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CONVERSION FYI

I. Blue Cross Blue Shield Transactions

Maryland Passes Legislation to Recommit Nonprofit Blues Plan to Its Intended Charitable Mission

In March 2003, Maryland Insurance Commissioner Steve Larsen denied the conversion application submitted by the CareFirst, Inc. holding company that controls the nonprofit Blues plans in Maryland, Delaware and the District of Columbia. Following the disapproval decision, at the urging of the Maryland Cares! coalition, legislation was passed and signed by the Governor to make CareFirst a more responsible nonprofit organization, committed to its charitable mission. On the day the Governor signed the bill, the Blue Cross Blue Shield Association filed a lawsuit to terminate CareFirst's license to use the Blue Cross and Blue Shield trademark arguing that the new legislation amounted to a state takeover of CareFirst, a violation of the BCBS Association licensing rules. Simultaneously, the Attorney General filed for an injunction to stop the Association from revoking the license. Days later, CareFirst filed a lawsuit against the state arguing that the new law is unconstitutional.

In the following weeks, the cases were combined and moved to federal District Court in Baltimore, Maryland where a settlement was reached restoring CareFirst's license and amending certain provisions in the newly enacted state law which included replacing fewer board members than those initially allowed for in the legislation, making the executive pay at CareFirst comparable to other nonprofit executives and banning the conversion of CareFirst for five years.

In the middle of this fast moving process, Commissioner Larsen's term ended and Alfred Redmer, who continued the work Larsen had started, replaced him.

Following the conclusion of the negotiations between the Association and the Attorney General, Commissioner Redmer released a report on July 8th outlining CareFirst's violation of certain state laws. The report identifies seven violations by the company including operating a nonprofit as a for-profit, corporate mismanagement, failure of the board to uphold their fiduciary duty, and failure to obtain independent consultants during the conversion. Commissioner Redmer will issue civil charges against CareFirst, its top management and the board for the identified violations of state insurance laws.

During the legislative session and subsequent negotiations, the insurance commissioners in the other CareFirst jurisdictions, D.C. and Delaware, expressed concern over the negative impact the new law would have on the affiliation agreements between CareFirst and the Blues plans in those states. As a result, the Delaware Insurance Commissioner Donna Lee Williams is conducting a public hearing beginning November 4, 2003 to examine whether the new Maryland law violates her order approving the original affiliation between BCBSDE and CareFirst.

Most recently, during the second week of August, the U.S. Attorney's office for Maryland, the FBI and a federal grand jury issued subpoenas to CareFirst, WellPoint and the Maryland Insurance Administration as part of a federal investigation into possible mismanagement regarding the proposed conversion.

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Kansas Supreme Court Upholds Insurance Commissioner's Disapproval of Anthem's Acquisition Plans

On August 6, 2003, the Kansas Supreme Court ruled that a decision made to deny the proposed sale of the mutual insurance company Blue Cross and Blue Shield of Kansas (BCBSK) to Anthem Insurance of Indiana (Anthem) will stand. Former Kansas Insurance Commissioner Kathleen Sebelius (who is now the state's governor) disapproved the sale in her February 11, 2002 Final Order. The Insurance Commissioner concluded that the acquisition would likely be "hazardous and prejudicial to the insurance buying public" if approved and she denied the proposal. BCBSK and Anthem immediately challenged the decision in District Court.

On June 7, 2002, District Court Judge Terry Bullock vacated the Final Order and remanded the matter to the Commissioner for reconsideration. Judge Bullock agreed with the argument offered by the plaintiffs that the Commissioner had exceeded her authority under Kansas law when she rejected the proposed Anthem takeover. Vowing "to protect the families and businesses of Kansas from millions of dollars in increased insurance rates," the former Insurance Commissioner immediately appealed the District Court's decision. Given the important and novel legal issues involved, the Kansas Supreme Court agreed to hear the appeal.

In addition to the briefs submitted by the parties, the Kansas Supreme Court allowed *amicus curiae* briefs by the Kansas Hospital Association, the Kansas Medical Society, the National Association of Insurance Commissioners and Community Catalyst. In its August 6th Opinion reversing the lower court's decision, the Kansas Supreme Court held that, when considering a proposed acquisition of a state health insurer, the Insurance Commissioner has the authority to consider factors relevant to understanding the likely impact the sale will have on the public. The Kansas Supreme Court's reversal means that the Insurance Commissioner's February 11, 2002 Final Order is recognized and the proposed sale is disapproved. The Court's holding also validates the Commissioner's rigorous review process, which included multiple opportunities for public input, making relevant documents and hearings publicly accessible, and a focus on protecting health consumers from the likely negative impacts of the transaction.

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CHAP and State Partners Working within the National Association of Insurance Commissioners (NAIC)

Dawn Touzin, Community Catalyst's CHAP Director, has been appointed a Consumer Representative to the NAIC. The NAIC funds 13 representatives chosen from the nonprofit advocacy community so that the consumer voice can be heard in the organization. This appointment enables CHAP to play a role in an otherwise industry-dominated environment.

Consumer Representatives are able to attend the NAIC's national conferences (4 per year) and set the agenda for the Consumer Liaison Committee (CLC) meetings. The meeting of the CLC, which is comprised of the reps and 18 Commissioners, is a major gathering at each national conference.

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The position also enables representatives to attend all other conference meetings and to interact with insurance commissioners and staff, on a formal and informal basis, as well as to attend various special meetings and seminars sponsored by the NAIC.

At the most recent conference held in New York City (June 20-24, 2003), Touzin brought CHAP concerns, including the attempted conversions of Blue Cross Blue Shield plans in Maryland and North Carolina, and attempts by the BCBS Association ("Association") to use its licensing agreements to inhibit state regulation of the Blues transactions, to the agenda of two important meetings.

Speaking before the CLC, Touzin talked about how the Association has threatened to revoke plans' use of the BCBS trademark, which is governed by the Association's licensing agreements, as an attempt to discourage regulatory involvement and oversight. This inappropriate use of market power is a potential threat to any state in which the Blues plan has a significant share of the health insurance market.

Adam Searing (North Carolina Health Access Coalition), Chuck Bell (Consumers Union, New York) and Touzin spoke at the meeting of the Blue Cross Blue Shield Conversion Workgroup, a special task force of 15 Commissioners specifically examining conversion issues, each one presenting a different facet of the consumer perspective on Blues transactions.

Adam Searing told the story of BCBSNC's proposed conversion and its attempt to deprive North Carolinians of any future voice in the decision-making process of their plan. Searing recounted how advocates went from supporting the conversion – reasoning that a good foundation would be preferable to a plan already acting like a for-profit – to opposing the heavy-handed restrictions imposed by the Association on how the foundation could protect its interests post conversion. (See related story.)

Chuck Bell related the story of Empire's conversion, its backroom politics, and the diversion of billions of dollars that should have gone to the community for ongoing health care purposes but instead were usurped by special interests. While New York advocates continue to challenge the special law passed behind closed doors that laid the foundation for Empire's conversion, Bell described the Empire case as a clear example of how a conversion should not be done.

At the next NAIC conference (scheduled for Sept. 14th in Chicago), the BCBS Conversion Workgroup will have an hour-long open mike session. This offers another opportunity for state advocates to voice local concerns and issues related to conversions.

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Facing Difficult Questions from Consumer Activists and State Regulators, Blue Cross and Blue Shield of North Carolina Abandons Plan to Convert

This past July, the nonprofit health insurer Blue Cross and Blue Shield of North Carolina (BCBSNC) withdrew its proposal to convert to a for-profit corporation. A strong health conversion law, active and well-organized health advocates, and responsible public officials likely prompted BCBSNC's decision to remain a nonprofit company.

Consumer advocates, led by Adam Searing of the North Carolina Health Access Coalition (NCHAC), urged regulators to scrutinize BCBSNC's proposal very carefully. They 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

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assets in the conversion. Any dilution of asset value was unfair to North Carolinians, they argued, and the state insurance commissioner and attorney general took their complaints seriously.

Experts weighing in on the conversion proposal predicted that North Carolina individuals and small businesses would likely see a rise in health insurance rates if BCBSNC became a for-profit business. Others concluded that the company had not submitted a convincing argument for converting.
Finally, BCBSNC did not help its cause when it was revealed that the company was behind a pro-conversion group masquerading as a grassroots consumer organization called North Carolinians for Affordable Health Care (NCAHC), whose initials closely resemble Searing's NCHAC. Ultimately, the company's efforts to argue that the conversion was good for consumers fell flat and, instead of suffering a rejection of their proposal by regulators, BCBSNC withdrew its own proposal.

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Tax Exemptions for Puerto Rico's Blue Shield Plan Declared Improper; Over $60 Million Ordered Returned to the Public

After looking into allegations that Blue Shield of Puerto Rico (Triple-S, Inc.), the island's largest health insurance provider, was misusing assets dedicated for the public's health benefit, the Puerto Rican government decided to eliminate the tax exemption Triple-S has enjoyed for over 25 years. Additionally, Triple-S will be required to pay at least $67 million in retroactive taxes dating back to 1976. The inquiry into how the insurer was using its assets was initiated in the summer of 2002 when concerned legislators and health advocates raised suspicions that the corporation was redirecting charitable assets earmarked for the public's benefit to maximize profits for its for-profit lines of business.

Although Triple-S was incorporated in 1959 as a for-profit corporation, it was granted a special tax exemption from Puerto Rico's Department of the Treasury (Treasury) to conduct its business as would a traditional nonprofit health insurer. The provisions detailed in the Treasury's official documents include a commitment from Triple-S to promote the social welfare as well as an agreement that earnings from stocks would be used exclusively to reduce health insurance premiums or otherwise improve the health services available to the public. After conducting an audit of the insurer that was completed earlier this year, the Treasury decided that Triple-S's tax-exempt status was improperly granted and revoked it. Supporting the Treasury's findings were similar conclusions resulting from an investigation, also completed earlier this year, of Triple-S conducted by the House of Representative's Banking, Insurance and Financial Affairs Committee, chaired by Rep. Roberto Rivera Ruiz de Porras.

While advocates applaud 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 even after it pays almost $70 million in back taxes. The additional assets are 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.

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II. Hospital Transactions

Slidell Residents Celebrate Signing of Law Improving Hospital Governance

After the vote on April 5, 2003 when the public overwhelmingly rejected Tenet's bid to purchase Slidell Memorial Hospital, activists kept on pushing for more transparency and a more public process in the governance of the hospital. They supported the introduction of substantial revisions to the governing law with a bill submitted on April 29, 2003. Their hard work paid off when Louisiana Governor Mike Foster signed Act No. 562 on June 27, 2003. The law immediately terminated the current board of commissioners for the hospital district, provides for the appointment of a new board and nominating committee, and specifies the qualifications required for new board members. Nominees for the board of commissioners will be chosen from a permanent nominating committee that solicits individuals from the community as a whole by widely publicizing the openings on the board. The law instructs the nominating committee to make reasonable efforts to include individuals with experience in the areas of health law, hospital finance, bonds, managed care, and health services delivery. The nominating committee will hold candidate interviews in a public forum.

The law also provides for the creation of a community advisory board. This advisory board will provide suggestions, input and comment to develop programs and administer services that will provide the maximum assistance in promoting better health and health care for the residents of the hospital district. The advisory board will also produce a study and report its findings on any matter directed by the board of commissioners.

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Los Angeles Advocates Ensure Restitution Funds Are Wisely Spent

On July 14, 2003, the West Los Angeles Metropolitan Alliance and Community Health Councils, Inc. provided vital information on the community's health care needs at a public meeting held by the California Community Foundation (CCF). In attendance were representatives from organizations interested in obtaining grant funding from the settlement agreement between the California Attorney General and Tenet Healthcare Corporation.

As part of the settlement for Tenet's failure to abide by certain conditions in the sale of the Daniel Freeman Memorial and Marina Hospitals, Tenet was required to deposit $400,000 with the CCF for grants to one or more non-hospital, tax-exempt charitable organizations that provide medical care at low cost or free to low income residents in the hospital's service area.

Since the settlement agreement was announced on April 1, 2003, local health care advocates have sought to participate in CCF's grant-making process. After contacting CCF representatives, advocates fought strenuously for the right to ensure that grantees are appropriately addressing the community's health care priorities in their proposals.

At the meeting held at the Venice Public Library in Venice, CA, members of the Metropolitan Alliance provided information obtained from in-person surveys conducted in the communities of Mar Vista and Oakwood. The recommendations focused on the challenges to the 36% of residents who are Spanish-speaking, namely: increasing bilingual health care staff, providing translation services, and increasing outreach activities in the communities in Spanish. Community Health Councils presented significant research on the prevalence of certain diseases in the target population including diabetes, asthma and obesity.

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The potential grantees are expected to incorporate the information presented into grant applications. The deadline for grant submissions is August 18, 2003. Public notice regarding grant selection will be made available on September 15, 2003.

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New Conversion Foundation Created; Community Applauds Action by West Virginia Health Care Authority

Residents and health advocates applaud the creation of and proposed funding for a new hospital conversion foundation in Logan, West Virginia. Organizing documents for the Logan Healthcare Foundation ("the Foundation") were filed on July 1, 2003, marking the first step for the Foundation to fulfill its mission to improve the health status of and health care access for the residents in the area surrounding Logan General Hospital.

The Foundation is a component of the sale of bankrupt Logan General to for-profit LifePoint Hospitals, Inc. finalized in December 2002. Since April 2002, the Logan County Family Resource Network, Consumers Union, and Community Catalyst have participated in the bankruptcy. While it remains unclear how much funding the Foundation will receive in total, the hospital announced at a hearing on July 1, 2003 that the Foundation will receive $5 million in the first distribution expected in October 2003.

At the same time, the West Virginia Health Care Authority is redirecting its entire claim of $5.8 million to the Foundation. At a July 22, 2003 hearing, the hospital announced that 80% of the $5.8 million claim will also be paid to the Foundation during the first round of distribution. The remaining 20% will be paid when the hospital has collected all of the assets and resolved the disputed claims. In addition, the Foundation is the remainder beneficiary and will receive all of the residue that is left after the creditors are paid and pension issues are resolved.

The groups provided recommendations to improve the plan termination and annuity purchase because every dollar saved will go to the Foundation. Advocates are working with the Logan Healthcare Foundation board of directors to implement accountability mechanisms to ensure that its policies and procedures are responsive to the health care needs of the area residents. A hearing is expected to be scheduled in September to confirm the hospital's revised reorganization and distribution plans.

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Oregon Attorney General Imposes Conditions on Triad Joint Venture

Earlier this year, Texas-based Triad Hospitals. Inc. sought to enter into a joint venture with McKenzie-Willamette Hospital (MWH), a fifty-year old community hospital located in Springfield, Oregon. On July 18, 2003, Oregon Attorney General Myers approved the proposed joint venture between MWH and Triad, but placed several conditions upon the parties to protect the community's interest in MWH. Many of these conditions grew out of concerns raised by local advocates, Ellen Pinney and Mary Ann Holser, and Community Catalyst at the June 24th public hearing convened by Myers. The conditions provide community members with a voice in the continued operation and direction of their hospital. Included among these community-enabling conditions was a mandate that a member of

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the nominating committee (which nominates members to the Board of Trustees) be someone with "a demonstrated concern about community health care needs."

Myers also demanded that stronger consumer protections regarding charity care provisions be part of the conditions, including: clearer notice provisions, counseling for patients on eligibility for low-income assistance programs, elimination of charges for patients with household incomes above 200% of the federal poverty level, reduced charges for many patients with incomes between 200% and 500% of the federal poverty level, and more patient-sensitive collection practices. Further, Myers' order contained several protections regarding the replacement hospital contemplated by the agreements. These protections included a condition on the replacement hospital to accept Medicare and Medicaid patients, full involvement of the community-based trustees on the Board in decisions about potential termination of essential services, and more public participation in the determination of the location of the replacement hospital. These conditions lay a solid foundation for communities elsewhere to build upon when working to protect health consumers' interests in nonprofit joint ventures with for-profits.

According to Triad CEO Denny Shelton, Triad is currently in talks with 13 to 14 nonprofit community hospitals nationwide, including hospitals in Palmer, Alaska; Fairmont, West Virginia; Erwin, North Carolina; and Denton, Texas. The Oregon experience may be instructive for communities in these areas.

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New California Law Prohibits Limiting Future Medical Services in Nonprofit Hospital Conversions

On July 14, 2003, California Governor Gray Davis signed SB 932 making it illegal for a nonprofit hospital to restrict medical services that are delivered at the facility as part of a sale or conversion. Previously, the California Attorney General had the authority to approve any proposed sale of a nonprofit health facility and the law allowed the seller to attach conditions preventing the new buyer from providing certain types of medical services, such as those restricted by the Ethical and Religious Directives for Catholic Healthcare. Now the Attorney General will be prohibited from approving any sale where the seller of the nonprofit health facility tries to impose restrictions on or limit the types of services the new owner can provide.

When Daniel Freeman Marina and Daniel Freeman Memorial hospitals were sold to Tenet in 2001, they were required to abide by the Ethical and Religious Directives, even though the seller, Sisters of Carondelet, no longer owns any hospitals in California. Advocates argued that allowing sellers to restrict medical services was inappropriate because all patients have a right to comprehensive health care in their communities and reproductive health care should not be limited by religious doctrine. Instead, services should be based on the medical needs of patients. Further, there were questions raised about whether requiring such a limitation actually restricts the number of potential buyers for a hospital and, as a result, artificially lowers the sale price.

The bill was supported by the Congress of California Seniors, the California Women's Law Center, Planned Parenthood, California Medical Association, and the American College of Obstetricians and Gynecologists.

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Public Hearings for the First Proposed Hospital Conversion under Washington Statute Provide Opportunity for Community Input

The Washington Department of Health held two public hearings on July 8, 2003 to hear from the community on the proposed sale of two nonprofit hospitals to a for-profit chain, putting the hospital conversion law to the test for the first time. Health Management Associates, Inc. (HMA), has proposed to buy Providence Toppenish Hospital and Providence Yakima Medical Center. These two hospitals are currently operated by the Sisters of Providence, who founded and have maintained the Yakima hospital since the 1890s.

Among the statute's requirements, the DOH and Attorney General are required to ensure charitable assets are properly safeguarded and that any proceeds from the acquisition are used for appropriate charitable health purposes. Also, a transaction may not be approved unless the DOH determines that there are "sufficient safeguards" to ensure "the continued existence of accessible, affordable health care that is responsive to the needs of the community."

With approximately 250,000 residents and more than 35% Spanish-speaking, Yakima County was ranked as the most vulnerable county in the state when assessing income, housing and unemployment statistics. The hearings, which were held in Toppenish and Yakima, drew dozens of residents including lawmakers, patients, doctors, nurses, and health care advocates. If the sale is approved, it will be the first time a nonprofit hospital has converted to for-profit status in the state.

Attendees raised issues regarding the delivery of charity care, the hospitals' responsiveness to the community, and the quality of care delivered by the facilities. In regards to charity care, there were questions about whether the policies put forward by HMA conform to the state law on charity care. Residents testified that the hospital has not done enough to reach out to Yakima County's Spanish-speaking residents. In addition, there were recommendations made on actions HMA should take, including surveying the patients themselves about the quality of care received; tracking medical outcomes, medical error and infection rates; and making information available to the DOH and the public in English and Spanish.

HMA has proposed to put $1 million a year for ten years into the new community foundation. Washington law requires that the charitable health assets be dedicated to continuing the hospital's original purpose and to include providing health care to the disadvantaged, the uninsured, and the underinsured and providing benefits to promote improved health in the affected community.

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Consumers Win Big in South Dakota

In May, the South Dakota Supreme Court issued a landmark charitable trust decision in the case of Banner Health System v. Lawrence E. Long, 663 N.W.2d 242 (2003). This case sets several important precedents in the area of charitable trust law, and is a big victory for consumers.

The South Dakota court explicitly held that the assets of a nonprofit health care corporation, as well as the proceeds from the sale of those assets, are subject to the law of charitable trust. It also held that an out of state nonprofit corporation must leave the proceeds of a hospital sale with the local community upon divestiture, even if the community hospital remains a nonprofit after the sale. You will find a summary of the decision attached.

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Consumers Union filed an *amicus curiae* brief with the court supporting the efforts of the South Dakota attorney general to protect the charitable assets of seven nonprofit hospitals and nursing homes. The facilities were sold in 2002 by multi-state nonprofit Banner Health System (Banner) as part of an effort to sell facilities in several states and reinvest the proceeds in its operations in Colorado and Arizona. Over the past year, Banner has sued the attorneys general of New Mexico, South Dakota, and North Dakota for alleging charitable trust violations after Banner attempted to remove the proceeds from sales in those states. In South Dakota and North Dakota, the attorneys general have countersued Banner. In New Mexico, the case settled in May 2002 for nearly $14 million.

The South Dakota case will now proceed to trial in federal court. If the facts alleged by the attorney general are proven at trial, the judge could require Banner to leave the proceeds in the state. In North Dakota, a federal judge has dismissed Banner's lawsuit on the grounds that the Eleventh Amendment to the U.S. Constitution bars a state from being sued in federal court. That case is now being litigated in state court, where the attorney general's countersuit against Banner was stayed pending the federal court decision.

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For more information on the South Dakota Supreme Court case, please see the case summary below.

III. Community Benefits/Free-Care

Momentum Building in California for Legislation to Help the Uninsured

Legislation aimed at helping the uninsured obtain needed health care without facing financial ruin is gaining momentum in the California legislature. AB 232, introduced by Assembly Member Wilma Chan, has already passed the California Assembly and was approved by the Senate Health Committee on July 9, 2003. The Senate Health Committee vote brings the legislation one step closer to becoming state law and providing critical protections to the uninsured that could establish a precedent for the rest of the nation.

Under AB 232, hospital charges to uninsured patients would be limited to the price paid under the Medicare, Medi-Cal or workers compensation fee schedule, whichever is greater. The bill also requires hospitals to notify uninsured patients about the availability of charity care and other public health insurance programs, to delay aggressive bill collection tactics so that reasonable payment plans can be established and to inform patients of their rights under laws applying to collection agencies.

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Hartford Advocates Negotiate Improvements to Free Care Access at Area Hospitals

Just a few months after the April 2003 release of its report entitled "Holes in Our Safety Net: The Difficulty of Accessing Free Care in Hartford, Connecticut," the health advocacy organization, Building Parent Power (BPP), is already winning improvements to free care access for Hartford's health consumers. The group's report, which can be downloaded from the www.communitycatalyst.org web site, focuses on four Hartford-area hospitals and recommends several ways that these hospitals can improve access to charity hospital care, including simplifying the application process, better training the staff about the hospitals' free care policies, and providing translation services for those with limited English proficiency. The four Hartford-area hospitals surveyed for the report were Saint Francis Hospital and Medical Center, Hartford Hospital, Connecticut Children's Medical Center, and the University of Connecticut Health Center.

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Before the report was released in April, BPP members met with representatives from each of the four surveyed hospitals to discuss the group's findings and to propose that the parties continue meeting after the report's release to work on implementing the improvements to free care access outlined in the report. All of the hospitals agreed.

In July and August 2003, BPP members began the first of what is expected to be several meetings with each of the four hospitals to negotiate how the group's recommendations could be implemented. Even during the first meeting, one hospital reported that it had changed several of its training procedures and free care policies in response to the BPP report. Yet another hospital made a commitment to collaborate with BPP on an informational forum at the hospital to educate community members about the availability of free care and other financial assistance programs. BPP members also negotiated improvements in training staff on the appropriate use of language interpretation services, making free care applications in several languages to accommodate the linguistic diversity of the community, and posting more informative and visible signs about available free care programs throughout the hospitals in at least two languages.

While the group is thrilled by these early wins, BPP members realize that much more work will be necessary to secure the needed improvements to free care access for Hartford families. Later this year, BPP plans to report on the successes achieved and challenges encountered, perhaps by producing a follow-up report, in its efforts to improve access to free care at the four hospitals.

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