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July 8, 2003

The Honorable Robert L. Ehrlich, Jr.
Governor
State of Maryland
State House
Annapolis, Maryland 21401-1991

The Honorable Thomas McLain Middleton
Chairman, Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen Street
Annapolis, Maryland 21401-1991

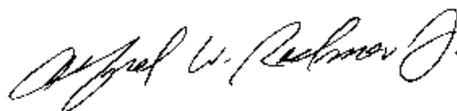
The Honorable John Adams Hurson
Chairman, Health and Government Operations Committee
Lowe House Office Building, Room 161
Annapolis, Maryland 21401-1991

RE: Maryland Insurance Administration's July 3, 2003 Legislative Report
on MIA Order No: 2003-02-032

Dear Governor Ehrlich, Chairman Hurson and Chairman Middleton:

Pursuant to Chapters 356 and 357, Acts 2003, I am reporting my determinations and
recommendations pursuant to MIA Order No: 2003-02-032.

Sincerely,



Alfred W. Redmer, Jr.
Insurance Commissioner

AWR:izm
Enclosure

cc: Kenneth H. Masters, Chief Legislative Officer, Office of the Governor
Cheryl Matricciani, Committee Counsel, Senate Finance Committee
Linda Stahr, Committee Staff, Health and Government Operations Committee
Sarah T. Albert, Library & Information Services, Dept. of Legislative Services
CareFirst Board Members

LEGISLATIVE REPORT

OF THE

MARYLAND INSURANCE ADMINISTRATION

ON

MIA ORDER NO.: 2003-02-032

JULY 8, 2003

**Alfred W. Redmer, Jr.
Insurance Commissioner**

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I. INTRODUCTION

A. Requirement for This Report

During the 2003 legislative session, the Maryland General Assembly passed Senate Bill 772 and House Bill 1179. On May 22, 2003, both bills, which are identical, were signed into law by the Governor as Chapters 356 and 357, Acts of 2003. Chapter 357 requires the Insurance Commissioner of the State of Maryland (the "Commissioner") to fully review MIA No: 2003-02-032 (the "Order"), and Attachment A to the Order (the "Conversion Report"), which were issued on March 5, 2003, for the purpose of:

- determining whether any of the conduct identified in MIA No: 2003-02-032 violates the provisions of §§ 14-116 or 14-139 of the Insurance Article, as in effect before the effective date of Chapters 356 and 357, or any other provision of the Insurance Article not identified in MIA No: 2003-02-032; and
- making recommendations regarding whether any changes to Maryland law need to be made to ensure that the regulatory oversight of nonprofit health service plans subject to Title 14 of the Insurance Article is sufficient to protect the public interest.

The Commissioner is required to take any action, if any, deemed appropriate made as a result of the Commissioner's review of the Order and the Conversion Report. The Commissioner's determinations must be reported, by July 1, 2003, to the board of directors of CareFirst, the Governor of Maryland, and in accordance with §2-1246 of the State Government Article, to the Maryland General Assembly. In addition, the Commissioner must report on the recommendations, as required by Chapter 357, to the Governor of Maryland and, in accordance with § 2-1246 of the State Government Article, to the Maryland General Assembly and the Office of the Attorney General.

B. Scope of This Report

This Report (hereinafter referred to as the "Legislative Report") is a detailed account of the analysis conducted by the Commissioner in accordance with Chapter 357. It makes determinations as to whether there is a basis to conclude that the conduct highlighted in the Conversion Report violated any applicable provisions of the Insurance Article. In addition, if the Commissioner determines that a violation exists, the Commissioner is required to take appropriate action. The Legislative Report also identifies what additional legislative action should be considered by the Maryland General Assembly and the Governor to ensure that the regulatory oversight of nonprofit health service plans is sufficient to protect the public interest.

II. BACKGROUND

A. Submission of Conversion Application

On January 11, 2002, CareFirst, Inc. ("CareFirst"), CareFirst of Maryland, Inc. ("CFMI"), and WellPoint Health Networks, Inc. ("WellPoint") filed with the Maryland Insurance Administration (the "MIA") a consolidated document denominated "FORM A STATEMENT REGARDING THE ACQUISITION OF CONTROL OF OR MERGER WITH A DOMESTIC INSURER" (the "Application"). The Application sought the prior approval of the Commissioner for the conversion of CareFirst and of CFMI to for-profit status pursuant to Title 6.5 of the State Government Article; and the subsequent and immediate acquisition of control of CareFirst, and the indirect control of its subsidiaries by WellPoint. On January 17, 2003, CareFirst and WellPoint submitted an Amended Application to the MIA. The Amended Application included an "AMENDED AND RESTATED AGREEMENT AND PLAN OF MERGER." (The transaction proposed in the Application and Amended Application is hereinafter referred to as the "Proposed Transaction".)

B. Investigation by Insurance Commissioner

On or about January 11, 2002 the Commissioner began an exhaustive and detailed investigation of the Proposed Transaction. In addition to reviewing the Application and the Amended Application submitted by CareFirst and WellPoint, the Commissioner reviewed all filings, documents, and materials (including experts' reports) submitted therewith by CareFirst and by WellPoint. Public hearings were held by the Commissioner; public comment on the Proposed Transaction was received by the Commissioner's office; depositions were taken; and experts were retained by the Commissioner to review critical aspects of the Proposed Transaction. The Commissioner's review of the Proposed Transaction was conducted in accordance with Title 6.5 of the State Government Article and Title 7 of the Insurance Article.

C. Issuance of Insurance Commissioner's Order

On March 5, 2003, the Commissioner issued MIA No: 2003-02-032, which disapproved the Proposed Transaction. The Commissioner's Order incorporates the Conversion Report and the reasons for the disapproval, including a summary and analysis of the record. (The Order and the Conversion Report are available on the MIA website at www.mdinsurance.state.md.us)

D. Development of Legislation

In recent years, the Maryland General Assembly has become increasingly concerned about whether the conduct of CareFirst is consistent with the mission of a nonprofit health service plan. During the legislative sessions of 2001 and 2002, the Maryland General Assembly enacted legislation for the purpose of ensuring that the public interests are served by a nonprofit health service plan such as CareFirst.

The interests of the Maryland General Assembly during the 2003 legislative session would be no different. The Maryland General Assembly responded swiftly to the Conversion Report with the introduction of legislation in both the Senate of Maryland and the House of Delegates that would establish, in statute, the mission of a nonprofit health service plan; create changes to the composition of the Board; and enhance regulatory oversight of a nonprofit health service plan. The purpose of the 2003 legislation is to ensure that a nonprofit health service plan subject to the provisions of Chapter 357 adheres to the mission as provided for in the legislation.

Chapter 357, as set forth in the Preamble, provides an overview of the history of CareFirst since its creation in 1937; the conduct of CareFirst as a nonprofit health service plan through March 2003; and the findings of Commissioner Larsen in the Order. The Preamble explains why the Maryland General Assembly was compelled to enact legislation that prescribed the mission of a nonprofit health service plan and many duties and responsibilities of the plan's board and management.

Chapter 357 ensures that the mission of CareFirst will be to:

- (1) provide affordable and accessible health insurance to the plan's insureds and those persons insured or issued health benefit plans by affiliates or subsidiaries of the plan;
- (2) assist and support public and private health care initiatives for individuals without health insurance; and
- (3) promote the integration of a statewide health care system that meets ... health care needs....

Chapter 357 requires the development of goals, objectives and strategies that support the mission required under the legislation, and establishes greater oversight of the activities of a nonprofit health service plan, including:

- (1) requiring the Maryland General Assembly to establish a Joint Nonprofit Oversight Health Service Plan Committee that is charged with examining and evaluating the ability of nonprofit health service plans in Maryland that carry the BlueCross BlueShield Trademark to meet certain goals intended to support the mission stated in House Bill 1179 and Senate Bill 772;
- (2) establishing a Nominating Committee to oversee the appointment and removal of twelve members of the CareFirst board by July 1, 2004;
- (3) requiring a nonprofit health service plan to offer health care products in certain markets in Maryland;

- (4) establishing maximum compensation fee limits for board members;
- (5) requiring compensation guidelines for executive compensation to be established and adhered to by the nonprofit health service plan as determined by the Commissioner; and
- (6) prohibiting a conversion or acquisition for five years.

E. Litigation

Prior to the enactment of Chapter 357 on May 22, 2003, the Blue Cross and Blue Shield Association (the “Association”) had notified CareFirst that, in the opinion of the Association, Chapter 357, if enacted, would so extend the scope of the State’s regulatory control over CareFirst that it would automatically terminate the agreement (the “Licensing Agreement”) by which CareFirst holds the license to use the Blue Cross and Blue Shield service marks (the “Marks”). Consequently, immediately upon the signing of Chapter 357, the State of Maryland, through Attorney General Joseph J. Curran, Jr., filed suit in the Circuit Court for Baltimore City to enjoin the Association from terminating the Licensing Agreement. The complaint, which was filed against both the Association and CareFirst, sought a declaration that Chapter 357 did not automatically terminate that Agreement and, thus, deprive CareFirst of the right to use the Marks. That suit was subsequently removed by the Association to the United States District Court for the District of Maryland.

Upon the filing of the State’s suit, the State and CareFirst were notified of an action filed prematurely by the Association on May 21, 2003 in the United States District Court for the Northern District of Illinois, Civil Action No. 03-C-3422. That suit sought a declaration that the Licensing Agreement had been terminated by the passage of Chapter 357 and sought to prohibit CareFirst from continuing to use the Marks and from participating as a member of the Association.

On May 23, 2003, CareFirst filed Civil Action No. JFM 03-1521 in the United States District Court for the District of Maryland against officers of the State, including the Governor, the President of the Senate, the Speaker of the House and the Commissioner, as well as the Insurance Commissioners of the State of Delaware and of the District of Columbia. The CareFirst suit challenged the constitutionality of Chapter 357 and sought to enjoin the State from enforcing it. In addition, the CareFirst suit took the position that directives contained in Orders issued by the Delaware Insurance Commissioner and the District of Columbia Insurance Commissioner were in conflict with the directives of Chapter 357 and asked the District Court to relieve CareFirst of the obligation to comply with that law.

F. Consent Order and Judgment

By consent, on May 23, 2003, the United States District Court stayed all pending litigation, enjoined the Association from treating the Licensing Agreement as terminated, and enjoined the State from enforcing Chapter 357 for a period of eleven days in order to permit the parties to attempt to reach a universal resolution of the issues raised in the litigation. Lengthy negotiations were undertaken and, on June 6, 2003, a final resolution was reached among the State, the Association and CareFirst. The terms of that resolution are embodied in the Consent Order and Judgment executed by the State and the Association and entered by the Court on June 6, 2003. A copy of the Court Order and Judgment and a summary are attached hereto as Exhibits 1 and 2.

The Consent Order and Judgment restored CareFirst's license to use the Marks and its status as a member of the Association. The Order and Judgment also made three changes to Chapter 357.

First, Chapter 357 added § 14-139(d) to the Insurance Article. That new section required certain nonprofit health service plans to prepare salary guidelines for executives to the Commissioner for approval. Executives would have to be paid within the scope of the approved guidelines. Under the Consent Order and Judgment, the approval of the Commissioner was removed. As revised by virtue of the Consent Order and Judgment, § 14-139(d) requires the following with regard to compensation guidelines:

- The Compensation Committee must establish by June 1, 2004, guidelines as to what constitutes reasonable compensation for executives and officers, based on compensation paid to executives of similar nonprofits.
- The Guidelines do not have to be submitted to the Commissioner for approval and are not subject to his disapproval.
- The Guidelines must be reviewed by the Board annually.
- Officers and executives cannot be paid in excess of the guidelines, and the Commissioner retains the authority to prohibit compensation outside of the guidelines.
- The Commissioner retains the authority to assure that guidelines are developed, that they are developed in the manner required by the statute, and that the guidelines are implemented and followed.

Second, Chapter 357 required the removal and replacement of the twelve directors of CareFirst that represented CareFirst of Maryland, Inc. The Consent Order and Judgment altered the manner in which those twelve directors were removed and replaced. Uncodified § 4 of Chapter 357, as amended, requires the following.

- Recognizes that the terms of all 12 Class II (Maryland) Directors of CareFirst terminate on December 31, 2003.
- Five of the 12 will be replaced on January 1, 2004 by individuals selected by the Nominating Committee provided for in Chapter 357.
- Those five, working with the remaining seven, will select the replacements for those seven from a pool of candidates who are certified by the Nominating Committee according to objective criteria. Those seven will assume office by July 1, 2004.

Finally, Chapter 357 provided at Uncodified § 5 that the terms of the remaining members of the CareFirst board (the "Board") would terminate in March, 2006. That section, which applied only to the directors representing Group Hospital and Medical Services, Inc. ("GHMSI") and Blue Cross and Blue Shield of Delaware ("BCBSD") was removed. The Delaware and the District of Columbia directors' terms will expire in accordance with their normal term limits, which have been limited by Chapter 357 to six years.

III. SUMMARY OF PROPOSED VIOLATIONS AND ACTIONS TO BE TAKEN BY THE INSURANCE COMMISSIONER:

- (1) **Potential Violation:** Operation of CareFirst for profit in violation of §§ 14-110, 14-112, 14-116(d), 14-115(c)(2) and 14-139(a)(1) of the Insurance Article. *Infra.* at 9 - 10, 35 - 38

Actions:

- The Commissioner will issue an Order against CareFirst under §4-113(a)(2) and (b)(1) for the violation of §§ 14-110, 14-112, and 14-116(d) that assesses an appropriate penalty against the company under §4-113(d).
- The Commissioner will issue civil charges against the Chairman of the Board, Daniel J. Altobello, under §14-139(d) for the violation of §§ 14-115(c)(2) and 14-139(a)(1).
- The Commissioner will issue civil charges against William L. Jews, the President and Chief Executive Officer of CareFirst, and David D. Wolf, Executive Vice-President under §14-139(d) for the violation of §§ 14-110, 14-112, 14-116(d) and 14-139(a)(1).

- (2) **Potential Violation:** Corporate mismanagement and wasting or transfer of assets in violation of §§ 14-116, 14-133 and 14-139 of the Insurance Article. *Infra.* at 11 - 12, 38 - 40

Actions:

- The Commissioner will conduct an examination to determine whether losses sustained by CareFirst in its non-risk business resulted from unsound and unsafe business practices.
- The Commissioner will conduct an examination to determine whether Potomac Physicians Group is a controlled affiliate or subsidiary of CareFirst and whether payments made to that group were improper investments.
- The Commissioner will send each of the current directors of CareFirst, and each of the current officers who are in charge of the financial operation of CareFirst, a warning in accordance with §14-116(b).

- (3) **Potential Violation:** Failure of the members of the CareFirst board to comply with their fiduciary obligations under § 14-115(c)(2) of the Insurance Article in connection with development of a conversion strategy, the selection of WellPoint to acquire a converted CareFirst and the approval of the sale terms with WellPoint. *Infra.* at 13 -22, 41, 43 - 44

Action:

- The Commissioner will enforce the terms of Chapter 357 as they relate to the removal and replacement of directors, as modified by the Consent Order and Judgment.

- (4) **Potential Violation:** Making willful misrepresentations regarding the ranking of bidders to the CareFirst Board in violation of §14-139(a)(3) of the Insurance Article. *Infra.* at 18 - 19, 41 - 42

Action:

- The Commissioner will issue civil charges against Mr. Jews and Mr. Wolf under §14-139(d) for the violation of § 14-139(a)(3).

- (5) **Potential Violation:** Failure of CareFirst to secure an independent evaluation of the value of the company before agreeing to a purchase price by WellPoint in violation of § 14-112 of the Insurance Article which incorporated Title 6.5 of the State Government Article. *Infra.* at 21, 43

Action:

- The Commissioner will enforce the terms of Chapter 357 as they relate to the removal and replacement of directors, as modified by the Consent Order and Judgment.
- The Commissioner will issue an Order against CareFirst under §4-113(b)(1) for the violation of §14-112 that assesses an appropriate penalty against the company under §4-113(d).

- (6) **Potential Violation:** Failure of CareFirst to obtain independent community impact and fairness reports on the terms of the Proposed Transaction with WellPoint in violation of §14-112 of the Insurance Article, which incorporates Title 6.5 of the State Government Article. *Infra.* at 23 - 24, 44 - 45

Action:

- The Commissioner will enforce the terms of Chapter 357 as they relate to the removal and replacement of directors, as modified by the Consent Order and Judgment.
- The Commissioner intends to issue an Order under §4-113(b)(1) and will, in lieu of suspending or revoking CareFirst, Inc.'s certificate of authority, assess an appropriate penalty under §4-113(d).

- (7) **Potential Violation:** Mr. Jews' willful misrepresentation of Mr. Neuberger's role during testimony given before Commissioner Larsen in violation of §§14-139(a)(2) of the Insurance Article and his arrangement for the payment of Mr. Neuberger's large legal fees by CareFirst. *Infra.* at 24 - 25, 45 - 46

Action:

- The Commissioner will pursue civil charges against Mr. Jews under §14-139(d) for the violation §14-139(a)(2) and (4).

IV. CONDUCT OF CONCERN AS RAISED BY CONVERSION REPORT¹

This section summarizes key areas of concern identified in the Conversion Report.

¹ All references to page numbers are to the Conversion Report unless otherwise noted.

A. Operation of the Corporation as a For-Profit vs a Nonprofit Entity

(1) CareFirst Exited Medicare, Medicaid and SAAC Programs

The Conversion Report identifies actions taken by CareFirst to exit from certain public programs and SAAC (Substantial Available Affordable Coverage)

- “CareFirst made decisions to exit Medicare, Medicaid and SAAC based on the argument that these were losing money. All of these products involve vulnerable populations of high-risk individuals, the poor or the elderly.” (Page 91)
- “In a December 2001 presentation to the Board, the Chief Financial Officer presented the following 2002 Goal: ‘Target [underwriting margins] in all segments, exit unprofitable segments’ ... To achieve these goals and revenue growth, CareFirst will ‘Increase Premiums 15%’.” (Page 101)
- "In 2001, CareFirst proposed rate increases for especially sick, high-risk individuals in the SAAC program covered by CareFirst which would have increased rates for current subscribers by 50%." (Page 114)

(2) Dissolution of the FreeState HMO

The withdrawal of the FreeState HMO enabled CFMI to improve its book of business.

- “[W]hat was being accomplished through the withdrawal of one CareFirst HMO, FreeState, from the market and the routing of “preferable” business to another CareFirst HMO, BlueChoice, was the shedding of the less healthy FreeState members out of the medically underwritten pool. Although FreeState was “withdrawing”, an affiliated HMO owned by CareFirst was maintaining a full presence in the market but accepting “only” healthy FreeState members.” (Page 103)
- “This action, it was argued, would have enabled CareFirst to be more “competitive” by having a book of business with healthier, lower cost individuals. However, this business goal was achieved at the expense of less healthy, FreeState HMO members.” (Page 103)
- “This episode illustrated how the ‘profitability’ of BlueChoice outweighed the significant negative consequences to thousands

of FreeState enrollees who were non-renewed...It is hard to imagine a more profit-oriented action taken at the expense of a relatively small but vulnerable population of sicker CareFirst members.” (Page 103)

- “CareFirst’s withdrawal of the FreeState HMO, and the subsequent requirement that its insureds undergo medical underwriting, forcing several thousand former FreeState members into Maryland’s high-risk program, illustrate the point. The record suggests it is characteristic of for-profit entities to focus on achieving profitability on a product by product basis.” (Page 202)

(3) Additional For-Profit Strategies

The Conversion Report identifies conduct by the Board and management of CareFirst that is indicative of operating for-profit.

- "The Board of Directors did not consider in any meaningful way the implications of the strategic plan on the mission of the Company as a nonprofit health service plan . . .," (Page 110)
- “Mr. Altobello stated ‘To me [CareFirst is] not really nonprofit.’” (Page 100)
- “In the October 1999 Board meetings, Mr. Jews indicates that CareFirst was ‘evolving into a new company’, was ‘not the insurer of last resort’ and was ‘more profit oriented.’ The company was ‘seeking profitable business; exiting unprofitable segments.’” (Page 100)
- “From 1997 to the present, CareFirst management retreated from, and ultimately abandoned, its mission as articulated in the Articles of Incorporation and assumed all the operating characteristics and corporate goals and mission of a for-profit company.” (Page 111)
- “The Board did not question the action by management to abandon the corporate mission and took no action to prevent it.” (Page 111)

B. Soundness of Fiscal Management of the Corporation

(1) Treatment of Non-Risk Business by CareFirst

The Conversion Report identifies several concerns with respect to the management of non-risk business by CFMI.

- "Mr. Chaney [CFO of CareFirst] explained that although CFMI knew there would be some losses on [non-risk accounts]:

A significant piece of that non-risk business are governmental accounts [with] which we had long term relationships. Municipalities including county, city and state, it's important for us to maintain those relationships." (Page 90)

- "CareFirst has frequently blamed its participation in Medicare and Medicaid, mandated benefits, and inadequate rate increases as the cause of the Maryland plan's troubling weaknesses. Yet the \$24 million loss on non-risk business in 2001 far exceeds even the largest amount of loss for either Medicare or Medicaid in any year CFMI participated in either of those two programs before it exited both." (Page 90)
- "Non-risk business is not subject to state mandated benefit laws, so the General Assembly cannot be the cause. It is not subject to oversight by the Insurance Commission; so inadequate rate approvals cannot be blamed. It is not a federal or state program [Medicare or Medicaid], so inadequate reimbursement cannot be blamed. This loss is solely the result of management activity and decision-making, and as such, can only be attributed to management performance." (Page 91)
- "In 2001, CFMI lost \$24.1 million on its "non-risk" business—business for which it does not assume insurance risk but rather administers claims and provides other service for a negotiated fee from the account it is servicing. CareFirst failed to negotiate a fee that covered its expenses. If the business had been priced at a break-even level, the net underwriting gain reported by CFMI of \$43.4 million (statutory) would have increased by \$19.6 million. This loss is disclosed in material filed with the MIA but is not contained in public statements regarding CareFirst's financial condition such as press releases and pre-filed testimony." (Page 109)

- "Since 1999 CFMI and its subsidiaries have sustained tens of millions of dollars in losses for reasons related to management decisions and action or inaction, rather than the reasons cited publicly by management, such as mandated benefits and inadequate rate approvals or reimbursement from the federal or state governments." (Page 109)

(2) Subsidization of Potomac Physicians, P.A. by CareFirst

The Conversion Report identifies the relationship between CFMI and Potomac Physicians as a concern.

- "The ownership structure of Potomac in relation to CFS [a subsidiary of CFMI] is unclear. It is considered a 'controlled affiliate.'" (Page 92)
- "Mr. Chaney conceded that some of Potomac's losses were incurred in serving the members of other health plans and therefore CareFirst was subsidizing the care of other health plans." (Page 92)
- "Business arrangements in which FreeState funds the losses incurred by two separate physician groups, one of which is not owned by FreeState, caused tens of millions of dollars in losses for FreeState just in 2000 and 2001. In 2000, FreeState subsidized Potomac Physicians, P.A. losses in an amount of \$21 million, and subsidized \$13.9 million in 2001. FreeState subsidized the losses of Patuxent Medical Group for \$12.2 million. These business arrangements are not set forth in any documents provided to the MIA, notwithstanding the MIA's request for copies and additional requests that oral agreements be reduced to writing." (Page 109)
- "Because the agreement with Potomac Physicians, P.A. requires FreeState to subsidize all losses for the group, and the group sees patients on behalf of other health plans in addition to CareFirst, CareFirst is subsidizing losses incurred by the physician group that the group incurs for treating patients insured by other health plans rather than CareFirst. While CareFirst estimated that this number was small in 2000 and 2001, and could be larger in 2002 and beyond, it asserted it could not determine how much it was subsidizing the losses arising from treatment of the customers of its competitors." (Page 109)

(3) Lack of Oversight by the Board

The Conversion Report concluded that the Board did not exercise "due diligence", in part, because it accepted, without independent analysis, actions or positions articulated by management that were significant to the operation of the plan.

- "The Board has accepted the public explanations offered by management, even though information filed with the MIA and available to the Board does not support the assertions of management regarding the reasons for the losses incurred by CFMI and its subsidiaries. The Board took no action to determine independently why CF[M]I's financial performance was weaker than the other CareFirst plans in light of the fact that CFMI received over \$100 million in net subsidies from the State for the period 1997 – 2001." (Page 109)
- "The Board did not question the action by management to abandon the corporate mission and took no action to prevent it." (Page 111)
- "One final area where the Board failed to discharge its duty of care is that of the financial oversight of the company... the Company has in many respects prospered in spite of both huge losses attributable to management decisions and perhaps because of the generous State subsidies that its competitors do not receive. There is no evidence that the Board has held management accountable in any particular way for these events, based on a review of the Compensation Committee minutes and Board materials." (Page 118)
- "It seems clear that the Board completely abdicated its responsibility under §14-115 of the Insurance Article, which requires that 'the business and affairs of a nonprofit health service plan shall be managed under the direction of a board of directors.' This process appears to have been driven by management from beginning to end, and unfortunately, it appears that the interests of management were driving the process." (Page 143)

C. Decision to Convert and to Be Acquired

(1) Risks of Merger

The Conversion Report identifies risks of merger, none of which were considered by the Board or management.

- ". . . Blackstone cited a study by *Business Week* and The Boston Consulting Group on the effect of mergers and shareholders value. Among the findings was the following: Managers did not fully understand the implications of the deal. Often, they envisioned grand synergies that proved illusory or unworkable. They underestimated the costs and logistical nightmares of consolidating the operations of companies with very different cultures. They overestimated cost savings and failed to keep key employees aboard, sales forces selling, and customers happy. These failures to integrate operations after the merger delayed the realization of potential benefits." (Page 79)
- "CareFirst's failure to consider the possibility that by merging it would create diseconomies of scale rather than economies of scale – "negative synergies" rather than "synergies" – is particularly noteworthy in view of the substantial body of literature demonstrating that large mergers are likely to have adverse consequences for shareholders as well as others." (Pages 79-80)
- "The Board's apparent failure to consider the possibility that a merger could create inefficiencies rather than efficiencies is also noteworthy because of the difficulty Aetna had in integrating Prudential's health care business after it acquired it and CareFirst's knowledge of that difficulty. In fact, in it[s] presentation to Standard & Poor's CareFirst emphasizes how the Aetna-Prudential acquisition has caused Aetna to become more inefficient, and argues that that acquisition has created a competitive advantage for CareFirst." (Page 80)
- "In considering the strategic plan that led to the Proposed Transaction, the Board failed to consider that the State and Federal antitrust laws potentially created a significant barrier to any in-market acquisitions because of CareFirst's dominant market share. Yet capital for defensive and offensive acquisitions were a significant component of the strategy identified by Accenture and management." (Page 105)
- "In considering the strategic plan that led to the proposed acquisition, the Board failed to consider that, while there were possible benefits associated with a merger or acquisition, there are also risks associated with that strategy." (Page 105)

- "While increased scale may have *potential* benefits, empirical evidence reviewed by Blackstone does not show a clear relationship between scale and operational efficiencies. Other analysis suggests there is no correlation between scale and efficiency." (Page 106)

(2) Objectives of Prior Business Combinations

The Conversion Report states that CareFirst did not consider its experience from prior business combinations.

- "CareFirst attempted to engage in a conversion in 1995 in its attempt to establish the FreeState HMO as a stock company. This effort was disapproved by the Insurance Commissioner. CareFirst of Maryland cited a need for access to capital as the reason for that effort." (Page 104)
- "Expansion efforts have been implemented through the business combinations of CareFirst of Maryland, GHMSI, and the Delaware BlueCross/BlueShield Plan. The stated reasons for the business combinations were to enable the combined companies to better compete through efficiencies gained from larger scale. The Company has asserted that these combinations have resulted in efficiencies for CareFirst generally, and for the Maryland plan in particular." (Page 104)
- "Some of the most important goals of the business combination, as articulated by CareFirst management in support of the business combination between the District of Columbia and Maryland plans, have not yet been achieved and are behind schedule." (Page 104)

(3) Case for Change

The Conversion Report expresses concern regarding CareFirst's stated "Case for Change".

- "Accenture, in conjunction with management, estimated a significant shortfall in CareFirst's ability to make needed capital investments in the long term, in order to stay competitive. The majority of the capital shortfall identified by Accenture was for mergers and acquisitions and a lesser amount was for investments in technology, e-commerce, new products, and other capital expenditures." (Page 104)

- “In considering the adoption of the strategic plan and goals, the Board was not presented with a specific list of proposed capital expenditures that could not be implemented, or which were delayed, because of the lack of access to capital.” (Page 107)
- "In 2001, CareFirst management presented information to the Board and Standard & Poor's implying that CareFirst was making significant progress in investments in e-commerce and information technology. These presentations to the Board and Standard & Poor's contained no suggestion that progress in these areas was impeded by a lack of access to capital." (Page 107)
- “CSFB’s report casts doubts on management’s claims made at the time – that the Company needed additional capital to invest in e-commerce and information technology. In essence CareFirst’s own advisor provided documents to the Board that showed that, in fact, but for spending on mergers, CareFirst had enough capital to satisfy its requirements. There is no evidence that the Board took note that some claims by management were being called into question by its own advisors.” (Page 116)
- "If one considers the information available to the Board relating to capital expenditures, coupled with reasonably available information about which the Board should have inquired, the diligence of the Board was sorely lacking." (Page 117)

(4) Value of Nonprofit Mission

The Conversion Report states that CareFirst failed to consider its nonprofit mission as part of its strategic plan.

- “While the board was advised early in the process that one way to access capital was to convert to a for-profit BlueCross BlueShield plan as some plans had done, the Board did not determine why other similarly situated nonprofit BlueCross BlueShield plans did not view the lack of access to capital markets as a compelling reason to engage in a business combination such as a conversion.” (Page 107)
- "In assessing the advantages and disadvantages of maintaining the status quo, the Board did not consider the nonprofit mission of the company to be an advantage or disadvantage. The Board

largely focused on the impact that the nonprofit status had on the company's ability to raise capital." (Page 110)

- "Highmark, the only not-for-profit plan even considered as a partner for CareFirst, was ultimately excluded from consideration because it has not converted to a for-profit company." (Page 110)
- "The CareFirst RFP [Request for Proposal] does not reflect any consideration by the Board regarding how the Company's mission, as reflected in its Articles of Incorporation, would be impacted by the contemplated conversion, or that it was even considered in the strategic planning process." (Page 110)
- "The Board of Directors did not consider in any meaningful way the implications of the strategic plan on the mission of the Company as a nonprofit health service plan" (Page 110)
- "The Board did not consider that the mission of the company as set out in the Article[s] of Incorporations constrained their decisions regarding the corporate form of the company or options being considered. CareFirst's nonprofit status played a role in the decision making only to the extent that the Board understood there would be heightened public scrutiny of the decision." (Pages 110-111)

D. Selection of Conversion Partner

(1) Auction Process

The Conversion Report identifies many reasons the "auction" was flawed.

- "It is clear from the record that the auction was not a true auction, at least for the price component...the two bidders were not pitched against each other in an effort to extract from each the highest price each was willing to pay ... The resulting "tie" excused the board from having to engage in the more difficult task of balancing its duty of getting "fair value" with the other objectives it sought to achieve and the other factors it felt were important. Mr. Wolf, in his deposition, conceded that it was a goal in this transaction to get the purchase price of the two bidders to be close, and that similar bides made comparison of nonprice issues easier." (Page 122)

- Mr. Jews testified that “CareFirst was relying on the regulatory process to ultimately set the fair value of the company.” (Page 122)
- "The fact that CareFirst never received a formal valuation of the Company by CSFB before the bidding began lends further credence to the view that the process was flawed and possibl[y] designed to establish price parity to facilitate selection on nonprice issues.” (Page 123)
- “Although Highmark was originally considered as a merger partner, it was excluded from final consideration because it was not a for-profit company.” (Page 139)
- "[T]he auction that was conducted by CareFirst was flawed in many respects. The most notable flaw was CareFirst’s failure to vigorously seek the highest price from [Trigon and WellPoint]. The evidence is clear that the auction was designed to end in a tie, and that non-price factors were the main subject of negotiation ... the evidence is also clear that CareFirst believed it could rely on the regulatory process to set the fair value of the company.” (Page 185)

(2) **Ranking of Critical Factors**

The Conversion Report examines the ranking of bidders during the selection process.

- “The prevailing winds shifted over time and Trigon through February, March and April fell more clearly into disfavor with CareFirst management. It was during this period that CareFirst management performed a complete turn of 180 degrees and now what had once been perceived as significant advantages with Trigon, such as geographic synergies, were now viewed as colossal liabilities. But the evidence suggests that factors relating to Mr. Jews’ personal relations with Mr. Snead and his perception of Trigon’s credibility are more likely to have been the cause of the lack of preference tha[n] some of the reasons articulated.” (Page 121)
- “Representations by CareFirst’s CEO to the Board in April 2001, that a deal with Trigon would result in 2000 jobs being lost, were not supported by staff analysis, and contradicted earlier assessments by the Company and its advisors. These estimates were not credible and were most likely used to justify

a recommendation that WellPoint be selected as the preferred partner.” (Page 134)

- “A critical analysis of the content and timing of [CSFB’s and management’s] rankings, coupled with the testimony received from the individuals involved reveal a troubling pattern of significant inconsistencies. As the findings of fact illustrate, factors which were emphasized in one set of circumstances or at a given point in time in the negotiations are later viewed with much less significance. The net effect of these many, and in some cases major, inconsistencies is to cast doubt on the credibility of the reasons offered by CareFirst for WellPoint’s superiority.” (Page 139)

(3) Treatment of Bidders

The Conversion Report states that Trigon and WellPoint were not treated the same.

- “The testimony from WellPoint and Trigon reflected a material difference in the manner [in] which the two bidders were treated on the issue of price. WellPoint’s investment bankers testified that they were given specific “guidance” that its price was too low. Trigon officers testified that not only was Trigon never asked to increase its price, but they were rebuffed when they inquired of CSFB if Trigon needed to increase its price. Although CareFirst and [CSFB] dispute that they ever discouraged Trigon from increasing its price, they admit that they never asked Trigon to increase its initial offer.” (Page 51)
- “Mr. Altobello cited [downside protection] as a key distinction between the offers and testified that Trigon’s offer would have required CareFirst to bear the risk if Trigon stock dropped substantially ... According to the CareFirst Board minutes, Trigon offered to provide protection that was acceptable to CareFirst. Mr. Nolan of Trigon confirmed this in his deposition.” (Page 141)
- “[D]etailed analysis of the reasons offered by CareFirst in support of its selection leads to the unfortunate conclusion that inappropriate factors played a role in the selection of WellPoint, and that, in permitting these factors to play such a role, the Board breached its duty of care and loyalty.” (Page 142)

- “The double standard the Board applied in evaluating the bids can be seen in yet another area...WellPoint required indemnification against the potential that the IRS would issue an unfavorable ruling on the tax consequences of the deal ... There is no evidence that the Board ever debated whether this condition is more or less risky to the deal that the conditions sought by Trigon to which CareFirst objected, such as the request for the timely initiation of hearings on the deal. Yet if the Board had been weighing seriously the pros and cons of the deal on the factors stated, such an analysis should have occurred.” (Page 142)

(4) Additional Concerns with Selection Process

The Conversion Report identifies other concerns regarding the selection of WellPoint.

- "Trigon and WellPoint both offered "downside protection," and although there were suggestions that WellPoint's proposal was materially better, Trigon's was viewed by CareFirst as "acceptable." In any event, no effort was made to quantify the difference in value attributable to these provisions, and therefore CareFirst management and consultants did not place themselves in a position to evaluate whether a higher offer by Trigon (which seems to have been available for the asking) would have offered greater total value, even if WellPoint offered greater such protection." (Page 138)
- "The auction was designed to obtain purchase price parity, which in turn facilitated the selection of the winning bidder on nonprice factors." (Page 138)
- "The [selection] process “was dominated by the use of selection factors that largely advanced the interests of the management team, rather than the company or more particularly its insureds.” (Page 200)
- “Trigon was not selected in part because CareFirst’s CEO would not have assumed the role of Chairman and CEO of the merged Trigon/CareFirst entity, a role he desired.” (Page 200)
- “While in the course of this proceeding the company offered a number of reasons why WellPoint was the superior bidder, upon closer examination the vast majority of the reason offered have little merit or are specious. In some cases, CareFirst has in

fact misrepresented the nature of the offers from the two bidders.” (Page 200)

- "There is no evidence that in all its deliberations over the bidders, the Board took any steps to determine whether Trigon or WellPoint would negatively impact policyholders or access of availability in Maryland.” (Page 203)

E. Terms of Proposed Conversion

(1) Valuation

The Conversion Report indicates in several places that CareFirst did not place the appropriate importance on the need for a valuation of the company or on the need to get the best price for the company.

- “[O]ne of the Board members requested that a valuation be done in January 2001, before the formal bid[] letters were issued. This would give the Board members a benchmark against which to compare the bids.” (Page 123)
- “The lack of a meaningful valuation *before* the bidding began prevented the Board from knowing in advance what price could be viewed as fair.” (Page 124)
- “CareFirst fail[ed] to vigorously seek the highest price from the two competing bidders.” (Page 185)
- “The evidence is clear that the auction was designed to end in a tie, and that non-price factors were the main subject of negotiation in the discussion with potential bidders.” (Page 185)

(2) Inurement and Retention Bonuses

The Conversion Report identifies several examples of CareFirst’s insistence on management bonuses.

- “Throughout the entire negotiation process and leading up to the renegotiation of the merger agreement...CareFirst management and the Board has been insistent on the notion that management receive large payouts from the deal.” (Page 129)
- “While it may certainly be true that the Board discussed that there would be public relations problems with the bonuses as

constituted, there is simply not a shred of evidence that the concept of inurement or its application to this deal were analyzed by the Board or its lawyers or discussed.” (Page 132)

- “It is ... hard to believe that those in positions of responsibility at CareFirst involved in this transaction [were] unaware of the law and would not have flagged it for the Board. Mr. Wolf testified that he was aware of it. CareFirst was involved in the development and passage of the conversion statute in 1998.” (Page 132)
- “Mr. Schaeffer made clear that it was only through the agreement to pay the executive bonuses that WellPoint [would] be granted the privilege of purchasing CareFirst.” (Page 133)
- “The CareFirst Board viewed the interest of the executives as paramount to the corporation. This was impermissible and a violation of their fiduciary duties to the corporation.” (Page 133)
- “The Board never asked for, and never received, legal advice as to whether the merger incentives and severance payments constituted improper inurement under the conversion statute. The Board had reason to know that the payments could be improper under the statute, and that they were inconsistent with prior rulings of the MIA regarding severance payments paid for by nonprofit health service plans.” (Page 138)
- “The evidence is strong that WellPoint’s ultimate agreement to the merger incentives played a significant role in its selection of the prevailing bidder.” (Page 142)
- “The Board’s unyielding defense of these bonuses, particularly when informed they could result in the disapproval of the proposed conversion, is yet another confirmation that this deal was about money for the executives. Even after the merger incentives were renegotiated, bonuses were still attached to the deal.” (Page 142)
- “[T]he Board’s failure to at least seek a determination that the bonuses were proper under the conversion statute amounts to willful neglect.” (Page 143)

F. Conflicts of Interest

(1) Credit Suisse First Boston (CSFB)

The Conversion Report states that the Board failed to appreciate possible conflicts of interest on the part of its investment banker, CSFB.

- “The Board relied on the CSFB Valuation Analysis and the CSFB Fairness Opinion in approving the Proposed Transaction. In doing so, it does not appear that the Board appreciated or considered the fact that actual or apparent conflicts of interest existed in connection with CSFB’s issuance of either of these Opinions.” (Page 148)
- “CSFB’s compensation for its role in the negotiation of the WellPoint transaction included a percentage of the purchase price if the merger is consummated. This method of compensation was intended to give CSFB an incentive to bring a transaction to consummation.” (Page 148)
- “CSFB represented CareFirst in the negotiation of the agreement with WellPoint. A question naturally arises as to CSFB’s ability to supply an independent and unbiased opinion as to the fairness of an agreement that it produced. There exists an inherent conflict in assessing the fairness of one’s own product. The Board, however does not appear to have appreciated or acknowledged that inherent conflict and, thus, never considered the potential impact of such a conflict.” (Page 148)
- “One must question the reasonableness of CareFirst’s decision to accept and rely upon an opinion from CSFB on the fairness of the purchase price, when the bulk of CSFB’s compensation depended upon the merger with WellPoint being consummated, which in turn depended upon an opinion that the proposed purchase price was fair.” (Page 149)
- “The Board, however, appears to have given no consideration to the potential impact of the compensation arrangement on the independence of CSFB’s Fairness Evaluation.” (Page 149)
- “CSFB has acknowledged that it is a large trader in WellPoint stock, a circumstance that again raises a question as to CSFB’s ability to provide an independent and unbiased opinion as to the fairness of the Proposed Transaction, including an unbiased analysis of the value of CareFirst.” (Page 150)

(2) Accenture

The Conversion Report states that the Board failed to appreciate possible conflicts of interest on the part of Accenture.

- “The same individual who authored the strategic plan and the Case for Change, Mr. Maribito, authored the Community Impact Analysis.” (Page 150)
- “The failure of the Board to acknowledge and address the conflicts that were inherent in Accenture’s performance of the Community Impact Analysis again represents a serious flaw in the decision making process. The failure of the Board to appreciate and account for such conflicts supports the conclusion that the Proposed Transaction is not in the public interest.” (Page 151)
- “There is no indication that the Board ever considered whether Accenture might have a conflict and, thus, be unable to provide an independent evaluation.” (Page 151)

(3) Attorney Client Relationship

The Conversion Report condemns the participation of personal counsel on negotiations with bidders.

- “Mr. Neuberger was involved in discussions and negotiations relating [to] the selection of a merger partner. Although Mr. Neuberger never appeared before the Board, he was a significant player behind the scenes, meeting with CareFirst officers, counsel, investment bankers, and potential merger partners on a routine basis.” (Page 145)
- “In 1998 and 1999, Mr. Neuberger represented Mr. Jews personally in the negotiation and drafting of his employment agreement and compensation package with CareFirst.” (Page 145)
- “Mr. Neuberger also represented Mr. Wolf in 1996 and 1997 in connection with the negotiation and drafting of his employment agreement with CareFirst.” (Page 145)
- “[I]t is clear from Mr. Neuberger’s billing records that Mr. Neuberger[] played a significant role in the analysis, and comparison of the executive compensation for Mr. Jews and other CareFirst executives.” (Page 145)

- "Mr. Jews testified in his deposition that all of the work done by Mr. Neuberger in connection with the Proposed Transaction was done as counsel for CareFirst. According to Mr. Jews, Mr. Neuberger was not engaged to act on behalf of any individual officer." (Page 145)
- "Mr. Altobello, the Chairman of CareFirst's Board, testified that he was aware that Mr. Neuberger had given Mr. Jews 'some advice' on the Proposed Transaction. Mr. Altobello did not think that Mr. Neuberger was representing CareFirst in connection with the giving of that advice and testified that Mr. Neuberger did not represent the CareFirst Board." (Page 146)
- "The interests of CareFirst and the interests of Mr. Jews and the other CareFirst executives were divergent on the issue of compensation." (Page 146)
- "These facts clearly support the conclusion that Mr. Neuberger appeared to have a conflict of interest in his representation of CareFirst." (Page 146)
- "The fact that CareFirst had retained the services of Mr. Muedeking to advise CareFirst, the corporation, on issues relating to compensation further supports the conclusion that Mr. Neuberger was representing the interests of the executives. The Board Chair did not believe he [Mr. Neuberger] represented the corporation, although the billing records show Mr. Neuberger was paid by the corporation." (Page 146)
- Mr. Neuberger's representation of CareFirst, " ... his almost daily contact with CareFirst management during key periods, his in-depth involvement in the development and negotiation of the outrageous executive compensation packages which fueled the public outcry against the Proposed Transaction, and his frequent contacts and negotiations with representatives of Trigon and WellPoint were never disclosed to, or authorized by, the Board. The Board apparently had no idea that the discussions between CareFirst and Trigon, at least as to executive compensation, were being guided and shaped by an attorney who had previously represented Mr. Jews in negotiations against the Board, and who may have owed his loyalty primarily to Mr. Jews. " (Page 147)

V. PERTINENT STATUTORY PROVISIONS²

Chapter 357 requires the MIA to determine whether any conduct identified in the Conversion Report violated any provision of the Insurance Article, including §§ 14-116 and 14-139, as it existed prior to the passage of the bills. Section IV of this Legislative Report identifies the categories of conduct described in the Conversion Report that may have violated provisions of the Insurance Article. This Section: a) identifies the specific statutes that may have been violated; b) sets forth the legal standards that the Administration will apply in determining whether the conduct in question violated those statutes; and c) identifies the statutory remedies generally available under the Insurance Article for the violation of those statutes.

A complete listing of the provisions of the Insurance Article applicable to nonprofit health service plans is attached hereto as an Exhibit 3. Of those statutory provisions, the MIA has concluded that the statutory provisions that may have been violated by the conduct described in Section III are: §§ 14-112, 14-115, 14-116, 14-133, and 14-139. In addition, the MIA has reviewed the conduct of CareFirst in relation to the NonProfit Acquisition Law, which is codified at § 6.5-101 *et seq.* of the State Government Article, because the requisites of that provision are pertinent to the question of whether the directors of CareFirst violated the fiduciary duties set forth in § 14-115 and because compliance with that Title is required under § 14-112.

A. Statutes That Establish Pertinent Substantive Standards of Conduct for Nonprofit Health Service Plans and the Individuals Who Control the Operations of Such Plans

The Insurance Article establishes substantive standards of conduct for nonprofit health service plans and the individuals who operate such plans. Those standards are established in two ways. Statutes such as §§ 14-115 and 14-139 contain clear directives in the form of express mandates or prohibitions. Other statutes, such as §§ 14-112 and 14-116, contain implied directives by punishing certain defined conduct.

(1) Section 14-112 of the Insurance Article

Nonprofit health service plans are governed and regulated primarily by the provisions of Title 14 of the Insurance Article. In order to qualify for, and maintain, a certificate of authority as a nonprofit health service plan, an entity must establish to the satisfaction of the Commissioner that the entity “has been organized in good faith for the purpose of establishing, maintaining, and operating a nonprofit health service plan.” *See, e.g.*, §§ 14-110, 4-113(a)(2). The Commissioner has the authority to revoke the certificate of authority and institute delinquency proceedings if “[t]he Commissioner has reason to believe that the corporation . . . is being operated for profit.” § 14-112(2).

² All statutory citations in this section refer to the Insurance Article unless otherwise noted.

Implicit in the requirements for licensure set forth in § 14-110 and the consequences identified in § 14-112, is the legislative directive that a nonprofit health service plan not be operated for profit. That implicit directive was made explicit as of June 1, 2002, when the General Assembly added to § 14-116 an express prohibition against operating a nonprofit health service plan for profit. Section 14-116(d) states:

A nonprofit health service plan formed or organized under the laws of this State may not:

* * *

(2) alter its structure, operations or affiliations, if such alteration results in the for-profit activities of the plan becoming so substantial that the Insurance Commissioner determines that the purpose of the nonprofit health service plan may no longer be characterized as operating a nonprofit health service plan.

The Insurance Article does not define the terms "nonprofit" or "for profit." Nor does the Insurance Article describe what constitutes the operation of a plan "for profit" in violation of §§ 14-112 or 14-116(d). It is necessary, therefore, to identify the operational attributes of a for profit entity that distinguish it from a nonprofit entity.

The defining characteristic of a nonprofit organization is that it is barred from distributing profits, or net earnings, to individuals who exercise control over it, such as its directors, officers, or members. This does not mean that a nonprofit organization is prohibited from earning a profit. Rather, it is only the distribution of profits that is prohibited; net income, if any, must be retained and devoted to the purposes for which the organization was formed.

Henry B. Hansmann, *Reforming Nonprofit Corporation Law*, 129 U.Pa.L.Rev. 497, 501 (1981) (quoted in *O'Donnell v Sardegna*, 336 MD. 18, 40 (1994)).³

Thus, a key distinction between a nonprofit and a for-profit entity is the use to which profit is put. The excess revenue of a nonprofit may only be used to carry out the purpose for which the corporation was formed, whereas the excess revenue of a for profit may be distributed to the individuals who own or operate it.

Inherent in the rule against distributions is a second critical distinction between a nonprofit and a for profit entity: the nature of the purpose for which the entity is formed. While a nonprofit may be formed for any lawful purpose, such entities generally are formed for a charitable, a public, or a beneficent purpose. That is, they are not formed to acquire wealth for distribution to corporate owners/operators, but

³ Operating a nonprofit health service plan so as to accumulate an excess of returns over expenditures is not prohibited by the Insurance Article. Nonprofit health service plans are both allowed and required to accumulate and maintain such excesses in the form of reserves and surplus. See § 14-117.

to promote some mutual goal of the members or to effect a public or charitable benefit. See, Hansmann at 503 – 504; Denise Ping Lee, *The Business Judgment Rule: Should It Protect Nonprofit Directors?* 103 Colum. L. Rev. 925, 928-931 (2003); *Summers v. Cherokee Children & Family Services, Inc.*, 2002 WL 31126636 *6 (Tenn. 2002). Thus, a “basic question to be asked in determining whether a corporation is ‘nonprofit’ is whether the corporation is being exploited for direct monetary gain.” 19 William Meade Fletcher, *et al.*, *Fletcher Cyclopedia of the Law of Private Corporations* § 68.05 (Perm. ed. 1994).

A final, critical distinction between nonprofit and for profit entities is that “nonprofits are distinguished by ‘the absence of stock or other indicia of ownership that give their owners a simultaneous share in both profits and control’.” Lee, *supra* at 931 (quoting Henry B. Hansmann, *The Role of Nonprofit Enterprise*, 89 Yale L.J. 835, 838 (1980)). The “owners” of nonprofits do not act for or in their own interest, but on behalf of the purposes for which the nonprofit was established.

In summary, a nonprofit differs from a for profit entity in at least three critical aspects: a) nonprofits generally are formed for a public, beneficent purpose and not for anyone’s direct monetary gain; b) the “owners” of nonprofits do not act for their own pecuniary interests, but in support of the purpose for which the nonprofit was formed; and c) the net income of a nonprofit may not inure to the benefit of the individuals who run it, but must be used to further the purposes of the organization. It follows, therefore, that a nonprofit is being operated “for profit” if: a) the entity is being operated for direct monetary gain and not in pursuit of its public, beneficent purposes; b) the “owners”/operators of the entity are acting in their own interests and not in support of the purposes for which the entity was formed; or c) the net income or assets of the entity inure to the benefit of the individuals who run it.

(2) Section 14-115 of the Insurance Article

Section 14-115 addresses the management of a nonprofit health service plan by its board of directors. That section provides:

- (1) The business and affairs of a nonprofit health service plan shall be managed under the direction of a board of directors.
- (2) The board and its individual members are fiduciaries and shall act:
 - (i) in good faith;
 - (ii) in a manner that is reasonably believed to be in the best interest of the corporation; and

- (iii) with the care that an ordinarily prudent person in a like position would use under similar circumstances.

The Conversion Report sets forth the legal standards that govern the analysis of whether the directors of CareFirst met their statutory obligations under § 14-115. *See* Conversion Report at 68 – 75. Those are the same standards that will be applied in this Legislative Report.

(3) Section 14-116 of the Insurance Article

An "unsound or unsafe business practice" is defined as:

- (a) ... a business practice that:
 - (i) is detrimental to the financial condition of a nonprofit health service plan and does not conform to sound industry practice; or
 - (ii) impairs the ability of a nonprofit health service plan to pay subscriber benefits.

Section 14-116 subjects an officer or director who engages in an "unsound or unsafe business practice" to disciplinary action by the Commissioner. The articulation of a negative consequence for engaging in such practices clearly reflects the legislative intent to prohibit such practices by officers and directors of nonprofit health service plans.

(4) Section § 14-133 of the Insurance Article

The Insurance Article regulates the circumstances in which a nonprofit health service plan may invest in or acquire an affiliate or subsidiary. Section 14-133(a) defines affiliates and subsidiaries as, in essence, entities controlled, directly or indirectly, by the plan.

Under § 14-133(b),

A nonprofit health service plan may not invest in or otherwise acquire an affiliate or subsidiary unless:

- (1) the affiliate or subsidiary is licensed by the Commissioner; or
- (2) (i) the affiliate or subsidiary is majority owned by the nonprofit health service plan; and

- (ii) the business of the affiliate or subsidiary is directly related to the operation of the nonprofit health service plan or the administration of a health benefits program.

In addition, § 14-133(c) provides:

- (1) A nonprofit health service plan shall submit a statement of proposed action to the Commissioner before the plan may:
 - (i) create, acquire, or invest in an affiliate or subsidiary in order to control the affiliate or subsidiary;
 - (ii) alter the structure, organization, purpose, or ownership of the plan or an affiliate or subsidiary of the corporation;
 - (iii) make an investment exceeding \$500,000; or
 - (iv) make an investment in an affiliate or subsidiary.
- (2) The nonprofit health service plan shall file the statement of proposed action required under this subsection at least 60 days before the effective date of the proposed action.
- (3) The nonprofit health service plan may not engage in a proposed action described under paragraph (1)(i) through (iii) of this subsection unless the Commissioner approves the action in writing.

(5) Section 14-139 of the Insurance Article

Section 14-139(a) provides:

An officer, director, or employee of a corporation operating under this subtitle may not:

- (1) willfully violate a provision of this article or a regulation adopted under this article;
- (2) willfully misrepresent or conceal a material fact in a statement, report, record, or communication submitted to the Commissioner;
- (3) willfully misrepresent a material fact to the board of directors;

- (4) misappropriate or fail to account properly for money that belongs to the corporation, an insurer, insurance producer, subscriber, or certificate holder;
- (5) engage in fraudulent or dishonest practices in connection with the provision or administration of a health service plan;
- (6) willfully fail to produce records or allow an examination under § 14-125 of this subtitle; or
- (7) willfully fail to comply with a lawful order of the Commissioner.

The provisions of § 14-139 that are relevant to an analysis of the conduct described in the Conversion Report are (a)(1)-(4) and 6. Each of those provisions prohibits only conduct that is “willful.” The word “willful” is not defined in the Insurance Article. Case law, however, makes it clear that the term is intended to encompass behavior that is intentional, as opposed to negligent or inadvertent. *See Nuger v. Commissioner*, 238 Md. 55, 67 (1965) (stating that “[t]he term 'willful violation' as used in [10-126(a)(1)] clearly means an intentional act of omission or commission”).

While a “willful” violation of a statute necessarily requires an intentional act, it does not also require an intent by the actor to break the law. That is, a willful violation does not include the requirement that the guilty party act with the knowledge that a particular statute exists and that his conduct violates that statute. Maryland courts generally have *not* required proof that a person have the specific intent to violate a law before that person may be found to have “willfully” violated a statute.

As the Court of Appeals noted in *Diebler v. State*, 365 Md. 185, 194 (2001), its cases have “construed ‘willful’ in several different ways,” but “[m]ost of these interpretations, although not all, have . . . requir[ed] only that the act be committed intentionally, rather than through inadvertence.” *Id.* at 195 (citing *Nuger, supra*). In recent cases, both the Court of Appeals and the Court of Special Appeals have concluded that one could “willfully” violate a statute by intentional and deliberate action, regardless of whether one knew that those actions were prohibited. *Id.* at 199 (2001) (under Maryland’s wiretap act, “an interception that is not otherwise specifically authorized is done willfully if it is done intentionally-purposely”); *Chen v. State*, 370 Md. 99, 114 (2002) (finding that “any knowing . . . transportation of unstamped cigarettes” would constitute a violation of statute prohibiting willful transportation of unstamped cigarettes); *Suburban Hospital, Inc. v. Maryland Health Res. Planning Comm’n*, 125 Md. App. 579 (1999) (concluding that “willful” violation of Open Meetings Law required only intentional action, and did not require knowledge that law was being violated).⁴

⁴ This interpretation of “willful” corresponds with the Court’s definition of the term in a number of other contexts which do not involve statutory violations, and which have focused on the deliberate nature of a defendant’s conduct. *See, e.g., Cover v. Taliafarro*, 142 Md. 586 (1923) (stating that the term “willful” “implies a deliberate intention, for which no reasonable excuse can be given, to do or refrain from doing some act which good faith in the performance of some duty required the promisor to do or not to do, as the case may be.”); *Singer Company v. Baltimore Gas & Elec. Co.*, 79 Md. App. 461, 480 (1989) (defining

In summary, in assessing whether conduct by an officer, director or employee of CareFirst violated §§14-139(a)(1), (2), (3), (4), or (6), this Legislative Report will look at whether the conduct was intentional, as opposed to negligent or inadvertent. The MIA will not, however, require a finding that the conduct was intended specifically to violate the law, or performed with conscious disregard of the law, as an element of the violation.

(6) Title 6.5 of the State Government Article

Title 6.5 of the State Government Article governs the acquisition of nonprofit health service plans. The requirements of that Title and the standards to be applied thereunder are detailed in the Conversion Report and will not be repeated herein.

What is critical about Title 6.5 for purposes of this Report are the substantive standards that are imposed on nonprofit health service plans that wish to convert and on the directors of such plans. Section 6.5-201 requires an entity that wishes to convert to for profit status to file an application with the Commissioner that includes a "financial and community impact analysis report from an independent expert or consultant that addresses the criteria in § 6.5-301." Section 6.5-301 addresses the criteria that must be satisfied in order to conclude that a conversion is in the public interest, as well as the mechanisms for determining fair value.

Section 6.5-201 places an affirmative obligation on a nonprofit health service plan that is considering conversion to produce a comprehensive report from an independent expert that addresses the criteria set forth in § 6.5-301. In addition, that same criteria necessarily establishes the considerations that the nonprofit's directors are required to consider in determining whether to convert or to be acquired, in selecting a transferee and in negotiating/approving the terms of transfer. Thus, in connection with a conversion/acquisition, the extent to which a director has fulfilled his fiduciary obligations under § 14-115 must be analyzed with reference to § 6.5-301 of the State Government Article.

In addition, § 14-112(2)(v) authorizes the Commissioner to revoke the certificate of authority of, or place in rehabilitation, a nonprofit health service plan that "has violated the provisions of Title 6.5 of the State Government Article." Hence, nonprofit health service plans are required by the Insurance Article to act in compliance with Title 6.5.

B. Pertinent Statutory Enforcement Mechanisms for Violations of the Pertinent Substantive Standards

The standards imposed on nonprofit health service plans and the individuals who operate those plans are subject to different enforcement mechanisms.

"willful" as "[i]ntending the result which actually comes to pass; designed; intentionally; not accidental or involuntary," quoting *Black's Law Dictionary* 1434 (5th ed. 1979)).

Some of those mechanisms also incorporate generic standards in the context of identifying the circumstances in which the insurer is subject to regulatory action.

(1) Section 4-113 of the Insurance Article

Section 4-113 of the Insurance Article sets forth the bases on which the Commissioner is required or authorized to deny, refuse to renew, suspend or revoke the certificate of authority of an insurer, including a nonprofit health service plan. Section 4-113(d) authorizes the Commissioner to fine an insurer or to order the insurer to make restitution in addition to, or in lieu of, suspending or revoking a certificate of authority.

The Commissioner is required to act under § 4-113(a) under certain circumstances, including a finding that:

- (2) the insurer no longer meets the requirements for the certificate of authority because of a deficiency in assets or any other reason.

The Commissioner has discretion to act under § 4-113(b) under additional circumstances, including a finding that the insurer:

- (1) violates any provision of this article other than one that provides for mandatory denial, refusal to renew, suspension, or revocation for its violation

Sections 4-113(a)(2) and (b)(1) authorize the Commissioner to fine or to take regulatory action against the certificate of a nonprofit health service plan that has violated § 14-112 by operating for profit.

(2) Section 14-112 of the Insurance Article

Section 14-112 expressly authorizes the Commissioner to revoke the certificate of a nonprofit health service plan or to place that plan in rehabilitation or liquidation if the plan is being operated for profit or has violated the provisions of 6.5 of the State Government Article.

(3) Section 14-116 of the Insurance Article

If the Commissioner believes that an officer or director of a nonprofit health service plan has engaged in an unsound or unsafe business practice, the Commissioner is required to send a warning to that individual. If the nonprofit plan is domiciled in Maryland, the Commissioner may remove an officer or director who continues the unsound or unsafe business practice after the warning.

(4) Section 14-133 of the Insurance Article

For a violation of § 14-133, the Insurance Commissioner, under § 14-133(e), is required to order the corporation to file a plan of divestiture or liquidation of the affiliate or subsidiary.

(5) Section 14-139 of the Insurance Article

Violations of § 14-139 are subject to the imposition of a civil penalty. In addition to, or in lieu of, that penalty, the Commissioner may order the individual to make restitution to any person (including a nonprofit health service plan) that has suffered financial injury as a result of the violation.

Section 14-139 expressly provides a remedy for a willful violation or of any provision of the Insurance Article by an officer, director or employee of a nonprofit health service plan. That clearly would include a willful violation of § 14-115 or of any other directive contained in the Insurance Article, including the directives implicit in §§ 14-112 and 14-116.

VI. ANALYSIS OF CONDUCT

This Section of this Legislative Report addresses whether the conduct summarized in Section IV may have violated the statutes identified in Section V, and what action, if any, the MIA intends to take with regard to such potential violations.

As a preliminary matter, it should be noted that the Conversion Report was issued in the context of a quasi-legislative hearing designed to evaluate whether the proposed conversion transaction was in the public interest. Factual findings and legal conclusions made in the Conversion Report, in most instances, permit the MIA to state at this juncture whether there is sufficient cause to believe that violations of the Insurance Article occurred and whether further investigation should be undertaken, a hearing should be scheduled on civil charges, or an order of violation (subject to a hearing request) should be issued.

No action, however, can be taken by the MIA on a possible statutory violation, except in conformity with enforcement provisions that entitle the alleged violators to notice and to the opportunity to be heard at a quasi-judicial hearing on the issue of whether they, in fact, violated the law and, if so, the appropriate consequence for that violation. Since the Commissioner or his designee would serve as the hearing officer in any such proceeding, it would be inappropriate to make actual determinations as to whether violations did in fact occur at this juncture.

Mindful of the role that the Commissioner may be called upon to play at subsequent proceedings, this Legislative Report will, as to each category of conduct identified in Section II, assess: a) whether there is probable cause to believe that a

statutory violation occurred; and b) whether further investigation or further action by the MIA is warranted.

A. Was CareFirst Operated For Profit In Violation of the Insurance Article?

Sections 14-110, 14-112, and 14-116(d) make it clear that an entity that holds a certificate of authority to operate as a nonprofit health service plan may not be operated for profit. As explained in Section IV, a nonprofit health service plan will be deemed to be operated for profit if: a) the plan is being operated for direct monetary gain and not in pursuit of its public, beneficent purposes; b) the individuals managing the entity are acting in their own interests and not in conformity with the purposes for which the entity was formed; or c) the net income or assets of the entity inure to the benefit of the individuals who run it.

CareFirst is a nonprofit health service plan. It does not provide health insurance coverage or other services directly to third parties. Rather, CareFirst was formed to serve as the sole member of other nonprofit health service plans, namely: CFMI, GHMSI and BCBSD. It is those underlying nonprofit plans that actually supply health insurance coverage and related services within their respective geographic areas.

As the sole member of those underlying nonprofit plans, CareFirst controls, and is responsible for, the operation of those entities as nonprofits in accordance with their articulated corporate purposes and missions. Those purposes and missions are essentially the same. CFMI's corporate mission is to "establish, operate and maintain a nonprofit health service plan . . . so that such health care and service may be obtained at a minimum cost and expense." (CFMI Articles of Incorporation) GHMSI was expressly formed by federal charter as a "charitable and benevolent institution" that "shall not be conducted for profit, but shall be conducted for the benefit of [its] certificate holders." (GHMSI Charter) The articulated purpose of BCBSD is to provide health insurance "at reasonable costs," to "promote policies and programs which foster effective health care cost containment," and to "assist individuals in defraying the costs of all types of health services." (BCBSD Articles of Incorporation) Those mission statements each require, essentially, that the plans, consistent with sound fiscal management, be operated in a manner that makes health coverage available to the broadest segment of the public at the most reasonable rates.

Because CareFirst and its three subsidiaries are all nonprofits, they cannot be operated for direct monetary gain, but must be operated in conformity with their corporate missions. Similarly, the individuals who operate CareFirst have no ownership rights in that entity or its assets and, thus, are prohibited from running the corporation for their own economic benefit. Finally, CareFirst may not allow its assets or its profits to inure to the benefit of any of the individuals who run it.

(1) Probable Cause to Believe That CareFirst Was Operated By Its Officers, With the Consent of Its Directors, For Profit

The Conversion Report notes that the Chief Executive Officer and the Chairman of the Board of CareFirst declared that the corporation would be operated for profit. Those declarations, alone, are sufficient to find a probable violation of the Insurance Article in the operation of CareFirst.

In addition, however, the Conversion Report provides examples of business decisions made by CareFirst that were consistent with its declared intent to operate for profit. As noted in Section IV, CareFirst withdrew from the Medicaid and Medicare markets and from the SAAC program on the ground that those programs were not profitable, without exploring alternative means of supplying those markets or subsidizing those products while maintaining the corporation's fiscal soundness. And, most significantly, the Conversion Report concludes that CareFirst gave no real consideration to its nonprofit mission in developing its strategic plan of conversion and acquisition. Indeed, when considering how to broaden its market and expand its access to capital, CareFirst dismissed an affiliation with Highmark out of hand, simply because it was a nonprofit entity.

The withdrawal from markets that represent the most vulnerable and poorly served segments of the population and the lack of consideration of its nonprofit mission in adopting a strategic plan for the company make a prima facie case that the company was operated for profit.

(2) Potential Violations and Actions

a. §§14-112, 14-116 and 4-113 as Applied to the Company

Section 14-112 manifests the legislative intent that a nonprofit health service plan not be operated for profit. That section authorizes the Commissioner to respond to a violation of its directives by revoking a plan's certificate of authority or to place it in rehabilitation. CareFirst may have violated the directives of § 14-112. However, because neither of the remedies authorized by that section would serve the public interest, the MIA will not initiate action against CareFirst for such a violation under that section.

Section 14-116(d), which became effective on June 1, 2002, also prohibits a nonprofit health service plan from altering its operations such that the for-profit activities of the plan become so substantial that it can no longer be characterized as operating as a nonprofit. However, there is no remedy provided in § 14-116 for a violation of that section.

Violations of the Insurance Article by licensees such as CareFirst are subject to regulatory action under §4-113(a) and (b). Those provisions, in

conjunction with § 14-113(d), authorize the Commissioner to revoke or suspend a carrier's certificate of authority or to fine the carrier up to \$125,000.

As noted above, the revocation or suspension of CareFirst's certificate of authority would serve no useful purpose and would be harmful to the public interest. Hence, the MIA will not initiate such action. A penalty, however, is appropriate where a carrier has embarked upon a declared course of corporate conduct that is in direct violation of a clear statutory mandate. The MIA will, therefore, issue an Order under §4-113 (a)(2) and (b)(1) and will, in lieu of suspending or revoking CareFirst's certificate of authority, assess an appropriate penalty under §4-113(d).

b. §§ 14-115 and 14-139 as Applied to Directors

Pursuant to §14-115(c)(1), the operation of a nonprofit is vested in its board of directors. That section recognizes that the directors are fiduciaries and requires that they act: a) “in good faith;” b) “in a manner reasonably believed to be in the best interest of the corporation;” and c) “with the care that an ordinarily prudent person in a like position would use under similar circumstances.” As the Conversion Report concludes, the failure of the directors to operate a nonprofit entity in conformity with its nonprofit mission would be a breach of their fiduciary duties in violation of §14-115(c)(2). Conversion Report at 74-75.

The Conversion Report recognizes that the operation of CareFirst for profit was approved and supported by its board of directors, particularly the Chairman of the Board, Daniel J. Altobello, who specifically declared that CareFirst was no longer a nonprofit. Consequently, as the Conversion Report concludes, there is ample cause to believe that the directors of CareFirst breached their duties of loyalty to CareFirst in violation of § 14-115(c)(2) by allowing it to abandon its corporate purpose in support of a for profit operation.

Prior to the passage of Chapter 357, there was no remedy provided in Title 14 against an individual director for a violation of § 14-115.⁵ The remedy for a violation of that provision is found in § 14-139(a)(1), which prohibits a director from willfully violating a provision of the Insurance Article. Thus, a director who willfully approved any decision that lead to the operation of CareFirst for profit in violation of his fiduciary obligations under § 14-115(c)(2) would be in violation of 14-139. Such a violation would subject the offending director to, among other things, a civil penalty.

The Conversion Report does not analyze whether the conduct of any particular director constituted a willful, rather than a negligent, breach of fiduciary obligation. Nor, with one exception, does the Conversion Report contain any evidence from which the MIA could make even a preliminary finding as to whether or not each or some of the twenty-one members of the board acted willfully. The MIA does

⁵ Chapter 357 makes the violation of § 14-115 an “unsound and unsafe business practice” that subjects an offending director to removal under § 14-116.

not, therefore, based on the Conversion Report, have reason to take action against the individual directors, as individuals.

The one exception is the Chairman, Mr. Altobello, who clearly declared that CareFirst would be operated for profit. That blatant statement of willful intent by the Chairman of the Board does provide a basis on which the MIA may issue civil charges against Mr. Altobello under § 14-139(d) for a violation of § 14-139(a)(1). The MIA, therefore, will issue such charges.

c. § 14-139 as Applied to Officers

It also is a violation of § 14-139(a)(1) for an officer to willfully violate a provision of the Insurance Article. Hence, an officer who willfully caused CareFirst to be operated for profit in violation of §§ 14-110, 14-112, and 14-116 would also be in violation of § 14-139(a)(1).

Based on the information included in the Conversion Report, there is probable cause to believe that the individuals who were in charge of the operation of CareFirst willfully operated the corporation for profit. Specifically, Mr. Jews, the President and Chief Executive Officer, and Mr. Wolf, the Executive Vice President in charge of Strategic Planning, were responsible for the operations of the corporation and the decisions that underlie the conclusion contained in the Conversion Report that the corporation was being operated for profit. Mr. Jews in particular clearly articulated his intent to operate CareFirst for profit. The MIA, therefore, will issue civil charges against Messrs. Jews and Wolf under § 14-139(d) for a violation of § 14-139(a)(1).

B. Did Mismanagement Rising to the Level of a Statutory Violation Occur?

(1) Losses in CareFirst's Non-Risk Business

The Conversion Report notes that CareFirst lost substantial money in its non-risk business. Those losses resulted from agreements to administer claims and to provide other services to self-funded plan at fixed rates that were inadequate to cover the costs of providing those administrative services. The Conversion Report does not contain sufficient information to determine whether or not these losses constitute or arise out of unsound or unsafe business practices. The MIA intends, however, to conduct a target financial examination of CareFirst to specifically investigate that issue. A report containing the results of that investigation will be issued in accordance with Title 2 of the Insurance Article.

(2) Payments to Potomac

Potomac is affiliated in some manner with CareFirst and CFMI and has received substantial monies, amounting to millions of dollars, from CFMI.

However, CareFirst has never produced documents that detail or explain the relationship between CareFirst and Potomac or that evidences and defines the scope of the purported indemnity obligation.

a. § 14-133

Section 14-133 prohibits a nonprofit health service plan from investing in a subsidiary or controlled affiliate without meeting certain statutory criteria and without the permission of the Commissioner. The Conversion Report highlights the problems associated with the Potomac payments, but does not contain sufficient information to permit a conclusion as to whether Potomac meets the statutory definition of a controlled affiliate of CareFirst or whether the subsidies paid to Potomac by CareFirst amounted to investments in Potomac. The MIA has received additional information on the relationship between CareFirst and Potomac from CareFirst, is in the process of evaluating that information, and is initiating a target financial examination of CareFirst on this issue. The MIA will issue a report detailing its findings and conclusions on this issue in accordance with the procedures outlined in Title 2.

b. § 14-116

Section 14-116 authorizes the Commissioner to take action against an officer or director who engages in an unsound or unsafe business practice. An unsound and unsafe business practice is defined as a “business practice that is detrimental to the financial condition of a nonprofit health service plan and does not conform to sound industry practice.”

The information contained in the Conversion Report supports the conclusion that the payments made to Potomac constitute unsound and unsafe business practices. Millions of dollars of CareFirst's assets were paid to Potomac each year to cover its operational losses. CareFirst has never produced any documentation that evidences the existence of the terms of this asserted obligation. There is no indication that CareFirst ever audited Potomac, required that it justify its losses, or insisted on better and more efficient operations by Potomac before payments were made. There is evidence that some of the losses for which CareFirst indemnified Potomac related to health service provided to individuals insured by other carriers, including for profit commercial carriers in competition with CareFirst.

Section 14-116(b) provides for the issuance of a warning to officers and directors who engage in a business practice that the Commissioner believes to be unsound or unsafe. Because Commissioner Redmer believes that the payments to Potomac are unsafe and unsound, the Commissioner will send each of the directors of CareFirst and each of the officers in charge of the finances or operations of CareFirst, a warning in accordance with § 14-116(b).

c. Officer Conduct

The circumstances under which payments were made to Potomac raise questions as to whether any of the officers of CareFirst involved in the making of such payments violated any statutory obligations. The Conversion Report does not contain sufficient data to make that analysis. However, an evaluation of how payments came to be made and an assessment of whether any officers involved in those decisions violated the Insurance Article will be part of the targeted financial examination to be conducted of CareFirst.

(3) The Abdication of Managerial Responsibility by the Board

Section 14-115(c)(1) vests the management of the affairs of a nonprofit health service plan in its board. The Conversion Report details many instances in which the board appears to have abdicated that responsibility and to have accepted the recommendations of management without sufficient, independent inquiry. Those instances could support a finding that the board violated its obligation to manage the company under § 14-115(c)(1).

Prior to the passage of the Chapter 357, there was no express remedy provided for a violation of § 14-115(c)(1). Such a violation would be subject to regulatory action under § 14-139(a)(1) if the violation was willful. However, the only applicable remedy available under that section is the imposition of a civil fine.

In Chapter 357, the General Assembly made the violation of §14-115 an unsound and unsafe business practice that subjects an officer or director to removal. In doing so, the General Assembly recognized that that is the most appropriate regulatory response to the failure of a director to fulfill his management role. Consistent with that approach, the General Assembly, through Chapter 357, effectively restructured and reconstituted the CareFirst board. All of the CareFirst directors who represent CFMI will be removed and replaced by July 1, 2004. The terms of all remaining directors have been reduced and will expire by the end of 2006. In addition, Chapter 357 now details the precise decisions that must be made by the board and that cannot simply be delegated wholesale to management.

Launching an extensive investigation into past management practices in order to determine whether there is basis to charge individuals directors with malfeasance, followed by a lengthy and complicated judicial process which, under § 14-139, can result only in the imposition of a civil fine that does not exceed \$10,000 would not serve the public interest. This is particularly so given that the directors of CareFirst may be entitled to indemnification from the corporation, which, under the by-laws must, at a minimum, advance their attorneys' fees. Removal of the Maryland directors, coupled with the shortened term limits for the remaining directors and clear directives on the specific oversight obligations of the board is a sufficient consequence for any defects in their conduct and the MIA will take no further action.

C. Were Actions Taken in Connection with the Decision to Convert and to Be Acquired Violative of the Insurance Article?

The Conversion Report concludes that the directors of CareFirst breached their fiduciary duties in violation of § 14-115(c)(2) in deciding to convert and to be acquired. That conclusion is based on a substantial body of evidence gathered during the hearings and summarized in Section IV of this Legislative Report.

Prior to the passage of Chapter 357, violations of § 14-115(c)(2) were only subject to regulatory action by the Commissioner if those violations were willful and, thus, a violation of § 14-139(a)(1). While the Conversion Report criticizes the conduct of the CareFirst directors, it does not provide any basis on which the MIA can assess whether the behavior of any particular director was willful. Hence, there is no basis on which the MIA may, on the basis of the conduct described in the Conversion Report, proceed against directors under § 14-139.

D. Were Actions Taken in Connection with the Selection of WellPoint as Acquiror Violative of the Insurance Article?

(1) The Actions of the CareFirst Directors

The Conversion Report concludes that the directors of CareFirst breached their fiduciary duties in violation of § 14-115(c)(2) in selecting WellPoint as the entity to acquire a converted CareFirst. That conclusion is based on a substantial body of evidence gathered during the hearings and summarized in Section IV of this Legislative Report.

As was true above, only the willful violation of that section was subject to regulatory action prior to the passage of Chapter 357. The Conversion Report, however, was not required to analyze, and does not address, the conduct of individual members of the board and does not indicate whether any of the directors acted in willful violation of their fiduciary obligations. Hence, there is no basis on which the MIA may, on the basis of the conduct described in the Conversion Report, proceed against directors under § 14-139.

(2) Willful Misrepresentations by CareFirst Officers on the Relative Merits of Trigon and WellPoint as Conversion Partners

Section 14-139(a)(3) prohibits an officer of a nonprofit health service plan from willfully misrepresenting a material fact to the board of directors. Officers of CareFirst made presentations to the board regarding the relative merits of Trigon and WellPoint as potential conversion partners to the CareFirst board. The Conversion Report concludes that certain of the statements made to the board about those entities were inaccurate and, further, appeared to be concocted for the purpose of pushing

the board toward an agreement with whichever of the two entities was willing to pay large bonuses to the executives of CareFirst.

For example, in describing management's use of a potential loss of jobs as a reason for selecting WellPoint over Trigon, the Conversion Report states:

The evidence around this issue cannot all be reconciled, but the weight of the information collected shows that the issue of jobs was a tool that was used to justify a preference from one bidder [over] the other that was actually based on other considerations. This is a reasonable conclusion for the following reasons. Mr. Jews' sudden estimate of huge job loss[es] in a Trigon deal seems to coincide with the breach of trust that occurred between [him] and Mr. Snead over Mr. Snead's alleged broken promise to move corporate headquarters. Mr. Jews was most upset over this because he had made representations to legislators that turned out not to be true. The issue subsided as it became clear in the summer of 2001 that a deal with WellPoint would adversely impact associate benefits, and Trigon would have to be reconsidered. CareFirst made clear it believed it could not get approval for a deal in which associate benefits were reduced. WellPoint then had added problems as potential partner because it expressed concern over the merger incentives. The facts suggest[] these factors led management back to the table with Trigon, at which point the discussion of Mr. Jews' role dominated the discussion. The failure to reach agreement on this issue, coupled with Trigon's vehement objections to the merger incentives placed WellPoint back in the running again. WellPoint reluctantly agreed to the merger incentives, and the evidence is that Trigon did not. Since using the fact that a partner was selected because it agreed to pay large bonuses to the executives as a basis to justify the selection of WellPoint would obviously draw public scorn, it seems the fear of job loss, a non-issue in the summer, again was resurrected. (Conversion Report at page140)

Management's manipulation of data in order to steer the board in whatever direction would benefit management's own financial goals would violate § 14-139(a)(3). Based on the information contained in the Conversion Report, there is cause to believe that Mr. Jews and Mr. Wolf made willful misrepresentations to the directors. The MIA, therefore, will issue civil charges against Messrs. Jews and Wolf under §14-139(d) for a violation of §14-139(a)(3) .

E. Did the Terms of the Acquisition as Approved by the Board Violate the Insurance Article?

(1) The Absence of an Independent Valuation Before the Terms of the Sale Were Approved

Title 6.5 of the State Government Article clearly requires a finding by the Commissioner that the value of the public assets of a nonprofit health service plan be safeguarded and distributed to the appropriate charitable entity as a condition of approving a proposed conversion transaction. As CareFirst conceded as part of its conversion application, all of the assets of CareFirst, including the full value of the underlying nonprofit plans, are public assets. It was critical, therefore, to assure that the purchase price offered by WellPoint constituted fair consideration for those assets.

The members of the board clearly recognized their obligation to secure an appropriate price for CareFirst, because they asked for an independent valuation. Nonetheless, the members of the board unanimously agreed to sell CareFirst to WellPoint for \$1.3 billion, without having obtained that valuation. As the Blackstone Report included in the Conversion Report concludes, that price was inadequate and did not reflect the actual value of the company.

The Conversion Report concludes that the directors of CareFirst breached their fiduciary duties in violation of § 14-115(c)(2) by authorizing negotiations and accepting WellPoint's offer without having secured an independent valuation of CareFirst. Given that the directors had asked for the valuation, and then proceeded without it, there is a basis to conclude that that violation was willful and, thus, a violation of § 14-139(a)(1).

Notwithstanding that violation, the MIA is not inclined to file individual charges against the individual directors of CareFirst. As noted above, a penalty of greater consequence than the potential imposition of a fine has already been imposed by the General Assembly through Chapter 357. The removal of 12 directors, limiting the terms of the remaining directors, limiting compensation, and redirecting the focus and the duties of directors is a sufficient response to this violation by those individuals and there is nothing constructive to be served by taking further action on this issue. However, the failure to comply with the State Government Article is a serious violation by CareFirst itself that devalued the company and that must be addressed under § 4-113(b). The MIA, therefore, will issue an Order under that section and will, in lieu of suspending or revoking CareFirst's certificate of authority, assess an appropriate penalty against the company under § 4-113(d).

(2) Approval of Conversion-Related Executive Bonus for Officers

The Conversion Report concludes that the Board violated its fiduciary duties by approving merger incentive bonuses for CareFirst executives. In doing so, the Board ignored the advice of its counsel regarding the propriety of those

bonuses and never even considered their legality under the anti-inurement provision of the Nonprofit Acquisition Law. The Board was aware the payments that it voted to give to executives were, at best, controversial and likely to result in substantial criticism. Even after that occurred, and additional legislation was passed to prohibit not only inurement but any remuneration beyond salary in connection with a conversion, the Conversion Report reflects the Board's intransigence on the bonus issue. While the merger incentives were withdrawn and the purchase price increased by WellPoint, the Board still authorized a transaction that included generous retention bonuses that were to be paid to CareFirst executives by WellPoint. The Conversion Report concludes that those retention bonuses violated the anti-bonus provision of the Nonprofit Acquisition Law.

The actions of the Board were egregious. Chapter 357, however, already extracts the most appropriate penalty for this conduct: it removes and replaces all of the Maryland directors and shortens the terms of the D.C. and Delaware directors. There is no useful purpose to be served by initiating a process to assess civil fines against these same individuals.

(F) Did the Existence of Conflicts of Interest Violate Any Provision of the Insurance Article?

(1) The CSFB and Accenture Conflicts

CSFB was engaged by CareFirst to negotiate the terms of the acquisition of CareFirst by WellPoint. After an agreement in principle had been reached as to those terms, CSFB was also asked to issue an opinion verifying the fairness of the transaction it had just negotiated. The Conversion Report concludes that CSFB had a conflict of interest in issuing an opinion as to the fairness of its own product and could not possibly provide an independent analysis of fairness. The Conversion Report concludes that the failure to appreciate and account for this conflict was a serious flaw in the Board's process.

Similarly, the Board failed to appreciate or ignored conflicts of interest that existed with regard to Accenture. Accenture developed the Case for Change that recommended and supposedly substantiated CareFirst's conversion and acquisition. The Proposed Transaction with WellPoint could not occur without regulator approval under Title 6.5 of the State Government Article. That Title required CareFirst to submit a community impact report to the MIA with its Application. By statute, the community impact report had to be prepared by an *independent* consultant. The Conversion Report concluded that Accenture, as the author of the strategy that led to the WellPoint transaction, could not possibly have made an independent analysis of whether that transaction and, indeed, the entire concept of conversion, was in the public interest.

The Nonprofit Acquisition Law sets out the criteria that the Commissioner must consider in determining whether a proposed transaction is in the public interest. As the Conversion Report notes, a prudent board, mindful of its fiduciary

obligations, would not approve a transaction without making its own evaluation of the transaction under those criteria. Indeed, § 14-112 authorizes the Commissioner to take regulatory action against a nonprofit health service plan that violates the provisions of Title 6.5 of the State Government Article.

Assuming that a violation of § 14-112 occurred as a result of the failure to secure truly independent community impact and fairness reports and to otherwise consider and address conflicts of interest in their experts, the public interest is not served by taking action to revoke CareFirst's charter or to place it in receivership, the only remedies expressly authorized by § 14-112. The MIA, therefore, will take no action against CareFirst under that section.

Action is appropriate, however, under § 4-113. The board is the embodiment of CareFirst and the willful failure of that entity to comply with the requirements of Section 6.5 of the State Government Article is a violation of § 14-112 which, in turn, is a violation of § 4-113(b). The MIA intends, therefore, to issue an Order under §4-113(b)(1) and will, in lieu of suspending or revoking CareFirst's certificate of authority, assess an appropriate penalty against the company under § 4-113(d). For the reasons stated above, the MIA will not, however, take action against individual directors.

(2) The Retention of Neuberger

The Conversion Report notes that an attorney who had served as private compensation counsel to Mr. Wolf and to Mr. Jews was engaged by Mr. Jews at CareFirst's expense to participate in negotiations with Trigon and WellPoint. Mr. Neuberger's bills indicate that his primary role was not to serve CareFirst's interests, but to evaluate and to negotiate compensation that CareFirst executives were to receive as part of any acquisition of that entity. Mr. Neuberger's role was not disclosed to, and not known to, the members of the board.

The Conversion Report properly criticizes Mr. Jews for having his private compensation counsel participate in negotiations for the sale of CareFirst in order to promote his personal interests at the expense of the corporation. That act and Mr. Jews failure to disclose his action to the board are not, however, violations of the Insurance Article. Section 14-139(a)(3) does prohibit a corporate officer from willfully making material misrepresentations to the board. That subsection, unlike subsection (a)(2), does not penalize the concealment of material information from the board. There is, therefore, no action for the MIA to take for Mr. Jews' engagement and use of Mr. Neuberger and his failure to reveal that to the board.

There are, however, two areas in which the MIA may act with reference to this conduct. First, § 14-139(a)(2) prohibits an officer of a nonprofit health service plan from making a willful misrepresentation of a material fact to the Commissioner. At his deposition, Mr. Jews denied that Mr. Neuberger was his private attorney. The records produced by Mr. Neuberger's firm, including billing records,

together with Mr. Altobello's testimony that Mr. Neuberger did not represent CareFirst, indicate that Mr. Jews misrepresented the true nature of Mr. Neuberger's engagement to the Commissioner. The MIA will, therefore, issue civil charges against Mr. Jews for the violation of § 14-139(a)(2).

Second, despite the fact that Mr. Neuberger was representing only the interests of Mr. Jews, interests which were directly in conflict with the interest of CareFirst, Mr. Jews had CareFirst pay Mr. Neuberger's large legal fees. Those payments clearly were not authorized by the board, which was not even aware that Mr. Neuberger was involved in the matter. There is, therefore, probable cause to believe that directing CareFirst to absorb the costs of Mr. Neuberger's legal fees was a misappropriation of CareFirst's assets in violation of § 14-139(a)(4). The MIA will pursue civil charges against Mr. Jews under 14-139(a)(4) and, if those charges are sustained, will require Mr. Jews to reimburse CareFirst for the fees that it paid to Mr. Neuberger.

VII. RECOMMENDATIONS

It is important for Maryland to recognize the impact that public policy decisions made affecting nonprofit health service plans operating in Maryland may also impact the public policy of the District of Columbia and Delaware. Therefore, any proposed changes to the Conversion law or the Insurance laws of Maryland that may impact GHMSI or BlueCross BlueShield of Delaware should be considered in consultation with the Insurance Commissioner in the District of Columbia and the Insurance Commissioner of Delaware.

A. Recommendation No. 1

Under Title 6.5 of the State Government Article, Maryland law requires the Insurance Commissioner to analyze the “due diligence” the Board followed in its decision to convert and sell to WellPoint. As part of its due diligence, it is reasonable to expect that the Board would have taken certain action before making a decision to pursue a conversion to a for-profit or an acquisition by a for-profit so that the Board could make an educated decision based on certain factors obtained from an independent expert. In particular, the Board failed to obtain an independent valuation of CareFirst prior to the bidding process. As a result, the Board did not have firsthand knowledge of the value of the company that they had agreed to offer for sale.

- Require the Board to request and give consideration to an independent valuation of the nonprofit health service plan prior to the consideration of any bid or offer to acquire the nonprofit health service plan.

B. Recommendation No. 2

Further clarification of the mission in the Insurance Article would ensure that the officers and the directors of a nonprofit health plan are required to pursue the

mission of a nonprofit health service plan as required under § 14-102 (c) of the Insurance Article. Therefore, the following change to §14-102 is offered:

- Amend § 14-115(c)(2)(iii) by striking "in a manner that is reasonably believed to be in furtherance of the corporation's nonprofit mission;" and substituting "IN A MANNER CONSISTENT WITH THE NONPROFIT HEALTH SERVICE PLAN'S MISSION AS REQUIRED BY §14-102(C)."
- Amend 14-115(c)(4), after "mission" and before "of" by inserting "AS REQUIRED by 14-102(C)".

C. Recommendation No. 3

As part of the evaluation of the bids submitted by both Trigon and WellPoint, the Board put a great deal of emphasis on the retention of Board seats, the future role of the current CEO, and compensation of management. Clearly, Maryland law prohibits inurement to officers and directors of a nonprofit health service plan. However, the law should be clarified to ensure that neither the directors nor the officers of a nonprofit health service plan may make decisions that place personal gain ahead of the needs of the nonprofit health service plan. The proposed change would clarify the intent of the law as to the duties of loyalty and care of the directors and officers of a nonprofit health service plan in a manner that is consistent with the mission of the nonprofit health service plan.

- Amend § 14-115(c) by adding "(3) THE BOARD AND ITS INDIVIDUAL MEMBERS MAY NOT USE THEIR POSITION FOR PERSONAL GAIN AT THE EXPENSE OF THE NONPROFIT HEALTH SERVICE PLAN OR THE MISSION OF THE NONPROFIT HEALTH SERVICE PLAN EXCEPT IN CONFORMITY WITH § 14-115."
- Adding to § 14-115.1 of the Insurance Article:

"(A) OFFICERS OF A NONPROFIT HEALTH SERVICE PLAN SHALL ACT:

- (1) IN GOOD FAITH;
- (2) IN A MANNER THAT IS REASONABLY BELIEVED TO BE IN THE BEST INTERESTS OF THE CORPORATION AND ITS CONTROLLED AFFILIATES OR SUBSIDIARIES THAT OFFER HEALTH BENEFIT PLANS;
- (3) IN A MANNER THAT IS REASONABLY

BELIEVED TO BE IN FUTURE OF THE CORPORATION'S NONPROFIT MISSION; AND

(4) WITH THE CARE THAT AN ORDINARILY PRUDENT PERSON IN A LIKE POSITION WOULD USE UNDER SIMILAR CIRCUMSTANCES.

(B) THE OFFICERS OF A NONPROFIT HEALTH SERVICE PLAN MAY NOT USE THEIR POSITION FOR PERSONAL GAIN, AT THE EXPENSE OF THE NONPROFIT HEALTH SERVICE PLAN OR THE MISSION OF THE NONPROFIT HEALTH SERVICE PLAN EXCEPT FOR THE RECEIPT OF REASONABLE REMUNERATION IN CONFORMITY WITH § 14-139.

(C) A VIOLATION OF THIS SECTION IS AN UNSAFE AND UNSOUND BUSINESS PRACTICE UNDER § 14-116 OF THIS ARTICLE.”

D. Recommendation No. 4

The recommended change makes all of the provisions of §14-139(a) and (b) violations of §14-116 of the Insurance Article. The behavior described in § 14-139(a) are all acts that would be detrimental to the company and reflect and include willful violations of the Insurance Article, willful misrepresentation of material facts to the Board or the Commissioner and misappropriation of funds. This change would make these acts unsafe or unsound business practices and would subject the corporation to the penalties available under § 14-116, which include removal of a director.

- Amend § 14-139(a)(3) by inserting "or conceal" after "misrepresent" and before "a material".
- Amend § 14-139(a)(2) by striking "submitted" and inserting "provided".
- Amend § 14-116(a)(1)(iii) by inserting "(a)" between § 14-139 and (c).

E. Recommendation No. 5

This recommended change provides a new penalty under § 14-116. Currently, the Commissioner has the obligation to issue a warning if an unsafe or unsound business practice is determined. If the behavior is continued, he may remove a director after a hearing on the matter. This change would add a monetary penalty of \$125,000, consistent with the penalty under § 4-113, that the Commissioner could impose at his discretion when an unsafe or unsound business practice is determined.

- Amend § 14-116(b) by inserting:

"(2) IF THE COMMISSIONER BELIEVES THAT AN OFFICER OR DIRECTOR OF A NONPROFIT HEALTH SERVICE PLAN HAS FAILED TO HEED A WARNING OR HAS RECEIVED A SECOND WARNING UNDER THIS SECTION, THE COMMISSIONER MAY IMPOSE A CIVIL PENALTY NOT EXCEEDING \$125,000."

[(2)] (3) The Commissioner shall send a copy of the warning "OR ORDER:"

F. Recommendation No. 6

Section 6.5-201 of the State Government Article lays out what must be submitted as part of a conversion application. Through the review of CareFirst's conversion application, it became clear that key factors were not thoroughly examined by the company during their decision to convert. By requiring the company to conduct an independent valuation of the company and an antitrust analysis prior to filing with the Commissioner, it ensures that they look at these factors and demonstrates to the Commissioner whether the process was done with due diligence.

Recommended changes to the State Government Article:

- Amend § 6.5-201(b)(5) by striking "and" after "title".
- Amend § 6.5-201(b) by inserting "(7) an independent valuation of the nonprofit health service plan which was obtained prior to the consideration of any bid or offer;".
- Amend § 6.5-201(b) by inserting "(8) an antitrust analysis prepared by an appropriate expert; and ".

G. Recommendation No. 7

As previously discussed, the Board failed to show “due diligence” in consideration of whether CareFirst should convert to a for profit and be acquired. Two significant factors that were not considered by the Board are whether: (1) an acquisition would result in diseconomies of scale; and (2) the proposed transaction violates antitrust laws.

- Amend § 6.5 of the State Government Article so that the MIA, in its determination as to whether the nonprofit health service plan exercised due diligence, may not determine that due diligence was exercised unless the nonprofit health service plan considered the risks of an acquisition, including:

- (1) an acquisition would result in diseconomies of scale; and
- (2) the proposed transaction violates federal or state anti-trust laws.

H. Recommendation No. 8

Amend § 6.5 of the State Government Article so that conversion/acquisition proceeds are required to be “spent in a manner that correlate with the potential risks associated with an acquisition...” as suggested on page 204 of the Conversion Report.

Under current law, conversion/acquisition proceeds are to be used for “improving health status”. While this provision is well intended, it can be interpreted very broadly so that the use of conversion/acquisition proceeds may not be related to the impact on a community or population adversely impacted by the conversion/acquisition.

VIII. CONCLUSION

As required under Chapter 357, the Conversion Report has been reviewed to determine whether any conduct identified in the Conversion Report violates the applicable provisions of the Insurance Article. In those instances in which a proposed violation has been identified, the Commissioner has stated in this Legislative Report the appropriate action(s) that he will take in response to the proposed violation. In several instances, the Commissioner will enforce the terms of Chapter 357 as they relate to the removal and replacement of directors as modified by the Consent Order and Judgement.

In addition, this Legislative Report provides certain recommendations for consideration by the Maryland General Assembly. The Conversion Report identifies certain conduct by the Board and management of CareFirst that the Maryland General Assembly may want to address through legislative action to ensure that regulatory oversight is sufficient to protect the public interest.



UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

CAREFIRST, INC.,)
)
 Plaintiff,)

v.)

Civil Action No. JFM 03-1521

THE HONORABLE ROBERT L. EHRlich,)
 JR., IN HIS OFFICIAL CAPACITY AS)
 GOVERNOR OF THE STATE OF)
 MARYLAND; THOMAS V. ("MIKE"))
 MILLER, JR., IN HIS OFFICIAL CAPACITY)
 AS THE PRESIDENT OF THE MARYLAND)
 SENATE; MICHAEL E. BUSCH, IN HIS)
 OFFICIAL CAPACITY AS THE SPEAKER)
 OF THE MARYLAND HOUSE OF)
 DELEGATES; ALFRED W. REDMER, JR., IN)
 HIS OFFICIAL CAPACITY AS MARYLAND)
 INSURANCE COMMISSIONER OF THE)
 MARYLAND INSURANCE ADMINIS-)
 TRATION; DONNA LEE H. WILLIAMS, IN)
 HER OFFICIAL CAPACITY AS THE)
 INSURANCE COMMISSIONER OF THE)
 DELAWARE INSURANCE DEPARTMENT;)
 and LAWRENCE H. MIREL, IN HIS)
 OFFICIAL CAPACITY AS THE)
 COMMISSIONER OF THE DISTRICT OF)
 COLUMBIA DEPARTMENT OF INSUR-)
 ANCE AND SECURITIES REGULATION,)

Defendants.)

STATE OF MARYLAND,)
)
 Plaintiff,)

v.)

Civil Action No. JFM 03-1510

BLUE CROSS & BLUE SHIELD)
 ASSOCIATION,)

And

CAREFIRST, INC.,

Defendants.

)
)
)
)
)

ORDER AND CONSENT JUDGMENT

This matter is before the Court on the joint motion filed by the Attorney General of the State of Maryland on behalf of the State of Maryland, the Honorable Robert L. Ehrlich, Jr., in his official capacity as Governor of the State of Maryland, Thomas V. ("Mike") Miller, Jr., in his official capacity as the President of the Maryland Senate, Michael E. Busch, in his official capacity as the Speaker of the Maryland House of Delegates, and Alfred W. Redner, Jr., in his official capacity as Maryland Insurance Commissioner of the Maryland Insurance Administration (collectively the "State"); and Blue Cross and Blue Shield Association (the "Association"). Hereinafter, those are the "Parties."

WHEREAS, the Association is the owner of the BLUE CROSS and the BLUE SHIELD design service marks and names and certain derivative marks (collectively the "Blue Marks");

WHEREAS, the Association has licensed the use of the Blue Marks to CareFirst, Inc. and affiliates ("CareFirst") as primary licensee and to Group Hospitalization and Medical Services, Inc. ("GHMSI"), CareFirst of Maryland, Inc. ("CFM"), BCBSD, Inc. ("BCBSD"), CareFirst BlueChoice, Inc., and PHN HMO, Inc., (collectively the "Controlled Affiliates") through Controlled Affiliate license agreements;

WHEREAS, CareFirst's Board is made up of 21 members (one seat currently is vacant): (a) six Class I directors from the GHMSI area (the "Class I Directors"); (b) twelve Class II

directors from the CFM area (the "Class II Directors"); and (c) three Class III directors from the BCBSD area (the "Class III Directors");

WHEREAS, the Maryland General Assembly has passed and the Governor has signed legislation on May 22, 2003 (House Bill 1179 and Senate Bill 772) that relates to regulation of non-profit health service plans incorporated in or licensed by the State of Maryland, including CareFirst (the "Act");

WHEREAS, CareFirst has challenged the constitutionality of the Act and has initiated the above-captioned case, Civil Action No. JFM 03-1521 (the "CareFirst Action");

WHEREAS, the Association has taken the position and also informed the other parties that CareFirst's licenses relating to the Blue Marks automatically terminated when the Act became law (the "Termination") and has initiated litigation, including claims under the Lanham Act, in the United States District Court for the Northern District of Illinois, Civil Action No. 03-C-3422 (the "Association Action");

WHEREAS, the State of Maryland has taken the position that the enactment of the Act did not cause the automatic termination of CareFirst's licenses relating to the Blue Marks and has initiated the above-captioned case, Civil Action No. JFM 03-1510, which has been removed from the Circuit Court for Baltimore City (the "Maryland Action"), challenging the Association's interpretation of the License Agreement with CareFirst on the issue of automatic termination;

WHEREAS, contemporaneously with the entry of this Order and Consent Judgment, the Association has filed an intervening complaint in the CareFirst Action asserting the claims it has asserted in the Association Action against CareFirst and the Controlled Affiliates, and the State of Maryland has filed a cross complaint and counterclaim in the CareFirst Action asserting the same claims asserted against the Association and CareFirst in the Maryland Action;

WHEREAS, resolution of the issues concerning CareFirst's right to use the Blue Marks could avoid confusion among and harm to CareFirst's subscribers, including Marylanders, and is in the public interest;

WHEREAS, the Parties and CareFirst recognize that it is in the best interests of CareFirst to maintain the marks on behalf of itself and for the benefit of its Controlled Affiliates;

WHEREAS, the State wishes to resolve the foregoing issues to ensure that Maryland, Delaware, District of Columbia, and Northern Virginia consumers have uninterrupted access to Blue Cross and Blue Shield branded products and services for which they have contracted while also ensuring the protection of the public interest;

WHEREAS, the Commissioners of Insurance of the District of Columbia and the State of Delaware have issued Orders regarding the Maryland Act which may conflict with the Act;

WHEREAS, the Parties and CareFirst have agreed that it is in their interests and in the public interest to avoid the expense, uncertainties, and burden of litigation concerning the Act or the Termination;

WHEREAS, the Parties and CareFirst wish to resolve the CareFirst Action, the Association Action, and the Maryland Action;

WHEREAS, the Parties agree to the terms of this Order and Consent Judgment conditioned on this Court's approval and the full effectiveness and enforceability of the Order and Consent Judgment; and

WHEREAS, CareFirst has stated in open court that it agrees to, and will adhere to and be bound by the terms of and will not challenge this Order and Consent Judgment.

NOW, THEREFORE, the Court FINDS and ORDERS as follows:

1. The current Class II Directors (the "Outgoing Directors") shall serve out the remainder of their current terms, which end on December 31, 2003, and shall continue in office until replaced as provided herein. The replacements for the Outgoing Directors shall be selected as provided in paragraphs 2 and 3 of this Order and Consent Judgment. To the extent practicable, the directors selected to replace the Outgoing Directors shall represent the racial and gender diversity of the State and the geographic regions of the State and shall have experience in accounting, information technology, finance, law, large and small businesses, and organized labor. The directors shall include two consumer members, one of whom shall be a subscriber and one of whom shall be a certificate holder of CareFirst.

2. The Nominating Committee authorized under Section 4(b) of the Act shall select five persons who meet the qualifications for "certified applicants," as described below, for election to the CareFirst Board as new Class II Directors for terms commencing January 1, 2004, to replace those five Outgoing Directors designated by the current Class II Directors. The Class II Directors shall elect the five persons so selected by the Nominating Committee.

3. The Class II Directors as constituted after the election of the five persons selected in Paragraph 2 shall elect seven new Class II Directors to replace the seven remaining Outgoing Directors to serve commencing July 1, 2004. Those directors shall be elected according to CareFirst's current Bylaws from a pool of applicants certified by the Nominating Committee (the "Certified Applicants").

4. The Nominating Committee shall solicit applications for the position of Class II Director, and shall review the application of each candidate for election to the position of Class II Director, including candidates submitted by the CareFirst Board, and conduct such inquiry as

it deems necessary to determine whether the candidate satisfies the criteria set forth herein for the pool of Certified Applicants subject to the following provisions:

(a) the Nominating Committee shall determine whether any candidate has experience in accounting, information technology, finance, law, large and small businesses, nonprofit businesses, and organized labor, and provide that information to the Board;

(b) the Nominating Committee shall certify each applicant for Class II Director who satisfies each of the following criteria:

i. The applicant has not (1) defaulted on the payment of a monetary obligation to CareFirst; (2) been convicted of a criminal offense involving dishonesty or breach of trust or a felony; (3) habitually neglected to pay debts; or (4) been prohibited under any federal securities law from acting as a director or officer of any corporation;

ii. The applicant does not hold an elective or appointive governmental office and is not an employee of any governmental body and has not held such office or position for twelve months prior to election to the Board;

iii. The applicant has acknowledged in writing that upon election he or she will owe a fiduciary duty to CareFirst, as set forth in Section 14-115(c)(2) of the Insurance Article, as amended;

iv. The applicant has not previously served as a director of a nonprofit health service plan subject to the provisions of Section 14-115 of the Insurance Article, as amended by the Act;

v. If a consumer representative, an applicant: (1) is a member of the general public; (2) may not be considered an agent or employee of the State of Maryland for any purpose; (3) is not a licensee of or otherwise be subject to regulation by the Insurance Commissioner of the State of Maryland; (4) is not employed by or does not have a financial interest in a nonprofit health service plan or its affiliates or subsidiaries or a person regulated under either the Insurance Article, as amended by the Act, or the Health General Article of the Annotated Code of Maryland; (5) has not, within three years before appointment, been employed by, had a financial interest in, or received compensation from a nonprofit health service plan or its affiliates or from a person regulated under either the Insurance Article, as amended by the Act, or the Health General Article of the Annotated Code of Maryland; and,

vi. The applicant: (1) is not an officer or employee of CareFirst or any of its affiliates or subsidiaries and is not an immediate family member of another board member or an officer or employee of CareFirst; (2) has not in the current year or any of the past three years received in excess of \$60,000 (excluding payments for health care services) in compensation for services from CareFirst or any of its affiliates; and (3) is not a partner or controlling shareholder or executive officer of any organization to which or from which CareFirst or any affiliate made or received payments (excluding payments for health care services or premiums) that exceed 5% of the recipient's consolidated gross revenues or \$200,000, whichever is more, in the current fiscal year or any of the past three fiscal years.

(c) The Nominating Committee shall not certify any applicant who fails to satisfy the criteria specified in Paragraph 4(b) above, and shall certify any applicant who does satisfy the criteria.

5. After discharging its duties as provided in Paragraphs 2 through 4 above, the Nominating Committee shall be dissolved.

6. No provisions of the Act shall be affected by this Order and Consent Judgment, except that the following provisions shall not be implemented or enforced: those provisions of Section I codified in the Insurance Article at Sections 14-139(d)(2) through 14-139(d)(4) and Section 14-139(d)(5) in so far as it implements Sections 14-139(d)(2) - (d)(4); Section 4(a), Section 4(b)(1), except insofar as it governs creation of the Nominating Committee, and Section 5; and other provisions, if any, of the Act to the extent that they are inconsistent with this Order and Consent Judgment. The two non-voting directors to be appointed under Section 14-115(d)(2)(i) and (ii) of the Insurance Article shall meet the qualifications for Certified Applicants as described in paragraph 4 of this Order and Consent Judgment.

7. The Blue Cross and Blue Shield License Agreements of CareFirst and its Controlled Affiliates in their service areas are deemed to have remained in effect without interruption since May 21, 2003. CareFirst and the Controlled Affiliates shall be subject to the License Agreements, Standards, Guidelines, By-Laws and all other rules and regulations of the Association (collectively "Licensure Rules"). Hereafter, this Order and Consent Judgment shall not govern any relationship, duty, obligation, or right between or among the Association, CareFirst or its Controlled Affiliates under the Licensure Rules or otherwise.

8. CareFirst and the Controlled Affiliates shall covenant and warrant that they are in compliance with all, and have no plans to engage in conduct that would violate any, Licensure Rules of the Association.

9. Nothing in this Order and Consent Judgment shall be construed as a limitation upon the Maryland General Assembly's power to enact legislation pertaining to the regulation of insurance or any other subject at any future legislative session, or upon the State's ability to implement and enforce such future legislation.

10. The Association, CareFirst, and the Controlled Affiliates shall mutually release one another and their attorneys, representatives and agents from all claims asserted or that could have been asserted in or are related to the CareFirst Action, the Association Action or are related to the Termination. Nothing in this Order and Consent Judgment serves as an admission or waiver, on the part of any party, of any claim or defense related to the litigation.

11. This Order and Consent Judgment fully and finally resolves all claims asserted by the parties in the Maryland Action and the CareFirst Action. The Association shall dismiss the Association Action without prejudice and without cost. Each party shall be responsible for its own attorneys fees.

12. Nothing in this Order and Consent Judgment shall be construed as a limitation upon the power of the Insurance Commissioners of Delaware and the District of Columbia to regulate insurance according to their respective laws.

13. Notwithstanding any other provision of this Order and Consent Judgment, if conflicting orders by the District of Columbia and Delaware Insurance Commissioners are issued, this Court retains jurisdiction on the motion of any party (including CareFirst) or the District of Columbia or Delaware Insurance Commissioner to resolve such conflict.

14. This Court shall retain jurisdiction to enforce this Order and Consent Judgment until September 30, 2004.

AGREED:

Date: June 6th, 2003

THE STATE OF MARYLAND

By: J. Joseph Curran, Jr.

J. Joseph Curran, Jr.
Attorney General of Maryland
Attorney for the State of Maryland and its
Officials

Date: June __, 2003

ROBERT L. EHRlich, JR.

Governor

Date: June 6th, 2003

ALFRED W. REDMER, JR.

Alfred W. Redmer, Jr.
Commissioner of Insurance

Date: June __, 2003

MICHAEL E. BUSCH

Speaker of the House of Delegates

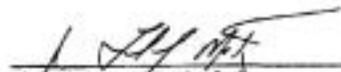
Date: June __, 2003

THOMAS V. ("MIKE") MILER, JR.

President of the Senate

SO ORDERED:

Date: June 6, 2003


United States District Judge

STATUS OF HB 1179/SB 772

Prepared by:

MARYLAND INSURANCE ADMINISTRATION

Alfred W. Redmer, Jr., Commissioner

June 10, 2003

- **IN 14-102(a) and (b) – Nonprofit Mission Statement**

- Prescribes a corporate mission for certain nonprofit health service plans that hold a certificate of authority in this State, as well as their controlled affiliates and subsidiaries - including for-profit affiliates and subsidiaries.
- Requires such plans to develop goals for carrying out the statutory mission.
- Requires such plans to report on their compliance with the statutory mission to the Joint Oversight Committee.
- Establishes that plans that comply with the law are public benefit corporations exempt from taxation as provided by law.

NO CHANGE

- **IN 14-106 – Premium Tax Exemption**

- Clarifies how the value of the premium tax exemption applicable to nonprofit health service plans is to be spent by the plan.

NO CHANGE

- **IN 14-107 – Premium Tax Exemption**

- Addresses consequences for failure to use premium tax exemption as required in 14-106.

NO CHANGE

- **IN 14-109 – Application for Certificate of Authority**

- Requires applicant for certificate of authority as nonprofit health service plan to include in its application its corporate mission statement, the total compensation paid or proposed to be paid to each officer and to members of the board of directors, and a list of the beginning and ending terms of board members.

NO CHANGE

- **IN 14-110 – Issuance of Certificate of Authority**
 - Requires Commissioner to issue certificate of authority to nonprofit health service plan if the nonprofit health service plan is committed to a nonprofit corporate structure, seeks to provide affordable and accessible health insurance, and recognizes responsibility to contribute to the improvement of the overall health status of Maryland residents.
 - Adds that the Commissioner may refuse to renew a certificate of authority if a plan does not continue to meet the requirements of the subtitle.

NO CHANGE

- **IN 14-111 – Access to Capital**
 - Provides that nonprofit health service plans issued a certificate of authority in Maryland have access to certain capital improvement project funding through the State.

NO CHANGE

- **IN 14-115(b) - Directors**
 - Expands application of section from plans incorporated in Maryland to plans issued a certificate to do business in Maryland, regardless of the state of incorporation.

NO CHANGE

- **IN 14-115(c) – Directors - Duties**
 - Changes the duties of the board of directors by adding that the board’s duty of loyalty runs not only to the corporation, but also to its controlled affiliates and subsidiaries.
 - Adds a duty of obedience to the corporation’s nonprofit mission. Identifies the principle functions of the board.
 - Adds that each member of the board must demonstrate a commitment to the mission of the nonprofit health service plan.

NO CHANGE

- **IN 14-115(d) – Directors - Governance**
 - Applies only to a plan that is issued a certificate of authority and is the sole member of a corporation that itself holds a certificate of authority in the State.
 - Expands the CareFirst board from 21 to 23.
 - Two new board seats are non-voting seats appointed by the General Assembly.
 - Adds that to the extent possible, the board as a whole shall include individuals with certain skills, including experience in accounting, information technology, law, the operation of nonprofits, etc.
 - Clarifies that, except for the two non-voting members, the board is self-perpetuating.
 - Requires the board to have certain standing committees: audit, finance, compensation, nominating, service and quality oversight, mission oversight, and strategic planning. Each standing committee must have representation from the voting members and from each subsidiary plan. The nonvoting members must serve on the compensation and nominating committees.
 - Requires the board to approve certain actions by the plan or its subsidiaries relating to benefit changes, provider networks, underwriting guidelines, modification of rates, product withdrawals, or other changes that could impact health care in the state.
 - Adds that a decision to convert to for-profit status may be rejected by any three members of the Board.
 - Requires that complete minutes of board meetings be taken and retained. Provides that consumer members of the board cannot have been employed by certain plans or insurers for a period of 3 (instead of 1) years prior to service on the board.

NO CHANGE

- **IN 14-115(e) – Directors - Terms**
 - Changes the maximum term of directors to two three year terms, or 6 years maximum.
 - Adds that persons prohibited from acting as an officer or director under federal securities laws may not serve on the board.
 - Adds that board must represent the racial and gender diversity of the State.

NO CHANGE

- **IN 14-115(g) – Directors - Compensation**
 - Limits the compensation payable to members of the board.

NO CHANGE

- **IN 14-116 – Unsound and Unsafe Business Practices**
 - Expands definition of an “unsound or unsafe business practice” to include the violation of 14-102 (corporate mission), 14-115 (board requirements), or 14-139(c) (no unreasonable compensation).
 - Adds that if the Commissioner fails, after notice by the Attorney General, to take action with regard to an unsound or unsafe business practice, the Attorney General may act to remedy the practice, including seeking the removal of the officer or directors.

NO CHANGE

- **IN 14-126 - By-Laws**
 - Creates standard for approval of changes to articles of incorporation or by-laws submitted for approval. Changes must be approved unless they are contrary to the public interest.

NO CHANGE

- **IN 14-133 – Affiliates and subsidiaries**
 - Creates standard for disapproving request by nonprofit to create or acquire affiliate or subsidiary, alter its structure, or make certain investments. Such action must be approved unless the Commissioner finds it is contrary to the public interest.

NO CHANGE

- **IN 14-139(c) – Anti-Inurement**
 - Prohibits officers, employees, directors and executives from approving or receiving corporate assets other than fair and reasonable compensation for work performed.

NO CHANGE

- **IN 14-139(d) – Compensation Guidelines**
 - Requires compensation committee to establish by June 1, 2004 guidelines of what constitutes reasonable compensation for executives and officers, based on compensation paid to other executives of similar nonprofits.
 - Guidelines must be approved by Commissioner.
 - Guidelines must be reviewed by the Board annually.
 - Officers and executives cannot be paid in excess of the guidelines and the Commissioner can prohibit excess payment.

The Consent Order and Judgment changes this section. Guidelines must be developed and implemented per the statute. The Guidelines do not, however, have to be submitted to the Commissioner for approval and are not subject to his disapproval. The Commissioner retains the authority to assure that guidelines are developed, that they are developed in the manner required by the statute, and that the guidelines are implemented and followed. The Commissioner retains the authority to prohibit compensation outside of the guidelines.

- **IN 14-139(e) - Guidelines – Excess Compensation**
 - Receipt or approval of compensation outside of the guidelines violates a board member’s fiduciary duty under 14-115(c) and is an unsound and unsafe business practice under 14-116.

NO CHANGE

- **IN 14-504 - MHIP**
 - Makes MHIP the recipient of any premium tax revenue collected from a nonprofit that loses its exemption from premium tax payment.

NO CHANGE

- **SG 2-10A-08 to the State Government Art. - Joint Oversight Committee**
 - Creates Committee

NO CHANGE

- **Uncodified § 3 – Ratification**
 - Ratifies the MIA’s denial of the conversion application

NO CHANGE

- **Uncodified § 4 – Nominating Committee/Changes in Directors**
 - Requires that 10 members representing the Maryland Plan be removed by December 1, 2003 and replaced by a nominating committee appointed by the Governor, the President and the Speaker. Of the 10, two shall be consumer members. The nominating committee determines which of the Maryland existing 12 are replaced.

The Consent Order and Judgment change this section. The terms of all 12 Class II (Maryland) Directors of CareFirst terminate on December 31, 2003. Five of those 12 will be replaced on January 1, 2004 by individuals selected by the Nominating Committee provided for in the Reform Bill. Those 5, working with the remaining 7, will select the replacements for those 7 from a pool of candidates who are certified by the Nominating Committee according to objective criteria. Those 7 will assume office by July 1, 2004.

- **Uncodified § 5: - Additional Director Replacements**
 - Two remaining Maryland board members must be replaced by June 1, 2004 by the nominating committee of the Board itself. All other board members (including DC and Delaware representatives) must be removed and replaced by March 31, 2006.

This Section will not be enforced. The Class II (Maryland Directors) will be turned over as set forth above. Delaware and DC directors will not be removed outside their normal term limits – which have been limited to six years.

- **Uncodified § 6: - Staggered Terms**
 - Provides for staggering of terms of new board members by approval of the Commissioner.

NO CHANGE

- **Uncodified § 7: - No Conversion**
 - No conversion application for 5 years after denial.

NO CHANGE

- **Uncodified § 8: - Retroactivity of 14-139(c) Regarding Compensation**
 - Provides that 14-139(c) applies to remuneration agreements entered into or revised after January 20, 1995.
 - Provides that the Commissioner may only examine compensation increases occurring after January 20, 1995.

NO CHANGE

- **Uncodified § 9: Disqualification of Directors On Retirement**
 - Once removed, a director can never serve as a director again.

NO CHANGE

- **Uncodified § 10: Encouraging Participation in Public Programs**
 - Notes the intent of the General Assembly to encourage certain nonprofit health service plans to participate in public programs such as Medicaid and Medicare, when participation is consistent with the mission of the plan and does not impair its financial condition.

NO CHANGE

- **Uncodified § 11: Cooperation with State Arrangement**
 - Requires certain nonprofit health service plans to work with the MIA and other agencies to study and, if desirable, develop a State arrangement to offer health insurance coverage to individuals eligible for federal tax credit under § 35 of the federal tax code.
 - Requires such a plan to report on this study by August 1, 2003

NO CHANGE

- **Uncodified § 12: MIA and OAG Report**

- Requires the MIA to issue, by July 1, 2003, a report determining whether any actions identified in MIA No. 2003-02-032 violated certain provisions of the Insurance Article, to recommend action if violations are identified, and to make recommendations regarding any changes to that law that should be made to provide adequate regulatory oversight of nonprofit health service plans.
- Requires the Office of the Attorney General to issue, by September 1, 2003, a report determining whether any conduct identified in the aforesaid order of the MIA violated any federal or State law other than those to be addressed in the MIA's report and to identify any changes in law that should be made to protect the public interest.

NO CHANGE

***Statutory Authority granted to Commissioner
over Nonprofit Health Services Plans (“nphp”)***

<u>Statute</u>	<u>Summary</u>
Title 2 <i>Enforcement</i>	
§2-205	Whenever the Commissioner considers it advisable, they shall examine the affairs transactions accounts records, and assets of each insurer
§2-206	When advisable to determine compliance with this article the Commissioner may examine the records accounts documents, and transactions that relate to the insurance affairs of insurance producers, managers and others.
§2-209	Commissioner shall make a report of examinations and investigations
§2-502	Commissioner shall collect an annual assessment fee calculated pursuant to statute
Title 3	
§3-127	Must file required registration for proposed sale of securities with Commissioner; Commissioner may issue and serve a cease and desist order
Title 4 <i>General Requirements for Insurers</i>	
§4-113 <i>Denials, refusals</i>	The Commissioner shall refuse to renew,
<i>to renew, suspend</i>	suspend, or revoke a certificate of authority if:
<i>and revocations</i>	
(a) <i>Mandatory</i>	9 mandatory grounds including: insurer no longer meets requirement’s for a certificate of authority; business is fraudulently conducted; insolvency; willfully fails to provide Commissioner with required information about medical malpractice insurance; issuance or renewal is contrary to public interest; Commissioner finds that the principal management personnel of the insurer is untrustworthy or so lacking in insurer managerial experience as to make the proposed operation hazardous; Commissioner has good reason to believe there is an affiliation, directly or indirectly, through ownership, control, management reinsurance transactions, or other insurance business relations with a person whose business has been marked by the manipulation of assets, account, or reinsurance or bad faith to the detriment of insureds, stockholders or creditors

(b) <i>Discretionary</i>	15 discretionary grounds including knowingly fails to comply with Commissioner's order; refuses or delays payments without just cause; refuses examination or to produce files etc for examination; found by the Commissioner to be in unsound condition or in a condition that renders further transaction of insurance business hazardous to the insurer's policyholders or the public; refuses to provide information that the Commissioner considers advisable in considering an application for renewal.
§4-114(b) <i>Home office</i>	may not move its Home office or executive office out of State without approval of Commissioner
(c)	shall keep its general ledger accounting records and all of its assets (with specified exceptions) in the State.
(d)	may not keep more than 15% of assets outside of State without approval of Commissioner
Title 5 <i>Assets Liabilities, Reserves, and Investments of Insurers</i>	
§5-201	Reserve Requirements for a nonprofit health services plans
(c)	annual submission of opinion of actuary required
§5-202	If Commissioner determines they are inadequate, Commissioner may require insurer to increase the unearned premium reserve and the loss reserves and maintain them at an adequate level.
§5-205	Commissioner requirements for unearned premiums reserves
§5-301	Commissioner requirements for valuation
§5-401	Insurer's investments shall be value at Commissioner's discretion
Title 7 <i>Maryland Insurance Acquisition Disclosure and Control Act</i>	
§7-104(c)	Commissioner may find that a person presumed to have control of an insurer does not have control or that a person not presumed to have control of an insurer or person does have control of the insurer.
§7-105(b)	Commissioner may discount an investment or treat it as non-admitted asset for purposes of determining adequacy of surplus
§7-202(f)	Limitations on investments in subsidiaries; Commissioner must approve certain investments in subsidiaries

§7-203	Commissioner may extend statutory time for disposal of assets after control of subsidiary ends
§7-302	Nonprofit health services plans must comply with all requirements of title before making a tender offer for, invite tender offers of, enter into an agreement to exchange securities for or otherwise acquire any voting security or security convertible into voting security of a domestic insurer or
(2)	make an agreements to merge or otherwise acquire control of a domestic insurer
§7-303 <i>Pre-acquisition Notification</i>	must be filed with Commissioner
§7-304	Statement must be filed with Commissioner
§7-305(a)	Invitations for tenders and agreements must be filed with Commissioner
§7-306 <i>Review of trans.</i>	Commissioner has 60 days to approve or fail to disapprove a transaction <i>by Commissioner</i>
(b) <i>Grounds for disapproval</i>	may substantially lessen competition in insurance in the State or tend to create a monopoly; financial condition of acquirer might jeopardize financial stability of domestic or prejudice interests of policyholders; or <i>inter alia</i> , interests of policyholders might otherwise be prejudiced
§7-307	Commissioner may hire additional experts at expense of nonprofit health services plans.
§7-308(b)	Commissioner appointed as attorney for service of process n any proceeding arising out of a violation of this subtitle.
Title 9 <i>Impaired Entities</i>	
§9-102(a)	Fifteen (15) factors for the Commissioner to consider in determining a financially hazardous condition

(b)(4)	Powers of Commissioner in determining whether the financial condition of nonprofit health services plans would cause continued operations to be hazardous to policyholders or creditors or to general public
§9-103	Commissioner may require insurer to reduce the total amount of present and potential liability under policies; reduce , suspend or limit the volume of business being accepted or renewed; reduce general insurance commission expenses by specified methods; increase capital surplus; suspend or limit the declaration and payment of divided to policyholders or stockholders; file a report in a form acceptable to the Commissioner about market value of its assets; limit or withdraw certain investments or discontinue certain investment practices to the extent Commissioner deems necessary; document the adequacy of premium rates in relation to risks insured; or file, in addition to regular annual statements, interim financial reports on NAIC for required by the Commissioner.
§9-211	Commissioner may apply to the court for an order that directs Commissioner to conserve or rehabilitate an insurer
§9-215	On application of Commissioner, a court may issue ex parte order that directs the Commissioner to take possession and control of all o part of the property of an insurer and enjoins the insurer and its officer etc. from the transaction of its business.
Title 10 <i>Regulation of Insurance Professionals</i>	
§10-104	Insurance producers must pass examination given by Commissioner
§10-109(d)	Commissioner shall adopt reasonable regulations for grading of examinations and educational requirements for insurance producers

Title 14 <i>Entities That Act as Health Insurers</i>	
§14-106(c) <i>Report</i>	Premium Tax exemption report must be filed with Commissioner annually by March 1 on form approved by Commissioner, and must demonstrate that plan used funds equal to value of premium tax exemption in a manner that serves the public interest (public service requirement)
§14-112 <i>Revocation</i>	Commissioner may revoke certificate of authority if grounds exist under §4-113 or if Commissioner has reasons to believe it is being operated for profit, fraudulently conducted or is not complying with the articles, knowingly failing to comply with rules, regulations or order of Commissioner.
§14-115 <i>Board of Directors</i>	Composition and duties of the Board of Directors; appoint 2 additional Board members to serve as voting consumer members, 1 subscriber & 1 certificate holder
§14-116 <i>Unsound or unsafe</i>	If Commissioner finds that Corporation is practicing unsound or unsafe business practices he shall issue a warning; and if corporation is unresponsive, Commissioner may remove aff. Or D.if Commissioner determines (after hearing etc) that unsound or unsafe business practice is continued after warning
(d)	May not alter its structure, operation, or affiliations if Commissioner determines purpose of non-profit health plan (“nonprofit health services plans”) may no longer be characterized as operating a nonprofit health services plans
§14-117 <i>Surplus Req’t’s</i>	Commissioner may require larger surplus
§14-119	Commissioner must be notified of impaired surplus
§14-120 <i>Investments</i>	Permissible investments; Commissioner may allow investments over statutory amount
§14-121	Audited statement of financial condition must be filed with Commissioner annually
§14-124	Commissioner may conduct any investigation or hearing he deems necessary to enforce subtitle and may adopt regulations
§14-125	Commissioner may inspect & audit offices of nonprofit health services plans and affiliates or subsidiaries

§14-126	
(a)(1)	may not amend its certificate of incorporation, by-laws or terms and provisions of contracts issued or proposed to be issued until approved by Commissioner
(a)(2)	may not change table of rates charged without approval of Commissioner
§14-133	may not invest or acquire an affiliate or subsidiary unless Commissioner approves in writing
§14-136	Discriminatory or unfair trade practices prohibited
§14-139	officer, director or employee may not willfully violate this article; conceal a material fact in a statement report, record or communication; misappropriate or fail to account properly for money; engage on fraudulent or dishonest practices in connection with the provision or administration of a health services plan; willfully fail to produce records or allow an examination; or willfully fail to comply with an order of the Commissioner
(b)	officer, director or trustee may not receive any immediate or future remuneration as the result of an acquisition or proposed acquisition
§14-140	may not engage in business of operating nonprofit health services plans unless has certificate of authority from Commissioner
Title 15 <i>Health Insurance</i>	
§15-104	Commissioner shall adopt non-duplication and coordination provisions in nonprofit health services plans policies
§15-110	Must notify the Commissioner of prohibited referrals within 30 days of knowledge
§15-119	Must use referral form adopted by Commissioner
§15-124	required to provide enrollment information regarding dependents
§15-126	may not require pre-authorization for access to 911 services
§15-130	Benefit card requirements
Title 27 <i>Unfair Trade Practices and other prohibited practices</i>	
§27-103	Commissioner shall order a cease and desist if he finds nonprofit health services plan is engaged or engaging in a prohibited act.

§27-104	If Commissioner believes that nonprofit health services plan is engaged in a method of competition that, although not defined in this title, is an unfair method of competition or an unfair or deceptive act or practice, he may charge a violation and bring an action to enjoin and restrain the nonprofit health service plans
§27-603(e)&(f)	Commissioner must approve each plan of withdrawal or amendment
The following Subtitles are applicable to a nonprofit health service plan and the Commissioner has authority to enforce:	
§2-201 et seq.	<i>Enforcement</i>
§7-401 et seq.	<i>Acquisition of Control of Insurer</i>
§7-501 et seq.	<i>Acquisition of Health Service Plan</i>
§9-201 et seq.	<i>Liquidation, Rehabilitation, Reorganization and Conservation</i>
§15-401 et seq.	<i>Eligibility for coverage</i>
§15-601 et seq.	<i>Required Reimbursement of Institutions</i>
§15-801 et seq.	<i>Required Health Insurance Benefits</i>
§15-901 et seq.	<i>Medicare Supplement Act</i>
§15-1001 et seq.	<i>Utilization review</i>
§27-201 et seq.	<i>Unfair methods of competition prohibited</i>
§27-301 et seq.	<i>Unfair claim settlement practices</i>
§27-401 et seq.	<i>Fraudulent Insurance Acts</i>
§27-501 et seq.	<i>Discrimination in Underwriting prohibited</i>
§27-601 et seq.	<i>Cancellations, Non-renewals, premium increase and reduction in coverage</i>
§27-801 et seq.	<i>Reporting and preventing insurance fraud</i>
§27-913	Misc. Different policy terms based on diagnosis prohibited