Legislative Guide to Nonprofit Health Plan Conversions

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January 11, 2001

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate

The Honorable Casper R. Taylor, Jr.
Speaker of the House of Delegates

Honorable Members of the Senate
Honorable Members of the House of Delegates

Given the recent public concern and scrutiny paid to nonprofit conversion activities nationally, and the recent announcement by CareFirst BlueCross BlueShield that it intends to convert from a nonprofit health service plan and be acquired by WellPoint Health Networks, Inc., the issue of nonprofit conversions will be discussed in public and private forums across the State. This report on the conversion of nonprofit health care entities was prepared by the Department of Legislative Services, Office of Policy Analysis to assist members of the General Assembly throughout deliberations on this subject.

This report was prepared by Ms. Stacy Goodman, Ms. Susan John, Ms. Kristin Jones, Ms. Cheryl Matricciani, Ms. Shannon McMahon, and Ms. Marilyn McManus under the supervision of Dr. Simon Powell. We would like to acknowledge the cooperation and assistance provided by interested parties throughout the preparation of this report.

Sincerely,

Karl S. Aro
Executive Director

WGD/SMM/lc

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Executive Summary

The issue of health plans merging, seeking joint ventures, or converting to for-profit entities has aroused considerable policy focus in recent years. Many of these conversions have been justified by the converting entities as a natural progression for the business of health care. Increasingly, converting plans have indicated that they need greater access to capital, better utilization management, and a greater ability to focus on geographic expansion of services. However, several plans have reaffirmed their commitment to maintain their nonprofit status. Nationally, 17 plans have announced their intention to convert or have completed a conversion.

On November 20, 2001, CareFirst BlueCross Blue Shield announced its intention to convert to a for-profit company and to subsequently be acquired by WellPoint Health Networks, Inc. A formal conversion application was filed on January 11, 2002. CareFirst is the largest health plan in Maryland, with 3.1 million enrollees in Delaware, the District of Columbia and Maryland. The proposed conversion of CareFirst will undoubtably impact all residents of the State. The future direction of CareFirst as a company, provider of health benefits, and as an employer in the State is a critical issue for policymakers to consider.

Conversions of nonprofit health plans raise concerns on several fronts: (1) the potential decrease in the number and types of available health care services; (2) the disposition and transfer of the charitable assets of the converting nonprofit; (3) possible loss of local control of the plans; (4) potential decrease in the affordability and availability of health insurance; and (5) potential job loss as the result of an acquisition. At the same time, however, a conversion may also create new possibilities for the creation of new programs and the expansion of existing health programs.

Through the examination of conversions that have occurred in other states, it is clear that there is a need for: (1) a clear legal process for conversion; (2) third party valuation of the converting entity; (3) a plan for the disposition of the assets of the converting entity; and (4) well-established foundations to manage the assets received by the State after the conversion takes place. This report looks at conversions and proposed conversions in other states with regard to these four considerations.

Blue Cross Blue Shield: History and a Changing Mission

The Evolution of Blue Cross Blue Shield Plans Nationally

Prepaid health coverage was first offered in the United States in 1929 when an official at Baylor University hired to shore up the finances of University Hospital offered a health plan to schoolteachers guaranteeing 21 days of hospital care for $6 a year. Prepaid hospital services solved financial problems for struggling community hospitals and protected the general public from incurring catastrophic hospitalization costs. The idea took hold nationally, and by 1939 the American Hospital Association (AHA) was overseeing the operation of these hospital service plans. AHA adopted the Blue Cross as the plans' trademark symbol and appointed a commission to establish guidelines for Blue Cross plans. In 1960 the commission was replaced by the Blue Cross Association which ultimately severed ties with the AHA in 1972.

The first Blue Shield plan was established in 1939 as a means for employers to provide physician services to employees. In 1948 a group of nine physician service plans adopted the Blue Shield symbol. This group eventually became known as the National Association of Blue Shield Plans.

The existing national Blue Cross and Blue Shield Association (the association) was created in 1982 as the result of a merger between the Blue Cross Association and the National Association of Blue Shield Plans. The association is the trade organization for Blue Cross and Blue Shield (BCBS) plans across the country. Every BCBS plan is a dues paying member of the association and must adhere to association guidelines and standards in order to use the BCBS trademarks.

Nonprofit health service plans, like most BCBS plans, receive favorable tax treatment and other benefits from both federal and state governments that are not accorded their for-profit counterparts. Prior to 1987, these plans had tax-exempt status because they performed public services that, absent the organization, would have to be provided by the government. In fact, BCBS plans have been referred to as "a quasi-public alternative to government health insurance."[1]

Spurred by complaints from commercial insurers that such tax treatment represented an unfair competitive advantage, Congress repealed the full tax exempt status of BCBS plans under the federal Tax Reform Act of 1986. However, Congress created a special tax class for the plans in recognition of the unique community service they

[1] Cunningham, Robert III and Robert M. Jr., *The Blues A History of the Blue Cross and Blue Shield System*, Northern Illinois University Press, 1997, p. xi.

provide. Beginning January 1, 1987, BCBS plans became subject to a corporate tax rate that is significantly lower than the prevailing corporate tax rate.

CareFirst is the State's largest health insurer and by far its largest nonprofit health service plan. As a health insurer, CareFirst BlueCross BlueShield is exempt from the State corporate income tax, and as a nonprofit health service plan, it is exempt from the 2 percent tax on gross direct premiums that most other insurers, including the Maryland Automobile Insurance Fund, are required to pay. In 2000 there were 44 BCBS plans in the United States with a combined net worth of approximately $23 billion and combined annual revenue of $126 billion.

The Evolution of the Blues in Maryland

In Maryland, the General Assembly passed enabling legislation in 1937 that cleared the way for 12 Baltimore hospitals to start a Blue Cross plan. The State's Blue Shield plan was begun in 1948. Blue Cross of Maryland, Inc. and Blue Shield of Maryland, Inc. merged into a single company in 1984: Blue Cross and Blue Shield of Maryland, Inc. The modern day BCBS plan in Maryland is the product of two later business combinations: in 1997 with the Washington, DC plan and in 2000 with the Delaware plan.

The enabling legislation for the Maryland Blue Cross plan declared that every corporation licensed as a hospital service plan is "a charitable and benevolent institution, and all of its funds shall be exempt from all and every state, county, district and municipal tax, other than taxes on real estate and office equipment." For over 40 years, BCBS plans were organized under section 501(c)(4) of the Internal Revenue Code as tax-exempt, nonprofit, social welfare organizations. Such organizations operate and maintain assets primarily for the benefit and common good of the community as a whole.

The Maryland BCBS plan, CareFirst, Inc., is an independent, nonprofit holding company that provides health care through three wholly-owned affiliates: CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc. (both of which do business as CareFirst BlueCross BlueShield), and Blue Cross Blue Shield of Delaware. CareFirst, Inc., through these affiliates, provides health care services to over three million people in the mid-Atlantic region, employs over 6,000 individuals, and in 2000 had annual revenue that exceeded $5 billion and a combined surplus of almost $700 million.

Product Diversification, Financial Losses, and Increased Regulation

As a direct result of losing the full federal tax exemption in 1986, BCBS plans were able to enter into new lines of business, including the creation and purchase of for-

profit subsidiaries. By the early 1990s, many of the plans had lost significant sums of money on these business ventures that were widely believed to be too far from the plans' core business. In addition to losses resulting from poor business decisions, a number of plans were suffering from mismanagement and questionable ethical practices on the part of board members and company executives.

The Maryland plan was no exception. In 1992 the U.S. Senate Permanent Subcommittee on Investigations held hearings to explore allegations against Blue Cross and Blue Shield of Maryland that included questionable business decisions, high executive salaries, and lavish entertainment of both government officials and business clients. At the time of the hearings, the plan's subsidiaries had lost over $120 million. The chief executive officer of BCBS of Maryland was forced to resign only months later.[2]

Following the 1992 Congressional hearings, the Maryland legislature addressed the crisis at BCBS by passing legislation that significantly increased State oversight of the plan. In addition to reconstituting the board and codifying the terms and responsibilities of board members, the legislation established minimum surplus standards and required that all affiliates and subsidiaries of a nonprofit health service plan be licensed and related to the business of health insurance. The bill also put in law a process regulating the conversion of a nonprofit health service plan to a stock or mutual company.

For-profit Conversion and Maryland's Legislative Response

In 1994 the National Blue Cross and Blue Shield Association repealed its long-standing requirement that all BCBS plans be operated as nonprofits and a wave of conversions and conversion attempts by BCBS plans began around the country. The justification for this move was largely to allow BCBS plans to raise capital and to undertake market diversification in order to become more competitive. As enumerated in a 1997 report to the General Assembly by the Department of Legislative Services, conversions of nonprofit health service plans raise a number of issues, including: loss of community control, potential decrease in access to and availability of health care services, private benefit, breach of fiduciary duty and conflict of interest, preservation of financial value of the nonprofit, and disposition, protection, and appropriate use of nonprofit assets.[3] Maryland addressed many of these issues in 1998 when the General Assembly altered and updated the statutory process regulating the conversion of

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[2] Cunningham et al, at p.238.

[3] Department of Legislative Services. *Nonprofit Health Entity Conversions: A Legislative Guide*. December, 1997, pages 2-3.

nonprofit health service plans.

The conversion statute enacted in 1998 requires the Insurance Commissioner to approve a nonprofit health service plan's application to convert "unless [the Commissioner] finds the acquisition is not in the public interest." The statute expressly provides that a conversion is not in the public interest unless appropriate steps have been taken to ensure that the value of the public or charitable assets is safeguarded and to ensure that the fair value of those assets is distributed to the Maryland Health Care Foundation. Chapter 701, Acts of 2001 requires the Health Care Foundation to place any funds received as a result of a conversion in a trust for use pending legislative enactment.

Maryland Blues: Movement Away from Nonprofit Mission Culminates in November 2001 Decision to Seek For-profit Status

CareFirst was once considered the insurer of last resort in Maryland, willing to underwrite risks that commercial insurers avoid. Today some of the company's business practices more closely resemble that of a commercial insurer:

- In 1994 then Blue Cross Blue Shield of Maryland (BCBSM) proposed to create a new for-profit commercial health insurance company which would sell indemnity health insurance products under a separate logo. The Insurance Commissioner ultimately rejected the proposal on the grounds that the plan would have converted the company to a for-profit enterprise.

- The company's recent exit from several segments of the Maryland health insurance market was perhaps a further sign that CareFirst was distancing itself from its nonprofit mission. In 1999 CareFirst announced its withdrawal from the Medicare+Choice program in the State's rural counties. By January 1, 2001, the company had withdrawn entirely from the Medicare+Choice program. In April of the same year, CareFirst terminated participation in HealthChoice, Maryland's Medicaid managed care program.

- In May 2001 the company announced the withdrawal of its subsidiary HMOs, FreeState and Delmarva, from both the individual and small group insurance markets in Maryland. In consolidating this business under its Washington, DC based HMO, BlueChoice, the company predicts that over 6,000 individuals who had purchased medically underwritten individual health insurance will now not satisfy the more stringent medical underwriting standards of BlueChoice and will, therefore, be deemed medically uninsurable.

- In a related move, CareFirst decided to no longer offer an HMO open enrollment plan to medically uninsurable individuals under the Substantial, Available,

Affordable, Coverage program for which the company receives a 4 percent discount on hospital rates for all of its members.

CareFirst cites changing market conditions and losses incurred in the Medicaid, Medicare+Choice, individual, small group, and medically uninsurable markets as justification for its recent actions. However, despite the losses reported, the 2000 Annual Report of CareFirst, Inc. states that the company's reserves, "a common measure of financial strength under generally accepted accounting principles" have risen from $598 million at the end of 1999 to $692 million at the end of 2000.[4]

On November 20, 2001, CareFirst publically announced its intention to convert to a for-profit company and be acquired for $1.3 billion by a larger, for-profit company, WellPoint Health Networks, Inc. (formerly Blue Cross of California). The company will have to file a conversion application with all three jurisdictions to which its charitable assets would inure: Maryland, the District of Columbia, and Delaware. The application was formally filed on January 11, 2002. The $1.3 billion purchase price is one indication of the value of the company's charitable assets. However, regulators from each of the jurisdictions involved will undoubtedly obtain independent valuations of the company.

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[4] CareFirst BlueCross BlueShield. *Annual Report of CareFirst, Inc., 2000.*

What Is a Conversion?

Conversion encompasses several forms of organizational transformation and includes a broad range of business transactions including:

- *Acquisition/Sale of Assets:* A sale of assets conversion is an outright sale. The nonprofit insurer sells its assets with the proceeds usually going to a created foundation.

- *Affiliations:* This type of conversion describes the coming together of two entities to form an operating entity in which the assets of the partners are not joined.

- *Consolidation:* A consolidation is the union of the two existing corporations to form a new corporation. Both corporations disappear and a new corporation is created.

- *Joint Ventures:* A joint venture is a conversion that is similar to a partnership. The nonprofit insurer sells a share of its assets to the for-profit company for a portion of the sales price. In return, the nonprofit insurer retains some type of control, while investors still can realize a return on their investment. Usually, the retained control is cursory, meaning that seats on the board of the for-profit company have limited voting rights.[5]

- *Mergers:* A merger is the absorption of one corporation (the acquired or target corporation) by another corporation (the acquiring corporation). The acquired corporation ceases to exist and the acquiring corporation survives.

- *Mutualization:* Mutualization involves the transfer of ownership of an insurance company from stockholders to policyholders. The change of ownership is brought about by stockholders surrendering to insurance company their stock for an agreed price. On surrender of the stock, the company then belongs to the policyholders.

Across the country, BCBS plans have converted to for-profit status through various methods and processes. Most commonly, the conversion of a BCBS plan takes place as part of a merger transaction or by an acquisition. The acquirer might be another BCBS plan operating as a conventional nonprofit or a converted investor-owned

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[5] National Conference of State Legislatures, Health Policy Tracking Service, "Change in Nonprofit Entities," December 30, 2000, p. 2.

company, or a commercial company, a traditional title given to for-profit entities organized either as stock companies owned by investors or as mutual companies owned by policyholders.[6] When a BCBS plan converts to for-profit status, the issue arises of what to do with the assets, commonly referred to as charitable assets, that the plan has accumulated as a nonprofit organization in the nonprofit sector.

Charitable Assets Generally

Nonprofit charitable organizations have no individual owners. Unlike public corporations that operate for the benefit of shareholders, nonprofit charitable organizations are operated and their assets are maintained for the benefit of the community as a whole. These organizations receive their unique legal status in exchange for the public service they perform. The common law charitable trust doctrine and the *cy- pres* doctrine govern the disposition of charitable assets. In addition, Section 14-115 of the Insurance Article codifies the fiduciary responsibilities of board members of a nonprofit health service plan.

The Charitable Trust Doctrine: Under the charitable trust doctrine, charitable assets are forever designated as charitable and are to be used to fulfill an organization's charitable purpose even if the nonprofit alters its purpose or converts. Charitable or public assets are the tangible and intangible property of a nonprofit corporation, benevolent corporation, or a trust and may include real estate, capital, money, financial holdings, reputation, good will, and a brand name.

Many courts have ruled that the assets of charitable corporations are subject to charitable trust law. Consequently, charitable corporations may only use their assets for the purposes for which they were donated. Courts have further ruled that several legal doctrines available previously only in charitable trust law also apply to corporations holding charitable or public assets. These doctrines aid in determining whether the corporation is using the charitable assets for their intended purpose.

The Cy-pres Doctrine: Cy-pres means "as nearly as possible" in French. The doctrine essentially states that if a charitable purpose for which a charitable trust can no longer be continued or no longer applies, the assets of the trust must be used for a charitable purpose that is as close to the original purpose of the trust as possible. The *cy-pres* doctrine is codified in Maryland law in § 14-302 of the Estates and Trusts Article of the Annotated Code. This test requires a two part analysis:

- Is the trust a valid charitable trust?

[6] Schramm, Carl J., "Blue Cross Conversion: Policy Considerations Arising From A Sale of the Maryland Plan" November 2001, p. 43.

- If a gift giver had known that it would be impossible to follow the express terms of the charitable bequest, would the gift giver prefer to bequeath the funds to a similar charitable purpose or would the gift giver have wanted them withdrawn from charitable channels?

Maryland law imposes specific duties of nonprofit health service plan directors. Section 14-115(c) of the Insurance Article requires the board members of a nonprofit health service plan to act:

- in good faith;
- in the best interests of the company;
- with the care that an ordinarily prudent person in a like position would use under similar circumstances.

Valuation of Charitable Assets

Legally, the charity proposing for-profit conversion must obtain fair market value for the charitable assets it transfers to the foundation and must be able to demonstrate that it has done so. Moreover, it is important to recognize that a converting plan may have value in addition to the stock it holds in the new for-profit. For example, a plan may hold real estate or engage in other nonprofit insurance business that will be converted to the new for-profit under a final conversion agreement. In addition, BCBS conversions allow the transfer of the exclusive right to the Blue Cross and Blue Shield trademark to the for-profit, which means that the value of the mark will be converted to the for-profit business.

To assure that fair market value is received, financial experts are retained to evaluate the purchase price in a proposed transaction and confirm that the negotiated price reflects fair value.[7] There are four basic approaches used by valuation experts to arrive at a conclusion about whether a proposed purchase price is fair.[8] Some or all of these approaches, called valuation methodologies, are used to balance the results of any one approach and arrive at an opinion as to the fair value, or range of values, attributable to the charitable assets purchased:

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[7] Massachusetts Office of the Attorney General.

[8] In his report, Schramm identifies a hybrid valuation methodology called the Community Economic Value Model. This methodology relies on an economic perspective and examines the nature of the capital invested and its present value with regard to an equitable claim form the current owners, the likely efficiency of the successor entity, and the risks associated with an altered ownership structure. A community economic approach also considers the gain or loss to the social welfare that the transaction will have on the community. See Schramm, "Blue Cross Conversion," p. 96-97.

- *Discounted Cash Flow (DCF) Analysis:* This approach estimates value by calculating the present value of an organizations's future income stream and assumes ongoing business operations. Using this model, cash flow from business operations is projected into the future for a period of years and then discounted to reflect present market value.[9] The DCF technique requires assumptions be made about market growth, product demand pricing, underwriting gains and losses, general inflation, unemployment rates, medical trend factors, and regulatory/legislative actions, among other factors. History indicates a great deal of volatility in several of these variables, particularly medical care cost inflation.[10]

- *Simple Comparison Analysis:* This market test, also known as acquisition analysis, relies on comparison of the proposed purchase price with prices paid in comparable transactions. Key to this approach is an adequate pool of truly similar transactions for comparison with the proposed sale.[11]

- *Capitalize Historic Earnings Analysis:* Similar to Simple Comparison Analysis, this method uses comparisons of value with similar publicly-traded companies for which value can be inferred from stock prices. By comparing the earnings of the subject company to the fair market price per share of comparable publically-traded companies, the analysis derives a measure of value as to how the market might treat the subject company's earnings.[12]

- *Adjusted Book Value Analysis:* In this approach, the fair market value of the company is estimated based on review and restatement of the company's balance sheet to current market rates.[13] The book value approach is simple; it captures the value of a business by determining the market value of the sum of its parts if the parts were to go to the market today.[14]

It is important to recognize that in any acquisition, the same valuation methodology may yield very different results when performed by a buyer or a seller. In past BCBS conversions, assets of the converting BCBS plan have been undervalued

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[9] Massachusetts Office of the Attorney General at 12.

[10] Schramm at 87.

[11] Massachusetts Office of the Attorney General at 12.

[12] Schramm at 88.

[13] Massachusetts Office of the Attorney General at 12.

[14] Schramm at 89.

causing the loss of charitable assets and windfall profits for the investor-owned company. Undervaluations also raise serious questions about improper private benefit from the sale of charitable assets. Specifically, that much of the value of the charitable assets associated with the original nonprofit organization. At the same time, in other BCBS conversions, fair and reasonable value has been attained through the use of valuation experts and open lines of communication between the interested parties.

Conversion Foundations and the Disposition of Charitable Assets

Valuation of the charitable assets is often the most important issue in any nonprofit health care conversion. As a nonprofit health service plan, the assets of CareFirst belong to the public. Therefore, placing an accurate value on CareFirst's assets is a primary concern to the citizens of Maryland.

As mentioned earlier, the *cy-pres* doctrine as well as the Internal Revenue Code requires that a charity's assets be dedicated irrevocably to charitable purposes. Thus, in the sale or conversion of a nonprofit health entity, the proceeds must be transferred to another nonprofit entity. The receiving entity could be a new or existing tax-exempt organization such as foundation or public trust, or a state, local or federal government.[15] As of 2000, there have been 129 foundations created as the result of the conversion of a hospital or health plan.[16] Out of the 129 foundations included in the 2000 Grantmakers In Health survey, 73.6 percent were formed between 1994 and 2000. Most of the new health foundations developed as a result of the sale of a nonprofit hospital, health system, or health plan. Hospital conversions made up 73 percent of the new foundations, while 24 percent were the result of the conversion of a nonprofit health plan or health system. As pressures from Wall Street and payors mount, nonprofit health plans are increasingly considering conversion to gain greater access to capital, create efficiencies, and garner greater market share nationally. This pressure only increases the likelihood of more foundations of this type being established across the country.

Despite a growing number of health entity conversions, there is not one widely used model for establishing and developing a mission-driven health care foundation or trust used for the disposition of the assets in the event of a conversion. Issues arise with regard to the type of trust, the trust's structure, use of assets, appointments, mission, requirements of its governing board, and accountability. Additionally, the type of foundation established for hospital conversions should be substantially different from one

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[15] Department of Legislative Services. *Nonprofit Health Entity Conversions: A Legislative Guide*. December, 1997, page 24.

[16] Grantmakers In Health. "Philanthropy's Newest Members: Findings from the 2000 Survey of New Health Foundations." March, 2001.

created for the conversion of a health plan. This is a critical distinction because the conversion of a large health plan has statewide implications and must serve "a broader statewide charitable mission,"[17] while the conversion of a hospital generally has impact only in the geographic area served by the hospital.

In an effort to assist states in the creation of conversion foundations, Consumer's Union (the parent company of *Consumer Reports*) and Community Catalyst (a nonprofit organization dedicated to consumer and community participation in the health care system) have developed a handbook for creating effective foundations. The joint venture, called the Community Health Assets Project, works to provide technical assistance to communities, legislators, regulators, and philanthropic organizations. Both organizations are committed to seeking consumer input into the disposition of assets of nonprofit organizations. The handbook outlines the key elements to assure consumer input into the creation and operation of a conversion foundation:

- *Strong foundation planning.* This includes the creation of an initial governing board with advice of a key government regulator such as the Insurance Commissioner or Attorney General. The initial governing board should include community representation and members of the health care provider community. In addition, strong planning is a critical element in the decisions on how best to utilize the assets of the newly created foundation. This includes performing a community needs assessment as well as evaluations of the health care market both before and after a conversion takes place.

- *Defining the mission and population served by the conversion foundation.* This should ensure that the assets are dedicated to health needs. Since the charitable trust doctrine states that charitable trust assets must be used as closely as possible for the purpose for which they were initially created, it is important that a conversion foundation be dedicated to meeting health needs.

- *Appointment of Foundation Board Members.* The appointment of a board for the foundation should be made by the initial governing board and should be made impartially. The board should be independent from the succeeding for-profit company, though individuals formally or informally associated with the former nonprofit should not be excluded from appointment on the board. The average size of conversion foundation boards in past conversions is 12 members, and most foundations do not allow lifetime appointments. Community Catalyst and Consumer's Union suggest that the foundations have broad authority with regard to the disposition of assets and that the bylaws of the organization specify the level of experience required of foundation staff.

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[17] DeLucia, Michael. "Creating New Health Care Foundations". *Nonprofit and Voluntary Sector Quarterly*, v. 30, no. 1, March, 2001, page 133.

- *Performance Measures and Accountability.* During the conversion process, provisions for regular evaluation of the foundation can be established in the foundation's budget and charter. These reporting requirements can include the impact the foundation is having on the insurance market as well as an assessment of the structure and grant making activities of the foundation.

Conversion in Maryland: What's in Place, What Will Happen

What's in Place: The Maryland Health Care Foundation

The Maryland Health Care Foundation ("foundation") was established in 1997 by Chapter 180, 1997 Laws of Maryland. The model for the foundation was the Chesapeake Bay Trust, which was created by the General Assembly in 1985 to aid in the protection of the Chesapeake Bay.

Like Chesapeake Bay Trust, the Maryland Health Care Foundation was initially established to receive moneys to provide financial support to programs that expand access to health care services for uninsured Marylanders. The foundation is statutorily established in perpetuity and is designed to be a charity.

Chapters 123 and 124, Acts of 1998 established the foundation's statutory role in a nonprofit conversion. The mission of the foundation, defined in §20-502 of the Health General Article, is "to promote public awareness of the need to provide more timely and cost-effective care for Marylanders without health insurance and to receive moneys that can be used to provide financial support to programs that expand access to health care services for uninsured Marylanders."

Chapter 701, Acts of 2001 established the Maryland Health Care Trust to hold the charitable/public assets of a converted nonprofit health service plan or nonprofit HMO pending distribution of those assets via an act of legislature. The Maryland Health Care Foundation is named trustee of the Maryland Health Care Trust.

The foundation is governed by a board of trustees that includes 19 appointees. Of the 19 members of the board, 14 of them are appointed by the Governor with advice and consent of the Senate. Members of the board may not serve more than two consecutive four-year terms. The statute governing Maryland's foundation does not require the use of a community advisory group, though it does require four members of the general public without connection to the health care community to be appointed to the board.

What Will Happen: Maryland's Conversion Law

Prior to October 1, 1998, Maryland law gave the Insurance Commissioner regulatory jurisdiction over the conversion and restructuring activities of nonprofit health

service plans and HMOs. If the transaction involved a nonprofit HMO, however, the law required the Insurance Commissioner to consult with the Secretary of the Department of Health and Mental Hygiene (DHMH) over health-related services, operations, and functions that fell under the regulatory jurisdiction of DHMH. Prior to 1998, hospital mergers, consolidations, and acquisitions in Maryland were subject to oversight by the Health Resources Planning Commission (HRPC).[18]

Although the pre-1998 law did provide an outline for conversion, it did not provide the comprehensive model necessary to protect a nonprofit's charitable assets or ensure that the public's interests were considered upon a proposed conversion. These factors, along with the growing number of nonprofit health entity conversions around the country, resulted in the introduction of Senate Bill 531/House Bill 753 and House Bill 287 during the 1997 session. These bills did not pass the General Assembly and instead were sent to interim study.

Nonprofit Conversion Law: Post 1998

The 1998 session of the General Assembly saw the introduction of Senate Bill 143/House Bill 167 to regulate the conversion and restructuring activities of nonprofit health care entities in Maryland. The bills were enacted as Chapter 123 and Chapter 124, respectively, of the Acts of 1998 and are codified in Title 6.5 of the State Government Article.

Under the statute, there are two possible methods of conversion. The nonprofit plan may convert through a public offering of stock, or it may sell one hundred percent of its stock to an existing for-profit corporation.[19] Current law provides that the regulating entity for the conversion of a nonprofit health service plan is the Maryland Insurance Administration (MIA). Sections 6.5-201 through 6.5-306 set forth the conversion process as follows:

- *Process for Approval* (6.5-201): The entity seeking to convert must submit an application to the MIA which includes specific information including:
    - terms of the proposed conversion, including sales price;
    - a copy of the acquisition agreement; and
    - a financial and community impact analysis report from an independent expert or consultant that address criteria contained in Section 6.5-301.

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[18] Department of Legislative Services at 14.

[19] Different procedures may apply to the conversion of a nonprofit hospital.

- *Notice of Application* (6.5-202): Within ten working days after receiving the application, the MIA must publish notice of the application in the newspapers of the nonprofit's service area and notify by mail any person that requested, in writing, notice of the filing.

- *Public Hearing* (6.5-203): No later than ninety days after receipt of a complete application, the MIA must hold public, quasi-legislative hearings. Any person may file written comments and exhibits or make a statement at the hearing. The MIA may subpoena information and witnesses, require sworn statements, take depositions, and use related discovery procedures.

- *Retention of Outside Experts* (6.5-203(e)): The MIA may contract with experts, subject to State procurement laws. Reasonable costs for the retained experts are paid for by the transferee to:

  - determine whether to approve the conversion;

  - perform an independent valuation of the public or charitable assets of the transferor;

  - evaluate the impact of the conversion on the affected community;

  - determine whether the transferor has performed due diligence; and

  - determine the existence of conflicts of interest.

- *MIA Decision Timeframe* (6.5-203(f)): Within 60 days after the record is completed (including the hearing process), the MIA must approve (with or without modifications), or disapprove the application. If the application is not approved or disapproved within 60 days after the record is closed, the application is deemed approved. The MIA may extend the process for 60 days for good cause, but the MIA is limited to a maximum of two 60-day extensions.

- *Public Interest Standard* (6.5-301): The MIA must approve a conversion unless it finds that the acquisition is not in the public interest. To determine if the conversion is in the public interest, the MIA must ensure that:

  - the value of the public or charitable assets are safeguarded;

  - the fair market value will be distributed to the Maryland Health Care Foundation; and

  - no part of the public or charitable assets of the conversion inure directly or indirectly to any officer, director, or trustee of the nonprofit entity.

The public interest standard in Maryland law requires the Commissioner to approve a conversion *unless* the proposal is found *not* to be in the public interest. At least 12 states have laws governing the conversion of a nonprofit health entity require the interest of the public or subscribers of the converting entity to be considered by regulators when a proposed conversion is under review. In some states, such as Massachusetts, the regulator must consider the public interest as one of many factors evaluated during a proposed conversion investigation.[20] In Georgia, however, a conversion of a nonprofit health service plan can be approved after the Insurance Commissioner determines that such a conversion is in the best interest of "the company, its policyholders and the general public."[21]

- *Fair Value Determination* (6.5-301(d)): In determining fair value, the MIA may consider:

  - the value of the nonprofit health entity as if the entity has voting stock outstanding which was freely transferable and available for purchase;
  - the value of the entity as a going concern;
  - the market value;
  - the investment or earnings value;
  - the net asset value; and
  - a control premium, if any.

- *Conditions for Approval* (6.5-303): In determining whether to approve the conversion, the MIA must consider the criteria listed in Section 6.5-301 and whether the acquisition:

  - is equitable to enrolles, insureds, shareholders, and certificate holders of the transferor;
  - is in compliance with Title 2, Subtitle 6 of the Corporations and Associations Article relating to the amendment or reinstatement of charter; and

[20] Mass. Ann. Laws ch. 180, §§ 8-A(d)(1)(v)

[21] Ga. Code Ann. §§ 33-20-34(a)(1)

- provides that the resulting stock health insurer has sufficient surplus required under law and provides for the security of policyholders and certificate holders.

The Role of the Attorney General

In comparing Maryland's conversion law before and after the 1998 legislative enactments, it is clear that the regulation of nonprofit health entity conversions has been expanded considerably. There is a process in place for regulatory review of a proposed transaction. With the notable exception of the condition that the conversion be approved by at least two-thirds of the certificate holders, the elements of the prior law have been enhanced to include a greater emphasis on the conversion process, the importance of valuation of the charitable assets, and the impact that a conversion will have on Maryland's public health system.

While the consideration of whether or not a nonprofit health service plan should be allowed to convert rests primarily with the MIA, the Attorney General's authority over a conversion of a nonprofit health service plan arises from statute and common law. The General Assembly by statute can confer common law power, and it has done so in the areas of charities, charitable trusts, and corporate powers.[22]

Some of the Attorney General's power in these areas was outlined in a Letter of Advice to Honorable Thomas L. Bromwell, dated February 17, 1998. In that advice letter, it was noted that the Attorney General could go to court if it was believed that a charitable trust was not being enforced or that a corporation, whether charitable or not, was abusing its power.[23] The letter also remarked that there may be common law powers of a supervisory or investigatory character that are incidental to or implicit in the right to go to court.[24] Further, it has been noted that although this authority may not require preapproval by the Attorney General for the conversion of a nonprofit health service plan, such prior approval is required to avoid the possibility of court action against the plan and for the Attorney General to reasonably determine whether legal action is necessary.[25]

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[22] Letter of Advice to Honorable Casper R. Taylor, Jr., dated December 7, 2001.

[23] Letter of Advice to Honorable Thomas L. Bromwell, dated February 17, 1998.

[24] Id.

[25] Letter of Advice to Honorable Casper R. Taylor, Jr., dated December 7, 2001.

A recent example of Attorney General action to protect the charitable assets of a trust is the sale of the Boston Red Sox. Prior to a public auction held in December, the majority of the team was controlled by a trust. Red Sox ownership held an auction for the team, and though team management indicated that it has responsibility to choose the highest bidder, the final bidder chosen was not the highest bidder, but the "most qualified bidder."[26]

Massachusetts Attorney General Tom Reilly has publically indicated that his office does not have regulatory authority over the sale of team. However, the Massachusetts Attorney General's Office does "oversee the public charities that are beneficiaries of that private trust."[27] Reilly is reviewing the sale after receiving complaints that the auction favored a one group over another. In his role as the protector of charitable interests, Reilly has stated that said he is particularly interested in why the team did not accept the highest bid.

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[26] Statement from Red Sox CEO John Harrington, December 20, 2001, redsox.mlb.com.

[27] Press Release from the Office of Attorney General Tom Reilly. "AG Reilly Seeks Facts on Proposed Sale of Red Sox." December 21, 2001.

Case Studies of Conversions in Other States or Why Conversions Have Not Occurred

Since health care conversions are happening on a state-by-state basis, each conversion has been handled differently, since state law governs the disposition of the assets for these plans. Even more difficult to quantify is the impact of a conversion on the stability of the insurance market and health care delivery system after a conversion takes place.[28] **Appendix 1** details the conversions of BlueCross plans across the U.S. Nationally, 17 plans have announced their intention to convert or have completed a conversion. Additionally, Blue Cross and Blue Shield of North Carolina is currently contemplating a conversion.[29]

Missouri, California, New York, and Virginia have had one of their nonprofit health insurance plans convert to for-profit status or propose a conversion in recent years. The details surrounding these conversions are instructive because each state has had a different experience with the valuation of assets, creation of a foundation, and disposition of the assets to the community.

The First Conversion: The History of Blue Cross of California's Conversion to For-profit Status

In California, conversions of nonprofit hospitals and health plans to for-profit status first began occurring in the 1970s. In 1991, Blue Cross of California applied to the California Department of Corporations (DOC) to transfer 90 percent of Blue's assets and all of its managed care business to WellPoint, a for-profit subsidiary.[30] WellPoint had been created in 1992 to operate Blue Cross of California's managed care business. Blue Cross argued that this type of restructuring was not a conversion. The DOC initially approved the restructuring on January 7, 1993, agreeing that it did not constitute a for-profit conversion. The DOC, however, did require Blue Cross to withdraw a stock option plan for its senior executives that resembled the generous arrangements in

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[28] DeLucia, Michael. "Creating New Health Care Foundations". *Nonprofit and Voluntary Sector Quarterly*, v. 30, no. 1, March, 2001, DeLucia at 131-132.

[29] Accenture, Ltd. "Assessment of Health Coverage Industry Trends and CareFirst's Strategic Response."Appendix p. 42.

[30] Fox, Daniel M., and Phillip Isenberg. "Anticipating the Magic Moment: The Public Interest in Health Plan Conversions in California." *Health Affairs*, Spring 1996.

previous conversions of California health plans. WellPoint stock began trading on the New York Stock Exchange.

In March 1993, legislation was introduced in the California Assembly that required individual members of the board of a restructured nonprofit organization to preserve the charitable assets and maintain the same level of corporate charitable expenditures as before the restructuring. This bill passed the Assembly but failed in the Senate. However, Blue Cross and WellPoint were concurrently undergoing negotiations with regard to charitable assets and agreed to give $5 million a year in charitable contributions for twenty years, or $100 million total.

However, in August 1993, the commissioner of DOC asked Blue Cross to submit a plan for meeting its obligations to the public as a result of its restructuring. The DOC and Blue Cross could not agree on the size of the charitable trust to be created, who should run it, and how the funds would be distributed. In response, the DOC commissioner later deemed the public the shareholder of Blue Cross and himself the representative of the public. He indicated that the proposed payment to charity of $100 million over twenty years was less than 0.2 percent of the value of Blue Cross/WellPoint. On September 15, 1994, Blue Cross proposed to create a new philanthropic foundation that would receive the assets of WellPoint, then about $2.5 billion. Moreover, the board of Blue Cross would become the board of the new foundation.

In an effort to hold Blue Cross accountable for its charitable assets, bills introduced in the California Assembly and Senate in 1995 proposed rules that applied to nonprofit health plans that converted or restructured to for-profit entities. Some of the proposals prohibited board members and officers of converted or restructured corporations from receiving benefits from the transaction as well as outlined specific methods of valuing the assets of the nonprofit entity to determine the appropriate return to the public.

The DOC solicited public comment at the first public hearings ever held in California on a proposed conversion. Instead of accepting the new proposal, the commissioner hired independent experts to review both the full fair market value of the nonprofit Blue Cross of California and the proper formation of the new foundations. Finally, Blue Cross/WellPoint agreed to place approximately $3.2 billion in two grant-making foundations and formally complete its conversion to for-profit status. The charitable assets were distributed in a combination of cash and an equity interest in the new for-profit. Two foundations were established, one which is a 501(c)(4) and another which is a 501(c)(3). The board selection was extremely thorough for the (c)(3), requiring an executive search consortium to determine new board members. In 1996, Blue Cross and WellPoint formally merged into a single stockholder-owned company, WellPoint Health Networks, Inc.

The dissatisfaction with the DOC's oversight of nonprofit health plan conversion reached its peak with the Blue Cross/WellPoint conversion process and resulted in a law passed in 1996, which gave the Attorney General (AG) veto power over health plan conversion agreements. It also mandated that public hearings be conducted by the AG's office, that an analysis be done of the transactions' likely impact on the local community, and that the state be reimbursed by the parties proposing a conversion for the expense of hiring experts and doing the proper analyses. Finally, the bill codified the transaction review protocol that the AG's office had been using for years with respect to nonprofit hospital conversions.

Creation of the Foundations

The Blue Cross of California conversion created two grant-making foundations in 1996, the California HealthCare Foundation (CHCF), which is focused on improving delivery and financing systems in California health care, and the California Endowment, which awards grants to organizations and institutions that directly benefit the health and well-being of Californians. Under the conversion agreements, CHCF received 80 percent of WellPoint's outstanding shares in 1996.[31] Over the years, as directed by the conversion agreements, CHCF has sold its WellPoint stock and has transferred the bulk of the proceeds (a net $2.5 billion) to its sister foundation, The California Endowment, the principal philanthropic product of the conversion.

The California Endowment is the state's largest health care foundation with $3.5 billion in assets. Since its inception, the Endowment has awarded more than 2,100 grants totaling nearly $695 million to community-based organizations throughout California. The Endowment awards grants to organizations that directly benefit the health and well-being of the people of California.

The Endowment uses a variety of funding approaches to meet the needs of local communities including an open application grant program (CommunitiesFirst), requests for proposals, funding partnerships, commissioned grants, and program-related investments. Funding is restricted to not-for-profit and governmental organizations within the State of California. No grants are made to individuals.

The Endowment has adopted a regional, community-based approach for all of its grant-making activities. It has offices in Los Angeles, Sacramento, San Diego, Fresno, and San Francisco and has program staff working throughout the state.

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[31] California HealthCare Foundation, "Health Care in California: Improving Delivery and Financing Systems." *Foundation Report 1999-2001*.

CHCF focuses on critical issues in the health care marketplace: managed care, the uninsured, health policy and regulation, health care quality, and public health. Grants focus on areas where CHCF's resources can initiate meaningful policy recommendations, innovative research, and the development of model programs.

Conversion of Missouri Blue Cross Blue Shield

Blue Cross Blue Shield of Missouri (BCBSM) was originally incorporated as Group Hospital Services, Inc. of St. Louis, Missouri in 1936. It later changed its name to Blue Cross Health Services, Inc. of Missouri and merged with Missouri Medical Service (its Blue Shield counterpart) in 1986. The new company was named Blue Cross and Blue Shield of Missouri.

BCBSM's articles of incorporation stated that its corporate purpose was to conduct business in accordance with the Missouri Nonprofit Corporations Act, and in the event of dissolution its assets should be distributed pursuant to the provisions of the Act, and

> to serve the interests of its members and of the public by advancing the availability of quality health care on a voluntary, nonprofit basis, by promoting and safeguarding the public health by collection of information, statistics, and data on health care matters and by participation in such benevolent, educational and related activities as are intended to benefit the public health. [32]

In late 1993 and early 1994, BCBSM began making plans to reorganize the company and issue stock of a newly formed for-profit subsidiary. On April 6, 1994, following a meeting with the Director of the Missouri Department of Insurance (DOI), BCBSM filed a Notice of Transaction with the Director describing the proposed reorganization and seeking formal approval. On April 14, 1994, the plan was approved by the Director.

The plan required BCBSM to incorporate a for-profit subsidiary named RightChoice. BCBSM would contribute all of the assets and liabilities of its managed care business and certain excessive investment assets to another wholly-owned subsidiary company Healthy Alliance Life Insurance Company (HALIC). BCBSM would then transfer all of its issued and outstanding capital stock of HALIC and three other wholly-

[32] Ferber, Joel and Beekman, Mary; *The Blue Cross and Blue Shield of Missouri Settlement: Questions and Answers*, Legal Services of Eastern Missouri, Inc., June 16, 2000, p. 7.

owned subsidiaries to RightChoice in exchange certain RightChoice stock. These companies then entered into agreements with BCBSM.

HALIC agreed to reinsure all of BCBSM's managed care subscriber agreements and RightChoice provided BCBSM with various administrative, financial, and public relations services. RightChoice also agreed to approach the Blue Cross and Blue Shield Association to get a license to use its name and service marks. RightChoice then issued Class A common stock for profits totaling about $30 million. The end result is RightChoice and other subsidiaries (including HALIC) run the managed care business and BCBSM retains the traditional indemnity insurance business and continues to operate as a nonprofit corporation.

In the summer of 1995, the DOI, at the instigation of some consumer advocate groups, began an investigation into BCBSM's operations. The advocacy groups claimed that the BCBSM plan was actually a nonprofit to for-profit conversion – not a reorganization – which was illegal under Missouri law. The investigation showed that RightChoice planned to, and did, retain all of its earnings for business development and expansion and BCBSM had no plans to receive any dividends from its RightChoice stock in the near future. Further, BCBSM made three illegal changes to its articles of incorporation. The changes were made to its corporate purposes article and essentially deleted any mentions of its nonprofit status or benevolent or charitable purposes.

Upon these findings, the DOI demanded that BCBSM transfer all of its assets into a nonprofit foundation as a result of its conversion. The DOI alleged that BCBSM had misrepresented the scope of its reorganization by transferring all of its fee-for-service Medicare Supplement business to its for-profit subsidiary Right Choice, while telling the state that only the managed care business would be transferred. BCBSM filed suit in the trial court of Missouri seeking a declaratory judgment that DOI had no authority to overturn the Director's earlier order. The trial court originally ruled for BCBSM then reversed itself, entering a judgment for DOI.

During an appeal to the Supreme Court of Missouri, the Court instructed the parties that they could reach a settlement without court approval. The settlement agreement was finalized on January 6, 2000. The parties agreed to create the Missouri Foundation for Health funded with the full value of the assets of BCBSM.

Conversion In-progress: New York's Empire Blue Cross and Blue Shield

Empire Blue Cross and Blue Shield, which has 4 million members in 28 counties in eastern and southern New York State has been seeking approval to convert to a for-profit company for nearly six years. The process has been long and has been subject to the influence of regulators, as well as many community and provider groups throughout

the state. The recent attack on the World Trade Center also delayed the process since 30 percent of Empire's workforce was located in one of the towers.

In 1996, Empire announced plans to convert to a for-profit company and transfer all of its assets to a charitable foundation. Similar to statements recently issued by CareFirst BlueCross and BlueShield, Empire states in its for-profit restructuring proposal that the company "needs capital even though we have substantially improved Empire's financial condition."[33]

In 1997, Empire, which currently operates eight regional offices in the state from the Canadian border down to Manhattan, filed documents with the New York Insurance Commissioner and Attorney General. Throughout the public hearing process, the Service Employees International Union (SEIU) indicated that it may be interested in taking over Empire to keep it nonprofit. Empire rejected this proposal, and in 1999, the insurance commissioner approved the insurance aspects of the proposed conversion.

In 1998, Eliot L. Spitzer was elected state Attorney General and shortly after his election issued a decision that stated that legislation is required in order for Empire to convert. New York law does not authorize medical or dental expense indemnity corporations or hospital service corporations to convert to for-profit status. However, the state's nonprofit corporation law does establish rules for the dissolution of other nonprofit corporations.

In 2000, Spitzer announced his approval of a "conceptual" conversion plan. Its terms included the creation of an independent nonprofit foundation that would hold the stock of the for-profit company in trust for the people of New York.[34] Under Empire's proposal, the conversion would be accomplished by the creation of "a new charitable public health foundation, which initially will own 100 percent of the stock of the new for-profit Empire. In addition, the agreement with Empire would give the new foundation important rights to protect the value of the stock it receives."[35]

In April 2001, Empire proposed funding the conversion foundation with $1 billion. According to their proposal, the funding would be used to provide health coverage for 100,000 children in New York's Child Health Plus Program, which is a Medicaid expansion health program for children. Additionally, Empire recommended that the conversion foundation fund an expansion of New York's Elderly Pharmaceutical

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[33] Empire Blue Cross and Blue Shield. "For-Profit Restructuring Proposal." www.empirehealth.org.

[34] Community Catalyst. "Blue Cross Blue Shield Update." September 2001, p. 26.

[35] New York Office of the Attorney General "Statement by Attorney General Eliot Spitzer Regarding Legislation to Protect the Public Interest in Health Insurer Conversions," May 31, 2000, www.oag.state.ny.us.

Insurance Coverage program.[36] This announcement came shortly after investment bank Credit Suisse First Boston issued a research report indicating that Empire's projected value was closer to $1.2 billion rather than the previously reported $1 billion.

The main opposition to the conversion has come from the SEIU. The Greater New York Hospital Association (GNYHA) initially supported the conversion but later became its most vocal opponent. In June 2001, Empire struck a deal with the SEIU and GNYHA that would require Empire to support legislation that would earmark half for the conversion foundation funds to the state's hospitals. The hospitals would use the funds to improve computer infrastructure in an effort to eliminate medical errors across the state. Consumer groups have voiced their opposition to the GNYHA proposal, arguing that it violates the charitable trust doctrine.

There has been no action on proposed legislation in the New York Assembly or Senate to change the insurance laws in the state in order to allow Empire to move forward with its proposed conversion. Both bills remain pending in committee. There is, however, recent interest from Governor George Pataki in moving conversion legislation forward and possibly using funds to supplement budget shortfalls due to expenditures resulting from increased unemployment in the state and the terrorist events of September 11.[37]

Conversion of Trigon Blue Cross and Blue Shield of Virginia

Trigon Blue Cross and Blue Shield of Virginia converted from a health services corporation to a mutual insurance company in 1987. This change meant that the policyholders were the owners of the corporation. Trigon then promoted legislation in the Virginia legislature to allow the company to convert to a for-profit corporation without dissolving and reincorporating.[38] This change meant that the policyholders would become stockholders in the company.

Initially, Trigon denied having any charitable assets. However, in December 1995, Attorney General James S. Gilmore, III negotiated a deal with Trigon to provide $159 million for a state foundation to benefit higher education and medical research, as well as some for the ailing State's General Fund. In exchange, Gilmore agreed to sign off on the conversion deal. The State Legislature learned of the imminent agreement between the attorney general and demanded a higher payment from Trigon. On February 15, 1996,

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[36] American Health Line. "Empire Blue Cross: Offers $1B to Ease For-Profit Move." April 6, 2001, p. 1.

[37] Memorandum from Assemblyman Pete Grannis, Chair, New York Assembly Insurance Committee to participants of Milbank Foundation's Maryland Roundtable Discussion on Conversion, January 2, 2002.

[38] Community Catalyst. "Blue Cross Blue Shield Update." September 2001, p. 26.

the House of Delegates voted to require that Trigon pay $175 million to the state and a small stock disbursement to policy holders. 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 March 1997, the Governor signed into law Chapter 615, a law regulating the disposition of assets by nonprofit health care entities.

Nonprofit Health Service Plans Committed to Nonprofit Structure

While many BCBS plans have, or are considering, conversion plans, other BCBS plans remain committed to a nonprofit corporate structure. The Campaign for Advancing Nonprofit Health Care is an association of nonprofit health plans and other entities that seeks to promote and advance community-based nonprofits. The stated objectives of the group are as follows: "(1) to offset investment banker messages; (2) to return better balance to public policy discussions of health care; (3) to demonstrate value to gain respect for community-based nonprofit institutions; and (4) to highlight the benefit of community value versus mere shareholder value."[39]

The Campaign for Advancing Nonprofit Health Care counts among its members 13 of the nation's 44 BCBS plans. The member BCBS plans are united in a belief that "it is important to have a significant presence of non-profit, community focused health plans in the health care industry."[40]

There is clearly an ideological divide between those BCBS plans that have or seek to become for-profit and those that do not. A recent editorial written by the chairman and chief executive of Blue Cross and Blue Shield of Oklahoma in response to an article about the need of Blue Cross plans to merge in order to remain competitive highlights this division:

> "Some Blue Plans believe they must go public in order to remain viable in a highly competitive environment. That's not the case in Oklahoma . . . . Remaining independent allows us to take the longer view. We can look beyond making our numbers this quarter and concentrate on what's really important. We are Main Street-driven, not Wall Street-driven. We reinvest in our communities and put first things first: people ahead of profits, a healthy Oklahoma ahead of returns to investors. As a not-for-

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[39] www.nonprofithealthcare.org/learn.html, January 6, 2002.

[40] www.bluecaucus.org, January 6, 2002.

> profit we are able to put more of our members' premiums toward the payment of health care costs, instead of toward payment to stockholders. . . The essence of a not-for-profit company is to be profitable with respect to citizens, businesses, and government - to benefit its members, its provider partners, its clients, and its employees."[41]

While many argue that the nonprofit structure is preferable because it allows a company to focus on the provision of health care as opposed to profit, there is also ample evidence that nonprofit companies can be financially strong as well. Nine members of the Campaign for Advancing Non-Profit Health Care were included in A.M. Best's recent ranking of the 25 BCBS plans with the highest net premiums earned for the year 2000.[42] A.M. Best issues financial strength ratings for a variety of health care organizations including commercial health insurers, health maintenance organizations, and BCBS plans. A.M. Best has assigned A or A- (excellent) financial ratings to many nonprofit BCBS plans despite the fact that the companies' access to capital is restricted when compared to their publically traded counterparts. In fact, when asked its view of nonprofits, A.M. Best states that this "restricted access to capital is offset by the advantages of nonprofit status, including: not having to be concerned with stockholder expectations; and focus on long-term results over short-term results that may not be in the best interests of the company."[43]

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[41] King, Ronald F. *The Daily Oklahoman*, October 31, 2001.

[42] *BestWeek*, Blue Cross Blue Shield Plans Show Strength, October 8, 2001.

[43] A.M. Best Health-Care Methodology, August 2001.

Conclusion

While public hearings required under the Maryland conversion statute are expected to shed light on this issue, health care providers, members of the general public, and some policy makers have already begun expressing a number of concerns. Concomitantly, debate is likely to be rejoined about what to do with the proceeds from the sale of CareFirst now that the sale is a tangible reality rather than an abstract proposition.

It is unclear what impact the CareFirst's past actions or a potential conversion will have on the State's overall insurance market and health care delivery systems. However, there are several lessons learned from other states, including the need for:

- *A clear legal process for conversion.* New York, California, Missouri, and Virginia experienced some sort of legal challenge to the conversion process established by common law or statute;

- *Third party valuation of the converting entity.* In Missouri, California, New York, and Virginia, the transfer of assets or initial valuation of the company was either not done, has not been agreed to, or was altered when an outside valuation was conducted.

- *A plan for the disposition of the assets of the converting entity*. In both New York and Virginia, the plans for using the assets of the converting entity were not or have not yet been made public. In Virginia, the assets of the conversion of Trigon resulted in a one-time transfer of dollars to the General Fund of the state. A specific process for conversion was not in law until after the state's largest insurer converted.

- *Well-established foundations*. California's two charitable health care foundations are looked to as models for post-conversion protection of the state's assets.

Maryland is fortunate to have already established a framework which has learned from the lessons of other states. Within that framework, however, lies issues of valuation, the best interest of the public, and how assets should be used. In addition, it is important for policy makers to determine whether or not a conversion needs to take place, since there are nonprofit health service plans across the country that remain solidly committed to their nonprofit status and continue to be focused on providing health care to enrollees rather than value for shareholders.

Appendix

State/Plan	Original Amount Offered to be Placed in Foundation	Purchase Price	Year Transaction Closed	Amount Donated to Foundation	Number of Subscribers at time of Transaction
Blue Cross of California	$0	N/A – Blue Cross transferred all of its assets to a wholly-owned for-profit subsidiary.	1996	$3.2 billion distributed to two foundations – California HealthCare Foundation California Endowment	2.7 million subscribers PPO and HMO members 3.1 million subscribers – Medicare supplement enrollees
Blue Cross Blue Shield of Colorado	$100 million	Sold to Anthem for $155 million	1999	$155 million Caring for Colorado Foundation	500,000 subscribers (includes small service area in Nevada).
Blue Cross Blue Shield of Connecticut	$0	Sold to Anthem in a non-cash transaction	Plans merged in 1997; settlement reached in 1999	$40.8 million to be donated to the Anthem Foundation of Connecticut, which in turn will distribute money to the Connecticut Health Advancement and Research Trust. Distribution was anticipated at the end of 2001.	900,000 subscribers
Blue Cross Blue Shield of Georgia (Cerulean)	In May 1996, BCBSGA filed for conversion and established the privately held company Cerulean. The transaction was approved without any assessment of the plan's trust obligation.	WellPoint offered $500 million for Cerulean.	Initial conversion to a for-profit occurred in 1996; WellPoint purchased Cerulean in 2001.	$70-$80 million was initially placed in a foundation, and after consumer lawsuits, the endowment was increased to $124 million.	1.5 million members
Blue Cross Blue Shield of Kansas (BCBSK); Initial Distribution of Assets to Foundation	$0	As a result of a proposed merger (that ultimately failed), the Attorney General, Insurance Commissioner, and BCBSK arrived at a settlement of the charitable value of BCBSK, resulting in a $75 million donation to the Sunflower Foundation.	1997	$75 million was initially placed in the Sunflower Foundation as a result of a settlement of the question of charitable value. (distributed in 2000).	2.6 million members
Blue Cross Blue Shield of Kansas (BCBSK); Affiliation with Anthem	On May 31, 2001, BCBSK and Anthem Insurance Companies, Inc., an Indiana-based mutual insurance company that is currently trying to convert to a stock corporation, jointly announced their intent to affiliate.	The total of $190 million in cash consideration that Anthem BCBS is paying for the stock of BCBSKS represents a $35 million premium above the $155 book value that BCBSKS will retain. BCBSK will then become a wholly owned subsidiary of Anthem.	Still in negotiation.	Policyholders will receive a special distribution of an estimated $131 million (consisting of the excess of BCBSKS' closing book value over $155 million), plus a cash payment of $142 million from Anthem BCBS.	2.6 million members

State/Plan	Original Amount Offered to be Placed in Foundation	Purchase Price	Year Transaction Closed	Amount Donated to Foundation	Number of Subscribers at time of Transaction
Blue Cross Blue Shield of Kentucky	$0	Merged with Anthem in 1993; regulators did not initially value the charitable assets.	1999	$45 million donated to foundation to fund unmet health needs of the state; used primarily for the endowment of research chairs at state universities	Over 1 million subscribers
Blue Cross Blue Shield of Maine	$120 million for the purchase price with $90 to $100 million going into the foundation)	$120 million	1999	$81.69 million	320,000 at the time of the conversion (today it is 465,000 plus)
CareFirst Blue Cross Blue Shield (Maryland, Delaware and District of Columbia)	$1.3 billion	$1.3 billion	To Be Determined; CareFirst and WellPoint have publicly stated that it will take "at least 18 months" for the deal to close.	Maryland Health Care Foundation is the trustee of the Maryland Health Care Trust	3.1 million members in the three jurisdictions;
Blue Cross Blue Shield of Missouri	$0	Subsequent to the restructuring, BCBS of Kansas City (Missouri) indicated that it is willing to pay approximately $278 million for BCBSMO	1998	Foundation will be endowed with BCBSMO's 80% interest in Right CHOICE (approximately 15 million shares) and a cash payment of $175,000	2.14 million members
Blue Cross Blue Shield of Nevada	$0	Merged with Colorado Blue Cross Blue Shield in 1996	Combined companies were sold to Anthem in 1999.	Foundation established in Colorado	500,000 subscribers (includes Colorado)
Blue Cross Blue Shield of New Hampshire	$80 million	$120 million	1999	$83 million to Endowment for Health, Inc.	330,000 subscribers (1/3 of the population)
Blue Cross Blue Shield of New Mexico	$5 million	$55 million	2001	$20 million to the Con Alma Health Foundation	218,000 subscribers
Empire Blue Cross Blue Shield (New York)	$500 million	$1.2 billion	Still in Negotiation	$1.2 billion	668,000 subscribers; 4 million members
Community Mutual (BCBS licensee for Cincinnati, Ohio)	$0	Department of Insurance approved the merger without safeguarding the charitable assets of the plan.	1998	$28 million (in valuing the company, only considered the value of the Cross and not the Shield. The Shield was always a mutual corporation and thus AG deemed never held charitable assets). Anthem Foundation	1.7 million subscribers

State/Plan	Original Amount Offered to be Placed in Foundation	Purchase Price	Year Transaction Closed	Amount Donated to Foundation	Number of Subscribers at time of Transaction
Blue Cross Blue Shield of Texas	$0	The transaction was an affiliation between the Texas and Illinois plans	1999	Currently in litigation. If BCBSTX is found to be charitable, then the for-profit BCBSIL has agreed to pay $350 million to a charitable trust over 20 years (a total of $560 million, including interest).	2.1 million subscribers
Blue Cross Blue Shield of Virginia (Trigon)	$0	Trigon became a mutual insurance company in 1987. In 1996, the company converted to a for-profit corporation without dissolving and reincorporating, denying that it held charitable assets.	1996	$175 million was set aside for the state budget; Charitable assets were not placed in a foundation.	1.8 million members worldwide– 30% of market in Virginia
Blue Cross Blue Shield of Wisconsin	Full value of the stock at the IPO	Estimated value of IPO was $250 million	2001	Estimated $250 million; BCBSW claims its charitable assets are worth $250 million and will "donate" them to the Medical College of Wisconsin; this plan has been approved by the Insurance Commissioner.	700,000 subscribers