

Conversion and Preservation of Charitable Assets of Blue Cross and Blue Shield Plans: How States Have Protected or Failed to Protect the Public Interest

March 2004

Alaska

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.

Initially, Premera proposed to set aside stock in a nonprofit "Foundation Shareholder" as part of its effort to convert to a for-profit. But the company did not detail how the value of the stock would have been established, or whether the value would have reflected important assets such as the value of the Blue Cross trademark, goodwill, the value of its contracts with providers, and its subscriber lists.

In February 2003, Washington Insurance Commissioner Mike Kreidler allowed over two dozen individuals and organizations asserting a "significant interest" to intervene in the conversion of Premera Blue Cross of Washington and Alaska. Several of the intervenors oppose the conversion of Premera, and have raised questions about whether the full value of the company would be preserved for the public if the conversion is approved.

In granting the motions to intervene, Kreidler grouped the intervenors into five categories and required each of the five groups to appoint a lead attorney. Each group will be treated as a single party for purposes of discovery, presentation of evidence, oral and written argument, and cross-examination. The groups include: 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 February 2004, Premera filed its amended Form A with the Insurance Commissioners in both states. The Washington Insurance Commissioner will convene the formal adjudicative hearing on Premera's conversion request in May 2004 and expects to make a final decision in the matter by July 2004. The Alaska Commissioner will hold hearings in June on issues relating to the transaction and to Premera's proposals regarding the creation of a foundation.

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 Department Commissioner 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 regulator hired independent consultants for assistance with determining the appropriate valuation 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. In October 2003, Anthem, Inc. and WellPoint Health Networks Inc announced that they had signed a definitive merger agreement. If the merger is completed, the combined company will be the nation's largest health insurer with 26 million subscribers, and will control the Blue Cross or Blue Cross Blue Shield licenses in 13 states.

Providers and consumer groups have expressed concern that the merger of the nation's two largest Blues insurers would result in serious antitrust issues. In addition, Rep. Pete Stark (D-CA), and other members of the Ways and Means Health Subcommittee urged the FTC to review the proposed acquisition of WellPoint by Anthem very closely to ensure that it will not negatively affect the competition in the health insurance market and the welfare of the general public. Congressman Stark expressed concern that "the sizable market share and financial resources created through this acquisition would radically increase the future for-profit conversion of additional Blue Cross/Blue Shield programs. Such conversions would change these plans' focus from meeting community needs to meeting needs of Wall Street."

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Colorado

In January 1997, BCBS of Colorado (BCBSCO) filed a proposal to convert. Two weeks before filing the proposal, it merged with Nevada BCBS, forgiving \$9.8 million in debt that the Nevada plan owed to the Colorado plan. [See Nevada below.] BCBS originally proposed to distribute 100% of the stock of a holding company to two 501(c)(4) foundations. In May 1997, the Colorado plan filed an amended plan of conversion after community representatives raised a number of issues about the original proposal. The amended plan proposed to distribute the net proceeds of an initial public offering of stock in a holding company to one 501(c)(3) foundation. A formal regulatory process ensued, where consumer groups were permitted to intervene and participate in the conversion approval process. Hearings to determine the mission, governance, and structure of a foundation created to receive the proceeds of the conversion occurred in 1997. The Caring for Colorado Foundation was thereby established, with a community advisory committee. The hearing process to determine the value of BCBSCO never occurred. Instead, in June 1998, the plan moved to postpone the conversion altogether.

In March 1999, BCBSCO announced that it was withdrawing its proposal to convert itself to a for-profit stock company. Immediately thereafter, BCBSCO announced that it was planning to "affiliate" with Anthem Insurance Companies, Inc. [See more on Anthem in Kentucky, Ohio, New Jersey, Connecticut, New Hampshire and Maine below.] Anthem agreed publicly to set aside at least \$100 million in a nonprofit foundation.

As part of the plan to affiliate, BCBSCO entered a surplus note agreement that would allow Anthem to earn millions from BCBSCO's nonprofit dollars if BCBSCO ultimately decided not to affiliate with Anthem. Included in the terms were the following: an increase in the interest rate BCBSCO would have to pay Anthem on the original loan, a break-up fee of \$6 million that BCBSCO would have to pay to Anthem and, if BCBSCO were to pull out of the deal by going with a company offering a higher bid than Anthem, BCBSCO would have to give Anthem half of the difference it obtained from the higher bid. Consumer groups were highly critical of these conditions. In order to complete the affiliation, on August 16, 1999, Blue Cross and Blue Shield of Colorado) filed a new application to convert to a for-profit. This time, Anthem offered \$155 million and promised to preserve at least \$140 million of the purchase price in the Caring for Colorado Foundation.

The proposal was filed on the heels of an announcement by Wellpoint Health Networks, Inc. (the for-profit successor to Blue Cross of California) to withdraw an earlier offer to buy BCBSCO for \$266 million, \$111 million more than Anthem's offer. Wellpoint promised \$10 million more to the foundation. WellPoint withdrew its offer when BCBSCO

failed to answer whether it was going to enforce Anthem's onerous breakup provisions included in its surplus note agreement.

During this process, Governor Bill Owens unraveled an earlier administrative decision approved by the former Insurance Commissioner, Jack Ehnes, that the foundation's by-laws must include a Community Advisory Committee (CAC). Consumer groups involved in the conversion had pushed hard for a Community Advisory Committee and had testified at the 1998 public hearings held by the Department of Insurance. Governor Owens requested that the foundation's Board of Directors change the by-laws to give him the power to appoint directors without any community process. The new by-laws effectively dismantled the Community Advisory Committee's role in ensuring that the board nomination process is fair and that the board members are representative of the community. In July 1999, the new Insurance Commissioner, William Kirven III, approved the changes to the by-laws. In contrast to the original process in 1998, Kirven approved these changes without any public hearings or notice.

Consumer groups questioned Kirven's decision and called for a public process. In response to consumer concerns, Kirven scheduled a hearing for September 1st to re-examine his decision. After the hearing, the consumer groups, the Governor's office and the foundation reached a settlement on the foundation by-laws. The new 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 of Directors vacancy. The Governor appoints Board of Directors members from the list the CAC provides. The Governor may remove a director he or she appointed for cause only. A vote of $\frac{3}{4}$ of the directors can be used to remove any director with or without cause. The Board of Directors shall have at least one public meeting annually, where the public can address the board.

In August 1999, Health Care Service Corp., which owns BCBS of Illinois and BCBS of Texas, made a bid to buy BCBSCO, and promised \$155 million to the foundation. Anthem increased its bid from \$140 million, and offered \$160 million if BCBSCO agreed to stop considering any other offers. BCBSCO did not agree to stop reviewing other offers, but it did accept Anthem's match of \$155 million and rejected Health Care Service Corp.'s bid.

In November 1999, after a 2-day hearing in October, Kirven approved BCBSCO's proposed conversion and sale to Anthem. Anthem placed \$155 million in the Caring for Colorado Foundation, \$55 million more than it had originally proposed.

Consumer groups appealed the final decision, asserting that Anthem's willingness to pay \$160 million if BCBS agreed to stop reviewing competing offers indicates the true full fair market value is equal to \$160 million. The Colorado Court of Appeals ruled against the consumer groups and the groups petitioned the Supreme Court of Colorado for a writ of certiorari. In 2001, the Supreme Court denied the petition.

In February 2001, Anthem announced its intention to convert from a mutual insurance company to a stock corporation ("demutualization"), and filed its demutualization plan with the Indiana Department of Insurance in June 2001. The plan deprived policyholders in Colorado, Maine, Nevada and New Hampshire of any right to receive shares in the new company whereas policyholders in Connecticut, Indiana, Kentucky, and Ohio were eligible. Consumer groups in all Anthem states (the eight already owned by Anthem along with soon to be acquired Kansas) concerned about the potential impact of this conversion on health care coverage, encouraged regulators in the Anthem states 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. [See also Connecticut, Indiana, Kentucky, Kansas, Maine, Nevada, New Hampshire and Ohio].

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million subscribers, and will control the Blue Cross or Blue Cross Blue Shield licenses in 13 states.

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Connecticut

Since 1984, BCBS of Connecticut (BCBSCT) had been a mutual insurer with a certificate of incorporation stating that it was to be operated exclusively for the social welfare of Connecticut residents. (BCBSCT previously was a nonprofit health services corporation.) In July 1997, the Department of Insurance approved the merger of BCBSCT with Anthem Insurance Companies, a for-profit mutual insurance company. 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. [See also Kentucky below.] 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. Anthem agreed to transfer approximately \$41 million to a foundation to serve the underserved and uninsured as a condition of the settlement. 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 1996, New Jersey BCBS (BCBSNJ) announced that it was proposing to merge with Delaware BCBS (BCBSD). Under the proposal, BCBSNJ would have paid \$5 million to buy BCBSD's existing for-profit subsidiary, AllNation, Inc., which held all of BCBSD's business operations. The nonprofit BCBSD, to be renamed the Center for HealthCare Economics, would have retained \$103 million from the transaction to provide comparative information on health services and plans. But in August of 1996, a month before the deal was to close, the Department of Insurance put the deal on hold because of concerns about undervaluation and what the proceeds would fund. By April 1997, BCBSNJ and BCBSD called off their deal citing legal and regulatory hurdles in both states.

In December 1998, CareFirst, the holding company that owns the District of Columbia and Maryland BCBS plans, announced that it planned to affiliate with BCBSD. [See District of Columbia and Maryland below.] During 1999, the 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 Insurance Department conducted two days of hearings on the proposed combination.

In January 2000, the hearing officer issued her findings. Key recommendations included that BCBSD be required to maintain its nonprofit status for a period of two years, and that BCBSD agree to a "snapshot" valuation to enable Delaware regulators to facilitate the transfer of nonprofit assets, should BCBSD convert in the future. The Delaware Insurance Commissioner approved the affiliation in March 2000. In her order, she adopted many of the hearing officer's suggested recommendations, and augmented others to give both her office and the Attorney General's office clearer oversight over future activities of CareFirst-BCBSD.

On January 11, 2002, CareFirst filed an application with the Insurance Commissioner to convert to a for-profit corporation and merge with WellPoint Health Networks, a California based for-profit which owns Blue Cross of California, Blue Cross and Blue Shield of Missouri, Blue Cross and Blue Shield of Georgia and Blue Cross of Wisconsin. The application for conversion was filed in Maryland, Delaware, Virginia and the District of Columbia with the understanding that all three Insurance Commissioners must approve the merger before it can go through. A hearing officer appointed by the Insurance Commissioner will review this application.

Because there had been rumors of this conversion since February 2001, in the 2002 legislative session, both the Delaware Attorney General and the Governor filed legislation seeking to establish a conversion law. Neither bill passed the legislature in 2002 but conversion legislation supported by a consumer coalition and similar to the AG's bill was refiled in 2003 to be considered during the 2003/2004 legislative session.

Following the Maryland Insurance Commissioner's decision in March 2003 [see Maryland] to deny the conversion of CareFirst, WellPoint withdrew its application. In addition, following the passage of the legislation in Maryland to make CareFirst a more responsive nonprofit [see Maryland], BCBSDE expressed its disagreement with this legislation. As a result, BCBSDE negotiated with both Carefirst and the Commissioner to change its affiliation with Carefirst to allow BCBSDE to reestablish control of its plan and its board. This change in affiliation is BCBSDE's attempt to shield itself from the requirements of the new Maryland law including the moratorium on conversion. As part of the change, BCBSDE received its own separate license from the Blue Cross Blue Shield Association.

District of Columbia

In mid-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). Like many BCBS plans around the country, GHMSI was created in the late 1930's as a "charitable and benevolent corporation." Unlike other Blues plans, however, 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 combination 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. [See Delaware above.]

In January 2002, CareFirst filed an application with the Insurance Commissioner to convert to a for-profit corporation and merge with WellPoint Health Networks, a California based for-profit which owns Blue Cross of California, Blue Cross and Blue Shield of Missouri, and Blue Cross and Blue Shield of Georgia. 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. [See also Virginia, Delaware and Maryland.]

As part of his review of the CareFirst proposal, D.C. Insurance Commissioner Lawrence Mirel held two public forums in May 2002. Similarly, in September 2002, the Office of the Corporation Counsel ("OCC") held two public forums. In July 2002, the D.C. Council voted on emergency legislation and new protections were won for the District's health consumers including: 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.

On March 5, 2003, Maryland's Insurance Commissioner Steven Larsen announced his decision to deny the proposed transaction. D.C. Commissioner Mirel 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. A subsequent press release stated that WellPoint requested that D.C. stop its review process for 30 days, which would allow the applicant an opportunity to decide its next steps. D.C. agreed to the request.

The Maryland legislature later voiced its approval of Larsen's denial and took steps to introduce new law that would remove 10 of the 21 present Board members of CareFirst for failing in their duties to the non-profit corporation by pursuing the conversion and sale. D.C. Commissioner Mirel publicly challenged the removal of the Board members and appealed to the Maryland Governor, Robert Ehrlich, to veto the bill. In April 2003, the Maryland legislature passed the new law intended to hold CareFirst more accountable to its original non-profit mission, despite the opposition from the D.C. Insurance Commissioner. [See Maryland for details on the law.]

Although no formal public announcement was ever made, the D.C. Insurance Commissioner's office says that the conversion proposal by CareFirst was withdrawn sometime in the fall of 2003. As of March 2004, the D.C. Commissioner has requested that the Maryland legislature make certain changes to the new law and is waiting to hear from Maryland's legislature if these changes have been made before next steps are considered. According to Commissioner Mirel, the new Maryland law, as it currently exists, violates the affiliation agreement between the two health plans and could cause D.C. to seek a disaffiliation from the Maryland plan if the Commissioner's concerns are not appropriately addressed.

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 plaintiffs and Cerulean/BCBSGA reached a settlement. The settlement calls for the transfer of between \$70 million and \$80 million to a new charitable foundation. The new foundation's board will include three appointees chosen by the plaintiffs, three chosen by Cerulean/BCBSGA, and three designated by prominent Georgia nonprofit organizations. Also on July 8th, 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.

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Idaho

1) In May 1997, WellPoint Health Networks, Inc. announced the creation of a joint venture with Blue Cross of Idaho to form the Idaho Benefits Administration (IBA). Through the IBA, the two companies launched a new dental plan to consumers. According to a press release, the venture is in part designed to increase the ability of businesses to access regional coverage for their employees. WellPoint Health Networks is the for-profit company created from the conversion of Blue Cross of California.

2) 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). [See Illinois and Texas.]

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 transfers 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 in letters to 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.

Illinois

Several years ago, Illinois BCBS (BCBSIL) and Texas BCBS (BCBSTX) submitted proposals to merge. BCBSIL is a

mutual insurance company that can become for-profit by a vote of a majority of its board, while BCBSTX was a nonprofit health services corporation. The Texas Attorney General filed a lawsuit to block the proposed merger in 1996, arguing that the proposed 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 BCBSIL meets the Texas definition of a nonprofit corporation.

In 1998, BCBSIL 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, BCBSIL received \$1.29 million in undeserved bonuses.

Also in 1998, the Texas Attorney General agreed not to appeal the issue of whether BCBSIL met the Texas definition of a nonprofit corporation and allowed the merger to move forward. In exchange, BCBSIL agreed to pay \$10 million over five years to Texas Healthy Kids Corporation (to use 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 and has now been consummated.

Health Care Service Corporation (HCSC), the Illinois company that operates the plans in Illinois and Texas (and New Mexico, see below), remains unwilling to admit that the 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 appealed 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. A decision by this Court is expected by summer 2004.

HCSC acquired Blue Cross Blue Shield of New Mexico in May 2001. [See New Mexico below.] 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, HCSC announced it was withdrawing its application.

Indiana

Indiana Blue Cross and Indiana Blue Shield were created in the 1940s. 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 conducted an initial public offering of Accordia stock in 1992 and in 1996, the name was changed to Anthem Insurance Companies. Anthem, a mutual insurance company, has purchased BCBS plans in Colorado, Connecticut, Kentucky, Maine, Nevada, New Hampshire and Ohio.

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In July 2002, the Virginia State Corporation Commission approved the sale of Trigon Healthcare to Anthem Insurance Company for \$3.5 billion. The Corporation Commission did require, in their decision, that Anthem maintain certain services locally in Virginia as well as retain a licensed Virginia medical director for entities conducting utilization review for Trigon.

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Kansas

In fall 1996, BCBS of Kansas (BCBSK) proposed a merger with Missouri's BCBS of Kansas City (BCBS-KC). BCBSK had been a mutual insurance company since 1992; prior to that BCBSK had been a nonprofit corporation. BCBS-KC is a nonprofit corporation. In March 1997, BCBSK called off the planned merger after the Attorneys General of Kansas and Missouri questioned the legality of the proposed combination. Among the most contentious issues were whether either plan possessed assets impressed with a charitable trust.

BCBSK then filed a lawsuit against the Kansas Attorney General seeking a declaration that the plan had no charitable trust obligation to the people of Kansas. The Attorney General responded by filing a counterclaim alleging in part that the board of BCBSK breached its fiduciary duty by using substantial corporate assets in its attempt to merge with BCBS-KC. The counterclaim also asserted that some or all of BCBSK's assets were impressed with a charitable trust. BCBSK filed a motion to dismiss the Attorney General's counterclaim, asserting that only the Commissioner of Insurance had jurisdiction to raise those issues. In January 1998, the court ruled in favor of the Kansas Attorney General, denying the motion to dismiss and holding that the Attorney General had a right to enforce charitable obligations and seek damages against BCBSK if she prevailed in the case. The Kansas Commissioner of Insurance intervened in the case in support of the Attorney General.

In January 2000, shortly before the trial was to begin, the court issued summary judgment rulings. In one ruling, the court found that BCBSK possessed charitable assets from its inception in the early 1940's through 1969, the year the Kansas legislature repealed the enabling statutes that created Blue Cross and Blue Shield. BCBSK then asked the court to reconsider that decision and to clarify some aspects of it. In April 2000, the court rejected BCBSK's motion to reconsider, and in response to the motion to clarify ruled that the 1969 "assets" referred to in the court's January order were net assets only, not all of the company's assets.

In August 2000, the Attorney General, the Insurance Commissioner and BCBSK reached a settlement that placed \$75 million into the Sunflower Foundation, a new foundation dedicated to serving the health needs of Kansans, including providing health care to indigent and uninsured persons. Although original reactions to the settlement were very positive, consumer groups questioned the Kansas AG's subsequent decisions in establishing the foundation. Rather than forming an independent foundation, the AG's office established the foundation as a supporting organization to the Kansas AG's office, an unprecedented move. This raised concerns among local advocates that the foundation may be vulnerable to undue political influence in the future. Despite these concerns, the foundation's Articles of Incorporation and Bylaws were approved by the Kansas Secretary of State's office and a nine-member Board of Trustees was named in December 2000.

In spring 2001, members of the state legislature voiced their disapproval of the Attorney General's role in crafting the settlement with BCBSK and establishing the foundation. Although the Kansas press reported that state legislators were considering challenging the Attorney General in the state Supreme Court for overreaching her authority, the only formal action taken was to consider a bill that included an amendment that specifically applied the Kansas Open Records Act to the Sunflower Foundation. In August 2001, an Executive Director was named to the Foundation and in November the Community Advisory Committee was appointed.

In May 2001, 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 Anthem.

Under Kansas statute, the Insurance Commissioner was responsible for reviewing the proposed transaction. During the review process the Commissioner served as an impartial adjudicator and a testimonial team, comprising

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 was conducted from September 2001 to January 2002 and 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 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 eligible policyholders approved the conversion with a vote of 63% to 37%. However, only 58% of the approximately 172,000 eligible policyholders voted.

Also 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 in her Final Order 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 executive summary of the final order stated that the deal was rejected because it was found to be, "unreasonable to policyholders and not in the public interest, and hazardous and prejudicial to the insurance-buying public." On February 19, BCBSK announced that it would appeal the Commissioner's final order and formally began the appeals process.

In June 2002, Judge Terry Bullock of the Shawnee County District Court issued a Memorandum Order and Decision vacating Sebelius's Final Order and remanding the case back to her for further proceedings consistent with the ruling. In his ruling, Bullock concluded that Sebelius had exceeded her authority when she disapproved the proposed transaction because she is not authorized to take such regulatory action based upon anticipated premium rates or surplus levels that satisfy the requirements of some section of the Kansas Insurance Code.

Undeterred by Bullock's decision, Sebelius 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, Sebelius filed a Notice of Appeal in June 2002 arguing that it was within her statutorily-granted authority to disapprove the proposal as she did. Anthem and BCBSK also appealed Judge Bullock's decision arguing that Bullock should not have remanded the case back to Sebelius, but should have ordered her to allow the sponsored demutualization. After Sebelius requested that the case be heard in the Kansas Supreme Court, the Kansas Supreme Court agreed to the transfer and heard the appeal in March 2003. In August 2003, the Kansas Supreme Court upheld Sebelius's decision to deny the proposed sale of BCBSK to Anthem Insurance.

Kentucky

Kentucky BCBS (BCBSKY) became a mutual insurance company in 1987 but retained its nonprofit purposes. Prior to 1987 it was a nonprofit health services corporation. In 1993, it merged with Anthem Insurance Companies, Inc., a for-profit mutual insurance company. 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 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. [Anthem's public relations campaign was replicated in Connecticut.] In March 1998, the Commissioner of Insurance ruled that Anthem conducted a "highly misleading" campaign, but decided to take no action against Anthem.

In 1998, the trial court dismissed the Attorney General's Consumer Protection Act claims. He appealed that ruling. In April 1999, a unanimous appellate court reversed the trial court's dismissal and ruled that the Attorney General should have the opportunity to investigate and bring to trial the consumer protection claims against Anthem.

In the meantime, in June 1998, Anthem filed a motion for summary judgment, which asked the trial court to dismiss the charitable trust claims without a trial. The Attorney General opposed the motion. Consumer groups filed three "friend of the court" briefs supporting the Attorney General's arguments. Anthem opposed the three briefs and asked the trial court judge not to consider them. In November 1998, the trial judge ruled against Anthem and accepted all three "friend of the court" briefs because they provided information that could be useful in reaching a decision in the case.

In March 1999, the trial court held a hearing on Anthem's motion for summary judgment on the charitable trust claims, and in May 1999, the court denied the motion. The trial court's decision 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 has 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. During the interim period, the \$45 million is being held in an interest bearing state governmental trust account. The members of the Advisory Board will be appointed by the Franklin Circuit Court upon nomination by the Attorney General and will be charged with making recommendations to the Court about the structure and composition of the new foundation.

In September 2000, Governor Patton appointed a 35-member advisory committee from over 80 people who were nominated. The advisory committee is diverse both geographically and demographically. It includes individuals from universities, provider groups, businesses, and philanthropies, with no single interest appearing to dominate. Among the groups represented on the committee are consumer groups who were deeply concerned about the potential loss of charitable asset dollars when Kentucky Blue Cross merged with Anthem. The advisory committee was set up to establish a foundation.

Initially, the 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. Early in 2001, the Franklin Circuit Court approved the advisory committee's articles of incorporation and bylaws to establish the Foundation for a Healthy Kentucky, Inc. Among the characteristics of the Foundation is

an important role for a continuing Community Advisory Committee that will have as its members many of the individuals who served on the advisory committee. The new foundation has 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 plan with the Indiana Department of Insurance in June 2001. The plan deprived policyholders in Colorado, Maine, Nevada and New Hampshire of any right to receive shares in the new company whereas policyholders in Connecticut, Indiana, Kentucky, and Ohio were eligible. Consumer groups in all Anthem states (the eight already owned by Anthem along with soon to be acquired Kansas) concerned about the potential impact of this conversion on health care coverage, encouraged regulators in the Anthem states 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. [See also Colorado, Connecticut, Kentucky, Kansas, Maine, Nevada, New Hampshire and Ohio].

In October 2003, Anthem, Inc. and WellPoint Health Networks Inc announced that they had signed a definitive merger agreement. If the merger is completed, the combined company will be the nation's largest health insurer with 26 million subscribers, and will control the Blue Cross or Blue Cross Blue Shield licenses in 13 states.

Providers and consumer groups have expressed concern that the merger of the nation's two largest Blues insurers would result in serious antitrust issues. In addition, Rep. Pete Stark (D-CA), and other members of the Ways and Means Health Subcommittee urged the FTC to review the proposed acquisition of WellPoint by Anthem very closely to ensure that it will not negatively affect the competition in the health insurance market and the welfare of the general public. Congressman Stark expressed concern that "the sizable market share and financial resources created through this acquisition would radically increase the future for-profit conversion of additional Blue Cross/Blue Shield programs. Such conversions would change these plans' focus from meeting community needs to meeting needs of Wall Street."

In February 2004, the FTC gave its approval to the proposed merger, eliminating one of the biggest hurdles for the two for-profit insurers. The deal still requires approval from state regulators, both companies' shareholders and the Blue Cross and Blue Shield Association.

Maine

In 1996, BCBS of Maine (BCBSME) proposed joint ventures with two nonprofit hospitals in Maine in order to establish for-profit HMOs. Before the Superintendent of Insurance issued a decision on the proposed joint ventures, BCBSME and the Attorney General announced that they had reached an "agreement in principle" on BCBSME's charitable status. The agreement between BCBSME and the Attorney General included legislation that required a charitable set-aside in the event of an outright sale to a for-profit corporation. Unfortunately, the legislation also had several shortcomings. It allowed BCBSME to transfer some of its fair market value to its subscribers upon conversion, even though it is not and has never been a mutual corporation. It also contains a very narrow definition of conversion that does not encompass many transactions that would allow a nonprofit corporation to convert to for-profit status. Finally, it expressly authorizes a nonprofit health service corporation to create a for-profit subsidiary, called a health insurance affiliate, by using a material or substantial amount of the nonprofit corporation's assets.

In July 1999, BCBSME and Anthem Insurance Companies announced plans to "affiliate." The terms of the proposed agreement included a purchase price of \$120 million and a foundation with assets valued at \$90-\$100 billion. In August 1999, consumer groups met with representatives of the Maine Attorney General's office to begin a dialogue

about the structure of the foundation. Under the Blue Cross conversion law, the Attorney General must approve, disapprove, or modify the charitable trust plan before the Insurance Commissioner can examine other aspects of the transaction.

Over the course of the Attorney General's review of the charitable trust plan, a large 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. The Kennebec County Superior Court approved the modified foundation plan in December 1999. 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 ensured that at least 3 members of the governing board represent the interests of medically uninsured and underserved populations of the State. The plan also established a community advisory committee that will oversee required periodic needs assessments and be represented on the nominating committee to fill seats on the foundation board.

The Superintendent of Insurance held a public meeting in January 2000 and evidentiary hearings in April 2000. A key member of this coalition, Consumers for Affordable Health Care (CAHC), was granted intervenor status in the insurance department proceedings. CAHC participated in the evidentiary hearings.

A number of consumer and advocacy groups, including CAHC, opposed the sale. Their reasons for opposing the sale include that fact that Anthem will be acquiring BCBSME's growing market share in the state at a reduced price. As a result of the liquidation of Tufts' Health Plan and the precarious state of Harvard Pilgrim Health Care, BCBSME's membership has increased by over 60,000 since this summer. BCBSME was also recently awarded a sizable state contract.

The Superintendent approved the deal on May 25, 2000. In his order, the Superintendent accepted the valuation performed in July of 1999 that fixed BCBSME's fair market value at \$102.5 million. He then deducted \$18.1 million in 1999 losses and \$3.9 million in transaction expenses, leaving only \$80.5 million for the resulting foundation. (Anthem has also agreed to include an extra \$1.2 million to the resulting foundation.) In June 2000, both the Attorney General (AG) and CAHC appealed the Superintendent's Order, challenging his valuation of the fair market value of the plan. In the meantime, the Attorney General named an 18-member 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.

In February 2001, Anthem announced its intention to convert from a mutual insurance company to a stock corporation ("demutualization"), and filed its demutualization plan with the Indiana Department of Insurance in June 2001. The plan deprived policyholders in Colorado, Maine, Nevada and New Hampshire of any right to receive shares in the new company whereas policyholders in Connecticut, Indiana, Kentucky, and Ohio were eligible. Consumer groups in all Anthem states (the eight already owned by Anthem along with soon to be acquired Kansas) concerned about the potential impact of this conversion on health care coverage, encouraged regulators in the Anthem states 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. [See also Colorado, Connecticut, Indiana, Kentucky, Kansas, Nevada, New Hampshire and Ohio].

In October 2003, Anthem, Inc. and WellPoint Health Networks Inc announced that they had signed a definitive merger agreement. If the merger is completed, the combined company will be the nation's largest health insurer with 26 million subscribers, and will control the Blue Cross or Blue Cross Blue Shield licenses in 13 states.

Providers and consumer groups have expressed concern that the merger of the nation's two largest Blues insurers would result in serious antitrust issues. In addition, Rep. Pete Stark (D-CA), and other members of the Ways and Means Health Subcommittee urged the FTC to review the proposed acquisition of WellPoint by Anthem very closely to ensure that it will not negatively affect the competition in the health insurance market and the welfare of the general public. Congressman Stark expressed concern that "the sizable market share and financial resources created through this acquisition would radically increase the future for-profit conversion of additional Blue Cross/Blue Shield programs. Such conversions would change these plans' focus from meeting community needs to meeting needs of Wall Street."

In February 2004, the FTC gave its approval to the proposed merger, eliminating one of the biggest hurdles for the two for-profit insurers. The deal still requires approval from state regulators, both companies' shareholders and the Blue Cross and Blue Shield Association.

Maryland

In 1994, BCBS of Maryland (BCBSMD) proposed to convert from a nonprofit health services corporation to a for-profit stock insurance company. The plan characterized its proposal as a "restructuring." The proposal included financial incentives for executives, including stock options, and ignored the plan's charitable purposes. In January 1995, the Maryland Commissioner of Insurance rejected the proposal. BCBSMD then lobbied for legislation that would permit it to convert, but the legislation failed. Subsequently in mid-January 1997, 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 Maryland-based nonprofit holding company that governs both plans is called CareFirst, Inc. [See District of Columbia above for more information on the merger.]

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 in statute 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. [See Delaware above.]

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 WellPoint Health Networks, a California based for-profit which owns Blue Cross of California, Blue Cross and Blue Shield of Missouri, and Blue Cross and Blue Shield of Georgia. All three Insurance Commissioners had to approve the merger in order for it to go forward.

Anticipating the CareFirst conversion, the Maryland Legislature amended the state's conversion law in April 2001. This amendment requires that the conversion assets be preserved in a trust within the existing conversion foundation to be expended only at the direction of the state legislature. The legislative session of 2002 ended with the passage of two very significant bills that created more stringent requirements for conversions including a shift in the burden of proof to the applicant to demonstrate 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 valuation 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, multiple hearing with testimony from CareFirst, Wellpoint, the Commissioner's experts and the public throughout 2002 and early 2003.

There was significant publicity and 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 denied the application by CareFirst to convert to a for-profit and sell it to WellPoint finding that it was not in the public interest. In his 300 page decision released on March 5, 2003, the Commissioner also carefully explained that the Board of CareFirst failed to uphold their fiduciary duty, the company has been acting like a for profit and has abandoned its nonprofit mission, the Board failed to obtain an appropriate purchase price for the plan and that the Board and management did not consider the impact on the community in deciding to sell the plan.

A few days following the decision of the Commissioner, legislation was introduced in the Maryland General Assembly 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. This legislation was passed by the legislature in April 2003 and was signed by the Governor. The very day it was signed, The Blue Cross Blue Shield Association filed a lawsuit to remove Carefirst's trademark, the Attorney General of Maryland countersued. Eventually a settlement was reached between the two parties, which allowed parts of the legislation to be implemented, and Carefirst to maintain its mark. The final agreement includes the removal and replacement of certain Carefirst Board members by a committee established by the legislature; an oversight committee and a moratorium on conversion for five years. The Delaware and District of Columbia Insurance Commissioners were not pleased with the passage of the legislation which they believed established requirements that affected their jurisdiction. [See also District of Columbia, Delaware and Virginia]

Since the passage of the legislation, the Insurance Commissioner in Maryland has conducted an investigation and has established that he will file charges against Carefirst. However, these charges are on hold until the US Attorney's office conducts an investigation in which they have thus far issued federal subpoenas.

Mississippi

Blue Cross and Blue Shield of Mississippi (BCBSMS) converted from a nonprofit to a mutual insurance company in 1995. A law enacted in 1998 would allow it and other mutual insurers to convert to stock corporations. BCBSMS has denied that it has plans to convert at this time.

Missouri

1) Kansas City: In March 1997, BCBS of Kansas City, Missouri (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 that consistently has 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) “restructured” in 1994, placing approximately 80% of its business into a for-profit subsidiary, RightChoice. 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 RightChoice to a new foundation. Four months later, in August 1998, a 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 RightChoice (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 a surprise at the second hearing, BCBSMO announced that it was willing to acquire BCBSMO for \$278 million. In March 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 both the fair market value of RightChoice stock and the assets that BCBSMO currently holds as a nonprofit.

Immediately after the Special Master issued his recommendation, BCBSMO, the Attorney General, and several community groups met to refine the settlement agreement. A revised agreement was proposed to the trial court judge overseeing the case. The judge rejected the modified settlement. In particular, he expressed concerns that the Attorney General should not be involved in the selection of community advisory members or board members of the foundation, and that the amount of money BCBSMO had agreed to set aside might not constitute full fair market value. In December 1999, when the trial court had not issued a formal opinion on the modified settlement the Missouri Supreme Court ruled that the parties could mutually dismiss the underlying suits and come to agreement without the trial court’s approval. The out-of-court settlement was announced on January 6, 2000, and represented an accord among the Attorney General, the Department of Insurance, and BCBSMO.

The settlement agreement called for the creation of 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 RightChoice Managed Care Inc. of St. Louis. 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 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 to appoint a 13-member Community Advisory Committee (CAC). 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 agreed to purchase RightChoice 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 RightChoice shares. At that time, the Foundation was valued at approximately \$880 million.

In October 2003, Anthem, Inc. and WellPoint Health Networks Inc announced that they had signed a definitive merger

agreement. If the merger is completed, the combined company will be the nation's largest health insurer with 26 million subscribers, and will control the Blue Cross or Blue Cross Blue Shield licenses in 13 states.

Providers and consumer groups have expressed concern that the merger of the nation's two largest Blues insurers would result in serious antitrust issues. In addition, Rep. Pete Stark (D-CA), and other members of the Ways and Means Health Subcommittee urged the FTC to review the proposed acquisition of WellPoint by Anthem very closely to ensure that it will not negatively affect the competition in the health insurance market and the welfare of the general public. Congressman Stark expressed concern that "the sizable market share and financial resources created through this acquisition would radically increase the future for-profit conversion of additional Blue Cross/Blue Shield programs. Such conversions would change these plans' focus from meeting community needs to meeting needs of Wall Street."

In February 2004, the FTC gave its approval to the proposed merger, eliminating one of the biggest hurdles for the two for-profit insurers. The deal still requires approval from state regulators, both companies' shareholders and the Blue Cross and Blue Shield Association.

Montana

Early in 2002, a representative of Montana People's Action (MPA) began evaluating the state's readiness for nonprofit hospital and health plan conversions. While MPA is not aware of existing intentions by health insurers or hospitals in Montana to convert, the organization would like consumers in the state to be in the best possible position if a conversion proposal is submitted. CHAP staff have been evaluating Montana law and have provided answers to MPA's specific questions about the benefits of strong conversion legislation.

Nevada

The Insurance Commissioners in Nevada and Colorado approved a merger between BCBS of Nevada (BCBSNV) and BCBS of Colorado (BCBSCO) on December 31, 1996. The public learned of the transaction two weeks later, on January 14, 1997, the same day that the 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. It is unclear whether there was a full fair market valuation of BCBSNV, and whether the public received adequate notice of the transaction and opportunity to be heard.

A consumer coalition was formed in Nevada to work to ensure that the merger did not result in a loss of assets to Nevada citizens. The coalition was not formally permitted to intervene in the BCBSCO proposal to convert, but a Nevada subscriber intervened and asked the Colorado Commissioner of Insurance, who had to approve BCBSCO's proposal to convert to for-profit status, to consider the interests of the 40,000 Nevada subscribers affected by the conversion. BCBSCO held a hearing in Nevada at which Nevada subscribers and the public raised their concerns. The transcript of the Nevada hearing was entered into the record of the Colorado conversion proceedings.

Meanwhile, the Colorado Commissioner of Insurance allowed the Nevada subscriber who intervened in the Colorado conversion proceedings to file a written brief addressing the issue of whether any assets should accrue to the benefit of Nevada citizens rather than Colorado citizens. In early January 1998, the Commissioner ruled against Nevadans and declared that they have no right to any of the assets that are now part of BCBSCO. The order was deemed a final order.

During the 1999 legislative session, the Nevada Assembly passed a bill that would have required BCBSCO to preserve any nonprofit assets accrued in Nevada in a foundation to benefit the people of Nevada. However, the

Nevada Senate did not pass this bill.

On November 5, 1999, after a 2-day hearing in October, the Colorado Insurance Department approved BCBSCO's proposed conversion and sale to Anthem Insurance Companies, Inc. The Attorney General of Nevada appealed the decision denying her office party status in the proceedings, but her appeal was denied. [See Colorado above for more details on Anthem's takeover of BCBS of Colorado and BCBS of Nevada.]

In February 2001, Anthem announced its intention to convert from a mutual insurance company to a stock corporation ("demutualization"), and filed its demutualization plan with the Indiana Department of Insurance in June 2001. The plan deprived policyholders in Colorado, Maine, Nevada and New Hampshire of any right to receive shares in the new company whereas policyholders in Connecticut, Indiana, Kentucky, and Ohio were eligible. Consumer groups in all Anthem states (the eight already owned by Anthem along with soon to be acquired Kansas) concerned about the potential impact of this conversion on health care coverage, encouraged regulators in the Anthem states 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. [See also Colorado, Connecticut, Indiana, Kentucky, Kansas, Maine, New Hampshire and Ohio].

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In February 2004, the FTC gave its approval to the proposed merger, eliminating one of the biggest hurdles for the two for-profit insurers. The deal still requires approval from state regulators, both companies' shareholders and the Blue Cross and Blue Shield Association.

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 (expected to be between \$70 million and \$80 million) would go to a newly created charitable health foundation. This is the first transaction in which Anthem agreed at the outset to create a charitable foundation. All of its BCBS acquisitions prior to this one (Kentucky, Ohio, and Connecticut) were mutual BCBS plans and Anthem denied that these companies held charitable assets. Nonprofit Blue Cross and Blue Shield of Massachusetts (BCBSMA) had also bid on the New Hampshire plan. BCBSMA signed a confidentiality agreement as part of the bidding process and subsequently filed litigation seeking to be released from a "gag clause" which prohibited discussion with the public or regulators about the terms of its offer. On March 8, 1999, the federal district court judge ruled that BCBSMA could speak with regulators about the deal and the bidding process. Subsequently BCBSMA filed papers with the New Hampshire Attorney General arguing that the common law standard for dissolution of a nonprofit corporation had not been met because there is a viable option that would enable BCBSNH to continue as a nonprofit through affiliation with the Massachusetts plan.

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. Among the conditions are that Anthem must: 1) create a local advisory board (intervenors will be consulted in 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 NH that proportionately match Anthem's employment levels in other states; 3) provide community benefits for the next 36 months 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 the next 36 months; 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.

In February 2001, Anthem announced its intention to convert from a mutual insurance company to a stock corporation ("demutualization"), and filed its demutualization plan with the Indiana Department of Insurance in June 2001. The

plan deprived policyholders in Colorado, Maine, Nevada and New Hampshire of any right to receive shares in the new company whereas policyholders in Connecticut, Indiana, Kentucky, and Ohio were eligible. Consumer groups in all Anthem states (the eight already owned by Anthem along with soon to be acquired Kansas) concerned about the potential impact of this conversion on health care coverage, encouraged regulators in the Anthem states 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. [See also Colorado, Connecticut, Indiana, Kentucky, Kansas, Maine, Nevada, and Ohio].

In October 2003, Anthem, Inc. and WellPoint Health Networks Inc announced that they had signed a definitive merger agreement. If the merger is completed, the combined company will be the nation's largest health insurer with 26 million subscribers, and will control the Blue Cross or Blue Cross Blue Shield licenses in 13 states.

Providers and consumer groups have expressed concern that the merger of the nation's two largest Blues insurers would result in serious antitrust issues. In addition, Rep. Pete Stark (D-CA), and other members of the Ways and Means Health Subcommittee urged the FTC to review the proposed acquisition of WellPoint by Anthem very closely to ensure that it will not negatively affect the competition in the health insurance market and the welfare of the general public. Congressman Stark expressed concern that "the sizable market share and financial resources created through this acquisition would radically increase the future for-profit conversion of additional Blue Cross/Blue Shield programs. Such conversions would change these plans' focus from meeting community needs to meeting needs of Wall Street."

In February 2004, the FTC gave its approval to the proposed merger, eliminating one of the biggest hurdles for the two for-profit insurers. The deal still requires approval from state regulators, both companies' shareholders and the Blue Cross and Blue Shield Association.

New Jersey

In 1995, Blue Cross and Blue Shield of New Jersey ("BCBSNJ") sought to pass legislation that would permit it to convert from a nonprofit health services corporation to a mutual insurance company. It also announced its plan to purchase BCBS of Delaware (BCBSD). [See Delaware above.] In October 1996, BCBSNJ filed proposals to convert to a mutual company and merge with Anthem Insurance Companies, Inc. -- which was, at the time, a for-profit mutual insurance company based in Indiana. Both BCBSNJ and Anthem denied that the proposal obligated them to protect and preserve BCBSNJ's charitable assets. In response, the Attorney General issued an advisory opinion stating that the BCBSNJ plan was a charitable organization. In February, 1997 BCBSNJ filed a lawsuit against the Department of Banking and Insurance, asking the court to declare that the plan was not and never had been a charity.

In March 1997, the trial court ruled that BCBSNJ is a charitable corporation. Although BCBSNJ announced it would let its agreements with BCBSD and Anthem expire and no longer would pursue the merger, it appealed the trial court's decision. Later that year, the appellate court ruled in favor of the Department of Banking and Insurance, affirming the trial court decision that BCBSNJ is a "charitable and benevolent institution." The New Jersey Supreme Court denied BCBSNJ's petition for review. The appellate court's decision is now final.

In June 2001, the New Jersey Legislature enacted a law permitting BCBSNJ – now known as "Horizon BCBSNJ" -- to convert to for-profit status. The Legislature passed this law over the objections of consumer groups, who asserted that it did not contain clear standards of review that would protect consumers. On December 14, 2001, BCBSNJ's Board of Directors authorized management to explore the process of conversion. BCBSNJ has submitted documents to the Attorney General's Office and the Department of Banking and Insurance for their review. In 2003, BCBSNJ

announced that it was in no rush to convert; however, it has given no indication of reversing its plans. Advocates continue to educate the community and government officials on issues this potential conversion would present. If executed, it is expected that this conversion will be accomplished through an initial public offering.

In February 2004, New Jersey news reports indicated an increased interest in Horizon's possible conversion to for-profit. From the reports, it appears that the Governor of New Jersey, facing a large state deficit, is interested in obtaining the assets from a BCBS conversion for the state. Apparently Horizon has been in contact with the Governor and legislators on this subject. Under New Jersey's conversion law, 100% of the fair market value of the company must go to a charitable foundation that serves the health care needs of the citizens of the State. Therefore, the conversion proceeds could not be used for the state budget without changing the State's conversion law.

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 affiliated with Health Care Service Corporation (HCSC), the owner of plans in Illinois and Texas.

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 the 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, Save Our Health Resources, a coalition representing consumer, labor unions and religious groups intervened in the Insurance Division's regulatory hearing reviewing the proposed sale of Blue Cross Blue Shield of New Mexico. This coalition intervened in the proceedings and argued that the full fair market value—an amount much higher than \$5 million—must be set aside for the enormous 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 Coalition to Save Health Resources, announced in April 2001 that they had reached a settlement. Under the agreement, the companies promised to provide approximately \$15 million initially plus \$1 million annually over the next five years 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, New Mexicans were guaranteed representation on the HCSC board of directors, HCSC promised to maintain levels of employment in New Mexico, HCSC promised to maintain local operation of claim processing and other services in New Mexico and it agreed to grant New Mexican policy holders the same rights as Illinois policy holders. In May 2001, the Superintendent issued his final order on Phase I 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, Superintendent Serna and Attorney General Madrid convened an eleven-member Advisory and Planning Committee. At the first meeting of the Committee, Serna and Madrid 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 and governance of the foundation. After its meeting on October 8, 2001, the Committee provided its final recommendations to Serna and Madrid.

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 a foundation accountable to the people of New Mexico with a strong mission to serve the unmet health needs of the people of New Mexico.

The Committee decided to establish an independent, private 501(c)(3) charitable foundation. While the Committee properly considered other potential forms for this foundation, its decision to choose a private foundation structure reflected the Committee's desire to create an entirely new and independent health foundation for the people of New Mexico.

The Committee wanted to ensure that the foundation's mission was clear and would serve the unmet health needs of the people of the state. To achieve clarity of mission, the Committee decided to elaborate on its mission with a more detailed set of core values to guide the foundation. The foundation's mission and core values indicate an exceptionally accountable organization by requiring that the foundation: Seek to improve the health status of all New Mexicans; maintain the public trust; involve, collaborate and partner with communities in New Mexico; be an innovative leader; teach and learn; and be an effective advocate for a health policy that will address the unmet health needs of all New Mexicans.

The Committee recommended that foundation resources should not be used to replace federal, tribal, state, city, town, or county government health programs. Thus, the foundation will not, by its very existence, encourage the public sector to reduce its commitment to addressing New Mexico's health care concerns.

When it turned to decisions about the governing structure of the new foundation, the Committee benefited from its careful consideration of foundation mission and core values. The Committee proposed the creation of a 12-to-15 member Board of Directors to manage the foundation. The Board was designed to represent the geographic, ethnic, gender, age, and socioeconomic diversity of New Mexico. Three directors represent the medically uninsured and underserved and three represent the Navajo Nation, the Apache Nations, and the Pueblo Tribes.

The Committee also decided to create a Community Advisory Committee (CAC) of at least 15 members to provide advice and counsel to the Board. The CAC will act as a liaison between health care consumers in New Mexico and the foundation's Board. The CAC structure represents an important new method for ensuring a health foundation that will be accountable to the people it is designed to serve.

Consumers Union and Community Catalyst participated in almost all of the Committee meetings and project staff testified at the final hearing convened by the Superintendent to endorse the recommendations of the Committee. Both the process undertaken by the advisory and planning committee and the recommendations made by the Committee will be fine examples for future conversion foundations to follow.

The Con Alma Health Foundation is now operating in New Mexico. Unfortunately, one aspect of the new foundation does not comport with foundation best practices. The Superintendent of Insurance named himself to the initial board of directors and, at the first meeting of the board in January 2002, was elected president of the board. His membership on the board, while he remains New Mexico's Superintendent of Insurance, is out of character with the otherwise exemplary characteristics of the Con Alma Health Foundation.

In separate meetings with the Superintendent and the Office of the Attorney General in May 2001, project staff advocated that foundation best practices require regulators to refrain from participating as board or advisory committee members in the continued operation of health conversion foundations. Project staff oppose ongoing board and advisory committee membership by government regulators because the assets that endow a health conversion foundation were created in the private nonprofit sector. Board membership by governmental officials gives an inappropriate impression: it wrongly suggests that private, nonprofit, charitable assets are under governmental control.

and that the assets may be used to supplant monies now spent by government on health care initiatives. Such membership may also violate the charitable trust doctrine. It is this blurring of distinctions between private assets and governmental prerogatives that project staff find most troubling in the precedent set by the Superintendent's decision in New Mexico.

Project staff are also concerned that New Mexicans might perceive the Superintendent's membership on the board as antithetical to the goals of good government in the state. Some might perceive, for example, that his vote as a board member in favor of a particular proposal might be based on a political decision rather than on the merits of the proposal. Project staff is concerned that this will give New Mexicans, who are watching how the Con Alma Health Foundation grows and establishes itself, a poor perception of the Foundation's independence from government.

New York

Because of gravely flawed state legislation rushed through in January 2002, New York is poised to miss a crucial opportunity to improve the health of its most vulnerable citizens. The product of a surprising alliance between a conservative governor and the leader of the state's largest labor union, the new law permits nonprofit Empire Blue Cross and Blue Shield to convert to a for-profit corporation without a fair and equitable charitable asset set aside. Instead, the Governor has earmarked fully 95 percent of Empire's charitable assets – over \$950 million -- to fund salary increases for health care workers, most of whom are members of the union that cut the deal with the Governor. Only 5% of the funds have been preserved for a small foundation dedicated to expanding access to health coverage. Finally, the law imposes a virtual stranglehold by the government on that small foundation by giving elected officials significant nomination and oversight authority. The Governor's plan for the foundation ignores well established best practices in the creation and governance of new health foundations.

In June 2002, Empire filed an amended conversion plan under the new law. In October, the New York State Insurance Department approved Empire's application to become a for-profit company. The Superintendent of Insurance extended some limited additional protections against rate increases for certain policyholder groups.

In August 2002, Consumers Union, Disabled in Action, Housing Works, the New York Chapter of the National Multiple Sclerosis Society, the New York StateWide Senior Action Council, and several individual policyholders filed suit against New York State and Empire Blue Cross to challenge the conversion, on the grounds that the state legislation that authorizes it is unconstitutional. The Court issued a decision in March 2003, dismissing claims made by the plaintiffs. Nevertheless, consumers won some significant victories. The court recognized the right of some consumers to sue by holding that individual Empire subscribers and Consumers Union, which buys Empire coverage for some of its employees, had legal standing. The Court then outlined another viable constitutional claim: that the legislation violated New York's constitutional prohibition on "private" laws, defined in New York as legislation designed to benefit a single company. Plaintiffs filed an amended cause of action asserting the private-law constitutional claim. The court dismissed the defendants' motion to dismiss this claim. Plaintiffs have appealed the court's ruling on their original claims and cross-appealed on the private-law constitutional claim. The State has appealed the decision to dismiss their motion to dismiss and cross-appealed on the original claims. The Appellate Division heard arguments on all appeals on January 28, 2004.

The situation in New York was not always this bleak. In 1995, Empire established a for-profit managed care subsidiary. In late 1996, Empire announced that it would convert completely 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. The Attorney General held a series of public meetings throughout the state and, late in the year, the Greater New York Hospital Association and 1199/SEIU expressed interest in taking over Empire. After lengthy correspondence and a series of meetings among Empire, 1199/SEIU, and the Hospital Association, Empire rejected the proposal. Both the

union and the 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, Attorney General Spitzer announced his approval of the valuation and foundation aspects of Empire's conversion plan.

Despite six years of fervent opposition to Empire's conversion, the Greater New York Hospital Association and 1199/SEIU changed their opinions when, in June 2001, Empire offered to give half of the \$1 billion in charitable assets to the Greater New York Hospital Association and 1199/SEIU. This proposed political payoff would have been a blatantly inappropriate use of Empire's charitable assets. Then, when it appeared that things could not get any worse in New York, they did get worse. Governor Pataki strong-armed a piece of legislation through both houses of New York's legislature. His legislation bought the support of 1199/SEIU president Dennis Rivera with money that should have gone to help New York's least privileged residents. Instead, the new law would fund, for the next three years, salary increases of approximately 13% for 1199/SEIU employees. Devoting charitable assets for this purpose squanders, in three years, several generations of accrued charitable assets.

North Carolina

In 1998, North Carolina passed a comprehensive conversion law that details the regulatory review that must be undertaken after a conversion proposal is made and that requires 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 its proposal to convert to a for-profit corporation.

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. Enabled by the state's strong health conversion law, NCHAC emphasized the risk involved in the company's attempt to maintain a virtual stranglehold over a foundation that would have been established to receive charitable assets in the conversion. 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 own proposal in July 2003.

North Dakota

BCBS of North Dakota (BCBSND) filed a proposal to convert from a health services corporation to a mutual insurance company 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 prohibits 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 early April 1997. The new 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 the mutualization petition.

Ohio

1) BCBS Mutual of Ohio – Columbia/HCA: In 1996, BCBS Mutual of Ohio submitted a proposal under which it would 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 the multi-million dollar payout to top BCBS executives and attorneys who worked on the deal. 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. Additionally, 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. On March 12, 1997 the Ohio Department of Insurance (ODI) rejected the deal and found that the multi-million dollar payments to insiders were unfair. On March 26, 1997, 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 nonprofit 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 for-profit mutual insurance plan. 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.

On February 12, 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 Anthem appoints. 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 plan with the Indiana Department of Insurance in June 2001. The plan deprived policyholders in Colorado, Maine, Nevada and New Hampshire of any right to receive shares in the new company whereas policyholders in Connecticut, Indiana, Kentucky, and Ohio were eligible. Consumer groups in all Anthem states (the eight already owned by Anthem along with soon to be acquired Kansas) concerned about the potential impact of this conversion on health care coverage, encouraged regulators in the Anthem states 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. [See also Colorado, Connecticut, Indiana, Kentucky, Kansas, Maine, Nevada, and New Hampshire].

In October 2003, Anthem, Inc. and WellPoint Health Networks Inc announced that they had signed a definitive merger agreement. If the merger is completed, the combined company will be the nation's largest health insurer with 26 million subscribers, and will control the Blue Cross or Blue Cross Blue Shield licenses in 13 states.

Providers and consumer groups have expressed concern that the merger of the nation's two largest Blues insurers would result in serious antitrust issues. In addition, Rep. Pete Stark (D-CA), and other members of the Ways and Means Health Subcommittee urged the FTC to review the proposed acquisition of WellPoint by Anthem very closely to ensure that it will not negatively affect the competition in the health insurance market and the welfare of the general public. Congressman Stark expressed concern that "the sizable market share and financial resources created through this acquisition would radically increase the future for-profit conversion of additional Blue Cross/Blue Shield programs. Such conversions would change these plans' focus from meeting community needs to meeting needs of Wall Street."

In February 2004, the FTC gave its approval to the proposed merger, eliminating one of the biggest hurdles for the two for-profit insurers. The deal still requires approval from state regulators, both companies' shareholders and the Blue Cross and Blue Shield Association.

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). [See Illinois and Texas.]

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 transfers 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 in letters to 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.

Pennsylvania

During the 2001-2002 legislative session, numerous bills that would have governed the conversion of the state's four Blues plans were introduced. A state-wide coalition of consumer advocates tracked each of these bills in order to ensure that they (1) covered a wide variety of transactions that impact charitable assets; (2) required a charitable set-aside; (3) prevented any adverse effect on premiums or access to health care coverage; and (4) provided meaningful opportunities for public participation.

1) Highmark: In December 1995, Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield proposed to consolidate into a single nonprofit corporation called Highmark. Both Blue Cross and Blue Shield were nonprofit corporations that owned, in whole or in part, numerous for-profit subsidiaries. In November 1996, the Insurance Commissioner issued an Order declining jurisdiction over the consolidation itself, but approving both the change in control of the subsidiaries and the new Highmark bylaws. The Commissioner required Highmark to annually contribute 1.25% of its direct written premiums to charitable endeavors as well as to continue participating in the pre-existing programs benefiting low-income adults and children. In addition, the Order imposed a two-year moratorium on Highmark's conversion to for-profit status.

A local medical society and individual doctors challenged this decision, but the case was transferred back to the Insurance Department to determine if others should be granted standing to intervene and to hold a hearing to resolve any factual disputes. In November 1997 several petitions to intervene were filed, including one representing the interests of consumers. The consumer representatives: (1) sought to fully participate in all hearings on this matter; (2) alleged that the consolidation will result in the transfer of charitable assets to the for-profit subsidiaries, leaving the nonprofit an empty shell; and (3) maintained that the level of community benefits is inadequate. Almost one year later, the Insurance Commissioner issued a decision granting two medical provider intervenors full party status. The consumer representatives were given “limited standing,” which allowed them to file an amicus curiae brief, to receive notice of all documents filed or issued in the matter and to “participate in briefing and oral argument as applicable.”

2) Independence Blue Cross: Community groups in Pennsylvania have long believed that Independence Blue Cross, the Blue Cross licensee of the Philadelphia area, has undergone a de facto conversion because it has transferred most of its assets to out of state, for-profit subsidiaries, thereby becoming a nonprofit shell. Since the late 1990s, Independence has invested over \$100 million into Texas, Florida, Puerto Rico [see Puerto Rico below], the Virgin Islands and Jamaica. No charitable set-aside has been made. Press accounts in the Fall of 2000 revealed that nearly 90% of Independence's annual revenue was generated from for-profit subsidiaries. At the same time, this research found that spending on charitable activities, such as subsidized insurance for low-income children and adults, had fallen dramatically.

Blues Surplus: In August 2001, a class action suit was brought on behalf of subscribers, policyholders and members of Independence Blue Cross (“IBC”), seeking relief from violations of Pennsylvania's Non-profit law and for breach of contract and breach of fiduciary duty by IBC in amassing an excessive surplus. In October of 2001, IBC filed

preliminary objections to plaintiffs' class action claims. By an order dated June 13, 2002, the Court of Common Pleas of Bucks County denied IBC's preliminary objections. Nevertheless, the Commonwealth Court reversed the lower court's order denying IBC's preliminary objections and dismissed the complaint, holding that all matters raised in the Complaint were to be resolved by the Insurance Department. In January 2003, plaintiffs appealed the Commonwealth Court's decision. Community Legal Services, Inc., on behalf of eleven non-profit organizations and unions committed to improving the health of all Pennsylvanians, and Community Catalyst filed an amicus brief in this appeal.

While the case against IBC was pending, the Department of Insurance held a public informational hearing about the reserve and surplus levels of the Pennsylvania Blues plans. Comments and testimony can be found at <http://www.insurance.state.pa.us/bchearing/bchearing.html>. On January 16, 2004, the Insurance Department issued a notice requiring Capital Blue Cross, Highmark, Inc. d/b/a Highmark Blue Cross Blue Shield and d/b/a Pennsylvania Blue Shield, Hospital Service Association of Northeastern Pennsylvania d/b/a Blue Cross of Northeastern Pennsylvania and Independence Blue Cross (collectively, Blues Plans) to make applications for approval of the reserves and surpluses they maintain. In the application, each Blues Plan must, in a manner the Department deems necessary and proper: (a) state what reserve levels it and all of its insurance subsidiaries are holding and what surplus levels it and all of its insurance subsidiaries are currently maintaining; (b) state the maximum RBC ratio within the 350% to 650% range that is appropriate, and explain the rationale for that maximum ratio; (c) identify the Plan's funds dedicated, allocated or expended for charitable purposes in 2002 and 2003, and those planned for 2004 through 2006; and (d) provide a proposed business plan explaining how any maintained surplus that results in an RBC ratio that is in excess of the maximum RBC ratio will be fairly and equitably distributed to benefit Plan participants and the Commonwealth's underinsured and uninsured citizens in a manner befitting charitable and benevolent institutions such as the Blues Plans.

Puerto Rico

In 1959, Puerto Rico's largest health insurance provider, Triple-S, Inc. ("Triple-S") was incorporated as a for-profit corporation. In 1976, Triple-S (which is the Blue Shield plan of Puerto Rico) received a special ruling from Puerto Rico's Department of the Treasury granting the corporation a total exemption from both income and property taxes even though the insurer retained its for-profit status. Official documents from the Treasury state that, in exchange for these tax exemptions, which previously were only given to non-profit corporations, Triple-S would be expected to conduct itself much like a charitable non-profit business would. Among these expectations detailed in the official documents was that the insurer would conduct its business to promote the social welfare and that earnings from stocks would be used exclusively to reduce health insurance premiums or otherwise improve the health services available to the public.

In 1995, Triple-S commenced what it called a "reorganization" of its corporate structure and created a for-profit holding company, Triple-S Management, with various other for-profit subsidiaries under it. When this "reorganization" was completed in 1999, the original Triple-S health insurance corporation also became a subsidiary of the new for-profit holding company.

In 2002, concerned legislators and health advocates in Puerto Rico began questioning whether Triple-S had misused assets earmarked for the public's benefit to maximize profits for private shareholders of the for-profit. After looking into the allegations, the Puerto Rican government eliminated the tax exemption Triple-S had enjoyed for over 25 years. Additionally, Triple-S was required to pay approximately \$67 million in retroactive taxes dating back to 1976.

While advocates applauded the decision to revoke Triple-S's tax-exempt status, many believe that the health insurer still owes at least \$150 million more in charitable assets to the public over and above the \$70 million in back taxes that it paid. The additional \$150 million is thought to be the result of assets and profits generated when Triple-S redirected funds to the for-profit lines of business controlled by its larger holding company, Triple-S Management

Corporation.

Rhode Island

In early 1999, it was rumored that both Anthem and Blue Cross Blue Shield of Massachusetts (BCBSMA) were interested in either acquiring or affiliating with Blue Cross Blue Shield of Rhode Island (BCBSRI). In April 1999, BCBSMA presented several affiliation options to the Rhode Island plan. In anticipation of any transaction involving BCBSRI, the Rhode Island legislature recently 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 Insurance Companies Inc. criticized this provision of the law in local papers. BCBSRI announced in September 1999 that it plans to stay an independent, nonprofit firm.

South Dakota

Blue Cross of Western Iowa and South Dakota (IASD), a mutual company, merged with South Dakota Blue Shield in July 1996, creating a for-profit corporation, SD Health Services Inc. (also known as Wellmark). Regulators approved the transaction without requiring either plan to preserve and protect its charitable assets.

Texas

Several years ago, Illinois BCBS (BCBSIL) and Texas BCBS (BCBSTX) submitted proposals to merge. BCBSIL is a mutual insurance company that can become for-profit by a vote of a majority of its board, while BCBSTX was a nonprofit health services corporation. The Texas Attorney General filed a lawsuit to block the proposed merger in 1996, arguing that the proposed 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 BCBSIL meets the Texas definition of a nonprofit corporation.

In 1998, BCBSIL 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, BCBSIL received \$1.29 million in undeserved bonuses.

Also in 1998, the Texas Attorney General agreed not to appeal the issue of whether BCBSIL met the Texas definition of a nonprofit corporation and allowed the merger to move forward. In exchange, BCBSIL agreed to pay \$10 million over five years to Texas Healthy Kids Corporation (to use 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 and has now been consummated.

The Texas Attorney General appealed 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. A decision by this Court is expected by summer 2004.

Health Care Service Corporation (HCSC), the Illinois company that operates BCBSTX and BCBSIL, acquired Blue Cross Blue Shield of New Mexico in May 2001. [See New Mexico above.] 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, HCSC announced it was withdrawing its application.

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). [See Illinois and Texas.]

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 transfers 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 in letters to 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.

Vermont

In January 2002, nonprofit BCBSVT sought to enact legislation that would have permitted it to “reorganize.” Under this 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 essence as a nonprofit health care insurer.

The reorganization legislation was refiled for the next legislative session and requested the same permission to change its corporate structure. No hearing has been scheduled for this bill.

Virginia

Trigon BCBS of Virginia (Trigon) changed from a health services corporation to a mutual insurance company in 1987. In 1995, Trigon promoted legislation to allow the company to convert to a for-profit corporation without dissolving and reincorporating. In 1996, Trigon proposed to convert to a for-profit corporation. Trigon 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 January 2002, CareFirst, the nonprofit holding company that, at the time, controlled the non-profit Blues plans in Maryland, Delaware and the District of Columbia, filed its application with the Insurance Commissioners in those states to convert to a for-profit corporation and merge with WellPoint Health Networks, a California based for-profit which owns Blue Cross of California, Blue Cross and Blue Shield of Georgia, and Blue Cross and Blue Shield of Missouri. The D.C Blues plan, Group Hospitalization and Medical Services Inc., also provides insurance coverage to subscribers in Northern Virginia. Since the filing, the Insurance Commissioner of Virginia decided not to review the conversion transaction. However, the Attorney General of Virginia 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. [See District of Columbia, Delaware and Maryland].

In July 2002, the Virginia State Corporation Commission approved the sale of Trigon Healthcare to Anthem Insurance Company for \$3.5 billion. As part of their decision, the Corporation Commission required that Anthem maintain certain services locally in Virginia as well as retain a licensed Virginia medical director for entities conducting utilization review for Trigon. [Anthem is also the for-profit owner of Blues plans in Indiana, Colorado, Maine, New Hampshire, Ohio, Kentucky, Nevada, and Connecticut].

In October 2003, Anthem, Inc. and WellPoint Health Networks Inc announced that they had signed a definitive merger agreement. If the merger is completed, the combined company will be the nation's largest health insurer with 26 million subscribers, and will control the Blue Cross or Blue Cross Blue Shield licenses in 13 states.

Providers and consumer groups have expressed concern that the merger of the nation's two largest Blues insurers would result in serious antitrust issues. In addition, Rep. Pete Stark (D-CA), and other members of the Ways and Means Health Subcommittee urged the FTC to review the proposed acquisition of WellPoint by Anthem very closely to ensure that it will not negatively affect the competition in the health insurance market and the welfare of the general public. Congressman Stark expressed concern that "the sizable market share and financial resources created through this acquisition would radically increase the future for-profit conversion of additional Blue Cross/Blue Shield programs. Such conversions would change these plans' focus from meeting community needs to meeting needs of Wall Street."

In February 2004, the FTC gave its approval to the proposed merger, eliminating one of the biggest hurdles for the two for-profit insurers. The deal still requires approval from state regulators, both companies' shareholders and the Blue Cross and Blue Shield Association.

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. Until 1986, Premera enjoyed Federal tax-exempt status; until the early 1990s, the company enjoyed a significant state tax exemption on premiums.

Initially, Premera proposed to set aside stock in a nonprofit "Foundation Shareholder" as part of its effort to convert to a for-profit. But the company did not detail how the value of the stock would have been established, or whether the value would have reflected important assets such as the value of the Blue Cross trademark, goodwill, the value of its contracts with providers, and its subscriber lists.

In February 2003, Washington Insurance Commissioner Mike Kreidler allowed over two dozen individuals and organizations asserting a "significant interest" to intervene in the conversion of Premera Blue Cross of Washington and Alaska. Several of the intervenors oppose the conversion of Premera, and have raised questions about whether the full value of the company would be preserved for the public if the conversion is approved.

In granting the motions to intervene, Kreidler grouped the intervenors into five categories and required each of the five groups to appoint a lead attorney. Each group will be treated as a single party for purposes of discovery, presentation of evidence, oral and written argument, and cross-examination. The groups include: Washington consumers, Washington hospitals, Washington providers, and the Alaska parties. [See Alaska above.]

In February 2004, Premera filed its amended Form A with the Insurance Commissioners in both states. The Washington Insurance Commissioner will convene the formal adjudicative hearing on Premera's conversion request in May 2004 and expects to make a final decision in the matter by July 2004. The Alaska Commissioner will hold hearings in June on issues relating to the transaction and to Premera's proposals regarding the creation of a foundation.

The Regence Group: 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). [See Illinois and Texas.]

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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.

West Virginia

In April 1999, Highmark Blue Cross Blue Shield (see 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. Prior to this announcement the Attorney General had also responded to earlier community concerns that BCBSUW was not upholding its charitable obligations in a letter dated April 28, 1999, stating that his review of the issues concluded that no formal investigation of BCBSUW by his office was warranted under Wisconsin law.

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, on March 28, 2000. In her decision, Commissioner O'Connell 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, which was established exclusively 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 on August 24, 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 of 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. On December 6, 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 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 were dedicated to directly benefiting the community's unmet health needs. 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 supposed to function as a simple transfer mechanism for exchanging stock and conveying the proceeds to the schools. However, Commissioner O'Connell'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 of 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. To date local advocates have

created in increased level of accountability among the medical schools and WUHF Board, which has yet to approve the medical schools plans for the assets. 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 in September 2003.

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