, the Attorney General asked for the Superintendent's resignation, and the Superintendent then resigned his post on the foundation board of directors.

Premera Blue Cross – Dozens of Interveners Make a Difference

Thanks to a consumer-friendly insurance commissioner, several consumer groups were given the legal right to help shape the outcome of the conversion of Premera Blue Cross of Washington and Alaska. In February of 2003, Washington Insurance Commissioner Mike Kreidler granted intervention status to over two dozen individuals and organizations asserting a “significant interest” in the conversion. The Premera conversion is an excellent model of community participation in the regulatory process.

Several of the interveners opposed the conversion of Premera, and raised questions about whether the full value of the company would be preserved for the public if the conversion were approved. Intervener status allowed them to fully participate in the adjudicative hearing (in essence, a “trial”) on the conversion proposal. This meant the consumer groups were given the

right to conduct discovery, call their own witnesses and experts, and cross-examine witnesses called by Premera.

In July of 2004, Kreidler formally rejected Premera's proposal to convert to a for-profit corporation. Ten days later, Alaska Director of Insurance Linda Hall echoed Kreidler's decision by rejecting the company's effort to convert Premera's holdings in Alaska. Each regulator thoroughly and critically examined the company's conversion proposal and concluded that it was not in the best interests of consumers. Premera appealed the decisions in both Alaska and Washington. The Washington decision was upheld on appeal (*see* 133 Wash.App. 23, 131 P.3d 930 (2006)) which prompted Premera to withdraw the appeal in Alaska.

CareFirst – It Helps to be Prepared

When CareFirst, the nonprofit insurer that operates Blues plans in Maryland, Delaware and the District of Columbia, filed an application in January of 2002 to merge with for-profit Wellpoint Health Networks, government officials and consumer groups were prepared.

Anticipating a conversion, the Maryland Legislature had amended the state's conversion law in April 2001. This amendment required that the conversion assets be preserved. After the conversion application was filed, the legislature passed two more bills that created more-stringent requirements for conversions, including a requirement that the applicant bears the burden to prove that the conversion is in the public interest and restrictions on compensation packages for executives.

The Insurance Commissioner contracted with four experts to assist him in his review of the application. Valuation experts returned their report on the value of CareFirst and advised the Commissioner that CareFirst was worth much more than the \$1.3 billion purchase price. Experts also studied whether CareFirst had exercised due diligence in the transaction, the health impact of the conversion and the compensation packages of the executives of CareFirst. The Insurance Commissioner also conducted five public meetings throughout the state.

Moreover, a coalition of consumer advocates conducted its own valuation and health impact studies to determine what the true value of CareFirst would be if it were sold, and how the proposed transaction would have likely impacted consumers and their ability to access quality affordable health care.

Due to this high level of public awareness, there was significant public outcry regarding the compensation arrangements for executives of CareFirst. Under the proposal, \$27.4 million would have been provided to CareFirst executives as incentive bonuses to stay on after the conversion and \$47.8 million would have been provided to them in other post-conversion payments.

In March of 2003, after holding hearings, analyzing the documents, and listening to the concerns expressed by the community, the Maryland Insurance Commissioner rejected CareFirst's application because it was not in the public interest. In a 300-page decision, the Commissioner explained that the Board of CareFirst had failed to uphold its fiduciary duty, had abandoned its nonprofit mission, had failed to obtain an appropriate purchase price for the plan, and had not considered the impact on the community in deciding to sell the plan.

Kansas – A Tenacious Regulator Stands up to a Giant

In May 2001, Blue Cross Blue Shield of Kansas filed an application to merge with soon-to-be for-profit Anthem Insurance Companies, Inc., which operated in eight other states at that time.

Concerned about the impact on health services and access, several groups were granted intervener status in the proceedings. Over 1,200 Kansans attended the meetings to question various aspects of the deal, including whether the conversion would benefit them and to criticize the lack of objective information available on the deal. An expert hired by the state, PricewaterhouseCoopers, found that imposing a shareholder profit requirement on the Blues plan would increase premiums in the small and individual group markets.

In February 2002, Kansas Insurance Commissioner Kathleen Sebelius formally rejected the proposed conversion and became the first regulator in the nation to reject a for-profit health insurer's proposal to buy a state's Blue Cross and Blue Shield Plan. The proposal was found to be, "unreasonable to policyholders and not in the public interest, and hazardous and prejudicial to the insurance-buying public." BCBSK appealed the Commissioner's order. A few months later, a trial court judge vacated the Commissioner's order and remanded the case back to the Commissioner.

Undeterred, the Commissioner issued a written statement in which she promised "to protect the families and businesses of Kansas from millions of dollars in increased insurance rates." Making good on this vow, the Commissioner filed a Notice of Appeal in June 2002 arguing that it was within her statutorily-granted authority to disapprove the proposal as she did. In August 2003, the Kansas Supreme Court upheld the Commissioner's decision to deny the conversion.

BLUE CROSS/BLUE SHIELD **AFFILIATIONS & STATUS**

Affiliation	Status	Name of Health Plan	Status: November 2007
	Nonprofit	<u>Alabama, Blue Cross and Blue Shield</u>	
Premera	Nonprofit	<u>Alaska, Premera Blue Cross Blue Shield</u>	In 2004, the Director of Ins. formally rejected the conversion proposal which Premera initially appealed. Premera withdrew the appeal after losing a similar appeal in Washington state.
	Nonprofit	<u>Arizona, Blue Cross and Blue Shield</u>	
	Mutual	<u>Arkansas Blue Cross and Blue Shield</u>	
	Nonprofit	<u>California, Blue Shield</u>	
Wellpoint	For Profit	<u>California, Wellpoint Health Networks (Blue Cross)</u>	Anthem and Wellpoint merged in 2004 into Wellpoint Inc.
Wellpoint	For Profit	<u>Colorado, Anthem Blue Cross and Blue Shield</u>	Anthem and Wellpoint merged in 2004 into Wellpoint Inc.
Wellpoint	For Profit	<u>Connecticut, Anthem Blue Cross and Blue Shield</u>	Anthem and Wellpoint merged in 2004 into Wellpoint Inc.
CareFirst	Nonprofit	<u>Delaware, Blue Cross and Blue Shield</u>	Wellpoint withdrew application after Maryland deal rejected.
CareFirst	Nonprofit	<u>District of Columbia, CareFirst Blue Cross Blue Shield</u>	Wellpoint withdrew application after Maryland deal rejected
	Mutual	<u>Florida, Blue Cross and Blue Shield</u>	
Wellpoint	For Profit	<u>Georgia, Blue Cross and Blue Shield</u>	Anthem and Wellpoint merged in 2004 into Wellpoint Inc.
	Mutual	<u>Hawaii Medical Service Association</u>	
	Mutual	<u>Idaho, Blue Cross</u>	
Regence	Mutual	<u>Idaho, Regence Blue Shield</u>	Proposed an "affiliation" with HCSC but withdrew application after tough questions from Oregon Insurance Commissioner.
HCSC	Mutual	<u>Illinois, Blue Cross and Blue Shield</u>	
Wellpoint	For Profit	<u>Indiana, Anthem Blue Cross and Blue Shield</u>	Anthem and Wellpoint merged in 2004 into Wellpoint Inc.
Wellmark	For Profit	<u>Iowa, Wellmark Blue Cross and Blue Shield</u>	

	Mutual	<u>Kansas, Blue Cross and Blue Shield</u>	State Supreme Court upheld Insurance Commissioner's decision not to allow Anthem to buy plan.
Wellpoint	For Profit	<u>Kentucky, Anthem Blue Cross and Blue Shield</u>	Anthem and Wellpoint merged in 2004 into Wellpoint Inc.
	Mutual	<u>Louisiana, Blue Cross and Blue Shield</u>	
Wellpoint	For Profit	<u>Maine, Blue Cross and Blue Shield</u>	Anthem and Wellpoint merged in 2004 into Wellpoint Inc.
CareFirst	Nonprofit	<u>Maryland, CareFirst Blue Cross Blue Shield</u>	Commissioner rejected deal with Wellpoint
	Nonprofit	<u>Massachusetts, Blue Cross and Blue Shield</u>	
	Nonprofit	<u>Michigan, Blue Cross and Blue Shield</u>	
	Nonprofit	<u>Minnesota, Blue Cross and Blue Shield</u>	
	Mutual	<u>Mississippi, Blue Cross and Blue Shield</u>	
	Nonprofit	<u>Missouri, BlueCross and BlueShield of Kansas City</u>	
Wellpoint	For Profit	<u>Missouri, BlueCross BlueShield of Missouri</u>	Anthem and Wellpoint merged in 2004 into Wellpoint Inc.
	Nonprofit	<u>Montana, Blue Cross and Blue Shield</u>	
	Mutual	<u>Nebraska, Blue Cross and Blue Shield</u>	
Wellpoint	For Profit	<u>Nevada, Anthem Blue Cross and Blue Shield</u>	Anthem and Wellpoint merged in 2004 into Wellpoint Inc.
Wellpoint	For Profit	<u>New Hampshire, Anthem Blue Cross and Blue Shield</u>	Anthem and Wellpoint merged in 2004 into Wellpoint Inc.
	Nonprofit	<u>New Jersey, Horizon Blue Cross and Blue Shield</u>	In early 2005, Governor and legislative leaders initiated discussion about reviving Horizon's conversion bid.
HCSC	Mutual	<u>New Mexico, Blue Cross and Blue Shield</u>	
HealthNow	Nonprofit	<u>New York, Blue Cross and Blue Shield of Western NY</u>	
HealthNow	Nonprofit	<u>New York, Blue Shield of Northeastern</u>	
Excellus	Nonprofit	<u>New York, BlueCross and BlueShield of Central</u>	
Excellus	Nonprofit	<u>New York, BlueCross and BlueShield of Rochester</u>	
Excellus	Nonprofit	<u>New York, BlueCross and BlueShield of Utica-Watertown</u>	

Wellpoint	For Profit	<u>New York, Empire Blue Cross and Blue Shield</u>	In 2005, the NY Ct. of Appeals ruled that state has authority to take Empire's charitable proceeds to spend on health care.
	Nonprofit	<u>North Carolina, Blue Cross and Blue Shield</u>	Withdrew application to go for profit after expert analysis showing possible negative health impact.
	Mutual	<u>North Dakota, Blue Cross and Blue Shield</u>	
Wellpoint	For Profit	<u>Ohio, Anthem Blue Cross and Blue Shield</u>	Anthem and Wellpoint merged in 2004 into Wellpoint Inc.
HCSC	Mutual	<u>Oklahoma, Blue Cross and Blue Shield</u>	
Regence	Mutual	<u>Oregon, Regence Blue Cross and Blue Shield</u>	Proposed an "affiliation" with HCSC but withdrew application after tough questions from Oregon Insurance Commissioner
	Nonprofit	<u>Pennsylvania, Blue Cross of Northeastern-Wilkes-Barre</u>	
	Nonprofit	<u>Pennsylvania, Blue Shield</u>	
	Nonprofit	<u>Pennsylvania, Capital Blue Cross -- Harrisburg</u>	
	Nonprofit	<u>Pennsylvania, Highmark Blue Cross and Blue Shield -- Pittsburgh</u>	
	Nonprofit	<u>Pennsylvania, Independence Blue Cross -- Philadelphia</u>	
	Nonprofit	<u>Rhode Island, Blue Cross and Blue Shield</u>	
	Mutual	<u>South Carolina, Blue Cross and Blue Shield</u>	
Wellmark	Nonprofit	<u>South Dakota, Wellmark Blue Cross and Blue Shield</u>	
	Nonprofit	<u>Tennessee, Blue Cross and Blue Shield</u>	
HCSC (II)	Mutual	<u>Texas, Blue Cross and Blue Shield</u>	
Regence	Mutual	<u>Utah, Regence BlueCross and BlueShield</u>	Proposed an "affiliation" with HCSC but withdrew application after tough questions from Oregon Insurance Commissioner.
	Nonprofit	<u>Vermont, Blue Cross and Blue Shield</u>	
Wellpoint	For Profit	<u>Virginia, Anthem Blue Cross and Blue Shield</u>	Anthem and Wellpoint merged in 2004 into Wellpoint Inc.

Premera	Nonprofit	<u>Washington, Premera Blue Cross</u>	State Appellate Court upheld the decision by the Ins. Commissioner rejecting the conversion proposal.
Regence	Mutual	<u>Washington, Regence Blue Shield</u>	Proposed an "affiliation" with HCSC but withdrew application after tough questions from Oregon Insurance Commissioner.
	Nonprofit	<u>West Virginia, Mountain State Blue Cross and Blue Shield</u>	
Wellpoint	For Profit	<u>Wisconsin, Blue Cross and Blue Shield United (Cobalt)</u>	Anthem and Wellpoint merged in 2004 into Wellpoint Inc.
	Nonprofit	<u>Wyoming, Blue Cross and Blue Shield</u>	

**Proceeds Set Aside from the Conversion
Of Blue Cross and Blue Shield Plans**

Prepared by Consumers Union

<i>STATE</i>	<i>APPROXIMATE PROCEEDS SET ASIDE</i>
California	\$3.2 billion
New York	\$1.1 billion
Missouri	\$400 million
Wisconsin	\$250 million
Virginia	\$175 million
Colorado	\$155 million
Georgia	\$124 million
New Hampshire	\$83 million
Maine	\$82 million
Kansas	\$75 million
Kentucky	\$45 million
Connecticut	\$41 million
Ohio	\$28 million
New Mexico	\$20 million
Texas	\$10 million
Nevada	\$1.5 million