



# THE SAGA OF A FAILED CONVERSION TO FOR-PROFIT

## The CareFirst BCBS Story, Part 1

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### INTRODUCTION

This article presents in detail the relevant facts surrounding CareFirst's failed attempt to convert to for-profit status and be acquired by the for-profit company, Wellpoint Health Networks, Inc. It chronicles events and describes the political environment leading up to the Maryland insurance commissioner's review of the application, the review process and roles played by various stakeholders and the media, the commissioner's decision and rationale, and the aftermath of actions and reactions by various parties, including state legislation to reform CareFirst. This case study was based on interviews with several key players, as well as a review of numerous newspaper articles and the wealth of documents prepared for, and emanating from the review process. Providing an in-depth look at the missteps by CareFirst's board and executives, this article sets the stage for a second one translating these details into lessons for other states and for all types of nonprofit health care organizations involved in any kind of strategic decision making that affects the public interest.

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Judging from several recent failed or aborted conversions of nonprofit health insurers to for-profit companies – namely in Kansas, North Carolina, Maryland, and Washington state – the pendulum seems to be swinging in favor of maintaining an infrastructure of nonprofit health insurers. In these instances, government agencies and legislative bodies, in addition to advocacy organizations and community groups, have articulated a need to preserve the community benefit component of nonprofit health insurance plans.

A detailed analysis of attempts by CareFirst, a nonprofit health insurer in Maryland, to convert to for-profit<sup>1</sup> status yields important lessons for policymakers and regulators in other states, for all types of nonprofit health care organizations engaged in any type of major strategic decision making, as well as for community leaders and advocates of the nonprofit business model for health care financing and delivery. Despite the unique health care political climate in Maryland and the singular details of this case, the failed CareFirst conversion pinpoints the barriers that stand in the way of conversions and the benefits that can derive from continued status as a nonprofit health insurer.

This paper presents a detailed outline of the relevant facts.<sup>2</sup> The lessons of the CareFirst case will be highlighted in a subsequent article.

## **BACKGROUND**

The state of Maryland has enjoyed a long history and tradition of partnership among its policymakers, physicians, hospitals (all but one of which is nonprofit) and Maryland BlueCross BlueShield. Maryland policymakers, by design, helped CareFirst become dominant in the market. As a nonprofit holding company for BlueCross BlueShield plans based in Maryland and eventually in the District of Columbia and Delaware, CareFirst was exempted from state income taxes, premium taxes, and property taxes. It also enjoyed a special price differential under the Maryland all-payer hospital rate regulatory system. The differential, amounting to a 4% discount initially and an estimated \$31 million in current savings to the plan, was established to reward the plan for assumption of risks in providing “substantial, available and affordable coverage” to individuals not otherwise able to obtain health insurance coverage (Schramm 2001).

Despite this special relationship, CareFirst found itself on the brink of insolvency in the early 1990s. In 1993, the board hired a new chief executive officer, Bill Jews, to save the plan. Under the leadership of the new CEO and his executive team, CareFirst sought in 1994 to convert its health maintenance organization (HMO) subsidiary to a for-profit company and other components to a nonprofit mutual insurance

company, but the Maryland insurance commissioner denied the proposal. CareFirst subsequently combined with the nonprofit Washington, D.C. BlueCross BlueShield Plan (Group Hospitalization and Medical Services, Inc.) in 1998,<sup>3</sup> the same year in which the Maryland Conversion Act was passed. The nonprofit Delaware BlueCross BlueShield Plan was added in 1999 (Schramm 2001).

Despite this merger of nonprofit plans, rumors persisted that CareFirst was interested in converting to for-profit. The rumors were supported by several actions taken by CareFirst during the period 1999 to 2001, namely its withdrawal from participation in programs serving the elderly, poor, and individual at high health risk. These actions angered regulators and some legislative leaders, resulting in legislative proposals to modify the board's composition and to require CareFirst to justify its tax exemptions.

At the same time, however, other bills were introduced on the disposition of the proceeds resulting from a CareFirst conversion. CareFirst's board and executives appear to have ignored or downplayed all of the other negative signals, perhaps seeing the latter bills as a clear sign that the application for conversion and sale would face relatively smooth sailing. They may have speculated that Maryland regulators and legislators viewed a sale providing a huge windfall of cash as too good to pass up. Any

such speculation was far from accurate as events proved.

On Nov. 20, 2001, CareFirst formally announced its intent to convert to a for-profit company, then to be immediately acquired by Wellpoint Health Networks, Inc., a national for-profit BlueCross BlueShield company, for \$1.3 billion. Pursuant to the Maryland Conversion Act, CareFirst submitted its application to the Maryland Insurance Administration (MIA) on Jan. 11, 2002, for review and approval. Under the act, the Maryland portion of the proceeds of such a conversion, if approved, would go to a nonprofit Maryland Health Care Foundation.

On March 5, 2003, following a lengthy and turbulent review process, with highly visible public hearings, extensive newspaper coverage, and two legislative interventions along the way, Maryland Insurance Commissioner Steven Larsen publicly announced his denial of the proposed conversion and sale, releasing a detailed report of his findings and conclusions (Larsen 2003). The report was harsh in its criticisms of the leadership of CareFirst and its consultants. That was only the beginning. Close on the heels of the denial came lawsuits, legislation to reform CareFirst, and a federal investigation.

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## BARRIERS TO CONVERSION

A number of stumbling blocks tripped up the effort to convert CareFirst into a for-profit company: corporate governance and executive missteps (policy, politics, and public relations), a legislature and insurance commission disinclined to forgo its long-term investment in nonprofit health insurance, energetic opposition voiced by nonprofit organizations and community groups,<sup>4</sup> and aggressive reporting by the local media.<sup>5</sup>

### Failure to Exercise Due Diligence

The Maryland insurance commissioner concluded that CareFirst had not exercised due diligence in deciding that it needed to convert and sell, noting that the board did not recognize and take into consideration the impacts of a conversion and sale on its mission, stated in its articles of incorporation to be “to provide coverage at minimum cost and expense.” CareFirst also failed to address whether the status quo was a viable or preferred option (Larsen 2003). The commissioner emphasized that in reviewing thousands of pages of board minutes and presentations, his department and his consultants could not find a single reference to CareFirst’s mission, and that testimony by the board chair and CEO indicated that they saw “little distinction” in for-profit vs. nonprofit ownership (Larsen 2003). Contending that minutes were merely summaries

of discussions, Board Chair Daniel Altobello claimed, “We were looking constantly at how this would affect all our stakeholders, and that’s looking after your mission” (Salganik 2003a).

Altobello also said in testimony that maintaining nonprofit status was always on the table as an option, until a decision was made to select Wellpoint as a partner. However, the commissioner pointed out that Highmark, Inc., a nonprofit Blues plan in Pennsylvania, had been dismissed earlier as a viable partner option. He also cited a Tennessee court ruling that a nonprofit board had a duty to consider the impact of its decision to abandon its nonprofit status on subscribers, providers, and the availability or accessibility of health care (Larsen 2003).

The MIA was not alone in its skepticism. The Abell Foundation, a philanthropic organization, commissioned a study in late 2000 by Carl Schramm, a private consultant at the time and a former for-profit health insurance executive. The report, which was publicly released in November 2001, criticized CareFirst for recent for-profit-oriented behaviors. It found no economic or business reasons why the plan should be converted and sold, noting lack of benefits of similar transactions involving other Blues plans, and pointed to many prosperous Blues plans still operating independently and on a nonprofit basis. The report concluded that CareFirst should recommit to its nonprofit

mission, with increased regulatory oversight and control over the CareFirst board and management practices (Schramm 2001).

Prior to the decision to convert and sell, the board failed to question or express concerns over management's stated intent for CareFirst to become more profit-oriented (Larsen 2003). In addition, the board failed to recognize what should have been clear signals from regulators, the legislature, and the media that CareFirst's actions to withdraw from programs providing coverage to elderly, poor, and high-health risk individuals were being viewed as contrary to its nonprofit mission.

The board failed to consider whether and how other nonprofit Blues plans were able to succeed financially while carrying out their public benefit missions (Larsen 2003). While the strategic plan was to convert and sell based on the need for substantial capital to achieve regional dominance and economies of scale, the board failed to prudently question: 1) how CareFirst, already dominant regionally, could become more dominant without risking anti-trust violations; 2) whether it could successfully achieve economies of scale, given its past problems in integrating operations from the mergers with the Washington, D.C. and Delaware plans and given the well-publicized integration problems experienced by prominent for-profit insurers involved in mergers regionally

and nationally; 3) the generally circuitous argument that CareFirst needed to grow through mergers or acquisitions to access capital so that it could undertake mergers or acquisitions; and 4) the lack of any presentation by CareFirst of its capital requirements to Wellpoint, as well as lack of any specific commitments of capital by Wellpoint (Larsen 2003).

CareFirst already had been spending more capital than many other nonprofit and for-profit Blues plans to meet its other capital needs related to information technology infrastructure, e-commerce, and product development, and would have had sufficient capital for at least the next two to five years (Larsen 2003). One of CareFirst's own consultants provided data to the board showing that CareFirst had sufficient capital to meet all its requirements except for mergers or acquisitions (Larsen 2003). In fact, the MIA and its consultants found that CareFirst would have had more capital available if it had eliminated losses attributed to bad management decisions (Larsen 2003).

The commissioner emphasized that "directors of an organization vested with a public trust must act with a higher degree of care than directors of a general corporation." He said that the business judgment rule (that CareFirst's experts had contended was the litmus test for the board's decision-making processes) was designed only to

limit judicial interference and to insulate for-profit corporate directors from personal liability from disgruntled stockholders, and did not apply to a regulatory proceeding (Larsen 2003). Thus, the commissioner appeared to assert that a nonprofit organization board must meet a higher test than a for-profit board for being fully engaged and independent of management, and that a state attorney general or insurance commissioner of a state has the authority to apply that higher standard.

The commissioner also found lack of due diligence by CareFirst in selecting a buyer and in setting the price and other terms, stating that the auction conducted by CareFirst between Wellpoint and Trigon, a for-profit Blues plan contiguous to CareFirst in Virginia, was not a real auction. The factors considered and emphasized shifted throughout the process "depending on which potential buyer was in favor or disfavor at the time" (Larsen 2003), with an apparent primary motivation of meeting the needs of CareFirst executives in terms of both immediate and future compensation and job roles. The commissioner stressed repeatedly in his report that Trigon had been unwilling to accept the bonus payments to CareFirst executives, whereas Wellpoint had agreed reluctantly to these payments because it understood from CareFirst that this was a "deal-breaker" (Larsen 2003). The commissioner pointed to several key findings to support

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these conclusions:

- Wellpoint was advised specifically by CareFirst to increase its bid, which initially was lower than Trigon’s, while Trigon never was asked to do so. The commissioner speculated that CareFirst wanted a tie on price, even if it were not the best price, so that it would be easier to compare and negotiate the non-price terms and conditions of the sale (Larsen 2003).



Trigon offered the CareFirst CEO chairmanship of the combined board and offered a total of four seats on its board to CareFirst, providing substantially more control than Wellpoint was offering (Larsen 2003).

- Being geographically contiguous to CareFirst, Trigon furthered CareFirst’s strategic goal of regional dominance (Larsen 2003).
- CareFirst failed to include and apply important statutory criteria bearing on the public interest, while relying inappropriately on nonstatutory factors like location of headquarters, job loss, employee benefits, executive roles and bonuses, and individual legislator concerns to make its decision. The commissioner found glaringly absent from CareFirst’s criteria and analyses the impacts of the acquisition by the specific bidders on subscribers and

on the availability and affordability of health care in Maryland (Larsen 2003).

- CareFirst never received upfront a formal valuation of itself from its consultant, only an informal opinion “not to expect \$2 billion.” This meant that in advance of the bidding process the board could not have any meaningful parameters of what was fair and in the public interest (Larsen 2003). The commissioner’s own consultant, as well as a consultant (Meyer 2003) engaged by a Washington, D.C., volunteer advocacy organization, the Washington, D.C. Appleseed Center for Law and Justice, found the purchase price to be below or at the bottom of an acceptable range.

### Conflicts of Interest


Perhaps the most damaging information to be released in the review process was word that CareFirst’s executives stood to reap significant financial gains from the proposed conversion and sale. The public was particularly outraged to learn that CareFirst CEO Bill Jews was reported to be making \$2 million in salary and bonuses and would receive \$9.1 million in merger incentives and retention bonuses if the deal went through, and an additional \$18.9 million in severance if he were terminated by Wellpoint or left for “good reasons,” such as a transfer out of town. One state senator calculated that the \$28 million in payouts to Jews roughly equaled

one year's premiums for 9,000 Maryland families (Salganik and Dresser 2002). Compensation consultants countered that CareFirst was competing with both nonprofits and for-profits for leadership talent and needed to provide alternatives to stock options as a nonprofit, and that it was common practice to offer incentives and rewards to executives for successful mergers or acquisitions. Even so, the compensation plan in this case seemed to represent an overwhelming and disproportionate incentive to convert – an incentive that was at odds with the nonprofit mission of providing affordable health care coverage.

By April 2002, the Maryland legislature had amended the Conversion Act, banning the bonus payments and requiring that any sale be for cash only. CareFirst amended its application in January 2003 (CareFirst of Maryland, Inc. 2003a) in an effort to comply with the amendments. Under the amended application, Wellpoint agreed to a cash purchase at an increased price of \$1.37 billion, allegedly as a result of the elimination of the bonus payments. However, it appears Wellpoint had merely restructured the merger incentives as "retention bonuses." Noting this, the commissioner ruled that "the retention bonuses represent a windfall of cash made available to CareFirst executives only if the merger is consummated" (Larsen 2003). In certain instances the retention

bonuses were to be payable even if the executive did not remain, and the commissioner found that executives already were to receive more than ample compensation for continued employment via their salaries, various benefits, and performance bonuses (Larsen 2003). The commissioner concluded that there was "substantial and credible evidence" that the CEO and other executives were spending considerable time from the very outset working directly with CareFirst's consultants and with the board's compensation committee on these bonus and severance issues. Compensation, in essence, was "driving" the decision-making process toward a result that would most benefit them personally, with the board in full support and ignoring information, objections, and concerns raised by their own lawyers about the legality of the bonuses (Larsen 2003).

The commissioner also identified several other major apparent or possible conflicts of interest that were not identified, acknowledged, or addressed in any manner by the CareFirst board. On the very same day, Credit Suisse First Boston (CSFB) presented to the CareFirst board its after-the-fact formal valuation of the company as well as its fairness opinion of the proposed sale to Wellpoint. With CSFB also representing CareFirst in its negotiations with Wellpoint and to receive \$13 million if the deal were consummated and only \$750,000 if it were not, the commissioner

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saw inherent conflicts of interest that the board apparently did not appreciate or consider. CSFB countered that in its field of business reputation and integrity were paramount, and the commissioner's own consultant noted that these practices were typical in the investment banking community and had not been invalidated in the courts. Nonetheless, the commissioner asserted that while it might be an appropriate exercise of the board's duty of care to rely on a common industry practice, it still might be in violation of Maryland statutes (Larsen 2003).

In addition, he saw a conflict of interest in CSFB also being a significant trader of Wellpoint stock, despite CSFB's claims that there were "Chinese fire walls" to address this potential concern. The commissioner concluded that, at a minimum, the CareFirst board should have considered whether these potential conflicts might have had some bearing on the fairness opinion, and whether any additional opinions should have been sought from "completely independent experts" (Larsen 2003).

In a somewhat similar vein, the commissioner questioned how Accenture, a CareFirst consultant that had assisted in developing and implementing the health plan's conversion and sale strategy (identifying Wellpoint as a potential merger partner), could independently, without conflict, prepare an objective community impact analysis for inclusion in the application. The commissioner

also noted that Accenture simultaneously had Wellpoint as a client, with fees from the latter growing from \$800,000 to more than \$4 million in 2001. The commissioner found that the board was delinquent in not even considering whether Accenture might have conflicts and be unable to provide an independent analysis (Larsen 2003).

A lawyer involved in internal discussions and external negotiations on compensation and other matters also appeared to have had a conflict of interest in his representation of CareFirst. For example, he had personally represented the CEO in the negotiation of his employment agreement and compensation with CareFirst in 1998 and 1999; he was paid for his work on this transaction by CareFirst, even though his involvement was not authorized or known by the board, and CareFirst already had a lawyer with another firm advising the corporation on compensation matters. This lawyer "was a significant player behind the scenes, meeting with CareFirst officers, counsel, investment bankers, and potential merger partners on a routine basis." The billing records demonstrated a major focus by the lawyer on analyses of compensation for the CEO and other executives and on discussions of compensation, with direct participation in a meeting between the CareFirst CEO and the Trigon CEO on the former's role under a merger, apparently without any other CareFirst counsel in attendance

(Larsen 2003).

### Other Findings

While noting that his various consultants (Feldman, Wholey, and Town 2003; Delmarva Foundation 2003; Wakely Consulting Group 2003) had provided generally mixed and inconclusive findings on whether the proposed conversion and sale would have adverse impacts on the availability or affordability of health care in the state, the commissioner stressed that, despite assurances of confidentiality, Wellpoint had failed to make available important pricing and underwriting information that would have permitted the consultants and MIA to conduct a full impact analysis (Larsen 2003).

Lastly, the commissioner noted the findings of a study he requested on the effectiveness of conversion foundations. While providing some specific recommendations on how the Maryland law might be improved and how a Maryland foundation might best operate if this conversion and sale were to proceed, the consultant performing the study concluded more fundamentally that conversion foundations had limited ability to make systematic changes or improvements in access to health care. That is, the amount of money available annually from investment of the proceeds of a conversion or sale could not begin to cover the costs of care or coverage for the uninsured and underinsured in a state (Larsen 2003; LECG LLC 2003).



## AFTERMATH

Reacting to the commissioner's decision and report, CareFirst Board Chair Altobello said that the board did not feel any changes in structure or personnel were needed. Maryland Cares!, a broad-based coalition of conversion opponents, called for the resignation of the CareFirst board and management. A Wellpoint spokesman was quoted as saying that the decision "made it very clear the current environment in Maryland is just not conducive to a conversion of CareFirst" (Salganik 2003b).

That quote proved to be an understatement. While the Maryland legislature had 90 days in which it could overturn the MIA's decision, only one month later, on April 7, 2003, the Maryland Senate and House both unanimously passed legislation to:

- require that CareFirst adopt a mission that embraced assisting and supporting "public and private health care initiatives for individuals without health insurance";
- ban any conversion efforts by CareFirst for the next five years;
- give the insurance commissioner approval authority over executive compensation terms and set annual board member compensation at \$12,000 (\$15,000 for the board chair and board committee chairs);
- establish public control over the selection of the Maryland members of the CareFirst board;
- create for two years a 17-member legislative oversight committee to monitor CareFirst's goals, activities, and performance (Salganik 2003c).

A state nominating committee appointed by the governor, house speaker, and senate president as to appoint 10 of the 12 Maryland board members by the end of 2003, with the remaining two to be replaced in 2004. (The Washington, D.C. plan had six board seats and the Delaware plan, three.)

About one month after this legislation, it became public knowledge that another national for-profit Blues company, Anthem, based in Indiana, had purchased Trigon for \$4 billion, almost triple Wellpoint's final offer for CareFirst, even though CareFirst had about 33% more subscribers than Trigon (Salganik 2003d). During this same period, outcries were emerging from both Delaware and Washington, D.C. that the Maryland legislature and/or insurance commissioner had overstepped their bounds and disrupted good working relationships between their plans and CareFirst. CareFirst was reported to have raised no objections with the legislature, but then lobbied unsuccessfully against its actions by seeking a gubernatorial veto (Dang and Salganik 2003).

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As soon as the new Maryland governor signed the legislation, the BlueCross and BlueShield Association (BCBSA) went to federal court to remove CareFirst’s license to use the BlueCross and BlueShield name and trademark, claiming that Maryland had illegally taken control over this multi-jurisdictional plan. Maryland countersued BCBSA, and then CareFirst sued the state, claiming the reform law was unconstitutional.

In early June 2003, a federal judge accepted a settlement among Maryland government officials, BCBSA, and CareFirst, maintaining the license in exchange for two modifications in the Maryland legislation: 1) the five new CareFirst board members who were to be appointed by December would work with the remaining seven Maryland board members to replace those seven by the end of June 2004, with two nonvoting members also to be appointed; and 2) compensation for executives would be required to be comparable to that of nonprofit health insurer peers (Dang 2003a).

From newspaper accounts it appears that by this time Maryland legislative leaders were even more distrustful of CareFirst for allegedly seeking the governor’s veto “behind their backs,” working behind the scenes with BCBSA in its suit, and then filing its own lawsuit to kill the legislation. The Senate president concluded, “It didn’t have to be this way.... They

[CareFirst officials] are masters at making enemies and losing the public relations battle” (Dang 2003b).

Within three weeks of the settlement, CareFirst CEO Jews announced publicly that he still thought he was “the best man for the job,” and that all the public criticism was “based on miscommunications and bad timing.... The legislature has determined that [the conversion] was not the right thing to do. Having heard that message clearly, it is now time to embrace the new mission.... We made an attempt to make this company stronger and viable long term....” (Dang 2003c).

Steven Larsen, who resigned as commissioner with the change in administration, responded that he felt that Bill Jews could still lead CareFirst: “The blame was not his alone.... He is a very capable businessman. He is not very adept at dealing with elected officials or with regulators. It is a significant blind spot that somehow needs to be remedied. It’s not going to be easy” (Dang 2003c).

Less than two weeks later, on July 8, 2003, the new Maryland insurance commissioner, Alfred Redmer, Jr., publicly announced that he would be issuing civil charges against CareFirst, its CEO, executive vice president, and board for seven major violations (Dang 2003d) related to violation of its mission, breach of fiduciary responsibilities, misrepresentations, mismanagement, and lack of

independent valuations and impact studies. The CareFirst board lashed back, accusing Maryland legislators and regulators of vindictive attacks that threatened its future. One board member stated, “We feel like we’ve been chastised for making a company that was insolvent solvent.... If the legislative intent was to get rid of Bill Jews – and that’s what some of us feel this is all about – they didn’t want to attack him personally so they went after the board. The best thing that ever happened to the policy holders of BlueCross BlueShield is Bill Jews” (Dang 2003e).

Another board member complained, “If we’re expected to... lose huge sums of money, where will the resources come from? Who will pay for that?” The new commissioner responded, “I don’t expect them to act as a charity.... If there are board members who don’t believe that they can have a healthy competitive carrier with revenues that exceed expenses and still have a nonprofit mission, I would suggest that’s the very reason why the legislature has chosen to replace them.” A state senator echoed this sentiment: “If they still don’t understand what they did wrong, then maybe that’s why we decided the board makeup needs to change” (Dang 2003e).


About one month later those civil suits were tabled, as federal investigators subpoenaed extensive records on the proposed conversion and sale of CareFirst. The investigation,

of undisclosed nature and in process as of this writing, is reported to involve the FBI, a federal grand jury, and the Maryland attorney general (Salganik 2003e).

In early December 2003, the CareFirst board announced a new mission statement, intended to “meet the intent of the Maryland legislation while also being sensitive to concerns of regulators in Delaware and Washington, D.C. who fear that CareFirst’s members in their areas would be forced to subsidize Maryland’s nonprofit activities” (CareFirst of Maryland, Inc. 2003b) The new mission statement is as follows:

The mission of CareFirst BlueCross BlueShield is to provide health benefit services of value to customers across the region comprised of Maryland, Delaware, and the National Capital Area. To fulfill this mission, CareFirst BlueCross BlueShield commits to:

- Offer a broad array of quality, innovative insurance plans and administrative services that are affordable and accessible to our customers
- Fairly address the needs of customers in each jurisdiction in which we operate
- Conduct business responsibly as a non-profit service plan, to ensure the plan’s long-term financial viability and growth

 “... ‘If we’re expected to... lose huge sums of money, where will the resources come from? Who will pay for that?’”

“...with the right leadership, CareFirst can be an effective partner in providing more coverage to more people and in developing win-win relationships with the provider community and other stakeholder groups...”



- Collaborate with the community to advance health care effectiveness and quality
- Support public and private efforts to meet needs of persons lacking health insurance
- Foster health systems integration and health care cost containment to benefit the people in areas we serve, and
- Promote respect, fairness and opportunity for our associates.

In the same announcement, outgoing CareFirst Board Chair Altobello stressed what he called the board’s commitment to “maintaining a high standard of corporate governance in all of its operations in Maryland, Delaware and the National Capital Area” and reported that the board had engaged a senior partner in a Washington, D.C. law firm, who had served on a special task force on corporate responsibility of the American Bar Association, to assess and advise the CareFirst board on its structure.

In early May 2004, Maryland’s general assembly passed additional legislation reinforcing the insurance commissioner’s oversight of CareFirst, giving the commissioner approval authority over officer and executive compensation, as well as over any proposed material change in benefit plans offered, marketing goals, provider networks, provider payment levels, premium rate changes, underwriting guidelines, and the availability or affordability of

## health care. **CONCLUSION**

Some of those interviewed for this report opined that, had the CareFirst Board or CEO volunteered at an early stage to remove the controversial components from CareFirst’s compensation policies and from the proposed transaction, the outcome might have been a much closer call.

Those interviewed generally shared the belief that, with the right leadership, CareFirst can be an effective partner in providing more coverage to more people and in developing win-win relationships with the provider community and other stakeholder groups to improve patient safety, disease management, and other aspects of care as well as to improve health status. There were varying levels of skepticism and optimism expressed by these interviewees, however, as to whether the right leadership would emerge to, in effect, “put the for-profit genie back in the bottle.” The level of skepticism or optimism in this regard depended on how they saw the make-up of the future board shaking out and on whether they felt that the CEO and his team should and/or would be replaced.

Two recent developments bear mentioning. Steven Larsen has accepted the position of president and CEO of the Maryland office of a for-profit health insurer, whose sole product is Medicaid managed care coverage. And at press time, Wellpoint and Anthem were appealing the denial of their merger bid by the California

insurance commissioner.

## NOTES

*The Alliance for Advancing Nonprofit Health Care is a new national group composed of a mix of nonprofit health care providers, nonprofit health insurers, and nonprofit integrated health care financing and delivery organizations, dedicated to preserving the unique roles and responsibilities of nonprofit health care organizations in the United States while improving their performance. The views presented are the author's and are not positions taken by the Alliance.*

<sup>1</sup> Because the devil is often in the details, this account is intentionally much more detailed than James C. Robinson's article, "For-Profit Non-Conversion and Regulatory Firestorm at CareFirst BlueCross BlueShield" (*Health Affairs*, July/August 2004).

<sup>2</sup> The information for this article was derived from two sets of sources. First, a variety of documents were reviewed, almost all of which were readily available from the Maryland Insurance Administration (MIA), either through downloading from its website, [www.mdinsurance.state.md.us](http://www.mdinsurance.state.md.us), or by online request. The MIA documents reviewed included all the reports of experts/consultants engaged by CareFirst and by MIA, selected testimony and depositions by CareFirst officials and opponents to the conversion, CareFirst's original application

to convert and subsequent amendments thereto, and the insurance commissioner's full report denying the conversion. Also reviewed were reports prepared by Carl Schramm for the Abell Foundation and by the Milbank Memorial Fund for the Maryland speaker of the House of Delegates and the president of the Maryland Senate. In addition, more than 40 *Baltimore Sun* newspaper articles were reviewed about the proposed conversion, its denial, and the aftermath.

Secondly, I interviewed several individuals, who graciously gave of their time and perspectives: Carl Schramm, formerly a consultant who prepared a significant report on this proposed conversion; Steven Larsen, the former Maryland insurance commissioner who denied CareFirst's proposed conversion and sale; Cal Pierson, president, and Nancy Fiedler, senior vice president for communications, of the Maryland Hospital Association; Michael Preston, executive director of the Maryland State Medical Society; Dawn Touzin, community health assets project director and Nomita Ganguly, staff attorney of Community Catalyst, a national advocacy group dedicated to increasing consumer participation in health care decision making; and Bill Salganik, the principal reporter for the *Baltimore Sun* on the proposed CareFirst conversion. Because of time constraints and because their views were well documented in the newspaper articles reviewed, no efforts

were made to interview leaders of the Maryland Senate and House engaged in the CareFirst debate and aftermath. The former board chair of CareFirst involved in the conversion effort, Daniel Altobello, declined to be interviewed, stating that "it is a good time to be silent" and that his position was "a matter of public record." CareFirst declined the author's request for an interview with one or more of its current leaders who were involved in this controversy. Their views were extracted from the MIA documents and newspaper quotes.

<sup>3</sup> Interestingly, in order to gain the support of the Maryland State Medical Society (MedChi) for this merger, the CareFirst CEO reportedly wrote a letter to MedChi's CEO stating that he no longer had any intentions to convert CareFirst to for-profit.

<sup>4</sup> The Maryland State Medical Society and the Maryland Hospital Association (MHA) voiced strong opposition to the proposed conversion, joining in and funding a coalition, Maryland Cares!, with almost 40 consumer, labor, and community groups and with Community Catalyst, a Boston-based national consumer advocacy group with experience in conversion debates in other states. MedChi and MHA could not envision how their historical partnership with CareFirst and state policymakers could continue if CareFirst not only converted to for-profit, but was also acquired by a national company. It was conceivable to MHA and the coalition that over

time Wellpoint might even try through Medicare amendments or other means to eliminate the all-payer hospital rate regulatory system in Maryland, so that Wellpoint could use its market leverage to “ratchet-down” its rates paid to hospitals. Moreover, on substantive grounds, the coalition felt strongly that CareFirst had not made a convincing case that the conversion and sale were necessary for its financial well-being.

<sup>5</sup> Throughout the review process the *Baltimore Sun* was particularly thorough in its coverage of the details of CareFirst’s application, the content of expert reports from both MIA and CareFirst, the results of public hearings and depositions, and the results of its own interviews with key players within the state and with outside experts.

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