STATE OF MARYLAND
MARYLAND INSURANCE ADMINISTRATION

IN RE:	*	
	*	
The Consolidated Application	*	
Conversion of CareFirst, Inc. and	*	
CareFirst of Maryland, Inc. to	*	MIA No. 2003-02-032
For-Pofit Status and the Acquisition	*	
of CareFirst, Inc. by Wellpoint	*	
Health Networks, Inc.	*	

* * *

EXHIBIT A

REPORT OF THE MARYLAND INSURANCE ADMINISTRATION, *STEVEN B. LARSEN, COMMISSIONER,*

REGARDING THE PROPOSED CONVERSION OF CAREFIRST, INC. TO FOR-PROFIT STATUS AND ACQUISITION BY WELLPOINT HEALTH NETWORKS, INC.

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I. FOREWORD

On January 11, 2002, CareFirst, Inc. ("CareFirst"), CareFirst of Maryland, Inc. ("CFMI" or "BCBSMD"), and WellPoint Health Networks Inc. ("WellPoint") filed with the Maryland Insurance Administration" ("MIA") a consolidated document denominated "FORM A STATEMENT REGARDING THE ACQUISITION OF CONTROL OF OR MERGER WITH A DOMESTIC INSURER" (the "Application" or "Form A") seeking the prior approval of the Commissioner of Insurance of the State of Maryland for (i) the conversion of CareFirst and CFMI, both Maryland non-stock corporations, to for-profit status pursuant to Title 6.5, Subtitle 2, of the Maryland Code, and (ii) the acquisition of control of CareFirst, Inc. and the indirect control of CFMI and its wholly-owned, for-profit subsidiaries by WellPoint. (Together, the proposed conversion and acquisition are referred to herein as the "Proposed Transaction.")

This report represents the MIA's analysis of, and conclusions regarding, the Proposed Transaction. It includes a brief history of CareFirst (with an emphasis on events related to the proposed conversion), describes the Proposed Transaction, summarizes the history of the acquiring party, WellPoint, analyzes the law applicable to the conversion, explains the process by which the MIA has reviewed the Application, and details the observations and conclusions resulting from that review. For the convenience of the public and interested parties, the MIA has placed on its world wide web site (www.mdinsurance.md.state.us) copies of the Application, related documents, transcripts of hearings and depositions, pre-filed testimony, and expert reports regarding the Proposed Transaction.

In a filing dated January 17, 2003, CareFirst and WellPoint submitted an amended "FORM A STATEMENT REGARDING THE ACQUISITION OF CONTROL OF OR MERGER WITH A DOMESTIC INSURER" (the "Amended Application" or "Amended Form A").[1] The Amended Form A includes an "AMENDED AND RESTATED AGREEMENT AND PLAN OF MERGER" (the "Amended Merger Plan") containing certain substantive changes in the parties' agreement relating to executive compensation, purchase price, and the suspension of the breakup fee. Although most of the evaluation of the Proposed Transaction by the MIA occurred before the filing of the Amended Application, this report, includes an analysis of the Amended Application.

The analysis contained in this document is intended for several audiences. First and foremost, it represents the MIA's evaluation, which serves as the basis for the Order issued by the MIA on the Proposed Transaction. While portions of the report are specifically labeled "key points" or "conclusions," the report in its entirety forms the basis of the MIA's decision, and the decision was informed not just by the material presented here, but also by the record in its entirety. The report should also serve to inform the citizens of this state about the MIA's analysis of the proposed

[1] This amendment should be distinguished from the amended application filed by WellPoint, CareFirst, and GHMSI on August 19, 2002, with District of Columbia regulators (the "Amended D.C.March 4, 2003, Form A").

conversion and the steps the agency has taken for the protection of the public interest. The report is annotated so that interested parties can refer to the documents underlying many of its observations. The annotations refer at times to transcripts and other documents that can be found on the MIA web site. Other references are by "Bates number" to documents gathered as part of the evaluation process, and which are public, but not posted on the web site.

It is difficult in compiling a report of this nature, to strike the proper balance between the desire to be fully informative and the practical constraints that must limit the material included within. Over 100 hours of testimony was taken, over 85,000 pages of documents requested and reviewed, ten expert reports were obtained, and the MIA staff also performed various analysis on finance and actuarial issues, and benefit comparisons. The general principle that has guided the MIA in compiling this document has been the need to provide adequate context within which the Proposed Transaction and the Commissioner's decision may be understood by those most affected, the citizens of this State.

II. TERMS OF THE PROPOSED TRANSACTION

This section describes the essential terms of the Proposed Transaction, with an emphasis on economic terms.

A. Structure of the Transaction

The Proposed Transaction would consist of essentially of (I) the conversion of CareFirst and CFMI, both Maryland non-stock corporations, to for-profit status and (ii) the acquisition of control of CareFirst and the indirect control of CFMI and its wholly-owned, for-profit subsidiaries by WellPoint. CareFirst is also the sole member of Group Hospitalization and Medical Services, Inc., a non-stock corporation organized under federal law ("GHMSI" or "BCBS-NCA"), and BlueCross BlueShield Delaware, a Delaware non-stock corporation ("BCBSD"), each of which owns various for-profit insurance-related subsidiaries.

The Merger Agreement provides for an immediately successive two-step process: a conversion of CareFirst, Inc. and GHMSI, CFMI, and BCBSD (the "Primary CareFirst Insurers") to for-profit status (the "Conversion"), followed by a merger of Congress Acquisition Corp. ("CFAC"), a wholly-owned subsidiary of WellPoint, with and into CareFirst (the "Merger"). After the Merger is consummated, WellPoint would own 100% of the issued and outstanding stock of CareFirst which would, in turn, own 100% of the issued and outstanding stock of the Primary CareFirst Insurers.

As part of the Conversion, each of the Primary CareFirst Insurers will issue 100% of its outstanding shares of common stock to CareFirst, thus becoming a wholly owned subsidiary of CareFirst. CareFirst would issue 100% of its outstanding shares of common stock to certain tax-exempt Foundations in Maryland, the District of Columbia and Delaware, representing the percentage of the aggregate value of CareFirst, represented by each subsidiary insurer, as determined by the Insurance Commissioner of the State of Maryland, the Insurance Commissioner and Corporation Counsel in the District of Columbia, and the State of Delaware. Thus, immediately preceding the Merger, CareFirst would own 100% of the common stock of the three Primary CareFirst Insurers and would itself be owned 100% by the various tax-exempt foundations. Each share of CareFirst, common stock held by the tax-exempt foundations will be converted into a consideration amount comprised of cash having an aggregate value of $1.37 billion.

B. Purchase Price

As the agreement was executed, WellPoint was to pay an aggregate consideration of $1.3 billion. The cash component would not be less than $450 million (35% of the purchase price), and the balance would consist of WellPoint stock with a value of not more than $850 million (65% of the purchase price). WellPoint would also have the option to increase the cash component up to 100%.[2] If the WellPoint stock fell below $70 per share, WellPoint could still calculate the value of the stock component at $70 per share, but make up the difference between the lower stock price, and the stipulated $70 share price by issuing subordinated notes.[3] The Amended Form A, filed on January 17, 2003, eliminates the non-cash components and raises the purchase price by $70 million.

C. Foundation Indemnification

In order to limit WellPoint's tax exposure, WellPoint negotiated a provision whereby the charitable foundation receiving the consideration as part of the Proposed Transaction would be required to indemnify WellPoint in the remote possibility that the IRS ever revoked its ruling that this would be a tax-free transaction. The magnitude of this risk has not yet been quantified with certainty, but it can certainly be very substantial. Counsel for CareFirst has estimated that it might be as much as $100 - $125 million. In order to cover this risk, WellPoint would contribute up to $5 million for the purchase of insurance to cover this risk.[4] In the event that insurance that would protect the foundation adequately against the risk created by this agreement can be purchased for $5 million or less, this indemnification provision may not present a risk to the foundation. On the other hand, if adequate insurance cannot be obtained at a reasonable price, the risk may become more substantial.

D. Fiduciary Out

Under the parties' agreement, CareFirst has a "fiduciary out," whereby it could accept an unsolicited superior proposal from another bidder. The Merger Agreement provides, *inter alia*:

CareFirst has entered into a non-solicitation clause whereby it agrees not to solicit a third party merger proposal; however, it may negotiate with a third-party making an unsolicited merger proposal if the CareFirst board concludes that failure of such negotiations is a breach of fiduciary duty.[5]

> [The agreement may be terminated by] CareFirst or Purchaser in writing, if the Board of Directors of CareFirst authorizes CareFirst to execute a binding written agreement with respect to a transaction that constitutes a Superior Proposal; provided, however, that prior to any such authorization, (I) the Board of Directors of CareFirst, after consultation with legal counsel, shall determine in good faith that contemplation of such Superior Proposal and termination of this Agreement is required for such Board of Directors to comply with its

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[2] March 6, 2002, pre-filed written testimony of Stuart F. Smith at 6, CF-0012467

[3] Id. Testimony of R. W. Smith, Jr., Day 3, March 14, 2002, at 111 – 112.

[4] Id. at 171 – 174.

[5] Form A Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer, at 31, Section 6.14 "Non-Solicitation.", CF-0000053.

> fiduciary duties under applicable law, (ii) CareFirst notifies Purchaser in writing that it intends to enter into such an agreement and provides Purchaser with the proposed definitive documentation for such Superior Proposal and (iii) Purchaser does not, within seven days after the receipt of such written notice and documentation, provide a written offer that the Board of Directors of CareFirst determines in good faith to be at least as favorable as the Superior Proposal. [6]

The agreement provides that if either party terminates due to the above-stated reasons, then CareFirst will have to pay a $37.5 million termination fee to WellPoint (the "break-up fee"). By statute, the Maryland Legislature authorizes the Commissioner to disapprove termination fees if they are not in the public interest.[7] The Amended Form A suspends the break-up fee (other than the expenses of regulatory review, including consultants) for 60 days after the Amended Merger Plan was signed, January 24, 2003.

E. Assumption of Coverage

By law, all outstanding contracts of CareFirst shall remain in full force and effect after the conversion and need not be otherwise endorsed unless ordered by the regulating entity.[8]

III. APPLICABLE LAW

A. Applicable Statutes

MD. CODE ANN., STATE GOV'T §§ 6.5-101, *et seq.* (the "Conversion/Acquisition Statute"), governs the acquisition of a nonprofit health service plan such as CareFirst with "acquisition" defined broadly as:

(1) a sale, lease, transfer, merger, or joint venture that results in the disposal of the assets of a nonprofit health entity to a for-profit corporation or entity or to a mutual benefit corporation or entity when a substantial or significant portion of the assets of the nonprofit health entity are involved or will be involved in the agreement or transaction;
(2) a transfer of ownership, control, responsibility, or governance of a substantial or significant portion of the assets, operations, or business of the nonprofit health entity to any for-profit corporation or entity or to any mutual benefit corporation or entity;
(3) a public offering of stock; or

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[6] Id. at 38, Section 8.1 "Termination of Agreement" sub-paragraph (h), CF-0000060.

[7] MD. CODE ANN., STATE GOV'T 6.5-203(g) (2002). According to the Merger Plan, the termination fee was $37.5 million, but that represented less than three percent of the purchase price. According to testimony from Piper Rudnick, the termination fee was a very reasonable provision and was typical of other similar merger agreements, in which termination fees ranged from two to five percent. In addition, a study of 144 public company transactions in the year 2000 showed that the mean and median breakup fee was 2.9%. Moreover, the termination fee is only payable if CareFirst accepts a superior offer.

[8] Md. Code Ann., State Gov't § 6.5-304(c) (2002).

(4) a conversion to a for-profit entity.[9]

Thus, either a conversion to a nonprofit company or an acquisition of a nonprofit by a for-profit triggers the acquisition statute. CareFirst is the sole member, and holding company, of CFMI, a domestic insurer. Both CareFirst and CFMI are licensed in the State of Maryland as nonprofit health service plans. In addition, Subtitle 3 of the Maryland Insurance Acquisitions Disclosure and Control Act (the "Insurance Acquisitions Act") applies to any merger that would result in the acquisition of direct or indirect control of a domestic insurer or nonprofit health service plan, or of an insurance holding company controlling a domestic insurer or domestic nonprofit health service plan.[10]

B. Review Standards

The conversion of CareFirst and BCBSMD to for-profit entities, and WellPoint's acquisition of control of the companies through merger, are subject to the requirements of the Conversion/Acquisition Statute. The proposed acquisition of control by WellPoint is also subject to approval under the requirements of the Insurance Acquisitions Act.

1. The Conversion Statute

The Administration *may not* approve a conversion/acquisition to for-profit status unless it finds such conversion/acquisition to be in the public interest.[11] A conversion to for-profit status and acquisition are not in the public interest unless appropriate steps have been taken to:

(1) ensure that the value of public or charitable assets is safeguarded;
(2) ensure that the fair value of the public or charitable assets of a nonprofit health service plan will be distributed to the Maryland Health Care Foundation that was established in § 20-502 of the Health-General Article;
(3) ensure that no part of the public or charitable assets of the acquisition inure directly or indirectly to an officer, director, or trustee of a nonprofit health entity; and
(4) ensure that no officer, director, or trustee of the nonprofit health entity receives any immediate or future remuneration as the result of an acquisition or proposed acquisition except in the form of compensation paid for continued employment with the acquiring entity. Id.

The Conversion/Acquisition Statute defines "public assets" as:

(1) assets held for the benefit of the public or the community;
(2) assets in which the public has an ownership interest; and
(3) assets owned by a governmental entity. [12]

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[9] Md. Code Ann., State Gov't § 6.5-101(b) (2002).

[10] Md. Code Ann., Ins. §§ 7-103; 7-301(a); and 7-302 (2002).

[11] Md. Code Ann., State Gov't § 6.5-301(a) (2002).

[12] MD. CODE ANN., STATE GOV'T § 6.5-101(I) (2002). "It is undisputed that the public 'owns' the entire consideration paid by WellPoint to acquire CareFirst." Memorandum of Law in Support of The Compensation Arrangements Approved by the Board of Directors of CareFirst, Inc., November 13, 2002, at 15.

In determining the fair value of public or charitable assets, the regulating entity may consider all relevant factors, including, as determined by the regulating entity:

(1) the value of the nonprofit health entity or an affiliate or the assets of such an entity that is determined as if the entity had voting stock outstanding and 100% of its stock was freely transferable and available for purchase without restriction;
(2) the value as a going concern;
(3) the market value;
(4) the investment or earnings value;
(5) the net asset value; and
(6) a control premium, if any.[13]

In addition to those factors in Section 301(a), which if not satisfied, prohibit a determination as a matter of law that the transaction is in the public interest, the conversion statute sets forth additional standards for "consideration" by the MIA. In determining whether a conversion/acquisition is in the public interest, the MIA shall consider:

(1) whether the transferor exercised due diligence in deciding to engage in an acquisition, selecting the transferee, and negotiating the terms and conditions of the acquisition;
(2) the procedures the transferor used in making the decision, including whether appropriate expert assistance was used:
(3) whether any conflicts of interest were disclosed, including conflicts of interest of board members, executives, and experts retained by the transferor, transferee, or any other parties to the acquisition;
(4) whether the transferor will receive fair value for its public or charitable assets;
(5) whether public or charitable assets are placed at unreasonable risk if the acquisition is financed in part by the transferor;
(6) whether the acquisition has the likelihood of creating a significant adverse effect on the availability of health care services in the affected community;
(7) whether the acquisition includes sufficient safeguards to ensure that the affected community will have continued access to affordable health care; and
(8) whether any management contract under the acquisition is for fair value.[14]

Finally, the conversion statute sets forth additional criteria for "consideration." In determining whether to approve a conversion/acquisition of a nonprofit health service plan, the Administration shall also consider:

(1) the criteria listed in § 6.5-301, see supra and
(2) whether the acquisition:
    (a) is equitable to enrollees, insureds, shareholders, and certificate holders, if any, of the transferor;
    (b) is in compliance with Title 2, Subtitle 6 of the Corporations and Associations Article (relating to amendment and restatement of charter);
    ©) ensures that the transferee will possess surplus in an amount sufficient to:

[13] Md. Code Ann., State Gov't § 6.5-301(d) (2002).

[14] Md. Code Ann., State Gov't § 6.5-301(e) (2002).

(i) Comply with the surplus required under law; and
(ii) provide for the security of the transferee's certificate holders and policyholders.[15]

2. The Insurance Acquisitions Statute

Pursuant to the Insurance Acquisitions Act, the Commissioner shall disapprove a proposed transaction if he finds that:

(1) after the transaction, the domestic insurer could not satisfy the requirements for the issuance of a certificate of authority to engage in the insurance business which it intends to transact in the State, taking into consideration the financial and managerial resources and future prospects of the domestic insurer;
(2) the transaction may substantially lessen competition in insurance in the State or tend to create a monopoly;
(3) the financial condition of an acquiring person might jeopardize the financial stability of the domestic insurer or prejudice the interests of its policyholders or, in the case of an acquisition of control, the interests of any remaining stockholders who are unaffiliated with the acquiring person;
(4) the acquiring person has plans or proposals that are unfair or prejudicial to policyholders for liquidating the domestic insurer, selling its assets, merging it with another person, or making any other major change in its business or corporate structure or management;
(5) it would not be in the interest of policyholders, shareholders, or the public to allow the acquiring person to control the domestic insurer based on the competence, experience, and integrity of the persons that would control the operations of the domestic insurer;
(6) any party to an agreement to merge with a domestic insurer is not itself an insurer; or
(7) the interests of the domestic insurer's policyholders and stockholders might otherwise be prejudiced, impaired, or not properly protected.[16]

In disapproving a transaction based on a finding under subsection (b)(2), based on competition in insurance:

(1) the Commissioner may not disapprove a transaction if the Commissioner finds that any of the following situations exist:
    (a) the acquisition will yield substantial economies of scale or economies in resource utilization that cannot be achieved feasibly in any other way, and public benefits from those economies outweigh the public benefits from not lessening competition; or
    (b) the acquisition will increase substantially the availability of insurance, and public benefits from that increase outweigh the public benefits from not lessening competition.
(2) the Commissioner may condition the approval of a transaction on the removal of the basis of disapproval under subsection (b)(2) within a specified time; and

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[15] Md. Code Ann., State Gov't § 6.5-303 (2002).

[16] MD. CODE ANN., INS. § 7-306(b) (2002).

(3) the disapproval is subject to § 7-405(c) and the informational requirements under § 7-403(c).[17]

C. Attorney General Rulings

1. GHMSI

On November 12, 2002, the Attorney General issued an Opinion that confirmed that the Insurance Commissioner has the authority to review the conversion and sale of GHMSI, even though GHMSI is domiciled in the District of Columbia. 87 *Opinions of the Attorney General* ___ (2002) [Opinion No. 02-019 (November 12, 2002)]. The Opinion noted that transfer of control of GHMSI to WellPoint would be achieved through the merger of GHMSI's parent, CareFirst, Inc. which is a Maryland nonprofit health insurance plan. Under the Insurance Acquisitions Disclosure and Control Act, the Commissioner must review the proposed conversion and sale of CareFirst.

In addition, the conversion and sale of GHMSI is subject to the Commissioner's review under § 14-133 of the Insurance Article. Under that section, CareFirst is required to obtain the Commissioner's approval to change the ownership or structure of its subsidiaries. GHMSI is a subsidiary of CareFirst. The Commissioner must, therefore, consider that part of the proposed transaction that involves GHMSI in deciding whether to approve CareFirst's request to change its ownership as well as the ownership and control of its subsidiaries, including GHMSI.

Finally, the conversion and sale of GHMSI are subject to the Commissioner's approval under the Conversion Statute. Pursuant to §§ 201 and 307, an acquisition of a nonprofit health entity (which includes a nonprofit health service plan) may not occur without the Commissioner's approval. GHMSI is a nonprofit health service plan, as that term is defined in the statute. That is, GHMSI is a corporation without capital stock with a certificate of authority from the Insurance Commissioner to operate as a nonprofit health service plan.[18] While the Commissioner may rely on the investigation and the decision of the District of Columbia Insurance Commissioner in assessing whether to approve the GHMSI conversion under the Maryland conversion law, the Commissioner is not required to do so and, indeed, should not do so unless the Commissioner is able to find that the review of the District of Columbia Commissioner will result in the protection of the public or charitable assets that serve health care needs in Maryland.

2. Anti-Bonus Provision

On January 27, 2003, the Attorney General issued an Opinion regarding the application of MD. CODE ANN., STATE GOV'T § 6.5-301(4) (the "Anti-Bonus Provision") to the application of

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[17] MD. CODE ANN., INS.§§ 7-306©) and 7-405(b) (2002). According to the Conversion Statute, within 60 days after the record, including the public hearing process, has been closed, subject to a maximum of two 60 -day extensions, the Administration shall: (1) approve the acquisition, with or without modifications; or (2) disapprove the acquisition. MD. CODE ANN., STATE GOV'T §§ 6.5-203(f)(2) and (g) (2002). The Administration's approval or disapproval is not effective until 90 days after the Administration's decision. Id. at § 6.5-203(h). Moreover, a transaction subject to subtitle 3 of the may not be made unless, within 60 days after the statement required by § 7-304 filed with the Commissioner or within any extension of that period, the Commissioner approves the transaction or does not disapprove the transaction. MD. CODE ANN., INS. § 7-306(a).

[18] Md. Code Ann., State Gov't § 6.5-102(h).

CareFirst to convert to for-profit status and to be acquired by WellPoint. 88 *Opinions of the Attorney General* ___ (2003) [Opinion No. 03-002 (January 27, 2003)]. That section was added to the law in the 2002 session of the General Assembly. The Opinion concludes that the application of the Anti-Bonus Provision to a transaction that was proposed prior to its enactment would not violate any State or federal constitutional rights of the parties to the proposed transaction.

In addition, as the Opinion confirms, the amended application filed by CareFirst on January 17, 2003, makes moot the question of whether the Anti-Bonus Provision would preclude approval of the transaction contemplated in CareFirst's original Form A filing. The Amended filing reflects what purports to be a different agreement with regard to executive compensation issues in connection with the proposed conversion and acquisition. That agreement and the Amended Form A were submitted *after* the affective date of the Anti-Bonus Provision.[19]

IV. PROCEDURAL HISTORY

On January 11, 2002, WellPoint and CareFirst submitted their Form A to the Commissioner, seeking approval of the proposed conversion of CareFirst to for-profit status, and WellPoint's acquisition of CareFirst (and the indirect acquisition of CFMI and its wholly-owned, for-profit subsidiaries), pursuant to an Agreement and Plan of Merger dated November 20, 2001.

Concurrently with the filing of the Form A with the Commissioner in Maryland, WellPoint and CareFirst filed applications with Delaware and District of Columbia regulators for approval of the Proposed Transaction. On January 11, 2002, WellPoint, CareFirst, and GHMSI filed their application with the Department of Insurance and Securities Regulation and the Office of Corporation Counsel in the District of Columbia. On the same day, WellPoint, CareFirst, and BCBSDE filed their application with the Delaware Department of Insurance. On August 15, 2002, WellPoint withdrew its application in Delaware, in order to defer incurring additional transaction costs until after it could review the valuation report prepared for the Commissioner in Maryland. On August 19, 2002, WellPoint, CareFirst, and GHMSI filed an amended application with District of Columbia regulators (the "Amended D.C. Form A"). On October 18, 2002, WellPoint refiled its application in Delaware. Review of the Proposed Transaction is proceeding in Delaware and the District of Columbia concurrently with, but independently from, review by the MIA.

A. Public Notice

The conversion statute contains certain requirements for notice and hearing after an application is filed. Under the conversion statute, within ten working days after receiving an application for acquisition of a nonprofit health service plan, the Administration shall:

(1) publish notice of the application in the most widely circulated newspapers that are part of the nonprofit health care plan's service area; and
(2) notify by first-class mail any person that has requested in writing notice of the filing of an application.[20]

The notice shall:

(1) state that an application has been received;

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[19] See Opinion at 11 n. 11.

[20] Md. Code Ann., State Gov't § 6.5-202(a) (2002).

(2) state the names of the parties to the acquisition;
(3) describe the contents of the application;
(4) state the date by which a person must submit written comments on the application; and
(5) provide the date, time, and place of the public hearing on the acquisition.

MD. CODE ANN., STATE GOV'T § 6.5-202(b) (2002). The applicant shall bear the cost of the notice.[21]

Pursuant to these provisions, the MIA provided notice of CareFirst's application to convert and be acquired by publishing a notice of public hearing during the weeks of January 20 and 27, 2002, in the most widely circulated newspapers that are part of CareFirst's service area, including, but not limited to, The Baltimore Sun and the Washington Post.

Initial opportunities for public comment were provided in hearings scheduled as follows:

Monday, February 4, 2002	Bel Air
Thursday, February 7, 2002	Wye Mills
Monday, February 11, 2002	Rockville
Wednesday, February 13, 2002	Hagerstown
Wednesday, February 27, 2002	Clinton
Thursday, March 14, 2002	Catonsville
Tuesday, April 30, 2002	Baltimore

B. Requests for Information

The Conversion Statute permits broad discovery by the MIA in connection with the review of a proposed conversion. Under the statute, the Administration may:

(1) subpoena information and witnesses;
(2) require sworn statements;
(3) take depositions; and
(4) use related discovery procedures.[22]

There is no provision for the conduct of discovery by any person other than the Administration.

On February 22, 2002, the MIA served its First Subpoena *Duces Tecum* to CareFirst (the "Subpoena") and WellPoint regarding the Proposed Transaction, with the requested documents to be produced on March 6, 2002.

Counsel for CareFirst and WellPoint sent a letter in response to the Subpoena on February 28, 2002, in which they asked for an extension of time due to the voluminous number of documents requested. In that letter they requested that the document production be bifurcated, so that documents required in preparation for the previously scheduled March 2002 hearings would be produced on March 6, 2002, and additional documents would be produced by April 12, 2002.

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[21] Id. at § 6.5-202(c) (2002).

[22] Id. at § 6.5-203(d) (2002).

The MIA responded by letter on March 1, 2002, requesting production of documents by March 6, 2002, for 37 of the items listed on the Subpoena. The deadline for production of documents in response to all other items was extended to April 1, 2002.

The MIA received documents responsive to the Subpoena on both March 6, 2002, and April 1, 2002. Subsequently, CareFirst asserted confidentiality for Minutes of the Board of Directors, Strategic Planning Committee and Compensation Committee dated October 25, 2001, through February, 2002 ("the Minutes"); the BlueCross BlueShield Association Capital Benchmark calculation for the years ended December 31, 1996, to December 31, 2001; and all rating agency presentations made by CareFirst entities during the five years ending December 31, 2001.

On August 5, 2002, the Commissioner sent written notice to CareFirst of his intent to make public the documents for which CareFirst asserted confidentiality. CareFirst was instructed to respond in writing by August 16, 2002, setting forth reasons, if any, why the information should not be disclosed.

On August 16, 2002, CareFirst consented to the release of the document given to the MIA regarding Capital Benchmark calculations (the document in question was one paragraph asserting confidentiality). CareFirst did not consent to release of the Board and Committee Minutes and the rating agency presentations, claiming both contained confidential commercial information and confidential financial information. CareFirst proposed to redact those portions of the minutes and the rating agency presentations that it claimed were confidential. CareFirst also asserted its right to an administrative hearing before the MIA made any confidential material public.

On September 16, 2002, CareFirst submitted two binders containing the minutes and rating agency presentations, with certain information highlighted as proposed redactions, along with an Affidavit of G. Mark Chaney. The Affidavit described in detail the information CareFirst had concluded was confidential and the reason why disclosure would likely cause substantial competitive injury to CareFirst.

On December 31, 2002, the MIA responded by letter to CareFirst, attaching a log of the pages that contained proposed redactions. The log indicated the page, the description of information that CareFirst wanted redacted, the MIA's determination ("P" for public or "C" for confidential), and the rationale for release, if appropriate. Also attached was a description of "reason codes" with reference to comparable or similar information that is already available to the public. The MIA determined that a vast majority of the type of information that CareFirst claimed was confidential commercial information is either widely available for public companies, has already been released, or is available in other forms such as NAIC or MIA filings. Therefore, the MIA found no basis to conclude it was confidential commercial material. Even if it had been confidential, which the MIA ruled it had been, it found release of the material is in the public interest in order to facilitate the public's understanding of the transaction.

C. RFP, Review Areas, Evaluation Process, and Selection of Advisors

The Conversion Statute permits the MIA to retain experts, at WellPoint's expense. The selection of experts was conducted in accordance with the State procurement process. To assist, both with the analysis of the Proposed Transaction, and to retain and coordinate the work of consulting experts, CANTILO & BENNETT, L.L.P. was retained by the MIA in January 2002, through a sole source procurement. On January 29, 2002, the MIA issued its Request for Proposals ("RFP") seeking expert assistance in four functional areas to determine the effect of conversion on citizens of Maryland and the health insurance industry. Experts were sought to (1) determine whether

CareFirst had exercised due diligence in deciding to engage in the acquisition and whether all conflicts of interest had been identified and disclosed, as required by § 301 of the Conversion Statute (the "due diligence analysis"); (2) analyze the terms and conditions of the Proposed Transaction to determine whether the acquisition has the likelihood of creating a significant adverse effect on the availability or accessibility of health care services in Maryland and whether the acquisition is fair and equitable to subscribers, enrollees, insureds, and certificate holders (the "fairness analysis"); (3) analyze the Proposed Transaction to provide an opinion on whether the fair value of public assets of CareFirst would be distributed to the State as required by §§ 301(b) and (d) of the Conversion Statute (the "valuation analysis"); and (4) analyze the performance of charitable foundations established in those states in which a BlueCross BlueShield plan has converted and public assets were placed in a foundation (the "foundation analysis").

By the February 27, 2002, closing date, the MIA had received seven proposals for the due diligence analysis, eight proposals for the fairness analysis, ten proposals for the valuation analysis and nine proposals for the foundation analysis. The proposals were subject to extensive review and evaluation by a five member review team including current and former state officials outside the MIA, and a representative of the Office of the Maryland Attorney General. Of these 34 proposals, contracts were awarded for all areas. Roger Brown & Associates ("Brown") was retained for the due diligence analysis. Though initially the Lewin Group was retained for the fairness analysis, the MIA accepted the consulting firm's offer to withdraw after commencing the process due to potential conflicts of interest. Brown was then retained to coordinate and conduct the fairness analysis in conjunction with the Wakely Consulting Group ("Wakely"), University of Minnesota Professor Roger D. Feldman ("Feldman"), and the Delmarva Foundation for Medical Care, Inc. ("Delmarva"). The Blackstone Group, L.P., ("Blackstone") was engaged for the valuation analysis. LECG, LLC ("LECG") was retained for the foundation analysis. The contracts were approved by the Board of Public Works on March 27, 2002.

Detailed work plans were developed by the MIA with the assistance of CANTILO & BENNETT, L.L.P. in order to direct the work of the experts and ensure all appropriate criteria were considered by the experts. The work plans were guided largely by the statutory criteria, but also by issues identified by the MIA as necessary to a full and complete analysis, informed also by issues raised in public forums held throughout the State.

As more fully detailed within this report and the documents to which it refers, the process of compiling the expert reports deemed necessary by the Commissioner has been demanding and time-consuming. The complexity of the Proposed Transaction, and the fundamental importance of the many issues to which it gives rise that are of great public significance, have required a well developed and comprehensive review process.

D. Initial Evidentiary Hearings

In addition to the opportunities for public comment, the MIA held numerous evidentiary hearings. These hearings were intended to provide the applicants a forum within which to explain the elements and background of the proposed conversion. Witnesses were also questioned regarding documents that had been obtained in response to the first subpoena. The questioning at all public hearings was conducted by the Insurance Commissioner.

Hearings were noticed and held as follows:

Monday, March 11, 2002	University of Maryland, Baltimore County, Catonsville
Wednesday, March 13, 2002	University of Maryland, Baltimore County, Catonsville
Thursday, March 14, 2002	University of Maryland, Baltimore County, Catonsville
Monday, April 29, 2002	Inner Harbor Marriott, Baltimore
Tuesday, April 30, 2002	Inner Harbor Marriott, Baltimore

On the MIA's behalf, the following individuals were present at each hearing: Insurance Commissioner Steven B. Larsen, Christina Beusch, Esq., Assistant Attorney General, and Patrick H. Cantilo, Esq. WellPoint and CareFirst were represented principally by David N. Funk, Esq.

1. Day 1: March 11, 2002

On Monday, March 11, 2002, testimony in support of the Proposed Transaction was offered by Leonard D. Schaeffer, Chairman and CEO of WellPoint, and Daniel J. Altobello, Chairman of the Board of CareFirst.[23] Mr. Schaeffer testified about issues regarding the conversion/acquisition that included: CareFirst's due diligence, acquisition terms, CareFirst's management compensation, availability, accessibility and price, effect on providers, and effect on the local employment. Mr. Altobello testified about issues similar to those addressed by Mr. Schaeffer, but in addition, Mr. Altobello testified about CareFirst's selection of WellPoint.

2. Day 2: March 13, 2002

The hearing continued on Wednesday, March 13, 2002, with the testimony of William Jews, CareFirst's President and Chief Executive Officer, and Mr. Stuart Smith, CareFirst's investment banker from Credit Suisse First Boston. Mr. Jews provided a general explanation of the need and rationale for the Proposed Transaction. Mr. Smith testified about issues regarding the conversion/acquisition that included: due diligence regarding the selection of WellPoint, the deal terms, and any potential conflicts of interest that CSFB may have had regarding the structure of the fee arrangements, as well as conflicts that may have been present regarding previous work CSFB had performed for WellPoint.

3. Day 3: March 14, 2002

The hearing continued on Thursday, March 14, 2002, with the testimony of Deborah Lachman, Senior Vice President of Blue Cross of California, regarding the Proposed Transaction's potential effects on competition and providers. In particular, Ms. Bachman presented a perspective on WellPoint's business philosophy and practices. There followed the testimony of Michael Burks, Actuarial Vice President at Blue Cross Blue Shield of Georgia ("BCBSG"), who testified as to the positive or neutral effect that WellPoint's acquisition has had on BCBSG, in areas such as availability, accessibility, price, and providers. The third witness on this third day was Robert William ("Jay") Smith, Jr., Esq., Partner at Piper Marbury Rudnick & Wolfe LLP ("Piper"). Mr. Smith explained how his firm provided legal advice to CareFirst throughout the acquisition, and testified about conversion/acquisition issues including the following: duties of the board, negotiations, purchase price, management role and compensation, and availability, accessibility, and price. Gene E. Bauer, Ph.D., Managing Director at Hay Group, Inc. ("Hay") testified next. Dr. Bauer explained that his firm was engaged by CareFirst's Board of Directors and, specifically, the

[23] Mr. Jews was scheduled to testify, but rescheduled on March 13, 2002.

Compensation Committee, to provide advice and counsel on acquisition- related management compensation. Dr. Bauer described Hay's work in response to this engagement.

Following the formal testimony of these witnesses, opportunity was provided for comments from the public and interested persons. Among those testifying was Cal Pierson, President of the Maryland Hospital Association, who testified that the conversion is not necessary for CareFirst to maintain its market position. Then, Bart Naylor, representing the Maryland Citizens Health Initiative, testified that the acquisition would have a negative impact on the availability, accessibility, and price of insurance coverages, and a negative impact on provider relations. Mr. Naylor also testified that the compensation packages for CareFirst's management were unnecessary and excessive. Dawn Touzin, Project Director with Community Catalysts Health Assets Project, opined that the Proposed Transaction would likely lead to increased premiums for the Maryland public. Janet Rosen, Executive Director of the Maryland Chapter of Juvenile Diabetes Research Foundation, then testified as to the positive effects that the funds contributed to the foundations would have on the uninsured and the underinsured, as well as expected positive impacts to programs that have been under funded, such as drug treatment programs. Bill Simmons, President and CEO of Group Benefit Services, Inc., a third-party administrator, closed the third day by testifying in support of the acquisition, indicating his belief that Proposed Transaction would not result in premium increases or increases in the number of uninsured.

4. Day 4: April 29, 2002

The initial evidentiary hearings continued on Monday, April 29, 2002, with the testimony of Joseph Marabito, a Partner at Accenture, who testified as to the specifics of the engagement Accenture had with CareFirst in 1999 regarding the business strategy CareFirst should undertake to remain successful. Mr. Marabito further testified to the specifics of a report Accenture presented to CareFirst in the fall of 2001 regarding general capital investment trends and requirements of insurers with greater than $500 million in revenues.

5. Day 5: April 30, 2002

The initial evidentiary hearing concluded on Tuesday, April 30, 2002, with the continuing testimony of Mr. Marabito, and panel testimony by Mr. Jews, David Wolf, CareFirst's Executive Vice President for Managed Care and Strategic Planning, and Mark Chaney, CareFirst's Executive Vice President, Chief Financial Officer, and Treasurer. Mr. Marabito continued his testimony from the previous day regarding Accenture's 2001 report, and also testified as to the specifics of Accenture's community impact statement. Messrs. Jews, Wolf, and Chaney then offered additional testimony regarding the decision to convert, management's role, compensation issues, deal terms, CareFirst investment capabilities, the negotiations with WellPoint and Trigon, and Trigon's reaction to the proposed management compensation.

At the conclusion of the hearing of April 30, 2002, the Commissioner continued the evidentiary hearings to resume at a date, time, and location to be announced.

On May 15, 2002, CareFirst filed its First Supplemental Filing of Information Requested During Public Hearings, consisting of several items that the Commissioner requested during the public hearings of March 11-14, and April 29-30, 2002, from various witnesses who testified on behalf of CareFirst and WellPoint.

E. Second Evidentiary Hearings

The Commissioner continued the evidentiary hearings at the Baltimore Marriott Inner Harbor Hotel on December 16 - 18, 2002, on January 28 - 31, 2002, and on February 3 - 5, 2003, to hear additional testimony on issues including valuation, executive compensation, and CareFirst's "business case" for conversion. A chart listing all the exhibits presented during these hearing dates is presented in Schedule G. On the MIA's behalf, the following individuals were present at each hearing: Commissioner Larsen, Lisa Kulishek, Esq., and Patrick H. Cantilo, Esq., Christina Beusch and Kathleen A. Birranne, Assistant Attorneys General, also attended. David N. Funk, Esq. appeared on behalf of CareFirst and WellPoint.

1. Day 6: December 16, 2002

On December 16, 2002, the following witnesses testified: Martin Alderson-Smith, Jonathan Koplovitz, and Gregory L. Sorenson.

Messrs. Smith and Koplovitz testified about the contents of the Blackstone Valuation Report dated August 16, 2002. See below for a discussion of the report. Mr. Sorenson, of Banc of America Securities representing WellPoint, testified that private companies are traded at a discount to public companies because of the illiquidity of securities.[24]

Mr. Sorenson indicated that after the first bid, a conversation was held where CareFirst indicated that WellPoint was not competitive, which implied that the bid was too low. That probably meant that a higher bid existed. CareFirst never gave any specific guidance as to the amount by which WellPoint should increase its bid, although there were numerous conversations with WellPoint that did not involve Mr. Sorenson. After WellPoint's third and final bid of $1.3 billion, the Board passed a resolution directing management to execute a definitive merger agreement with WellPoint. Mr. Sorenson agreed that "a definitive merger agreement [is] essentially something that you do after [a] best and final [offer] to bring a deal to closure," and it was his understanding that CareFirst had asked for a "best and final" offer. However, after the resolution, "It was a frustrating period of time because we thought we had come to an agreement but yet, you know, it wasn't – we weren't moving towards closure." In fact, WellPoint never discovered the reason for the delay even after several unreturned calls. After April 24, 2001, Mr. Sorenson received some idea of the magnitude of the merger incentives, and was surprised by the size. Mr. Sorenson agreed with Blackstone's testimony that "the feeling was at WellPoint that this constituted an increase in the purchase price."[25]

2. Day 7: December 17, 2002

The hearings continued on Tuesday, December 17, 2002, with the testimony of Jay Angoff, Esq., Sheldon Cohen, Esq., Gene E. Bauer, Ph.D., Robert W. Smith, Jr., Esq., Mark Muedeking, Esq., Elizabeth Grieb, Esq., Daniel J. Altobello, and Joseph Haskins, Jr. All testimony related to the compensation arrangements of the officers of CareFirst.

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[24] Testimony of Gregory L. Sorenson, December 16, 2002, at 153:18-154:1.

[25] Id. at 161 - 169.

3. Day 8: December 18, 2002

The hearings continued on December 18, 2002, with additional testimony by Martin Alderson-Smith, Jonathan Koplovitz, Mark Chaney, Joseph Marabito, and David Wolf. In addition, Edward Zechman, on behalf of the Children's National Medical Center, briefly described the ongoing contract dispute with CareFirst to the Commissioner.

Messrs. Smith and Koplovitz testified about the contents of Blackstone's Draft Report on the validity of CareFirst's business case rationale. Messrs. Chaney, Marabito, and Wolf raised several disagreements with Blackstone's assessment, and Commissioner Larsen requested that these differences be presented in writing.

F. Third Evidentiary Hearings

During the third and last set of hearings, all held at the Baltimore Marriott Inner Harbor Hotel, the MIA primarily received testimony from its consultants and from CareFirst's management. On the MIA's behalf, the following individuals were present at each hearing: Commissioner Larsen, Kathleen A. Birrane, Esq., Assistant Attorney General, Lisa M. Kulishek, Esq., and Patrick H. Cantilo Esq. On CareFirst's and WellPoint's behalf, David N. Funk, Esq. was present.

1. Day 9: January 28, 2003

The last set of hearings began on Tuesday, January 28, 2003. On January 28, 2003, testimony regarding the validity of CareFirst's business case was offered by Martin Alderson-Smith and Jonathon Koplovitz, in response to CareFirst's rebuttal to "Analysis of CareFirst, Inc. Business Case," December 2002, The Blackstone Group (the "Blackstone's Business Case Report"). Although Mr. Smith and Mr. Koplovitz modified some of their analysis based on CareFirst's criticisms, their overall conclusions essentially remained the same. Testimony continued with Jay Angoff and Christopher Slusher with respect to their report on CareFirst's due diligence in connection with the proposed conversion and merger. In response to the testimony of Messrs. Angoff and Slusher, Mr. Funk, Stuart Smith, Esq. and Robert W. Smith, Jr., Esq. testified on CareFirst's behalf.

2. Day 10: January 29, 2003

The hearings continued on Wednesday, January 29, 2003. Professor Roger Feldman testified as to the effect that HMO conversions to for-profit status have on the community. D. Dale Hyers, FSA, MAAA, CLU, the Wakely Consulting Group, testified as to an actuarial analysis of the proposed conversion and focused on the availability and accessibility of health care services, and fairness and equity to individual and small group members. Patricia Newcomb, Howard Townsend, and Jeffery Zale, M.D., all of Delmarva, testified as to whether the proposed conversion would cause a significant adverse or negative effect on the availability or accessibility of health care services in Maryland. Mr. Townsend presented Delmarva's findings on complaint indices, state and private accreditation reports and brand measures. Dr. Zale testified as to the conversion's impact on providers, the impact on medical loss ratios, and WellPoint's various benefit and product offerings.

3. Day 11: January 30, 2003

The hearings continued on Thursday, January 30, 2003. Robert H. Cameron, Director of LECG's health care practice, and Michaelyn C. Corbett, an economist/project manager with LECG testified as to the potential impact that the charitable health foundations will have on health care. D. Louis Glaser, Esq., of Gardner, Carton & Douglas, testified as to the advice he provided to LECG

regarding the control over the assets in the foundation. Jean C. Drummond, M.A., P.A., of HCDI, testified as to the benefits the foundation would provide to the community through community-based organizations, grantees and beneficiaries. Mr. Funk and Mr. Joseph Marabito provided rebuttal testimony to Wakely and Delmarva. Mr. Funk also testified as to his interpretation of what constitutes an independent expert, and contradicted Mr. Angoff's prior assertions that Accenture did not provide an independent report.

4. Day 12: January 31, 2003

The hearings continued on Friday, January 31, 2003. Chairman Daniel J. Altobello testified as to the Board's due diligence with respect to the decision to convert and merge. WellPoint CEO Leonard D. Schaeffer testified as to WellPoint's evolution, and the benefits that WellPoint could provide to Maryland. Woodrow A. Myers, M.D., the Executive Vice President and Chief Medical Officer of WellPoint, testified as to WellPoint's quality assurance mechanisms and practices.

5. Day 13: February 3, 2003

The hearings continued on Monday, February 3, 2003. John P. Monahan, Senior Vice President of WellPoint's state-sponsored program business unit, testified as to the history and overview of WellPoint's involvement in state-sponsored programs. John A. O'Rourke, President of WellPoint's Central Region and RightCHOICE's former Chairman, testified as to the merger between WellPoint and RightCHOICE. Marvin Kanter, M.D., was a practicing pediatrician in Southern California for about 30 years and is now CEO of Southern California-based Progressive Health Care Systems, which is a medical service organization providing administrative services to physicians, physician practices, IPAs and medical groups. Dr. Kanter testified as to WellPoint's practices from a physician's perspective.

6. Day 14: February 4, 2003

The hearings continued on Tuesday, February 4, 2003. Thomas C. Geiser, WellPoint's General Counsel, and Mark Nathan, WellPoint's Vice President of Compensation and Benefits, testified as to the revised executive compensation benefits. MIA Consultant, Jay Angoff, then testified as to his view of the legality of the revised executive compensation benefits.

7. Day 15: February 5, 2003

The hearings concluded on Wednesday, February 5, 2003. Mark Chaney, WellPoint's CFO, testified about a chart that the Commissioner requested to be prepared, which compared GAAP net income with statutory net income and also identified nonrecurring items. Mr. Chaney also testified with respect to Wakely's comment's that over-reserving may have occurred in a prior year. In addition, Mr. David Wolf, WellPoint's Executive Vice President of Medical Management and Corporate Development, testified about another chart that the Commissioner requested to be prepared, which tracked the integration of the various systems and networks used with various CareFirst products. There followed comments from public witnesses.

G. Depositions

Over the course of its review, the MIA participated in eight sworn depositions generating 1,640 pages of testimony. Excerpts of certain salient points developed during these depositions follow.

1. Deposition of Timothy P. Nolan, Senior Vice President, Marketing and Corporate Development, Trigon, taken on August 19, 2002.

Mr. Nolan acted as the point person in the analysis and the initial negotiations of the potential alliance between CareFirst and Trigon and he reported directly to Mr. Snead, CEO of Trigon.[26] He feels that had CareFirst combined with Trigon, there was opportunity for improving service and lower costs through synergies in the areas of technology spending and arrangements with brokers/agents, neither of which would have resulted in Maryland job losses. Trigon was prepared to open with an offer of $1.4 billion to $1.5 billion but received information from Mr. David Wolf that they could offer less money if they would offer more Trigon board of director positions to former CareFirst directors.

During negotiations, CareFirst's concerns were limited to social issues such as the location of the combined company's headquarters, Mr. Jews' role in the combined company, potential job loss or relocation for a handful of CareFirst executives but the most important issue to Mr. Jews seemed to be what his continuing role would be. It became apparent that there was an anticipation by CareFirst of an ongoing role for Mr. Jews and many members of the CareFirst executive team. The merger incentive, or merger bonus, payments to Mr. Jews and other members of the CareFirst management team became an issue. Mr. Snead was concerned that those incentives were not performance related or related to potential job loss as the result of a change of control, but rather were just based on completing a merger.[27]

2. Thomas G. Snead, President and Chief Executive Officer, Trigon, taken on August 19, 2002.

Trigon first expressed an interest in a strategic alliance with CareFirst in late 1999 or early 2000.[28] He and Mr. Jews *agreed* that an alliance would better serve their companies, members, and potential members. The issue of Mr. Jews' role in the combined company permeated the talks during 1999 and 2000. Had CareFirst combined with Trigon, the headquarters of CareFirst as a division of the combined company would have remained in Owings Mills. The contiguous nature of the Trigon and CareFirst plans, which meet along Route 123, was an important reason why marketing and administrative synergies were possible, because duplication could be eliminated as the result of a merger. Although Trigon's offer was part cash, part stock, Trigon was willing to absorb the first 20% of any decline in its stock value pending closing of the deal. He did not recall CareFirst ever asking Trigon to increase the cash percentage of its offer price. He thought that he and Mr. Jews had finally satisfactorily worked out what Mr. Jews' continuing role would be in the combined company–*i.e.,* Mr. Snead would be CEO with responsibility over day-to-day operations, and Mr. Jews would be Chairman of the Board with responsibility for strategic, legislative, and regulatory issues, etc. At the time CareFirst signed a definitive agreement with WellPoint, CareFirst could have thought that Trigon had conceded on the merger incentive issue because Trigon gave up on their request for a "walk around" with regulators to pre-screen their reaction. But later, his opinion was that there was no way that after the meetings in late October and early November 2001, a reasonable person could have thought that he had no concerns with the merger incentives. He is

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[26] Deposition of Timothy P. Nolan, August 19, 2002 at 10 – 11.

[27] See Deposition of Timothy P. Nolan, August 19, 2002.

[28] Deposition of Thomas G. Snead, Jr., August 19, 2002, at17 - 22.

of the opinion that CareFirst's valuation has increased as a result of the Maryland Legislature having eliminated the merger incentive payments to CareFirst's management.[29]

3. William L. Jews, President and Chief Executive Officer, CareFirst, Inc., taken on September 6, 2002.

In connection with the bidding process, Mr. Jews stated he made it clear to Mr. Wolf that CareFirst was going to be in a bid process and management's obligations were to get the highest price they could for the company, but that he (Jews) did not tell Wolf to go ask Mr. Snead to increase Trigon's bid.[30] He explained that CareFirst was in a bid process, and obviously the company would be sold to the highest bidder, based on a number of other strategic factors. He denies that CareFirst was trading for directors' seats in lieu of an increase in purchase price, but admits that he had representatives for CareFirst say to Trigon, "Give me more seats." He did not use his having a continued managerial job with the combined company as a factor in evaluating offers to purchase CareFirst. In general, he assumes that initial offers are not the last offers or the best offers, but that he did not try to drive the prices higher after the initial offers were made because the regulatory process was likely to cause the valuation to go higher.

With regard to bidders, he explained that Highmark and Anthem were dropped from consideration fairly early in the process, and were not sent formal bid and solicitation letters because, unlike WellPoint and Trigon, they were not for-profit companies and, therefore, were not good strategic fits with CareFirst, which wanted to convert to for-profit in order to have better access to the capital markets. He was representing to his board that Trigon was the only suitor, assumed that they were going to do a deal with Trigon, until he became angry over Trigon's bid for Cerulean. After February 22, 2001, the view that Trigon would produce desirable synergies changed to the view that a relationship with Trigon would be problematic, with the critical issue being the employment issue. His conclusion that Trigon would cut 2,000 jobs, despite Trigon's commitment not to cut employment, was not based upon any formal analysis but rather was a conclusion that he extrapolated based on his experience. He admits that from April 2001 forward, he believed that CareFirst's best interest lay in executing a definitive agreement with WellPoint. Trigon remained in the game until November 2001, and CareFirst thought Trigon would have been the best partner if: (1) Trigon and CareFirst could have worked out the corporate governance issues, (2) Trigon could stay in the hunt, and (3) Trigon had enough cash to up the price where they should be.[31]

4. David D. Wolf, Executive Vice President, Medical Services, CareFirst, Inc., taken on September 19,2002, and January 13, 2003.

Mr. Wolfe's responsibilities within CareFirst included corporate development, such as mergers or acquisitions or other type of investments that CareFirst might make in that regard.[32] His responsibilities in the transaction were to coordinate the communication and interaction with the identified bidders or potential partners, as well as to coordinate from a communication standpoint with Bill Jews, and with the Strategic Planning Committee. Mr. Jews was the primary decision

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[29] See Deposition of Thomas G. Snead, Jr., August 19, 2002.

[30] Deposition of William L. Jews, September 6, 2002.

[31] See Deposition of William L. Jews, September 6, 2002.

[32] Deposition of David D. Wolf, September 19, 2002, at 45 – 46.

maker, and any decision presented to the Board would be cleared by him. He understood from Mr. Jews that he expected him to maximize the purchase price to be paid by whoever merged as the successful company. One of his goals was to bring to the regulators the highest price that you could bring to the table when the deal was filed. Prior to receiving the proposal from WellPoint, CareFirst viewed Trigon as a good possible partner to combine with. After receiving the proposal from WellPoint, that was no longer the case. It was starting to become clear that this transaction was very risky to Trigon and it became less clear that they were going to be in a position to ultimately close the transaction successfully. He thought Trigon was less experienced in doing business combinations. Trigon looked to CareFirst for that expertise, given CareFirst's integrations with D.C. and Delaware. Trigon was concerned about how vulnerable they would be in the market as this transaction was pending, and it became clear that one concern could be that they could be acquired prior to being able to close the transaction. That which would have brought a transaction between CareFirst and Trigon into a very questionable state, at best. Mr. Jews estimated that the Trigon deal would result in approximately 2,000 job cuts. He had no analysis to support this figure, rather, only his experience. His own due diligence, did not anticipate significant job losses. There was a general consensus among the Board that there would be job losses, and that Wall Street would expect job losses.

Trigon was not specifically asked to increase its purchase price, but CareFirst continually improved the original purchase price they had on the table. He denied that additional board seats were traded for money. Although Trigon was never specifically asked to increase its price, management met its duty to get the highest price because they believed that additional offers would drive up Trigon's price. The merger incentives would be a significant consideration in the approval process. He did discuss with Mr. Jews the concerns raised by Tim Nolan regarding the salability of the incentives in the approval process.[33]

5. Mark Muedeking, Esq., Partner, Piper Marbury Rudnick & Wolfe LLP, taken on October 10, 2002

Mr. Muedeking is a Partner with the law firm of Piper Marbury Rudnick & Wolfe LLP, which acted as outside counsel to CareFirst, Inc. He dealt with compensation issues in the proposed transaction. He explained that the SERP benefit, provides an accrued benefit that is one lump sum payment based on 40% of the final compensation for each of the participant's first five years of executive service and then 30% of the participant's final average compensation for each year thereafter.[34] However, when reading Mr. Jews' executive's employment contract with the SERP document, the employment agreement provides that the benefits are paid in an actuarial lump sum if there is a change of control, and the executive is terminated without cause by the company, or with good reason by the executive, within 12 months before a change of control or 24 months following a change of control. The SERP does not have a vesting concept, but rather, is paid on death, disability or retirement as defined in the plan; however, the committee has discretion to make payment for reasons other than retirement, death or disability. Termination not in connection with a change of control also triggers payment of the SERP benefit under the employment agreement, but the payment is deferred until 55 or 62 as the case may be.

Parachute payments are generally payments made on a change of control based on calculation of three times the executive's base amount (the base is the five year average compensation), and if the payments exceed three times the base amount, then all payments over the

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[33] See Deposition of David D. Wolf, September 19, 2002.

[34] Deposition of Mark Muedeking, Esq., October 10, 2002, at 37.

base amount are subject to the excise tax, and nondeductible by the employer. According to the CareFirst employment agreement, CareFirst would indemnify the executive for tax liability related to payments made pursuant to a plan entered into before or after the employment agreement, whereby payments to the executives were deemed parachute payments. He informed the CEO of CareFirst that there would be significant negative reaction to the compensation arrangements. He believed that the CareFirst Compensation Committee was concerned with CareFirst's status as a nonprofit company, but no one specifically posed that issue. He did not know of any nonprofit with which he could compare the compensation structure of CareFirst.[35]

6. Stuart F. Smith, Managing Director, Credit Suisse First Boston ("CSFB"), CareFirst Investment Banker Consultant, November 22 and 25, 2002.

Mr. Smith's personal involvement in this transaction as an investment banker began at the end of the calendar year 2000. It was his understanding that CSFB was instructed that in negotiating a deal, the foundation, the citizens, and the associates who worked for the company were important constituents and in this deal, he was instructed to give maximizing price a lower priority than is usually the case in the sale of a for-profit company.[36] In studies dated July 11, 2000, and January 22, 2001, prepared by Donaldson, Lufkin & Jenrette ("DLJ") (predecessor to CSFB)), and CSFB studies, Trigon was viewed as a superior strategic partner to WellPoint on a number of factors, including geographic proximity, which was regarded as an advantage because the contiguous nature of the two companies would offer opportunities for marketing synergies, seamless provider networks, integrated customer service, standardization of medical policy, and improved provider contracting. There was great concern from the CareFirst board and management that the acquisition not lead to substantial layoffs, which was a significant concern with Trigon. CSFB did not do an independent analysis of whether, or how many, job cuts would result from a combination with Trigon. Protecting the benefits that associates enjoy at the company in any merger was also a concern with CareFirst, which was an issue with WellPoint.

Important negotiating considerations included not only overall price, but down side protection (*i.e.*, preserving value until closing), associates' futures, avoiding a merger that would lead to a large number of redundancies, a fiduciary out and the size of a break-up fee. In the auction process, CSFB did not share with Trigon or WellPoint what the other parties bid, but they did specifically tell WellPoint that their price was not high enough and they needed to increase it. Some of the reasons why Trigon's bid was not viable were Trigon's insistence on a "regulatory walk-around," its inability to offer the type of down side protection that WellPoint offered, and its insistence that it have a contractual out if the deal did not close within 18 months. CareFirst's problem with Trigon's desire for a regulatory walk-around was that it would commit CareFirst to select Trigon with no legal fallback if, after the regulatory walk-around, Trigon changed its mind and did not want to do the deal. Other factors were headquarters location, benefits for CareFirst's associates, and board representation.[37]

CSFB determined that Anthem was not a qualified bidder because of risk and uncertainty concerns regarding Anthem's ability to come up with enough cash and because Anthem itself was in the middle of a regulatory approval process. CSFB didn't really do any investigation regarding

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[35] See Deposition of Mark Muedeking, Esq., October 10, 2002.

[36] Deposition of Stuart F. Smith, November 22 and 25, 2002 at 53 - 56.

[37] Id. at 158:2 - 161:4.

these concerns. When WellPoint's offer stood at $1.25 billion and Trigon's stood at $1.3 billion, CSFB was instructed by CareFirst management to seek a higher price from WellPoint, and CSFB got WellPoint to increase their bid by telling them that they were weak price. WellPoint was clearly preferable to Trigon from the standpoint of employee interests but was never preferable to Trigon from the customers' perspective, and putting weight on these factors theoretically could have prevented CareFirst from achieving a higher price or might have resulted in CareFirst getting a lower price.[38]

7. Mark Chaney, Executive Vice President and Chief Financial Officer, CareFirst, Inc., January 13, 2003.

Mr. Chaney identified capital projects that CareFirst management believes have been potentially impacted over recent years due to either limitations on access to capital, or the fact that CareFirst had a set capital amount that was targeted to spend each year. The list of unfunded projects has not been provided to CareFirst's Board, nor to WellPoint, prior to providing it in the deposition. CareFirst has made investments in e-commerce, but still considers CareFirst very much first tier e-commerce, versus some of their competitors who are second tier and third tier, and have done much more than what CareFirst has been able to do, with what has been invested. The list represents the best estimate of what would have to be expended over the next two to four years.

One of the key competitors that CareFirst is concerned about with their e-commerce investments is United Healthcare. The goal for year-end 2002 was to integrate five systems from the prior combinations, but they have not achieved that goal due to lack of access to capital. Mr. Chaney believes that, in order to service their customers, they first need to make sure whatever modifications are necessary are completed, which is more costly than they first had thought. Between 2000 and 2002, CareFirst has spent $22 to $23 million on platform integration. He estimates that it will take an additional $30 to $50 million for the core systems integration. HIPAA compliance is a good example of a need for access to capital. WellPoint has never indicated to CareFirst a dollar amount it would provide to CareFirst to enhance or supplement CareFirst capital expenditures.[39]

H. Materials gathered during MIA review

During the course of its review, the MIA has amassed a considerable volume of information about CareFirst, WellPoint and the Proposed Transaction. To assist the reader, attached to this report are a series of schedules regarding this information. Schedule A is a list of the individuals who were CareFirst's directors and officers during the events considered in this report. Schedule B is an alphabetical directory of individuals affiliated with the companies, the MIA, the parties' consultants and advisors, and other interested parties. Schedule C, is the directory of these individuals grouped by affiliation. Schedule D is a list of the public comment and evidentiary hearings held in this matter and of the depositions taken by the MIA and its advisors. Schedule E is a catalogue of the information requested by the Maryland Insurance Administration and its advisors from CareFirst and WellPoint. Schedule F is an inventory of the documents gathered by the MIA, including those produced in response to the requests on Schedule E. Schedule G identifies the 256 documents which have been marked as Exhibits at the Evidentiary Hearings and depositions listed on Schedule D.

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[38] See Deposition of Stuart F. Smith, November 22 and 25, 2002.

[39] See Deposition of Mark Chaney, January 13, 2003.

V. GENERAL BACKGROUND ON CAREFIRST AND WELLPOINT

A. Early History of CareFirst: Prior Business Combinations

The group of affiliated insurers that now operates as CareFirst began as a Baltimore based hospital service plan. Recognizing the economic impact of hospitalization on the average family, the Associated Hospital Service of Baltimore, Inc. was formed in 1937 to:

> Establish, operate, and maintain a nonprofit hospital service plan . . . whereby hospital care is provided by a hospital . . . to persons who become subscribers to such plan, so that such hospital care and service may be obtained at a minimum cost and expense.

The plan was extended throughout the state and, in 1947, became known as the Maryland Hospital Service, Inc. In 1969, the plan became affiliated with Blue Cross and changed its name to Maryland Blue Cross, Inc. and, in 1973, to Blue Cross of Maryland, Inc.

Building on the success of the original hospital subscriber plan, physician services were the subject of a second entity formed in 1950 by physicians to provide medical care "at a minimum cost and expense." This corporation, originally known as Maryland Medical Service, Inc., became Maryland Blue Shield, Inc. and, in 1973, Blue Shield of Maryland, Inc.

Blue Cross of Maryland, Inc. and Blue Shield of Maryland, Inc. were consolidated into a single entity known as Blue Cross and Blue Shield of Maryland, Inc. ("BCBSMD") effective January 1, 1985. It is significant that the bylaws of the consolidated entity require that "[a]ll Directors shall be chosen on the basis of their recognized interest in the welfare of the community, their desire to further the aims and purposes of the Corporation, and their ability to contribute to the intelligent guidance of the Corporation's affairs." The articulated purpose of the corporation was, as it had always been, 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."

In July 1990, BCBSM filed an application with the Insurance Division of the Department of Licensing and Regulation requesting permission to convert from a nonprofit health service plan to a mutual nonprofit insurer. Both the Insurance Division and BCBSM agreed that the application would be reviewed under the general principles articulated in Article 48A, Section 356AA, which governed the conversion of nonprofit health plans to for-profit status. *See* Memorandum and Order of July 27, 1990. That section prohibited the Commissioner from approving a conversion unless he found that it was "equitable to enrollees and shareholders, if any, of the corporation" and assured that "no part of the assets or surplus of the nonprofit health service plan will inure directly or indirectly to any officer or director of the corporation."

On December 26, 1990, Commissioner John A. Donaho concluded that the conversion of BCBSM to a nonprofit mutual would not be in the best interest of subscribers and policyholders, nor the citizens of Maryland. In doing so, Commissioner Donaho noted:

> Pursuant to Subtitle 20, the activities of BCBSM are circumscribed. BCBSM cannot, without my permission, engage in certain activities or financial ventures unrelated to its primary purpose of delivering health care coverage to its subscribers. BCBSM stated that it wished to mutualize to enable it to compete "on an even playing field," yet it promises to continue to be the "insurer of last resort" to Maryland's uninsured and ailing citizens. *It is apparent to me that the activities*

> *envisioned by management to enable BCBSM to compete with commercial insurers will only deviate from and dilute the primary purpose for which BCBSM was legislatively created.*

Order at 5. (Emphasis added.)

Shortly after its efforts to mutualize failed, BCBSM became embroiled in controversy regarding its management practices. The company was near insolvency, and BCBSM was the subject of a highly critical report issued by the United States Senate in September 1992. Shortly thereafter, in March, 1993, BCBSM officers and directors became the subject of what purported to be a subscriber derivative action. And, BCBSM faced regulatory action in light of it poor financial condition.

> In response to these events, BCBSM's Board was reconstituted and a new management group was put in place. As part of that process, and in direct response to criticisms of officers and directors of the corporation, the bylaws of the corporation were amended in 1993. Included in the changes was the articulate of the specific duties that the directors of the corporation owed, including the duty to act "in good faith," "in the best interest of the Corporation," and with "ordinary" care. In addition, the revised bylaws state, at Article VII:
>
> The fiduciary responsibilities of the Corporation *to the public* require members of the Board and Corporate Officers to exercise *utmost good faith* in all transactions touching upon their duties to the Corporation and its property.[40]

Thus, BCBSM clearly understood that while the actions of corporate officers and directors may normally be governed by the requirement that those actions be taken in good faith and with ordinary care, because of BCBSM's self-acknowledged duty to the public, the officers and directors of BCBSM owe a *higher* duty, particularly with regard to the protection of BCBSM's assets.

It also is significant that a special Committee of the Board, which was created to assess whether to maintain the "subscriber" litigation initiated against certain officers and directors, noted in its report that:

BCBSM plays a special role in the Maryland health care system. Like commercial insurers, it provides health insurance and related services; BCBSM services more than 1.5 million people through products ranging from traditional insurance to health maintenance organizations ("HMOs). Unlike commercial insurers, *BCBSM is an insurer of last resort.* It considers itself responsible to provide coverage for those who cannot obtain it from other sources.[41]

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[40] ByLaws Approved by the Maryland Insurance Administration on September 29, 1993 at 15. (Emphasis added.)

[41] Report of the Special Litigation and Indemnification Committee of the Board of Directors of Blue Cross and Blue Shield of Maryland, Inc., October 28, 1993. It should be noted that George L. Russell, Jr.. Esq. then a Partner at Piper Marbury Rudnick & Wolfe LLP, was a member of the Committee and a signatory to the Report. (Emphasis added.)

Shortly after the new management team was installed, efforts at changing the essential nature of BCBSM renewed. In October, 1994, BCBSM filed a plan of reorganization. The reorganization contemplated limiting BCBSM's nonprofit business to the sale of indemnity health insurance under the BCBS logo, while transferring the remainder of BCBSM's existing and contemplated business, particularly its managed care business, to a newly created, for-profit subsidiary. That new subsidiary would act as a holding company for: BCBSM's for-profit HMOs; a for-profit general insurance agency yet to be formed; a for-profit "unbranded" indemnity company to be formed; and third party administrative services. The new holding company subsidiary would be authorized to sell up to 35% of its stock to the general public through an initial public offering, with the possibility that an additional 40% could be sold in the future, leaving BCBSM with as little as a 25% interest in the entity.

Commissioner Dwight K. Bartlett, III recognized that the proposed reorganization was in effect a conversion to a for-profit insurance company.[42] Commissioner Bartlett noted that the profit-making aspects of the enterprise would be "so substantial that BCBSM would lose its character as a nonprofit health services plan."[43] Consequently, the Commissioner denied the request to reorganize BCBSM in the mode outlined in its filing.[44] Commissioner Bartlett noted that if BCBSM wanted to transform the company to essentially a for-profit entity, it would have to follow the conversion procedures then contained in the Maryland Insurance Code.[45]

In subsequent years, BCBSMD rebounded.[46] However, management and the board of directors concluded that the company's long term vigor, even its very survival, required that it grow into a regional insurer, pursuing significant growth beyond Maryland's borders. Id. This perceived need for extra-territorial growth reflected an underlying belief that, in the current health care environment, financial stability depended upon growth and improved access to capital.[47] The company determined that opportunities for continued growth in Maryland were limited.[48] BCBSMD adopted a growth-through-affiliation strategy, which led to the proposed merger of its operations with those of GHMSI, a/k/a BlueCross Blue Shield of the National Capital Area. Id.

On December 23, 1997, the Commissioner issued a formal ruling approving the proposed merger of the operations of GHMSI and BCBSMD. Pursuant to the approved proposal to merge operations, GHMSI and BCBSMD avoided mingling assets by forming CareFirst, Inc. ("CareFirst") as a holding company, and maintaining GHMSI and BCBSMD as separate subsidiaries of CareFirst, both companies doing business as CareFirst Blue Cross Blue Shield. In order to maintain full regulatory authority over the combined entity the Commissioner required that the holding company of GHMSI and BCBSMD, CareFirst, Inc., also be licensed as a nonprofit health service plan. As a consequence, GHMSI became a subsidiary of a Maryland nonprofit health service plan.

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[42] *See* Order of January 20, 1995.

[43] Id. at 11.

[44] Id. at 21.

[45] Id. at 15, 21.

[46] CF-0012290, pre-filed written testimony of William L. Jews, March 6, 2002.

[47] Testimony of Daniel J. Altobello, March 11, 2002, at 188:17-189:10.

[48] CF-0012290, pre-filed written testimony of William L. Jews, March 6, 2002.

The Commissioner's ruling also required an analysis of the relative contributions to CareFirst by BCBSMD and GHMSI (the "snapshot"), and further required that in the event of the future conversion of the company, its public assets be distributed in accordance with applicable nonprofit law. The accounting firm of Ellin & Tucker ("E&T") was engaged to perform the snapshot analysis. As of January 16, 1998, E&T opined that the value of CareFirst was allocated 64% to Maryland and 36% to the District of Columbia, based on seven primary benchmarks: (1) assets, liabilities, and surplus as reported on a statutory basis; (2) assets, liabilities, and surplus as reported on a generally accepted accounting principles ("GAAP") basis; (3) historical revenues, both risk and fee based; (4) number of subscribers and providers by geographic area; (5) market value of investments; (6) market value of non-invested assets; and (7) actual claim reserve run-off data. Four secondary benchmarks were also taken into consideration: (1) profitability analysis; (2) staffing; (3) relative position of the plans with respect to competitors; and (4) relative strengths and weaknesses of the management.

In March of 2000, the Maryland and Delaware Insurance Commissioners issued Orders permitting the affiliation of CareFirst, Inc. and BCBSDE, with BCBSDE remaining a separate company but, as with D.C., a subsidiary of a Maryland nonprofit health service plan. As was the case with the earlier transaction between BCBSMD and GHMSI, the Commissioner required an allocation of relative value contributed by CareFirst and BCBSDE, *i.e.*, a new "snap shot." As of March 22, 2000, E&T provided a draft analysis opining that the value of the resulting holding company was allocated 92% to the pre-transaction CareFirst (*i.e.*, the Maryland and District of Columbia entities) and 8% to BCBSDE, based on six primary benchmarks: (1) assets, liabilities, and surplus on a statutory and GAAP basis; (2) historical revenues; (3) number of subscribers; (4) market valuation of investments; (5) market value of non-investment assets; and (6) actual claim reserve run-off data. Two secondary benchmarks were also taken into consideration: (1) profitability analysis; and (2) staffing.

The affiliation with BCBSDE resulted in CareFirst as it exists today, with $6 billion in revenue (in premiums and premium-equivalents), and 3.1 million members (including Blue Card members for whom CareFirst is the host plan).[49] CareFirst, the holding company, is the sole member of the Maryland, District of Columbia, and Delaware Blues.[50] It was in that context, and in an environment of competition from national carriers in Maryland and throughout the Mid-Atlantic region, that CareFirst continued to examine the strategic options that would best enable it to compete on measures of service, access, choice, quality, and affordability with much larger, innovative, and well capitalized for-profit companies.[51] The boards of directors of the three operating companies and the holding company, collectively, were engaged and involved in the strategic planning process.[52]

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[49] CF-0012290-91, pre-filed written testimony of William L. Jews, March 6, 2002, at 4.

[50] CF-0012308, pre-filed written testimony of Daniel J. Altobello, March 6, 2002, at 1.

[51] CF-0012290-91, pre-filed written testimony of William L. Jews, March 6, 2002, at 4-5.

[52] Testimony of Daniel J. Altobello, March 11, 2002, at 175:1-181:6.

B. History and Background of WellPoint

1. Pre-conversion History

In 1929, a Baylor University official offered a health plan to schoolteachers through the University's hospital. Due in part to the Great Depression, health care was virtually unaffordable. In California, humanitarians such as Ritz E. Heerman and Howard Burrell, attempted to implement legislation that would authorize hospital service plans. Californians were able to receive affordable health care through the Associated Hospital Service of Southern California and the Alameda County Medical Association. By 1939, the American Hospital Association ("AHA") governed the operations of hospital service plans modeled after the Baylor plan. In 1982, Blue Cross of Northern California and Blue Cross of Southern California merged to form Blue Cross of California ("BCC"). BCC was formed because of the similarity between the two plans and the anticipated ensuing benefits from increased efficiency derived from technological advances.

In 1992, BCC formed its subsidiary WellPoint Health Networks, Inc., a Delaware public for-profit corporation ("Old WellPoint"), to own and operate substantially all of BCC's managed health care businesses. In 1994, the Blue Cross Blue Shield Association ("BCBSA") repealed the requirement that all BCBS plans be operated as nonprofits, in part, due to the 1987 loss of BCBS' tax exemption. Thus, many BCBS plans began converting to for-profit. In 1996, BCC converted into a for-profit corporation through the following process.

2. Conversion

After extensive negotiations with regulators, in 1996 Old WellPoint, BCC, and two newly created nonprofit foundations, the California HealthCare Foundation (the "Foundation") and the California Endowment (the "Endowment"), executed a recapitalization agreement. Pursuant to the agreement: (a) Old WellPoint distributed an aggregate of $995 million to BCC, which donated its portion ($800 million) to the Endowment; (b) BCC donated its assets, other than the previous cash distribution and its commercial operations (the "BCC Commercial Operations"), to the Foundation; BCC changed its corporate structure to a California for-profit business corporation (the "BCC Conversion") and issued to the Foundation 53,360,000 shares of Common Stock and a cash payment of $235 million to reflect the value of the BCC Commercial Operations and the value of the Blue Cross mark; and (d) Old WellPoint merged with and into BCC (the "Merger") forming the surviving entity of WellPoint Health Networks, Inc.

BCBSA and WellPoint entered into a new License Agreement effective as of May 20, 1996 (the "License Agreement"), pursuant to which WellPoint has become the exclusive licensee for the right to use the Blue Cross name and related service marks in California and has become a member of the BCBSA. There remains in the state an independent Blue Shield plan.

3. Post-Conversion History

a. Life and Health Benefits Management Division of Massachusetts Mutual Life Insurance Company and the Group Benefits Operations of John Hancock Mutual Life Insurance Company.

In conjunction with the BCC Conversion, WellPoint began pursuing a nationwide expansion strategy through selective acquisitions and start-up activities in key geographic areas. In an effort to pursue the expansion of WellPoint's business outside the state of California, WellPoint acquired two businesses in 1996 and 1997, the Life and Health Benefits Management Division of

Massachusetts Mutual Life Insurance Company and the Group Benefits Operations of John Hancock Mutual Life Insurance Company.

b. Rush Prudential Health Plans

In December 1999, WellPoint announced agreement with co-owners Rush-Presbyterian-St. Luke's Medical Center and Prudential Insurance Company of America to acquire Rush Prudential Health Plans ("Rush Prudential") for approximately $200 million. At the time, the health maintenance organization operated primarily in the Chicago area, serving approximately 300,000 medical members.

c. Cerulean Acquisition

More recently, WellPoint has pursued an acquisition strategy focusing on acquisitions of businesses with significant member concentrations outside of California. On March 15, 2001, WellPoint acquired Cerulean Companies, Inc., the parent company of BCBSG. Cerulean's business generally consists of insured and administrative services primarily in Georgia. As a result of the BCBSG acquisition, WellPoint's membership increased by approximately 1.9 million members. WellPoint paid $700 million in cash for Cerulean and incurred $134.5 million in expenses, primarily related to change of control payments to Cerulean management and transaction costs.

d. RightCHOICE Acquisition

On January 31, 2002, WellPoint merged with RightCHOICE Managed Care, Inc. ("RightCHOICE"), BCBS of Missouri's parent company. RightCHOICE served approximately 2.2 million medical members in Missouri, Arkansas, Illinois, Indiana, Iowa, Kentucky, and West Virginia. RightCHOICE common stockholders and holders of employee stock options were paid approximately $379.1 million in cash and $16.5 million shares of WellPoint Common Stock, resulting in a total purchase price of approximately $1.45 billion. In addition, WellPoint will have incurred $114.8 million in expenses primarily related to change-in-control payments to RightCHOICE management and transaction costs. RightCHOICE is the largest provider of managed health care benefits in Missouri, based on number of members, through its exclusive license to use the BCBS names and service marks in most of the state. Nonprofit BCBS Kansas City retains the exclusive right to market "branded" products in that metropolitan area, both in Missouri and in two adjacent Kansas counties. RightCHOICE, through its HealthLink subsidiary, also provides network rental, administrative services, workers' compensation, managed care services, and other non-underwritten health benefit programs.

e. MethodistCare Acquisition

On April 30, 2002, WellPoint acquired MethodistCare, which serves over 70,000 members in the Houston, Texas area.

f. Pending Major Litigation

In June 2000, the California Medical Association ("CMA") filed a lawsuit (the "CMA case") in U.S. district court against BCC. The CMA case alleged that BCC violated the RICO Act by making misrepresentations and taking inappropriate actions against health care providers. In late 1999, a number of class action lawsuits were brought against several of WellPoint's competitors alleging, among other things, various misrepresentations regarding their health plans and breaches of fiduciary obligations to health plan members. In August 2000, WellPoint was added as a party to Shane v. Humana, *et al.*, a class-action lawsuit brought on behalf of health care providers

nationwide. In addition to the RICO claims brought in the CMA case, this lawsuit also alleges violations of ERISA, federal and state "prompt pay" regulations, and certain common law claims. In October 2000, the federal Judicial Panel on Multidistrict Litigation issued an order consolidating the CMA case, the Shane lawsuit, and various other pending managed care class action lawsuits before federal Judge Federico Moreno in the Southern District of Florida. In March 2001, Judge Moreno dismissed the plaintiffs' claims based on violation of the RICO Act, although the dismissal was made without prejudice to the plaintiffs' ability to subsequently refiled their claims. Judge Moreno also dismissed, with prejudice, the plaintiffs' federal prompt pay law claims. On March 26, 2001, the CMA filed an amended complaint in its lawsuit, alleging, among other things, revised RICO claims and violations of California law. A hearing on the plaintiffs' motion to certify a class was held in early May 2001. Judge Moreno issued an order certifying a nationwide class of physicians in the Shane matter, setting a trial date in May 2003 and ordering the parties to participate in non-binding mediation. In October 2002, WellPoint filed a motion with the 11th Circuit Court of Appeals seeking to appeal Judge Moreno's class-certification order.

In March 2002, the American Dental Association and three individual dentists filed a lawsuit in U.S. district court in Chicago against WellPoint and BCC. This lawsuit alleges that WellPoint and BCC engaged in conduct that constituted a breach of contract under ERISA, trade libel and tortious interference with contractual relations and existing and prospective business expectancies. The lawsuit seeks class-action status. In July 2002, the federal Judicial Panel on Multidistrict Litigation granted WellPoint's motion requesting that the proceedings in this case be consolidated.

g. Current Market Position

WellPoint is one of nation's largest publicly traded managed health care companies. WellPoint's membership was approximately 13.1 million medical members and approximately 46.6 million specialty members as of September 30, 2002. WellPoint offers network-based managed care plans to large and small employers, individual and senior markets. In addition, WellPoint's business includes managed care services, including underwriting, actuarial service, network access, medical cost management and claims processing. WellPoint also offers various other specialty services. WellPoint markets BlueCross branded products in California, Georgia, and 85 counties of Missouri (including the greater St. Louis area), and unbanded products in various other parts of the country. WellPoint has a diversified customer base, with extensive membership among large and small employer groups and individuals, but is also gaining share in the Medicare and Medicaid markets.

VI. HISTORY, CHRONOLOGY, AND BACKGROUND FOR THE PROPOSED TRANSACTION

A. Factual Background

Among the issues the MIA is required to analyze in its review of the transaction is the "due diligence" the Board followed in the steps leading to the final decision to convert and sell to WellPoint. The initial due diligence analysis requires first an examination of the threshold determination to engage in an acquisition, which is defined by statute as either a conversion to for-profit or acquisition by a for-profit. As will be discussed below, the Proposed Transaction involves both, and there is some dispute as to whether the transaction is a single transaction preceded by a "single decision,"[53] or two separate and legally distinct transactions as argued by Jay Angoff. Whether the transaction is viewed as one or two events or decisions, what is common to both is the precedent decision to alter the corporate form, changing the nonprofit structure to a for-profit

[53] Testimony of R. W. Smith, January 28, 2003, at 156 – 177.

structure. From this threshold decision flows subsequent decisions that will be analyzed such as the selection of a partner from among competing bidders and the terms and conditions of the deal.

The following chronology of significant events and decisions is based on the record reviewed by the MIA, including subpoenaed documents, written and pre-filed testimony, and oral testimony at public hearings and depositions.

1. The Board Retains Accenture to Assist in its Strategic Planning

After CareFirst emerged from its period of financial distress in the early 90's, the directors and management continued deliberating about the best long-term strategic direction for the company.[54] The CareFirst Board established a Strategic Planning Committee, whose charter provides, among other things, that it shall "provide assistance and expertise to the company's management in developing and monitoring the long-range strategic plan . . . develop and recommend to the Board the strategic plan for the company ... [and] recommend each year to the Board an annual business plan and its quarterly review and/or update."[65] In September 1998, after the merger with the GHMSI was approved, the Strategic Planning Committee was already discussing a broad range of options for CareFirst, which included aligning or merging with another Blue plan, merging with a larger regional/national managed care company, or selling the company.[56]

The beginning of the more formal strategic planning process that led to the decision by CareFirst to convert and be acquired by WellPoint can reasonably be said to be the retention by the Board of its outside consultant to provide strategic planning advice. On February 11, 1999, David Wolf forwarded to Andersen Consulting, now Accenture, a solicitation for an expression of interest to assist CareFirst in the strategic planning process. Attached to the letter was a RFP with detail on CareFirst's needs and objectives and time frame for hiring a consultant.[57] In that document CareFirst declared that one of its strategic drivers is to "seek opportunities to build scale through acquisitions and mergers." The RFP described this strategic objective as follows:

> In order to maintain market dominance and to be strategically positioned for the future, the Company will seek to build greater scale through local and regional acquisitions and mergers. In the first half of 1998, the company successfully completed the business combination of BCBSMD and BCBSNCA. This has resulted in a stronger regional presence for CareFirst which will provide the foundation for future regional growth. CareFirst is currently in the due diligence phase of the proposed affiliation with BlueCross

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[54] Supplement to Amended Form A Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer filed with the Department of Insurance and Securities Regulation and the Office of Corporation Counsel of the District of Columbia on January 11, 2002, at 3.

[55] CF-0012309, pre-filed written testimony of Daniel J. Altobello, March 6, 2002.

[56] CF-0002793 - CF-0002848 CareFirst, Inc. Strategic Planning Committee Meeting Minutes, September 23, 1998. These minutes are important in understanding the proposed merger and conversion from CareFirst's perspective.

[57] CF-0009742 - CF0009755, letter from CareFirst's David D. Wolf to Andersen Consulting's Shawna Russell, enclosing "Strategic Advisor Request for Proposal," February 11, 1999.

> BlueShield of Delaware. Pending regulatory approval, closing of the transaction should occur by May 31, 1999. (Emphasis added.)[58]

The RFP also requested that a bidding organization provide in detail "your company's mergers and acquisition experience in health care."

This RFP illustrates some basic themes that continued throughout the strategic planning process and which bear directly on the regulatory review of the acquisition. First, it is evident that CareFirst had pre-determined one element of its strategic plan even before hiring its consultant: It would seek to maintain dominance and build scale through "regional acquisitions and mergers." Not surprisingly, as set out in more detail below, Accenture's recommendations to the Board all involved an increase in scale, and it was determined by the Board that to achieve the goals set by Accenture, a conversion would be necessary. In fact, Mr. Jews testified that growth and expansion were, from the beginning of his tenure, part of CareFirst's long term plan.[59]

The second notable aspect of the RFP is the absence of any reference to the mission of the company as articulated in its organizational documents. The Articles of Incorporation for CareFirst of Maryland, Inc. described the purpose of the organization:

> The purposes for which and any of which the Corporation is formed and the business and objects to be carried on and promoted by are:
>
> (1) To establish, operate and maintain a nonprofit health service plan as authorized by Title 14, Subtitle 1 of the Insurance Article of the Annotated Code of Maryland and any and all amendments thereto, whereby hospital, medical, dental and other health care is provided by hospitals, physicians, dentists, and other providers to persons who become subscribers to such plan, so that such health care and service may be obtained at a minimum cost and expense. [60]

The omission of this purpose statement from the RFP is important because in analyzing the conduct of the Board and whether the transaction is in the public interest, it is necessary to evaluate whether the Board appropriately considered the impact its strategic planning process would have on this corporate purpose.

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[58] RFP dated February 11, 1999.

[59] Deposition of William L. Jews, March 13, 2003, at 307 – 310.

[60] January 22, 1998, Orientation Book for Board Members, attachment "Blue Cross and Blue Shield of Maryland, Inc., Articles of Amendment and Restatement" at page 1, CF-0001751.

2. Accenture identifies trends of industry consolidation, and the rise of "e-commerce" and "consumerism."

Accenture worked closely with management and the Strategic Planning Committee, and met separately with management and the CEO without the Board in preparation for the Board meetings and to refine the Board presentations.[61]

Accenture focused on three objectives in its work for CareFirst: (1) to assess the competitive environment and the industry trends that could have implications on how health plans evolve, and specifically how CareFirst was going to be affected; (2) to assist management in developing a strategic vision and direction for CareFirst; and (3) to determine key enabling strategies to fulfill that strategic vision.[62]

At the meetings of the Strategic Planning Committee, Accenture presented handouts analyzing the health care market, identifying trends in the industry, and laying out possible courses of action.[63] The materials identified the consolidation of health plans as one dominant trend, but also identified others, such as the advent of internet focused companies, the investment such companies were making in "e-commerce," and the trend of consumers becoming more informed and using information for health care decisions.[64]

Accenture believed that, while CareFirst generally had a strong competitive position at that point, it was not well positioned to respond to these trends it had identified.[65] Accenture identified for the Board some CareFirst weaknesses, such as the fact that "CareFirst appears to have the highest market share in segments with the lowest profitability" and CareFirst "Prices are higher than regional competitors and the gap appears to be widening."[66] CareFirst had no e-commerce capability.[67]

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[61] See e.g., Andersen Consulting presentations - May 28, 1999; "CEO Discussion, Environment and Strategy Options" at 1 - 54, CF-0009953 - CF-0010007; June 3, 1999, "CEO Discussion, Strategy Options Discussion" at 1 - 51, CF-0010078 - CF-0010129; June 11, 1999, "Meeting with William L. Jews, Strategy Options Discussion" at 1 - 79, CF-0010191 - CF-0010270; "Discussion with William L. Jews, Strategy Options Selection" at 1- 57, CF-0010332 - CF-0010387.

[62] Supplement to Amended Form A Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer filed with the Department of Insurance and Securities Regulation and the Office of Corporation Counsel of the District of Columbia on January 11, 2002, at 3. Pre-filed written testimony of Joseph V. Marabito, March 6, 2002; testimony of Joseph V. Marabito, Day 4, April 29, 2002, at 4 – 19.

[63] See, e.g., CF-0006878, CF-0006928 - CF0007015, CareFirst, Inc. Strategic Planning/Finance Committees Meeting Minutes, November 23, 1999, Andersen presentation of "Strategic Advisor Overview" and "2001-2002 Strategic Plan and Vision".

[64] Id. at CF-0006941.

[65] Testimony of Joseph V. Marabito, April 29, 2002, at 14.

[66] Minutes of the Strategic Planning Committee, August 23, 1999, Andersen Consulting Slide at 24, CF-0006666.

[67] Testimony of Joseph V. Marabito, April 29, 2002, at 13.

3. Accenture presents its "Case for Change" to the Board

On October 28, 1999, the Board was presented with "The Case for Change", which indicated "CareFirst needs to change of order to thrive in the future." According to Andersen, the need for changes was driven by the following factors:

The Case for Change[68]

- Significant national and local consolidation will continue to threaten CareFirst's market position
- The e-Economy is changing the economics of the industry and competitors are partnering with new internet entrants
- In the future industry environment CareFirst will experience a shift of power toward the consumer
- CareFirst's competitiveness is increasingly challenged

4. Accenture determines that regional scale and market share, rather than absolute scale, is a better indicator of financial success.

In support of its case for change, Accenture presented data to the board, which showed that the greater a health plan's local market share, the lower its expense ratio.[69] The lower the expense ratio, the less per dollar of premium is spent on administrative costs. From a competitive standpoint, a company's relative market share, *i.e.*, a company's market share in comparison to those of its competitors, impacted the expense ratio more than the absolute size of a company. Data presented by Accenture to the Board indicated that "absolute scale does not appear to generate any cost benefits."[70] On this point, at the hearings Mr. Marabito testified that "what we concluded from the analysis was that … there are more advantages to have the scale concentrated … we also believe that there were advantages to having absolute scale, but it was much more difficult to get and there is much more variability between a company's ability to achieve that . …"[71] Separate charts given to the Board showed that high relative market share drives superior financial returns.[72]

5. Accenture estimated CareFirst's Needs for Capital Expenditures

In 1999, Accenture, working with CareFirst management, developed projections of what CareFirst would need to spend in the following three to five years to execute the

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[68] Minutes of the Strategic Planning Committee, August 23, 1999, Andersen Consulting Slide at 10, CF-0021307.

[69] Id. at 44, CF-0006686.

[70] CareFirst, Inc. SPC Minutes, August 23, 1999, Andersen "Strategy Selection Discussion," CF-0006686; Testimony of Joseph V. Marabito, April 29, 2002 at 41.

[71] Testimony of Joseph V. Marabito, April 29, 2002, at 41.

[72] Id. at 47.

strategic vision. In fact, a driving force behind the Board's decision to achieve larger scale was the projected capital investment needed by CareFirst in order to stay competitive, and this has been one of the most prevalent reasons articulated by CareFirst in support of the transaction.[73]

The following projections were presented to the Board and Strategic Planning Committee:

The Case For Change	Potential Investments	Cost Range (millions)
■Significant national and local consolidation will continue to threaten CareFirst's market position	■ Mergers ■ Merger Integration ■ Contingency for price wars and acquisitions	$800-900
■The e-Economy is changing the economics of the industry and competitors are partnering with new internet entrants	■ e-commerce ■ Partnerships/interconnectivity	$30-50
■ In the future industry environment CareFirst will experience a shift of Power toward the consumer	■ New Products ■ Entering new metro markets with Next Generation Consumerism products ■ Call Center	$170-250
■CareFirst's competitiveness is increasingly challenged	■Information management system ■ Integrated IT platforms ■Medical management tools ■Reforming Networks ■Revamping provider contracts ■Bringing on new talent ■Organization structure change ■Restructure broker relationships[74]	$80-120

Mr. Marabito of Accenture described the development of these projected investments in the following way:

> …that was a bottom-up calculation. We took a step back and said, okay, if CareFirst is going to be successful in this strategy what is it going to need to do?[75]

Regarding the spending for e-commerce, Mr. Marabito testified that the numbers were not based on CareFirst's numbers, but rather "we looked at the capabilities that we thought would have to be built."[76] For the shift to consumerism, which included e-commerce capabilities and new

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[73] Testimony of Daniel J. Altobello, March 11, 2002, at 188 - 189.
[74] November 23, 1999, Board Minutes "CareFirst Strategy Implications" Discussion by Andersen Consulting.
[75] Testimony of Joseph V. Marabito, April 9, 2002, at 82.
[76] Id. at 90.

product development, the figures were based on the discussion Accenture had with other companies at the time making such investments, as well as Mr. Marabito's own experience as a former manager for product portfolio at the Missouri plan.[77]

According to the Blackstone Report, Mr. Marabito stated that the total of these capital expenditures ("CapEx") was above and beyond what CareFirst already projected in its five-year budget. This issue, whether these projected CapEx needs were "incremental" to already budgeted capital expenditures or whether they simply reflected total spending, inclusive of prior budgets, was not quite resolved, although not for lack of trying. As will be seen below, it is not necessary to resolve this question because this report concludes that the projected needs identified by Accenture not related to mergers and acquisitions could in fact be satisfied by CareFirst through internally generated cash.[78] .

6. Accenture identifies key strategic objectives requiring significant increases in scale for CareFirst.

Accenture's analysis of the market trends, CareFirst's historical spending on capital investments like technology, and CareFirst's strengths and weaknesses in the market, led Accenture to recommend a strategic vision whose fundamentals changed little over the following years. The strategy was premised on the notion of "geographic dominance." This approach allows for "significant scale increases while maintaining benefits of narrow geographic focus." In the longer term, the company would move to an approach named "next generation Consumerism", which entails focusing on specific and attractive consumer segments.[79]

The foundation for implementing the strategy to achieve regional scale consisted of three specific goals for CareFirst for the years 2000 - 2003:

(1) $8 billion to $11 billion in revenues, producing 15 - 22% annual revenue growth between 1999 and 2003;

(2) minimum capital of $500 million to $600 million and excess/contingency capital of $1.0 billion to $1.2 billion, resulting in a total capital base of $1.5 billion to $1.7 billion, with underwriting margins of 1 - 2 %; and

(3) the top position in key consumer segments with a diversified portfolio and 3 times the relative market share of the next competitor in the core service area.[80]

These factors are analyzed in more detail below. Accenture summarized the two methods it used to generate the revenue target of $8 to $11 billion in the following way:

> We used two methods to estimate a potential target revenue range for CareFirst. First we analyzed CareFirst's recent income statements to assess how much income CareFirst has been able to devote to strategic acquisition investments. We compared CareFirst's historical investment budgets with our estimates of investment needs in order to estimate the desired scale. Second, we examined the size and growth rates

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[77] Testimony of Joseph V. Marabito, April 29, 2002, at 81 - 96.
[78] See Blackstone Draft Business Case Report at 27.
[79] See CareFirst Special Meeting of the Board of Directors, November 23, 1999, handout titled "CareFirst Strategy Implications Discussion" at 1-36, CF-0003778-814.
[80] CareFirst, Inc., Special Meeting of the Board of Directors, November 23, 1999, handout titled "CareFirst Strategy Implications Discussion" at 3, CF-0003814.

of CareFirst competitors in the mid-Atlantic region, and projected the size CareFirst would have to be in order to not lose ground (in terms of scale) relative to those competitors. The result of those two methods was an estimate of $11 - $16 billion in annual revenue.[81]

Thus there were two approaches used by Accenture to estimate the required scale CareFirst would need to achieve in order to maintain its competitiveness. One was an examination of CareFirst's ability to make needed investments to stay competitive, including acquisitions of other carriers. Second, Accenture compared CareFirst to some of its in-market competitors such as Aetna, Cigna, and United and assumed that as they grew, CareFirst should grow at a rate to maintain its size relative to them.[82]

7. CareFirst could not achieve the strategic objectives through growth in its own market; it would have to combine with another health plan to achieve the objectives.

Mr. Marabito acknowledged at the hearings that it would be "near impossible" for CareFirst to meet this revenue objective simply by growing within its own market, referred to as "organic growth".[83] Therefore, CareFirst would need to acquire, be acquired, or otherwise combine with another company.

The repeated focus of Accenture in its presentations to the Board was the need to achieve scale and access capital through mergers or acquisitions. In one presentation, Accenture identified "clear priorities for CareFirst's merger and acquisition strategy."[84] These priorities were:

Merger and Acquisition Priorities

Priority	Rationale
1. Gain Scale contiguously	■ Gain scale and capital necessary for envisioned investments ■ Strengthen position for future consolidation ■ Seize window of opportunity with contiguous plans
2. Deepen Market Share	■ Solidify ability to dominate ■ Pre-empt competitors from gaining relative share
3. Support "consumerism"	■ Acquire capabilities necessary to succeed in future consumer-oriented environment ■ Diminish competitors' ability to differentiate against CareFirst

[81] Accenture I Report at 6.
[82] Testimony of Joseph V. Marabito, April 30, 2002, at 16:16-17:2.
[83] Testimony of Joseph V. Marabito, April 29, 2002, at 86.
[84] Id. at 15.

The strategy clearly is rooted in notions of growth: growth within the market, to "deepen market share" and also contiguous growth, *i.e.*, markets such as Virginia or Pennsylvania.

8. In 1999 Accenture recommended to the Board that achievement of the strategic objectives was more important than whether the company was for-profit or not-for-profit.

Early in the planning process Accenture advised the Board that "strategy should drive corporate structure" and that CareFirst should "pursue the optimal path to implement the business strategy, regardless of the consequences."[85] CareFirst was advised that "[i]f the opportunity to convert and go public presents itself during strategy implementation …. seize it" and "All else being equal pursue M & A opportunities that lead to a conversion and going public before those that do not."[86] It was an assumption for this recommendation that "CareFirst needs access to capital beyond reserves and cash flow to implement its strategy and remain competitive over the long term." In analyzing the status of the company as a nonprofit, Accenture did advise the Board that maintaining the status quo was "consistent with [its] historical mission." There is no discussion in any Accenture material as what this "historical mission" was, nor the implications of not continuing the mission. Accenture identified several disadvantages to the nonprofit structure, including the fact that the status quo "limits CareFirst's access to capital" and "perpetuates 'business as usual'; less impetus to change organization to respond to 'consumerism' challenge."[87] A presentation prepared by Accenture for the October 28, 1999, meeting of the Strategic Planning Committee characterizes one outcome of the prior meeting in September in the following way:

> The Committee is open to CareFirst being a for-profit company in order to increase its flexibility to respond to the changing needs of the market.

Accenture also focused on some measures of "control" CareFirst could seek in a new, combined company. The key measures of control identified by Accenture were:

Parameters to Define Control

- Number of board seats CareFirst receives
- Who is named Board Chairman
- Number of key management positions in which CareFirst executives are placed
- Who is named CEO
- Headquarters location
- CareFirst control over governance
- Name of combined company

See Board Meeting Strategy Implication Decisions, CF-0019781.

9. At that meeting, Accenture recommended "negotiating with Trigon to determine what measure of control might result for CareFirst."

As Accenture was recommending the strategic plan in 1999, CareFirst management conveyed to the Board that CareFirst was changing its focus and mission.

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[85] Id. at 29.
[86] CareFirst, Inc. Special Meeting of the Board of Directors, November 23, 1999, handout titled "CareFirst Strategy Implications Discussion" at 28, CF-0003806 .
[87] Id. at 31.

Perhaps to lay the foundation for a decision to achieve the strategic objectives by combining with a for-profit rather than nonprofit insurer, at an October 28, 1999, Executive Session of the Boards of Directors, Mr. Jews led a discussion on the changing role of CareFirst. To set the stage for the meeting, Mr. Jews sent a letter to the directors describing how increasing costs, federal and state fiscal cut backs, and political and regulatory pressures "are forcing actions and reactions by CareFirst, as you have noted and voted."[88] He described how these "actions and reactions" could impact the strategic planning process, and laid the foundation for the discussion to follow at the Board meeting:

> Clearly, our business decisions are well-founded yet there remains misunderstanding(s) about our Company's role. This confusion is/may cause reactions to us. Over time, these reactions could jeopardize our ability to properly provide value to our customers and ultimately cause deterioration in the progress we have made.
>
> It is timely for us to have some discussion about our mission, role and responsibility and how it is being perceived. This will logically lead us to discussions to fully examine whether we should stay the course or make changes toward providing value to our customers and supporting the growth of our Company. Id.

At the meeting, Mr. Jews informed the Board that "Today's CareFirst" was "responding with business-based decisions," was no longer insurer of last resort, was "more profit-oriented," could no longer be "all things to all people," was "seeking profitable business; was exiting unprofitable segments," was "evolving into a new kind of company," "need[ed] to think differently." He added that "CareFirst's struggle to be competitive forces us to act/react in a more business-like manner to survive," "our survival behavior causes questions relative to any perceived relief we receive (*i.e.*, SAAC/Premium Tax)," and "Our purpose as a company is confusing to many politicians."[89] He forwarded that CareFirst "need[ed] to be prepared to respond to criticism."[90] In the general session, Mr. Jews made his case why the "stay the same" strategy was rejected–essentially, because CareFirst's competitiveness and profitability would decline as competitors gained greater scale and ability to invest, while CareFirst would be limited to a market of declining attractiveness. [91]

10. Accenture's selection criteria for partners were based largely on the ability of the partner to achieve the objectives underlying the strategic plan developed by Accenture

On November 23, 1999, Accenture identified ten potential merger and acquisition candidates as having passed a screening process, including WellPoint, Highmark, Anthem and Trigon. [92] Accenture's candidate criteria were:

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[88] Letter dated October 22, 1999, William L. Jews to Daniel J. Altobello.
[89] Id. titled "Causes for Change,"CF-0003690.
[90] CareFirst, Inc. Board of Directors Meeting, October 28, 1999, executive session handout at titled "Preamble," CF-0003689.
[91] Id. at 28 – 30, CF-0003739-41
[92] CareFirst, Inc. Special Meeting of the Board of Directors, November 23, 1999, handout titled "CareFirst Strategy Implications Discussion" at 18, CF-0003796.

(1) health plan: (2) based in the U.S.; and (3) has sufficient size to make a meaningful contribution to CareFirst's business.[93]

Accenture's screening criteria were largely rooted in the assumption for the strategic plan it had developed relating to enhanced market share, contiguous growth:

(1) ability for CareFirst to drive its own destiny;
(2) allows CareFirst to maintain its Blue license; and
(3) is geographically contiguous, or has high potential to lead to contiguous expansion, or allows deepening of market share. Id.

Accenture prioritized candidates based on rankings on similar criteria as the screening criteria:

(1) contribution to geographic dominance;
(2) platform from which to launch "Next Generation Consumerism";
(3) opportunities for synergies;
(4) "doability"; and
(5) stand alone attractiveness. Id.

In 1999 Strategic Planning Committee identified as an important consideration in selecting a partner the level of control CareFirst would have after a potential merger or acquisition.

Accenture's report further noted that a merger and acquisition strategy depended heavily on factors beyond CareFirst's control such as: (1) cultural fit, transaction terms (financial, control, governance, board seats, management positions, headquarters location, etc.), state of target's business, and actual amount and achievability of synergies.[94] Based on its analysis of all factors, Accenture ranked Trigon ahead of WellPoint and Anthem recommended that CareFirst initially begin negotiations with Trigon to determine what degree of control might result for CareFirst if the two companies combined.[95] The Board accepted and adopted the Strategic Plan as recommended by the Strategic Planning Committee in consultation with Accenture.[96]

11. CareFirst's investment bankers, hired to implement the Accenture Strategy, generally validated Accenture's findings and strategy, advising CareFirst that the "status quo" as a nonprofit was not viable.

[93] Id. at 17, CF-0003795.

[94] Id. at 26, CF-0019785.
[95] CareFirst, Inc., Special Meeting of the Board of Directors Minutes, November 23, 1999, at 1-3, CF-0003763-65.
[96] Id. at CF-0003765.

In the summer of 2000, CareFirst retained the services of an investment bank, DLJ, to assist the company in achieving its strategic goals.[97] DLJ was purchased by Credit Suisse First Boston ("CSFB") soon after it began working with CareFirst, and CSFB continued the engagement. While DLJ did review the strategic objectives established by Accenture, and generally validated them,[98] its role was to assist CareFirst's effort to find a strategic partner based on the strategy that had already been adopted. As Mr. Stuart Smith of CSFB put it, by the time CSFB was hired, Smith believed that "[CSFB's] role largely rested with the execution of [the] strategy *once the company determined change was in order*…"(emphasis added).[99] This makes clear that by this time CareFirst had reached a decision that the "status quo" was not an acceptable alternative and some type of merger or acquisition was in order.

Notwithstanding this general understanding that the retention of the investment bankers signaled that a threshold decision to seek a merger or acquisition had been made, CSFB did devote some time to revisiting Accenture's strategy. In the same vein, CSFB presented to the Board the following view of the advantages and disadvantages of "continuing with the current corporate structure:"[100]

Advantages

- No action required
- Avoid probability of significant media and political scrutiny

Disadvantages

- Limited access to capital markets
- Limited acquisition currency
- Limited ability to pursue strategic mergers or acquisitions
- Sub-optimal positioning for long-term plan growth
- Foregoing first-mover advantage during market consolidation
- Vulnerability to larger, better capitalized competitors
- Impaired ability to fund competitive technology improvements

Mr. Altobello testified regarding this chart that "I think that the option of status quo, as you can see from the two advantages and half dozen or more disadvantages, was moving down the scale of value."[101] Notably absent from any analysis done by CSFB, as was the case with the Accenture analysis, is any mention of the significance of, or "status" of anything relating to a nonprofit mission or function. Not listed among the "Advantages" are any benefits to Maryland stakeholders such as policyholders or the participants in the system resulting from the continuation of CareFirst as a nonprofit. The only "advantages" identified are nothing more than the avoidance of the possible consequences of pursuing a conversion, such as political or media scrutiny.

This apparent bias against the status quo, is not surprising given that CSFB's role was to facilitate a strategic combination. CSFB's analysis was more confirmatory than explanatory. That

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[97] Supplement to Amended Form A Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer filed with the Department of Insurance and Securities Regulation and the Office of Corporation Counsel of the District of Columbia on January 11, 2002, at 4. Testimony of Stuart F. Smith, March 13, 2002, at 481 - 486. This testimony is important in determining the negotiations that CareFirst had with various merger partners.

[98] Testimony of Stuart F. Smith, March 13, 2002, at 509 – 513.

[99] Id. at 481.

[100] Exhibit 6, December 4, 2000, "Project Chesapeake" presentation by CSFB to CareFirst Board of Directors, at 13.

[101] Testimony of Daniel Altobello, March 11, 2002, at 243.

this is so is confirmed by the fact that by the time this presentation was made to the Strategic Planning Committee, the Committee had already begun to narrow consideration of potential merger partners to Trigon and Highmark, the former a for-profit and the latter a nonprofit.

12. CSFB generally validated Accenture's conclusion that CareFirst lacked access to capital, but with some modifications.

After being retained by CareFirst, CSFB did not conduct an exhaustive independent review of Accenture's estimates of CareFirst's capital needs, although it generally "validated" them. It did take into account CareFirst's debt capacity and other factors such as spending underway and came to a shortfall of $354 - $594 million. This was set out in the following chart given to the Board.

2000–2003 CapEx Requirements		Capital Sources: 2000–2003 Incremental Free Cash Flow		Incremental Debt Capacity	Additional Funding Needs
eCommerce	$30–$50				
New Products	170–250				
Information Management	80–120	Change in Cash	$323		
Mergers	800–900	Less: Required Capital (1)	(112)	$375	$354 - $594
Total	1,080–1,320	Incremental Free Cash	$211		
Less: Forecast CapEx	(140)				
Incremental CapEx	$940–$1,180				

DLJ "Presentation to Project Chesapeake," at 10, July 27, 2000; also Exhibit #5, March 2002 Hearing. As will be discussed in more detail later, the bulk of the shortfall related to spending on mergers.

13. CSFB identified a range of potential partners in 2000, but Trigon is the leading candidate.

In the summer of 2000, CSFB also began to rank potential partners for CareFirst. In a report presented at the July 11, 2000, meeting of the Strategic Planning Committee, CSFB evaluated thirteen potential strategic partners on eleven evaluation criteria weighted according to importance.[102] The criteria, including the percentage weight assigned to each, were: geographic proximity (25%), access to capital (15%), deal doability (15%), BCBS licensee (10%), size (10%), control (10%), market penetration (5%), information technology (2.5%), membership quality (2.5%), customer preference (2.5%), and network quality (2.5%).[103] Trigon outscored WellPoint on geographic proximity, deal doability, membership quality, customer preference, and network quality.[104] WellPoint outscored Trigon only on size and information technology. Id.

Based on these criteria, Trigon ranked first with a score of 2.78, with Highmark and MAMSI tied for second and third with a score of 2.20, and WellPoint and Kaiser tied for fourth and fifth at

[102] CareFirst, Inc. Strategic Planning and Finance Committee Meeting, July 11, 2000, at handout titled "Project Chesapeake" at 2, CF-0004824.
[103] Id. at CF-0004823.
[104] Id. at CF-0004822.

2.08, on a scale with 1.0 as the worst possible score and 3.0 as the best possible score.[105] CSFB concluded that "Trigon represents the Company's best current strategic alternative."[106] While one member of the committee raised questions about the "do-ability" of a Trigon merger and CSFB agreed to explore the issue at the next committee meeting[107] the Strategic Planning Committee reached a "general consensus that a merger with Trigon, simultaneous with conversion is the optimal recommendation from a strategic perspective."[108]

In a report presented at the July 27, 2000, meeting of the Strategic Planning Committee, CSFB had broadened its conclusion to state that "a combination with Trigon or Highmark represents the Company's best current strategic alternative."[109] CSFB's July 27, 2000, report noted: "The window of opportunity [for a merger with Trigon] may be very limited given Trigon's public statements that it intends to undertake a strategic transaction," whereas on July 11, 2000, Trigon and Highmark had been rated equally on "do-ability."[110] The Strategic Planning Committee concluded that either affiliation scenario (CareFirst-Trigon or CareFirst-Highmark) would largely result in achievement of CareFirst's long-term strategic goals and recommended further discussions with both companies.[111] On July 27, 2000, the boards of directors instructed management, through the CEO to continue discussions with both Trigon and Highmark.[112]

In September of 2000, CareFirst and Trigon signed a confidentiality agreement in connection with the "consideration of a possible transaction".[113] During the fall of 2000, substantial efforts were undertaken by CareFirst and Trigon staff to explore the feasibility and advantages of a business combination. A preliminary report on a combination of CareFirst and Trigon sets forth numerous "synergies" to be obtained form the deal:

- Incremental market share growth
- Incremental hospital discounts
- Lower physician fee schedule
- Administrative cost savings
- Broker commission savings[114]

The study also set out other "non-unique" synergies that have been created in other similar combinations. The report estimates five-year savings of $193 million from unique synergies and $165 million in nonunique synergies.

The focus on Trigon continued in late 2000 as set forth in the following chronology developed by Jay Angoff from the minutes of the Strategic Planning Committee:

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[105] CareFirst, Inc. Strategic Planning and Finance Committee Meeting, July 11, 2000, at handout titled "Project Chesapeake" at 2, CF-0004824.
[106] Id. at 25, CF-0004826.
[107] Id. at 1, CF-0004792.
[108] Id. at 1 – 2, CF-0004792-93.
[109] CareFirst, Inc. Strategic Planning and Finance Committee Meeting, July 27, 2000, at handout titled "Project Chesapeake" at 3, CF-0004860.
[110] CF-0004883, Id. at 26.
[111] CF-0004849, Id. at 2 of minutes.
[112] CF-0004206 - CF-0004210, CareFirst, Inc. Board of Director Meeting Minutes, July 27, 2000, at 1-5.
[113] T0026 – T0029 A copy of this agreement was furnished by Trigon representatives in response to a MIA subpoena, but has not been marked as an exhibit.
[114] October 2000 "Business Case Discussion," Exhibit 115 to August 19, 2002, deposition of Timothy P. Nolan at T0227.

October 26, 2000, Strategic Planning Committee Meeting:

- DLJ reports that a Trigon deal is more compelling than one with Highmark due to unique marketing synergies achievable in the Route 123 Corridor. DLJ assures the committee that Trigon would be a strong source of capital. Mr. Jews reports that the main considerations in a Trigon deal would be headquarters location, job preservation and continuation of a local presence.
- Minutes state that "in addition to the aforementioned another key consideration in a Trigon transaction would be Foundation size."
- Committee agrees that CareFirst should continue to pursue the Trigon and Highmark possibilities.

November 21, 2000, Strategic Planning Committee Meeting:

- CSFB, which has acquired DLJ, reports that there is dialogue with multiple plans but that it is preparing a data room for preliminary due diligence by Trigon.

December 3, 2000, Board Meeting:

- CSFB recommends continued consideration of Trigon as the primary partnership candidate but that the analysis also be widened to include WellPoint and Anthem.

December 4, 2000, Board Meeting:

- CSFB presents the criteria used in assessing potential candidates, primary criteria are geographic proximity and substantial size. Trigon scores better than WellPoint in this analysis.[115]

14. Highmark, and later Anthem, the only not-for-profits to receive consideration as a potential merger partner, were ruled out because they had not converted to for-profit status.

As described in more detail below, the Board did initially consider Highmark, a large Pennsylvania nonprofit Blue Cross/Blue Shield plan as a potential merger candidate. However, at the October 2000 SPC meeting, DLJ reported that a deal with Trigon is more "compelling" than Highmark due to unique marketing synergies in the Route 123 corridors in Virginia[116] This recommendation was made, even though Highmark, a nonprofit, had roughly ten times the membership as Trigon, had reserves of $2.2 billion compared to Trigon's $937 million, and revenue of $8.2 billion compared to Trigon's $3.3billion.[117] DLJ's analysis showed a combined Highmark/CareFirst entity was larger in all key measurements than a combined Trigon/CareFirst entity.[118]

Material provided to the MIA indicate the Boards' decision to exclude Highmark as a merger partner was based on the following: (1) a Highmark affiliation would provide only limited access to capital markets; (2) a Highmark affiliation would provide virtually no acquisition currency; (3) the complicated existing governance and management structure of Highmark would be further

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[115] "The Due Diligence Exercised by CareFirst, Inc. in Deciding to Convert to For-Profit Status and to be Acquired by WellPoint Health Networks, Inc.", Roger G. Brown & Associates, January 10, 2003, (the "Brown Due Diligence Report") at 70 – 71.

[116] CF-0004900, William L. Jews Deposition Exhibit 127-- CareFirst, Inc., SPC Meeting Minutes, October 26, 2000.

[117] CareFirst, Inc. SPC Meeting Minutes, October 26, 2000, at CSFB "Executive Summary" handout, CF-0004987.

[118] Id. at CF-0004988.

exacerbated by an affiliation with CareFirst; (4) there would be limited ability to effectuate efficiencies through systems integration with Highmark; and (5) the complicated structure resulting from a Highmark affiliation would make further strategic moves virtually impossible.[119]

In an October 26, 2000, Presentation by the Strategic Planning Committee, CSFB did not rule out Highmark, stating:

> As a next step, DLJ would suggest that CareFirst begin to analyze the deeper impact of a transaction with Trigon or an affiliation with Highmark, as each level of the organizational structure faces its own set of integration issues.

David Wolf, however, favored Trigon in his own presentation to the Strategic Planning Committee, where he presented the following "Conclusions:"

- Both alternatives represent a significant growth opportunity for CFI, aligned with long-term strategic goals (revenue, membership, capital)
- A partnership with Trigon creates significantly greater marketing synergies across the "123 corrido" than does an affiliation with Highmark (approximately $56 million in the first three years)
- Complexity of multi-jurisdictional rule under Highmark affiliation scenario significantly complicates any subsequent transaction: multiple approvals required
- Additionally, multi-jurisdictional rule under Highmark scenario significantly restricts ability to access and deploy capital, as well as remain nimble in an increasingly competitive marketplace
- In contract, access to capital and flexibility in its deployment are much less complicated in a Trigon scenario
- CFI's relatively smaller scale could limit ability to influence company direction in an affiliation with Highmark: the scales are more evenly balanced in a partnership with Trigon.[120]

Mr. Jews stated that Highmark and Anthem were dropped from consideration fairly early in the process, and were not sent formal bid solicitation letters because, unlike WellPoint and Trigon, they were not for-profit companies and, therefore, were not good strategic fits with CareFirst, which wanted to convert to for-profit in order to have better access to the capital markets.[121] Mr. Wolf testified that Highmark's nonprofit status would make it difficult to deploy capital across state lines due to regulatory requirements.[122] However, he could cite no legal or other analysis to support this impression. The basis for this concern is unclear in light of the fact that CareFirst has touted the successes of its affiliations between Maryland, D.C., and Delaware and the efficiencies that have resulted. With respect to Anthem, when asked whether Anthem could have provided sufficient capital to CareFirst, Mr. Jews replied "it's not about the money, it was about conversion and the money".[123]

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[119] Supplement to Amended Form A Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer filed with the Department of Insurance and Securities Regulation and the Office of Corporation Counsel of the District of Columbia on January 11, 2002, at 4-5. CF-0012311 - CF-0012312, pre-filed written testimony of Daniel J. Altobello, March 6, 2002, at 4-5.

[120] October 19, 2000, Memorandum from David Wolf to the Strategic Planning Committee at 5.
[121] Deposition of William L. Jews, September 6, 2002, at 146 – 149.
[122] Deposition of David D. Wolf, September 19, 2002, at 36 – 37.
[123] Id. at 148.

15. CSFB recommended expanding the field in December of 2000 to include consideration of WellPoint and Anthem.

As noted in the above referenced chronology, the Board of Directors met in early December 2000, and received an extensive presentation by CSFB. At the Strategic Planning Committee's and boards' December 3-4, 2000, meetings, CSFB presented a report analyzing the advantages and disadvantages of the Company's various strategic options.[124] Options considered included keeping the *status quo*, conversion followed by an IPO, forming a strategic alliance, or merging.[125] Based on CSFB's recommendation and meetings with Highmark, the Boards decided that an affiliation with Highmark was not in the best interest of the CareFirst companies because it would not further the Boards' strategic goals/imperatives.[126] The Boards' decision was based on the following: (1) a Highmark affiliation would provide only limited access to capital markets; (2) a Highmark affiliation would provide virtually no acquisition currency; (3) the complicated existing governance and management structure of Highmark would be further exacerbated by an affiliation with CareFirst; (4) there would be limited ability to effectuate efficiencies through systems integration with Highmark; and (5) the complicated structure resulting from a Highmark affiliation would make further strategic moves virtually impossible.[127] CSFB advised that without undertaking a conversion, CareFirst's capital sources were limited to internally generated free cash flow and external debt financing. Id. In evaluating 13 potential partners, CSFB identified only Trigon, MAMSI, WellPoint, and Coventry as having high access to capital, whereas Highmark had medium access to capital and Anthem had low access to capital.[128] CSFB recommended that WellPoint and Anthem be added to the list of potential partners, that Trigon be retained on the list, and that Highmark be dropped to a secondary candidate.[129] Trigon was the potential strategic partner ranked highest by CSFB and seemed by far the best fit for CareFirst.[130] The Boards requested that CSFB shift the focus of its analysis to potential conversions and acquisitions by either Trigon or WellPoint.[131]

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[124] CF-0012311 - CF-0012312, Pre-filed written testimony of Daniel J. Altobello, March 6, 2002, at 4-5; CF-0004425, William L. Jews Deposition Exhibit 129, CareFirst, Inc. Annual Planning Session of the Directors Meeting Minutes, December 4, 2000, at 4; William L. Jews Deposition Exhibit 130, CSFB presentation to CareFirst, Inc., Board of Directors titled A Project Chesapeake, December 4, 2000.

[125] Testimony of Daniel J. Altobello, March 11, 2002, at 236:11-242:21. CF-0004646 - CF-0004650, William L. Jews Deposition Exhibit 130, CSFB presentation to CareFirst, Inc. Board of Directors titled A Project Chesapeake, December 4, 2000, at 10-14.

[126] CF-0012311-12, pre-filed written testimony of Daniel J. Altobello, March 6, 2002, at 4-5.

[127] Supplement to Amended Form A Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer filed with the Department of Insurance and Securities Regulation and the Office of Corporation Counsel of the District of Columbia on January 11, 2002, at 4-5. CF-0012311 - CF-0012312, pre-filed written testimony of Daniel J. Altobello, March 6, 2002, at 4-5.

[128] William L. Jews Deposition Exhibit 130, CSFB presentation to CareFirst, Inc. Board of Directors titled "A Project Chesapeake," December 4, 2000, at 22, CF-0004658.

[129] William L. Jews Deposition Exhibit 129, CareFirst, Inc. Annual Planning Session of the Directors Meeting Minutes, December 4, 2000, at 4, CF-0004425.

[130] Deposition of William L. Jews, September 6, 2002, at 93 - 95, CF-0019819; William L. Jews Deposition Exhibit 130, CSFB presentation to CareFirst, Inc. Board of Directors titled "Project Chesapeake", December 4, 2000, at 22, CF-0004658.

[131] Pre-filed written testimony of Daniel J. Altobello, March 6, 2002, at 5, CF-0004658.

In fact, Anthem was corresponding with CareFirst and making overtures for a potential affiliation. Mr. Jews and Mr. Glasscock met in late November about the strategic options CareFirst was exploring.[132] Glasscock expressed his interest in being included in CareFirst's "process". They met again in late December to discuss a potential affiliation.[133] Mr. Glasscock followed up with a letter in early January suggesting further meetings. Id. Mr. Jews discounted the initial seriousness of Anthem, testifying that "I don't think Anthem suggested they wanted to talk deals. I believe they wanted to talk about the opportunity to express their strategy."[134] Anthem wrote again in early January expressing continued interest in being included in the bidding and selectMarch 4, 2003ion process. Mr. Jews also met with both Mr. Schaeffer and Mr. Snead during January.

16. Anthem was considered excluded from the selection process early on at the recommendation

On January 22, 2001, the Strategic Planning Committee met again. The minutes of that meeting describe Mr. Jews' summary of the process to date. These minutes indicate that:

> further development of the business case narrowed the field to Trigon and WellPoint, two plans that the Board acknowledged as being the most viable partners during the December's Year 2000 annual meeting. Mr. Jews reported that multiple conversions [conversation] and meetings between himself and the principles have occurred, and that preliminary outlines of an agreement have been reached with both Trigon and WellPoint.

Notably, the minutes suggest that while CSFB recommended inclusion of Anthem in December 2000, the main focus was on WellPoint and Trigon, even though there were discussions and correspondence from Anthem. The minutes reflect that Mr. Jews did not mention the meetings with and letters from Anthem. The key factors for deciding between Trigon and WellPoint were, according to Mr. Jews' statements to the Strategic Planning Committee, total economic value and "do-ability."[135] In its presentation, CSFB listed other factors such as governance, long-term strategy and goals, and the overall business case as well.[136]

A pointed letter was sent to Mr. Jews in early February by Mr. Glasscock expressing his enthusiasm for a possible deal, and outlining Anthem's financial strength ($226 million in earnings in 2000; $1.9 billion in GAAP equity year end 2000).[137] Mr. Glasscock highlighted Anthem's affiliation track record, and its announced to plan to demutualize, which Glasscock believed would occur before CareFirst's conversion. On February 13, 2001, Mr. Jews responded to Glasscock "upon recommendation from CSFB."[138] Mr. Jews' letter politely rebuffed Anthem's overtures on the following grounds:

> There was no consistency between Anthem's "current purchase strategy" and the ways CareFirst was operated. - Any

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[132] William L. Jews Deposition Exhibit 131, December 7, 2000, Glasscock letter to Jews.
[133] William L. Jews Deposition Exhibit 132 at 99, January 3, 2001, Glasscock letter to Jews.
[134] Deposition of William L. Jews, September 6, 2002, at 103.
[135] CF-0005713, William L. Jews Deposition Exhibit 133, CareFirst Inc. Strategic Planning Committee Meeting, January 22, 2001, at 1.
[136] CF-0005713, William L. Jews Deposition Exhibit 133, CareFirst Inc. Strategic Planning Committee Meeting, January 22, 2001.
[137] February 5, 2001, letter from Mr. Glasscock to Mr. Jews, Exhibit 134.
[138] Exhibit 135.

demutualization and initial public offering would take too long, and although "you may have current financial resources, our investment bankers did not see a transaction with you occurring for some time". - It was necessary to complete the current process before "we expand or change the criteria and timing we have in place."

The exclusion of Anthem was communicated to the Board's SPC at the February 22, 2001 meeting.[139]

17. The selection criteria used by CSFB in January 2001 did not focus as heavily on geographic dominance and control, although these continued to be considered

The inclusion of WellPoint among the two finalists shifted away from the idea that the transaction should be part of a contiguous geographic strategy.[140] As a result of preliminary discussion with the bidders, in January 2001, CSFB prepared a side-by-side comparison of Trigon and WellPoint on the key transaction issues that had been discussed with the parties. This analysis suggested that a Trigon partnership would have been superior to a WellPoint partnership in terms of synergies, potential resulting competitive threats, potential earnings growth, benefits to constituents (seamless provider networks, integrated customer service and standardization of medical policy across a large geographic region), the strength of the business case that could be made to legislators (due to contiguous nature), directorships, and next merger opportunity.[141] The WellPoint transaction was described as having "no geographic synergies" and "no immediate contiguous growth synergies". Under the category "DO-ABILITY" with legislators, it was viewed that for the WellPoint deal, "non-contiguous nature complicates business case," an apparent recognition that WellPoint diverged from the geographic dominance theory underlying the business case.

Specific criteria for evaluating deal terms were also identified. CareFirst believed the criteria accurately reflected the key issues impacting the company and its constituencies.[142] These criteria were:

- the price
- the form of consideration (cash/stock),
- the exchange ratio, the degree of price protection,
- the existence of financial requirements,
- the termination provisions,
- the representations and warranties,
- the definition of material adverse changes that might void the deal,
- the potential post-closing obligations to any charitable foundations,
- headquarters location,
- the extent of Board representation,
- management role and composition; and
- the effect on CareFirst associates and subscribers. Id.

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[139] Exhibit 137, February 22, 2001 SPC Meeting Minutes, CF-0005756-5757.
[140] Testimony of Daniel J. Altobello, March 11, 2002, at 249:20-250:14.
[141] CF-0005739 - CF-0005741, William L. Jews Deposition Exhibit 133, CareFirst Inc. Strategic Planning Committee Meeting, January 22, 2001, see attachment titled "Executive Summary" at 4-6; CF-0005739 to CF-0005741, see also William L. Jews Deposition Exhibit 137, CareFirst Inc. Strategic Planning Committee Meeting, February 22, 2001.
[142] CF-0012312 - 0012313, Id.

The Board considered price "absolutely crucial" but "not solely determinative."[143] Besides price, the "other crucial element" was the Boards' commitment not to approve a proposed transaction if it had an adverse impact on the companies' associates or its customers.[144]

Mr. Jews remarked at the meeting that there were no "fatal flaws" in either proposal. The two potential partners compared equally with respect to access to public equity and debt markets. Insufficient information existed at that time to compare the two potential partners in terms of realization of economic benefit. The two potential partners were viewed differently in terms of headquarters location (Trigon might involve a move) and management composition (Jews' role). Id. However, as will be discussed in more detail below, both Trigon's Mr. Snead and CareFirst's Mr. Wolf agree that the headquarters location eventually became a non-issue below the CEO level.[145]

The side-by-side comparison at this point did not include a proposed purchase price. The testimony was that price was not discussed with the bidders until the formal bids came in late February. There are some indications however, that some guidance was offered to potential bidders, even including Anthem. In his letter of February 5, Mr. Glasscock thanked Mr. Jews for receiving "guidance on your timing and *valuation objectives*".[146] (Emphasis added.) Glasscock indicated his belief he could satisfy these "objectives," noting that in the past Anthem had moved quickly in other deals to "pay full and fair prices to the stakeholders of our acquired businesses." This suggests that more discussions were held about price than the participants admitted to, but that could not be confirmed.

18. Representation on the Acquirors' Board was discussed early in the process in January 2001.

It is clear that discussions were held about seats on the board of directors of the combined entity prior to the submission of formal bids. According to a side-by-side analysis of offers being floated, Trigon was offering "three Directors out of a total of 16" and WellPoint was offering one out of nine.[147]

One disputed fact is whether CareFirst gave board representation priority over price. As previously noted, Accenture's November 23, 1999, report opined that board seats was a factor affecting a merger and acquisition strategy that was beyond CareFirst's control.[148] Trigon representatives testified that Trigon was prepared to open with an offer of $1.4 billion to $1.5 billion for CareFirst, but received information from Mr. David Wolf that Trigon could offer less money if it would offer more Trigon board of director positions to former CareFirst directors.[149] Mr. Jews denies that CareFirst was trading for directors' seats in lieu of an increase in purchase price, but he admits that he had representatives for CareFirst say to Trigon, "Give me more seats."[150] Mr. Wolf

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[143] Id. at CF-0012312 – 0012313.
[144] Id. at CF-0012313.
[145] Deposition of Thomas G. Snead, Jr., August 19, 2002, at 70 – 71; Deposition of David D. Wolf, September 19, 2002, at 85.
[146] William L. Jews Deposition Exhibit 134, CF-0006316.
[147] Strategic Planning Committee Meeting handout prepared by CSFB entitled "Key Transaction Issues" at 6, CF-0005779.
[148] CareFirst presentation titled "Strategy Implications Discussion" for Special Meeting of the Board of Directors, November 23, 1999, at 26, CF-0019785.
[149] Deposition of Thomas G. Snead, Jr., August 19, 2002, at 53 – 59, 84 – 86; Deposition Exhibit 102, February 20, 2001, letter from CSFB to Thomas G. Snead, Jr.; Deposition of Timothy P. Nolan, August 19, 2002, at 44 – 49.
[150] Deposition of William L. Jews, September 6, 2002, at 20 – 22.

also denies that additional board seats were traded for money.[151] Stuart Smith never heard of CareFirst telling Trigon that CareFirst would prefer to see a greater level of board representation as opposed to a higher price.[152]

However, the evidence suggests that Trigon's version of events may be the correct one. In January 2001, before a formal purchase price offer had been made by the bidders, Trigon was offering 3 out of 16 seats on the combined Board. When the formal bids came in with a purchase price, Trigon had increased the number of Board seats to 5 of 17. This fact, coupled with the fact that Trigon never increased its purchase price and said it was willing to do so, supports the possibility that it held back on price in return for more Board seats. There is also a possibility that CareFirst emphasized seats because, as it later admitted, it was going to rely on the regulatory process to obtain the highest price. Thus, it is understandable that CareFirst would have sought to maximize these nonprice factors over which the regulators were less likely to intervene, and allow the regulator to maximize price. If Trigon were ultimately determined to be the best candidate, this strategy was designed to maximize benefits without having to engage in difficult trade-offs.

19. The Board receives "formal" legal advice on its duties in February 2001

In February 2001, CareFirst's outside counsel, the firm of Piper, Marbury, Rudnick & Wolfe, LLP, ("Piper"), provided the only formal written advice to the Strategic Planning Committee on its duties and responsibilities in connection with the proposed transaction.[153] Piper advised the Strategic Planning Committee that "unlike a public company sale, the proposed transaction does not subject the CareFirst Directors to a duty to maximize price. Rather, the Directors must obtain a fair price, but can also consider other non-price factors."[154] Piper advised the Strategic Planning Committee that price clearly was a factor, but was not the only factor and that, while they had a duty ultimately under the statute to bring in a transaction that would satisfy the fair value test, it was appropriate for them, and they should have the responsibility, to consider other constituents such as policyholders, the public interest, and employees, which they did.[155] Nevertheless, CareFirst management claims to have sought to maximize the price.[156]

20. Formal invitations to bid were extended to WellPoint and Trigon in February 2001

Pursuant to the request of the Strategic Planning Committee, preliminary due diligence regarding the Trigon and WellPoint opportunities was performed during the latter half of January 2001.[157] In February of 2001, CSFB, on behalf of the boards, distributed a bidding procedures letter and draft merger agreement to WellPoint and Trigon, thereby beginning the formal auction/bidding process. Id. On February 20, 2001, CSFB separately solicited definitive proposals from WellPoint and Trigon, requesting from each submission of a proposal, including the price to be offered, no

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[151] Deposition of David D. Wolf, September 19, 2002, at 107.
[152] Deposition of Stuart F. Smith, November 25, 2002, at 212 – 213.
[153] Exhibit 1 to February 2, 2001, CareFirst Board of Director Minutes; Testimony of R. W. Smith, Jr., December 17, 2002, at 176 – 178, CF-0005169, CF-0005220 - CF-0005222.
[154] William L. Jews Deposition Exhibit 133, CF-0005713, CF-0005719.
[155] Testimony of R. W. Smith, Jr., March 14, 2002, at 118 – 119.
[156] Testimony of William L. Jews, April 30, 2002, at 165; Deposition of David D. Wolf, Sept. 19, 2002, at 129 – 131.
[157] Pre-filed written testimony of Daniel J. Altobello, March 6, 2002, at 5, CF-0012312.

later than February 28, 2001, and reserving the right to negotiate with one or more interested parties prior to the signing of a definitive agreement.[158]

21. No formal valuation of CareFirst was obtained prior to the bidding process

Although the Board minutes suggest that in January the Board requested that a valuation be done prior to the bidding,[159] it appears no formal valuation by CSFB was prepared until after "best and final" offers were received in April 2001. Prior to April it appears the Board was told simply that it should not expect $2 billion to $2.5 billion, but rather that a reasonable price would be "somewhere above $1 billion," and that CSFB would provide a fairness opinion to the Board "in the event a transaction is proposed."[160] The only formal valuation done by CSFB during the bidding process occurred after "best and final" offers were received in April 2001. The valuation range was based on three methodologies: comparison of selected publicly traded companies; comparison of selected merger and acquisition transactions; and discounted cash flow analysis.[161] The range using a comparison of selected publicly traded companies was $98 million - $1.2 billion; the range using a comparison of selected merger and acquisition transactions was $1.28 - $1.45 billion; the range using discounted cash flow analysis was $1.26 - $1.55 billion.[162] Prior to April it appeared that the Board was told simply that it should not expect $2 billion.[163]

22. Initial offers from the bidder were reviewed in February

At the February 22, 2001, meeting of the Boards, CSFB outlined and presented for discussion the anticipated terms of the WellPoint and Trigon offer.[164] A CSFB presentation to the CareFirst Strategic Planning Committee indicated that with Trigon as a strategic partner, there was a likelihood of maintaining local employment levels even while the contiguous nature of the two companies strengthened the business case, whereas the non-contiguous nature of WellPoint would complicate the business case.[165] As discussed below, the view that Trigon would produce desirable synergies changed dramatically to the view that a relationship with Trigon would be problematic, because of the potential for job loss.

On March 2, 2001, WellPoint and Trigon each submitted proposals in response to CSFB's solicitation on behalf of CareFirst, WellPoint offering $1.2 billion and Trigon offering $1.3 billion.[166]

In February 2001, and again in March 2001, CareFirst rebuffed Anthem's attempt to enter the bidding process, expressing doubt over Anthem's ability to finance a deal, concern that Anthem's demutualization would not be completed in time, and concern that Anthem's entry would slow down

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[158] Exhibit 136, February 20, 2001, Adams to Schaeffer soliciting bid, CF-0008528 – CF-0008531; Exhibit 102, February 2, 2001; CSFB letter to Snead to request bid, CF-0006331 – CF-0006334.
[159] Deposition of Stuart Smith November 11, 2002, at 94 - 95.
[160] CF-0005174, CareFirst, Inc. Board of Director Meeting Minutes, February 22, 2001, at 6.
[161] CSFB Presentation "Project Chesapeake," April 26, 2001, Page 24; Exhibit 202.
[162] Id. at 25.
[163] Testimony of Stuart F. Smith, March 13, 2002, at 534.
[164] CF-0019828-19830, CSFB presentation to CareFirst, Inc. Board of Directors, February 22, 2001, at 1-3.
[165] Deposition of Stuart F. Smith, November 25, 2002, at 187:22-190:22 at Deposition Exhibit 205 at 4 and 6.
[166] Thomas G. Snead, Jr. Deposition Exhibit 103. William L. Jews Deposition Exhibit 139.

the process already underway.[167] Mr. Altobello also asserts that Anthem was removed because of the uncertainty over its demutualization, and that, even when the demutualization was complete, the negotiations with Trigon and WellPoint were too far along to consider adding another third party to the mix.[168] However, Mr. Jews admitted that CareFirst's management "would have had the time necessary" to conduct reciprocal due diligence with Anthem and that Anthem's exclusion was not caused by concerns that including Anthem would have slowed down the process, but rather that CareFirst just didn't think that Anthem was a good strategic fit.[169]

On March 19, 2001, WellPoint increased its offer to $1.25 billion.[170] As of March 21, 2001, WellPoint's offer was $1.25 billion and Trigon's offer was $1.3 billion.[171] On March 23, 2001, CSFB remarked that "both [Trigon's and WellPoint's] bids were reasonable as it pertains to the total dollar amount submitted." CSFB was instructed by CareFirst management to seek a higher price from WellPoint, and CSFB persuaded WellPoint's representatives to increase its bid by telling them that WellPoint was weak on price.[172]

23. The bidders were treated differently

The testimony from WellPoint and Trigon reflected a material difference in the manner 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.[173] 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.[174] Although CareFirst and Trigon dispute that they ever discouraged Trigon from increasing its price, they admit that they never asked Trigon to increase its initial offer.[175] Indeed, Mr. Wolf admitted that one of CareFirst's goals was to get the price offered by Trigon and WellPoint as close as possible, to make it easier for CareFirst to choose between them based on non-monetary factors.[176] Even before offers were formally solicited from Trigon and WellPoint, CFSB's worknotes implied discomfort with CareFirst's strategy: "If this was an auction, how do we go about not choosing the highest bidder."[177]

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[167] William L. Jews Deposition Exhibit 140.
[168] Testimony of Daniel J. Altobello, March 11, 2002, at 250 – 252.
[169] Deposition of William L. Jews, September 6, 2002, at 140 – 143.
[170] William L. Jews Deposition Exhibit 142.
[171] William L. Jews Deposition Exhibit 143, CF-0005795.
[172] Deposition of Stuart F. Smith, November 22, 2002, at 104 – 107; Deposition of Stuart F. Smith, November 25, 2002, at 177 – 178.
[173] Testimony of Gregory L. Sorenson, December 16, 2002, 143, 160 – 165.
[174] Deposition of Thomas G. Snead, Jr., August 19, 2002, at 90, 108 - 109 and Exhibit 107; Deposition of Timothy P. Nolan, August 19, 2002, at 51 – 52, 57 - 58, 105 - 107, 117 – 118.
[175] Deposition of Stuart F. Smith, November 25, 2002, at 310 - 311; Deposition of William L. Jews, September 6, 2002, at 163 - 171, 39 - 45; Deposition of David D. Wolf, September 19, 2002, at 131.
[176] Deposition of David D. Wolf, September 19, 2002, at 147.
[177] Michael Muntner hand written Project Chesapeake work note entry for April 12, 2001, CFSB-0020128, produced by CSFB on December 31, 2002 in a black binder labeled CSFB 19601 - 20346.

24. Just prior to the receipt of "best and final" offer from the two bidders, the respective ranking of the two bidders changed on key issues, in some cases with little or no explanation

At the March 23, 2001, meeting of the Strategic Planning and Financial Committees, Mr. Wolf made a presentation on "Key Stakeholder Analysis" in which Trigon and WellPoint were compared.[178] The following groups were considered the key stakeholders:

- Regulators and Legislators (citizens General)
- Subscribers
- Associates
- Employer Groups
- Wall Street
- Providers
- Broker community

Trigon ranked higher for two groups, Employer Groups, and Regulators and Legislators. On "Regulators & Legislators (Citizens Generally)" the ranking was higher because of issues including foundation price, foundation control, local presence, jobs, product and segment continuity, and local headquarters. At this point Trigon was offering $1.3 billion while WellPoint was at $1.25 billion, which would explain the higher rankings on foundation price. Trigon also ranked higher in terms of "Employer Groups" because of issues including product rates, product and segment continuity, regional network, product spectrum, and provider choice. The rationale was "RT 123 Corridor consolidation is opportunity with Trigon" and "Trigon's consistent pricing practices are viewed favorably by employers." The presentation noted that "Trigon's contiguous nature will create additional goodwill" and that the "WellPoint deal presents potential Virginia regulatory issues."[179]

Trigon and WellPoint rated equally on key issues related to the "Associates" stakeholder group, including "job security", "benefit continuity", "local management", and "local headquarters", with explanatory rationales such as "Both committed to substantial local presence," "WLJ position will be viewed favorably by associates," and "Neither party expects benefits to change significantly with the exception of the introduction of long-term stock options."[180] In this presentation, WellPoint was not ranked superior to Trigon for any group.

Mr. Jews presented management's assessment of the potential partners, in which he seemed to focus primarily on the fact that "the WellPoint proposal provides a more clear delineation of reporting structure and scope of responsibilities."[181] As will be discussed below, this related to the fact that Jews believed that he should be the CEO of the combined entity if Trigon were to purchase CareFirst, a view not shared by the party proposing to pay more than a billion dollars.[182] The inability of negotiators for CareFirst and Trigon, which in some cases included Jews and Snead

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[178] William L. Jews Deposition Exhibit 143 at 1, CF-0005785; and attachment titled "Key Stake Holder Analysis," at 1 – 2, CF-0005800 - CF-0005801.
[179] Id., CF-0005800.
[180] Id. at 1, CF-0005800.
[181] William L. Jews Deposition Exhibit 143 at CF-0005785, CareFirst, Inc. Strategic Planning and Finance Committees Special Meeting Minutes, March 23, 2001.
[182] Deposition of William L. Jews, September 9, 2002, at 389; Deposition of Tom Snead at 46 - 50.

personally, to reach mutual agreement on Jews' role in a Trigon/CareFirst was a factor in Trigon's bid being rejected.[183]

On April 24, 2001, two days before the next meeting of the Strategic Planning Committee, WellPoint increased its offer to $1.3 billion,[184] and CSFB'S Stuart Smith opined on the results of what he termed the "best and final" bidding process."[185]

On April 26, 2001, the Strategic Planning Committee made a presentation to the Board on the "best and finals" which again included Mr. Jews' presentation of a "Key Stakeholder Analysis."[186] However, for reasons which are not set forth in the Board materials, the relative rankings were reversed on several key measurements.

Without explanation, WellPoint was now ranked higher on "Regulators & Legislators,"[187] one of two measurements on which Trigon had been ranked higher one month earlier. The other ranking on which Trigon was superior in March, "Employer Groups" now did not appear at all. In addition, WellPoint was now ranked superior to Trigon for "Associates" when they had been even before. Id. A new page of comparisons was added, entitled "Balancing Critical Deal points." These Deal points and the rankings are set out below:

"Balancing Critical Deal Points"

	WellPoint	Trigon
Job Retention	+	
Geographic Presence	+	
Expansion Capability	+	
Disruption Minimized	+	
Reputation of the Partner-Neutral	+	+
Economies of Scale		+
Foundation of Obligation/Closes		
Service Gaps	+	+
Doability	+	

On this presentation WellPoint ranked ahead of Trigon in five of seven categories.

Mr. Jews' explanation was that the change in the ranking "reflects the evolution of what happened in conversations and summary information in that one month period.[188] Based on Trigon's losing effort to top a bid WellPoint made to buy the Cerulean plan in November of 2000, Jews believed that " they had a history of exiting a business plan, or at least an opportunity they had in Georgia." Id. CareFirst became concerned that Trigon might not stay in the process for the extended regulatory approvals that would be required. He described them as "inexperienced." Jews also emphasized his view that Trigon might cut jobs because of economies of scale and synergies based on geographic proximity.[189]

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[183] William L. Jews Deposition Exhibit 143, CareFirst, Inc. Strategic Planning and Finance Committees Special Meeting Minutes, March 23, 2001at CF-0005797.

[184] Id. at Exhibit 144.

[185] Deposition of Stuart F. Smith, November 25, 2002, at 217 - 224.

[186] William L. Jews Deposition Exhibit 145, CareFirst Board of Director Meeting Minutes and Executive Session at 5 – 7, CF-0005238 - CF-0005330.

[187] Id. at 5-6, CF-0005328 – CF0005329.

[188] Deposition of William L. Jews, September 6, 2002, at 218.

[189] Id. at 214: - 217. This testimony is important in understanding the proposed merger and conversion from CareFirst's perspective.

25. Management estimates significant job losses in dealing with Trigon.

According to Board minutes, it was at the meeting of the Strategic Planning Committee in April 2001, that Mr. Jews told the Board that Trigon, despite a commitment not to cut employment, would cut up to 2,000 jobs if the plans combined.[190] This conclusion was not based upon any formal analysis but rather "just extrapolated" based on his experience.[191] The view expressed by Mr. Jews and Stuart Smith of CSFB was that Wall Street would "demand" job cuts because of the close proximity of the two plans.[192] Mr. Jews testified that certain legislators had told him that job cuts, particularly in an election year, would be unacceptable, and Mr. Jews believed the legislature would most certainly involve themselves in the conversion process.[193] Mr. Altobello asserts that CareFirst had a duty not to cut employment.[194]

Most importantly, this sudden and dramatic estimate of job loss was at odds with all prior analysis done by CSFB, which never cited the loss of jobs as an issue and which consistently ranked Trigon ahead of WellPoint. Stuart Smith conceded that it was not news in March that the plans were contiguous, a factor which Jews believed was suddenly a negative when, for months, contiguity had not only been an advantage but a core element of the strategic plan.[195] Mr. Jews' estimate was at odds with his point person on the deal, Mr. Wolf, who had led the due diligence team from CareFirst and who testified that he and the staff of CareFirst, in analyzing a Trigon-CareFirst combination, did not estimate any job loss. As late as October 25, 2001, CareFirst's Mr. Wolf indicated that Trigon's local presence proposal was superior to WellPoint's.[196] On the same date, CSFB advised CareFirst that it did not anticipate any reduction in employment levels as the result of a Trigon deal and ranked Trigon superior to WellPoint on that issue.[197]

The record suggests that a significant breach of trust had occurred between Mr. Jews and Mr. Snead, and in fact this, rather than some of the factors discussed above such as jobs or headquarters drove the decision to place a priority on a deal with WellPoint. Mr. Jews testified that because Mr. Snead had "reneged" on Snead's original offer to move the headquarters of the combined entity to Maryland. Mr. Jews had told the Board about the new headquarters and had to retract the news.[198] Mr. Jews said he was embarrassed by this. Mr. Jews described Mr. Snead as having "lied" to him. Mr. Jews also expressed anger over Trigon's bid for Cerulean in November 2000 while Trigon was also in discussions with CareFirst. As Mr. Jews described, "he said he didn't have a deal going on, he was concentrating on me, when he was bidding on Cerulean."[199]

In any event, by April 12, 2001, Mr. Jews' apparent preference is clear to CSFB. Their notes state: "*CareFirst Conference Call - Bill is leaning towards a Pacific* [WellPoint] *deal. . . Stuart*

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[190] SPC Minutes, April 26, 2001, CF-0005806.
[191] Id. at 226 – 227 and Deposition Exhibit 146 at 1; Deposition of Stuart F. Smith, at 191 - 192, 198.
[192] Deposition of David D. Wolf, September 19, 2002, at 47 - 54; Deposition of William L. Jews, September 6, 2002, at 519 - 160; Deposition of Stuart F. Smith, at 200 - 201.
[193] Deposition of William L. Jews, September 6, 2002, at 226 – 227, CF-0005806.
[194] Testimony of Daniel J. Altobello, March 11, 2002, at 265:10-14; Deposition of Stuart F. Smith, November 25, 2002, at 191 – 192, 198, and Exhibit 146.
[195] Deposition of Stuart F. Smith, November 25, 2002, at 190.
[196] Deposition of David D. Wolf, September 19, 2002, at 88, and Exhibit 158.
[197] Deposition of Stuart F. Smith, November 25, 2002, at 339 - 345; David D. Wolf Deposition Exhibit 158 at 4.
[198] Id. at 274 – 275.
[199] Id. at 233.

has lowered Atlantic's [Trigon's] *expectations on timing in order to keep them warm.*"[200] At this point, though, Trigon's was still the higher price offer.

26. In April 2001, the Board selects WellPoint as the preferred partner and orders the negotiation of "Definitive Merger Agreement."

At the April 26, 2001, Strategic Planning Committee Meeting, CSFB's Stuart Smith opined that WellPoint's proposal was "clearly superior,"[201] and on that same date he resummarized for the Board the key proposed terms of the WellPoint transaction and provided an overview of WellPoint as a company.[202] CSFB focused on the differences in the financial aspects of the deal, noting that WellPoint was guaranteeing the purchase price with a note if for some reason the value of WellPoint stock fell below a minimum price.[203] This "downside protection" which Stuart Smith described as very important, was not being offered by Trigon at that time. Id. It is also true, as Mr. Smith testified, that a bidder that could guarantee the purchase price would be more desirable than one that could not, all other things being equal.[204]

In all CSFB ranked Trigon's bid inferior based on the following reasons:

- Trigon wants the ability to replace some of the cash portion of the purchase price with notes;
- Trigon wants to reduce purchase price if stock falls below a certain floor, while WellPoint guarantees the purchase price even if its stock falls below a certain floor;
    - Trigon imposes financial performance criteria and WellPoint does not;
- Trigon's plan could lead to the loss of as many as 2000 jobs and WellPoint has made assurances of no job losses;
- Trigon's proposal for management structure is not as workable as WellPoint's proposal;
    - There are signs Trigon has a diminished commitment to a local presence.

At the April 26, 2001, Board meeting, the Board adopted a resolution selecting WellPoint as the preferred bidder which provided as follows:

> RESOLVED, that the Board authorizes management to enter into a due diligence and contract negotiation process with WellPoint Health System [sic], with the goal of producing a Definitive Merger Agreement and to do such without eliminating consideration for a potential transaction with Trigon.[205]

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[200] Michael Muntner's hand written Project Chesapeake worknote entry for April 12, 2001, at CSFB-0020196.
[201] Deposition of Stuart F. Smith, November 25, 2002, at 217:13-224:4; William L. Jews Deposition Exhibit 146 at CF-0005806.
[202] CareFirst, Inc. Board of Directors Meeting Minutes, April 26, 2001, CF-0005238.
[203] Deposition of Stuart F. Smith, November 25, 2002, at 217 – 224.
[204] Deposition of Stuart F. Smith, November 22, 2002, at 130 – 133.
[205] Minutes of the Board of directors, October 26, 2001, at 6.

27. Negotiations continued after Best and Final Offers in April

Although the Board issued a Directive to negotiate a deal with WellPoint, management and CSFB continued to negotiate between bidders, and in fact largely focused discussion on Trigon rather than WellPoint. The following chronology prepared by Jay Angoff illustrates this point:

June 5, 2001, Trigon Summary of Key Business Terms:

- Trigon sets out the terms of its proposed deal, which include the following:
  - 60% cash and 40% stock;
  - Trigon is willing to relocate its headquarters;
  - five members of the CareFirst Board of Directors will be appointed to the combined company's Board;
  - termination provisions to be discussed;
  - Jews as Chairman of the Board and CEO of the CareFirst Companies with Snead as overall CEO;
  - no anticipation of substantial employee dislocation.[206]

June 12, 2001, Trigon Letter to CareFirst:

- Nolan tells Wolf that Trigon is working on a letter on the "business" issues but that Trigon would like to have a better understanding of the "social" issues before responding in writing because they do not want to "miss the mark on the best way to resolve all of the outstanding issues."

June 22, 2001, Trigon Letter to CareFirst:

- Snead writes Jews and attaches a "Summary of Key Business Terms" that details terms of his proposed deal. He explains that those terms are the result of guidance received from CareFirst and its advisors. He states that Trigon has been guided "towards an express goal of maximizing price" and towards considering non-price issues such as Board seats, personnel integration and operating locations. He responds to concerns he understands Trigon has as follows:
  - Trigon is willing to accept "more traditional MAC language" if the parties can agree on an interim operating arrangement;
  - Trigon proposes an interim operating arrangement pursuant to which it would jointly make decisions with CareFirst on issues outside the ordinary course of business, including material changes in operations, acquisitions, and new business ventures.
  - Trigon does not expect reductions in employment levels;
  - the emergency financing mechanism of a Trigon note is designed only as a back-up, with disincentives for Trigon to issue the note and incentives for it to be paid quickly.

June 26, 2001, Trigon Letter to CareFirst

- Snead tells Jews that the CEO's getting together is the best way to resolve the open issues. He also makes the following proposals:

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[206] "The Due Diligence Exercised by CareFirst, Inc. in Deciding to Convert to For-Profit Status and to be Acquired by WellPoint Health Networks, Inc.", Roger G. Brown & Associates, January 10, 2003, (the "Brown Due Diligence Report") at 70 – 71.

- Jews would be Chairman of the Board and head of strategic development, and would run the day-to-day operations of the Maryland, Delaware, D.C. and Northern Virginia/DC corridor markets. Snead and Jews would be "operating partners" with each reporting to the Board of Directors;
- Snead and Jews would be responsible for creating and filling the new management structure;
- having the corporate headquarters in Richmond is the best alternative but Trigon considers this open for discussion.

July 19, 2001, Trigon Letter to CareFirst:

- In response to Jews's [sic] request, Snead proposes the following roles for Jews in the new company:
- responsibility for the management of the Board of Directors;
- development of corporate strategy;
- with Snead, would constitute the Executive Management Team and create and fill the management structure;
- would continue as CEO of the current CareFirst territories and likely a larger portion of Northern Virginia.

July 25, 2001, Strategic Planning Committee Meeting:

- CSFB reports that the WellPoint and Trigon proposals are similar as to price, consideration, stock floor, financial requirements and headquarters. WellPoint is superior on exchange ratio, termination provisions and management structure. Trigon is superior on Board representation and commitment to associates. Jews reports that there is no clear resolution to the negotiations with WellPoint on associate benefits. Altobello challenges the management structure proposed by Trigon.

July 25-26, 2001, Board Meeting:

- CSFB states that the WellPoint proposal's main negative is its impact on CareFirst associates, while Trigon's is its proposed organizational structure. The minutes state that management and the Board believe that an adverse impact on associates is not acceptable.

August 23, 2001, Strategic Planning Committee Meeting:

- Wolf reports that Trigon maintains a strong interest in a deal and has been conducting its due diligence. He says that many synergies have been identified, that Trigon has reiterated its commitment to associates, and that work levels could be maintained in a deal with Trigon for the same reasons that CareFirst could maintain the work force in its prior affiliations.
  - Jews reports that indemnification and associate benefits could be deal breakers with WellPoint.
  - Naftaly remarks that Trigon appears to be the best candidate; Jews cautions that Trigon's commitments would have to be made in writing before a final decision.
  - Committee agrees to refine the agreement with Trigon and maintain a dialogue with WellPoint.

September 7, 2001, Trigon and CareFirst Meeting:

- Nolan and Wolf discuss a partnership framework. Trigon's summary prepared indicates that change of control and severance terms are discussed and that

executives offered a position with the new company will receive new contracts intended to provide an incentive for them to stay. It also indicates that the merger incentive bonuses are discussed and notes the following:

- Trigon is concerned that the current form of merger incentives will not be saleable to regulators, politicians, the public or the public markets;
- if stay bonuses are applied they should be performance based and not incentive based;
- transaction incentives should apply to only those driving the transaction;
- an incentive to close a deal under any circumstances, rather than to preserve value between signing and closing, conflicts with future shareholders' interests;
- Trigon anticipates establishing incentive structures after the merger is complete.

September 25, 2001, Strategic Planning Committee Meeting

- CSFB reports that the Trigon and WellPoint proposals are largely unchanged since August, and that the key issue for Trigon is management structure, whereas the key issues for WellPoint are associate benefits and tax indemnification.

October 16, 2001, Trigon Letter to CareFirst:

- Snead writes Jews that in light of information received on June 22 Trigon is improving its offer in the following ways:
  - price of $1.3 billion with 40% stock and 60% cash with no financing contingencies and no walk away. Trigon takes the risk of up to a 22% decline in stock value, below which the companies would "share the plan" of the decline;
  - more specific terms on interim operations;
  - 5% break-up fee.

- Snead attaches a revised Key Business Terms summary and revised Definitive Agreement. He says he would like to discuss ways to best gain support for a deal before entering in agreement. He also says he will defer to CareFirst regarding visits, but attaches a list of persons that "at a minimum" Trigon would like to have gauge on.

October 16, 2001, Summary of Key Business Terms:

- Trigon prepares and submits a Summary of Key Business Terms, among which are the following:
  - Maximum issuance of 10.4 million shares of Trigon stock with Trigon bearing the burden of the first 22% drop in stock price and the parties sharing the risk of further declines;
  - Jews and four members of the CareFirst Board of Directors to sit on the new Board;
  - non-solicitation clause;
  - right to match offer and 5% termination fee;
  - Trigon's interest and expectation of no job reductions.

October 25, 2001, Strategic Planning Committee Meeting:

- CSFB that price has been set in negotiations with the two potential partners and that the next focal point is the regulatory process. It explains that Trigon has recently proposed more restrictive filing and closing time frames and this might signal less commitment to a deal. CSFB believes that management structure continues to be a problem with Trigon and indemnification a problem with WellPoint. Jews recommends that the next step is to present the parties CareFirst's remaining requirements.

October 25, 2001, Board Meeting:

- CSFB reports that WellPoint has an ongoing transaction with RightCHOICE and that therefore there is a small window of opportunity for a WellPoint deal. Stuart Smith distributes a handout to Board members comparing the current bids of WellPoint and Trigon. Smith informs the Board that Trigon wants to consult regulators in each state before any transaction; he also states that a Trigon transaction would work only if there are significant reductions in CareFirst associates. Jews recommended going back to both Trigon and WellPoint for a final position on each outstanding major issue and obtaining the final and best offer from each.

November 20, 2001, Board Meeting:

- CSFB and management recommend and Board approves the Definitive Agreement with WellPoint.[207]

Presentations to the Board throughout this period continually ranked the two bidders on "key transaction" points. As of October 25, 2001, CareFirst management and CSFB had ranked the Trigon and WellPoint proposals on side-by-side comparisons as "comparable" on the headquarters issue, notwithstanding other testimony by Mr. Jews and Altobello that Trigon's proposal for headquarters was inferior.[208] Trigon was also viewed as superior on commitment to associates and on "transaction objectives," an important sounding criteria the meaning of which, remarkably, Mr. Smith could not recall.

During the period of October 30, 2001, to November 2, 2001, Trigon again improved its offer by adding a subordinated note feature that removed any risk from CareFirst of a decline in Trigon's stock price.[209] Last minute meetings occurred between Trigon and CareFirst in efforts to rehabilitate Trigon's bid. CareFirst was satisfied that improvement in the downside protection of Trigon's offer, was "acceptable."[210]

By November 5, 2001, CareFirst claims that, in light of the Georgia experience,[211], where Trigon made a failed effort to make a topping bid for the Georgia Blue Plan being purchased by WellPoint, CareFirst was having doubts about Trigon's ability to commit to a potentially lengthy process. There was also concern about Trigon's smaller size, relative to WellPoint, and Trigon's

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[207] See The Brown Due Diligence Report at 74 - 78.

[208] Deposition of Stuart F. Smith, at 339:5-346:8; David Wolf Deposition Exhibit 158.

[209] Deposition of Timothy P. Nolan, August 19, 2002, at 93 – 95.

[210] Deposition of Thomas G. Snead, Jr., August 19, 2002, at 179 – 180.

[211] Trigon had made an unsolicited offer to acquire Cerulean, the Georgia BCBS plan, while a deal was pending between WellPoint and Cerulean. Trigon failed to top a subsequent bid enhancement by WellPoint, and the latter acquired Cerulean. Mr. Jews interpreted this as an indication that Trigon was unsophisticated and might not be able to close a CareFirst deal. Deposition of William L. Jews, September 6, 2002, at 165 – 176, 273 and 396.

unwillingness to waive the 18-month requirement (except that Trigon was willing to modify the latter requirement so long as a hearing started within 18 months).[212] These concerns conflict with Mr. Altobello's explanation for why Trigon was rejected that: "Despite good faith negotiations, ultimately Trigon could not overcome the fiscal reality that its purchase of CareFirst would result in adverse implications for CareFirst associates and the continuing operations of CareFirst."[213]

At the November 5, 2001, Strategic Planning Committee meeting, based upon the advice of its advisors, recommended the submission of the WellPoint proposal to the boards for final approval.[214]

According to the Form A filing:

> "The Boards approved the proposed transaction with WellPoint because it met all of the major criteria the Boards used to evaluate proposals, and the Boards believed it was superior to Trigon's proposal. The Boards foresaw the following benefits from the transaction with WellPoint: (1) continuation of existing CareFirst products and services along with enhancements to those products and services; (2) a slowed rate of increase in premiums because of the increased financial strength WellPoint will bring to CareFirst; (3) ensured continued local decision-making on health care issues and policy; (4) a benefit to providers through increased technology investments that will result in on-line, real time verification and claims status review; (5) continued employment and maintained regulatory oversight; and (6) the largest per capita public benefit donation to charitable foundations in the history of Blue Cross Blue Shield Plan conversions."

Supplement to D.C. Form A, at 7, accord.[215]

28. Trigon's bid is viewed as inferior based largely on social issues

The filing with the MIA identifies the key criteria which served as the basis for the ultimate selection of WellPoint over Trigon:

> "The Boards also believed that the WellPoint proposal was superior to the Trigon proposal for the following reasons: (1) the Trigon proposal would have resulted in substantial layoffs of the CareFirst workforce because of the relatively small size of Trigon, vis-à-vis CareFirst, whereas WellPoint, because of its significantly larger size and the structure of the organization it proposed, did not pose that

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[212] Deposition of Stuart F. Smith, November 25, 2002, at 230 – 234; David D. Wolf Deposition Exh.159 at 2.

[213] Id. at 7; accord, pre-filed written testimony of Daniel J. Altobello, CF-0012315.

[214] Supplement to Amended Form A Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer filed with the Department of Insurance and Securities Regulation and the Office of Corporation Counsel of the District of Columbia on January 11, 2002, at 6.

[215] Pre-filed testimony of Daniel J. Altobello, January 31, 2003, at CF-0012315 – 0012316.

> threat;[216] (2) Trigon proposed a management structure whereby there would be essentially dual CEOs, which the Board believed was unworkable and would have resulted in confusion in leadership and a lack of unified direction; (3) Trigon had proposed to move the headquarters of the public company from Richmond to Maryland, but the proposal was later withdrawn with an explicit requirement that headquarters would remain at Trigon's headquarters in Richmond, Virginia; (4) Trigon had no significant experience in integrating companies it purchased, whereas WellPoint had significant positive experience in that regard and a very strong track record of improving performance in companies it acquired; (5) Trigon required that should its stock fall below a certain price, both it and CareFirst would share in the decline creating the potential that the foundations would not receive the full value of the purchase price to benefit the communities, while the purchase price of the WellPoint proposal was guaranteed; and (6) the Trigon proposal permitted termination by Trigon after 18 months if the transaction had not been completed, while the WellPoint proposal was committed for three years."[217]

Of the reasons cited here in support of WellPoint at least three relate to non-price concerns about Trigon: the location of headquarters, the role of CareFirst management in the new organization, and the prospect of job loss.

29. The CareFirst Board is advised WellPoint's price is fair.

On November 20, 2001, CSFB presented its "Valuation Analysis" to CareFirst's Boards, estimating CareFirst's value at $1.01 to $1.2 billion based on a comparable public companies analysis, $1.17 billion to $1.59 billion based on a comparable M&A transactions analysis, and $1.2 billion to $1.525 billion on a discounted cash flow analysis.[218] The same opinion and analysis is included as Exhibit 4-B to CareFirst's Form A ("CSFB's Fairness Opinion"), and is offered as the report of an independent financial expert required pursuant to MD. CODE ANN., STATE GOV'T §§ 6.5-201(b)(6) & 6.5-301.[219]

On November 20, 2001, the CareFirst Boards voted to enter into definitive agreement with WellPoint.[220]

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[216] Trigon did promise that layoffs would not occur, but the Boards did not believe that the Trigon transaction was feasible without layoffs.

[217] Id. at 7; CF-0012315 - CF-0012316, accord Pre-filed written testimony of Daniel J. Altobello, March 6, 2002, at 8-9.

[218] CF-0005508 - CF-0005509, CSFB November 20, 2001, Fairness Opinion. CSFB presentation to Board of Directors titled "Project Chesapeake," November 20, 2001. Supplement to Amended Form A Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer filed with the Department of Insurance and Securities Regulation and the Office of Corporation Counsel of the District of Columbia on January 11, 2002, at 8.

[219] Exhibit 4B to Form A, Fairness Opinion Issued by CSFB to Board of Directors and Presentation to the Board, November 20, 2001.

[220] Supplement to Amended Form A Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer filed with the Department of Insurance and Securities Regulation and the Office of Corporation Counsel of the District of Columbia on January 11, 2002, at 6.

CareFirst received an opinion from Piper indicating that the process, including the exclusion of Anthem and the sending of solicitation letters to only WellPoint and Trigon, met the Boards' fiduciary responsibilities.[221] Piper provided its opinion orally on November 20, 2001, and confirmed the opinion in writing on November 30, 2001.[222]

30. Compensation issues received considerable attention during the bidding process

All throughout the negotiations with the parties, the issue of executive compensation was being addressed in the Compensation Committee of the Board. The Executive Compensation Committee met on March 23, April 20, April 26, May 24, June 12, July 9, and July 25 to consider the issues of merger incentives, retention bonus, and related issues.[223]

VII. ANALYSIS OF THE FACTORS THE CONVERSION STATUTE REQUIRES TO BE TO BE "CONSIDERED" IN DETERMINING WHETHER A TRANSACTION IS IN THE PUBLIC INTEREST

A. The Standard for Approval - Is the Transaction in the Public Interest?

Under Maryland law, the appropriate regulatory entity, in this case the Maryland Insurance Administration, may not approve the acquisition unless it affirmatively finds that the acquisition is in the "public interest." MD. CODE ANN., STATE GOV'T § 6.5-301. The statute does not expressly define the term "public interest." Case law, however, notes that, as a general rule "[t]he ultimate determination of what constitutes the public interest must be made considering the totality of the circumstances of any given case against the backdrop of current societal expectations." Seigneur v. National Fitness Institute, Inc., 132 Md. App. 271, 287 (2000), (quoting Wolf v. Ford, 335 Md. 525, 535(1994)).

In the case of the acquisition of a nonprofit health service plan, the legislature guides the analysis of what constitutes the "public interest" by establishing two sets of factors that bear on that determination. One set of factors, if not satisfied, require the conclusion, as a matter of law, that the public interest is not served. The other set of factors must be considered in determining whether the acquisition are in the public interest.

1. Review Factors Which must be Satisfied in determining the Public Interest

According to the conversion statute, an acquisition is not in the public interest unless appropriate steps have been taken to:

- ensure the value of public assets is safeguarded;
- ensure that the fair value of public assets will be distributed to the Maryland Health Care Foundation;

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[221] Testimony of Daniel J. Altobello, March 11, 2002, at 253 – 255.

[222] Hearing Exhibit 208 at Exhibit A, January 16, 2001, memorandum from Piper Marbury Rudnick & Wolfe to John A. Picciotto re: Fiduciary Duties of Directors in connection with possible business combination.

[223] Exhibits 177, 178, 179, 180, 181, 182, and 183; the minutes of the Executive Compensation Committee meetings for March 23, 2001, April 20, 2001, April 26, 2001, May 24, 2001, June 12, 2001, June 24, 2001, July 9, 2001, and July 25, 2001, respectively.

- ensure that no part of the public or charitable assets of the nonprofit entity inure directly or indirectly to an officer, director, or trustee of the plan; and
- ensure that no officer, director, or trustee of the nonprofit receives any immediate or future remuneration as the result of the acquisition except in the form of compensation paid for continued employment with the acquiring entity.

Md. Code Ann., State Gov't § 6.5-301(b).

2. Review Factors Which Should Be Considered, But Which Are Not Required To Be Satisfied, In Determining The Public Interest

Another set of factors must be "considered" by the regulating entity in determining whether the acquisition is in the public interest. None of these factors are dispositive, although they clearly identify the societal interests and expectations that the legislature deems critical in making that assessment. The factors which must be considered, but which do not by operation of law automatically disqualify the application, are:

(1) whether the transferor exercised due diligence in deciding to engage in an acquisition, selecting the transferee, and negotiating the terms and conditions of the acquisition;
(2) the procedures the transferor used in making the decision, including whether appropriate expert assistance was used;
(3) whether any conflicts of interest were disclosed, including conflicts of interest of board members, executives, and experts retained by the transferor, transferee, or any other parties to the acquisition;
(4) whether the transferor will receive fair value for its public or charitable assets;
(5) whether public or charitable assets are placed at unreasonable risk if the acquisition is financed in part by the transferor;
(6) whether the acquisition has the likelihood of creating a significant adverse effect on the availability or accessibility of health care services in the affected community;
(7) whether the acquisition includes sufficient safeguards to ensure that the affected community will have continued access to affordable health care; and
(8) whether any management contract under the acquisition.[224]

In addition, the conversion statute requires the MIA to consider: whether the acquisition is "equitable to enrollees, insureds, shareholders, and certificate holders, if any;" whether the proposed transaction complies with Title 2, Subtitle 6 of the Corporations and Associations Article (regarding the amendments of corporate charters); and whether the transferee will meet statutory surplus requirements.[225]

It is clear from this statutory scheme that the public interest analysis is a multi-tiered analysis. If the factors under MD. CODE ANN., STATE GOV'T § 6.5-301(b) are not satisfied, the transaction is automatically not in the public interest and must be disapproved. If those criteria are

[224] Md. Code Ann., State Gov't § 6.5-301(e).
[225] Md. Code Ann., State Gov't § 6.5-303.

satisfied, the public interest analysis involves an evaluation and balancing of the remaining criteria. It should be noted that the statute does not either expressly or implicitly limit the public interest analysis to those criteria which the Commissioner "shall" consider. However, this report will begin with the analysis of the factors that are expressly articulated in MD. CODE ANN., STATE GOV'T § 6.5-301(e).

3. "Due Diligence" and The Duties of the Board of Directors

The first factor that must be considered under MD. CODE ANN., STATE GOV'T § 6.5-301(e) is whether CareFirst "exercised due diligence in deciding to engage in an acquisition, selecting the transferee, and negotiating the terms and conditions of the acquisitions." MD. CODE ANN., STATE GOV'T § 6.5-301(e)(1). The statute does not define "due diligence." Case law, however, makes it clear that the exercise of "due diligence" is synonymous with the exercise of the fiduciary duties owed by the officers and directors of the transferor. In Hernandez v. Department of Labor, Licensing and Reg., 122 Md. App. 19, 26 (1998), the Court of Special Appeals noted that:

Black's Law Dictionary 411 (5th ed. 1979) defines "due diligence" as: "such a measure of prudence, activity, or assiduity, as is properly to be expected from, and ordinarily exercised by, a reasonable and prudent man under the particular circumstances; not measured by any absolute standard, but depending on the relative facts of the special case."

The measure of "prudence, activity, or assiduity" that is properly expected from the officers and directors of CareFirst is embodied in their fiduciary duties. Thus, in analyzing whether the Board of Directors exercised "due diligence," it is important first to understand the duties owed by the CareFirst Board.

4. The Experts' Evaluation of the Applicable Duties of the CareFirst Board.

CareFirst's corporate counsel, Piper Rudnick, LLP ("Piper"), and the expert retained by the MIA, Jay Angoff of Roger Brown & Associates, have addressed the legal standards that applied to the actions of the CareFirst Board. While Piper and Mr. Angoff agree as to the general framework within which the Board was required to act, there are significant areas of disagreement as to what factors relating the proposed transaction the Board was obligated to consider and what factors the Board was allowed to consider at various phases of the process.

In its only formal written legal advice to the Board on the subject, Piper analyzed the duty of care and the duty of loyalty that the Directors owed in connection with a sale of CareFirst. Piper wrote that the "duty of care":

> requires a director to be diligent and prudent in managing the corporation's affairs and to discharge his/her duties on an informed basis with due care. A director must inform himself of all material information reasonable available to him before making a business decision. Once informed a director must act with requisite care in discharging his duties. The level of care required rises with the significance of the decision being made.[226]

Piper advised the Board in writing that a director may rely on information and reports from officers or employees whom the director reasonably believes to be reliable and confident. The

[226] Memorandum of Piper Rudnick, January 16, 2001, at 2.

Board also was advised that it could rely on information and reports from experts such as lawyers or accountants, including compensation experts, "as to matters which the director reasonably believes to be within the person's professional or expert competence."[227]

With regard to the "duty of loyalty/fidelity," Piper advised the Board that a director must exercise his or her powers "in the best interest of the corporation and not in the director's personal interest or in the interest of another person."

After discussing these obligations, Piper noted that directors have special obligations when contemplating the sale/merger of a corporation. Piper described these additional duties as follows:

> Directors must act reasonably to find the best offer available to the Company. In deciding if the directors have acted reasonably, Courts will look at how the directors have come to their decision and whether that decision is reasonable in the context of those circumstances. The process followed in making a decision must be fair and the price obtained for the corporation must also be fair.[228]

Piper described this as a "more rigorous standard" which required Courts to not only look to see if a board used due care in preparing itself to make decisions, but also whether the board's decisions were "reasonably calculated to achieve a legitimate corporate objective."

In addressing the standards that governed board action in contemplating a sale of a corporation, Piper highlighted the case of Revlon, Inc., v. McAndrews and Forbes Holdings, Inc., 506 A.2d 173 (DEL 1976). In Revlon, the Delaware Supreme Court concluded that traditional formulations of a board's fiduciary duties of care and loyalty were not adequate to protect shareholder interests in sale of control transactions. Revlon established a new framework for such transactions, holding that in such cases, the predominant obligation of the board is "the maximization of the company's value at a sale for the stockholder's benefit."[229]

Piper advised the Board that when the Revlon standard applies, directors must "obtain the best possible price" for the shareholders and that factors that a board might ordinarily consider in making corporate decisions (such as the interest of employees or customers or the communities in which the corporation does business) can no longer be taken into account. Piper advised the CareFirst Board that "Revlon primarily applies to situations where there has been a change in

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[227] As discussed in more detail below, one aspect of Piper's advice which ultimately played a significant role in the conduct of the Board, as well as the Board's defense of its actions, related to the so-called "business judgment rule." According to the memorandum prepared by Piper:

> The business judgment rule protects directors who exercise good faith judgment from liability arising from an unwise or unsuccessful corporate action resulting from a decision of the directors. It insulates these decisions from judicial review, absent fraud, illegality or bad faith, as long as the director exercised informed business judgment. Hearing Exhibit 208 at Exhibit A, January 16, 2001, memorandum from Piper Marbury Rudnick & Wolfe to John A. Picciotto re: Fiduciary Duties of Directors in connection with possible business combination.

[228] Hearing Exhibit 208, at Exhibit A, January 16, 2001, memorandum from Piper Marbury Rudnick & Wolfe LLP to John A. Picciotto re: Fiduciary Duties of Directors in connection with possible business combination.

[229] Id. at 184.

control." Piper described a "change in control" as a circumstance in which shareholders are losing, once and for all, their opportunity to obtain a control premium. Piper distinguished that circumstance from a stock-for-stock merger in which the shareholders of the corporation continue as full equity participants in the ongoing post-merger venture.

There is disagreement on the applicability of the so-called "Revlon rule" to this particular transaction. In its memorandum to the Board, Piper indicated that, because "any possible transaction between CareFirst and another BlueCross BlueShield plan would involve a stock-for-stock merger or share exchange," it was unlikely that a Court would conclude that Revlon applied. That suggested that the CareFirst Board could consider factors other than the highest price in determining whether, when, and to whom to sell CareFirst.

As described in more detail below, Mr. Angoff took exception to Piper's analysis of the potential application of Revlon to the sale of CareFirst to WellPoint, noting that this particular transaction clearly involved a change in control, which (under Piper's analysis) would suggest that Revlon might apply. Piper has pointed out, however, that "no Court has applied Revlon to the Board of Directors of a not for-profit, either in the context of a conversion or a merger." Piper acknowledged that some commentators have argued that Revlon should apply to not for-profit Boards, but it advised CareFirst that "the CareFirst Board may rely on the fact that no Court has adopted this view."

Piper advised the CareFirst Board that, if Revlon did not apply, the Board needed only to follow a reasonable process to come to a reasonable decision in the context of the circumstances, and that the merits of a particular decision would not be second guessed in any circumstance in this which the "business judgment rule" applied.. If, however, Revlon did apply, what was important was not necessarily the "process" that the Board followed, but whether that process resulted in the best price for the company.

Piper's formal memorandum to the Board on its duties and obligations also included a description of the statutory standards set forth in the Conversion Statute. The Board enumerated the factors that the MIA must consider under MD. CODE ANN., STATE GOV'T § 6.5-301. The memorandum also pointed out to the Board that the Insurance Administration "must" also consider whether the acquisition is in the public interest, whether its equitable to enrollees, insureds and subscribers, and whether the acquisition is approved by a vote of the nonprofit's certificate holders, a requirement that was repealed during the Legislative Session in which this Memorandum was issued. As described *infra*, notably absent from Piper's review of the relevant statutory standards was the prohibition on inurement that ultimately became a focal point of much of the discussion regarding this transaction.

As Mr. Angoff points out in his report on the due diligence of the Directors, there are Maryland statutory provisions that relate to the duties of Boards of corporations generally. The duty of care which was described in Piper's memorandum is codified in two places in the Maryland statutes: § 2-405.1 of the Corporations and Associations Article for corporate directors generally, and § 14-115(c) of the Insurance Article for the Directors of nonprofit health service plans. As Mr. Angoff points out, the language of these statutes setting out the basic fiduciary duties of Directors is essentially identical. Both sections require Directors to act in good faith, in a manner they reasonably believe is in the corporation's best interest, and with ordinary care.

Mr. Angoff notes, however, that there are significant differences between the two statutes. First, subsection (e) of § 2-405.1 codifies the business judgment rule for directors of a corporation. That subsection states that: "An act of a director of a corporation is presumed to satisfy the standards

of subsection (a) of this section." No such subsection is included in § 14-115 for directors of a nonprofit health services plan.

Similarly, subsection (f) of § 2-405.1 appears to preclude the application of Revlon duties in connection with acquisitions of corporations. That subsection provides:

> An act of a Director relating to or affecting an acquisition or a potential acquisition of control of a corporation may not be subject to a higher duty or greater scrutiny than is applied to any other act of a Director.

No parallel limitation is found in § 14-115.

Analyzing both the transaction and the standards applicable to it, Mr. Angoff concluded that the Board's decision to convert to for-profit status and to engage in an acquisition is governed by the obligations of duty and care that typically govern the exercise of corporate discretion and that the judgment of the Board was insulated from liability by the business judgment rule. Mr. Angoff also concluded, however, that once the Board decided to sell control of CareFirst, the Board was subject to the heightened obligation reflected in the Revlon standard. Thus, in connection with the proposed sale of the company, the CareFirst Board was required to secure "the best value" for the company.

Taking issue with Piper's analysis of the application of Revlon to the transaction, Mr. Angoff wrote:

> Here it cannot be seriously argued that there is not change in control: immediately before the acquisition, the foundations control CareFirst, whereas afterward, they will own, at most, a small fraction of WellPoint stock, and thus will not control CareFirst. Moreover, prior to CareFirst's conversion to for-profit status, the directors control CareFirst, since directors of the three CareFirst affiliates constitute the Board of Directors of CFI, and CFI is the sole member of each affiliate; after the acquisition, in contrast, only one CareFirst Director will sit on the nine-member WellPoint [Board] and thus neither he nor any group of CareFirst directors will control CareFirst.[230]

In defense of the advice given to the Board, Jay Smith of Piper noted that, in advising the Board that Revlon did not apply, Piper did not suggest that price was unimportant in the discussions with the potential suitor.[231] As he said, "far from it."[232] Mr. Smith clarified that:

> what it means when we say that Revlon does not apply is that, in addition to price and factors relating to how likely the bidder is to be able to close… the Board may consider other factors such as the

[230] "The Due Diligence Exercised by CareFirst, Inc. in Deciding to Convert to For-Profit Status and to be Acquired by WellPoint Health Networks, Inc.", Roger G. Brown & Associates, January 10, 2003, (the "Brown Due Diligence Report") at 12.
[231] In addition, Piper pointed out that Revlon has never expressly been adopted by a Maryland court. According to Piper, *Revlon* is not part of the common law of Maryland and, in addition, has been expressly rejected, by the legislature. Pre-filed rebuttal testimony of R. W. Smith, Jr., January 21, 2003, at 5.
[232] Id. at 2.

impact of the proposed transaction on customers, employees, and the communities in which the company does business.

Mr. Smith, however, also argued that even if Revlon were deemed to apply, he believes that "the Board of Directors complied with Revlon." This defense is factual in nature rather than legal, and, therefore, will be addressed more fully below.

5. The MIA's conclusion as to the legal standard that governs whether CareFirst acted with "due diligence"

Section 14-115 of the Insurance Article governs the management of business by the board of directors of a nonprofit health service plans. The statute states, at subsection (c), that:

> (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.

These are the guiding principles and the standards that should be applied to the actions of the CareFirst Board in deciding whether to convert from nonprofit to for-profit status, in selecting an acquisition partner, and in negotiating a purchase price.[233] The question of whether the Board acted with due diligence is a question of whether the Board met the standard articulated in this section. Did the Board act in good faith? Did the Board act with ordinary care? Did the Board act in what it reasonably believed to be the best interest of the corporation?

Section 14-115 codifies the traditional fiduciary duties of care and loyalty that historically govern the conduct of directors of both for-profit and nonprofit corporations.

a. The duty of cared owed by the directors of a nonprofit board

The duty of care requires nonprofit corporate directors to discharge their duties with the care of an ordinarily prudent person under the circumstances. In doing so, nonprofit corporate directors generally are permitted to rely on information, opinions, and reports of other board members, board committees, counsel and qualified experts. They may not, however, do so blindly. See e.g., Daniel L. Kurtz, Board Liability: Guide for Nonprofit Directors 29 (1988).

The degree of care required by a nonprofit board is influenced by two things. First, as is true of any corporate board, the degree of care that must be exercised with regard to any particular decision depends on the significance of that decision. See Billman v. MDIF, 88 Md. App. 79, 107-08 (1991), cert. denied, 325 Md. 94 (1991). Obviously, acting on a proposal to, for example, change

[233] Indeed, in its current bylaws, CareFirst acknowledges that: "The fiduciary responsibilities of the Corporation require members of the Board and Corporate Officers to exercise utmost good faith in all transactions touching upon their duties to the Corporation and its property." October 1, 1998 Bylaws, Art. 9, Section A, at 21.

the identity of the corporation's resident agent is a decision that requires a lesser amount of care than, for example, the decision to hire a new chief executive.

Second, the degree of care that a corporate director must exercise depends on the nature of the enterprise in which the corporation is engaged. The directors of an enterprise that is vested with a public trust must act with a higher degree of care than the directors of a general corporation. Thus, in Billman, the Court of Special Appeals found that the trial court had not erred in instructing a jury that "in the context of a savings and loan, the directors and officers owe a higher duty of care than is owed by their counterparts in a general corporation" because "they are entrusted with funds belonging to the general public." 88 Md. App. at 106. Noting that the trial court had first instructed the jury that a director must act with ordinary care, Billman concluded that the "challenged instruction correctly advised that compliance with the standard of care for officers and directors of a banking institution should be determined by comparison to the care exercised by the officers and directors of that type of enterprise. That includes responsibility for the savings of others."[234] As the Court noted that what constitute ordinary care "under the circumstances" include consideration of the enterprise, which is part of the "circumstance" in which the directors are operating.

W. Keeton, Prosser and Keeton on the Law of Torts (5th ed. 1984) discusses comparative degrees of care, using as an illustration the common carrier's "highest" degree of care.

> "Although the language used by the courts sometimes seems to indicate that a special standard is being applied, it would appear that none of these cases should logically call for any departure from the usual formula. What is required is merely the conduct of the reasonable person of ordinary prudence under the circumstances, and the greater danger, or the greater responsibility, is merely one of the circumstances, demanding only an increased amount of care."[235]

CareFirst is a nonprofit corporation. Its was formed for a public purpose. Its economic "value" constitutes a public asset. The CareFirst Board is, therefore, entrusted with an enterprise whose assets belong to the public. The CareFirst Board was, therefore, required to act with the highest degree a care in approaching the questions of whether to convert, whether to embark on an acquisition strategy, by whom to be acquired and at what price. Indeed, CareFirst's own bylaws reflect both an understanding and an acceptance of this heightened standard. Under the conflict of interest section of the bylaws, CareFirst acknowledges that Board members and corporate officers must exercise the "*utmost* good faith" in fulfilling their duties to the corporation and to its property. October 1, 1998, Bylaws Art. 8, Section n A at 21. (Emphasis added.)

Clearly, the Board had to act with the highest degree of care in evaluating the proposed transaction. What, then, was the Board required to consider or prohibited from considering in the exercising that care? The conclusion as to what the Board was required to consider in the context of the proposed transaction must be assessed with reference to those specific statutes that govern the terms and conditions of the transaction. The Board's actions must be assessed in light of the terms, conditions, and requirements set forth in the conversion and acquisition statutes. The transaction contemplated by the Board could not occur without regulatory approval. No board acting in good faith and with the care of a prudent person under the circumstances could ignore or fail to consider the criteria that the General Assembly established for that regulatory approval.

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[234] Id. at 184.
[235] Id. at 107.

It was, therefore, incumbent upon the Board in exercising its duty of care in connection with the proposed transaction, to consider those factors that the regulator also was required to consider. The Board was bound to consider whether the proposed transaction was in the public interest and, in doing so, to consider all of the factors outlined in the conversion statutes.

Because the statutory framework directs the consideration of the Board, it is not necessary to resolve the legal disagreements between Mr. Angoff and Piper as to whether, and to what extent, the fact that the proposed transaction contemplates a change in control may have implicated Revlon like duties. The questions of whether Revlon is part of the common law of Maryland and, if so, whether it applies to nonprofit corporations do not need to be resolved in this case. The conversion statute specifically addresses the requirements that relate to the transaction, including, but not limited to, the purchase price.[236]

Under § 6.5-301(b) of the State Government Article, the regulator is prohibited from finding that the transaction is in the "public interest," unless appropriate steps have been taken to insure that the "fair value of the public or charitable assets of a nonprofit health service plan are distributed to the health care foundation established under State law." The statute in turn provides guidance to the appropriate regulating entity as to what may be considered in determining fair value. These factors include the "market value" and the value of the company being sold "as if the entity had voting stock outstanding and a 100% of its stock was freely transferable and available for purchase without restriction." Webster's 7th New Collegiate Dictionary defines fair as "adequate." Black's Law Dictionary (5th edition) defines fair value as follows:

> Present market value; such sum as the proper will sell for to a purchaser desiring to buy the owner wishing to sell; … the fair market value of the property as between one who wants to purchase and one who wants to sell the property … the amount the property would bring at a sale on execution shown to have been in all respects fair and reasonable…

The conversion statute also requires consideration of factors other than price in connection with as assessment of what is in the public interest. Matters such as the impact of the transaction on the affordability and accessibility of health care and whether the transaction is "equitable to enrollees, insureds, shareholder, and certificate holders." In light of this explicit requirement that the proposed acquisition of a nonprofit health service plan must not be approved unless it is in the public interest, which requires an analysis of whether the sale is for "fair value" as well as other factors, it is not necessary to consider the application of the common law "Revlon rule." The issue, in assessing the due diligence of the Board, is more cleanly stated as whether the Board acted "in good faith" and "with the care [with which] an ordinarily prudent person in a like position" would act in order to ensure that the proposed transaction was in the public interest, including whether "fair value" was obtained.

One additional issue must be addressed in connection with the Board's adherence to its duty of care. The question arises as to the relevance of the "business judgment rule" in this proceeding.

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[236] In one sense, the conversion statutes could be analogized to so-called "constituent statutes" enacted to broaden the concerns to which directors can, or must, respond when contemplating corporate action, including the sale of corporate control. Such statues authorize consideration of non-shareholder interests generally and overrule *Revlon* like decisions in the states in which they have been enacted. See Lisa M. Fairfax, Doing Well While Doing Good: Reassessing the Scope of Directors' Fiduciary Obligations in For-Profit Corporations with Non-Shareholder Beneficiaries. 59 WASH. & LEE L. REV. 409 (2002).

Throughout these proceedings, and repeatedly in the course of public testimony and in depositions, the executives of CareFirst and their experts (including their lawyers and investment bankers) invoked the business judgment rule as a defense against criticisms of the Board's judgment or the process it conducted in selling the company. Management and the Board especially relied on the "safe harbor" that the rule creates for actions taken in reasonable reliance on expert advice. As an example, when Mr. Jews was asked whether it was appropriate to rely on the fact that transaction bonuses were paid to the executives at Cerulean, a for-profit company, as a basis for granting bonuses to executives at a non-profit like CareFirst, he replied, "It was proper to rely on our experts". [237]The clear implication of this comment is that the advice of experts absolved management of the Board of the responsibility to exercise any independent judgment.

The business judgment rule is not a standard of conduct.[238] The directors of a corporation are required to act with a particular standard of care. When those decisions are challenged, the "business judgment rule" operates as a rebuttable presumption that the directors acted in conformity with their duty of care. Thus, absent evidence to the contrary, a court will not second-guess the director's decision or substitute its judgment for that of the directors.[239]

The business judgment rule was designed to limit judicial interference in corporate affairs and to insulate corporate directors from personal liability that might arise from suits filed by disgruntled shareholders.[240] The "rule", as such, has no place in this regulatory proceeding. While directors may be insulated from personal liability or interference with their business decisions in some circumstances,

> [c]haritable or nonprofit corporations are generally subject to statutory supervisory authority of the attorney general, who may institute judicial proceedings for mismanagement by the directors or trustees of the corporation or in exceeding or failing to carry out its charitable or corporate purpose.

5 Fletcher, supra at § 2104. Thus, as one court recently concluded:

> While the business judgment rule reflects a judicial policy of declining to substitute a court's judgment for that of a corporation's directors when they have acted in good faith and in the exercise of honest judgment in furtherance of corporate purposes, that policy has no application to allegations that a public benefit corporation has abandoned any charitable purpose and has pursued private rather than public interests. Similarly, while Tennessee courts have adopted a non-interventionist policy with regard to internal corporate matters,

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[237] Deposition of William L. Jews, September 6, 2002, at 339

[238] Yost v. Early, 87 Md. App. 364, 377 (1991).

[239] Id. at 377-78.

[240] Randolph Stuart Sergent, The Corporate Director's Duty of Care in Maryland: Section 2-405.1 and the Business Judgment Rule, 44 HOWARD L.J. 191, 211-15 (2001). Some courts have held that the business judgment rule "extends only as far as the reasons which justify its existence." Resolution Trust Corp. v. Acton, 844 F.Supp. 307, 314 (N.D.Tex. 1994), quoting *Joy v. North*, 692 F.2d 880, 886 (2d Cir. 1982), *cert. denied* 460 U.S. 1051 (1983). Because the business rule is intended to protect corporate management from liability for mistakes in business judgment, the rule has no application to breaches of the duty of loyalty. 5 Fletcher Cyclopedia of the Law of Private Corporations § 2104 (Per. ed. 1994).

> that policy is inapplicable here because the legislature has specifically given the Attorney General and the courts authority and responsibility to ensure that nonprofit public benefit corporations operate in the public interest and not for private gain. The public policy of this state, as expressed by the legislature, is that the Attorney General and the courts intervene in such situations because the public interest is involved and the activities are not merely "internal corporate matters."[241]

This case does not involve personal liability. It is not a civil lawsuit in which disgruntled shareholders are seeking to overturn the decisions of corporate management. More importantly, oversight of the Insurance Administration over insurance regulatory matters without exception involve evaluation of substantive outcomes rather than the process through which those outcomes were derived. A simple example can be found in the MIA's regulation of the financial condition of insurers operating in the State. Insurers always employ outside financial experts such as CPAs and independent auditors in connection with the preparation of financial statements submitted to the MIA. The retention of such experts is reasonable and indeed in some cases required, but the MIA is not bound by the financial statements submitted to the agency for review without critical and analysis and change, simply because the company followed a reasonable process and hired experts on the issues under review. Application of the business judgment rule in that type of setting would simply emasculate the role of the MIA in evaluating whether or not the company had complied with the statutory standards that govern financial transactions and financial condition.

Another example could be found in the MIA's oversight of the payment practices of insurance companies. Maryland law requires that health insurers pay claims "promptly" and sets out rigorous standards defining what constitutes prompt payment.[242]

The fact that an insurance company may have followed reasonable procedures in its attempt to pay claims promptly, or retained outside consultants to design systems to pay claims promptly, would never constitute a defense to a conclusion by the Insurance Administration that in fact that claims were not being paid promptly. The same reasoning applies to this transaction. The MIA's responsibility is to determine whether the statutory criteria have been satisfied, not simply to assess whether the Board engaged in a process which it reasonably hoped would result in the satisfaction of the criteria.

Reaching a conclusion that the business judgment rule as a rule does not apply to this proceeding, does not mean that certain ideas contained within that rule are not relevant here. As noted earlier, if following a particular process would constitute "the care that an ordinarily prudent person in a like position" would follow, whether that process was indeed followed may bear on whether the duty of care has been satisfied.

Jay Smith of Piper, counsel for CareFirst and WellPoint, seems to acknowledge that the Insurance Administration was not bound by the application of the business judgment rule in applying the substantive standards of the statute:

> With respect to the question that you asked in his testimony about the interaction of the business judgment rule and the statutory standard

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[241] Summers v. Cherokee Children & Fam. Serv., Inc., 2002 WL 31126636 (TENN. CT. APP) *32.

[242] Annotated Code of Maryland, Insurance Article, § 15-1005.

> on public interest and private inurement that you must apply as part of these proceedings, we certainly are not saying to you, Commissioner, that if the Board satisfied its fiduciary duties and if the business judgment rule applies then you are precluded from considering these issues. You certainly do need to consider those issues.[243]

The notion that the business judgment rule is not applicable to the ultimate decision in this case is support in the case of O'Donnell v. Sardegna, 336 Md. 18, 646 A.2d 398 (1994). There, the Maryland Court of Appeals rejected an effort by BlueCross BlueShield of Maryland subscribers to sue management for mismanagement. Maryland Court of Appeals acknowledged that the corporate structure of a nonprofit made oversight of the company by independent groups impossible:

> The kind of relationship that the plaintiffs alleged existed between the Board and the management of BCBSM is described in Dimieri & Weiner, the public interest and governing boards of nonprofit health care institutions, 34 VAND. L. REV. 1029 (1981).

The authors speak of the:

> Unfortunate situation [that] arises when either the corporation has no members or the Articles of Incorporation provide that the Board of Directors is coterminous with the corporation's membership. The absence of an effective membership means that the 'watchdog' function of shareholders, minimal though it may be is nonexistent and that no independent group is empowered to elect the Board of Directors. Self perpetuation of the existing Board and the appointment of friendly successors inevitably results from this type of arrangement. A self perpetuating Board of Directors in turn naturally exacerbates the possibility of role reversal between management and the Board, since control of the Board is more easily "captured" when the Directors need not account for their actions to a membership that elects them.'[244]

Although it recognized the lack of independent oversight under this corporate structure, the Court of Appeals declined to extend the right of derivative lawsuits to the members and subscribers of CareFirst, because the company was subject to regulatory oversight by the Insurance Commissioner. The thrust of the opinion is that it is the Insurance Administration, rather than shareholders that serves the "watchdog function" over the actions of the Board. While the Insurance Commissioner's authority is generally circumscribed by specific statutes, the Court of Appeals has noted that "we have strongly inferred the visitorial power at least embraces preventing conduct that is 'violative of public law or the charter and bylaws of the corporation.'"[245]

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[243] Testimony of Jay Smith, December 17, 2002, at 169.
[244] Id. at 1037.
[245] Insurance Commissioner v. BlueShield of Maryland, Inc., 295 Md. at 523.

In summary, the business judgment rule has no application to this proceeding. The decisions of the Board are not entitled to deference in determining whether the proposed transaction is in the public interest and otherwise in compliance with all of the statutes that govern the approval or disapproval of the proposed transaction. That is a determination that is expressly reserved for the MIA by statute. In addition, the MIA is required by MD. CODE ANN., STATE GOV'T 6.5-301(e)(1) to determine whether the Board actually acted with due diligence in considering the proposed transaction. There is no presumption that they did so.

b. The duty of loyalty owed by the directors of a nonprofit board

Among the duties imposed by § 14-115 of the Insurance Article is the duty to act "in a manner that is reasonable believed to be in the best interest of the corporation." Piper correctly characterized this as what is commonly referred to as the duty of loyalty. Piper described this duty as a requirement that a director "not use a corporate position for personal gain at the expense of the corporation." Piper's memorandum focused on the duty as it relates to a prohibition on "self dealing and misappropriation of corporate assets." No particular description was provided regarding what constituted the best interest of the corporation.

Courts, however, have recognized that what is in the "best interest" of a corporation must be assessed in the context of the corporation's articulated mission. And, because the mission of a for-profit company is different than the mission of a nonprofit company, the duty of loyalty owed by each also is different. As one court stated:

> …[B]ecause the missions of the two types of corporations are different, the duty of loyalty is defined differently. The officers and directors of a for-profit corporation are to be guided by their duty to maximize long term profit for the benefit of the corporation and the shareholders. A nonprofit public benefit corporation's reason for existence, however, is not to generate a profit. Thus a director's duty of loyalty lies in pursing or ensuring the pursuit of the charitable purpose or public benefit which is the mission of the corporation.[246]

Thus, while in many ways the legal principles that govern for-profit companies apply to nonprofit companies, the directors of nonprofits "have a special duty to advance its charitable goals and protect its assets."[247]

Some commentators express this particular obligation to pursue the charitable mission as a separate "duty of obedience."[248] Others treat obedience to the organization's mission as a special function of directors and officers that is part of the duty of loyalty and to which duties of care attach.[249]

The Articles of Incorporation of CareFirst and its nonprofit subsidiaries identify the corporate mission of those entities as the provision of health care "at a minimum cost and expense."

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[246] Summers, 2002 W.L 31126636 at *9.
[247] Oberly v. Kirby, 592 A.2d 445, 472-73 (Del. 1991).
[248] See, e.g,. Daniel L. Kurtz, Safeguarding the Mission: The Duties and Liabilities of Officers and Directors of Nonprofit Organizations, 726 AU-ABA 15 (1992).
[249] See, e.g., Harvey J. Goldschmid, The Fiduciary Duties of Nonprofit Directors and Officers: Paradoxes, Problems, and Proposed Reforms, 23 J. Corp. L. 631 (1998).

The CareFirst Board was obligated, therefore, not simply refrain from self-dealing and from misappropriating corporate assets in making corporate decision. The CareFirst Board also was required to obey the articulated mission of the corporation.

Thus, in assessing whether the Board acted with due diligence, the MIA must consider whether the Board met its duty of loyalty, which requires an analysis of whether the Board reasonably believed that the proposed transaction was in best interest of the corporation in light of its articulated corporate mission. Did the CareFirst Board reasonably believe that the proposed transaction would further the corporate goal of providing health care "at a minimum cost and expense?"

This point is significant, because the CareFirst Board took into consideration many factors that are not set forth in the conversion statute in deciding to convert and in selecting an Acquiror. Those factors included where the corporate headquarters of the combined entity might be located, the role of current CareFirst management in a successor organization, and whether or not jobs would be retained as a result of the merger. Because it concluded that the Revlon duty to obtain the highest price did not strictly apply to this transaction, Piper advised the Board that "non priced factors maybe considered by the Board in the exercise of its business judgment as part of the process of determining whether a particular offer is in the best interest of the corporation." The issue for analysis will be whether or not those non-price factors can reasonably be said to reflect a concern for what was in the best interest of the corporation and the fulfillment of its corporate mission. And, perhaps more importantly, did the Board fail to consider other factors, such as the impact of the proposed transaction on the cost of health insurance, that related to CareFirst's corporate mission.

VIII. ANALYSIS OF THE MANDATORY CONSIDERATIONS

A. Did CareFirst exercise due diligence in deciding to engage in an acquisition?

1. Expert report: Summary of Roger Brown: Due Diligence

The Brown Due Diligence Report analyzed the due diligence of the Board. In approaching the question of whether CareFirst exercised due diligence in deciding whether, and how, to convert, Brown notes that the Commissioner has broad discretion in determining what constitutes "due diligence" within the meaning of the controlling statute, §6.5-301(e) of the State Government Article. Brown analyzes separately the decision to convert and the decision to sell the company.[250]

Brown determines that although the directors failed to proper consider several factors they reasonably should have considered in arriving at their decision to approve the conversion, they did engage in a substantial, multi-year process during which they considered the relative advantages and disadvantages of various strategic alternatives and obtained substantial expert advice from qualified experts. However, the Angoff report found that the Board failed to adequately consider several factors in adopting the strategic plan and deciding to change CareFirst's corporate status:

- The Board never determined whether it had reached minimum efficient scale and failed to consider whether an acquisition could result in diseconomies of scale.
- The Board never considered whether anti-trust laws would prohibit CareFirst from actually executing its strategic plan because it could legally buy other competitors in its own market.

[250] Brown Draft Due Diligence Report at vi.

Brown opines that while the directors having engaged in a plans process does not compel a finding that they exercised due diligence in deciding to change CareFirst's corporate structure, it does create a presumption, under the business judgment rule, that would insulate the directors from personal liability for breach of fiduciary duty in making that decision. Brown opines that under a "bad faith" or "irrationality test" CareFirst's officers and directors did not violate their fiduciary duties in deciding to change the corporate structure of CareFirst. However, Brown also concludes that the business judgment rule does not bind the regulator in proceedings such as this.

In the context of the decision to sell the company, Brown asserts that the business judgment rule does not insulate the directors from personal liability in connection with selling the company. Id. Brown asserts that under well-established case law, once the board decides to sell the company it has a fiduciary duty to obtain the highest value for the company, and its conduct must be judged according to the so-called "enhanced scrutiny" first announced in Revlon, Inc. v. MacAndrews & Forbes Holdings, Inc., 506 A.2d 173, 182 (Del. 1986).[251]

Brown asserts that the Directors' conduct fell short of the Revlon standard in several ways: (1) the directors refused to allow Anthem to enter the bidding process, even though they had a legal duty to reasonably explore all opportunities for greater value for the shareholders, and Anthem presented such an opportunity; (2) in selecting a purchaser, the directors abdicated their duty to obtain the highest value for the company by relying upon the regulatory process to increase the price to be paid by the acquiring company, but regulators have only the authority to approve or disapprove a proposed transaction–they cannot establish the price of the transaction; (3) the directors treated WellPoint and Trigon differently in the course of the so-called "limited auction process" they conducted, asking WellPoint (the initial low bidder) to increase its bid but never asking Trigon (the initial high bidder) to increase its bid, and this disparate treatment of potential buyers could not possibly advance shareholder interests; (4) in evaluating the competing bids of Trigon and WellPoint, CareFirst considered impermissible non-price related factors, such as the extent to which CareFirst management would be able to control the company after the merger; and (5) the Boards' reliance upon outside counsel's opinion that CareFirst need not obtain the highest price was not reasonable under the circumstances because that opinion was based on the incorrect premise that any transaction involving CareFirst and another Blue plan would necessarily involve a stock-for-stock merger. For the foregoing reasons, Brown opines that, in deciding to sell itself to WellPoint, CareFirst did not exercise due diligence within the meaning of §6.5-301(e) of the State Government Article.[252]

2. Analysis of CareFirst's "Business Case" in support of the Acquisition

This section analyses the Business Case presented by CareFirst in support of the deal. The MIA retained The Blackstone Group to evaluate aspects of the Business Case.

Several sets of capital expenditure needs were presented to the Board. In 1999, Accenture and CareFirst management developed one set. In 2000, CSFB generally valuated these needs, with some modification. In November 2001, Accenture prepared a more generic, industry wide assessment for the Board regarding generally the same categories on the specific needs previously prepared.

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[252] Id. at viii – ix.

3. CareFirst's Capital Expenditure Needs

a. Spending for Geographic Dominance

As described above, a fundamental premise of the strategic plan recommended by Accenture was that CareFirst needed to access capital to enable a strategy of "serious and meaningful" growth leading to "geographic dominance" and perceived advantages of scale.[253] Accenture identified reasons supporting adoption of a growth strategy, the need to defensively bid for and acquire any local competitors that might come into play by virtue of another health plan trying to purchase them, and the maintenance of a reserve for a price war, should CareFirst be attacked by one of the large national players on a price basis.[254] Of the $1.5 to 1.7 billion in capital Accenture identified as being important to CareFirst's strategic objection, nearly $700 million was deemed required to enable CareFirst to make a defensive acquisition bid for Kaiser's Maryland block of business, or for MAMSI, in the event that one of CareFirst's other competitors attempted to acquire either block of business.[255]

As Accenture described in its impact statement made part of the Form A:

> *Studies have shown that companies across industries perform better if they are able to maintain a strong market share relative to their competition (relative market share).*
>
> *As the health industry consolidates, this phenomenon also presents a threat to health plans' competitiveness. A health plan's relative market share diminishes as the health plans with which it directly competes (those in its current markets, as opposed to those in adjacent or remote markets) consolidate. If it wishes to protect its relative market share in home markets, a health plan needs to participate in the consolidation. It needs to act when local, direct competitor health plans come up for sale. Of course, doing so requires capital.*
>
> * * *
>
> *Some health plans are increasing access to capital through the public equity markets. A common approach is to convert to for-profit status, and then issue shares for sale to the public.*[256] (Emphasis added.)

b. Potential Significant Legal Barriers to Accenture's objectives may exist

The Brown Report provides an extensive analysis under both State and Federal anti-trust laws regarding CareFirst's ability to make acquisitions within its current market as suggested by Accenture, whether for offensive or defensive purposes. Under the analysis, because of CareFirst's already dominant market share, an acquisition of Aetna, Kaiser or MAMSI would result in a rating on the Hefindahl-Hirschman Index ("HHI") so high as to create a prescription of an anti-competitive

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[253] Testimony of Joseph V. Marabito, April 29, 2002, at 17:2-3.
[254] Id. at 28:8-13.
[255] Id. at 83:8-85:5.
[256] January 2002 Accenture Impact Statement at 8 - 9.

effect under federal merger guidelines. Angoff argues the high HHI would be difficult to overcome because other factors add to the potential anti-competitive effects of the merger including CareFirst's pre-existing ability to price above the market due to its brand strength, and the fact that there are barriers to easy entry into the market for new competitors.[257]

Clearly the Board or at least its lawyers should have considered this issue as one requiring much closer scrutiny and analysis, given that this component of the capital projections was the largest by far. While Mr. Jews testified that potential acquisitions in-market were reviewed from an anti-trust perspective and CareFirst would be "concerned" about anti-trust implications, there is simply no evidence that such an analysis was done.[258]

Moreover if it were true that they would in fact be concerned; then a reasonable board would have requested whether antitrust laws would frustrate this objective. While counsel for CareFirst suggested at the hearings that Piper Rudnick would answer questions regarding the Board awareness of anti-trust issues, none of the advice rendered to the Board by Piper included any reference to anti-trust issues.

Furthermore, even if the capital assigned to mergers and acquisitions was used for contiguous acquisitions outside the current market, according to CSFB, CareFirst's other advisor, the amounts identified by Accenture would not, in the view of CSFB, be sufficient to make acquisitions on a scale to meet the strategic objectives of revenues, surplus, growth and membership.[259]

These two conclusions taken together severely undercut this component of the strategy, because state and federal laws may prohibit in-market acquisitions, and by CSFB's account it would not be sufficient to satisfy the strategic goals.

c. There are risks associated with mergers and acquisitions

The Blackstone Business Case Report looked at those factors the Board did or should have considered in connection with their decision to convert and sell the company. Blackstone concurs that, as a general proposition, there are certain legitimate and financial benefits associated with improved access to capital and enhanced scale (*i.e.*, size).[260] Blackstone also concurs that publicly held BCBS companies, as compared with their nonprofit counterparts, do have an advantageous access to capital, given their ability to issue public equity, equity-linked securities, and preferred equity, and to raise amounts of debt in excess of the amounts that could be raised by a non-public, not-for-profit BCBS company.[261]

However, Blackstone expressed the view that, in the short to medium-term, which it testified to as two to five years.[262] CareFirst could have been expected to continue as a viable nonprofit, without conversion and acquisition or merger. Blackstone notes that on a stand-alone basis, CareFirst had sufficient access to capital to fund all projected operating and capital investments, excluding major acquisitions.[263] Blackstone also notes that CareFirst already had regional scale (*i.e.*, size relative to competitors) and strong relative market share without a clear, immediate threat to

[257] Brown Due Diligence Report at 31 – 32.
[258] Testimony of William L. Jews, March 13, 2002 at 458 - 459.
[259] Testimony of Stuart Smith, March 13, 2002 at 509 - 510.
[260] Blackstone Business Case Report at 49.
[261] Id. at 54.
[262] Testimony of Martin Alderson-Smith, January 28, 2003, at 14.
[263] Id. at 48 - 49.

that position. Blackstone asserts that any benefits of absolute scale (*i.e.*, increased size, without reference to competitors) must be weighed against the risks of an acquisition strategy and the increased complexities associated with operating in multiple markets.

Blackstone concluded that CareFirst's longer-term competitive position is more difficult to assess, given continued industry consolidation and uncertainty as to how CareFirst's existing and potential competitors may act.[264] Blackstone agrees that the arguments CareFirst advances in support of the Proposed Transaction are generally supportable by verifiable industry trends and experience and are generally complete. However, Blackstone questions some of the key assumptions of CareFirst's arguments and notes that certain of the predictions made by Accenture have not occurred (as of December 2002). For example, Blackstone asserts that the assumption for the amount of capital required for acquisitions "seems somewhat arbitrary and neither Accenture nor CSFB took responsibility for the specific components of this estimate."[265] Blackstone also notes that the presence of the 2001 Accenture Study calls into question the validity of the numbers contained in the 1999 Accenture report, because the capital requirements set forth in the later, non-CareFirst-specific study were significantly lower than the amounts in the earlier, CareFirst-specific study. Blackstone states that it is unclear why CareFirst's capital requirements (as set forth in Accenture's 1999 study) should be so much higher than those for a large managed care company (as set forth in Accenture's 2001 study). Blackstone observes: "It is likely that CareFirst's capital needs, other than for a large acquisition, could have been satisfied by other means, such as an issuance of debt or organic growth."[266]

Among the benefits to absolute sale, are:

> (i) the ability to spread fixed costs over a larger revenue base which should result in lower administrative expense ratios; (ii) the potential to better implement medical management programs; (iii) potentially the ability to spread economic and regulatory risk over multiple jurisdictions; and (iv) potentially the ability to better service national accounts.[267]

However, 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.[268]

Jay Angoff of Roger Brown also noted the Board's failure to consider the risks of mergers and acquisitions:

> CareFirst's failure to consider the possibility that by merging it would create diseconomies of scale rather than economies of scale -

[264] Blackstone Business Case Report at 50.
[265] Id. at 53.
[266] Id. at 50 – 54.
[267] Blackstone Business Case Report at 49.
[268] Id. at 45.

> "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. A leading article is Robert Eccles's (sic) Harvard Business Review study, in which he concludes that "despite 30 years of evidence demonstrating that most acquisitions don't create value for the acquiring company's shareholders, executives continue to make more deals, and bigger deals." Eccles, Are You Paying Too Much for That Acquisitions, HARV. BUS. REV. 136 (1999). Dozens of other books[8] and scholarly articles,[9] as well as articles from the general press,[10] come to the same conclusion.[269]

This failure was significant because CareFirst recognized the negative impacts such deals had on its competitors:

> 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 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. Specifically, CareFirst tells Standard & Poor's that:
>
> - "Aetna has experienced migration from Prudential accounts due to integration problems and higher premiums" (010527);
> - "If there acquisitions are in distant markets, this could help CareFirst as they work through acquisition and consolidation efforts in other markets. CareFirst could capitalize on its marketplace advantage of being a large, stable local company" (010542); and
> - "Aetna's combination of businesses cause[s] systems and claims payment problems," and thus "CareFirst may be able to capitalize on Aetna's recent financial issues and its continual integration problems to lure Aetna customers away." (010545)

Just as the failure of the majority of mergers does not necessarily mean that a merger involving CareFirst would fail, the inefficiencies created by Aetna's acquisition of Prudential doesn't necessarily mean that a merger involving CareFirst would create inefficiencies. Nevertheless, in view of those inefficiencies, and of CareFirst's knowledge of those inefficiencies and its belief that they would result in a competitive advantage to CareFirst, CareFirst reasonably should have considered whether an acquisition involving CareFirst might backfire by creating inefficiency rather than efficiencies.[270]

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[269] The Brown Due Diligence Report at 25 – 26.

[270] Id. at 28.

Blackstone also noted problems that CareFirst's competitors have encountered in their expansions. According to Blackstone:

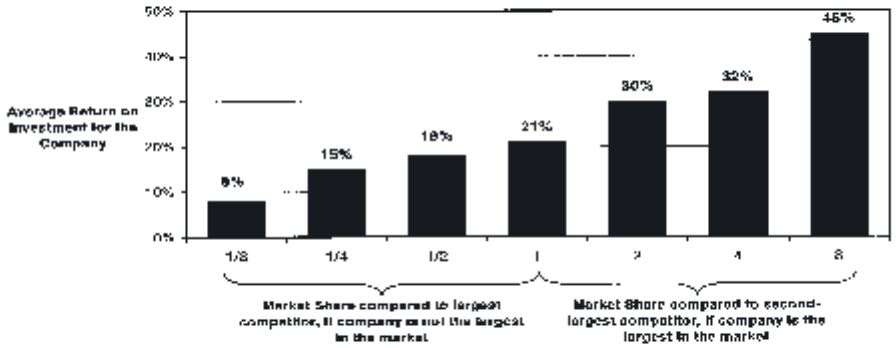
> During the late 1990's, Aetna built absolute scale through acquisitions. However since 2000, Aetna has been implementing a major reorganization plan that involves divesting unsuccessful lines of business and focusing on more profitable product segments, even at the expense of losing scale in terms of total members.[271]
>
> As a large-scale insurance company, Cigna experienced positive results during the late 1990s. However, starting in 2000, rising medical costs and poor stock market performance had a negative effect on Cigna's earnings. As a much larger company in terms of scale, Cigna was unable to manage its larger expense base in a tougher economic environment *(e.g.*, under-performing investment portfolio and rising medical costs).[272]

d. The Targeted Market Share

Accenture also established a relative market share goal for CareFirst of at least three times the market share of the nearest competitor, based on Accenture's assertion that research uncovered a significant link between relative market share and financial results.[273] However, the chart which Accenture presented the Board in support of the market share target showed little or no appreciable difference between a plan with two times the market share of its nearest competitor, and three or four times.

IMPORTANCE OF RELATIVE MARKET SHARE

In 1999, Accenture set forth the goal for CareFirst to maintain a market share of 3x its nearest competitor. While market share relative to competitors is important, it is not clear if 3x is the appropriate benchmark, based on the data provided by Accenture[1]. It appears there is little benefit in terms of ROI going from 2x – 3x market share. Also, Blackstone noted that this analysis is based on all industries and is not specific to managed care.



Source: Accenture Analysis; PIMS Prof. Impact of Market Strategies, based on 5,000 strategic business units across a variety of industries.
[1] Accenture report entitled, "An Assessment of Health Coverage Industry Trends and Carefirst's Strategic Response," dated November 16, 2001

[271] The Blackstone Business Case Report at 46.

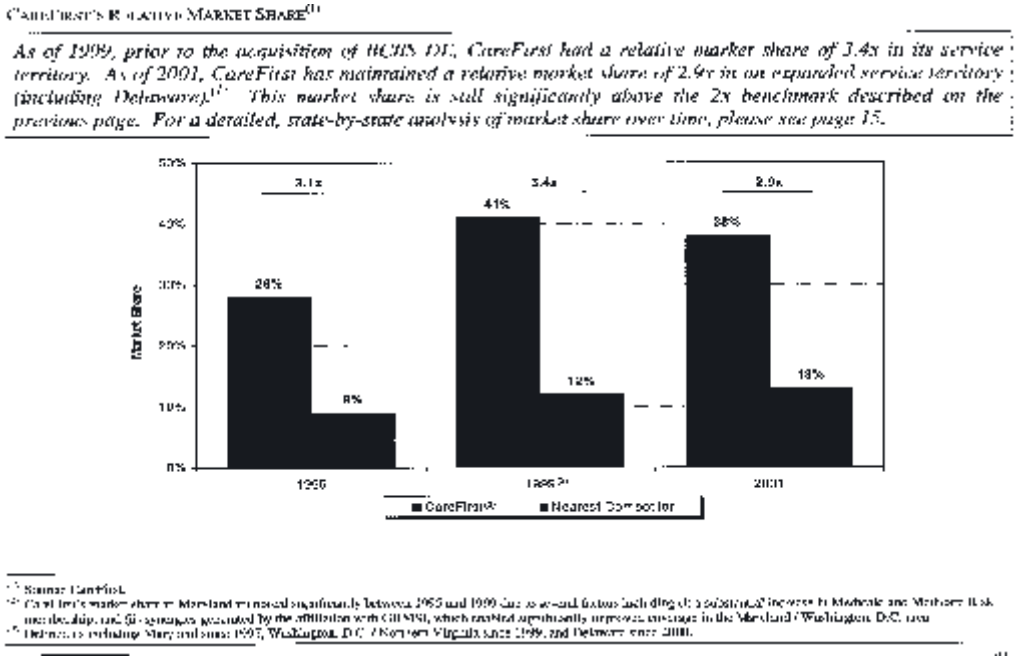
[272] The Blackstone Business Case Report at 47.

[273] Id. at 18.

Andersen at 43, October 28, 1999, Minutes of Meeting of Directors of CFI, "Strategy Selection Discussion." Marabito conceded this point upon questioning:

> Q: Although three times competitors is desirable, if you look at this chart, would you agree that at least based on this return on investment, that two percent or two times is not materially different than four?
> A: Yes, I would agree with that."[274]

To the extent this goal of achieving three times the market share of the nearest competitor of CareFirst was viewed as a compelling component for the Business Case, reliance on this alone is not reasonable because there is no material difference between two and three times market share, and at the time CareFirst had the following market shares relative to its competitor in each jurisdiction:



Blackstone Business Case at 41.

The MIA in fact obtained numerous documents describing CFMI and GHMSI's market share, and in some cases the numbers differed. One document listed CFMI's market share as of December 2001 as 46.2%, with a 48.6% share in "Central Maryland. See "CareFirst BlueCross BlueShield Market Share Trends by Competitor and State" undated.

e. Analysis of non-acquisition capital needs

Focusing next on those capital needs devoted solely to capital expenditures, it is evident the Board's treatment of this issue was also flawed.

[274] Testimony of Joseph V. Marabito, April 30, 2002 at 28.

To begin with, documents presented to the MIA in response to subpoena show that from 1996-1999 CareFirst spent over $179 million on capital expenditures, including $85 million on technology infrastructure.[275] While prior to 1999 CareFirst may not have focused that spending on "e-commerce", one of the categories Accenture identified as needing an increase, CareFirst then initiated an aggressive e-commerce program. According to documents produced by CareFirst, in 2000 the company spent $20 .6 million on e-commerce and $7.5 million in 2001.[276] The company budgeted additional spending for 2002-2005 at an additional $11.5 million, for a total of $39 million for the period 1996-2005. Notwithstanding this spending, Mr. Chaney testified, "we're not competitive in our e-commerce strategy".[277] Yet if this is the case, no hint of any deficiency was presented to the Board of Directors, or outside parties such as Standard & Poor's, ("S&P") a rating agency. In fact documents presented to management, to the Board, and to S&P laud CareFirst's efforts in these areas and did not indicate its spending was constrained. In 2001, material prepared for S&P, CareFirst claimed it was making "significant progress" in its e-commerce strategies.[278] Mr. Jews agreed that CareFirst had a robust, successful e-commerce program, at least compared to where it was in 1999.[279]

Mr. Chaney testified that numerous e-commerce initiatives were underway, including the availability of on-line selling for individual business, and a "Broker-Express" program in which brokers can get on-line quotes and determine how benefit changes will impact a rate quote.[280] Presentations to the Board of Directors outline how CareFirst is "Expanding Interactive Capabilities of Providers and Members",[281] including enhanced customer self-service for providers and members, and the expansion of electronic enrollment by 25%. Id. A Standard & Poor's presentation announces that CareFirst "[has] made significant progress in e-commerce since October 1999 when we completed our e-commerce strategy." The following list of accomplishments was provided:

2001

- Developed and rolled out Family Health Advisor as initial member portal
- Developed and rolled out eSales for Individual Products
- Developed and rolled out Broker Express for small group
- Developed industrial strength eArchitecture to support all e-commerce initiatives
- Developed and rolled out RealMed to provider offices
- Developed and deployed Intranet for internal applications
- Developed online compliance training capability
- Brought CareFirst.com development in-house

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[275] Exhibit 11, April 20, 2002, Preliminary Planning Document regarding future investments in Information Technology.
[276] Id. at 99 - 101.
[277] Testimony of G. Mark Chaney, January 13, 2002, at 461.
[278] Id. at 461.
[279] Testimony of William L. Jews, March 13, 2002, at 461 - 463.
[280] Deposition of G. Mark Chaney Depo, January 13, 2003, at 19 - 20.
[281] Presentation entitled "Expanding Interactive Capabilities of Providers and Members" at 4 - 6, CF-0022377.

- Transitioned hosting of most applications to CareFirst Servers

- Developed and deployed secure file transfer Medical Policy published on Internet and Intranet[282]

Another part of the 2001 presentation to Standard and Poor's states that, with regard to the status of the company's IT initiatives, the "current initiatives continue according to the plan." The status of particular elements were all in various states of progress:[283]

Strategic Components	**Appropriate for CareFirst**
Consolidate to Single Administration systems for regional Business, single system for national Business and a single local FEP	Partially Completed
Automate Utilization and Case Management	Mostly Completed
Enable Sales and Marketing Automation	Web Enabled
Consolidate to Single Financial System	Completed
Improve Information Access and Analysis	Basic Warehouse Implemented
Standardize Underwriting and Pricing Through Automation	Partially Completed
Implement Supporting Technical Infrastructure	Completed
Increase IT Effectiveness (Delivery Capacity and Capability)	Ongoing
Increase business effectiveness through e-commerce	Ongoing
Standardize medical policy	Partially Completed

All these representation to the CareFirst Board and S&P hardly support the claims CareFirst now make that their spending is constrained, or lack of capital is negatively impacting their ability to roll out IT and e-commerce initiatives. In a deposition Mr. Chaney asserted that CareFirst was behind its competitors on rolling out e-commerce to large employer groups, but could not name any particular company doing so.[284] Mr. Chaney testified that CareFirst had not been able to implement initiatives at the pace it would prefer, but acknowledged that even for-profit companies with access to capital must sequence and prioritize capital spending.[285] Significantly, CareFirst management testified that it had not presented a detailed list of its capital expenditure needs to WellPoint.

[282] Exhibit 10, Presentation to Standard & Poor's Ratings Group, November 13, 2001.
[283] Standard & Poor's Briefing Book, 2001, at 8.1 – 8.2.
[284] Deposition of G. Mark Chaney, January 13, 2003, at 21.
[285] Id. at 10-12.

Equally as important, Leonard Schaeffer's testimony indicates that no particular commitments had been made regarding CareFirst's needs, or whether capital would be developed here.[286] He described the decision where to deploy capital as a "very rigourous planning process."[287] According to Schaeffer, capital will only be deployed in Marland if the business case is made. Id. The testimony of Mr. John Monahan, Head of State Programs for WellPoint, confirmed that any requests for capital spending must be justified and are balanced against other competing needs.[288]

Late in the MIA's review process, CareFirst presented a list entitled "Unimplemented Capital Expenditures as of December 31, 2002."[289] Mark Chaney testified regarding the list and the projects on the list. His testimony revealed that, contrary to its title, the list contains many projects which were in various stages of completion. These included many e-commerce initiaves.[290] Mr. Chaney could not specifically identify wheter or not CareFirst's competitiors had superior capabilities with respect to the types of projects on the list. Id. He also testified that it made sence to sequence certain projects rather than do them all at once.[291] He also testified that certain effects in e-commerce and product development had been delayes for "a couple of years" because "there has been a question of whether we might be doing an affiliation."[292] He was not aware whether WellPoint had committed to fund any projects on the list, and stated that WellPoint had not committed to spending a specified dollar amount to supplement CareFirst's capital expenditures.[293]

f. Blackstone determined CareFirst could meets its capital expenditure needs

Blackstone independently analyzed the proposed capital expenditures for CareFirst as well as the projected shortfall predicted by Accenture for all categories of spending. Accenture predicted CareFirst would have a shortfall of over $830 million for the capital expenditures required under the strategic plan through 2003.[294] This estimate was based on the company reaching a scale of an $11 billion a year company, calculating the required reserves needed for a company of that size, estimating the net income of the company. If revenue were $11 billion, and then matching these needs and income against the "additional" CapEx required under Accenture's strategic plan. The following charts from The Blackstone report summarize Accenture's process:

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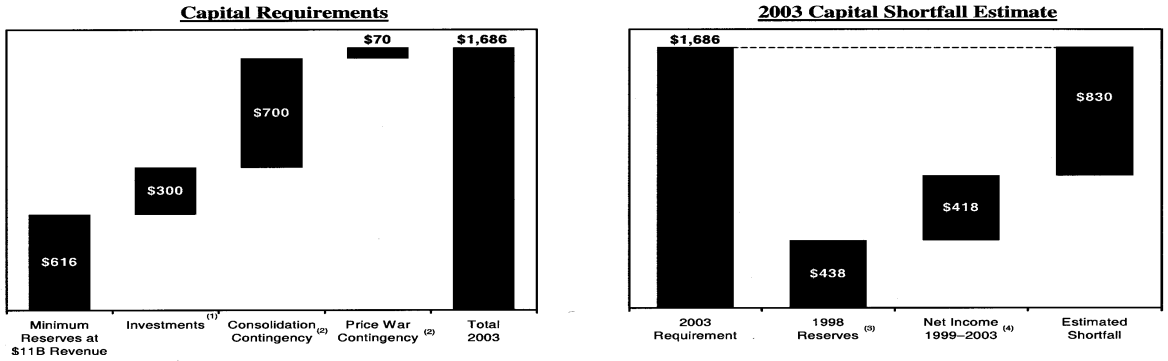
[286] Testimony of Leonard D. Schaeffer, March 11, 2002, at 103 – 119.
[287] Id. at 118.
[288] Testimony of John Monahan, February 23, 2003, at 53.
[289] Mark Chaney Deposition Exhibit 213, January 13, 2003, "CareFirst Capital Expenditure Overview."
[290] Deposition of G. Mark Chaney, January 13, 2003, at 27 – 31.
[291] Id. at 42.
[292] Id.
[293] Id. at 58 – 59.
[294] The Blackstone Business Case at 23.

PROJECTED CAPITAL SHORTFALL – ACCENTURE

In 1999, Accenture's analysis showed that CareFirst would have a capital shortfall of approximately $830 million by 2003. Set forth below are the analyses that were presented to CareFirst's Board of Directors by Accenture on November 23, 1999.

($ in millions)



(1) Investment to build the capabilities to defend the home turf and take advantage of the trend toward consumerism.
(2) Consolidation contingency if acquisition of Kaiser or Mid-Atlantic becomes necessary to maintain relative market share ($500 million inflated at 7% annually). Price War Contingency if competitor starts price war ($50 million inflated at 7% annually). Collectively, these two contingencies amount to $770 million. Accenture also refers to a $800 – $900 million figure in its analysis which refers to spending on mergers, integrations, and price wars / acquisitions.
(3) Equivalent to earned "surplus."
(4) Annual earnings based on 1996 – 1998 average of $68 million per year increasing at 7% per year. Inclusion of Delaware would increase annual earnings by approximately $4 million (1996 level).

The Blackstone Business Case Report at 23.

Even before to Blackstone's analysis, what is striking is that of Accenture's projected shortfall of $830 million, the merger and acquisition component is the vast bulk of the shortfall. If one accepts that $830 million is the shortfall, subtracting out $750 million for mergers and $70 million for price wars leaves a shortfall of capital spending of only $60 million over a five year period, 1999-2003, obviously much lower than the $830 million. It is reasonable and appropriate to examine the company's needs excluding the merger and acquisition activity because, as discussed earlier, there are significant barriers to in market acquisitions. Antitrust laws may restrain in-market acquisitions. Just as important, however, is Blackstone's analysis showing that CareFirst's shortfall would be much less than projected, for several reasons.

g. Blackstone determined Accenture's estimates of available cash for capital spending understated CareFirst's available cash

First, Accenture's plan posits a company with $11 billion in revenue, yet assumes that the growth in net income, a source of funding for CapEx, would rise much more slowly compared to revenues. Accenture estimated a 7% increase in net income, 1999-2003, while company data supports rates of growth between 8.7% and 22%. Analysis of CareFirst Business Case: Response to G. March Chaney and Joseph V. Marabito Rebuttal Testimony," January 2003, The Blackstone Group (the "Blackstone Business Case Surrebuttal") questioned Accenture's conservative estimate for growth in net income:

> Blackstone believes that there is still significant evidence to support a growth rate of higher than 7% for CareFirst:
>
> ■ As previously stated, CareFirst demonstrated growth in adjusted net income from continuing operations of 8.7% from 1997. 2002E
>
> ! CareFirst demonstrated growth in adjusted net income from continuing operations of 23.6% from 1997. 1999 and of 25.8% from 1997. 2002E

when comparing CareFirst as it existed in 1997 (Maryland only) to CareFirst today

- ! In 1999, CareFirst was projecting 10.0% growth in net income (excluding GTE write-off), for the next fiscal year
- ! CareFirst's long-term growth forecast at the announcement of the WellPoint transaction was 15%(1)
- ! CareFirst's current long-term growth forecast is 15%(2)
- ! CareFirst's projected growth in adjusted net income from continuing operations for 2001 to 2002E is 15%

■ Blackstone would also note that by focusing on continuing operations and excluding non-recurring items, the absolute level of recurring net income generation is significantly higher. The non-recurring net income figure for 1998 is $100 million. By basing its projected net income off a base figure of $68 million (which included several non-recurring items), Accenture underestimated CareFirst's potential future cash flow. By using $100 million as the 1998 base net income assumption as opposed to Accenture's $68 million assumption, cumulative net income from 1999. 2003 would equal $615 million instead of $418 million, a $197 million increase (please see page 19).(3)

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(1) CSFB fairness opinion dated November 20, 2001, which noted on page 37 a 15% growth rate in net income for 2003-2006. CSFB noted that the "2003-2006 projections are CSFB estimates based on guidance from Chesapeake [CareFirst] management".

(2) CareFirst projections as of August 2002. CareFirst noted on December 11, 2002 that its forecast for 2003 net income was $111 million, implying a 5% growth rate over 2002. However, management indicated that this does not impact its estimate of 15% growth in net income over the longer term.

(3)Assumes a 7% growth rate for comparative purpose.[295]

Based on these and other factors, Blackstone concluded that the proposed shortfall projected by Accenture should be modified by a range of $224 - $277 million.[296]

Blackstone made other adjustments to the Accenture projections, which also have the effect of further minimizing the scale of Accenture's projected shortfall. Blackstone projected an increase in cash flow of $76 - $140 million, which it modified to $20 - $140 million.[297] Finally, Blackstone calculated the availability of debt capital that could be available to assist CareFirst in meeting its needs, and that number was $90 - $171. The following chart summarizes the Blackstone adjustments, including their modifications after consultation with CareFirst:

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[295] The Blackstone Business Case Surrebuttal at 6.
[296] Id. at 9.
[297] See The Blackstone Business Case Report at 30; The Blackstone Business Case Surrebuttal at 10.

Amount		Comments
224 - $277	■	Represents change in minimum reserves and internally generated capital assuming 2003 revenue range of $8.0 billion - $11.0 billion and net income growth of 15% - 22% (to be consistent with growth in revenue to those levels)
Add: 76 - 140	■	Cash Flow Adjustments
Add: 90 - 171	■	Debt capital that could be raised by CareFirst on a stand-along basis
$390 - $588	■	Potential understatement by Accenture[298]

In light of this analysis and revised cash assumptions Blackstone concluded that "CareFirst could have covered all of its capital needs (before acquisitions) and had a contingency of $330 million - $528 million for acquisitions on price war.[299] The amount of the contingency, as noted above was modified, after consultation with CareFirst, to $334-588. The following chart illustrates this conclusion starting with the $830 million shortfall identified by Accenture, and then removing Accenture's understatement, and the merger component.

Amount		Comments
($830)	■	Accenture estimated shortfall
Less: (700)	■	onsolidation contingency
Less: (70)	■	Price War contingency
Less: (390) - (588)	■	Potential understatement by Accenture
$330 - $528	■	Equates to contingency/available funds for acquisition or price war[300]

In order to further measure whether CareFirst would have sufficient capital to meets its non-merger related capital needs, Blackstone looked at capital spending of other insurers. Blackstone found that the mean average annual level of capital expenditures for five public BlueCross BlueShield plans, including WellPoint and Trigon, for 1997-2001, was $33million, with WellPoint at $55million and Trigon at $24 million. For CareFirst, the spending average was $39M for the same period, but its average for 1999-2001 increased to $56 million.[301] Blackstone also looked at other BlueCross BlueShield nonprofits, such as the plans in Massachusetts, Florida, and Highmark. For the years 2000 and 2001, CareFirst also exceeded the mean of these plans.[302]

h. The impact of CareFirst's financial management to make capital expenditures

One theme underlying the business case in support of its proposed conversion is CareFirst's assertion that "Failure to convert could propel CareFirst - and particularly the

[298] Blackstone Business Case at 31, Blackstone Business Case Surrebuttal at 20.
[299] The Blackstone Business Business Case at 31.
[300] Id. at 31.
[301] The Blackstone Business Case Surrebuttal at 15.
[302] Id. at 16.

Maryland plan - into a vicious downward cycle."[303] (Emphasis added). CareFirst argues that the inability to convert and the attendant lack of capital will mean limited investment in products and services leading to a loss of membership which in turn leaves fewer members of which CareFirst can spread its fixed costs. Id. While this risk seems to apply equally to all three jurisdictions, the Maryland plan was singled out as being at particular risk. The CEO identified the fact that Maryland's BlueCross/BlueShield plan, CFMI has a relatively thin "cushion" in terms of surplus, placing it below BCBSA standards.[304] Mr. Jews posited a worst-case scenario in which the Maryland plan was placed on the BCBSA's "watch-list", as the company was in 1992. Id. Mr. Jews also posited a scenario where D.C. and Delaware could move forward and convert if Maryland denied the conversion, leaving the Maryland plan particularly vulnerable if left on its own as a nonprofit. Id.

CareFirst has also highlighted CFMI's condition in statements to the press. As part of its announcement regarding year end financial performance for 2001, CareFirst stated that "we face some troubling weaknesses with our Maryland operation."[305] (Emphasis added). In the press statement, these weaknesses were attributable to losses on its open enrollment product, the SAAC product, losses on its commercial HMO, FreeState, and greater than expected hospital rate increases. In his testimony Mr. Jews added to these causes the number of mandated benefits in Maryland and losses in public programs like Medicare and Medicaid.[306]

Because of the concern CareFirst has generated over the condition of the Maryland plan in particular, it is important to have a full and complete picture of the condition of the plan, and a full understanding of the causes of any financial challenges it may face. This issue was examined by the MIA in the course of its review of the application. In assembling all the relevant data a different picture emerges than the one presented by CareFirst management. While it does in fact appear to be true that CFMI is not performing at the same levels as the plans in D.C. and Delaware, the root causes of the differences are not necessarily those identified by management. In fact, in many cases the causes stem from poor management decisions rather than "external" forces over which the plan has no control, such as legislatively imposed mandated benefits or inadequate reimbursement in public programs.

Before beginning the analysis one point of clarification is necessary. Financial information for insurance companies can be reported in two different ways. Being subject to financial oversight by State regulators, insurers must comply with "statutory" accounting, those State laws that govern financial reporting of insurers, laws usually developed first by the National Association of Insurance Commissioners and enacted in the individual States. Wall Street and others typically follow "GAAP" accounting, referring to Generally Accepted Accounting Principles. Financial data can vary significantly depending on whether it is reported on a GAAP or statutory basis. While the rules are complex, there are a few basic differences. One significant difference is that net income for an insurer reported on a statutory basis does not include the income (or losses) of subsidiaries. It is reflected not in the profit/loss statement but in the balance sheet. In GAAP accounting, the subsidiary gains or losses are reflected in the parent's net income. The difference is significant in some cases. For example, CFMI's 2001 Annual Statement, prepared under statutory rules, shows a $43.4 million gain.[307] However, under GAAP accounting, the company lost $575,000, due to losses by a CFMI subsidiary, the

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303 Pre-filed written testimony of William L. Jews, March 6, 2002, at 13.
304 Id. at 14.
305 See February 28, 2002 Press Release.
306 Testimony of William L. Jews, March 13, 2002 at 359.
307 Exhibit 245, Annual Income Statement of CFMI.

FreeState HMO. Public statements issued by insurers regarding their financial condition are often on a GAAP basis.

Turning to CFMI's situation, it is clear that a number of factors have contributed to its reportedly negative performance. First, as noted above, CFMI's GAAP loss in 2001 was, under statutory accounting, a gain of $43.4 million because the losses were due to the performance of the FreeState HMO, discussed in detail below, and under statutory accounting, the losses are not reflected in the income statement. However, data first appearing in the 2001 Annual Statements show that even this $43.4 million gain could have been significantly higher had CFMI not incurred huge losses in its so-called "non-risk" business. As its name implies, non-risk business is business that is administered by CareFirst for large clients like school systems. When acting as an administrator CareFirst is not assuming insurance risk. Although it processes and pays claims, for example, it is doing so on behalf of a self-insured client, and the cost of care is borne by the "client" the school system, rather than CareFirst as an insurer.

It is therefore noteworthy that CareFirst lost $24.1 million on this business in 2001 because the loss stems not from high medical costs, but rather from CareFirst's failure to charge the self-insured clients enough to simply cover CareFirst's costs to process the claims and perform other administrative functions. Mr. Chaney the CFO explained that there are expenses associated with servicing these non-risk accounts, and "the reimbursements that we've been able to negotiate versus those expenses have not fully recovered our expenses."[308] Mr. Chaney explained that although CFMI knew there would be some losses on this program, but:

> 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. Id.

This $24 million dollar loss on the non-risk business had impacted the overall underwriting gain recorded on the Annual Statement for all lines by $19.6 million.[309] Therefore, had CareFirst priced sufficiently to simply reach the break-even point, without even pricing the product to be profitable, the underwriting gain reported would have increased by $19.6 million. It is also clear from the record that management did not view this as desirable, indicating that its goal was to achieve profitability.[310] Prior Annual Statements show that the "non-risk" business has in fact been risky, for CFMI has incurred losses the three prior years as well, although not as large.[311]

The revelation is significant in this proceeding for two reasons. First, it highlights the selectivity with which CareFirst management divulges and explains information bearing on its financial condition. 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.[312] Yet the $24 million loss on the 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.[313] None of the press releases explain the role this

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[308] Testimony of Mark Chaney, March 13, 2002, at 399.
[309] Exhibit 249, Affidavit of March Chaney, December 20, 2002.
[310] Exhibit 18 at 6 of handout titled "Strategy Selection Board Discussion, October 28, 1999."
[311] See, CFMI Annual Statements for years 1998, 1999, and 2000.
[312] Testimony of Jews at public hearing, March 13, 2002, at 357 - 360.
[313] See Annual Statements for years 1999 and 2000.

business had in CFMI performance, and at the hearings management did not cite it until specifically asked.

The clear reason for this selective reporting is that unlike losses in public programs like Medicaid and Medicare, in which the mantra of "inadequate reimbursement from the government" is used to explain the situation, these losses cannot be easily attributed to some external source or event beyond the control of management. 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, 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. Apparently under such circumstances candid reporting of financial performance is not desirable.

Second, the financial information illustrates the apparent selectively and subjectivity with which CFMI views the significance of groups of subscribers. 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. Apparently whatever the test for exiting a line of business does not apply to long-standing, higher profile accounts such as school systems or municipalities.

If the selective reporting of data were an isolated case, it would be unduly harsh to make these criticisms, but this is not an exception. As noted above, one reason why CFMI on a GAAP basis posted a loss of $575,000 was the money losing performance of its HMO subsidiary, FreeState. Closer scrutiny of FreeState reveals the same pattern of diverting attention from management failures to external causes in explaining financial performance.

One major component of the losses for FreeState is the result of arrangements with provider groups whose losses FreeState subscribers. One such group is Potomac Physicians, P.A. According to an independent audit of Potomac CFS, the holding company for FreeState and a subsidiary of CFMI:

> has an arrangement with [Potomac] whereby [CFS] funds all operating losses. Revenues under this management were $13,920,000 and $21,332,813 for the years ending December 31, 2001 and 2000, respectively.[314]

Mr. Chaney confirmed that the "revenues" noted by the auditors were in fact subsidies to Potomac by CFS.[315]

This revelation that FreeState was holding a provider group harmless for all its losses was remarkable. The practice of funneling millions of dollars each year to Potomac is based on an agreement that appears not to be in writing. According to Mr. Chaney, through the acquisition of smaller HMOs in the 1990's CFMI apparently purchased the obligation to hold the physician group harmless for all losses. The MIA asked for documents evidencing this obligation at the February 5, 2003, hearing and none were provided before the record closed on February 14, 2003, at 5:00 p.m. The MIA's financial examiners in their examination of FreeState Health Plan, Inc. as of December 31, 2000, also requested documentation of guarantee arrangements and they were told the arrangements had never been formally documented. As of

[314] Exhibit 246, Arthur Anderson audit of Potomac Physicians, P.S., January 26, 2002.
[315] Testimony of G. Mark Chaney, Day 15, February 5, 2003, at 16 - 28.

August 31, 2001, the examiners directed the company to execute written agreements, a request that may not have been complied with. Mr. Chaney also testified that there was not fixed date of termination for this "Agreement." The "ownership" structure of Potomac in relation to CFS is unclear. It is considered a "controlled affiliate."[316]

Mr. Chaney also testified that the subsidy was listed on a "medical expense" on FreeState's books, on the grounds that the losses were incurred for providing care to FreeState HMO members.[317] Listing the subsidiary as a medical expense has the effect of overstating the amount FreeState is reported to spend on medical expenses.

Mr. Chaney's arguments for booking this subsidiary as a medical expense are flawed. CareFirst appears to have no idea why Potomac incurred a loss. There is no direct connection between the fact that Potomac incurred a loss, and the assumption was due solely to greater spending on medical care than capitation received. More importantly, 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.[318]

Mr. Chaney also testified that when CFMI reported Medicare and Medicaid losses, which he said were $35 million combined in 2000 losses on Potomac were included in that number. However, Medicare and Medicaid losses have always been described in public materials as resulting from inadequate reimbursement:

> The company reported approximately $16 million in underwriting losses on its Medicare and Medicaid public sector programs. With underwriting losses on its Medi-CareFirst product of approximately $11 million in 1999 due to inadequate federal Medicare HMO reimbursements in the rural counties, the company decided to stop offering the product in rural Maryland, beginning in January of this year.

Press Release of February 28, 2000. (Emphasis added.)

* * * *

> CareFirst BlueCross BlueShield today announced that its subsidiary FreeState Health Plan, Inc. will no longer offer a Medicare HMO product after December 31, 2000. The exit affects about 32,000 Medicare beneficiaries in six metropolitan Maryland counties plus Baltimore City and the District of Columbia.
>
> Blaming inadequate federal reimbursements, the company projects financial losses on its Medicare HMO product, Medi-CareFirst, of $7.5 million by year's end. That is on top of nearly $25 million in losses on the product since 1996. Even if premiums charged Medi-CareFirst members were raised substantially, the company said its losses would accelerate next year.

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[316] Id. at 24 - 27.
[317] Id. at 30.
[318] Testimony of G. Mark Chaney, Day 15, February 5, 2003, at 38.

Press Release of July 3, 2000. (Emphasis added.)

* * * *

> "The public section programs -- Medicare and Medicaid -- continue to show significant financial losses," explained G. Mark Chaney, executive vice president and Chief Financial Officer for CareFirst. "Our Medicare HMO, Medi-CareFirst, has lost more than $8 million while underwriting losses on our Medicaid HMO total $4.8 million so far this year and are projected to exceed $8 million for the year."
>
> Chaney said the cost of providing health care services to Medicare and Medicaid members exceeded the reimbursements CareFirst receives from the federal and state government. The problem worsened when many physician groups who previously had shared the financial risks of providing care for these members unexpectedly dropped out of both programs.

Press Release of November 15, 2000. (Emphasis added.)

* * * *

Based on the Arthur Anderson audit, the subsidy to the money losing medical group Potomac in 2000 was $21 million, which accounts for the majority of the losses attributed to these public programs by Mr. Chaney. In light of this apparently undocumented commitment to cover all losses of an affiliate not owned by FreeState, it is not completely accurate to attribute such losses to inadequate reimbursement of federal programs. The cause of the losses would seem to be more accurately described as a business decision to delegate responsibility for health care services to a money losing physician group and agree to hold the group harmless from all losses for whatever reason. While it may be true that some losses incurred by Potomac were caused by the cost of care for FreeState insured treated by Potomac doctors exceeding initial capitation payments to Potomac, that cannot be documented. As noted above, the causes of Potomac's losses are unknown.

To add to the severity of this problem, Potomac is not the only money losing physician group whose losses FreeState covered. According to Mr. Chaney, FreeState also guaranteed the payments to Patuxent Medical Group, a holdover from the staff model of the Columbia Medical Plan, which was merged into FreeState.[319] Apparently FreeState became committed to make guaranteed payments to certain physicians through 2006.

This commitment cost FreeState $12.2 million in 2001. This relationship was noted ten years ago in 1993 in the "Report of the Special Litigation and Indemnification Committee of the Board of Directors of BlueCross and BlueShield of Maryland," dated October 28, 1993. That report was made in response to litigation filed against BlueCross in the case O'Donnell v. Sardegna, in which allegations of breach of duty and mismanagement were brought against certain Board members and officers after the committee completed its investigation of the Maryland BlueCross plan. In reviewing claims of mismanagement asserted against the Board, the report states:

[319] Id. at 40.

> A number of witnesses noted that Columbia (the "staff model" HMO), in particular, had high operating costs. Vadakin at 9; Colussy at 2; Sardegna at 26. These costs are attributable in large part to employment contracts with members of the physician group, the Patuxent Medical Group, that constituted Columbia's medical staff. Many of these contracts ran for twenty years and guaranteed compensation to the contracting physicians without regard to the profitability of Columbia.[50]

[50] The contracts obligated Columbia to pay approximately $10.2 million in salary and an additional $900,000 in bonuses. See Exhibit 23 CFHS Combined Financial Statements at Note 8.

Mr. Chaney testified that these guaranteed payments constituted "medical expenses" as well.[320]

These relationships created obvious financial drains on the resources of FreeState. Such losses are more properly attributable to poor management decisions than inadequate reimbursement from the federal government.

Other examples of money losing ventures exist. In response to a MIA request, CareFirst also submitted documentation showing separate losses of $12.6 million for 1998 - 2001 attributable to bankrupt or defunct provider groups (not Potomac or Patuxent) for which FreeState was responsible for unpaid medical bills, or for which FreeState otherwise had risk sharing arrangements or was forced to take write offs.[321] In 1999, CareFirst wrote off $22.1 million on a computer project after the vendor withdrew its support for the project.

Other factors than those cited can affect the financial condition and reporting of the company. One relates to the treatment of "non-recurring" expenses in the income statement. CareFirst took issue with Blackstone's estimated growth rate of net income used in Blackstone's analysis of whether CareFirst had sufficient capital to meet its needs without a WellPoint deal. CareFirst argued that the better measure of net income was to remove non-recurring items from the statements.

Finally, in it's fairness analysis, the Wakely Consulting Group noted that CareFirst had overstated unpaid claims liability by 19.3% at the end of calendar year 2000, which normally has a direct impact on underwriting gains and losses. Claim reserves in 2000 were understated by $59.8 million. Wakely requested detailed work papers, which showed the $59.8 million in claim reserves may be offset due to a discontinued risk sharing arrangement with providers in FreeState Medicare and Medicaid business. However, coupled with a $6.5 million overstatement in year-end 1999, the year 2000 underwriting gain appeared to be understated by $53.5 million. With further adjustments to the risk sharing and FEP business, Wakely found the net effect on CareFirst calendar year 2000 to be an understated underwriting gain of approximately $26 million.[322]

[320] Id. at 42 - 44, Testimony at Public Hearing, Feburary 5, 2003, at 42 - 44.
[321] Exhibit 249 to the Public Hearing, February 5, 2003, at 46 - 47.
[322] The Wakely Report at 23.

4. Analysis of CareFirst's decision to abandon its nonprofit status

a. Little discussion of the implications of abandoning nonprofit status

A review of the record, including an examination of all relevant Board minutes and presentations, shows that the discussions that took place at the Board level regarding the significance of CareFirst's status as a nonprofit company, and in particular the importance of its mission to provide insurance at "minimum cost and expense" were largely eclipsed by what was clearly perceived as the more important issue: how to achieve scale and market dominance. It is true some Board minutes make reference to the fact that such a discussion took place.[323] Mr. Altobello testified that until a "final decision" was made all options, including continuing as a nonprofit, were on the table."[324] However, the voluminous materials presented to the Board, reflect no analysis or discussion on the specific implications of altering the mission of the company to that of a for-profit company. The dismissal of Highmark on the grounds it had not converted lends clear support that the change in mission was not viewed as a selection criteria that could be accorded any positive weight. It was consistently viewed as a negative or disadvantage because it was perceived to impact the overriding strategic goals of scale and access to capital.

In none of the presentations or board minutes is reference made to the mission as articulated in the bylaws of CareFirst of Maryland. While there is extensive discussion on the possible benefits of gaining access to capital, there is no discussion on whether a change in structure from nonprofit to for-profit would impact subscribers, providers, or the availability and affordability of health care, whether or not the possible benefits of conversion might mitigate these impacts. Furthermore, the material presented to the Board appear pre-determined to lead to the conclusion the status quo is not an acceptable alternative. These pages have titles such as "CareFirst Must Act Now…," and "Do We Really Need Access to Capital?" and "Why Can't We Fund Our Capital Needs Internally?"[325]

One reason for this failure can be is that in CareFirst's view there is little difference operationally between a nonprofit and a for-profit.

b. Is there a difference between a for-profit and a nonprofit health plan?

The Board's failure to give adequate consideration to the abandonment of its nonprofit mission should be viewed as a material failure in its deliberations and its due diligence only if the nonprofit mission and the mission of a for-profit company were materially different. If there is no material difference, then the change in corporate structure would be immaterial to its mission, and thus the Board could be excused from a failure to consider factors immaterial to the mission of the corporation. The Chairman of the Board and the CEO both minimized the distinction, testifying that the operations of both were basically the same.

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[323] See, e.g., Board of Directors minutes, November 23, 1999, in which there was "extensive discussion" on the strategic plan, which included, among other issues, a discussion of "whether the company needed to remain nonprofit."

[324] Testimony of Daniel J. Altobello, March 11, 2002, at 242 – 243.

[325] Exhibit130, CSFB presentation to CareFirst, Inc. Board of Directors titled A Project Chesapeake, December 4, 2000.

There are several sources that shed light on the issue of whether there is a difference between the goals and mission of nonprofit and for-profit insurers, at least differences that matter to insureds, HMO members, and the Maryland health care market generally. These sources include the Article of Incorporation of CareFirst of Maryland, the Maryland statutes that govern the companies operations, judicial decisions interpreting the mission, and, from a practical standpoint, the activities and conduct of other, similarly situated nonprofit health insurers.

c. The CareFirst of Maryland Articles of Incorporations establish as the mission of the Company to provide insurance at "minimum cost and expense."

CareFirst Articles of Incorporation require that the company provide insurance at "minimum cost and expense." There is no other charge in the bylaws that specifically relates to the mission of the company. On its face this language directs the company to minimize the costs and expense to those who purchase policies offered by the company. The language creates a clear duty to the subscribers and insured of the organization.

The meaning of this language can be illuminated with reference to historical documents regarding CareFirst. As previously noted, these documents consistently refer to CareFirst's nonprofit mission. In 1959 public hearings were held by the General Assembly regarding Blue Cross's relationships and payment to hospitals in the state.[326] In those hearings the company described its "sole reason for existence" as being "to help the people of this community obtain the hospital care they need at the lowest possible cost. It is a nonprofit whose first concern, its fundamental concern is the welfare of its subscribers."[327]

This charge, insurance at "minimum cost and expense" can be contrasted with the mission of a for-profit company. As CareFirst's own consultant stated:

> As a for-profit CareFirst would continue to focus on the organization's competitive viability and financial strength, as it does today. However CareFirst's first priority would be to earn a return for shareholders."[328] (Emphasis added.)

This language creates a very different obligation than that in CareFirst's Articles. Whereas the language in the CareFirst Articles creates an obligation or duty to the purchasers of the product, as Accenture points out, the duty of a for-profit, publicly owned company is to its shareholders.

Leonard Schaeffer testified that WellPoint does not participate in programs that create a financial loss for the company.[329] In his view as the head of a publicly traded company, programs that cause financial losses should be funded by the foundations created from the conversions. Id.

A vivid illustration of the difference between a for-profit and a not-for-profit, and how the different missions create different duties for the Board of Directors, can be seen in several

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[326] Public Hearing of Committee on Blue Cross Insurance of the Legislative Council of the State of Maryland, 1959.
[327] Id. at 11.
[328] Accenture I at 14.
[329] Testimony of Leonard D. Schaeffer, January 31, 2003, at 169.

nonprofit Blue Cross plans just to the north, in Pennsylvania. There, several regional nonprofit Blues plans not only operate but are prosperous. They have been so successful financially that the Insurance Commissioner in that State held public hearings to determine if the companies had accumulated excessive surplus which should be returned to policyholders. These hearings show that at least some nonprofit Blues plans, are not only committed to, but are taking steps to fulfill a "social mission." which includes recognizing a duty to policyholders, not shareholders.

As one example, the President and CEO of BlueCross of Northeastern Pennsylvania testified in writing that:

> While understanding that there is no statutory requirement relative to social mission, we acknowledge that as a not-for-profit Blue plan doing business in the Commonwealth of Pennsylvania, we are held to a higher standard of social and community responsibility. We accept this role and are proud of the actions we have taken to positively impact the quality of health and life in the communities of northeastern and north central Pennsylvania.[330]

The President and CEO of Highmark described the obligation of a nonprofit in this way:

> We are a [sic] both an insurer, selling products and services of value to our customers, and a nonprofit company that recognizes its special obligation to pay for the care and administer the benefits of a population that many insurers will not, or are reluctant to, insure. Who are these people that some choose to ignore? They tend to be in poorer health. They tend to be older. And, they tend to have limited income or work in occupations or businesses, often comprising smaller groups, with higher health risks. For these groups and individuals, our products are often their only option. And, with the inherent risk resident in this population comes greater financial risk for us and, in part, another reason for us to have adequate surplus. These people are already vulnerable through no fault of their own. Why should we, by running our companies, by running our companies on a shoestring exacerbate their plight? As noted previously, many insurers do not routinely make these populations part of their risk pools. These actions, then, create even more demand for the Blues to uphold their commitment to small groups, individuals and those who wouldn't have insurance otherwise.[331]

According to the information provided by Highmark, it subsidizes at a loss, two programs for children, a "Special Care" program and the Children's Health Insurance Program for the Commonwealth of Pennsylvania, by more than $55 million.[332] Its total spending in social mission is $65.6 million.[333] Unlike CareFirst, Highmark considers itself "the insurer of last resort."

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[330] Testimony of Denise Cesare , President and CEO, BlueCross of Northeastern Pennslyvania, before the Pennsylvania Insuance Commissioner, Wednesday, September 4, 2002, at 3 – 4.
[331] Testimony of John S. Brouse, President and CEO, Highmark, Inc., before the Pennsylvania Insuance Commissioner, Wednesday, September 4, 2002, at 4.
[332] Id. at 7.
[333] Id.

The President and CEO of Independence Blue Cross ("IBC") testified that while IBC only receives a $6 million tax-exemption due to its nonprofit status, it would continue to fulfill IBC's "social mission" even if the tax break were repealed. According to that testimony IBC stayed in the Medicare+Choice program when other companies withdrew, and IBC's children's programs help Pennsylvania. The CEO reiterated IBC's commitment to maintaining its status as a nonprofit with no plans to convert, believing that IBC's structure "absolutely benefits our customers and our community, and that is why we have no plans to alter this structure, no intent to convert Independence Blue Cross to a publicly traded for-profit plan."[334]

Like the Highmark CEO, the IBC CEO testified that IBC subsidized premiums to the nongroup (individual) market. In his testimony the CEO testified that in 2003 IBC would provide direct and indirect subsidizes of over $18 million to these products. Finally, the CEO cited an operating structure similar to CareFirst's as the main reason for its success: The establishment of for-profit HMOs that are wholly owned subsidiaries of the nonprofit Blues plan. The "profits" from the for-profit subsidiaries permit IBC to fund the social missions.

The philosophy outlined in the testimony of the executives of the Pennsylvania nonprofits also contrast sharply with that of Leonard Schaeffer on the same topic of whether some products should be subsidized or sold at a loss.

> We try and make sure that every product we offer has value and every product offers a return. So we would not want to sell products that have losses and we have an underwriting and pricing process to try and be very rigorous about that.[335]

d. Court cases show the Board had a duty to consider the impact of its decision to abandon its nonprofit status.

As noted earlier, there is a distinction between the operations of a company and the goals and mission of a company. There is no disagreement that in many ways for-profit and nonprofit insurers must operate in similar ways. But those similar operations may be employed to further different goals. And those different goals create different legal obligations for the boards of directors. One court explained the difference this way:

> …[B]ecause the missions of the two types of corporations are different, the duty of loyalty is defined differently. The officers and directors of a for-profit corporation are to be guided by their duty to maximize long term profit for the benefit of the corporation and the shareholders. A nonprofit public benefit corporation's reason for existence, however, is not to generate a profit. Thus a director's duty of loyalty lies in pursuing or ensuring pursuit of the charitable purpose or public benefit which is the mission of the corporation. (Emphasis added.) 2002 WL 31126636 (TENN. CT. APP.)

[334] Testimony of G. Fred DiBona, Jr., President and CEO, Independence BlueCross before the Pennsylvania Insuance Commissioner, Wednesday, September 4, 2002, at 9.
[335] Testimony of Leonard D. Schaeffer, March 11, 2002, at 30 – 31.

This duty of seeking to pursue the public benefit for which a nonprofit is established translates in this case into a duty of the Board to make reasonable efforts to determine not only the impact of change in status on its policyholder, but also to ensure whether other means exist to further the public purpose without resort to a change in the nonprofit status.

The documents and hearings from the Pennsylvania proceedings illustrate a significant flaw in the Board's deliberations on whether or not it needed to convert to a for-profit company. There is no demonstrable evidence suggesting that the Board made any appreciable effort to examine the operations of other nonprofit Blues plans to test the assumptions and hypothesis of its management and its hired expert that change, and ultimately change to for-profit, was necessary. For example, when management declared that CareFirst was no longer the insurer of last resort and would exit unprofitable segments and contracts, there was apparently no resistance from the Board on this seemingly unilateral change in corporate direction. It would have been reasonable for the Board as stewards of the Company to investigate whether other nearby Blues plans had also abandoned their social mission.

The experience nearby in Pennsylvania demonstrates that at least in that State Blues plans can not only survive but also thrive as a social mission oriented nonprofit if the level of surplus is any indication of a thriving plan. Of particular note is the fact that some of the Pennsylvania nonprofits do not even have the scale CareFirst enjoys today, yet they have pursued their mission and increased surplus at the same time. In addition, Mr. Marabito, of Accenture, acknowledges that nonprofits have successfully achieved scale and become good success stories without converting.[336] In fact in seeming contradiction to the 1999 Board material urging the Board to opt for a conversion if the opportunity came along, Mr. Marabito later testified that "corporate form," whether a company is for-profit or nonprofit is less relevant than simply having what it needs to compete. Id.

It may certainly be the case that State laws or market conditions do not make Pennsylvania comparable to Maryland, D.C., and Delaware, and thus there could be legitimate reasons why the success enjoyed by the nonprofits in Pennsylvania, could not be replicated here. But the Board never inquired and took at face value the assumptions of management and Accenture. As noted earlier, in fact the whole Strategic Planning process seems pre-determined to lead to recommendations that, in all likelihood, would require a conversion because the RFP for services set out in detail the goal of building scale through acquisition and merger. Mr. Jews acknowledged that the basic strategy pursued from 1993 involved growth and expansion.[337] One of the potential merger partners was Highmark, a nonprofit that brought more scale to CareFirst than Trigon. Yet Highmark was rejected because it had not converted.

Had the Board made even a modest assessment of the universe of remaining nonprofit Blues plans, it would have realized that many plans are committed to the nonprofit model, to the social mission. Most ascribe to that model, and most importantly, appear to be on solid financial footing.[338] If the Accenture assumptions were universally true, common sense would indicate that all smaller regional nonprofit Blues would die on the vine. Pennsylvania suggests this is certainly not the case. By permitting the development of a culture that CareFirst's goals were indistinguishable from a for-profit company, as distinguished from its operations, without at least raising basic, self-critical questions about whether this course was inevitable, without examining the operations of other similar Blues plans that did not share this view, the Board

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[336] Testimony of Joseph V. Marabito, April30, 2002, at 35.
[337] Testimony of William L. Jews, March 13, 2002, at 307 – 310.
[338] See, Robert Cunningham, Douglass B. Sherlock, Bounceback: Blues Thrive as Markets Cool Toward HMOs, HEALTH AFFAIRS, Jan/Feb. 2002, Vol. 21, No. 1.

failed to act with due diligence. Further evidence of the Board's one-sided analysis of the arguments in favor of converting is outlined in detail in The Blackstone Business Case Report, and in The Brown Due Diligence Report.

e. In changing its operations to act like a for-profit, CareFirst also adopted the goals and missions of a for-profit company.

The CEO of Blue Cross of Northeastern Pennsylvania made the statement quoted above regarding the mission of the company while at the same time acknowledging that "a Blue Plan, despite being organized in a not-for-profit corporation, absolutely must manage itself as other companies do by selling products, charging a competitive market rate, and, when appropriate, planning for a marginal return on revenue to assure financial profitability."[339] This is an important point. There is a distinction between the ways a company is managed, and the goals or mission that should infuse major decision-making.

The CFO of Northeastern Pennsylvania testified that," while recognizing that we are organized as a nonprofit and have different corporate goals, our business operations are quite similar to that of for-profit companies." Accenture also recognized that a change in structure to for-profit and its attendant duty to its shareholders would necessitate changes to the *operations* of a company:

> A change in corporate form would require CareFirst to introduce more stringent financial discipline in order to ensure more predictable, stable earnings, in response to shareholder demands.[340]

The management of CareFirst sees little distinction of consequence between a nonprofit health service plan and a for-profit insurer. When asked whether there was a difference between his duties and obligations to customers as a nonprofit, and Leonard Schaeffer's duties to shareholders as CEO of a for-profit, Mr. Jews replied that "the responsibilities were the same."[341] The Chairman of the CareFirst Board, Mr. Altobello, was asked at the public hearings whether "…the role of CareFirst as a nonprofit health service plan figured into [the discussion on strategic alternatives]." Although he stated these discussions occurred, Mr. Altobello stated "To me [CareFirst is] not really nonprofit."

The minutes of the Board of Directors even more dramatically demonstrate that management of CareFirst did not view their corporate mission as restraining or guiding their business activities. These minutes demonstrate that in making decisions regarding pricing of insurance products, or even decisions to continue to offer certain products, whether or not the product was "profitable" was the key, and often the only determinant. For example:

- 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."

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[339] Testimony of Denise Lesare , President and CEO, BlueCross of Northeastern Pennslyvania, before the Pennsylvania Insuance Commissioner, Wednesday, September 4, 2002, at 3 – 4.
[340] Accenture II at 14.
[341] Testimony of Willliam L. Jews, March 13, 2002, at 325-326.

- In the lengthy presentation to the Board of Directors in December 2000, regarding the 2001 goals, one agenda item is entitled "Maximize Net Margin." In this presentation, the following goals were presented: "Exit Unprofitable Segments[342] and Exit Unprofitable Contracts." [p. 7.4]. The 2001 strategy for the under-65 individual market is described as "Maximize Profitability (Potential Partial Exit)." For the small group market of small business, the strategy is "Return" (Potential Partial Exit)." Both Medicaid and the Medicare HMO product strategies were to exit the market.

- 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".[343] As part of this presentation the Board was informed the "Critical Success Factors" for the year 2002 were "Aggressive rate filing strategies" and "Disciplined Actuarial and [underwriting] Policies and Processes." Notably, the "Vision" of the company for 2005 was to "improve the [underwriting] margin form 0.9% to 1.4% to support 15% annual bottom line growth." (Emphasis added.) This last point is a theme which dominates recent Board presentations and materials: the company is seeking 15% annual "bottom line" growth, referring to growth in net income, the "bottom line" as opposed to "top line" or revenue growth. To achieve these goals and revenue growth, CareFirst will "Increase Premiums 15%".

All of these goals and objective are identical to those articulated by for-profit companies. Premium increases are premised on growth objectives and "underwriting margins" rather than whether these increases would further the goal of providing insurance at "minimum cost and expense" to subscribers.

To suggest that these documents show an inappropriate focus on the profitability of products or the company as a whole is not to suggest a nonprofit cannot be profitable. Of course any non-charitable nonprofit must ensure its revenue exceeds its expenses and reserve requirements to continue as a viable entity. It is therefore true that there are some similarities between the business *operations* of a nonprofit health insurer and a for-profit insurer. But the fact that there are important similarities in their operations, or in the general business imperative that revenues exceed the costs of doing business, does not mean that the ultimate purpose or mission of the two types of organizations are identical. A for-profit company seeks to maximize value for its shareholders. This mission for example, would generally require not only that rates be sufficient to cover expenses, but that rates be established to maximize the profit margin of the product in question. A price for insurance that maximizes profit for the insurance company may not be the price that delivers the product at the least cost to those who buy it.

There are other examples of CareFirst failing to consider the mandate of its bylaws to the possible detriment of its subscribers. In 2001, CareFirst filed rates with the MIA for its open enrollment SAAC product that in some cases would have involved increases of more than 50% for existing insureds, and for some products more than 200% over existing products. The Insurance Administration rejected the proposed increases because CareFirst was receiving discounts on its hospital rates as a quid pro quo for offering the voluntary SAAC products, and the discount amounted to tens of millions of dollars in excess of the losses CareFirst clamed on the SAAC products. The MIA approved lesser increases for some products and none for others,

[342] Exhibit 18, handout entitled "Executive Session, Board of Directors Meeting," October 28, 1999; William L. Jews" at page titled "Preamble."
[343] Handout at Board of Directors Retreat, December 3, 2001, CF-0022401.

arguing that large proposed increases would not make the product "affordable" as its name implies, and that CareFirst was obtaining a large benefit in the form of hospital rate discounts that it was not returning to its subscribers in the form of lower premiums. The Health Services Cost Review Commission agreed with the approach taken by the MIA.

Remarkably, CareFirst sued in the Circuit Court for the right to charge the premiums the MIA had determined were excessive, and sought to prohibit the MIA from considering the tens of millions of dollars in rate discounts CareFirst received as relevant to whether CareFirst was losing money on the SAAC product. Although the Circuit Court agreed with CareFirst. The Maryland Court of Special Appeals reversed the Circuit Court in a unanimous, reported, opinion, upholding the MIA and rejecting the reasoning of CareFirst. While the litigation was pending, CareFirst the next year sought increases of the same magnitude. There were largely rejected by the MIA.

CareFirst's handling of the withdrawal of its mid-based HMO from the market provides another vivid example of how CareFirst management did not feel constrained by its nonprofit mission. FreeState was the for-profit HMO subsidiary of CareFirst of Maryland. At one point, CFMI participated in both the State managed-care Medicaid program and the Federal Medicare+Choice program through FreeState. CareFirst claims that mounting losses in these programs led to CareFirst's decision to withdrawal FreeState's participating in both public programs. FreeState relied on a system of contracting with provider groups and capitating these groups in order to limit the insurance risk to FreeState.

Due to the insolvency of certain of these "downstream risk" contractors, provider groups with whom FreeState had contracted, FreeState and CFMI concluded that the capitation model was not a workable delivery system and began to phase out this model.[344] As FreeState took back the insurance risk it had previously contracted away, it claimed to struggle financially. Its losses mounted and numerous presentations from management to the Board of Directors blame those losses on the public programs along with inadequate rates in the post-downstream risk period.[345] The decision was made to merge FreeState into the HMO subsidiary of GHMSI, then known as CapitalCare. CapitalCare was renamed BlueChoice, and BlueChoice was slated to become the single, "regional" HMO for the entire service area of the combined CareFirst market.

The problems arose when CareFirst made a decision to require the HMO members of FreeState to be "reunderwritten" to qualify for a BlueChoice product. As a consequence, thousands of FreeState HMO members who were healthy when they first joined FreeState and had "passed" medical underwriting had since developed medical conditions that caused them not to qualify for the BlueChoice underwritten products. The problems created by the decision to re-underwrite FreeState insureds was exacerbated by the fact that BlueChoice employed more stringent underwriting standards than did FreeState.[346] As a result, some FreeState individuals were not offered policies with BlueChoice, some qualified for policies only with "exclusionary riders" that excluded coverage for a particular medical condition, and some were only offered coverage with higher deductibles. The MIA received 30 complaints from individuals with cancer, diabetes, high blood pressure, and hearing loss who were adversely affected by this action.[347]

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[344] See Minutes, CareFirst of Maryland Board of Directors Meeting, April 26, 2001, at 2.
[345] See Minutes, CareFirst of Maryland Board of Directors Meeting, July 25 - 26, 2001, at 2.
[346] See October 18, 2001, letter from Commissioner Larsen to the President of the Maryland Senate, and Speaker of the Maryland House.
[347] See November 15, 2002, Memorandum to Commissioner Larsen from Joy Hatchette, Associate Commissioner for Consumer Complaints.

The impact, however, was more widespread. As to the fate of those thousands of FreeState members who did not qualify for the BlueChoice HMO coverage, CareFirst agreed to offer them coverage in the CareFirst of Maryland, Inc. open-enrollment SAAC product. However, the CareFirst SAAC policy was not an HMO product but was an indemnity policy with high deductibles and constituted a diminution in coverage by former HMO enrollees. In addition, this increase of SAAC enrollees from FreeState products caused the other SAAC carriers to announce their suspension in the SAAC program. Data from the Health Services Cost Review Commission ("HSCRC") show a huge spike in SAAC enrollees after the Freestate activity, rising from 3853 in 2000 to 5828 in 2001. In 1999 there were 3962 enrollees.

In this situation, no law compelled CFMI to require FreeState insureds to undergo medical underwriting. The entire "book of business" could have been transferred to the new company, BlueChoice. CareFirst viewed these sicker individuals as unprofitable, and stated it would not be fair for the BlueChoice members to cross-subsidize the "sicker" FreeState members. No documents, Board minutes or presentations suggest that the Board made any attempt to calculate the impact on these FreeState members, or, whether transferring the members to BlueChoice without underwriting would have had a material impact on the profitability of BlueChoice.

CareFirst broke no law in pursing this course of action. State law permitted separately licensed HMOs to withdraw from a market with proper notice. However, what 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.

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. This type of selective withdrawal from the individual health insurance market based solely on health status was the type of conduct which HIPAA, and our corresponding state laws were intended to prevent. While Maryland law contained a loophole that permitted this conduct, as noted above, it was immediately closed the following legislative session in legislation aimed specifically at CareFirst.[348]

This episode illustrated how the "profitability" of BlueChoice outweighed the significant negative consequences to thousands of FreeState enrollees who were nonrenewed. It is an action vastly at odds with the type of conduct the CEO's of the Pennsylvania BlueCross plans as their mission. Indeed, 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. This unfortunate incident was foreshadowed by those Board presentations in which management described CareFirst as "seeking profitable business" and "exiting unprofitable segments."

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[348] See House Bill 754, Acts of 2002; §§ 15-1308(g)(3) and 15-1308(h) - (j) of the Insurance Article.

B. SUMMARY OF KEY POINTS RELATING TO THE DECISION TO GROW THROUGH MERGER AND ACQUISTION.

Since the management of the company changed in 1993, it has been a continual goal of the company to expand.

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.

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.

Some of the most important goals of the business combination, as articulated by CareFirst management in support of the business combination between the D.C. and Maryland plans, have not yet been achieved and are behind schedule.

C. SUMMARY OF KEY POINTS RELATING TO THE STRATEGIC PLAN DEVELOPED BY ACCENTURE IN CONJUNCTION WITH MANAGEMENT AND ADOPTED BY THE BOARD THAT LED TO THE DECISION TO ENGAGE IN AN ACQUISITION:

Following the business combinations with D.C. and Delaware, CareFirst continued to consider expansion opportunities, and retained Andersen Consulting, now Accenture, through an RFP process to assist in its strategic planning.

The RFP issued by the Board in 1999 to obtain strategic assistance reveals that the basic strategic objective of the Company was largely agreed upon even before the Board engaged an expert. The RFP states that CareFirst's objective was to gain scale through regional mergers and acquisitions.

Accenture worked in conjunction with CareFirst management to develop strategic goals to present to the Board.

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.

Accenture, in conjunction with management, advised the Board that to remain competitive, CareFirst needed to be a much larger company with the following goals and characteristics: $8 - $11 Billion in annual revenues, membership of 4.2 to 6.1 million, underwriting margin of 1%-2%, market share of three times the next competitor, and surplus of $1.5 to $1.7 Billion.

Accenture advised the Board that achieving the strategic goals was more important to the Company than whether the Company was for-profit or nonprofit.

The Board adopted the Company goals and characteristics developed by Accenture and management as the strategic goals of CareFirst. These goals served as a basis for entering into the transaction with WellPoint.

D. Summary of key points relating to the mergers and acquisitions component of the strategic plan:

In 1999, Accenture emphasized to the Board the goal of "geographic dominance," which assumed that the higher the Company's relative market share, the better it would be able to perform. Accenture advised the Board that, while there were some advantages to "absolute scale," it was more important to achieve geographic dominance, or "relative scale." The Board was informed that "Absolute scale does not appear to generate any cost benefits." The Board was provided with advice that absolute scale did appear to correlate to better underwriting results.

CareFirst could not achieve the strategic goal of becoming a company with $8 to $11 billion in annual revenues, as identified by Accenture, without combining with another company

Of the $1.0 to $1.3 billion in capital Accenture estimated CareFirst would need for the period 1999 - 2003, $800 - $900 million was for mergers and acquisitions.

Accenture identified the need to make offensive and defensive acquisitions in CareFirst's market as a justification for the $800-$900 million dollar shortfall it identified.

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 significance component of the strategy identified by Accenture and management.

While there are potential benefits to mergers and acquisitions, data show there are potential risks of failure as well. Difficulties associated with mergers and acquisitions can have a negative effect on CareFirst's competitive position and undermine the strategic goal of maintaining high relative market share.

CareFirst documents acknowledge that Aetna's consolidation efforts in CareFirst's market created competitive difficulties for Aetna.

Two competitors of CareFirst that have large scale on a national basis, Aetna and Cigna, have both experienced negative results, and in Aetna's case, large scale has resulted in some contraction rather than expansion.

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.

The strategic goals relating to the desired size of CareFirst, a Company with $8 - $11 billion dollars per year in revenues, were developed based on CareFirst maintaining a

constant size in relation to other, national, rather than regional, companies operating in CareFirst's market, such as Aetna and United. Those two plans had less than one-third of the market in Maryland than CareFirst had in 2000 and 2001. Blackstone described this strategic goal of striving to be an $8 - $11 billion dollar a year company as arbitrary.

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.

CSFB generally validated Accenture's estimates for CareFirst's needed capital expenditures, and its analysis agreed with Accenture's in that the majority of the funds that were predicted as a shortfall related to spending by CareFirst for mergers and acquisitions.

CSFB did not believe that the amount of capital identified by Accenture as necessary for mergers and acquisitions was sufficient to make acquisitions outside the current CareFirst market.

WellPoint has made no decision or commitment to CareFirst regarding whether it would fund acquisitions either in CareFirst's current markets or contiguous to the current market.

E. SUMMARY OF KEY POINTS RELATING TO THE STRATEGIC GOAL THAT CAREFIRST MAINTAIN A RELATIVE MARKET SHARE OF AT LEAST THREE TIMES ITS NEAREST COMPETITOR:

The Board was presented with data showing that CareFirst's market share was shrinking and that the market share of certain competitors was growing. However, at all times relevant to the Proposed Transaction, CareFirst's market share was at least 2.7 times the market share of the nearest competitor, and in some markets and products, CareFirst's market share was higher. CareFirst's overall market share has increased since 1995.

CareFirst is the dominant health plan in Maryland with approximately, 43%- 46% of the overall market in 2001. In 2001 in central Maryland, CareFirst had 48.6% of the market. In the same year, MAMSI had 16% of the Maryland market and Aetna had 13%.

In the material provided to the Board showing changes in market share, one reason for the apparent increases in market share of some of CareFirst's competitors was that they had consolidated, so that the larger shares were the result of two smaller shares being combined.

The data provided by Accenture to the Board in support of the need to maintain a market share of at least 3 times the nearest competitor showed no appreciable difference in advantage between a market share of three times the nearest competitor and a share only two times that of the nearest competitor. CareFirst is in the range of 2 times to 3 times the market share of the next nearest competitor.

F. SUMMARY OF KEY POINTS RELATED TO THE CAPITAL EXPENDITURE NEEDS NOT RELATED TO MERGERS AND ACQUISITIONS:

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.

While Accenture claims that CareFirst has had to sequence capital investments because of inadequate capital, CareFirst acknowledges that for-profit companies must also sequence investments.

Even as a for-profit company, WellPoint does not have unlimited access to capital and must prioritize its capital spending.

Data show that for the period from January 1997 to June 30, 2002 public, for-profit companies did not access capital markets, *i.e.*, issue stock, in order to raise money for non-acquisition capital investments. These data show that typically these companies did access capital markets for acquisition purposes.

There is no evidence that WellPoint has indicated to CareFirst how much capital would be available to CareFirst after the acquisition, or what projects would be funded that are not currently funded. Leonard Schaeffer testified that decisions regarding CareFirst's capital spending after the acquisition have not been made.

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.

Based on data developed by Blackstone, the mean average annual spending for capital expenditures for comparable private nonprofit BlueCross/BlueShield plans was $66.4 million. CareFirst's annual capital expenditures for the years 2000 and 2001 was $63.0 million.

Based on data developed by Blackstone, CareFirst's annual capital expenditures for the years 1997 - 2001 were higher than the mean average annual capital expenditures for for-profit Blues plans, and for regional non-Blue plans.

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.

In November 2001, Accenture provided industry wide data to the CareFirst Board regarding the estimated capital spending for large health plans (, in excess of $500 Million in annual revenues) for the next three to five years. These figures going forward, for some categories such as new product development and IT infrastructure improvements, were significantly lower than the estimates made by Accenture for CareFirst in 1999. There is no evidence that the Board questioned why there was a dramatic change in the 1999

numbers and the 2001 numbers for comparable categories. CareFirst was spending within the ranges of several categories of spending identified by Accenture in 2001.

From 1996 to 1999 CareFirst spent $179 million on capital expenditures. For the years 2000 and 2001, the range of CapEx spending was $60 to $70 million per year.

In 2003, CareFirst presented to the MIA a document entitled "Unimplemented Capital Expenditures as of December 31, 2002. Many items on this list are in fact in the process of being implemented. In other cases, the projects are unimplemented because the Proposed Transaction caused management to delay implementation. Still others must await the completion of earlier projects.

As determined by Blackstone, taking into account CareFirst's debt capacity, Accenture may have understated the cash available to CareFirst for capital expenditures. The amount of the possible understatement ranges from $330 million to $528 million. Based on this understatement, CareFirst could cover all of its capital needs, excluding mergers and acquisitions, and have a contingency of $330 - $528 million.

CSFB, an advisor to CareFirst, estimated CareFirst's capital needs and provided this to the Board before the formal bidding began for the company. These estimates from CareFirst's own advisors were that if the projected needs for mergers and acquisitions were excluded, CareFirst would have sufficient capital to meet other needs, such as spending on e-commerce and information technology. Excluding acquisition spending, and including debt financing, CSFB estimated that CareFirst would have $306 - $446 million.

G. SUMMARY OF KEY POINTS RELATING TO WHETHER MORE EFFECTIVE MANAGEMENT OF THE COMPANY AND OVERSIGHT BY THE BOARD WOULD FURTHER IMPROVE THE FINANCES OF CAREFIRST, WHICH IN TURN WOULD LESSEN THE PERCEIVED SHORTFALL IN AVAILABLE CAPITAL FOR INVESTMENTS IN PRODUCTS, E-COMMERCE, AND INFORMATION TECHNOLOGY:

The financial performance of CFMI has been singled out by management as weaker than the performance of either the D.C. or Delaware plans.

CareFirst management asserts that CFMI is particularly vulnerable to the competitive pressures that the Board has cited in support of the transaction.

In press releases and testimony given in connection with this transaction, CareFirst management has attributed this weaker financial performance by CFMI to mandated benefits passed by the Maryland General Assembly, inadequate reimbursement from the federal and state governments in connection with Medicare and Medicaid, and inadequate rate approvals from the Maryland Insurance Administration.

CareFirst, has received subsidies from the State of Maryland in the form of a premium tax exemption, and also a hospital rate discount in return for offering an open enrollment product, the "Substantial, Available, and Affordable Coverage" ("SAAC") product.

The "net" value of these benefits to CareFirst for the years 1997 - 2001, after considering losses sustained in the SAAC program, Medicare, Medicaid, and the Senior Prescription Drug Program is estimated to be a total of approximately $130 million dollars. CFMI received the vast majority of these benefits.

A significant contributing factor to the performance of CFMI on a GAAP basis is the performance of the FreeState HMO, a subsidiary of CFS, which in turn is a subsidiary of CFMI.

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 request that oral agreements be reduced to writing.

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.

In 1998 - 2001, FreeState incurred an additional $12.6 million in losses due to the bankruptcy and discontinuation of other provider groups with whom FreeState contracted.

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.

In 1999, CFMI wrote off $22.1 million in software development costs due to a failed claims system development project.

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.

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 CFI'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.

While recent performance of CFMI has been weaker than the D.C., or Delaware plans, CareFirst management has described CareFirst as viable and said the need for conversion in based on competitive forces that may impact CareFirst in the long term.

CareFirst will remain a viable successful health plan in the next two to five years without engaging in an acquisition.

CareFirst's efforts to integrate the systems and networks of the Delaware, D.C. and Maryland plans is behind schedule and has not yet achieved the results predicted by management when the business combinations were proposed in 1997. There are still multiple provider networks and multiple claims systems in operation, and management predicts tens of millions of dollars will need to be spent over the next several years to complete the process.

H. SUMMARY OF KEY POINTS RELATING TO THE BOARD'S DECISION TO CONSIDER A BUSINESS COMBINATION WITH A FOR-PROFIT COMPANY AND THUS ABANDONING CAREFIRST'S NONPROFIT STATUS:

The Articles of Incorporation of CareFirst of Maryland, Inc. provide that it is a mission of the company to contract with health care providers to provide medical services to CareFirst insureds at "minimum cost and expense."

CareFirst has historically viewed itself as the insurer of last resort.

The Board, after extensive consideration by the Strategic Planning Committee, adopted the strategic goals recommended by Accenture.

Continuation of the "*status quo*" as a regional nonprofit health service plan was not considered a viable option by management, the Board, or its advisors in the process, even though it continued to be presented ostensibly as an option in materials provided to the Board.

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.

Even before the formal process of selecting possible merger partners began in February 2001, Trigon, a for-profit company, was identified as a possible merger candidate. Discussions were held with Trigon as early as 1998.

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.

The CareFirst RFP 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.

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 as articulated in its Articles of Incorporation: to provide health care services at "minimum cost and expense" to its insured.

The Board did not consider that that the mission of the company as set out in the Article 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.

While the strategic plan was being considered, CareFirst's management conveyed to the Board that CareFirst's business focus would change to become more profit-oriented. The Board did not object to this focus as articulated by management.

The Board and management testified that there was little distinction between a nonprofit and for-profit health plan.

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 characteristic and corporate goals and mission of a for-profit company.

The Board did not question the action by management to abandon the corporate mission and took no action to prevent it.

Other regional nonprofit BlueCross/ BlueShield plans have succeeded financially and accumulated strong surplus levels and also continued to pursue a "public benefit mission" of serving vulnerable populations of insureds and subsidizing products to increase affordability.

The Board took no action to determine how other nonprofit plans were able to continue as financially strong nonprofits while pursuing a public benefit mission when CareFirst management was abandoning its mission to provide insurance at least cost and expense.

While there are similarities between the manner in which for-profit and nonprofit companies are operated, their goals and mission are different. Publicly held health plans have a paramount duty to achieve long term profitability for shareholders. The obligation to shareholders means that certain activities associated with nonprofit plans, such as the subsidization of products to serve underserved populations, are inconsistent with the duty to shareholders.

1. Conclusions

It is clear from these findings that the Board failed to exercise due diligence in deciding to engage in an acquisition. While it is true, as CareFirst argues and as Mr. Angoff agreed, that the Board followed an elaborate strategic planning process prior to the retention of an investment banker to assist in finding a strategic partner, on a superficial level, it appears that the Board was deliberative in its decision, and sought the advice of experts, including lawyers, consultants, and investment bankers. However, the process used by the Board was based on faulty assumptions which in turn meant that however "diligent" the board was in following that process the result would not satisfy the applicable legal standards. The failure by the board in exercising due diligence, which we earlier described as whether it discharged its fiduciary duties in its decision making, was not just in its faulty premises. The record shows that the Board has misapprehended, or simply ignored, its overriding responsibility to the mission of the company and its insureds. The record also shows that the Board failed to seek and consider material information relevant to the decision to convert, information which an ordinarily prudent person would have sought and considered under the same circumstances, and which would likely have caused a prudent Board to reconsider the decision to convert.

First, the facts clearly show that this current attempt by CareFirst to expand is the latest in its long-term and ongoing effort to achieve larger scale that began in 1995. Already CFMI had combined with Delaware and D.C. to create a much larger combined entity. Mr. Jews testified that it had long been his goal to expand. Given that Accenture worked with management to develop its strategy, and in light of the testimony from Mr. Jews, as well as the prior efforts to take FreeState public and the other combinations that were achieved, there was little doubt that whoever was selected as the strategic advisor, the strategic plan produced in the process would recommend significant growth for the company. This conclusion is only bolstered by the fact that the RFP to solicit outside advisors prepared by management already had identified mergers and acquisitions as the desired strategic direction for the company. Because there were consolidations occurring in the industry at the time the plan was being developed, it was not difficult to support with industry data what now seems like a pre-determined plan. While the evidence shows that the result of the process appears to have been largely predetermined, at least from management's perspective, this alone does not render the process flawed. It simply casts doubt on the claims by CareFirst that the process led to the decision. As will be discussed later, there are other examples of instances in which it appears that the "process" was used to justify a decision rather than the process being used to produce a decision.

An early mistake relevant to the Board's due diligence in connection with the decision to convert was its failure to determine whether the stated objectives of the most recent business combinations with D.C. and Delaware were being achieved. This should have been not just a reasonable question, but an obvious one, because pursuing another business combination would constitute the third merger effort in four years for CareFirst, the first being the Maryland and D.C. combination, the second being the Delaware transaction. It would have been reasonable to question whether additional integration issues with yet another business partner could complicate or frustrate current integration efforts underway from the prior transactions. It would also have been reasonable to assess the potential benefits and costs of a new transaction in the light of those that had already occurred. It would have been relevant and material for the Board to know, in evaluating future business combinations, whether prior business combinations had not been successful in achieving their stated goals.

The importance of asking such questions can be seen in the testimony elicited from CareFirst management in hearings and depositions held in connection with the MIA's review. This testimony established that the broad goals of "seamless provider networks" and consolidated claims systems largely had not been achieved, even as of early 2003. Claims are still processed on multiple systems, and claims system integration is behind schedule. Only recently have the goals of a single regional provider network begun to be achieved, five years after the first merger, and only with respect to the BlueChoice HMO.[349] Remarkably, the Chairman of the Board believed that the integration was largely complete,[350] a belief fostered by CareFirst management.

[349] While management blamed this delay on the negotiations between D.C. and Maryland regulators over the ownership allocation of BlueChoice, this is not the case. The fact is that the development of provider networks is unrelated to the ownership issue. The Company had been licensed in both jurisdictions and the ownership issue did not prohibit the development of any networks. In fact, the evidence shows that some of the delays were simply an inability by CareFirst to induce physicians to move to the new, regional network. This is yet another example of management blaming other parties for their shortcomings. CareFirst management testified that tens of millions of dollars still remain to be spent to achieve these goals.

[350] Testimony of Daniel Altobello, January 31, 2003, at 61 – 63.

When asked to quantify the saving from the prior integrations, Mr. Jews could not do so.[351] While CareFirst claims that it has lowered its administrative expenses since the business combinations, it is not clear there is a cause and effect relationship between the two events, and the inability to pinpoint the savings achieved would undercut the claim that the reduction was due to the integration.

It would not have been a difficult task for the Board to ascertain whether the integration plans are complete. It requires no special or advanced technical skills. An ordinarily prudent Board member can perform the inquiry. It involves simple and direct questions on the status of integration efforts, such as those questions asked at the public hearings, followed by the formation of independent opinions, rather than reliance on management representations. The Board has failed to exercise sufficient oversight over management to understand what was to be achieved from the integrations of the D.C., Maryland and Delaware plans, and whether it had in fact been achieved. Notwithstanding the Chairman of the Board's belief that the efforts were largely complete, management of CareFirst testified that tens of millions of dollars, perhaps as much as $30 to $50 Million are still to be spent over several years before the plans can be integrated.[352] An ordinarily prudent Board member would have informed himself of these facts prior to deciding whether or not to engage in another business combination such as being acquired.

In this vein it is also evident that, in discussing the strategic options for CareFirst, the Board focused on the supposed benefit of expanding through mergers and acquisitions without considering the potential drawback that could impact its service to its insureds. In addition to discounting CareFirst's own experience at integration and the difficulties it entails, the Board did not look to generally available information regarding the risks attendant to combining companies. Both Blackstone and Mr. Angoff cited studies and literature documenting the risks associated with mergers. Often these transactions fail to achieve the desired results.

The fact that the CareFirst experts did not explore these drawbacks with the Board bolsters the view that the decision to pursue a strategy of mergers and acquisitions had already been made in the minds of management and key board members. The failure to consider risks of integration and the status of current integration efforts and risks posed by compounding those efforts with a new Acquiror is failure in the Board's diligence. Taken alone, however, these failures might not necessarily lead to the conclusion that the Board breached its fiduciary duties in a material way.

However, a much more significant and material flaw in the Board's due diligence is the Board's apparent disregard for the corporate mission of the Company as set forth in the Articles of Incorporation - to provide coverage at minimum cost and expense. The status of the Company's focus on mission came to the Board's attention at least as early as 1999, when, at a meeting of the Board, management unilaterally announced that CareFirst was becoming more profit oriented. Nothing in the Board minutes or other material suggests that the Board was concerned by this new direction or questioned its appropriateness. The documents from the Board and other historical material clearly show that this was in fact a new philosophy and change in direction for the Company. The Board's failure to appreciate the Company's mission, and its duty of care and loyalty relative to that mission, are apparent even before the specifics of a possible conversion began to materialize.

[351] Testimony of William L. Jews, March 13, 2002, at 355 – 357.

[352] Deposition of G. Mark Chaney, January 13, 2003, at 46 - 47.

As management took actions to implement the new philosophy after the proclamation to the Board, actions such as withdrawals from Medicare and Medicaid, the weight of the evidence is that the Board did not question these actions *in light of the corporate mission*. It took at face value that these actions were necessary, without weighing the consequence of its actions against its nonprofit mission and the fact that at the time the Company was also receiving tens of millions of dollars in tax subsidies.

There are other examples of instances in which the Board condoned operational decisions by management that negatively impacted current subscribers and ran contrary to the corporate mission. 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%. Some new applicants would have been forced to pay rates over 300% of the rates current subscribers were paying.[353] Such huge increases would have impaired the ability of these insureds to afford their coverage. While CareFirst claimed it was losing money on these policies, the MIA denied the increase on the grounds that the underwriting losses on the policies must be weighed against tens of millions of dollars in hospital rate discounts the company received as a quid pro quo for offering the SAAC policies. When factoring in the value of the discounts, the SAAC policies were a net benefit, not a net loss, to the company. The MIA and the HSCRC communicated to CareFirst that this approach to calculating losses was not correct and denied the increases. CareFirst persisted in its view and requested an administrative hearing. The MIA then ruled against CareFirst in an administrative hearing. Undeterred, CareFirst litigated the issue in court. Although a circuit court sided with CareFirst, the Maryland Court of Special Appeals rejected CareFirst's view and agreed with the MIA and the HSCRC, ruling that it was appropriate to consider the level of hospital discounts CareFirst received against the much smaller level of underwriting losses incurred by the SAAC policies. However, prior to the decision by the Court of Special Appeals, CareFirst again sought to impose large increases in subsequent filings in 2002. These filings sought a 180% increase for some current insureds, and rates for new insureds that would have been 250% more than certain current insureds. The MIA approved increases ranging from 0% to 25%.[354]

CareFirst certainly has a right to litigate decisions to which it objected and indeed may have a responsibility to do so if it would further the interests and mission of the company. What is notable here is CareFirst fought mightily to impose massive rate increases on a vulnerable population of insureds, while at the same time receiving huge benefits from the State designed to allow the Company to subsidize these very products and cover any underwriting losses the Company might have incurred. In essence CareFirst sought to have its cake and eat it too by charging the full rates to cover high-risk individuals and at the same time benefit from the millions of dollars in hospital rate discounts. As in other cases, there is little evidence that the Board questioned these actions or considered whether they ran contrary to the corporate mission.

Even when certain actions taken by CareFirst made newspaper headlines, an event which would cause an ordinarily prudent Board at least to evaluate independently the appropriateness of the events at issue, the Board was resolute in its inaction. For example, when the events surrounding the FreeState withdrawal led to the rather damning headline "Insurer Said To Put Profits Over Patients", the Board never wavered nor sought advice on the appropriateness of the conduct. In fact, the Board Chairman defended the conduct, and the Board clearly condoned this new direction. When management raised the prospect that participation in the SAAC program, a

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[353] Maryland Insurance Commissioner v. CareFirst of Maryland, Inc., Case No. MIA-265-5/01, at 11-13.

[354] See Letter from Steven B. Larsen, Commissioner, to William L. Jews, dated December 3, 2002.

program to assist high risk individuals in obtaining insurance, would need to be reconsidered because of mounting "losses", the Board seemed to accept at face value management's claim that the SAAC program was "losing" money, the same argument that led to the attempt to raise rates described above.

There are additional examples of warning signs that CareFirst was straying from its mission that were ignored by the Board. While CareFirst was in the midst of the strategic planning process, the General Assembly passed legislation requiring CareFirst to account for its premium tax exemption by showing it spent the money on a "public purpose". CareFirst receives a tax exemption on premiums it collects because of its nonprofit status; for-profit insurers are subject to a 2% tax on premiums collected. This law was a clear attempt by the General Assembly to bring some level of accountability to CareFirst's profit-oriented actions in light of its tax exemption, as evidenced by the statute's title, "The Nonprofit Health Entity Accountability Act."[355] As before, this signal of dissatisfaction from the State's elected officials regarding the disposition of the premium tax exemption did not deter the Board nor cause them to reevaluate the for-profit orientation adopted by the company. An ordinarily prudent board would have inquired both as to the basis for the General Assembly's need to bring "accountability" to the Company, and as to the legality of management's change of focus and mission.

Yet another example of the Board unreasonably turning a blind eye to public concern over CareFirst's for-profit focus can be seen in the testimony of the Board Chairman, Daniel Altobello, during the public hearings on the transaction. In the course of the MIA's review it came to light that CareFirst management informed the Board during a Board meeting in October, 2001 that the legislature was considering a proposal to modify the composition of the CareFirst Board because of concerns over CareFirst's operations.[356] Remarkably, even in the face of possible legislative action to change the governance of the organization, something that had not been considered since the aftermath of the Senate Report on the Maryland Plan in the early 1990's, neither the Board Chairman nor any member of the Board sought to meet with legislators to ascertain the nature of their concerns. Rather, the management team was dispatched to deal with the issue, the same team whose actions had generated the concern to begin with.[357]

This nonchalance by the Board in the face of a proposal that could threaten its own structure and membership suggests a total lack of direct engagement on issues of importance to the Corporation. By delegating to management all efforts to respond to what a reasonable Board would have viewed as a critical response to management's policies, the Board also demonstrated a lack of independence from management. This is precisely the problem identified by the O'Donnell v. Sardegna case.

This Board had a duty to ensure that management was acting in a manner consistent with the Articles of Incorporation of the Company, and the Board failed to perform this duty in at least three ways. First, the Board seemed unaware of the basic fact that there was a nonprofit purpose of the organization to provide insurance at minimum cost and expense. The Board Chairman said the Board did not really consider CareFirst a nonprofit, and in thousand of pages of Board minutes and presentations that were reviewed, *there was not a single reference to the mission as articulated in the Articles of Incorporation*. As noted earlier, the Board has a duty to further the interests and purposes of the organization, and it failed to do so, instead permitting management to stray from the corporate mission.

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[355] 2001 Acts of the General Assembly, Chapter 178.
[356] Exhibit 235, October 25, 2001, Board Minutes at 3.
[357] Testimony of Daniel Altobello, January 31, 2003, at 40 – 43.

Second, whether or not the Board was aware of the mission of the company, the Board then ignored obvious signs that should have led it to question whether the actions of management were consistent with the mission. Regulatory agencies with jurisdiction over the Company, and elected officials, all expressed concern over the direction of the Company through the passage of legislation and regulatory actions. While the Board presumably could have continued to conclude, incorrectly, that there was in fact no improper change in mission notwithstanding these expressions of concern, a reasonably prudent Board would at least have inquired as to why the executive and legislative branches of government had concerns. Such an inquiry could have led to enlightenment on the Board's part.

These failures related directly to the Board's due diligence in the Proposed Transaction because the Board's apparent disregard for, or ignorance of, the corporate mission led to its failure to view the mission as an item for consideration in weighing the pros and cons of a particular course of action or corporate form. In other words, the fact that the Board, in its consideration of strategic alternative merger partners, gave little or no consideration to the significance of abandoning its mission results from the fact that it had already condoned the pursuit of a for-profit approach, and thus did not view the change of mission as a matter of significance. At the point in which the company was considering its options in late 2000 and 2001, the change in mission was a *fait accomplis*. This flawed assumption tainted the entire diligence the Board performed in considering strategic options.

The Board's diligence in deciding to engage in an acquisition was also flawed because it failed to consider how state or federal antitrust laws would frustrate one of the basic foundations of the growth plan: to achieve geographic dominance. While this priority seemed to fade, as a deal with WellPoint became the reality, as described below, it was a major thrust of the case made by Accenture. Accenture advised the Board that it was market share dominance that produced the biggest returns to the Company. CareFirst must have capital to make offensive and defensive acquisitions if a larger national player sought to increase its market share in the region through acquisitions, the Board was told. However, as Mr. Angoff concluded, because CareFirst was already so dominant, such actions were likely to run into antitrust problems. The Board did not consider this rather significant flaw in the premise of its plan.

As noted earlier, the bulk of the capital expenditure need estimated by Accenture, management, and CSFB all related to the merger and acquisition component. If this component is stripped out of the equation, both CSFB and Blackstone concluded that CareFirst could fund its other capital needs and have a surplus for contingencies and price wars. While the Blackstone report was not available to the Board, the CSFB analysis was available to them. This is significant because CSFB's report cast 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.

The large spending needs in the strategic plan attributed to mergers and acquisitions seems to create a certain circularity to the whole strategic plan. The premise of the plan is that CareFirst needs to grow. Why does it need to grow? To access capital. Why does it need to access capital? To grow. In other words, the need to grow is the basis for the need for capital, and the need for capital is primarily driven by the need for growth. When, as here, each is largely dependent on the other, if the need for capital is extinguished, so is the need to grow.

To the extent that CareFirst argues that it is not just regional growth that is important, but absolute growth, the data presented to the Board as it considered its options discounted this as a compelling reason. Data prepared by Blackstone and others also casts significant doubt on the proposition that bigger is necessarily better, or bigger is more efficient. The experiences of Aetna and Cigna, two national companies the misadventures of which were known to management and the Board, are prime examples of this fact.

Other sources confirm that absolute size does not necessarily correlate with success. As the article in HEALTH AFFAIRS cited earlier noted, size alone is not as important factor in strong financial performance, as is strong management:

> Notwithstanding the advantages of scale and investor ownership, many of the most successful Blues plans in recent years have been nonprofits or mutuals operating in just one state. Plans that enjoyed double-digit annual growth in either revenues or membership in 1999 or 2000 include Florida, Massachusetts, Michigan, Georgia (before acquisition by WellPoint), South Carolina, and New Jersey, as well as the multi-state or for-profit companies of WellPoint, CareFirst, RightChoice, and Trigon."[358]

The Blackstone report evaluating the "Business Case for Change" tendered by CareFirst confirms what CSFB also believed, that non-merger related capital needs can be satisfied without resorting to a deal with WellPoint or anyone else. By recasting Accenture's calculations with more realistic assumptions and also through reference to public information regarding spending by CareFirst competitors, Blackstone makes a compelling case that all of CareFirst's non-merger spending needs could be satisfied, with some to spare for contingencies. While the Blackstone report itself was not available to the Board, it was based on publicly available data on capital expenditures by both nonprofit and for-profit companies.

Further evidence of CareFirst's ability to deploy capital on projects unrelated to mergers and acquisitions can be seen in numerous materials presented to the Board and to at least one rating agency outside the context of the conversion. In materials distributed at regularly scheduled Board meetings, management describes its efforts to implement such things as e-commerce strategies in positive, optimistic terms, with no indication that spending is constrained or inadequate. Similar representations were made to the rating agency Standard & Poor's. The clear impression given is one that satisfactory progress is being made in HIPAA compliance, e-commerce, and information technology. However, when the subject of capital expenditures is discussed in the context of a possible conversion, the prior optimism is lost and the unmet needs are great.

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. CareFirst's own advisors' data revealed that CareFirst could fund its non-merger spending needs. This undercuts any claims by management that CareFirst could not keep up with its competitors in terms of spending on technology or new products. This should have raised the Board's concerns over the credibility of the information being given to them by proponents of a merger. In light of the CSFB data, the entire case for a

[358] See Robert Cunningham, Douglass B. Sherlock, Bounceback: Blues Thrive as Markets Cool Toward HMOs, HEALTH AFFAIRS, Jan/Feb. 2002, Vol. 21, No. 1.

conversion or acquisition rested on the need to merge, acquire or be acquired. Yet on this issue the benefits of larger scale generally were not compelling. The risks were not considered. The benefits of in-market growth could very possibly not have been achievable because CareFirst was so dominant to begin with. And as we see from the proposed deal with WellPoint, to the extent that contiguous growth was the next most compelling reason to engage in an acquisition, that rationale was discarded given that WellPoint is located in California.

As a final point bearing on the issue of whether CareFirst needs to convert and gain access to more capital to meet its need, the testimony obtained during the public hearings revealed that, in fact, WellPoint has made no commitments regarding the amount of capital that CareFirst could access, or for what initiatives. Mr. Schaeffer testified that those decisions had not been made. No guarantees or commitments have been given. Furthermore, the testimony from other WellPoint representatives showed that difficult decisions regarding the allocation of capital at WellPoint are part of a process, and that requests for capital must be supported and considered in light of other competing requests. Even CareFirst acknowledged an understanding that for-profit companies do not have unlimited access to capital and must prioritize spending just as CareFirst does.

Therefore, to the extent that this deal is premised on the need for "access to capital", which is the rationale asserted by management, the fact is that at this point it is completely speculative to suggest the extent, if any, to which the supposed need will be filled. Indeed, CareFirst may be spending proportionately more for capital investments each year than its proposed for-profit partner.

One final area where the Board failed to discharge its duty of care is that of the financial oversight of the company. As Mr. Angoff pointed out in his analysis of the compensation provided to CareFirst management, the Board set goals for annual incentive payments for management that were modest and not difficult to attain, and granted bonuses that were large and generous. The Chair of the Board repeatedly expressed his belief in the excellence of the management team. He believed that the merger incentives were an appropriate reward for the growth the team brought to CareFirst. He called it a success fee. He is correct that the company has grown and apparently prospered under the current management team compared to where it was in 1993 and earlier. However, as outlined above there have been some rather significant failures that are only attributable to management decisions, which the Board seems to overlook in its assessment of their efficacy.

Tens of millions of dollars flow out the door due to undocumented agreements to subsidize the losses of certain provider groups. These losses were not part of any effort to provide less expensive care as part of a social mission, but rather are simply drains on the finances of the Company. Management pursued a delivery system for the FreeState HMO that collapsed, costing additional millions. Losses in the nonrisk market in 2001 exceeded those incurred in either Medicare or Medicaid in any given year. A failed computer project resulted in tens of millions more in losses.

Viewed in isolation from all the facts, the performance of the Company has been positive. But viewed in a more complete light, 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 Compensation Committee minutes and Board materials. Yet these losses, if turned around, further bolster the view that the need to access capital, already discredited as a basis for the transaction, is even less than predicted.

I. Did CareFirst exercise due diligence in selecting the transferee and negotiating the terms and conditions of the acquisition?

1. Factors used by the Board to select a transferee

There has been extensive testimony relating to the factors that CareFirst weighed in negotiating a definitive agreement with WellPoint. The relative importance of these criteria seem to shift somewhat, depending on the context in which each of the factors is being discussed. This section analyzes those factors that CareFirst testimony indicated were important not only in terms of whether the factor was appropriate, but also whether the conclusions articulated by the Board regarding the superior offer on that factor were reasonable.

The filing with the MIA identifies the key criteria which served as the basis for the ultimate selection of WellPoint over Trigon:

> "The Boards also believed that the WellPoint proposal was superior to the Trigon proposal for the following reasons: (1) the Trigon proposal would have resulted in substantial layoffs of the CareFirst workforce because of the relatively small size of Trigon, vis-à-vis CareFirst, whereas WellPoint, because of its significantly larger size and the structure of the organization it proposed, did not pose that threat;[359] (2) Trigon proposed a management structure whereby there would be essentially dual CEOs, which the Board believed was unworkable and would have resulted in confusion in leadership and a lack of unified direction; (3) Trigon had proposed to move the headquarters of the public company from Richmond to Maryland, but the proposal was later withdrawn with an explicit requirement that headquarters would remain at Trigon's headquarters in Richmond, Virginia; (4) Trigon had no significant experience in integrating companies it purchased, whereas WellPoint had significant positive experience in that regard and a very strong track record of improving performance in companies it acquired; (5) Trigon required that should its stock fall below a certain price, both it and CareFirst would share in the decline creating the potential that the foundations would not receive the full value of the purchase price to benefit the communities, while the purchase price of the WellPoint proposal was guaranteed; and (6) the Trigon proposal permitted termination by Trigon after 18 months if the transaction had not been completed, while the WellPoint proposal was committed for three years."[360]

Other testimony shed light on the factors the Board considered important. The Board considered price "absolutely crucial" but "not solely determinative."[361] Besides price, the "other crucial element" was the Boards' commitment not to approve a proposed transaction if it had an

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[359] Trigon did promise that layoffs would not occur, but the Boards did not believe that the Trigon transaction was feasible without layoffs.

[360] Id. at 7; CF-0012315 - CF-0012316, accord Pre-filed written testimony of Daniel J. Altobello, March 6, 2002, at 8-9.

[361] Altobello pre-filed at CF-0012312 - 0012313.

adverse impact on the companies' associates or its customers.[362] As Mr. Altobello characterized the issue, "Most importantly, during the course of negotiations, a question arose regarding employment benefits of CareFirst associates and how they compare to WellPoint associates."[363] (Emphasis added.) Associate interests seemed to weigh equally with price maximization in negotiations.[364] CSFB was instructed that in negotiating a deal, the foundation, the citizens, and the associates who worked for the Company were important constituents, and CSFB was instructed to give maximizing price a lower priority than is usually the case in the sale of a for-profit company (*i.e.*, the interests of associates were given more weight by CareFirst than is usually the case with the sale of a for-profit company).[365]

With respect to the price in particular, CareFirst had three goals for the merger: (1) getting the highest possible price for the company; (2) price certainty; and (3) liquidity.[366] Other negotiating considerations related to price included down-side protection (*i.e.*, preserving value until closing), a fiduciary out, and the size of a break-up fee (Trigon wanted a break-up fee of 5%, whereas WellPoint got down to 2.9%).[367] Important non-price "social issues" included the location of the headquarters, board representation, job protection/benefits, and the management structure including Mr. Jews' role in the combined company.[368] Another criterion included CareFirst's perception of the willingness of the prospective purchaser to stay through the regulatory process.[369]

2. Analysis of the Auction

As discussed above, the obligations of the Board in this case are not necessarily guided by the Revlon Rule per se, but rather by the requirement that the Foundation receive "fair value" for the public assets of CareFirst. While it can be argued that the statutory requirement does not place a direct obligation on the Board and is rather a standard to guide the regulator, the conversion also requires the regulator to evaluate whether the Board exercised due diligence in negotiating the terms and conditions of the acquisition.[370] Given that consideration for the sale is clearly a term and condition of the sale, it is clear that the statute imposes a duty to achieve fair value by the Board, and the regulator's role is to ensure that this has, in fact, occurred.

A substantial amount of questioning in the depositions and public hearings related to the "auction" conducted for CareFirst between WellPoint and Trigon, the only two bidders invited to participate in the auction. Mr. Stuart Smith, of CSFB, testified many times that the auction was designed to, and in fact did, achieve the highest price for CareFirst (see *i.e.*, pre-filed rebuttal testimony of CSFB). He also felt strongly that part of the negotiation process was to ensure that the price could be maintained over the course of the regulatory proceedings.[371] If there was a stock component to the transaction, and the bidding company's stock price dropped, then that could affect the purchase price paid. As a consequence, Stuart Smith felt that the "downside protection" was an important part of the price negotiations.[372]

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362 Id. at CF-0012313.
363 Id. at CF-0012315.
364 Deposition of Stuart Smith, November 22, 2002, at 62:4 - 14, 71:5-16, 74:3-15, 88:4 - 89:8.
365 Id. at 53:1 - 56:20.
366 Testimony of R. W. Smith, Jr., March 14, 2002, at 108 – 109.
367 Deposition of Stuart F. Smith, November 22, 2002, at 112 - 114.
368 Id. at 282.
369 Testimony of Daniel T. Altobello, March 11, at 263 - 265.
370 MD. CODE ANN., STATE GOV'T § 6.5-301(e)(1).
371 Deposition of Timothy P. Nolan, August 19, 2002, at 60 - 61.
372 Deposition of Stuart F. Smith, November 22, 2002, at 71 - 73.

a. CareFirst emphasized the importance of Boards seats, which may have affected the purchase price

With this in mind, an examination of the bidding process itself is in order to determine how the process negotiations occurred. First, as discussed below, at least in the beginning of the strategic planning process, the Board considered as quite important the level of "control" CareFirst would have in the successor organization. It asked Accenture to outline a measure of control. Before the formal bid solicitations went out, discussions were held with both Trigon and WellPoint. Trigon initially offered CareFirst three seats on its board. Tim Nolan testified that in fact it was communicated to him that board seats were more important than price,[373] which is consistent with the emphasis on "control" the Board had expressed. Notably, a this point in time, Trigon had also been ranked as the best partner for CareFirst by CSFB. If Trigon were viewed as the "preferred partner" at this time, it is logical that CareFirst would have sought to maximize a deal term it viewed as important with the bidder it may have viewed as the ultimate winner. The fact that Trigon's formal bid in February did in fact reflect an increase of two seats, from three to five, certainly validates the notion, that at a minimum, CareFirst was pushing for more board seats. CareFirst has strongly denied that it ever suggested it would trade board seats for price, and while it may have emphasized seats over price, it cannot be concluded with certainty that an actual "trade" occurred in which Trigon's price was reduced a certain dollar amount based on a given number of board seats.

However, as was discussed above, 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, leading to what Mr. Jews predicted as a possible cut of up to a third of CareFirst's work force. But, the evidence suggests that factors relating to Mr. Jews' personal relationship with Mr. Snead and his perception of Trigon's credibility are more likely to have been the cause of the lack of preference that some of the reasons articulated, especially in light of the fact that Mr. Jews' own staff had come to different conclusions on the issue. To cast further doubt on the credibility of the publicly stated reasons for Trigon's disfavor is that fact that latter in the bidding process, after April, Trigon was suddenly placed back on the radar screed, and little attention was paid to what in April was a fatal disability. As discussed below, when, once again, Trigon was out of favor and WellPoint was back in favor, the jobs issue was resurrected as a key reason why Trigon was not selected.

b. The Auction did not produce the highest price, but seemed designed to end in a tie

During the period February to April 2001, WellPoint, whose bid was initially $1.2 to Trigon's $1.3 billion, was told its bid was "not competitive."[374] Conversely, the testimony shows that similar instructions were never given to Trigon in the sense that Trigon was never asked or directed to increase its purchase price. While there was extensive testimony relating to the idea that Trigon had every "opportunity" to increase its purchase price,[375] CareFirst management testified that Trigon was not asked to do so. This was corroborated by Mr. Nolan

[373] Deposition of Timothy P. Nolan, August 19, 2002, at 46.
[374] Deposition of Stuart F. Smith, October 22, 2002, at 104.
[375] Testimony of Stuart F. Smith, March 13, 2002, at 548; Deposition of Stuart F. Smith, November 22, 2002, at 165; Deposition of William L. Jews, September 6, 2002, at 41 – 43.

of Trigon, who also testified it was not asked to pay more. He went further and testified that Trigon was indeed willing to pay more.[376]

While it is in fact true that Trigon had every "opportunity" to increase its bid, it is not clear why a bidder would voluntary bid against itself unless it were told its bid was not competitive. It would seem WellPoint and Trigon have to balance their desire to present the best bid so as to prevail with every bidder's desire to not overpay if the same result can be achieved with fewer dollars. These types of "auctions" for companies are interactive processes in which numerous discussions are held with investment bankers, lawyers and management of the companies involved. Because of the flow of communication occurring between the bidders and CareFirst, it would be unreasonable to expect Trigon to put more money on the table if it had no reason to believe it needed to. This is especially so given the fact that in the course of these ongoing communications guidance was provided in other areas such as the desire for board seats.

With all this in mind, it is clear from the record that the auction was not a true auction, at least for the price component in the following sense. The two bidders were not pitched against each other in an effort to extract from each the highest price each was willing to pay. Indeed notes obtained from a banker who worked at CSFB and assisted in the deal, asked, "If this was an auction, how do we go about not choosing highest bidder?"[377] Certainly the testimonial evidence supports the conclusion that Trigon was not "pushed" on price. 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, as discussed below. A tie on the amount of consideration also made easier the balancing of other price components, such that the scenario described above with different prices and different measures of downside protection was avoided. While all of the evidence supports this conclusion, 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 bids made comparison of nonprice issues easier. [378] The problem with this approach is that if, as Trigon testified, Trigon were willing to pay $1.5 Billion, then it could very well be the case a reasonable board would find this bid superior, even with lesser downside protection. The board's process foreclosed this option.

c. CareFirst was relying on the regulatory process to set the price

Further evidence that the auction process was flawed is found in the testimony of Mr. Jews who testified that in fact CareFirst was relying on the "regulatory" process to ultimately set the fair value of the company.[379] He in fact cautioned Trigon that it would need to have the staying power financially to meet whatever increases would result from the regulatory process.[380]

Although it is true that under the conversion law the regulator must ensure that the fair value of the public assets must be obtained, this does not translate into a reasonable reliance by CareFirst for the regulator to "set" the price. The method employed by the regulator is that which was employed by the MIA: the retention of an expert to estimate the value using a

[376] Deposition of Thomas G. Snead, Jr., August 19, 2002, at 60 - 61.
[377] CFSB-0020128, Michael Muntner hand written Project Chesapeake work note entry for April 12, 2001, produced by CSFB on December 31, 2002 in a black binder labeled CSFB 19601 - 20346.
[378] Deposition of David D. Wolf, September 19, 2002, at 146 – 147.
[379] Deposition of William L. Jews, September 6, 2002, at 163 - 171.
[380] Id. at 44.

combination of commonly accepted valuation methods. These methods produce a wide range of values which involve formulas and the judgments and expertise of the bankers involved. This can be seen from the draft and final valuation reports from Blackstone.

The purpose of the regulatory review is not primarily to set the price, but rather "ensure" the price has been achieved. If, for example, there were only one bidder and therefore no possibility of a meaningful auction, the regulatory valuation would be an important check to ensure the company had not sold itself at too low a price. In an auction situation, theoretically the competing efforts of two well capitalized bidders seeking ownership of a strategically valuable asset such as CareFirst, could produce a higher price than what might result from the formulaic calculations performed by Blackstone. While investment bankers attempt to capture nuances in their valuations, such as adding in factors such as control premiums and the value of synergies, none of these techniques can fully substitute for the particular dynamic which may be at play in a given transaction. To the extent both Trigon and WellPoint attributed particular strategic advantage to owning CareFirst, this could mean one or both were willing to pay a premium over the prices the valuation formulas might derive. The formulas and assumptions used by the bankers in applying them cannot capture the value of such considerations as strategic value, since such considerations may be closely guarded, or hard to quantify. In such a case the Blackstone valuations may certainly be valid as far as they go, and in fact may be the best and only tool to ensure "fair value" in some cases, but they are not necessarily a comparable substitute for a vigorous auction.

Anthem's subsequent purchase of Trigon illustrates these ideas. Anthem's purchase of Trigon could certainly have been driven by the strategic objective of obtaining a foothold in the mid-Atlantic region in light of the fact that the other consolidator, WellPoint, announced it had signed a deal with one of the two major mid-Atlantic Blues plan, CareFirst. Analysts noted the affect this competition can have on the purchase price of Blues plans:

> Gregory Crawford, an analyst for Fox-Pitt, Kelton, agreed, "When you have two large BlueCross Blue Shield plans attempting to consolidate the market, they will bid against each other," which would "most definitely" increase the value of Blues franchises.

VA Deal Fuels Doubt About CareFirst Sale, THE BALTIMORE SUN, April 30, 2002.

This illustrates how reliance on the regulatory process, rather than market forces, could result in something less than fair value for the company. The purchase price falls outside the final valuation ranges developed by Blackstone, lending credence to the view that the auction was flawed. Although WellPoint raised questions about certain elements of the Blackstone valuation, its investment banker ultimately agreed that techniques it criticized Blackstone for using were in fact the same techniques it used in preparing a valuation for the WellPoint Board.[381]

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 possible designed to establish price parity to facilitate selection on nonprice issues. Understandably, one of the Board members requested that a valuation be done in January 2001, before the formal bids letters were issued. This would give the Board members a benchmark against which to compare the bids. But for reasons not clear, while an informal estimate was

[381] Testimony of Gregory L. Sorenson, December 16, 2002, at 176 – 179.

made by CSFB to "not expect $2 Billion,"[382] it seems no more formal valuation was made. This is important because this report concludes that the fairness opinion performed *after* the bids were received, an opinion that gave its blessing to the purchase price, was not reasonably relied upon because of the conflict of interest of CSFB in being compensated based on the opinion it rendered. The lack of a meaningful valuation *before* the bidding began prevented the Board from knowing in advance what price could be viewed as fair. This failure to obtain a valuation before the bidding excerbated the flaws in the auction process.

In summary, while the auction regarding the price certainly has some of the trappings and indicia of an auction, particularly the fact that WellPoint did increase its purchase price, based on the evidence produced it is apparent that the process was flawed, and the flaws have led to a price which does not reflect the "fair value" of the company.

3. Jobs/Associate Benefits

As described earlier the exact role that the prospect of job loss played in the decision making process seems to change depending on the particular circumstances occurring during the bidding process. In 1998 through early 2001, a deal with Trigon was viewed positively, with the possibility of positive synergies and little if any job loss, and possible job growth. However, as described by lawyers at Brown, at the hearings in January 2003, as a deal with WellPoint appeared imminent, the prospect of major job loss reared its head. As negotiations appeared to stall with WellPoint over the summer and Trigon seemed to reenter the picture, job loss was, once again, less of an issue. In August 2001, Mr. Wolf commented to the Board that he did not anticipate job loss with Trigon.[383] Once a deal was finally struck with WellPoint, job loss was again set forth as a factor in making the decision.[384]

This record casts extreme doubt on whether, in fact, job loss actually played a role in the decision. The evidence suggests the issue was used as a tool to justify a preference for WellPoint at those points when WellPoint was viewed as a preferred partner. No other explanation justifies the inconsistent views of the issue throughout the negotiations. This explanation makes more sense also because while Mr. Wolf consistently expressed his view jobs would be not lost, it was Mr. Jews who expressed his personal distrust of Mr. Snead, and was also the source of the estimate that 2,000 jobs could be lost in a deal with Trigon. Since, however, the filings from CareFirst continue to assert this as a factor it considered, it will be analyzed briefly in the context of the Board's due diligence and allegiance to its duties of care and loyalty.

Whether or not it is appropriate for the Board to take into account possible job loss depends on several things. First, is it a statutory criterion? Second, is job retention in furtherance of the mission of the organization? Third, can it be said that job retention is "in the best interest of the organization", using the language of Section 14 – 115.

To begin the analysis, it is obvious that with job retention is not one of the many statutory criteria bearing on the public interest, and thus this cannot serve as a basis for relying on job loss to justify the decision.

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[382] CF-0005174, CareFirst, Inc. Board of Director Meeting Minutes, February 22, 2001, at 6.
[383] Testimony of Christopher Slusher, January 28, 2003, at 114.
[384] Pre-filed written testimony of Daniel J. Altobello, March 6, 2002.

Second, the issue of whether job loss impacts the mission of the company as articulated in its Articles of Incorporation, or whether job loss impacts the best interests of the organization is a more difficult question. If cuts were made that negatively impacted the ability to serve insureds, certainly this would not further the mission of the company or be in its best interests. On the other hand, if CareFirst were not operating at peak efficiency and had a bloated work force, job loss might not impact its insureds; in fact it might benefit them through lower administrative costs, which could be reflected in lower premiums. Technological advances, which might result in job loss, could also serve to benefit subscribers. Therefore, it is not possible to conclude job loss is automatically a negative, unless the interests of the corporation include a direct duty to its employees, as opposed to the mission of the company generally. But if the Board believed it had a duty to preserve jobs because it owed a duty to employees not to terminate their employment, whether or not it impacted subscribers, the Board was mistaken. While the economic benefits created by CareFirst are desirable, they are a desirable byproduct of a company whose mission is to provide coverage at "minimum cost and expense." Job cuts should not take precedence over the mission of the Company and duty to insureds.

Finally, the testimony suggests Mr. Jews in particular felt pressured from certain legislators to maintain employment levels. His attention to their demands is understandable, because he believed the General Assembly would ultimately weight in on the deal.[385] But the expressions of concern about the issue do not elevate the concern to one grounded in legislative intent as evidenced in the statutes passed by the General Assembly. While one or more legislators may view jobs in a particular legislative district as important, other individual legislators may view other issues with equal importance. Where does one draw the line on "unofficial" legislative concerns? What if an intervening election changes the composition of the General Assembly and the individual interests articulated by individual legislator's changes? However practical CareFirst believed it was being in giving weight to this factor, there is no legal basis for doing so, and thus under the regulatory analysis job preservation should not have played a role in the decision whether or not it actually did. However, as noted in the conclusions of the report, the evidence suggests that while often cited as a reason for the selection against WellPoint job loss was not in fact a significant factor in the decision.

Another issue that received significant attention in the negotiations was the importance of maintaining the current level of employee benefits. This was identified as a significant problem with WellPoint's bid, and most likely led to CareFirst's decision to restart negotiations with Trigon. The solution touted by CareFirst is in fact a temporary one. The final merger agreement with WellPoint only obligates WellPoint to maintain the current level for four years, after which the protection disappears. This is hardly superior to Trigon's bid, which apparently did not implicate the issue of employee benefits.

4. Headquarters

The weight of the evidence also shows that like the importance of jobs, the importance of headquarters as a point of comparison between the two bidders changed depending on the circumstances. There is some evidence that it is now being cited as a decision point and point of distinction between the two bidders when it was not viewed that way in November 2001 when the selection was made. This raises the question as to whether it in fact played an operative role, or was largely cited as an after the fact justification. And, like the jobs issue, it is also not a factor that should have played a role in the selection process, even if it did.

[385] Deposition of William L. Jews, September 6, 2002, at 177 – 178.

A review of relevant documents provided to the Board, as well as minutes of the Strategic Planning Committee show that CareFirst management and CSFB did not view Trigon's proposal that the corporate headquarters of the combined entity remain in Richmond. In July 2001, CSFB reported to the Strategic Planning Committee that the offers regarding headquarters were similar, meaning neither was superior or inferior. Color-coded charts prepared by management in conjunction with CSFB given to Board members in August, September and October all contained the same rankings. In depositions there was agreement that the issue of headquarters was largely symbolic. In his pre-filed testimony the Chairman of the Board emphasized the fact that Trigon's original offer to move the headquarters was withdrawn and there was an explicit requirement the corporate headquarters would remain in Richmond. The fact is, this is precisely the situation with WellPoint, whose offer was to keep the headquarters in California.

One difference in the WellPoint offer is the creation of a new Southeast region headquartered in Maryland. This promise is illusory. Mr. Schaeffer could not testify what precisely, the Southeast region would encompass. In addition, the merger agreement only obligates WellPoint to maintain these headquarters for two years. The prospect that the establishment of these headquarters is temporary severely undercuts the argument that notwithstanding the multiple ranking showing the offers as equal, WellPoint was superior.

As with the case with jobs, the issue of headquarters appears to be a tool to justify WellPoint's selection after the fact. There is also no evidence to support the argument that even if it were an issue of substance, it was one the Board should have considered. If either offer entailed a requirement that the CareFirst, Inc. and CFMI headquarters were to move, and the issue were among those listed in the statutory criteria, it would be appropriate to consider it. But that is not the case. For the reasons noted in the context of the jobs issue, preferences or opinions of particular legislators should not guide decisions impacting the selection of an Acquiror of CareFirst.

5. The role of management in the successor organization

One element of Trigon's proposal that has repeatedly been cited as a problem and a reason for selecting WellPoint was the "management structure" resulting a combined Trigon/CareFirst transaction.[386] The record is clear that particularly after April of 2001, when Trigon again apparently became a viable merger candidate, substantial time and effort of CareFirst representatives were devoted to achieving a mutually agreeable management structure between Mr. Jews and Mr. Snead.

Mr. Snead and Mr. Jews met in September of 1999 to discuss the benefits of a business combination.[387] In Mr. Snead's mind, he viewed CareFirst as an acquisition by Trigon. As a consequence, for Snead's part "I was very clear at that point and inconsistent that the CEO of the combined organization needed to be me." This was because "If Trigon was to write a check, then my view was, it needed to have a Trigon CEO." However, Snead claimed he was willing to share power. Id. He offered Jews a position as Chairman of the Board, and CEO of the CareFirst companies, an "unusual" relationship given that Snead would continue as CEO of the combined entity.[388]

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[386] See Prefiled testimony of Daniel J. Altobello, March 6, 2002, at 8 – 9; CF-0012315-0016; Testimony of Daniel J. Altobello, March 11, 2002, at 178 – 179; Supplement to Amended Form A.

[387] Deposition of Thomas G. Snead, Jr., August 19, 2002, at 19.

[388] Id. at 28 – 50.

Mr. Snead offered this arrangement because he believed it would favorably be received by Jews and be an advantage for Trigon's bid.[389] The shared management structure, William Jews as Chairman of the Board of Trigon was set out in writing in March 2001.[390] Snead sent Jews a lengthy letter on June 26th outlining in detail the nature of each CEO's responsibility.[391] In July, a meeting of Snead and Jews was preceded by a letter to both from Trigon's investment banker. The letter predicts the meeting will be "candid, direct and maybe blunt", but urges the two to "try to be accommodating and understanding."[392] The author noted that "We have pricing, structure, and a definitive agreement largely agreed upon." Id. (Emphasis added.) Mr. Snead recalled the meeting referred to was principally about the roles of the men.[393]

After the meeting, Snead wrote a follow-up letter, which again outlined detailed responsibilities of Mr. Jews.[394] Mr. Snead describes them as "meaningful, substantial responsibilities" and pleads, "in order for the two of us to succeed, you and I need to work together." Id. Mr. Snead continued to offer this arrangement throughout the summer and into October. In another letter, again outlining all the terms of the Trigon offer, Snead references a request made earlier to meet with key political and regulatory leaders in the jurisdictions with whom Trigon wanted to "clear some ideas before signing a definitive merger agreement." Id. This request was termed the regulatory "walk-around" and was later cited by CSFB as a drawback to the Trigon deal.

In November, Mr. Snead and Mr. Jews met yet again to discuss Mr. Jews' role. A lawyer, Isaac Newberer accompanied Mr. Jews. A chart of each CEO's responsibility was discussed. Id. On this chart, Mr. Jews' role was focused on his role as Chairman of Trigon and there was no "operating" role as CEO of CareFirst. Id. This change was made, according to Mr. Snead, because "it became clear that he [Jews] desired no operating role.[395] Snead believed after meeting he and Mr. Jews had reached an agreement on Mr. Jews' role.[396] Snead felt they had come "a long way." Id. Snead learned he was wrong when Mr. Jews called him the day of the announcement with WellPoint later in November[397] There is no question that a significant reason the Trigon bid was rejected was because Trigon refused to grant Mr. Jews a greater level of control than that of its current CEO, Mr. Snead. Stuart Smith testified that such an arrangement would be unusual unless a plan of succession had been agreed to as part of the deal.[398] Clearly Mr. Snead had no plan to leave. Trigon labored to find common ground, offering what was described as co-CEO roles, offering Mr. Jews the Board Chairmanship, and later offering to actually remove operational responsibility because it believed Mr. Jews wanted none. Mr. Altobello cites the inability to reach an agreement on the management structure as a reason to reject Trigon's bid.

What is particularly ironic about the outcome of the negotiations over Mr. Jews' role is that all of the offers made by Trigon were vastly superior to WellPoint's in terms of control. And, the Board had, early in the process, placed particular emphasis on obtaining control in the

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389 Id. at 82-83.
390 Exhibit 103.
391 Exhibit 108.
392 Exhibit 109.
393 Id. at 121.
394 Exhibit 110.
395 Id. at 132.
396 Id. at 132.
397 Id. at 135.
398 Deposition of Stuart F. Smith, November 25, 2002, at 216:13-217:8.

success or organization asking for criteria with which to measure it. This obvious inconsistency raises even more questions regarding the integrity of the auction process. Mr. Jews testified he believed he should be CEO of the combined company.[399] Mr. Wolf testified he knew this from the beginning of negotiations with Trigon and that Trigon understood this.[400]

6. The Role of Money in the Decision to Convert and Select Partner

There is substantial and credible evidence that the decisions to convert and be acquired were inappropriately influenced by the prospect of large payouts for some individuals at CareFirst. The idea that executives could profit from a conversion or acquisition by a for-profit company surfaced as early as 1999 date, in a presentation presented to CareFirst executives by Trigon executives. In reviewing the relative merits of a Trigon and CareFirst business combination, the deal promised "new levels of wealth" for executives of the new combined entity.[401] The Insurance Administration obtained a letter dated January 24, 2001, addressed to Bill Jews from Donald G. Barnes, a vice-president for the Hay Group, the compensation consultant retained by CareFirst. The letter, which was signed by Barnes but which was forwarded to Mark Muedeking, CareFirst's compensation lawyer at Piper Rudnick, was considered to be a draft letter. Another version of the letter dated February 19, 2001, was addressed to Mr. Joseph Haskins, Chairman of the Executive Compensation Committee. The January 24, 2001, letter addressed to Mr. Jews begins "as you requested, Hay Group has analyzed market trends, executive contract provisions, and competitive pay levels for various financial services organizations going through a merger." However, the analyses done in the charts attached to the letter relate only to Trigon, WellPoint and Cerulean.[402]

The first chart attached to the letter is a comparison of Mr. Jews' compensation to the compensation of Thomas Snead, then CEO of Trigon, and Leonard Schaeffer, CEO of WellPoint. According to the chart, in 1999 the total direct compensation to Snead was $2.24 million while the WellPoint Chairman, Schaeffer made $9.09 million. The chart also list the "pay-outs" to Cerulean executives received in connection with the acquisition of Georgia by WellPoint, which Barnes calls "significant." He notes that CareFirst is three times the size of Cerulean, "so you get some sense of the scale differences", implying that CareFirst bonuses could be higher. Barnes then writes "Exhibit VI shows my recommendations for target awards at the time of the merger." The suggested awards, for Jews $8.6 million, and the executive vice-presidents $2.3 million are larger than those in Cerulean, which Barnes writes "make[s] sense relative to the Cerulean experience."[403] Barnes allocated the $8.6 million between "signing stock share" and a "Signing Bonus."

It is therefore evident that CareFirst management was focused early in the process on the possibility that the deal could result in large payouts. They asked their compensation consultants to calculate not only the size of possible bonuses, but also their form and timing. The Hay Group responded by suggesting a deal with signing bonuses based on pay and bonuses and stock options with the acquiring company derived from looking at for-profit Blue plans. There is no

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[399] Deposition of William L. Jews, September 6, 2002, at 389.
[400] Deposition of David D. Wolf, September 19, 2002, at 93 – 96.
[401] Exhibit 120, Discussion with CareFirst and Trigon Senior Teams (slides), January 25, 2001, T0309
[402] Exhibit 164, Mark Muedeking, Esq.'s January 31, 2001, facsimile cover sheet transmitting HayGroup's draft of a proposed letter to William L. Jews sent to him on January 26, 2001, CF-02394 – CF-02403.
[403] Exhibit 166, February 2, 2001, letter from Donald G. Barnes to William L. Jews, CF-02372.

discernable legitimate reason why CareFirst Executives and later Board members should have been focused on incentives that involved signing bonuses and stock options with the acquiring company. Clearly decisions regarding whether the new management teams would be employed by the acquiring company, and the compensation for that new employment was a matter for the new company.

In addition, as Mr. Angoff pointed out, "to the extent that the seller insists that part of the price the buyer is willing to pay go to compensate management, the buyer has less money available that could otherwise go to fund the resulting Foundation."[404] Blackstone concurred with this assessment and later when CareFirst and WellPoint negotiated a new agreement, WellPoint it increased the purchase price to reflect the removal of certain bonuses. Throughout the entire negotiation process and leading up to the renegotiation of the merger agreement on January 24, 2003, CareFirst management and the Board has been insistent on the notion that management receive large payouts from the deal.

That the Board was insistent that bonuses be an integral part of the transaction nothwithstanding objections or concerns raised by others, including the Board's own lawyers:

- According to documents obtained and testimony from the lawyers involved, as early as February 2001, Piper Rudnick, on its own initiative, suggested a bonus structure that would at least link the payouts to some value added by the executives. Piper suggested bonuses that would be based on the executives negotiating a purchase price exceeded a targeted amount set before negotiations began. (Exhibit #165). The memorandum noted that "obviously such an incentive plan would be supportable on the basis that it encourages the creation of values for the foundations only if it is implemented before the price negotiations being." Id. The Board did not accept this suggestion from its own lawyers. In fact, their merger incentives were not formally approved by the Board until after the negotiations over purchase price occurred.

- In May of 2001, Mr. Muedeking made a presentation to the Compensation Committee, which noted that "allowing large severance at closing may create a disincentive to employment with the buyer." He suggested that the employment agreements be modified to require the executives to work at least one year for the buyer. (Exhibit #180). The Board also rejected this suggestion, at least for the CEO of CareFirst. Mr. Muedeking testified he and Mr. Smith of CSFB took it upon themselves to seek a modification of the bonuses as structured.[405]

Piper Rudnick lawyers, in an internal memorandum, took note that WellPoint was concerned about the bonus, it believed they could affect the approval process, and that they, WellPoint, felt "their purchase price did not contemplate payments at the levels currently under consideration."[406]

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[404] "Draft Report on CareFirst, Inc. Executive Compensation including Compensation in Connection with a Change of Control," Roger G. Brown & Associates, November 7, 2002, (the "First Brown Compensation Report").
[405] Deposition of Mark Muedeking, taken on October 10, 2002, at 234 – 237.
[406] Memorandum of June 13, 2001, from R Smith to E. Grieb, Mark Muedeking, and Taylor; Exhibit 196 to October 10, 2002, deposition of Mark Muedeking.

Internal memoranda from Piper Rudnick show that it also viewed the bonuses as possibly killing the deal. In discussing possible modifications to the bonuses, which would involve the referral of some amounts, Jay Smith noted that the new proposal was a "give-up" by the executives, but "if measured against the possibility that no deal will occur or that no incentive bonus will be paid, it would provide a positive to the executives."[407]

There are numerous examples of circumstances where the Board of Directors seemed determined to ignore, disregard, or fail to consider or disregard other facts and laws that would have caused a reasonable Board to revisit and revise its decisions. The fact that this Board did not do so inescapably leads to the conclusion that the transaction was premised on the notion that the executive team would be enriched as a result of its consummation.

For example, as noted in the report of Jay Angoff, facts were brought to the attention of the Board, which should have caused them to question the legality of the bonuses they were approving. As Mr. Angoff notes, in the only formal written advice to the Board of Directors regarding its duties and responsibilities under common law and statutory law in the three jurisdictions, Piper Rudnick noted that in a prior sale of a Blue Cross plan the presence of million dollar pay-outs was problematic. As Piper Rudnick wrote:

> When management of Blue Cross of Ohio accepted an offer to be sold to Columbia/HCA, four executives were to receive $19 million in payouts as part of the transaction, and seven former Directors were to receive $3 million. The size of these payouts raised questions about the integrity of the organization's decision-making process as well as the quality of information provided by the staff to the Board. The response of several jurisdictions has been to introduce legislation prohibiting bonuses as part of such transactions.[408]

Yet as Mr. Angoff notes, the Board did not seek legal advice regarding the lawfulness of its compensation packages. It apparently requested no research or further information based on this apparent problem from Ohio.

Again, as noted in the Angoff report, another red flag to the Board comes in the form of the 1997 Order by the Maryland Insurance Administration approving the business combination between the Maryland and D.C. Blue Cross plans. That Order required that no executive compensation could be paid in that deal until an independent consultant found that the contracts providing for such compensation were reasonable and "consistent with contracts and nonprofit settings." There were members on the Board in 1997 who were also members while the bonuses in this case were being considered. Clearly this explicit language in a prior Order of the Insurance Administration involving the Maryland and D.C. Blue Cross plans should have figured prominently in the Board's decision making. Mr. Wolf, the "point person" for CareFirst[409] on the deal and a subordinate to Mr. Jews testified that:

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[407] Exhibit 197 to October 10, 2002, deposition of Mark Muedeking, July 23, 2001, e-mail transmission from Debbie Hooker to Linda M. Thomas attaching draft memorandum to Michal A. Muntner and Stuart F. Smith, July 18, 2001.

[408] Hearing Exhibit 208 at Exhibit A, January 16, 2001, memorandum from Piper Marbury Rudnick & Wolfe to John A. Picciotto re: Fiduciary Duties of Directors in connection with possible business combination.

[409] Deposition of David D. Wolf, September 19, 2002, at 8.

A. In the previous two business combinations we put together, management compensation was always one of the key issues discussed in the approval process, and it was clear that this was going to be another one of those items that was going to be keenly discussed.

Q. So you believed that the presence of these incentives would be an issue in the approval process?

A. They would be a significant consideration in the approval process, yes.[410]

When asked whether the 1997 Order was relevant to the Board's deliberations on the bonuses, Mr. Altobello stated that, "I think frankly we're in an entirely enviroment."[411] The Chair of the Compenastion Committee was asked whether it would have been important to discuss the 1997 Order. He testified that, "I can't really speculate on that . . . we relied on advice of our consultants to bring forth the relevant data."[412]

Furthermore, Mr. Muedeking provided clear evidence that such bonuses are not normally paid in nonprofit settings when he testified that although he looked for comparable bonuses in nonprofit settings, he could find none.[413] Yet the Board apparently found this if no concern. Instead it defended the reference to for-profit companies in its comparisons, and the Compensation Committee minutes clearly indicate the Board relied on the comparisons to for-profit companies in setting the bonuses here.

The record also reflects that both of the bidders in the sale of CareFirst objected vehemently to the proposed bonuses, which also should have raised significant concerns and red flags for the Board of Directors. Timothy Nolan of Trigon testified under oath that he informed CareFirst management that the bonuses were "greedy, stupid and illegal." Although Mr. Wolf disputed he conveyed Trigon's opposition in such strong terms. However, Leonard Schaeffer, the CEO of WellPoint, testified under oath that WellPoint objected to the bonuses, believed they were inappropriate, but that the bonuses were a "take or leave it" proposition if WellPoint wanted to buy the company.[414] This view was reiterated by Thomas Geiser, General Counsel at WellPoint. Mr. Geiser testified regarding the negotiations held to revise the compensation packages:

> COMMISSIONER LARSEN: Well, let me try again. Was it your impression that this new arrangement would not be consummated unless the eight executives agree to it?
>
> MR. GEISER: Yes.[415]

Also of particular concern is the fact that the only formal written advice rendered by Piper to the Board of Directors regarding their duties and responsibilities in connection with the transaction completely omitted any reference to the provisions of the Maryland conversion statute, which prohibited private inurement.[416] Piper provided in response to a MIA subpoena a summary of the advice that it provided to the Board of Directors. Piper identified five instances

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[410] Id. at 24.
[411] Testimony of Daniel J. Altobello, December 17, 2002, at 255.
[412] Testimony of Joseph Haskins, Jr., December 17, 2002, at 256.
[413] Deposition of Mark Muedeking, taken on October 10, 2002, at 284 – 285.
[414] Testimony at Public Hearing, January 31, 2003, at 180 – 182.
[415] Testimony of Thomas C. Geiser, Day 14, February 4, 2003, at 65.
[416] April 22, 2002 Piper Rudnick Memorandum to John Picciotto, Exhibit 208 to December 2002 hearings.

in which it provided "formal advice" to the Board of Directors, only two of which were in writing: a January 22, 2001, memorandum by Elizabeth Grieb; and a November 20, 2001, memorandum by Jay Smith regarding the Board's duties in connection with its decision to decline Anthem's interest on bidding on CareFirst. The January 16, 2001, memorandum describes the conversion statute and lists most but not all of the statutory criteria to be considered by the Insurance Commissioner in reviewing the transaction.

Notable among the criteria not listed is the criteria that prohibit private inurement in connection with the transaction.[417]

Jay Smith, a Piper Rudnick lawyer who testified on behalf of CareFirst at the hearings, agreed that the anti-inurement provision in the statute was "a material standard" the law required and that if inurement were determined to be found, the deal would have to be disapproved.[418] Mr. Smith testified that the purpose of the memorandum was focused particularly on the Board's responsibility to look only at price as opposed to other non-price issues in its negotiations with potential suitors, and that the omission of the anti-inurement provision, although material, was "inadvertent."[419]

While Piper lawyers argued on numerous occasions that the anti-inurement provision was in fact discussed with the Board of Directors, there is simply no evidence that this is the case. While it may certainly be true that the Board discussed that there would be public relations problems with the bonuses as constituted,[420] there is simply not a shred of evidence that the concept of inurement or its application to this deal was analyzed by the Board or its lawyers or discussed. It is reasonable to draw a conclusion that if it were discussed it would be reflected in some of the documents obtained by the Maryland Insurance Administration in connection with the Proposed Transaction. The Administration received thousands of pages from the files of Piper, the Board of Directors and the Board's investment bankers, CSFB, all of which are devoted to extensive analysis of the compensation packages. In fact, one of the most remarkable, and in many respects disappointing, aspects of this review is the revelation regarding exactly how much time and effort went into formulating the compensation arrangements, reviewing the tax implications of the arrangements, calculating under innumerable scenarios the amounts of the pay-out to the executives and so on. What cannot be determined is why there is no discussion regarding the anti-inurement provisions. Mr. Wolf also testified that he had no recollection of any discussion on the inurement issue in the Strategic Planning Committee meetings. He did not know if it was discussed in the Compensation Committee meetings, as he did not attend those.[421]

It is also hard to believe that those in positions of responsibility at CareFirst involved in this transaction was unaware of the law and would not have flagged it for the Board. Mr. Wolf testified that he was aware of it.[422] CareFirst was involved in the development and passage of the conversion statute in 1998. Furthermore, the conversion statute is neither lengthy nor complex,

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417 Id. at 8.
418 Testimony of Robert William ("Jay") Smith, Jr., December 17, 2002, at 183 -184.
419 Id. at 184 - 185.
420 The Board was aware the public would react negatively to the bonuses. In response to a question about the bonuses, the Chairman of the CareFirst Board told the Senate Finance Committee that, "Believe me, we have done this conscious of the fact that there would be a firestorm about, to us, an issue that is a red herring, the compensation issue . . .." Senate Finance Committee Hearing, Senate Bills 410, 411, 413, 487, and 592, March 12, 2002, at 42.
421 Deposition of David D. Wolf, taken on September 19, 2002, at 23. The minutes of the Compensation Committee from 1998 through 2001 do not identify Mr. Wolf as an attendee.
422 Deposition of David D. Wolf taken on September 19, 2002, at 19.

and therefore, the anti-inurement provision is not easily overlooked. The record reflects extensive analysis on whether or not the various compensation arrangements constituted" excessive parachute payments under the internal revenue service tax code and what the tax implications of the bonuses would be to both the individuals and the corporations." Assuming it is true as Mr. Smith testified that the purpose of the January 16, 2001, memorandum was as he described it is a significant oversight that at no other point in time was advice rendered to the Board regarding the meaning of the anti-inurement provision. Mr. Muedeking testified under oath at his deposition that while he was generally aware that there was an anti-inurement provision in Maryland law, he was not aware that it was part of the conversion statute. He later testified that he was in fact aware that the anti-inurement provision existed in the conversion statute and that the merger incentives "*would be a significant consideration in the approval process.*"[423]

In sum, the reason for this oversight cannot be determined from the record and therefore, it cannot be determined with certainty whether the oversight rested with the Board, its lawyers, or both. Whether or not the Board and its advisors were operating a "don't ask and don't tell policy" as it relates to anti-inurement is a reasonable question. This failure to take this warning seriously is notable because the Board in other situations sought and received legal advice on the lawfulness of its corporate actions. But the absence of any discussion on the inurement issue ultimately is yet one more suggestion that this Board was determined to insure that the management team would receive payouts as a result of the transaction.

Some of the most compelling issue on the topic came from Leonard Schaeffer, the CEO of WellPoint. Mr. Schaeffer made clear that it was only through the agreement to pay the executive bonuses that would WellPoint be granted the privilege of purchasing CareFirst. As noted above, he described the bonuses as a take it or leave it proposition, meaning that without the payment of the bonuses the deal could not be consummated. Fomulated in this way, the bonus became a ransom that bidders, acting in good faith, were forced to pay for their bid to be viewed favorably.

Under these circumstances, the bonuses became nothing more than a ransom that had to be paid by an Acquiror in exchange for the ability to purchase the company and an agreement by the CareFirst Board of Directors. Formulated in this light, the bonuses seemed to have risen to a level of paramount importance to the Board, perhaps even being more important than whether or not the company itself would be sold. Obviously conditioning the sale of the company on the payment of the bonuses fundamentally calls into question the motives for the sale. If it were true that the sale of the company was deemed important by the Board in order to ensure the long term viability of the corporation, then clearly the importance of the bonuses would have to be subordinated to the broader interests of the corporation which, in the Board's view, was stated to be sale to a partner to ensure the company's long term viability. However, Mr. Schaeffer's testimony makes clear that in presenting the bonuses as "no bonus no deal," 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.

J. SUMMARY OF KEY POINTS RELATING TO FACTORS USED BY CAREFIRST IN SELECTING WELLPOINT

Early in the process of selecting a strategic partner, CareFirst and its advisors were placing a priority on a transaction that achieved the goals of geographic dominance, either through contiguous expansion, or by increasing market share. CareFirst also emphasized the need

[423] Deposition of David D. Wolf taken on September 19, 2002, at page 24, line 13-14.

to retain the ability to "control its destiny", which meant that it sought to maintain and maximize the level of control it could exert in the successor organization.

The partner ultimately selected by the CareFirst Board, WellPoint, does not directly or immediately further the goal of geographic dominance because WellPoint is not contiguous to CareFirst, and has made no commitment to capitalize any contiguous or in-market acquisitions.

A transaction with Trigon would have given CareFirst a greater level of "control" after the transaction, as measured by the Accenture criteria, than a deal with WellPoint because of the greater level of CareFirst representation on the Trigon Board as compared to the WellPoint Board. In addition, under the Trigon deal, CareFirst's CEO would have become Chairman of the Trigon Board, and he would have had a greater level of management authority in the combined company than with the WellPoint deal.

Trigon was identified as a potential merger partner even before Accenture recommended its strategic goals to the Board.

At least until January 2001, Accenture CareFirst staff and CSFB viewed Trigon as a preferable merger partner over WellPoint.

In a meeting of the Strategic Planning Committee in March 2001, the Board was presented with handouts listing criteria used to rank the relative advantages and disadvantages of Trigon and WellPoint as merger partners. WellPoint was not ranked superior on any measures, Trigon was ranked as superior on two measures, and the two were ranked equally on all remaining factors. At the April 2001 meeting of the SPC, at which the recommendation was adopted to negotiate a deal with WellPoint, those rankings used in March which favored Trigon were either deleted or altered, so that WellPoint was now ranked superior, without clear explanation. New Criteria were added that clearly favored WellPoint.

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.

WellPoint emerged as the favorite bidder in April 2001 primarily for reasons unrelated to the strategic objectives of gaining geographic dominance. WellPoint did provide absolute scale, but fewer synergies than Trigon because it was not geographically contiguous.
Nor was preference for WellPoint based on demonstrable advantages to CareFirst's customers or the citizens of the states in which it operates.

Trigon's attempt to purchase Cerulean while at the same time negotiating with CareFirst, in addition to causing CareFirst believe that Trigon had retreated on a perceived agreement to create a regional headquarters in Maryland, created a breach of trust with the CEO of CareFirst that contributed significantly to the preference for WellPoint in April 2001.

In May 2001, CareFirst conducted "confirmatory due diligence" on WellPoint, and no "fatal laws" were detected in that diligence.[424] However, one of two "key weaknesses" identified was the negative impact a WellPoint deal could have on CareFirst employees. These impacts included reductions in retiree coverage, pension plans, and incentive/bonus plans. However, the recommendation to the SPC at that time was to "Proceed with Final Negotiations of Merger Agreement" with WellPoint.

Although the Board of Directors adopted a resolution in April directing management to negotiate a definitive merger agreement with WellPoint, while not excluding Trigon from consideration, management restarted negotiations with Trigon in the late spring or summer of 2001. The reason negotiations with Trigon were restarted were most likely because of the reduction in employee benefits that could result from a deal with WellPoint, and this was viewed as not an acceptable outcome.

In the July 2001 meeting of the SPC, the CEO updated the Board on discussions with WellPoint and reported that the "gap in associate benefits does not have any clear resolution." Also in the July 2001 meeting of the SPC, CSFB ranked Trigon and WellPoint equals with regard to "headquarters." Trigon was ranked superior on "Commitment to Associates" and "Board Representation."

During the course of the summer and fall of 2001, after negotiations with Trigon were re-opened, numerous discussions were held between the CareFirst management and Trigon regarding the role the CareFirst CEO would play in the new organization, and who would have control and authority in the organization.

The CEOs of Trigon and CareFirst each believed that he should be the CEO of the successor organization. Trigon's CEO held this belief because Trigon was tendering the purchase price for CareFirst; the CareFirst CEO held this belief because CareFirst was larger than Trigon in important (but not all) respects.

Normally in situations involving the acquisition of one company by another, the CEO of the acquired company does not ascend to be CEO of the Combined company, absent a pre-arranged plan of succession to replace the CEO of the acquiring company. No such plan of succession was contemplated in this transaction.
CareFirst management employed outside counsel, at CareFirst's expense, to advise them on matters relating to the transactions, including executive compensation matters and the role of the CareFirst CEO in the Trigon organization. The counsel so employed had previously represented the CEO in a personal capacity in negotiations with CareFirst over his employment contract in 1998. The outside counsel in that negotiation obtained favorable terms for the CEO, and negotiated from a position adverse to the interests of CareFirst. The Chairman of the Board was unaware of the involvement of the outside lawyer at the time, did not consider the lawyer to be representing the corporation, and did not view the engagement as desirable.

In the summer and all of 2001, the discussions with Trigon were dominated by the issue of the roles and responsibilities of the two CEOs in the successor organization.

Trigon learned of the merger incentives approved by the CareFirst Board in the late spring or summer of 2001. Trigon clearly expressed its opposition to the incentives to CareFirst

[424] CareFirst, Inc. Strategic Planning Committee Meeting Minutes of the Board of Directors, May 24, 2001, Exhibit 152.

management, and indicated its belief that they would complicate the regulatory approval process.

In part to determine the level of negative reaction to the merger incentives, Trigon requested a "regulatory walk-around" to meet with the regulators in the affected jurisdictions so as to gauge the regulatory "buy-in" and "do-ability" of the deal.

The retention bonus, merger incentives, excise tax, and associate benefit level after the merger were all considered "Critical Deal Points" by CareFirst Management.

In September 2001, according to the minutes of the Strategic Planning Committee, "The main issue surrounding [WellPoint] negotiations is determination of how the associate benefit gap will be closed." The minutes also state that "The key outstanding issue for [Trigon] is lack of definition regarding how the business would be run on a day-to-day basis." The differences between the "downside protection" offered by Trigon and WellPoint were not described as a "Key outstanding issues."

In October 23, 2001, CareFirst's internal point person on the transaction, David Wolf, prepared a memorandum for the CEO describing outstanding issues regarding the bids of both Trigon and WellPoint. The merger incentive program was listed as an "open issue" for Trigon, but was not listed as an open issue for WellPoint. Of issues that were viewed as "open," or that "required partner concessions", no mention was made of a difference in the downside protection between the WellPoint and CareFirst bids. Open issues for Trigon included "incentive program," "WLJ Role," "partner commitment to closing," and "associate benefits and compensations".

As of the October 25, 2001, Strategic Planning Committee meeting, Trigon's "Commitment to Associates" in terms of benefits levels and employment levels was ranked by CareFirst management as superior to that of WellPoint.

As of the October 25, 2001, meeting of the Strategic Planning Committee, Trigon had not agreed to the merger incentive plan, while WellPoint had agreed to the plan in a modified form that included a component of WellPoint Stock.

The Strategic Planning Committee was advised by CSFB on October 25, 2001, that WellPoint's "imminent" filing of a registration statement in connection with its acquisition of RightChoice would prevent WellPoint from pursuing other partners until the RightChoice transaction was closed. The Board was advised this had implications for the timing of its decision on its strategic partner.

The minutes of the November 5, 2001, meeting of the Strategic Planning Committee memorialize the status of "open issues" that were "resolved" between CareFirst and the two bidders. Five "open issues" were listed regarding Trigon. Of these, three issues were resolved acceptably. These resolved issues relating to Trigon included "the elimination of the regulatory due diligence request," and "inclusion of subordinated notes to protect the transaction price."

As of November 5, 2001, the proposed organizational structure with Trigon, with Mr. Jews as Chairman of the Board and Mr. Snead as sole CEO of the combined company was still view as "unacceptable."

As of November 5, 2001, CareFirst also viewed as unacceptable a new requirement by Trigon that termination of the management agreement would be permitted if hearings on the deal had not commenced within nine months of signing, or if the deal did not close by April 1, 2003.

Trigon made this request because of questions regarding the impact the merger incentives might have on the regulatory process.

As of November 5, 2001, the merger incentive program was not agreed to by Trigon, whereas the status of the WellPoint proposal was that the "incentive program [would] be replaced by [a] restricted stock program."

Mr. Jews' merger incentive was structured differently than those of the other executives, and would be payable upon the closing of the deal whether or not he worked for any period of time with WellPoint.

Multiple and conflicting explanations were given for this disparate treatment. While Mr. Jews attributed this difference in treatment to Mr. Schaeffer, Mr. Schaeffer could not recall requesting the disparate treatment, and in fact believed the merger incentives were inappropriate but a condition that needed to be satisfied if CareFirst were to accept their bid.

No agreement was ever reached between Trigon and CareFirst regarding the role of the CareFirst CEO in the successor organization.

WellPoint ultimately agreed to transition over four or five years, the level of benefits provided to CareFirst employees, to those provided by WellPoint to its employees. The final merger agreement negotiated with WellPoint obligates it to maintain employee benefits for four years.

In Documents prepared by CareFirst staff for presentation to the Board in late summer and fall of 2001 evaluating the merits of both bids, the offers Trigon and WellPoint were making regarding the issue of the headquarters of the company were consistently ranked as "similar' with neither one being ranked inferior or superior to the other. WellPoint's offer was described as the corporate headquarters being located in Thousand Oaks California, with regional headquarters in Owings Mills, and Trigon's offer was described as having the headquarters being located in Richmond.

K. SUMMARY OF KEY POINTS RELATING TO THE ROLE THAT THE MERGER INCENTIVES PLAYED IN THE SELECTION PROCESS.

The CareFirst CEO requested that this company's compensation expert develop proposals for bonuses and stock options to be paid to CareFirst executives by the acquiring company.

CareFirst lawyers suggested that incentives be paid only if a purchase price was achieved that exceeded a predetermined level and that in order to be effective the incentives be enacted before price negations began. Neither of these suggestions was followed.

CareFirst lawyers knew that there would be public concern over the merger incentives and severance packages and sought to restructure the packages in order to minimize tax consequences and the amounts to be paid immediately upon closing, so as to address possible concerns.

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 by nonprofit health service plans.

The only written legal advice provided to the Board of Director regarding their duties and responsibilities in connection with a transaction, summarized the Maryland conversion statute but omitted any reference to the anti-inurement requirement in the law.

Both Trigon and WellPoint objected to the merger incentives, although WellPoint ultimately agreed to pay the incentives in a modified form. Both bidders clearly communicated their objections to CareFirst, including their concerns that the bonuses could impact the regulatory process negatively. CareFirst continued to require payment of the bonuses as a condition of purchase.
The merger incentives were listed as part of the critical deal points in discussions with WellPoint and Trigon.

The Chairman of the CareFirst Board testified that neither WellPoint nor Trigon objected to the merger incentives.

Leonard Schaeffer, the Chairman and CEO of WellPoint, believed that WellPoint had to pay the incentives in order to be eligible to purchase CareFirst.

CareFirst management was familiar with the anti-inurement statute.

L. SUMMARY OF KEY POINTS RELATED TO THE AUCTION AND ITS EFFECT ON FAIR VALUE.

The weight of the evidence supports the view that Trigon was not asked to increase its price but would have done so if asked or encouraged. A higher bid from Trigon could have resulted in "fair value" for CareFirst, even if Trigon's downside protection were less advantageous than WellPoint's.

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.

The auction conducted by CareFirst, at least with regard to the purchase price for the company, was flawed because it was not conducted in a way that attempted to achieve the fair value of the company, let alone maximize the purchase price.

The auction was designed to obtain purchase price parity, which in turn facilitated the selection of the winning bidder on nonprice factors.

No effort was made to assign monetary value to the non-price factors emphasized by CareFirst management. As a result, CareFirst management and its advisors did not place

themselves in a position that would enable them to evaluate all material elements of competing offers fairly. More importantly, this failure deprived CareFirst management and advisors of the ability to extract price considerations from either party to compensate for perceived inferiority of non-price proposals.

CareFirst was relying on the regulatory process, rather than the auction process, to ensure that "fair value" would be achieved rather. This reliance was inappropriate.

Although Highmark was originally considered as a merger partner, it was excluded from final consideration because it was not a for-profit company.

CareFirst's own due diligence revealed that due to Maryland's highly regulated market, WellPoint's ability to achieve success under the "WellPoint Way" may be limited.

In considering the bids from Trigon and WellPoint, the Board did not consider whether the acquisition by either bidder would be equitable to subscribers, or would have a significant adverse impact on the availability and affordability of health care in this State.

1. Conclusion

One of the difficult aspects of the MIA's review of this transaction has been the effort to determine what factors led to the Board's decisions to select WellPoint, and whether, in selecting and applying those factors, the Board complied with its duty of care and loyalty. At first glance, such a task might appear to be a relatively straightforward analysis because of the extensive documentation in the Board minutes and Board presentations prepared by CSFB and management ranking, re-ranking and evaluating the partners from month to month. However, a critical analysis of the content and timing of these 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. In one case, rankings of the bidders were changed without good explanation. Factors which have been presented in this proceeding as being important considerations were less so at the time negotiations occurred, and vice-versa. 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.

To begin with, much of the foundation for the strategic plan, which in turn drove the decision to be acquired, was premised on the goal of geographic dominance. To this end, Trigon was consistently viewed by CareFirst management and CareFirst advisors, including both Accenture and CSFB, as the optimal merger candidate. However, in April of 2001 the "synergies" that all parties involved had uniformly viewed as positives, and the perceived benefits that could be realized from Trigon as CareFirst's contiguous growth partner suddenly evaporated. In the end, CareFirst selected WellPoint, obviously not a contiguous plan. In fact, it was the least geographically proximate of any plan ever under consideration. Strangely, in a presentation to the Board in April, California-based WellPoint was, in counterintuitive fashion, ranked higher than Virginia-based Trigon in the category of "Geographic Presence." Yet Joseph Marabito from Accenture testified that this deal did not advance the goal of geographic dominance. Whatever significance the idea of geographic dominance played in the beginning of the process, it became less prominent in the end. While it can be argued that WellPoint could later provide capital to move toward this goal, and thus it would be a two-step process, there was no evidence that any commitments or plans had been made for the next step. That idea is purely speculative.

One explanation for this change in fortune for Trigon lies in the notion that a Trigon deal would lead to job cuts. This concern emerged later in the process, but more significantly, its currency as a basis of decision seemed to ebb and flow dramatically in the course of the final selection process. In all the positive rankings that were given to Trigon by CSFB, Accenture, and the CareFirst management from 2000 through April 2001, no mention was made or concern expressed about possible job cuts. However, by April 2001, the positive potential for job growth with Trigon was transformed into what would seem to be a deal-killing prediction by the CEO of CareFirst of massive job cuts. Later, in the summer and fall of 2001, a deal with WellPoint seemed hard to reach, and Trigon was once again a viable candidate and the subject of extensive negotiations. Later still, as WellPoint came back into favor in the late fall of 2001, the prospect of job cuts again reared its head as a concern expressed by the Board, CSFB, and management. Now in this proceeding job loss is again cited by management and the Board as one justification for the selection of WellPoint. But even this point is not clear-cut. Mr. Wolf consistently testified in this proceeding that, below the CEO level, job cuts were not a concern. The Board minutes confirm that he expressed this view to the Board.

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 for one bidder or 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 in a Trigon deal seems to coincide with the breach of trust that occurred between he 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 a potential partner because it expressed concern over the merger incentives. The facts suggests 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.

While this may be a harsh criticism of the Board and management, it is one, and perhaps the only reasonable explanation for what otherwise could not be explained in any rational way. If the Board and management truly believed 2000 jobs would be cut in a deal with Trigon, how could Trigon even possibly have continued to be considered as a partner given CareFirst's view that Maryland politicians would not stand for such a result?

CareFirst has often described the issue of corporate headquarters as playing a significant role in the decision making process, and the history here is similar to that of the jobs issue. The Board Chairman raised the concern in his testimony that Trigon had at one point suggested that corporate headquarters could be moved to Maryland, then withdrew this idea and stated that corporate headquarters of the combined entity would be in Richmond. On this issue however, there is little dispute now that maintaining the corporate headquarters in Richmond would not have a substantial impact on jobs. Mr. Snead, Mr. Jews, and Mr. Wolf all agreed on this in their testimony. The issue was more symbolic than substantive. In fact, CareFirst staff and CSFB consistently ranked the offers from WellPoint and Trigon as "similar" on this issue, with neither

one being superior. Under both proposals, each would maintain the corporate headquarters in the current location of the Acquiror. Each would maintain the headquarters of CareFirst in Owings Mills. The more significant "headquarters" issue with the Trigon bid seems to be the perception that, at one point, Mr. Snead either suggested or committed to move the headquarters, only to later back off the idea. This reversal seemed to weigh much more heavily than the actual location of the headquarters.

The purported advantages of the WellPoint offer on "headquarters" is similarly situated on shaky ground. CareFirst has trumpeted WellPoint's commitment to situate the headquarters for the "Southeast Region" in Maryland as a significant benefit. However, Leonard Schaeffer, the CEO of WellPoint, testified that Cerulean, the only WellPoint-owned Blue Cross plan near the eastern seaboard, was not part of this Southeast Region.[425] Perhaps more importantly, the Merger Agreement only requires WellPoint to maintain the headquarters for the Southeast region, whatever that region may entail, in Maryland, for two years. Whether or not it is symbolic, it may very well be temporary.

In summary, whatever weight the issues of corporate headquarters or jobs are given now as a justification for selecting WellPoint or rejecting Trigon, in both cases the issues fail to support the decisions actually made.

Another factor given considerable weight recently, particularly by CareFirst's investment bankers at the hearings held by the MIA, is the issue of "downside protection." Especially in response to questioning regarding the credibility of an "auction" that ended in a tie, Mr. Smith of CSFB emphasizes the efforts that went into securing the purchase price through the agreement by WellPoint to issue subordinated notes if WellPoint stock dropped so far as to jeopardize the full purchase price.[426] In his view this was an important element of obtaining "fair value" for CareFirst. Mr. Altobello cited this 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.[427]

Mr. Smith is correct that CareFirst could legitimately prefer a bid with superior downside protection in order to better secure the full purchase price for the company. This would be consistent with the Board's duty to obtain fair value. The problem is not that this is an inappropriate factor. The problem is that, 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.[428] This apparently uncontradicted fact seems to have escaped the notice of many, as the CareFirst testimony was prepared for the MIA's hearings in this matter. It simply cannot be said that WellPoint's bid on this factor was superior, because by early November, before the Board voted on a "winner", the Trigon offer on this issue was acceptable.

In addition, while this point of distinction between the two bids, which turns out not to be a point of distinction, was one that received much less prominence than it did during negotiations. During the summer and fall of 2001, when Trigon was back in the running, Trigon's weakness on downside protection was not flagged in any of the presentations to the Board. An October presentation to the Board noted five key "open issues" with Trigon, but this was not one of them. According to Board minutes, in September the "key" issue with Trigon was

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[425] Testimony of Leonard D. Schaeffer, March 11, 2002, at 89 – 91.
[426] Testimony of Stuart F. Smith, January 31, 2003, at 190 - 194.
[427] Testimony of Daniel J. Altobello, March 11, 2002, at 285.
[428] Deposition of Timothy P. Nolan, August 19, 2002, at 65 - 66.

the management structure. This material strongly suggests that like jobs and headquarters, downside protection became more of an issue in hindsight.

The double standard the Board applied in evaluating the bids can be seen in yet another area. While often unmentioned in public presentations, WellPoint required indemnification against the potential that the IRS would issue an unfavorable ruling on the tax consequences of the deal. This was estimated by CSFB as a potential exposure to the Foundation of $125 - $140 million. While WellPoint was willing to pay $5 million toward the purchase of insurance to cover the exposure, the agreement allows WellPoint to terminate if the insurance costs more. If no insurance is available, CareFirst may terminate.

This condition of the merger agreement to closure is rarely mentioned in the testimony. There is no evidence, that the Board ever debated whether this condition is more or less risky to the deal than 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.

This detailed 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.

The evidence is strong that WellPoint's ultimate agreement to the merger incentives played a significant role in its selection of the prevailing bidder. The reasons largely cited by management and the Board have been shown to be specious. This, coupled with the documents written at the time, which listed compensation as a critical deal point, and the very early focus by management on bonuses and options, clearly show that the issue was a key element of the deal. This point is clearly confirmed by the testimony of Mr. Geiser and Mr. Schaeffer. 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. The so-called retention bonus for the CEO of CareFirst would paradoxically be paid even if the executive was not retained.

The Board was complicit in this attempt to enrich the executives. It was presented with the same information the MIA reviewed, which showed clearly that the offers by WellPoint were ultimately deemed compatible on jobs, headquarters, commitment to local presence, downside protection, and purchase price. And on the issue of control, viewed as critical to the Board in late 2000 and 2001, WellPoint was clearly inferior. Moreover, on an issue that was viewed as critically important, WellPoint's bid could be salvaged only with a temporary fix - maintain current employee benefits for four years only. This was not an issue with Trigon. Trigon's last minute efforts to conduct a regulatory walk-around, and provide termination rights if the deal foundered, were triggered in large part *by the bonuses*, and their view that the bonuses could stall or kill the deal. Trigon was right, although their concerns were belittled at the time by CareFirst management.

It is also evident that the inability of Mr. Jews and Mr. Snead to reach an agreement led to the demise of Trigon as a bidder. The Board Chair cited this as a reason for rejecting Trigon.[429] Yet this disagreement is indefensible unless the Board's actions are dictated by Mr. Jews' personal desires rather than the interests of the corporation and its stakeholders. The original

[429] Testimony of Daniel J. Altobello, March 11, 2002, at 178 – 179.

offer by Mr. Snead gave the CareFirst Board authority and "control" in the new organization. Even when modified to give Mr. Jews the Chairmanship of the Board, it vastly exceeded anything offered by WellPoint. While the mechanics of the original proposal may have required fine-tuning, the evidence shows that Mr. Snead was ready, willing and able to share power. The stumbling block was the simple fact that Mr. Jews believed that he personally should be CEO of the combined companies, even though Trigon would be paying $1.3 billion to buy his entire company. It is incomprehensible why, if the Board viewed control as an important consideration, it rejected Trigon's bid. There is not one shred of evidence that any Board member even noticed or remarked that this issue, so important in the beginning, was now being abandoned. The case is the same for geographic dominance. Once an important issue, now suddenly it was not. No Board member seems to have questioned this about face.

In this instance, 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. Most revealing was the disclosure that a lawyer who had previously served as a personal lawyer to Mr. Jews conducted negotiations with Trigon on issues of job responsibility. He also reviewed compensation matters, and in some cases talked or met with Mr. Jews or Mr. Wolf, two, three, and four times a day. Even the Chairman of the Board, so unwaveringly supportive of management in all other respects, testified under oath that he was not aware of this arrangement, did not think it was advisable, and did not believe the lawyer was representing CareFirst.

The Board's decision granting the merger incentives is an even more egregious breach of its duties of care and loyalty. These bonuses were shocking by any measure. The evidence shows that contrary to the original assertions, management did play a role to initiate and evaluate various bonus ideas. The lawyers and experts dealt directly with management, as evidenced by subpoenaed documents from Piper Rudnick and CSFB, as well as testimony from The Hay Group. The evidence regarding the Board's failure to heed numerous warning signs that the bonuses were improper is especially damning. While fully documented below, the Board's failure to at least seek a determination that the bonuses were proper under the conversion statute amounts to willful neglect. Some members of the Board in 2001 were also members in 1998, when the legality and appropriateness of bonuses in a nonprofit setting were raised by the MIA. This willful neglect of its duties confirms what the totality of the evidence already revealed, that a key motivation behind this deal, if not the principal motivation, was the enrichment of the executives.

Another area where the Board failed to discharge its duties is its failure to consider some of the key statutory factors that would guide the regulatory decision. Conspicuously, one of the key factors the Board did not have on its list of items to be considered is whether the transaction with one or the other bidders would be "equitable" to subscribers, as the statute requires. Nor is there any reference to the statutory criteria regarding the impact on accessibility and affordability of health care in Maryland. There is no evidence the Board looked at how the pricing or underwriting processes of either Trigon or WellPoint might change CareFirst's product offerings and market practices. While hundreds of hours and thousands of dollars were spent working on, and revising, the compensation arrangements to try to minimize the tax consequences, it seems that no efforts were expended to examine whether the pricing or underwriting practices of either bidder would have a negative impact on the individuals to whom the Board had the highest duty.

M. Whether conflicts of interest were disclosed

In determining whether the proposed acquisition of a nonprofit health service plan is in the public interest, the MIA must consider:

> whether any conflicts of interest were disclosed, including conflicts of interest of board members, executives, and experts retained by the transferor, transferee, or any other parties to the acquisition;

Md. Code Ann., State Gov't § 6.5-301(e)(3).

The term "conflict of interest" usually refers to a clash between interests. It arises when regard for one duty tends to lead to disregard for another. It arises when one's discrete personal interests are at odds with one's duty to another. *See, e.g.* Black's Law Dictionary (6th ed.); 67 C.J.S. Officers § 244; *Allstate Ins. Co. v. Campbell*, 334 Md. 381, 395 (1994) (recognizing that conflict exists where interests diverge); *Attorney Grievance Comm. Of Md. v. Sachse*, 345 Md. 587, 588 (1997) (recognizing conflict as the attempt to act in two capacities or on behalf of two interest in the same transaction).

The conversion statute contains a number of provisions that seek to ensure that the decision to convert from nonprofit status is made for the right reasons, in conformity with duties owed to the nonprofit, and not for any improper reasons related to the self-interest of the decision-makers or third parties. Thus, the Act prohibits private inurement of the nonprofit's public assets (MD. CODE ANN., STATE GOV'T § 6.5-301(b)(3)), as well as the transfer of any remuneration that could influence the decision to convert (MD. CODE ANN., STATE GOV'T § 6.5-301(b)(3)). Similarly, the Act requires the transferor to act with due diligence, which includes the adherence by officers and directors to their respective duties of care and loyalty. The duty of loyalty includes, of course, the obligation to disclose any conflicts of interest and to refrain from any form of self-dealing.

The Act requires the MIA to consider whether conflicts of interest of officers, directors, and experts existed and were disclosed. This requirement is consistent with the legislative directive that a conversion decision be a fair and unbiased decision. Corporate decision makers may rely on experts and advisors in general and in the context of a conversion. See MD. CODE ANN., STATE GOV'T § 6.5-301(e)(2); Corp. & Assoc. Art. § 2-405.1(b)(1)(ii). Thus, in addition to assuring that they have no bias or conflicts of their own, it is critical that decision makers be aware of any bias or conflict that might influence the experts that they rely upon. The existence of a conflict does not necessarily disqualify the expert or advisor. The MIA, however, must consider whether such conflicts were disclosed and, thus, considered by the Board in relying on experts and in otherwise deciding to approve the Proposed Transaction.

There are three circumstances in which it appears that significant conflicts of interest may have existed with respect to third parties that played key roles in CareFirst's decision to convert and/or in negotiations relating to the selection of a merger partner. In one case, that conflict was not disclosed to the Board. It is uncertain whether the Board was aware of, appreciated, or took into consideration the other conflicts that existed.

1. The Neuberger Conflict

The first conflict involves the engagement of Isaac Neuberger by certain corporate officers to represent CareFirst in negotiations with potential merger partners without the knowledge or permission of the Board. Mr. Neuberger is an attorney and a principal in the law

firm of Neuberger, Quinn, Gielen, Rubin & Gibber, P.A. In 1998 and 1999, Mr. Neuberger represented Mr. Jews personally in the negotiation and drafting of his employment agreement and compensation package with CareFirst.[430] Mr. Neuberger also represented Mr. Wolf in 1996 and 1997 in connection with the negotiation and drafting of his employment agreement with CareFirst.[431]

Mr. Neuberger was involved in discussions and negotiations relating 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. In addition, Mr. Neuberger met with officers to assist them in preparing for presentation to the Board.

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.[432] According to Mr. Jews, Mr. Neuberger was not engaged to act on behalf of any individual officer.

The record does support the inference that Mr. Neuberger provided some general advice and guidance to CareFirst regarding the plan to convert and the selection of a merger partner. However, it is clear from Mr. Neuberger's billing records that Mr. Neuberger's played a significant role in the analysis, and comparison of the executive compensation for Mr. Jews and other CareFirst executives.

Mr. Neuberger began billing time to CareFirst in conjunction with what his bills describe as a "reorganization" in August, 1999.[433] By December, 1999, Mr. Neuberger was talking to Mr. Jews, Mr. Wolf, and various investment bankers several times per week. Id. This practice continued through 2000, with the intensity of the contacts increasing over that period.[434] By January 2001, it became clear from Mr. Neuberger's billing entries that a major focus of his role was executive compensation. The billing entries throughout 2001 appear to be directly related to his review of compensation arrangements, including comparisons of compensation offers from Trigon and WellPoint. For example, in January, 2001, Mr. Neuberger met with Billie Grieb, an attorney at Piper who was working on compensation issues.[435] On March 14, 2001, Mr. Neuberger reviewed the "Hay alternatives."[436] Hay was the executive compensation consultant for CareFirst. The following day, Mr. Neuberger had a telephone conference with Sharon Vecchinone, Mr. Jews' assistant, "to review compensation analysis." Id.

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[430] Indeed, it was Mr. Neuberger that proposed the excise tax "gross-up" of Mr. Jews' parachute payment. Exhibit 237, October 21, 1998, Isaac Neuberger letter to William L. Jews, N0000488 – N0000489; Exhibit 238, October 30, 1998, Neuberger letter to Jews, with attached Employment Agreement, N0000490 – N0000810; Exhibit 240, November 1, 1998, February 1, 1999, October 1, 1999, December 1, 1999, and July 1, 2000, Neuberger, Quinn, Gielen, Rubin & Gibber, P.A. invoices to William L. Jews, N0000211 – N0000215; Exhibit 241, October 14, 1998, Neuberger letter to William L. Jews, with attached draft Employment Agreement, N0000244 – N0000273.

[431] Exhibit 239, December 1, 1997, and November 1, 1998, Neuberger, Quinn, Gielen, Rubin & Gibber, P.A. Invoices to William L. Jews, N0000207 – N0000210.

[432] Deposition of William L. Jews, September 6, 2002 at 37.

[433] Exhibit 236, Neuberger, Quinn, Gielen, Rubin & Gibber, P.A., January1, 2000 Invoice to David Wolf (CareFirst) at N0000027 – N0000028.

[434] Id. at N0000029 – N0000048.

[435] Exhibit. 236 at N49.

[436] Id. at N53.

Mr. Neuberger's March, April, and May billings focused on an analysis of compensation issues, reviews of compensation matrices, meetings with attorneys from Piper who were addressing executive compensation issues, and "work" on the terms of compensation agreements and alternatives.[437] It is particularly interesting that in June, 2001, Mr. Neuberger began to have frequent, indeed almost daily, conversations with David Platter, the Trigon investment banker leading the negotiations for Trigon.[438] Throughout the Summer and into the Fall, 2001, Mr. Neuberger was focused on discussions regarding compensation first with Trigon and later with WellPoint. He also made comparisons of the "Atlantic and Pacific deals" based on pension, benefit and compensation arrangements.[439] Mr. Neuberger also attended a meeting between Mr. Jews and Mr. Snead regarding Mr. Jews role in the combined company. According to the testimony, no other lawyers purportedly representing CareFirst attended this meeting.

As discussed earlier, in the Spring and Summer, 2001, negotiations with WellPoint appeared to be at a standstill, while discussions with Trigon intensified. Trigon has testified that during this time frame a key element of the discussions involved the scope and the amount of compensation packages to be paid to CareFirst executives, including Mr. Jews and his role in the compensation. Trigon also testified that a key element of the breakdown of negotiations with CareFirst was Trigon's unwillingness to agree to the large compensation packages demanded by CareFirst, including the Management Incentive Bonuses. WellPoint, on the other hand, objected to the compensation arrangements proposed on behalf of CareFirst, but was willing to fund them as a cost of the acquisition.

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.[440] 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. Mr. Altobello was not aware that Mr. Neuberger was talking to Mr. Jews and Mr. Wolf on a daily basis at points in time. Mr. Altobello was not aware the Mr. Neuberger was having direct meetings and conversations with Trigon's President, Mr. Sneed. Mr. Altobello believed that CareFirst's in-house attorneys and Piper were reviewing any compensation arrangement connected to the Proposed Transaction; he was unaware that Mr. Neuberger was being paid by CareFirst to review them and revise them.

These facts clearly support the conclusion that Mr. Neuberger appeared to have a conflict of interest in his representation of CareFirst. Mr. Neuberger represented Mr. Jews and Mr. Wolf in the negotiation and drafting of the employment agreements that gave rise to many of the compensation arrangements that became an issue in the Proposed Transaction. According to his billing records, Mr. Neuberger played a significant role in the Proposed Transaction examining and reviewing the compensation proposed for executives. 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 represented the corporation, although the billing records show Mr. Neuberger was paid by the corporation.

The interests of CareFirst and the interests of Mr. Jews and the other CareFirst executives were divergent on the issue of compensation. CareFirst had made the decision to convert and was seeking the merger partner which would provide, among other things, the best value for the

[437] *Id*. at N53-60.
[438] Id. at N61–62.
[439] Id. at N61-75.
[440] Testimony of Daniel J. Altobello, January 31, 2003, at 69.

public assets of the company. Mr. Jews, on the other hand, had an interest is assuring that he received whatever compensation he might be entitled to under the employment agreement, plus whatever CareFirst and/or its merger partner was willing to pay in merger incentive bonuses. Thus, as Mr. Altobello acknowledged, having the CEO's personal compensation counsel representing the company in meetings with potential suitors was not "a good practice."[441]

The testimony demonstrates that Trigon was willing to increase the amount to be paid for CareFirst. It was not willing, however, to pay large executive compensation packages to Mr. Jews or the other executives. In addition, Trigon took the position that the executive compensation packages were probably unlawful and were unlikely to withstand regulatory scrutiny. These circumstances, raise questions as to how Mr. Neuberger could represent the interests of CareFirst in discussions with Trigon (or WellPoint) regarding a purchase of CareFirst. Could he, without bias, address the question of the reasonableness of the executive compensation packages and their legality, given his representation of Mr. Jews and Mr. Wolf?[442] At the point at which the interests of the officers diverged from the interests of the corporation, whose interests would Mr. Neuberger serve? The evidence suggest those interests indeed diverged. Trigon was viewed as a desirable merger partner, and thus it was in the corporation's interests to consummate a deal. Management's insistence on large bonuses and permanent roles in the combined company conflicted with CareFirst's interests because it impeded the ability to consummate the deal.

It is not within the province of this Report to resolve these questions. What is significant for the purposes of this Report is that 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. There is at least some evidence that this arrangment may have impaired the Board's ability to make an informed judgment about the status of negotiations with the bidders. Mr. Altobello gave the following testimony on whether either bidder objected to the bonuses:

> Q: Did the executive compensation become an issue or problem with either of the potential bidders, Trigon or WellPoint?
> A: No.
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> ***

[441] Id. at 78.

[442] The Rules of Professional Conduct prohibit a lawyer from representing a client if the representation is "directly adverse to another client" unless the lawyer "reasonably believes the representation will not adversely affect the relationship with the other client" and "each client consents after consultation." Rule 1.7(a). While a lawyer may represent both a corporation and its individual officers and directors, under Rule 1.13 the dual representations are subject to the requirements of Rule 1.7. Even with regard to a former client, counsel cannot represent another person in a substantially related matter if the new client's interests are materially adverse to the former client, unless the former client consents after consultation. Rule 1.9.

Q: Then, finally, did Trigon ever express any concern about the executive compensastion issue?
A: No.
Q: Never said "too much?"
A: No, not to my knowledge.[443]

The extent of Mr. Neuberger's involvement in the Proposed Transaction, his apparent conflict of interest, and the failure to make any disclosure of his role or his conflict to the Board raises significant questions about the process that lead to the rejection of Trigon. Consequently, the MIA concludes that the existence and the failure to disclose this conflict supports the conclusion that the Proposed Transaction is in the public interest.

2. The Failure to Appreciate CSFB's Conflict

As part of its application to convert, CareFirst was required to submit a financial analysis from an "independent expert or consultant" that addressed the criteria outlined in § 6.5-301. That criteria includes whether the public assets of the entity are fairly valued and whether that value has been safeguarded for distribution to the Foundation. MD. CODE ANN., STATE GOV'T § 6.5-301.

On November 20, 2001, CSFB presented its "Valuation Analysis" to CareFirst's Boards, estimating CareFirst's value at $1.01 to $1.2 billion based on a comparable public companies' analysis; $1.17 billion to $1.59 billion based on a comparable M&A transactions analysis; and $1.2 billion to $1.525 billion on a discounted cash flow analysis. On the same date, CSFB provided the Boards with its fairness opinion ("CSFB's Fairness Opinion"). CSFB's Fairness Opinion states that "as of the date hereof, the Merger Consideration is fair from a financial point of view to the holders of the Company Stock immediately prior to the Merger."

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 each of those Opinions.

First, CSFB represented CareFirst in the negotiation of the agreement with WellPoint. A question necessarily 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 in accepting the CSFB Fairness Opinion.

Second, 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.[444] If the transaction with WellPoint does not close, CSFB's fee for its services is approximately $750,000. If, however, the Proposed Transaction closes, CSFB will receive $13 million.[445] The Fairness Opinion was a necessary prerequisite to closing.

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[443] Testimony of Daniel J. Altobello, March 11, 2002, at 279 – 295.
[444] (Smith, Day 2, 490:11-14).
[445] (Stuart Smith, Day 2, 490:16-20).

Delegating the fairness analysis and opinion to CSFB, at a minimum, created the risk of a result oriented opinion, given the significant financial incentive that CSFB had to issue a positive opinion and, thus, advance the consummation of the transaction. CSFB counters the suggestion that its Opinions were biased by suggesting that it operates in a business where reputation and integrity are important, and CSFB would not risk its reputation and integrity.[446] However, recent events and revelations regarding apparently inappropriate, or even illegal, practices and arrangements at certain banking firms cast doubt on the efficacy and sufficiency of an investment banker's interest in maintaining its reputation and integrity as a safeguard against conflicts and undesirable practices. Furthermore, one could surmise that a reputation for frustrating management's plans - by opining to boards that the financial terms of proposed transactions are unfair - may be just as damaging to an investment banker's ability to be hired by companies intent upon consummating such deals. After all, outside consultants are typically hired by boards of directors upon recommendation of management.

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. 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. Brown's Due Diligence Report cautions that CSFB had conflicts of interest in issuing its Fairness Opinion, but "hasten[s] to add that both the structure of CSFB's compensation arrangement and its role as the issuer of an opinion opining as to the fairness of a price that it negotiated are typical in the investment banking business, and have not been invalidated by the courts."[447] The Draft Brown Report concludes: "Notwithstanding these criticisms, CSFB's conflicting interests do not under current law create a sufficient lack of impartiality to preclude a Board of directors from relying on CSFB's Fairness Opinion."[448].

This may be true from the perspective of assessing a director's potential financial liability in cases like shareholders' derivative actions, but it does not address whether, under these circumstances, CSFB can qualify as the "independent expert" or as the "appropriate expert assistance" contemplated by the Act. Nor does it excuse the Board for failing even to give consideration to the conflict.

The fact that a particular practice is common in the industry may suffice under the business judgment rule for a Board of Directors to rely upon that practice in exercising its duty of care. However, as we have learned recently, the fact that particular practices were prevalent on Wall Street or among investment bankers may not make such practice desirable or defensible in the context of the Maryland statutes governing this transaction. For example, the fact that, in some institutions, it was not uncommon for the stock analysts to report to the investment banking side, a structure which may have skewed the independence of the analysts, does not make that practice acceptable or desirable.

It is therefore fair to question the reasonableness of CareFirst seeking 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. Certainly they considered no alternatives and put in place no measures to offset the result of any potential bias by CSFB. This method of

[446] Testimony of Stuart Smith, Day 2, March 13, 2002, at 492 - 494.
[447] Brown Due Diligence Report, page 126.
[448] Id.

compensation is intended to give the investment bankers an incentive to bring a transaction to consummation.[449] In this case, if the transaction with WellPoint did not close, CSFB would receive approximately $750,000, whereas if the deal closes, CSFB will receive $13 million.

Finally, 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. Stuart Smith testified this does not pose a conflict of interest because there are "Chinese walls" in place to preclude the traders and the investment bankers from colluding with each other.[450] R.W. Smith testified that such arrangements are typical and safeguards include the fact that ultimately the investment banker's professional responsibility and reputation are on the line and, in any case, it is the board of directors that ultimately approves whether or not a transaction goes forward.[451] However, despite such "Chinese walls," CSFB consultants were aware that CSFB traded in WellPoint stock. They can be presumed also to be aware, therefore, that what is good for the right hand (*i.e.*, stock profits from trading in WellPoint stock) is good for the left hand (*i.e.*, CSFB consultants advising CareFirst with respect to a proposed transaction with WellPoint) because it benefits the same body (*i.e.*, CSFB). As the recent "tech wreck" illustrates, conflicts of interest cannot be prevented merely by erecting "Chinese walls" or presuming that an investment banker's left hand is unaware of the implications of its actions to the right hand, or that both hands contribute to the investment banker's profitability and, ultimately to each hand's benefit.

The fact that the Board failed to appreciate and consider the CSFB conflicts represents a significant deficiency in the Board's process. While it is not possible to say that the conflicts necessarily made it unreasonable for the Board to rely on CSFB's Valuation Analysis and Fairness Opinion, the Board, at a minimum, was required to acknowledge the existence of the conflicts and to address them. The Board, at a minimum, should have considered what impact the conflicts should have on the weight given to the Opinions and whether additional opinions should have been obtained from completely independent experts. The Board's failure to do so supports the conclusion that the Proposed Transaction is not in the public interest.

3. The Accenture Conflict.

CareFirst was required by MD. CODE ANN., STATE GOV'T § 6.5-201 to submit an analysis of the impact of the Proposed Transaction on the community with its application to convert. To fulfill this obligation, CareFirst engaged Accenture to perform a community impact analysis. Accenture's report, entitled "Community Impact Analysis" was produced in January, 2002 and submitted with the original Form A. The Analysis purports to assess the likely effect of the acquisition "upon the availability, accessibility, and affordability of health care."

Accenture is the same entity that assisted CareFirst in developing and implementing the strategy that lead to the Proposed Transaction, including the identification of WellPoint as a potential merger partner. Indeed, the same individual who authored the strategic plan and the Case for Change, Mr. Marabito, authored the Community Impact Analysis.

The Proposed Transaction is the fulfillment of the recommendations made and the guidance provided in the Case for Change. That fact immediately raises the question of whether Accenture, as the author of the Case for Change, could independently evaluate the impact of the

[449] Testimony of Stuart Smith, Day 2, March 13, 2002, at 490.
[450] Id. at 503 - 504.
[451] Testimony of R.W. Smith, Jr., March 14, 2002, at 137 - 139.

Proposed Transaction in the community. The Board, however, never considered whether Accenture was predisposed to find that the Proposed Transaction would not have a negative impact on the community. There is no indication that the Board ever considered whether Accenture might have a conflict and, thus, be unable to provide an independent evaluation.

In addition, in the Community Impact Analysis, Accenture discloses:

It should be noted that Accenture also provides services to WellPoint. These services are not related to the proposed merger with CareFirst, and the team of Accenture personnel involved in preparing this Report is entirely separate from the team providing services to WellPoint. Neither Accenture nor any Accenture Partners involved in preparing this Report currently hold directly or indirectly (other than through the holding of mutual funds) or plan to acquire the stock of WellPoint during the timeframe of this transaction. While Accenture will receive a pre-arranged fee from CareFirst for the preparation of this Report, the amount of the fee does not depend upon the approval or disapproval of the proposed transaction by the respective jurisdictions.[452]

This statement also raises serious questions about Accenture's independence and whether it had a conflict that prevented it from rendering an objective analysis. Documents received by the MIA show that Accenture received fees of $800,000 from WellPoint in 2000 and over $4 million from WellPoint in 2001. While efforts may have been taken to create a "Chinese Wall" to prevent Accenture's WellPoint's team from influencing the conclusions of Accenture's CareFirst team, the appearance of conflict remains. And, more significantly, there is no indication that the Board took this conflict into consideration when it allowed Accenture to conduct the community impact analysis or when the Board considered the conclusions reached by Accenture.

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.

N. Will the acquisition have the likelihood of creating a significant adverse effect on the availability or accessibility of health care services in the affected community?

The Maryland Insurance Administration retained several experts to assess the potential impact of the transaction on the availability or accessibility of healthcare services in the affected community. The conversion statute also required the MIA to determine whether the transaction is "equitable" to current enrollees, insureds, shareholders, and certificate holders, if any, of CareFirst. MD. CODE ANN., STATE GOV'T § 6.5-303(2)(i). The MIA viewed the "fairness" and "impact" analyses as overlapping areas of inquiry. Whether a transaction is equitable requires an examination of the treatment of insureds occurring after the acquisition. Relevant behaviors include pricing changes, underwriting changes, formulation of benefits, claims payment, network development, and customer service. Many of these same issues impact the availability and affordability of health care. Therefore, although this report expresses separate conclusions as to the two statutory criteria, the evidence bearing on both will be considered together.

[452] CF-0000224.

1. The Feldman Report

Roger Feldman, Ph.D., collaborating with Douglas Wholey, Ph.D., and Robert Town, Ph.D., all affiliated with the Division of Health Services Research and Policy in the School of Public Health at the University of Minnesota, was among the experts retained by the MIA to assist in the impact analysis. These economists conducted a study entitled "The Effect of HMO Conversions to For-Profit Status on Premiums, Claims Payable, Provider Payments, Members' Use of Services, and Profits." Their study was not specific to the WellPoint transaction, but instead utilized publicly available data filed with regulators and third party data consolidators, to extract evidence of trends and general conclusions that might be applicable to this transaction. While limited to HMO data only, the study provides one more tool in attempting to assess the possible impact of a WellPoint acquisition on CareFirst HMO subscribers. Their overall conclusion of the various specific effects of HMO conversions was that they are mixed, and in some cases inconclusive. Among the findings of the report are:

- For-profit HMO premiums are 4.4% lower than not for-profit HMO premiums.
- For-profit HMOs are not more profitable than nonprofit HMOs, and size and experience rather than form of ownership determine whether an HMO is profitable.
- For-profit HMOs had a higher administrative expense ratio by 1.57% than not-for-profits. HMOs less than 2 years old had a higher expense ratio by 4.29%.
- There is some evidence that for-profit HMOs take longer to pay providers than nonprofit HMOs, but the effect is small. A larger one-time delay in provider payments occurs one year before the conversion, which suggests that HMOs in financial trouble may delay paying providers and subsequently convert to for-profit ownership.
- The only significant difference in provider payments is a one-time increase of about 14% in hospital per diem payment two years before a conversion.
- Enrollees in for-profit HMOs account for significantly fewer hospital days than do enrollees in nonprofit HMOs.
- An HMO with ten competitors charges 4.2% less than one without competitors.
- WellPoint does not appear to earn excessive profits, although its actual premiums were higher than predicted premiums from 1996 through 2000.

2. The Delmarva Report

The Maryland Insurance Administration retained the Delmarva Foundation to review the potential impact the transaction would have on health care providers and provider networks in the State, utilization management practices, quality management practices, and whether any other measures relating to the availability or accessibility or quality of health care would be impacted by the transaction.

The Delmarva Foundation for Medical Care, Inc., is a non-profit health care organization founded in 1973 with the goal of improving the quality and value of health care services. Delmarva has worked with the Federal government, State agencies and private organizations to

review quality improvement, quality assurance, utilization review and external quality reviews in all settings of care. The Delmarva team includes physicians, nurses, health analysts and other professionals. The Delmarva Foundation reviewed numerous sources of information including interviews, review of testimony from public hearings and depositions, publicly available documents from regulatory agencies, surveys, and information received from both WellPoint and CareFirst.

Delmarva reviewed WellPoint's relationship with health care providers because, obviously, access to health care services can be affected substantially by WellPoint's arrangements with provider networks, physicians, hospitals, and other health care workers that actually deliver the care insured by WellPoint. Delmarva cited a 2000 HMO Performance Assessment Survey Report sponsored by the Pacific Business Group on Health, a large employer coalition in California, that ranked California HMOs, including BlueCross of California, the WellPoint HMO. WellPoint was consistently given low scores in those rankings.

Physicians ranked the eight largest HMOs in Southern California based on twelve different criteria, which included such areas of evaluation as, "negotiating style", "efforts to help resolve patient grievances", and "ease of reconciling reports and payments." Of the twelve criteria, WellPoint ranked either last (8/8), or next to last (7/8), in four. It ranked first (1/8) or second (2/8) in four, and in the rest its ranking varied among third, fourth, fifth or sixth. WellPoint's rankings were even worse with the hospital community. The hospitals evaluated WellPoint and other HMOs on fourteen criteria including such items as "accuracy of payment," and "timeliness of payments." WellPoint ranked either last (8/8), or next to last (7/8), in twelve out of the fourteen categories. The following charts from the Delmarva Report summarize the hospital and physician evaluations.

Table 1. Summary of rankings by physician organizations

Area of evaluation	Blue Cross of California	Blue Shield of California
Negotiating style	8/8	1/8
Flexibility to allow groups to decide on level of risk adopted	8/8	6/8
Time for eligibility verification	1/8	1/8
Accuracy of eligibility verification	2/8	3/8
Completeness of eligibility roster	2/8	3/8
Clarity of areas of responsibility for group and HMO	1/8	1/8
Member education on coverage and benefits	6/8	3/8
Efforts to help resolve patient grievances	5/8	4/8
Accuracy of pharmacy reports	4/8	3/8
Accuracy of capitation payments and reports	7/8	2/8
Ease of reconciling reports and payments	7/8	1/8
Completeness of capitation payments and reports	3/8	1/8

Table 2. Summary of rankings for hospital evaluations

Area of evaluation	Blue Cross of California	Blue Shield of California
Negotiating style	8/8	1/8
Responsiveness to contracting change requests	8/8	2/8
Time for HMO to verify eligibility data	1/8	1/8
Encounter report accuracy	2/8	4/8
Prompt response to questions	7/8	2/8
Willingness to help resolve hospital-physician group issues	8/8	1/8
Timeliness of payment (capitation contracts)	7/8	4/8
Timeliness of payment (FFS contracts)	7/8	3/8
Accuracy of payments (capitation contracts)	7/8	3/8
Accuracy of payments (FFS contracts)	7/8	4/8
Resolution of disputed payments (capitation contracts)	8/8	4/8
Resolution of disputed payments (FFS contracts)	8/8	2/8
Appropriateness of retro reviews	8/8	5/8
Overall satisfaction with HMO*	8/8	3/8

*46% of hospitals rated WP/BCC as the worst health plan.

In terms of the overall results of the physician organizations surveyed, only 5% rated Blue Cross of California as "the best health plan," and 13% rated it the worst.[453] The difference was even more striking in the case of the hospitals surveyed, almost 7% of which rated WellPoint the best health plan and 46% of which rated it the worst health plan." Id.

Delmarva also performed a separate survey of primary and specialty providers who contracted with BlueCross of California and BlueCross BlueShield of Georgia. These results were compared with those of the same survey of providers who contract with CareFirst. In this survey Blue Cross of California received satisfaction rankings substantially lower than CareFirst received from its providers. For example, 40% of the doctors who responded to the survey indicated that CareFirst was worse or much worse on a scale of satisfaction than other insurers, whereas only 23% indicated that CareFirst was better than average. However, this is contrasted with a larger percentage of respondents in California who said WellPoint was worse or much worse than others (58%), and a smaller number who indicated that WellPoint was better than average (17%).[454] Delmarva concluded that the acquisition would have a (slightly negative) impact on the measure of provider opinion.[455] According to Delmarva, on the issue of hospital contracting, the California Department of Managed Care (CDMHC) stated that "in 2002 California experienced significant hospital disruption, BC's level of disruption was significantly more severe when compared to other HMOs. BC maintains the lowest reimbursement rates with hospitals, and experienced a severe push back for the industry this year."[456]

There were a number of other important areas analyzed by Delmarva. However, as will be discussed below, its ability to render a complete and full analysis was impaired by WellPoint's refusal to provide requested information deemed essential for a complete analysis.

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[453] "The Potential Effects of a CareFirst Acquisition by WellPoint on Maryland Stakeholders", February 2003 (the "Delmarva Report") at 12.
[454] Id. at 18.
[455] Id. at 65.
[456] Id. at 20.

Delmarva reviewed issues relating to the utilization management of the two plans. Both CareFirst and Blue Cross of California were accredited by the National Commission on Quality Assurance (NCQA) for utilization management in 2001. As part of their utilization management functions, health plans use clinical criteria to assist staff in making medical appropriateness determinations. CFMI indicated that its staff uses the "Milliman and Robertson, Inc. Healthcare and Management Guidelines" and the "Modified Appropriateness Evaluation Protocol" which CareFirst Medical Directors have "customized for the plan areas." CareFirst also uses internal criteria for specific clinical circumstances to assist its staff. However, according to the Delmarva report neither WellPoint nor CareFirst provided the specific review criteria for Delmarva to compare what the staff uses to make medical determinations.[457] However, Delmarva noted that WellPoint recently purchased the rights to Milliman, Inc., Guidelines, which would indicate to Delmarva that both plans would use the same set of guidelines to conduct medical reviews.[458] However,Delmarva noted that they could not determine how the guidelines would actually be used.[459]

One of the goals of utilization management is to ensure appropriate utilization of health care services. CareFirst provided Delmarva with documents showing that processes were in place to monitor and analyze over-and under-utilization data. (Delmarva pg. 31) WellPoint provided a 1999 accreditation report indicating that BlueCross of California monitored certain utilization information, but WellPoint did not provide 2002 comparable data.

Delmarva also questioned whether, in reviewing medical appropriateness, local practitioners in Maryland would have to speak to WellPoint staff in California; and whether Maryland personnel would have a role on the review committees developed to examine WellPoint's medical criteria.[460] The testimony the MIA received later, which is discussed below, suggests that this would not be the case.

The appropriate and timely provision of services to mental health patients is a particular concern from an access standpoint, and Delmarva attempted to evaluate the potential impact on mental health patients. Unlike CareFirst, which contracts with Magellan to deliver its mental health benefits, WellPoint has its own contractor, WellPoint Behavioral Health Services (WPBHS). WPBHSconducts behavioral health review for WellPoint plans in several states. According to Delmarva, WellPoint indicated to them it had not determined whether it would replace Magellan with WPBHS.[461] However, in separate testimony before the MIA, WellPoint testified that (in order to obtain cost savings in the transaction) it would most likely substitute its own behavioral health vendor for the one currently used by CareFirst. WellPoint, however, declined to provide to Delmarva its clinical review criteria in conducting behavioral health reviews, noting only that the review criteria were internally developed.[462]

Another important area of inquiry is whether WellPoint would employ the appropriate professionals to make utilization management decisions. Delmarva concluded that "based on the lack of documentation provided by WellPoint in this area, there is not sufficient information to

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[457] Id. at 31.
[458] Id. at 24.
[459] Testimony of Patricia Windsor Newcomb, at the Public Hearing held before Commissioner Steven B. Larsen, on January 29, 2003, at 131 – 133.
[460] Id. at 24.
[461] Testimony of Patricia Newcomb, Day 10, January 29, 2003, page 127; Delmarva Report at 26.
[462] Id. at 131 - 133; Delmarva Report at 26.

make a comparative analysis with the information provided by CareFirst."[463] Delmarva noted that, although both of the plans use nurses and physician reviewers, the evaluation process for "appropriate use of criteria by staff" at WellPoint was not provided, limiting the ability to draw any conclusions on this issue.

Delmarva also examined the internal and external appeal process materials for both CareFirst and WellPoint. The internal and external appeal process can have a significant effect on whether medically necessary services are made available to members of a health plan. Delmarva concluded that the processes submitted by CareFirst of Maryland and WellPoint are "comparable,"[464] and noted that both organizations are accredited according to NCQA's standards and meet Maryland and California State standards. According to Delmarva, the California Department of Managed Care concluded that, at least with respect to activities in the area of Appeals & Grievances, WellPoint's "rate of complaints does not exceed acceptable standards." The California Department of Managed Care also noted that WellPoint's "overall responsiveness to member complaints processed by the Department is satisfactory." The Department believed that the proportion of complaints filed relating to WellPoint enrollees is consistent with most other plans. Id.

CareFirst provided Delmarva access to material relating to Quality Improvement efforts. For example, in one instance, the materials provided show that staffing shortages, inexperienced staff, and termination of medical groups served as causes for emergency room and outpatient appeal levels.[465] A Quality Improvement Report for CFMI noted that the 2001 provider satisfaction surveys showed that one of the lowest rated attributes of the BlueChoice program was the appeals process, with only "27% of the practitioners satisfied with the [BlueChoice] appeals process." Id. Delmarva could not perform any type of comparative analysis with respect to WellPoint's quality improvement efforts and its problems or responses because WellPoint did not provide access to comparable information. According to Delmarva "WellPoint did not provide policies nor results of program evaluations that could be comparable to policies and documents in the CareFirst of Maryland annual quality improvement program evaluations for 2001 and 2002." Id.

Delmarva also examined measures relating to the quality management structure of CareFirst and WellPoint. Delmarva staff attempted to perform a review of each evaluation component of the NCQA accreditation requirements for quality improvement as to both, CFMI and WellPoint. According to Delmarva, "accessing and comparing submitted quality improvement program documentation from CareFirst of Maryland and WellPoint may help to guage the impact of a possible acquisition on the future delivery of care and services by WellPoint."[466] To accomplish this analysis, Delmarva requested quality management policies and procedures from both CFMI and WellPoint. Also requested were meeting minutes from the Quality Improvement Council and associated committees, which would be should have been available because NCQA expects that the health plans it accredits report their results of performance measures to their leadership,develop a quality work plan, and evaluate quality improvement program results annually. Although CFMI provided a sample of Quality Improvement Council minutes from 2002, WellPoint did not provide examples of any committee minutes. However, because both organizations have maintained commendable NCQA accreditation throughout 2003, Delmarva concluded that "there is a high probability that the

[463] Delmarva Report at 26.
[464] Id. at 28.
[465] Id. at 30.
[466] Id. at 32.

written quality improvement program at WellPoint is comparable to the written program at CareFirst of Maryland."[467]

Both CFMI and WellPoint provided documents indicating they collect data on specific quality improvement performance measures annually. Although CFMI did provide Quality Improvement Advisory Council minutes that included an evaluation of its QI Program for the years 2000 and 2002, WellPoint did not provide results for all of its quality management and improvement measures.

There are other examples where Delmarva could not perform a comparison because of WellPoint's failure to provide documentation. According to the documentation provided to Delmarva, both CFMI and WellPoint have provided contracting standards that require practitioners to participate in quality improvements activities. However WellPoint did not provide specific policies that contained standards and goals for access to primary care, specialty care or behavioral health networks, but in an interview WellPoint officials stated that their goal "in any network is 80%" of providers. CareFirst did provide copies of its Quality Improvement Advisory Committee meeting minutes that revealed reports regarding CareFirst's "network accessibility analysis" conducted earlier in 2002. Those minutes show, for example, that there were deficiencies in CareFirst's networks in rural areas of the Eastern Shore and western, Maryland, as well as other areas.[468] WellPoint did not provide comparable information to determine its approach to identifying and addressing QI issues.

On the issue of disease management, which is one way health plans manage members with multiple or chronic conditions, both CareFirst of Maryland and WellPoint have extensive disease management programs for children, adults and seniors. Delmarva concluded that in many areas the two disease management programs were "comparable"[469]

The Delmarva Foundation compared CFMI with BlueCross of California on various "HEDIS" (Health Employer Data and Information Set) scores. According to Delmarva HEDIS "has become the national standard for health plan performance assessment." Delmarva selected a subset of 23 HEDIS measures for comparison between the two companies. The measures were selected to illustrate the quality of services rendered to certain populations (children, women, and those with chronic illness), which Delmarva considered the most likely to be affected by the proposed acquisition.[470] No clear pattern emerged from this extensive analysis with WellPoint companies scoring better on some measures and CareFirst companies scoring better on others. Delmarva stated:

> The likely impact of conversion and acquisition on HEDIS scores in Maryland is very difficult to assess because there are no clear trends available upon which to base an opinion. Although in 2001 CareFirst generally performed higher on the individual measures included in the subset of measures analyzed, certain domains of care are managed more effectively by the WellPoint HMOs, and in still others, there is no clear difference in performance … Following the possible conversion and sale of CareFirst entities, some measures may reflect increases while others may reflect decreases over time, depending on factors such as management

[467] Id. at 33.
[468] *Id*., at 35.
[469] *Id*., at 42.
[470] *Id*., at 47.

> focus, provider network stability, and health plan attention to data collection and reporting.[471]

According to Delmarva, "consumers' experiences with their health care and health plans are also important measures of performance used to monitor quality." Delmarva compared "CAHPS" (Consumer Assessment of Health Plans) survey results for both WellPoint and CareFirst. The CAHPS survey is administered to a sample of health plan members and measures consumers' perception of various aspects of care that are important to them.[472] No definitive conclusions could be drawn on the issue of access, availability, or quality from the comparison of the CAHPS survey results. Even within CareFirst, there were substantial inconsistencies among different CareFirst affiliates with the Delmarva Health Plan often ranking as the highest performer in certain measures and another BlueCross HMO BlueChoice ranking among the lowest performers. Delmarva did, however, make the following observations:

> On individual plan basis, the analysis indicates that members of some [CareFirst] plans are generally more satisfied with their health plans than are the members of the [WellPoint] plans. However, trend analysis indicates that the WellPoint members are increasingly satisfied with their health plans… the possible conversion and sale of [CareFirst] may in fact have a little substantive impact on members' perception of their health care or health plan when in fact only minimal changes in network make-up, customer service, or health plan management may have taken place. There may be declines in member health plan satisfaction in the event of a conversion and a sale, but the aspects of satisfaction related to the delivery of health care will likely remain high if providers of care currently in place maintain their relationships with their patients.[473]

Delmarva also examined the performance of WellPoint and CareFirst HMOs in HMO Report Cards for California and Maryland. As was the case with both HEDIS scores and CAHPS survey results, there was not appreciable difference in the performance of CareFirst and WellPoint in their respective home state HMO report card analysis.[474]

Delmarva also examined complaint indexes for CareFirst and WellPoint plans. Delmarva looked at not only Blue Cross of California but also RightCHOICE in Missouri and BlueCross BlueShield of Georgia, which were acquired by WellPoint. Although the data were not exactly comparable, Delmarva sought to create an "apples to apples" comparison by measuring whether a particular health plan was the subject of more or fewer complaints than the majority of other plans in the market. Using this index or ratio approach, if a health plan fell below the 50 percent level, then the plan received fewer complaints than the majority of other plans in the State, while a percentile greater than 50 indicates that the plan received more complaints than the majority of other plans in the State. Delmarva concluded that CareFirst was in the 56th percentile, while Blue Cross of California was in the 71st percentile. Delmarva concluded that this difference was "appreciable." However, WellPoint health plans, such as RightCHOICE in Missouri and Georgia BlueCross BlueShield, scored better than did WellPoint

[471] *Id*., at 50-51.
[472] *Id*., at 51.
[473] *Id*., at 53.
[474] Id. at 59.

in California.[475] Delmarva noted, however, that WellPoint had been running the Georgia and Missouri plans for much shorter periods of time.

Overall, based on its analysis of all of the factors cited above and others, Delmarva concluded that "the immediate impact of the proposed conversion on Maryland stakeholders would be neutral to moderately negative."[476] Of the thirteen areas reported on by Delmarva one area, provider reimbursement in networks, was viewed to be a negative impact. Three other areas, provider opinion, complaint indices and medical loss ratios, reviewed as "slightly negative." One area was inconclusive, and the rest were viewed as neutral. The following table summarizes Delmarva's conclusions:

Table 12. Impact opinion summary of the proposed conversion and sale

Report Section	Delmarva Opinion of Impact	Basis For Opinion
Provider Contracting	Negative	Decreased reimbursement may result in smaller networks based on contracting style and the need to show savings in MD.
Provider Reimbursement and Networks	Negative	Decreased reimbursement may result in smaller networks based on contracting style and the need to show savings in MD.
Complaint Indices	Negative	WP's BCC received comparatively more complaints than CF plans on average; however, some of the differences in complaint measures may be attributable to differences in populations that the plans serve in each state or differences in the types of competitors in each state.
Provider Opinion	Slightly negative	Because of low sample sizes, attributable to low response rates, strong conclusions about provider opinions are not possible; however, most of the provider comments tended to be negative.
Medical Loss Ratios	Slightly negative	Given the loss of the premium tax exemption, the loss of the SAAC discount, that hospital rates cannot be changed (at least, in the short term), and that new product selection and offerings may be limited by state mandates, savings will need to come from some area to demonstrate to shareholders' actual savings/growth of WP's status after the proposed merger. The savings/growth will most likely come from increasing administrative costs; therefore, a decrease in the medical loss ratio.
Benefit Package and Products	Slightly negative	Low-cost coverage will not only cause the currently uninsured to buy these insurance "lite" policies but this practice will also siphon off the better-risk or currently insured individuals from purchasing more comprehensive insurance (young healthy individuals) by encouraging them to buy this less extensive coverage.
Provider Incentives	Neutral	Incentives for FreeState had fewer utilization measures than the current BlueChoice and WP incentive plans. No change is expected.
Hospital Contracting	Neutral	This opinion is made assuming the Maryland Waiver is unassailable, although this is not certain.
Provider Credentialing/ Recredentialing	Neutral	CF and WP have the same structure and program as required by NCQA accreditation.
State and Private Accreditation Quality Reports	Neutral	Based on the HEDIS quality-of-care scores, CF and WP are comparable in quality. Based on the CAHPS consumer satisfaction survey results, CF and WP members generally have comparable levels of satisfaction with plan services.
Utilization Management Structure	Inconclusive	WP did not provide sufficient documentation or burden of proof in areas of Clinical Criteria for Medical and Behavioral Health Review, Appropriateness of Professionals to make UM decisions, Communication Plan for Practitioners, Member and Provider Satisfaction with UM Processes, Emergency Services, and Ensuring Appropriate Utilization
Quality Management Structure	Inconclusive	QMS is similar for WP and CF. However, WP did not provide a view of how it measures and what outcomes are in these areas of customer satisfaction: availability of practitioners, member satisfaction, provider satisfaction, member complaints, and termination of practitioners.
Brand Measures	Inconclusive	Only data for the 2000 CF BlueCross/BlueShield of Maryland Brand Measure Report were made available, so comparisons with current WP plans were not possible. CF tends to be in the moderate-to-high rankings of BlueCross/ BlueShield plans nationwide.

[475] Id. at 61.
[476] Id. at 65.

3. Community Impact -Wakely Report

The Maryland Insurance Administration retained the services of Wakely Consulting Group ("Wakely") to provide an actuarial analysis "Fairness Analysis Impact Opinion and Impact Report," February 13, 2003, Wakely Consulting Group ("The Wakely Report") of the terms and conditions of the proposed CareFirst acquisition by WellPoint. Wakely's analysis was designed to assist in the determination of whether the acquisition would have the likelihood of creating a significant adverse effect on the availability or accessibility of health care services in Maryland. In addition, much of the analysis performed by Wakely relates to whether or not the acquisition is "fair" and equitable to subscribers, enrollees, insureds, and certificate holders.

A detailed work plan was developed by the MIA in conjunction with Wakely to identify those particular areas that would bear on the impact analysis and the fairness analysis. Wakely was asked to provide an opinion on the following subjects:

1. The projected impact of the acquisition on the premiums to be paid by CareFirst's insureds, with particular focus on rates in the small group and individual market.
2. The projected impact of the acquisition on underwriting losses or gains, loss and claims reserves, and administrative expenses of CareFirst.
3. The projected impact the acquisition may have on provider compensation, prompt payment of claims, the terms of provider contracts and other factors which could impact the development of provider networks.
4. Whether the control of CareFirst by a California health insurer would be equitable to CareFirst's insureds.
5. Whether there are aspects of the acquisition which could otherwise impact or have an adverse effect on the availability or accessibility of health insurance, particularly regarding the extent of coverage provided to insureds.
6. Whether the acquisition would have an impact on Maryland's hospital rate setting system.

As part of its analysis, Wakely was asked to look at whether the acquisition would likely result in material changes to benefit levels, particularly for the individual and small group market products. Wakely was also asked to look at underwriting standards for individual and small group products used by WellPoint in other states, and whether it would be likely that WellPoint would change current CareFirst underwriting standards.

In order to perform its analysis, Wakely relied on numerous sources of information available to the public, such as rate filings, annual statements and other information and had discussions with individuals from WellPoint, CareFirst, the Maryland Insurance Administration, and others.

Unfortunately, much of the analysis that was requested of Wakely was unable to be performed because of the inability to analyze the relevant WellPoint data. Although in many cases CareFirst did provide requested information, particularly in the areas of pricing and underwriting, comparisons and projections were unable to be made because of the lack of comparable data provided by WellPoint. With this caveat in mind as will be discussed in more detail below, Wakely did make the following findings and observations:

First, based on discussions with the WellPoint Chief Actuary in Georgia, it appeared that after WellPoint acquired the Georgia plan, it did not dictate changes in the process for the

development of premium rates, loss ratios, profit requirements or administrative cost requirements.[477] However, Mr. Hyers, testifying on behalf of Wakely concluded that it was likely too early for any such changes to have been implemented in Georgia.[478]

Second, Wakely believed that the loss of the premium tax exemption would "add more than 2% to the premiums for CareFirst insurance products" and that the loss of the SAAC differential would also affect Maryland premiums. Wakely did note that the current CareFirst premium rate calculations "include an adjustment of 1.72% to overall claim costs to reflect the loss of this discount."[479]

With respect to underwriting gains and losses and the impact on administrative expenses and reserving requirements, Wakely looked at a number of sources of information. In its analysis of reserving practices, Wakely identified a significant reserving overstatement for CareFirst in the year 2000. A reserve overstatement has a direct impact on underwriting gains and losses. When reserves are overstated in a given year, it has the effect of depressing the underwriting gains in that same year. However, underwriting gains are also affected by reserves that are carried over from prior years. Taking into account, these two factors, Wakely concluded that, for calendar year 2000, the underwriting gain for CareFirst appeared to be understated by approximately $53.3 million dollars, most of which was attributable to the FreeState HMO. CareFirst provided additional information explaining why certain overstatements occurred, and Wakely adjusted the "net effect" of the overstatements in calendar year 2000 to be a $26.0 million dollar understatement of CareFirst's underwriting gain. Wakely examined the reserving practices at BlueCross BlueShield of Georgia, and did not find any similar significant overstatements.[480]

In looking at administrative expenses for CareFirst of Maryland, Wakely noted that these vary considerable by market segment. These "expense ratios" range from a low of 4.8% for non-risk business, to a high of 16.5% for individual indemnity business. Wakely also examined data reflecting administrative expense ratio of national and local health insurers, including MAMSI, WellPoint, Aetna, and Anthem. The mean of these administrative expense ratios was 11.2%, which compared less favorably to an administrative expense ratio for CareFirst of Maryland of 10%. Wakely cautioned, however, that the overall administrative expense can be affected by the relative product mix of a particular company. CFMI's overall low ratio can be attributed in part to its large proportion of non-risk business. Wakely noted that there was a downward trend in the administrative expense ratios of BlueCross BlueShield of Georgia, falling from 13% in 1997 to 10% in 2001. However, Wakely concluded that "the acquisition of BlueCross BlueShield of Georgia by WellPoint had little to no effect on this downward trend and expense ratios." This was because the acquisition occurred late in the first quarter in 2001, and most likely the Georgia plan had set its administrative processes and budgets well in advance of year 2001.[481]

Wakely examined the impact of WellPoint acquisitions on underwriting gains and losses in plans WellPoint had acquired, and reported that the MethodistCare and RightCHOICE acquisitions were too new to provide any reasonable conclusions regarding WellPoint's influence on the underwriting gains of those companies. Although BCBSG showed an underwriting gain for the period 1997 – 2001, again Wakely concluded that the gain was largely

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[477] The "Wakely Report" at 18.
[478] Testimony of D. Dale Hyers, Day 10, January 29, 2003, at 79.
[479] Wakely Report at 19 – 20.
[480] Id. at 22-23.
[481] Id., at 25 – 27.

attributable to the change in administrative expense ratios and did not view this as correlating to the acquisition by WellPoint.[482]

Wakely also examined data relating to provider compensation and concluded that CareFirst had essentially "held the line" and not granted significant increases to providers for the past several years. In many cases compensation to specialists was decreased significantly from the years 1998 – 2002. CareFirst did estimate that its 2003 physician fee schedules would increase by an average of 1.8%, but this could not be verified. In contrast to CareFirst, WellPoint "provided very limited and unsupported information with respect to physician fee schedules." The information that was provided could not be verified.[483] On the issue of pricing structure and mechanics, the Chief Actuary in the Georgia BlueCross BlueShield plan reported that, apart from area factors, "no risk factors have been changed since the WellPoint acquisition, and the majority of the components of the BCBSGA pricing structure have not been changed." However, because not supporting information was provided, these comments could not be verified by Wakely.[484]

With respect to whether the acquisition could lead to a change in the number of insureds or the extent of coverage, Wakely found that "WellPoint presented no plan for broadening CareFirst's current product offerings in Maryland." In fact, Wakely observed based on a review of the testimony of WellPoint representatives that "WellPoint had neither an understanding of Maryland law nor specific plans for expansion of the individual and small group markets." Wakely could not draw any conclusions with respect to WellPoint's ability and claim to be able to reduce the uninsured populations in Maryland.[485]

Wakely's overall findings were limited. With respect to the possible impact on premiums, as noted above, Wakely cited the prospect that the loss of the SAAC discount and premium tax exemption could result in an increase in rates. On a broader level, Wakely made the following statement:

> Premium rate changes are affected by claim trends, contractual payments to providers, provider fee schedules and claim experience. The data provided to date is not conclusive with respect to specific expected changes in 'base' premium rates resulting from an acquisition of CareFirst. However, WellPoint has targeted an overall improvement in the medical loss ratio by 1.1% through 'better underwriting discipline' and an improved SGA margin by 1.0%. WellPoint shared not other information or plans as to how it will accomplish these reductions. Regardless of the method for reducing cost, as long as the MIA continues its vigilant watch over the premium rate approval process, cost reductions should result in lower premium charges.[486]

With respect to administrative expenses, Wakely concluded, "it is likely that the proposed acquisition will not have a significant effect on administrative expenses" and cited the fact that the expense ratios of CareFirst and WellPoint are close. Wakely did not expect to see "dramatic changes to underwriting gains or losses with the proposed transaction." It did note that

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[482] Id., at 28 – 29.
[483] Id., at 31 - 32.
[484] Id., at 35.
[485] Id., at 37, (relying partly on WellPoint's own testimony).
[486] Id., at 45.

small gains could be realized through savings in the administrative expenses if they are not passed along to the buyers via reduced premiums. Wakely noted that "the greatest influence on underwriting gains will likely result from premium rate increases and their ability to maintain a favorable pace with claim costs trends." Wakely noted that this would be contingent on their approval by the MIA.[487]

As to whether the acquisition would be "equitable" to subscribers WellPoint provided "no specific information … with respect to WellPoint pricing structure algorithms and factors or how WellPoint may want or expect to change CareFirst's existing pricing structures." As Wakely stated, without input from WellPoint regarding its pricing philosophy, "a projection of specific expected rating structure changes after the proposed acquisition cannot be provided." In addition, on the issue of changes in coverage and underwriting practices, "without significant information with respect to underwriting guidelines, there is no way to evaluate the effect that WellPoint had [in other states] with respect to modifying the underwriting standards for individual and small group products of its acquired companies." Mr. Hyers agreed that nothing is more important in trying to determine the impact an acquisition might have on the availability of insurance than pricing and underwriting of products.[488] Mr. Hyers testified that "Because Maryland law allows relative freedom in the use of underwriting standards in the individual market, WellPoint would have some flexibility to make changes to CareFirst's practices."[489] He, therefore, concluded that WellPoint's "price right" philosophy and strict underwriting discipline are a cause for concern with respect to a reduction in persons determined to be eligible for medical insurance. Because current WellPoint standards could not be reviewed, it was not possible for Wakely to predict how the acquisition would result in changes to CareFirst's underwriting standards.[490]

4. CareFirst and WellPoint's Evidence Bearing on Impact and Fairness.

Accenture prepared a report for the CareFirst Board entitled "An Assessment of Health Coverage Industry Trends and CareFirst's Strategic Response" dated November 16, 2001. As a part of that report Accenture looked at the impact of the WellPoint conversion in 1993 on "constituents", and the Anthem acquisition of the Connecticut BlueCross BlueShield plan in 1997. Accenture believed that in both cases "the transformed Blue-banded plans improved their performance and out-performed the competition."[491]

Accenture emphasized the importance of premium stability to employer groups, and how the conversions had brought such stability. To achieve the desired price stability, Accenture concluded that:

> Both health plans appeared to have improved their ability to translate market demands and their customers' needs into terms for their doctor and hospital contracts. In this regard, they have become more accountable to their customers (members and employers). They also believe this has caused them to become more disciplined and businesslike in their negotiations with doctors and hospitals. According to the doctors and hospitals with

[487] Id. at 46 – 47.
[488] Testimony of D. Dale Hyers, January 29, 2003 at 99.
[489] Id. at 93.
[490] Wakely Report at 50 – 51.
[491] Accenture I, November 16, 2001.

> whom we spoke, Anthem Blue Cross Blue Shield in Connecticut was perceived to 'run a tighter ship' and Blue Cross of California was perceived to be 'tough and aggressive' in it's contracting.[492]

Accenture also offered observations that also supported Delmarva's conclusions. According to Accenture:

> Due to the way medical care and its financing has evolved, a tension has developed between doctors and health plans. The intensity of this tension varies from region to region and from situation to situation. In California, Blue Cross of California's relationship with doctors appears to have been strained.[493]

Mr. Schaeffer testified on subjects of tough contracting, and "disciplined pricing." Mr. Schaeffer described disciplined pricing as the process of closely managing risk.[494] In his view, it means understanding what the cost trends are and "when we see something pop, we want to do something about it." Id. By keeping rates in line with medical trends, WellPoint is able to maintain steady, more consistent pricing. Id. On this topic, he presented a chart purporting to show that WellPoint's price increases more closely matched medical trends then did some competitors, whose pricing appeared to out price medical trends. This chart, however, was prepared by an investment banking firm, CSFB, one that trades and analyzes WellPoint stock, not an independent source and certainly not a regulatory body. More importantly it was not possible to determine the source of the data that supported the CSFB conclusions, so its accuracy or veracity could not be verified. Such a comparison of actual trends experienced by WellPoint compared to increases (or decreases) in rates charged would require access to WellPoint's pricing data, information which WellPoint refused to give to the MIA. Presumably, CSFB's numbers are not based on data which WellPoint declined to provide to the MIA, but rather are based on second hand observations or self-reported, unverified WellPoint data.

On the issue of pricing, Mr. Schaeffer was adamant that the prices of products should reflect their actual costs, and as a consequence, cross-subsidized products, where one group is charged more so that another group would pay less, are not "ethical."

As to the issue of tough contracting, he believed that consumers value choice in providers, and WellPoint products emphasize choice. He and others emphasized the large network of hospitals and doctors WellPoint has assembled, and he believed that, "It's very rare that we don't reach some kind of conclusion" in negotiations with a provider.[495] But he also emphasized his view that WellPoint's customers want value for their money, and that WellPoint's negotiations keeps its products affordable.

WellPoint also provided extensive evidence relating to its participation in public programs for low-income and poor families. WellPoint participates in numerous state programs that serve underserved or vulnerable populations including Medicaid, Managed Care and S-CHIP in numerous jurisdictions, including California, Oklahoma, Virginia, Massachusetts, and Puerto Rico. WellPoint has over 1.7 million members under these programs. In some jurisdictions, WellPoint is the primary provider, and has broader participation than other health

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[492] Accenture I, November 16, 2001.
[493] Accenture 2002 Impact Statement, January 2002, at 22.
[494] Testimony of Leonard D. Schaeffer, January 31, 2003, at 139 – 143.
[495] Id. at 142.

plans in the area. John Monahan, Senior Vice President of WellPoint's state sponsored programs, testified that WellPoint was able to successfully participate in these programs because it had learned to address differences between these populations and those served in the commercial market.[496] Mr. Monahan testified that WellPoint does not subsidize these programs, but has learned how to operate in this markets profitably while WellPoint had made no decisions as to whether it would seek to re-enter the Maryland Medicaid market from which CareFirst had withdrawn. Mr. Monahan testified that based on his knowledge of the current health plans currently participating in Maryland, that WellPoint could do so profitably.[497]

WellPoint also provided evidence regarding its growth in membership and in its provider networks.[498] According to the testimony, "more hospitals and physicians contract with us than with any other plan."[499] Data presented by WellPoint also show large increases in membership and market growth for WellPoint in California since the conversion. WellPoint argues these trends establish the company is making available desirable, affordable products that are supported with large provider networks.

As part of the fairness and impact analysis, the MIA compared many of the products offered by WellPoint in California to products offered by CareFirst in Maryland. Several individual and small group products were compared. The analysis performed shows that the WellPoint products offered in California have fewer benefits than those offered by CareFirst in Maryland. For example, the individual medically underwritten policies in California do not appear to cover the following benefits: medical clinical trials, colorectal cancer screening, certain chlamydia screening, hearing aids for children, and home health visits after mastectomy. In addition, the child wellness benefit does not include newborn hearing screening and screening for conditions such as tuberculosis, anemia, and lead toxicity. The WellPoint benefit also reimburses for covered services at a lower level than in the CareFirst products. The WellPoint policies also often have higher cost sharing levels as well, and the mental health benefits are particularly more restrictive in the WellPoint policies.

One reason for the difference in policies is Maryland's mandated benefit laws. Apparently California has fewer mandates, and WellPoint has indicated it would offer products in accordance with State law. However, WellPoint has emphasized how its focus on consumer choice and its portfolio of "affordable" products has driven its success in California.[500] This analysis done by the MIA suggests that WellPoint's formula for growth and success in California will be severely constrained in Maryland, because it will not be able to offer many of its signature products. While this conclusion may not necessarily bear heavily on the impact and fairness analysis, it does mitigate some of the supposed benefits of a WellPoint acquisition as articulated in CareFirst's "Business Case".

WellPoint also presented testimony of Woodrow Myers, M.D., Executive Vice President and Chief Medical Officer of WellPoint. Dr. Myers reviewed many of the technological advances WellPoint has made that it believes serves its patients. For example, Dr. Myers provided a detailed explanation of “SUBIMO,” an on-line information source for WellPoint members on hospital quality.[501] This on-line tool allows patients who may be under going a

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[496] Testimony of John Monahan, February 23, 2003, at 29 – 30.
[497] Id. at 76 – 77.
[498] Pre-filed testimony of Leonard D. Schaeffer, January 31, 2003.
[499] Id. at 5.
[500] Exhibit 1, Pre-Filed testimony of Deborah Lachman at 2.
[501] Testimony of Woodrow Myers, M.D., January 31, 2003, at 214.

surgical procedure to determine which hospitals may provide the best outcomes for the procedure at issue.

Dr. Myers also described the physician quality and incentive program, or PQIP. This is a voluntary physician recognition program which allows WellPoint to measure performance on clinical quality, and provides administrative quality indicators. This program permits physicians to determine how they are doing vis-à-vis their colleagues in a particular specialty or geography.[502]

Dr. Myers also testified that he was not aware of any planned changes WellPoint might make to the medical management policies or practices of CareFirst, and responded that, "I can honestly say I don't know the medical policies and practices of CareFirst." Dr. Myers did testify that if such an examination had occurred by WellPoint, he would have been involved in that process.[503]

Finally, Dr. Myers also testified regarding the reporting relationships in the WellPoint organization. He testified that the BlueCross BlueShield of Georgia medical director and the BlueCross BlueShield of Missouri medical director report to the corporate medical director for WellPoint who is based in California.[504] However, Dr. Myers testified that medical questions would be handled by the medical operations management people, and the clinical management services people, in the particular state in which the issue arose. For example, if an internal appeal is made to the health plan, the decision to deny or uphold care is made in the particular state in which the issue arose.[505] Dr. Myers also noted that the corporate medical director of Georgia, for example, sits on the committees at WellPoint that help determine national medical policy.

CareFirst also filed in January of 2002 a "Community Impact Analysis of the proposed conversion of CareFirst, Inc. to a for-profit business entity and the merger between CareFirst, Inc. and WellPoint Health Networks Inc." (the Accenture Impact Analysis). The purpose of the report was "to determine the probable impact upon the availability, accessibility and affordability of healthcare in the primary community served by CareFirst" resulting from a conversion of CareFirst to a for-profit entity and its merger with WellPoint. As discussed earlier the Impact Analysis is of limited evidentiary value.

In it's Impact Analysis, Accenture observed that, "CareFirst's first priority would be to earn a return for shareholders" as a for-profit company. The Accenture report indicated that the change in corporate form would require CareFirst to introduce more "stringent financial discipline" in order to ensure more predictable stable earnings in response to shareholder demands.[506] The Accenture report concedes that "availability, accessibility and affordability may be affected to the extent that CareFirst's minor role today in implementing Maryland, Delaware, and Washington, D.C. health policy was not replaced by the foundations to be established." When asked at the public hearings whether Accenture had evaluated what exactly the "minor role" was that CareFirst was performing, Mr. Marabito acknowledged that they had not taken any specific steps to measure or quantify what that role was, although they believed

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502 Id. at 229 - 232.
503 Id. at 248.
504 Testimony of Woodrow Myers, M.D., January 31, 2003, at 204.
505 Id. at 252 - 253.
506 Accenture II at 14.

that it had "diminished over time as was evidenced by [CareFirst's] withdrawal from the Medicare and Medicaid markets."[507]

The Accenture Impact report states that "the real opportunity to effect the availability, accessibility and affordability of health care in the effected communities comes from the public benefit assets given to the various public benefit organizations in the conversion."[508] The report estimates that given a $1.3 billion purchase price and a grant rate of 4.5% to 5%, between $58 million and $65 million would be spent on health care across the three jurisdictions.[509] Accenture estimated that this could ensure an additional 46 thousand to 52 thousand people in Maryland, Delaware and Washington, D.C..

In measuring any potential negative impacts on the availability and accessibility of health care in Maryland, Accenture worked under the assumption that this deal would not result in any additional market power of significance for CareFirst.[510] This assumption led to the conclusion that "CareFirst's ability to impact the availability, accessibility and affordability of health care due to increased market power likely would not change to any significant degree." Id. Accenture also concluded that because CareFirst would not gain additional market share and therefore market power as a result of this transaction "its ability to impose reductions in network size would not be affective." Id. The assumption underlying these conclusions, that the transaction would not result in additional market power, seemed at odds with the underlying objectives of the CareFirst strategy, which was driven in large part by the need to gain geographic dominance. As noted earlier the need to maintain an increased market share has been articulated as an important driving force behind the acquisition. In response to questioning at the public hearings regarding this apparent inconsistency between the strategic objectives, and the assumptions made for the Impact Analysis, Mr. Marabito acknowledged that the transaction with WellPoint provided benefits relating to absolute scale but did not provide particular benefits relating to geographic dominance or relative scale.[511] Therefore, although one stated purpose of the business combination being recommended by Accenture was to ensure the ability to make defensive and offensive acquisitions within CareFirst's current market, the Impact Analysis Accenture prepared is premised on the notion that in fact those acquisitions would not occur, and therefore there would be no change in CareFirst's market power.

Accenture also reviewed the level of physician and hospital contracts for both BlueCross of California, and BlueCross BlueShield of Georgia, particularly comparing pre and post conversion levels. The data show the overall hospital contracts and physician contracts have increased for BlueCross of California for the period 1994 to 2000. However, for the years 1999 and 2000 the level of physician contracts for BlueCross of California have remained relatively flat and even declined. With respect to hospital contracts the level of hospital contracts was relatively flat from 1995 to 1999 and then increased in the years 1999 and 2000. While Accenture presented data relating to the physician and hospital contracts for BlueCross BlueShield of Georgia, Mr. Marabito acknowledged that it was too early to access whether any changes in levels of physician contracting could be attributed to the "WellPoint Way."[512]

Mr. Marabito also cited evidence showing extensive growth in membership for both individual and small group products for BlueCross of California. Mr. Marabito emphasized the

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[507] Testimony of Joseph V. Marabito, January 30, 2003, at 149.
[508] Accenture at 15.
[509] Accenture II at 17.
[510] January 2002 Accenture Impact Analysis at 19.
[511] Testimony of Joseph Marabito, January 30, 2003, at 160 - 161.
[512] Testimony of Joseph Marabito, Day 11, January 30, 2003 at pages 155-157.

importance of the individual and small group market to WellPoint and the other jurisdictions in which it operated. Because CareFirst currently has a strong presence in the small group and individual market, Accenture opined that "it is likely that continued participation in these segments would be important to CareFirst in the future."[513]

With respect to the issue of whether rates would increase if WellPoint were to acquire CareFirst, Mr. Marabito acknowledged that, "WellPoint has an incentive to achieve a return on its investment in CareFirst."[514] Mr. Marabito concluded that, "WellPoint's return and growth target could likely be achieved through cost savings and new product sales without raising prices beyond levels they would be otherwise." However, this statement was based on the assumption that WellPoint's targets "are similar to those of other publicly traded health companies," but, Mr. Marabito acknowledged, that he did not know exactly what WellPoint's targets were.[515] Mr. Marabito cited comments made by WellPoint executives that suggested that WellPoint would achieve a return on its investment by focusing on cost savings and new product sales rather than raising prices. According to the Accenture report, David Colby, WellPoint's CFO, indicated that the cost synergies would result from "reduced duplicate overhead costs, plus lower administrative cost due to economies of scale in the region."[516]

The Accenture report also identified a number of factors which it believed would result in continued local decision making for CareFirst even after the acquisition. For example, Accenture noted that a CareFirst representative would be appointed to the WellPoint Board of Directors. Accenture also noted that the CareFirst Chief Executive would continue to be in charge of operations in the CareFirst jurisdictions, and Accenture also noted that local advisory boards would be established to guide local relationships.[517]

O. SUMMARY OF KEY POINTS

Data developed by Professor Feldman demonstrates that, in general, for-profit HMOs do not charge higher premiums that nonprofits.

A change in benefit levels can impact premiums. The fewer the benefits offered, the lower the premiums that can be offered.

The pricing and underwriting practices of a health plan are the most important factors to examine in trying to estimate the impact an acquisition may have on the relevant health care market on the insureds and insureds of the acquired plan.

The most accurate and productive way to analyze the pricing practices of WellPoint specifically is to examine first hand pricing assumptions, structures and processes used by WellPoint in those jurisdictions in which it operates.

The MIA and its experts were not provided nearly sufficient access to WellPoint's pricing information and practices to allow for any meaningful analysis or conclusions to be drawn.

WellPoint views cross-subsidies between products as inappropriate and seeks to ensure that all products are priced profitably, and in line with medical trends.

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513 Accenture Community Impact Analysis, January 2002, at 30, CF-0000253.
514 Id. at 31.
515 Testimony at Public Hearing, January 30, 2003, at170 – 172.
516 Id. at 32.
517 Id. at 35.

Too little time has passed to determine whether the WellPoint acquisition of BlueCross BlueShield of Georgia will impact that company's pricing practices.

The Chief Actuary of BCBSG has a direct reporting line to the California company.

Wakely estimated that the premiums of some CareFirst insured's could increase due to CareFirst's loss of its premium tax discount. CareFirst has already included in its rate filings in 2002 a premium tax load to recover funds it expends for programs it must fund due to changes in state law.

WellPoint has targeted a 1.1% improvement in CareFirst's medical loss ratio, to be achieved through "better underwriting discipline." An improvement in the loss ratio can be achieved through an increase in premiums relative to medical expenses, or a decrease in medical expenses relative to premiums. Increasing premiums or decreasing medical expenditures can both negatively impact access to care and affordability of insurance.

WellPoint did not provide the MIA, or its experts, access to its underwriting standards or practices.

Physician reimbursement schedules, as a component of medical expenses, can impact the medical loss ratio. WellPoint did not provide access to its physician reimbursement schedules.

The level of physician reimbursement paid by a health plan, and the manner in which contract negotiations are carved out by a health plan can negatively impact provider satisfaction, and therefore network adequacy.

WellPoint in California has historically been viewed negatively by health care providers, especially hospitals.

BlueCross of California was viewed by the California Department of Managed Care more negatively than other HMOs in terms of its contracting practices with hospitals .

As a for-profit company, CareFirst's first priority would be to earn a return for its shareholders. This would most likely entail stringent underwriting and pricing discipline. BlueCross of California has experienced growth in membership since it converted to for-profit status.

WellPoint did not provide sufficient information for the MIA or its experts to evaluate fully WellPoint's utilization management, utilization review, quality management, or quality improvement process.

Many BlueCross of California products contain fewer benefits than those issued by CareFirst companies.

1. Conclusion

It is not possible to draw a definitive conclusion as to whether the acquisition of CareFirst by WellPoint would have a significant impact on the availability and accessibility of health care in Maryland. While the MIA developed a detailed work plan for determining whether or not there would be a significant impact on availability and accessibility of health care in the State, WellPoint’s failure to provide critical information that would allow the MIA to

complete its analysis frustrated those efforts. There is no question but that the best method for conducting the impact analysis would have been to examine the pricing and underwriting practices of WellPoint and its affiliated companies. WellPoint has indicated that it would comply with all applicable State laws relating to underwriting, pricing, and benefit content if it were to do business in Maryland. While this may be true, it does not provide an answer to the question asked by the statute. At best this is a commitment to adhere to absolute legal minima. The underwriting practices of HMOs and health insurance companies in the individual market are not fully regulated. Maryland law also permits insurers to withdraw from lines of business, and the ability to prevent this action is limited under Maryland law. A prime example of how underwriting guidelines can serve to impact the availability of health insurance was discussed earlier in the context of the withdrawal of the FreeState HMO and the requirement that FreeState members undergo medical underwriting before being issued a policy by BlueChoice underwriting. Due to its tight underwriting standards, BlueChoice imposed exclusionary riders on many FreeState members who had developed medical conditions. In other cases those conditions led to the decision by BlueChoice to deny coverage. Maryland law does not generally regulate the imposition of exclusionary riders and does not address in most cases the circumstances in which an applicant for individual coverage can be denied access to a policy. Beginning, July 1, 2003, individuals who are denied policies can seek coverage through the state's high risk mechanism, The Maryland Health Insurance Plan. Thus, WellPoint could take measures that would affect availability and accessibility adversely while nonetheless complying with applicable law.

Maryland law does provide the MIA with some oversight over the rating practices of insurers and HMOs in the State. Generally, rates cannot be excessive, and in some cases the law sets out minimum loss ratios with which insurers must comply. The minimum loss ratio in the small group market is 75%, and on one occasion the MIA denied a request by an insurer to increase its rates because it had not achieved the loss ratio required by statute. The minimum loss ratio established for individual products in the aggregate for an insurer is 60%. However, Maryland law does not dictate a particular profit margin that insurers may build into their rates. This is something that is often disputed and negotiated in the course of the submission of a rate filing. Therefore it is true that the MIA does have some tools at its disposal to mitigate the possible impacts from an acquisition of CareFirst by WellPoint, at least with respect to pricing, but the protection afforded by the tools is limited. So long as a health insurer has proposed rates that exceed the minimum 60% loss ratio and at the same time are not based on an unsupported or excessive medical trend, the carrier has some discretion in terms of setting the profit margin included in its rates. As a consequence it is true again as Wakely pointed out, that vigilance on the part of the MIA can serve to mitigate any possible rate increases. But the ability to do so is not absolute, and in some cases depends on business decisions made by the health plans submitting the rate filing. WellPoint has indicated it will seek to improve the medical loss ratio in Maryland by 1.1% through means which include better underwriting discipline. This alone creates the possibility that changes could be made in pricing or underwriting that could impact the affordability and availability of health insurance here. Given that even CareFirst's own expert acknowledged that a for-profit company has a paramount duty to its shareholders to maximize profits, one cannot ignore the possibility that a for-profit CareFirst would seek even higher profit margins in its rate filings. The best evidence of what types of margins might be used are the filings and the data that support rating activity in other WellPoint jurisdictions.

WellPoint's refusal to provide this critical information has forced the MIA and its advisors to rely on secondary and less reliable data to assess whether or not the transaction would have a negative impact on the accessibility and availability of health care in the State. This information is inherently less reliable and less predictive, and it is WellPoint's refusal that has forced reliance on it. WellPoint has offered alternative evidence to its own practices to

counter balance the idea that rates might increase. For example, WellPoint has demonstrated that it has been able to increase its market share in the California after its own conversion and in the face of competition from nonprofit companies. It has cited information suggesting that it has large and sufficient provider networks, notwithstanding the animosity that exists between California and hospitals the physicians, on the one hand, and WellPoint on the other hand. While WellPoint provides this data in an effort to suggest that it has adequate networks, no information relating to network adequacy was presented specifically, nor is it known whether California in fact regulates network adequacy. It is known that the majority of hospitals in California ranked WellPoint as the worst health plan with which to do business, and that the Department of Managed Care in California cited BlueCross of California as having the highest level of "disruption" with the hospital network in California.

WellPoint also cites its expanded market share as evidence that, if anything, the availability and accessibility of health care would increase if it were to acquire CareFirst. But as cited above the Maryland market and the California market are extremely different, and in particular Maryland has a much higher level of mandated benefits. Many of the products that have been touted by WellPoint would not be legal in the State of Maryland. Therefore its ability to influence the uninsured market in Maryland through the offering of new products may be severely limited. Whatever possible benefits WellPoint may have brought to California, these may not be able to be replicated here. WellPoint representatives could not identify or discuss any specific plans for product expansion in this State.

The fact that WellPoint has declined to provide critical pricing and underwriting information certainly raises the inference that such information, if provided, could lead to a conclusion that in fact, if it imported those practices to Maryland, WellPoint could have a negative impact on the availability and accessibility of health care in the State. In correspondence with the counsel for CareFirst and WellPoint, the MIA agreed to hold such pricing and underwriting information on a confidential basis. Under Maryland law, information acquired by the MIA in connection with a proposed transaction is presumed to be confidential unless the parties agree to its release. In fact, the MIA had demonstrated to both CareFirst and WellPoint its capacity to abide by the confidentiality requirements in the law. In the course of producing documents in response to a MIA subpoena, CareFirst declined to waive confidentiality for certain documents it believed to be of a sensitive nature. The MIA conducted a thorough and exhaustive review of the documents for which confidentiality was asserted, and pursuant to the statutory process set out in the conversion law, released to the public some documents, but also maintained other documents as confidential. CareFirst chose not to appeal the determinations by the MIA, as it had a right to do under the conversation statute. The MIA's handling of this confidentiality request by CareFirst demonstrated to the parties its ability to maintain confidential information, and to scrupulously follow the requirements of confidentiality set out in the law. If for example, the MIA had a demonstrated history of not complying with the confidentiality requirements in the conversion statute, WellPoint might have had a reasonable basis for declining to provide sensitive information, such as pricing and underwriting material. In the absence of any such conduct by the MIA relating to its handling of confidential information, there was little reasonable basis for WellPoint to decline to produce the information. This is particularly significant where, as here, WellPoint and CareFirst had the burden of demonstrating compliance with applicable standards. Consequently, it is reasonable to infer that the information that was not provided could have supported a conclusion that, in fact, a WellPoint acquisition may have a significant adverse effect on the availability and affordability of health care in this State.

IX. THE DISQUALIFYING FACTORS

A. Have appropriate steps been taken to ensure no part of the charitable or public assets inure directly or indirectly to an officer or director or trustee of the nonprofit health service plan?

1. The Anti-Inurement Provision prohibits officers and directors from receiving any benefit in connection with an acquisition except for reasonable compensation for work actually performed.

MD. CODE ANN., STATE GOV'T § 6.5-301(b)(3) of the State Government Article states:

An acquisition is not in the public interest unless appropriate steps have been taken to:

* * *

(3) ensure that no part of the public or charitable assets of the acquisition inure directly or indirectly to an officer, director, or trustee of a nonprofit health entity.[518]

The word "inure" is not defined in the Act. Nor does Maryland case law provide a definition of the term. The scope of prohibited inurement, however, is readily discerned from a variety of other sources.

First, and most simplistically, the word "inure" is defined by Black's Law Dictionary as: "to come to the benefit of a person or to fix his interest therein." Similarly, Merriam-Webster defines "inure" as "to become of advantage." Using these definitions, the Anti-Inurement Provision prohibits officers and directors from directly or indirectly benefiting from (*i.e.*, receiving) the "public assets" of a nonprofit in the context of an acquisition. Under the Act, the "public assets" of a nonprofit are those assets that must be valued and distributed to the Foundation. In this case, all parties to the Proposed Transaction agree that 100% of the fair value of CareFirst is a public asset and that 100% of Maryland's share of that fair value will be distributed to the Foundation under the Act. Thus, the Provision prohibits officers and directors from receiving an economic benefit that would otherwise go to the Foundation.

This construction of the Anti-Inurement Provision is consistent with its purpose. The rule against inurement in the context of a nonprofit conversion is an extension of the rule against inurement in the conduct of a nonprofit's business. The "defining difference between a nonprofit and a for-profit corporation is the nondistribution constraint, which prohibits a nonprofit corporation from paying dividends or otherwise distributing any part of its net income or earning to the persons who control it." Deborah A. DeMott, *Self-Dealing Transactions in Nonprofit Corporations*, 59 BROOK. L. REV. 131, 132 (1993). "A nonprofit organization is, in

[518] This provision is generally referred to as the "Anti-Inurement Provision." While enacted in this form as part of the enactment of the Nonprofit Conversion/Acquisition Act in 1998, the prohibition against inurement is not new. Maryland statutory law has historically prohibited the conversion of a nonprofit insurer to for-profit status unless the proposed transaction "provides that no part of the assets or surplus of the nonprofit health service plan will inure directly or indirectly to any officer or director of the corporation." See Md. Ann. Code Art. 48A, § 356AA, superceded.

essence, an organization that is barred from distributing its net earnings, if any, to individuals who exercise control over it, such as members, officers, directors, or trustees." Jaclyn A. Cherry, Update: The Current State of Nonprofit Director Liability, 37 DUQ. L. REV. 557, 558 (quoting Henry Hansmann, The Role of Nonprofit Enterprise, 89 YALE L.J. 837, 840 (1980)).

The purpose of the Anti-Inurement Provision is to assure that the rule against distributions is not compromised in the sale or conversion of the nonprofit to for-profit status. The conversion of nonprofits to for-profit status often "involves mammoth transfers of assets and can provide unscrupulous insiders with opportunities to enrich themselves at the expense of the not-for-profit organizations and ultimately the communities they serve." John F. Coverdale, Preventing Insider Misappropriation of Not-For-Profit Health Care Provider Assets: A Federal Tax Law Prescription, 73 WASH. L. REV. 1, 1-2 (1998).[519] In response to such abuses, a majority of states enacted comprehensive schemes to regulate the conversion of nonprofit health service and health care entities. Many of those statutory schemes were premised on model legislation drafted by the National Association of Attorneys General in 1998. A critical feature of the Model Act is that it requires consideration of: "[w]hether the nonprofit healthcare conversion transaction will result in private inurement to any person."[520]

In summary, the point of the Provision is to assure that the full value of the nonprofit is paid to the Foundation and that none of it is diverted to an officer or director. Thus, in reviewing the Proposed Transaction, the MIA must determine whether an officer or director is receiving a benefit in connection with the Proposed Transaction out of funds that would otherwise go to the Foundation.

In applying that standard, the critical inquiry is whether any sums that an officer or director receives constitute reasonable or fair compensation for work actually performed. Anything that is paid in excess of that amount from funds that would otherwise be available to the Foundation are, necessarily, paid out of the public assets of CareFirst. Thus, for example, as the Commentary to the Model Act states:

> All transactions should be scrutinized to insure that no officer, director, employee, spouse or family member, or private party receives inurement from the transaction. Special scrutiny should be used where specific items are found in a transaction, including stock options, pension plans, performance bonuses, corporate loans, golden parachute provisions, excessive salaries, and side letters and arrangement for officers, directors, and employees.

[519] The case law and commentary is replete with outrageous examples of self-dealing and self-enrichment in the conversion of health care related entities. For example, in 1991, Health Net, a California nonprofit health plan with 800,000 members converted to for-profits status. Although the corporation was valued by Salomon Brothers at between $250 and $300 million, and despite offers from outsiders that ranged from $130 to $300 million, the Health Net Board accepted an offer of $127 million from a group of insiders, including the chairman of the Board.

[520] While there are similarities between the Model Act and the Nonprofit Conversion/ Acquisition Act, Maryland's legislation is far more extensive. Unlike the Model Act, the Maryland Act does not make inurement merely a consideration in deciding whether a conversion should be approved. Maryland's Anti-Inurement Provision requires an affirmative finding that there will be no inurement before a proposed conversion can be deemed to be in the public interest.

Commentary at 9. As one commentator notes, "[p]roviding any amount of remuneration above reasonable value for services rendered improperly siphons away charitable assets that should be devoted to the continued provision of health care services in the affected community." Kevin F. Donohue, Crossroads in Hospital Conversions – A Survey of Nonprofit Hospital Conversion Legislation, 8 ANNALS HEALTH L. 39, 78 (1999).

In the November 7, 2002, version of his Draft Report on CareFirst, Inc. Executive Compensation, Mr. Angoff reaches the same conclusion, relying on federal tax law. As Mr. Angoff correctly notes, section 501(c) of the Internal Revenue Code extends certain exemptions from federal income taxation to certain organizations. These exemptions apply to organizations that meet the requirements of these sections, as long as "no part of the net earnings [of the organization] inure to the benefit of any private shareholder or individual." *See* I.R.C. § 501(c)(3). Compensation constitutes private inurement if it is "unreasonable" or "excessive." *See* Angoff Draft Report on Compensation at 38 and cases cited therein; See also Bramson v. CIR, T.C.M. (CCH) 1343 (1986); Knollwood Mem. Gardens v. Commissioner, 46 T.C. 764, 787 (1966).

Mr. Angoff notes that the extent to which compensation is "unreasonable" or "excessive" generally requires an analysis of the facts and circumstances. The Code, however, does provide what might be considered a "bright line" test of reasonableness in the context of payments made to an officer in connection with a change in control of a corporation. As a general rule, a corporation may only deduct only compensation that is "reasonable" as a business expense.[521] Under § 280(g) of the Code, payments made to an executive in connection with a change in control (*i.e.*, "parachute payments") that exceed a certain formula (three times the recipient's base salary as averaged over five years) are presumed to be unreasonable. Thus, such payments (known as "excess parachute payments") are not deductible as an expense of the corporation that paid them and they are subject to an additional excise tax of 20% by the executive that receives them. I.R.C. § 4999(a). The presumption against reasonableness can only be rebutted by "clear and convincing evidence. H. CONF. RPT. 98-861 (1984), 1984-3 C.B. (Vol. 2) 1, 106. As the Conference Committee explained:

> The conferees believe that in most large corporations, executives are not under-compensated. As a result, the conferees contemplate that only in rare cases, if any, will any portion of a parachute payment be treated as reasonable compensation in response to an argument that the executive was under-compensated in earlier years. Id.

In summary, in reviewing any benefits to be received directly or indirectly by officers or directors of CareFirst in connection with the Proposed Transaction, the MIA must look at whether those benefits are being paid as reasonable compensation for services actually rendered and, if not, whether the benefits in excess of what is reasonable would otherwise have gone to the Foundations. In assessing what is "reasonable" compensation, the MIA will be guided both by the "bright line" test articulated by Mr. Angoff under I.R.C. § 280(g) and by the relevant facts and circumstances.

[521] Testimony of Jay Angoff at Public Hearing, February 4, 2003, at 111.

2. The original executive compensation arrangement submitted as part of the Proposed Transaction clearly and blatantly violated the Anti-Inurement Provision.

Not surprisingly, given their magnitude, the various compensation arrangements made in favor of CareFirst executives in connection with the Proposed Transaction have dominated public attention. CareFirst is a nonprofit entity. As such, any value created in that entity is supposed to benefit only that entity and its nonprofit mission. The initial attempt by corporate officers to take over $68 million in that value for themselves as part of the original Proposed Transaction was, and is, outrageous. The Board's decision to allow that transfer, and its subsequent defense of that transfer, is inexcusable. Indeed, WellPoint's own executives believed the bonuses were not appropriate.

There is little question at this point that the compensation arrangements made with certain executives of CareFirst under the original Form A filing would have enriched those individuals by millions of dollars otherwise payable to the Foundations. There was no dispute at the hearings that the monies that were to be paid to the CareFirst executives in the form of bonuses and incentives reduced the sale price of CareFirst. WellPoint expressly acknowledged that the $68 million in executive compensation that was demanded by the CareFirst Board represented value that it was willing to pay for CareFirst. Thus, but for the Board's desire to insure the enrichment of certain individuals, the $68 million would have gone to the Foundation as part of the purchase price.

This Report will not repeat the analysis contained in Mr. Angoff's Report outlining the details of the original compensation arrangements and demonstrating the ways in which they violated the Anti-Inurement Provision. Mr. Angoff outlined in detail the listing of mistakes and lapses in judgment by the Board. These include improperly relying on for-profit companies to set the bonuses, failing to seek appropriately legal advice, unreasonably ignoring numerous signs that the bonuses were improper, offering up to ten different and sometimes conflicting reasons as to the purposes of the bonuses and payouts, and unprincipled decisions to grant large incentives without regard to the nonprofit status of the company. The MIA agrees with Mr. Angoff's analysis in its entirety. And, notwithstanding their initial protests to the contrary, both CareFirst and WellPoint apparently came to the same conclusion. The compensation terms set forth in the original Form A filing have been substantially altered and the purchase price has been increased by $68 million.

3. The record does not permit the conclusion that *no* part of the public assets of CareFirst will inure to the benefit of its officers.

CareFirst executives will receive substantial payments in connection with the Proposed Transaction under the revised Form A. In order to understand these payments and to properly analyze them, it is important to summarize the evolution and current status of the key terms.

CareFirst executives are parties to individual employment agreements. Those agreements generally provide for five categories of compensation: a) a base salary that is adjusted annually; b) an annual bonus based on the terms of the "CareFirst Annual Incentive Plan" ("AIP"); c) a second annual bonus based on the terms of the "CareFirst Long-term Incentive Plan" ("LTIP"); d) various perquisites such as leave time and health coverage; and e) retirement benefits accrued under the CareFirst Supplemental Executive Retirement Plan ("SERP").

Executives receive their annual salaries in increments throughout the year. No portion is deferred. Similarly, AIP bonuses are based on annual performances, are calculated annually, and, if earned, are paid in full each year. However, all of the employment agreements provide that CareFirst will make certain payments to Mr. Jews and the EVPs in the event of a change of control ("COC"). If a COC occurs, Mr. Jews would automatically receive a payment of three times his base salary, plus a pro-rated portion of his AIP bonus. The other executives would receive twice their base salary plus their target AIP bonuses.

Under the revised Form A, the executives have agreed to give up these "severance" provisions in connection with the Proposed Transaction. Instead, the executives have agreed to enter into a Retention Agreement with WellPoint. Pursuant to the Retention Agreement, the executives would receive from WellPoint the same amounts that would have been payable by CareFirst on a COC if they remain employed by WellPoint for two years after the merger, if they are terminated without cause during that two years, or if they terminate for cause within that two years. After the two year period, the executives would receive their Retention Bonuses and, if they remain employed by WellPoint, would participate in WellPoint's Officer Severance Plan and Officer Change in Control Plan.

The LTIP bonus plan is a complex plan that serves as a surrogate for stock option programs administered by public companies. The amount payable under the plan is calculated according to a formula that tracks CareFirst's "value" over overlapping three year "Performance Periods." At the beginning of each three year Performance Period, the executive is awarded a certain number of "Units" which are assigned a value at that time. The value may increase or decrease over the three-year Performance Period. The value of those Units at the end of the three-year period is the LTIP bonus earned by the executive for that Performance Period. The entire LTIP bonus is not, however, paid at the end of the three-year Performance Period. Seventy percent is payable as soon as practicable. The other 30% is deferred until the executive's employment terminates.

Each year is part of three Performance Periods. For example, the year 2003 is included in the 2001-03 Performance Period, the 2002-04 Performance Period, and the 2003-05 Performance Period. Under the LTIP Plan Document, in the event of a COC, all Performance Units are considered earned as of the date of the COC and all deferred payments become payable. Thus, under the Plan Document, on a COC, executives would receive the aggregate of the deferred 30% of past LTIP bonuses. In addition, the executive would receive the accrued portion of each Performance Period that had not yet ended at the time of the COC.[522] If the executive terminated, the executive also would receive the remaining "unaccrued" portion of each Performance Period that had not yet ended at the time of the COC.

Under the current Form A, the executive continues to receive the deferred 30% of past LTIP bonuses and the accrued portion of LTIP bonuses for on-going Performance Periods. Executives do not, however, vest in or receive the unaccrued portions of those bonuses. Instead, the executives receive restricted stock awards, with the number of shares being based on the value of the unaccrued Units.

CareFirst executives receive negligible benefits under CareFirst's qualified retirement plan. Their benefits are set forth in the SERP, which applies only to them and a handful of other senior managers. The SERP retirement benefit is a lump sum payment of 200% of the executives final

[522] For example, if the transaction closed on December 31, 2003, the executive would have accrued 100% of the 2001-03 Performance Period; 66% of the 2002-04 Performance Period; and 33% of the 2003-05 Performance Period.

average pay after five years of service, plus 30% per year for the next ten years of service, up to a maximum of 500% of the final average pay. The final total is reduced by any amount received under the qualified plan and the executive must refrain from competition for two years or the SERP benefits are waived. Certain executives, including Mr. Jews, were credited with additional years of service under their employment agreements for purposes of calculating the SERP benefit.

Under the executive employment agreements, if the executive terminates in connection with a COC, the executive will receive an immediate lump-sum payment equal to the actuarial present value of their accrued SERP, regardless of whether he has reached retirement age. The Form A filing alters this arrangement. Currently, the executive is not entitled to the SERP benefit if he voluntarily terminates; the lump sum is payable in connection with the merger only if the executive is terminated by WellPoint without cause. However, if the executive remains with WellPoint for a year, the executive may elect to receive payment of the SERP benefit, even if he continues employment beyond that year.

The original Form A also included payments to CareFirst Executives under a "Merger Incentive Bonus Plan" ("MIBP") adopted by the Board on December 2, 2001, after the merger agreement had been signed by WellPoint. The MIBP supposedly was enacted to give management an incentive to remain employed with CareFirst through the regulatory process and up until the date of the merger. The amount of each executive's MIBP was tied to his salary.

The MIBP became a lightening rod for criticism, particularly given the fact that it was adopted after the WellPoint agreement had been signed and was added on top of the already significant monies that CareFirst executives were to be paid in the event of a COC. The new Form A eliminates the MIBP.

CareFirst executives will receive substantial payments under the new compensation arrangements. Whether their receipt of those payments violates the Anti-Inurement Provision depends on two considerations. First, are the payments being paid out of monies that would otherwise have going to the Foundation? Second, if so, do the payments constitute reasonable compensation for services actually rendered to CareFirst?

CareFirst has obligations to its executives under their respective employment agreements, the LTIP Plan Document and the SERP. One might question the large salaries, bonuses and benefits payable under those agreements and also question whether such arrangements are reasonable compensation or constitute private inurement. That, however, is beyond the scope of the MIA's task at this time. At present, the question is whether "public assets . . . of the acquisition" are being paid to an officer or director. That is, whether monies that would otherwise have been paid as part of the value of CareFirst have been withheld from the purchase price to fund executive compensation over and above any sums that would already be due and owing to those executives absent an acquisition.

There can be little question that there are funds that are being paid to executives in connection with the Proposed Transaction that the executives would not receive in the absence of the Proposed Transaction, most notably the Retention Bonuses. Would WellPoint have paid more for CareFirst if it were not required to pay such sums to the CareFirst executives? Clearly, WellPoint considers payments to CareFirst executives to be part of the acquisition costs of CareFirst. WellPoint admits that the original value of the original compensation arrangement represented monies it would have paid as part of the purchase price and, indeed, WellPoint subsequently increased the purchase price by the full value of the executive compensation benefits. Can one say, therefore, that the present price represents a full and fair offer that is

unaffected by obligations triggered solely by the merger? Or is it logical to assume that any compensation to executives beyond normal compensation necessarily detracts from the purchase price? The difficulty of this inquiry is compounded by the testimony of Mr. Geiser, who indicated that the new arrangement needed to be agreed to by the eight CareFirst executives.[523] Thus, Mr. Geiser knew, as Mr. Schaeffer testified *he* knew, that in order to get an agreement to sell the company, the executives had to be satisfied. This raises the possibility that WellPoint had to agree to the retention bonuses to reach an agreement. This then raises the possibility that the purchase price in the general agreement could have been even more than $70 million but for the retention bonuses.

The MIA must assume that the funds being paid to executives solely as a result of the merger are monies that would otherwise have been paid for the public assets of CareFirst and given to the Foundation. The Anti-Inurement Provision specifically states that a proposed transaction is *not* in the public interest *unless* "steps have been taken to *ensure* that *no part* of the public . . . assets of the acquisition insure" to the benefit of officers or directors. (Emphasis added.) The burden, therefore, is on CareFirst to demonstrate that *no part* of the value of CareFirst otherwise payable by WellPoint has been diverted to corporate officers and directors. The burden was on CareFirst to demonstrate that none of the funds that WellPoint will pay under the various compensation arrangements would otherwise have been paid as additional consideration for the company. As long as CareFirst executives are demanding and receiving monies, solely by virtue of this transaction, the risk exists that WellPoint's payment of those sums is simply part of what it considers the overall acquisition costs and, thus, decreases by some amount what it would otherwise have paid directly to the Foundation.

CareFirst has not ensured that no part of its value is being paid in executive compensation as opposed to being added to the purchase price. That, alone, however, would not constitute inurement if the monies received by executives constitute reasonable compensation for their efforts on behalf of CareFirst. Payments to executives are not payments out of public assets if the payments represent reasonable compensation.

CareFirst has produced numerous experts to testify as to the reasonableness of the compensation received by the CareFirst executives. This Report will accept, *arguendo*, those experts' conclusions with regard to all of the elements of compensation except the conclusions reached with regard to the Retention Bonuses and SERP acceleration payments. The Roger Brown "FINAL REPORT: Proposed Executive Compensation in the January 17, 2003 Amended Form A Application of CareFirst and WellPoint", Roger G. Brown & Associates, February 14, 2003 (the "Second Brown Compensation Report") lays out both sides of the issue with respect to these payments. Mr. Angoff notes that Ernst & Young, relying on certain assumptions, has opined that these payments, which it characterizes as compensation for non-competition agreements, would not constitute excess parachute payments. On the other hand, the assumptions relied upon by Ernst & Young are not supported by the record; most notably, no reasonable basis is offered for treating all of the Retention Bonus and all of the SERP payment as consideration for a covenant not to compete, particularly when CareFirst had previously characterized only one-third of the severance payment as compensation for such a covenant. During the testimony regarding the new retention bonuses, no reference was made to these bonuses or the SERP being "consideration for a convenant not to compete." This lends credence to the view that this solution to the "reasonable compensation: problem was *expost facto* justification. Moving beyond 280G's "bright line" test, the question arises as to whether the compensation to be paid is reasonable under all of the facts and circumstances. This becomes, as Mr. Angoff notes, a battle of the "experts."

[523] February 4, 2003 at 42.

In a battle of the experts, CareFirst necessarily loses, because the burden is on CareFirst to demonstrate that there is no inurement. The MIA must find that a proposed transaction is not in the public interest unless it is able affirmatively to find that the steps have been taken to ensure that no part of the public assets benefit officers and directors. The record does not demonstrate that such steps were taken here. The initial transaction clearly intended to assure that officers received a part of CareFirst's value as a "bonus" for having created that value. The revised transaction eliminates many of the more obvious and repugnant elements of the original proposal. CareFirst executives will, nonetheless, receive very generous compensation packages in connection with the Proposed Transaction. In several cases, including Mr. Jews', the salaries and bonuses available are well-beyond amounts that WellPoint pays its own executives. And, with respect to the Retention Bonuses, the amounts exceed those amounts that WellPoint has paid in other cases.

In short, while the current compensation arrangements do eliminate many of the elements that clearly constituted unlawful inurement in the original proposal, the MIA cannot conclude on this extensive record that *no part* of the public assets of the acquisition will benefit CareFirst executives.

B. Have appropriate steps been taken to ensure that no officer or director receives remuneration as a result of the Proposed Transaction except in the form of compensation for continued employment?

1. The Legal Standards

Section 6.5-301(b)(4) of the Nonprofit Conversion/Acquisition Act states that the proposed acquisition of a nonprofit health service plan is not in the public interest unless steps have been taken to:

> ensure that no officer, director, or trustee of the nonprofit health entity receives any immediate or future remuneration as the result of an acquisition or proposed acquisition except in the form of compensation paid for continued employment with the acquiring entity.

The Anti-Bonus Provision prohibits remuneration, unless it is paid: a) as compensation and b) for continued employment. The statute does not define "remuneration," "compensation," or "for continued employment." Nor does the statute clearly indicate whether "compensation for continued employment" means only money for work actually done (such as salary or performance based bonuses), or whether it is intended also to encompass other payments that are linked to employment, such as a retention bonus.

The question of what kind of payments constitute compensation for continued employment, as opposed to impermissible remuneration, is critical to the assessment of whether the Proposed Transaction is in the public interest. The Proposed Transaction as it currently is structured provides for the payment of the Retention Bonuses to CareFirst executives. If those payments violate the Anti-Bonus Provision, the Proposed Transaction is not in the public interest as a matter of law and, thus, must be denied.

CareFirst, supported by an opinion letter prepared by Piper on February 5, 2003, contends that amounts paid under the Retention Agreements should be presumed to be compensation for continued employment, because the payments are, quite literally, paid to induce the executives to continue employment after the merger in order to assure an effective and efficient integration of

the two entities. Piper's memorandum does not purport to analyze the language or legislative history of the Anti-Bonus Provision and it cites no case law in support of its conclusion.

In his February 14, 2003, Final Report on Proposed Executive Compensation, Mr. Angoff argues that the Retention Bonuses should not be considered compensation for continued employment. First, he points out that there are circumstances in which the Retention Bonuses are payable even if the executive does not remain employed by WellPoint. Second, Mr. Angoff argues the Retention Bonuses should not be considered compensation for continued employment, because each executive already is receiving ample compensation in the form of salary, performance bonuses, stock options and benefits for employment with WellPoint. Third, Mr. Angoff suggests that, under 280G of the Internal Revenue Code, the Retention Bonuses are more appropriately characterized as severance payments.

Whether the Retention Bonuses violate the Anti-Bonus Provision or not depends on whether those bonuses can fairly be characterized as compensation for continued employment. It is necessary, therefore, to determine what kinds of payments the General Assembly intended to exempt from the general prohibition against an officer's receipt of remuneration in connection with the conversion or acquisition of a nonprofit health service plan.

The "paramount rule of statutory construction is to ascertain and effectuate the intent of the legislature." Medex v. McCabe, 372 Md. 28, 38 (2002). Statutory analysis begins

> by looking at the plain meaning of the words of the statute. When the words are clear and unambiguous, there is no need to search further. When we find ambiguity in the language of the statute, we look to the intent as evidenced in the legislative history or other sources extraneous to the statute itself. We cannot modify an unambiguous statute, by adding or removing words to give it a meaning not reflected by the words the Legislature chose to use, "nor engage in forced or subtle interpretation in an attempt to extend or limit the statute's meaning." Nor may we render, through our analysis, any portion of the statute superfluous or nugatory. It is clear, however, that the statute must be given a reasonable interpretation, "not one that is illogical or incompatible with common sense."[524]

Statutory language is considered ambiguous and, thus, subject to construction where the language is reasonably susceptible of one or more interpretations. Chesapeake Charter, Inc. v. Anne Arundel County Bd. of Ed., 358 Md. 129, 135 (2000).

According to the Merriam-Webster dictionary, "remuneration" means "recompense" or "something that remunerates." According to the same dictionary, "remunerate" means "to pay an equivalent for a service, loss, or expense." Merriam Webster defines "compensation" as "something that constitutes an equivalent or recompense." "Recompense" means "to return in kind."

The Anti-Bonus Provision prohibits the officers of a nonprofit from receiving "remuneration" in connection with an acquisition, except for "compensation" for "continued employment." Employing the plain meaning of the words used in the statute, the Provision prohibits officers from receiving any payments, including payments for services, losses, or expenses, except for those payments that are given in exchange for continued employment. Because "compensation" means a "return in kind" and an "equivalent" exchange, the legislature's use of that term

[524] Id. at 38-39 (citations omitted).

manifests its intent that "compensation " for "continued employment" be limited to the payment of a reasonable salary and other benefits, such as performance based bonuses, in consideration of work actually done.

The meaning of the legislature is clear. However, since Piper and Mr. Angoff have interpreted the Provision differently, it is reasonable to review the legislative history of the Anti-Bonus Provision and other extraneous sources to verify the legislature's intent.

In looking at legislative intent, it is significant that the Anti-Bonus Provision is not the only Maryland statute that draws distinctions based on whether "compensation" is "for" "employment." The Wage Payment and Collection Law, codified at Section 3-501, *et seq*. of the Labor and Employment Article, requires employers to pay employees all "wages" earned before the termination of employment.[525] The Law defines "wage" as "all *compensation* that is due to an employee *for employment*." Section 3-501(c)(1) (emphasis added). "Wages" (*i.e.*, "compensation for . . . employment") is further defined as: "(i) a bonus; (ii) a commission; (iii) a fringe benefit; or (iv) any other remuneration *promised for service*." Section 3-501(c)(2) (emphasis added).

The language of the Law makes it clear that "compensation . . . for employment" means money paid in exchange for services rendered. As the Court of Appeals recently noted,

> Section 3-501(c)(2) expressly includes "bonus" as an example of compensation that may fall within the ambit of the Act. This is in contrast to other jurisdictions where bonuses are separated from wages into a category of fringe benefits. In Maryland, not all bonuses constitute wages. We have held that it is the exchange of remuneration for the employee's work that is crucial to the determination that constitutes a wage. Where the payments are dependent upon conditions other than the employee's efforts, they lie outside the definition.

Medex, 372 Md. at 36.

Under the Wage Payment and Collection Law, a "wage" is defined as "compensation . . . for employment." The Court of Appeals has interpreted that to mean only payments that are conditioned on the employee's efforts. Payments that are conditioned on something other than the employee's efforts are not wages, *i.e.*, are not "compensation . . . for employment."

The Anti-Bonus Provision is not part of the Wage Payment and Collection Law. Nonetheless, both the similarity of language used in the two acts and the circumstances in which the Provision was enacted suggest that "compensation for continued employment" also should be construed to mean only payments that are conditioned on the employee's efforts.

The Anti-Bonus Provision was enacted by the legislature in 2002 in response to compensation packages that were being offered to executives of CareFirst as part of the Proposed Transaction. The extent of the compensation to be received by CareFirst executives upon the consummation of the Proposed Transaction became public in March 2002 and resulted in a fire-storm of controversy.[526]

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[525] Sec. 3-505.

[526] See, e.g., Jews' Golden Chute Glitters, THE BALTIMORE SUN, March 9, 2002 at 11C.

The Nonprofit Conversion/Acquisition Act as it existed in March 2002 included the Anti-Inurement Provision. The articulated purpose of that Provision was to "ensure that no part of the public or charitable assets of the acquisition insure directly or indirectly to an officer, director, or trustee of a nonprofit health entity." MD. CODE ANN., STATE GOV'T § 6.5-301(b)(3). Thus, to the extent that any of the monies that were to be paid to CareFirst officers could be said to be paid from the assets of CareFirst, or from funds that would otherwise be payable to the Foundation, those payments already were prohibited under the Anti-Inurement Provision.

Nonetheless, the legislature added the Anti-Bonus Provision, which further limited the circumstances in which an officer could personally benefit from the sale of a nonprofit. The Anti-Bonus Provision made it clear that no officer of a nonprofit may benefit economically from the acquisition of the nonprofit, regardless of the source of funds. While the Anti-Inurement Provision protected public funds, the Anti-Bonus Provision protected the public interest by assuring that officers would not be tempted to pursue a transaction for personal gain.

The exception to the general prohibition against acquisition-related remuneration confirms that the primary purpose of the Anti-Bonus Provision was to minimize the risk that officers would act out of personal greed in deciding to convert from nonprofit status. The only form of remuneration that an officer is allowed to receive in connection with an acquisition is "compensation for continued employment." Thus, the officer of the acquired entity is allowed to keep his job and to continue earning a living. The public policy that precludes the officer from receiving monies that could taint and improperly influence the decision to sell does not extend to the on-going payment of fair and reasonable wages (*i.e.*, a "return in kind" or an "equivalent") for on-going work. This is the only form of remuneration which does not necessarily act as an incentive to approve a proposed acquisition.

The legislative history of the Anti-Bonus Provision, coupled with the judicial interpretation of similar language in the Wage Payment and Collection Law, makes it clear that the only payments that CareFirst officers may receive in connection with the Proposed Transaction are reasonable monies paid in consideration of services actually provided. Payments conditioned on something other than an officer's actual efforts on behalf of his new employer fall outside the concept of employment-related compensation as that notion has been defined by the Court of Appeals and, in addition, undermines the legislative goals evident in the passage of the Provision. That conclusion is further supported by Mr. Angoff's analysis, particularly with regard to 280G of the Internal Revenue Code.

In short, in reviewing whether the payments payable to CareFirst executives under the Retention Agreements violate Anti-Bonus Provision, the appropriate examination is: a) whether those payments are made as a result of the Proposed Transaction; b) whether those payments are conditioned on the officer's on-going efforts on behalf of WellPoint after the transaction; and c) whether those payments are reasonable, that is, whether they represent an "equivalent" or "return in kind" for the work actually performed.

2. The Retention Bonuses Violate the Anti-Bonus Provision

Under the revised Form A, CareFirst executives have agreed to terminate their right to COC severance payments under their existing employment agreement and to waive any bonuses they may have received under the MIBP. In return for those waivers, the executives will execute Retention Agreements with WellPoint. Pursuant to those Agreements, executives that remain employed with WellPoint for two years will receive a bonus equal to the amount that they would have received in severance from CareFirst. Executives who voluntarily terminate without good cause in that two year period forego the Retention Bonus. If, however, the executive is

terminated without cause or terminates for good cause, the Retention Bonus is paid at termination.

WellPoint's CEO testified that the Retention Agreements were negotiated as part of an effort to address the conclusions contained in Mr. Angoff's draft report on compensation. The amounts that are payable as Retention Bonuses are equal to the amounts that executives would have received as severance payments under their employment agreements. Given this, there can be no good faith dispute that the Retention Bonus payments are being paid in connection with the acquisition of CareFirst by WellPoint. The question, therefore, becomes whether the Retention Bonuses can be characterized as compensation for ongoing employment with WellPoint; *i.e.*, under the standard outlined above, are those payments made as equivalent compensation for work actually performed for WellPoint?

The CareFirst executives subject to the Retention Agreement also participate in WellPoint's compensation program. In consideration of their employment by WellPoint, each executive will receive a base salary equal to their current CareFirst salary, annual incentives based on their CareFirst bonus targets, long-term stock-based incentives, and a standard package of benefits and perquisites. The salary and bonuses targets for the CareFirst executives are generally within the range of compensation paid to WellPoint executives, except that the compensation that WellPoint will pay to Messrs. Jews, Chaney, and Picciotto and Ms. Vecchioni are above that range.

A review of the entire structure of the WellPoint compensation plan makes it clear that the Retention Bonuses are not being paid to CareFirst executives as "in kind" consideration of the work that they are performing as employees of WellPoint. The executives are compensated for their work for WellPoint via salaries, bonuses, stock options, and benefits/perquisites. It is those items that constitute the executives' compensation for continued employment with WellPoint, the *quid pro quo* for the work that they do.

Whether one characterizes the Retention Bonuses as a clever means of assuring that severance payments are paid to CareFirst executives or as a genuine inducement to assure that highly valued CareFirst executives remain employed by WellPoint to manage the post-merger transition, the Bonuses are not compensation for continued employment with WellPoint. The Retention Bonuses are not paid as an equivalent for work performed. They are not in the nature of a salary or a performance based bonus or a benefit.

Indeed, the Retention Bonuses represent precisely the kind of inducement that the Anti-Bonus Provision clearly was intended to outlaw. The Retention Bonuses represent a windfall of cash – millions of dollars – that are made available to CareFirst executives only if the merger is consummated. No like remuneration is available to them if they simply go forward in their current roles and CareFirst remains a nonprofit. Thus the Retention Bonuses, like their predecessor severance payments and MIB payments, act as an economic inducement to pursuing a conversion and a merger. And that is precisely the kind of a conflict that the Anti-Bonus Provision was designed to prevent.

In summary, the Retention Bonuses are not compensation for continued employment with WellPoint. Consequently, it is the conclusion of the MIA that the Proposed Transaction is not in the public interest, because steps have not been taken to ensure that officers receive no remuneration in connection with the Proposed Transaction except for compensation for continued employment. To the contrary, the Proposed Transaction expressly provides for such remuneration.

X. HAS THE TRANSFEROR RECEIVED FAIR VALUE FOR ITS PUBLIC ASSETS?

An acquisition is not in the public interest unless appropriate steps have been taken to ensure that the fair value of the public assets would be distributed to the Maryland Health Care Foundation. The term fair value is not defined, but a reasonable approximation according to Blacks Law Dictionary is "present market value." The conversion law permits the MIA to retain expert assistance on the issue of fair value. The Blackstone Group was retained by the MIA to assist in the MIA's enforcement of the fair value requirement. At the request of WellPoint, and MIA agreed to have Blackstone perform a preliminary valuation early in the review process. WellPoint sought this preliminary valuation in order to determine whether or not it would continue to press for approval of its application to acquire CareFirst. When the General Assembly passed legislation requiring that consideration of this acquisition be in the form of 100% cash, the terms of the merger agreement with CareFirst provided WellPoint with the option to terminate the proceeding. The preliminary valuation was a tool to assist WellPoint in determining whether or not it would pursue the application.

The conversion statute sets out factors to be considered in determining the fair value of CareFirst. After reviewing these statutory factors, Blackstone concluded that four methodologies were appropriate for the CareFirst valuation. These methods were: comparable public traded company analysis plus control premium; comparable precedent transaction analysis; discounted cash flow analysis; and discounted cash flow analysis plus 50% of WellPoint synergies/adjustments. These four methodologies resulted in a broad range of possible values for CareFirst. The discounted cash flow analysis (D.C.F) estimates the value of CareFirst based on its projected free cash flows. As Blackstone points out this is highly sensitive to certain assumptions including income projections, the discount rate, and terminal value assumptions. The D.C.F methodology resulted in a range of $1.35 billion to $1.75 billion. The same analysis was performed, but 50% of the value of the synergies or improvements that WellPoint expects to gain from the transaction are included in the calculation. This resulted in a range from $1.68 billion to $2.25 billion. The comparable publicly traded company analysis estimates a value of CareFirst based on the value of selected companies that have similar business operations using multiples of certain business and financial metrics. Added to this was a control premium of 20% to 30% (based on comparable precedent transactions) to reflect the added value of purchasing a controlling interest in a company. That resulted in a range of $1.38 billion to $1.89 billion. The comparable precedent transaction analysis without a control premium yielded a range of $1.5 billion to $1.8 billion. These four methodologies resulted in a very wide range, with a low of $1.35 billion to a high of $2.25 billion.

As part of its analysis Blackstone identified certain "positives" and "negatives" that characterized the auction process run by CareFirst. While Blackstone viewed it as a positive that "WellPoint's sensed that it was in a competitive process" Blackstone viewed as a negative the fact that "Anthem was excluded from the process without CareFirst's understanding of what Anthem might be prepared to pay …" Blackstone also observed that "it appears that CareFirst's Board of Directors … thoughtfully and thoroughly analyzed the transaction proposals and strategic alternatives available to CareFirst."[527] However, the preliminary valuation report was prepared as of August 16, 2002 before the MIA had completed its thorough and in-depth review of the auction process and the factors used by the Board as described in this report.

The Blackstone Group issued a "Valuation Report on CareFirst, Inc." as of February 11, 2003, in anticipation of the issuance of the Final Order in this matter. In preparation for the issuance of

[527] First Blackstone Valuation Report, at 10.

its Valuation Report, Blackstone reviewed updated information from CareFirst, including more up to date financial results and projections for 2003. In the Valuation Report of February 11, 2003, Blackstone utilized the same valuation methodologies as it had in the preliminary Valuation Report of August 16, 2002. However, changes in the market, as well as changes in CareFirst's financial projections produced lower valuation ranges in February than were obtained in August of 2002. For example, in August 2002, Blackstone determined that BlueCrossBlueShield managed care companies were trading at approximately 17.1 times the 2002 estimated earnings per share of the companies. By February 2003, the same companies were trading at a multiple of 13.3 times the 2002 estimated earnings per share. Changes in CareFirst financial projections also resulted in a reduction of the valuation obtained under the discounted cash flow analysis. After considering these and other factors Blackstone established a valuation range of $.45 billion to $.65 billion.

At the public hearings held by the MIA, WellPoint and its investment bankers had the opportunity to comment on and respond to the Blackstone valuation. While some questions were raised regarding the methodology utilized by Blackstone, no arguments were presented to suggest that the Blackstone valuation was inappropriate or based on inappropriate or unreasonable assumptions. In fact at one point, the investment bankers for WellPoint criticized certain aspects of the Blackstone methodology, but later admitted that they had used the same methodology in advising the WellPoint Board on whether or not the price it was offering was fair.

A. Summary of Key Points

Blackstone utilized the appropriate valuation methodologies to value CareFirst as required by the Maryland conversion statute.

As of February 11, 2002, the valuation range established by Blackstone, $1.45 billion to $1.65 billion represents the minimum value that could be considered fair value under the conversion statute.

Because the auction process that was conducted by CareFirst was flawed, the fair value of CareFirst may likely exceed the $1.45 billion to $1.65 billion range established by Blackstone.

The controversy created by the CareFirst executive compensation proposals may discourage any other interested parties from bidding on CareFirst.

B. Conclusions

This report concludes that the 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 the two competing bidders. 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. The evidence is also clear that CareFirst believed it could rely on the regulatory process to set the fair value of the company. The testimony was clear that Trigon was willing to offer more money, but for the reasons described in this report it was not encouraged to do so. Furthermore as Blackstone pointed out CareFirst could not permit the inclusion of Anthem in the bidding process at least to determine what Anthem what might be willing to bid for the company.

As noted earlier, the Blackstone report is a check on the process conducted by CareFirst in selling itself. It is one way to measure whether or not the company obtained " fair value" but it is clearly not a substitute for a vigorous auction process. As a consequence the MIA cannot conclude that the deal will ensure that the fair value of CareFirst is transferred to the foundation.

XI. FOUNDATION ISSUES

A significant element of the case in support of the Proposed Transaction made by CareFirst and WellPoint rests on the promise of an infusion of significant amount of cash into the Maryland health care system. This money, which would be generated from Maryland's potion of the purchase price, can serve as a funding source to satisfy unmet healthcare needs in the state. A recent advertisement by CareFirst in local newspapers suggested the money could be spent on clinics, insurance for the poor, and populations currently unserved or underserved in the current system.[528]

Because the prospect of this infusions of possible spending on Maryland's health care system is such a key element of the case in support of the conversion, the MIA retained an outside consultant to evaluate the purpose, structure, operations and efficacy of foundations in other states that have been the recipients of conversion funds. By evaluating the performance of foundations in other states, the study was designed to help determine whether such a foundation could be expected to serve the needs or perform the functions posited by CareFirst, and generally whether the infusions of such funds furthers the "public interest" in way that would offset any possible disadvantages that might result from an acquisition by WellPoint of CareFirst.

The exhaustive study conducted by LECG, the consultant retained by the MIA provide valuable insight into the operations of other foundations and on whether and in what form the foundations proceeds could further the "public interest". LECG relied on numerous data gathering techniques, including primary research such as interviews with foundation personnel and grantees, surveys of foundations and grantees, and secondary research including web-based research and collections of demographic data. The Appendix to their report documents this work.

LECG developed the "Maryland Health Care Access Framework" for the purposes of their Report, to provide a common tool for identifying and discussing healthcare access issues in Maryland and other BCBS conversion situations. The Framework was divided into three categories, and is described below:

- **Insurance and financing:**
  - **Subsidizing insurance** - Efforts to directly subsidize health insurance or to support organizations that subsidize health insurance; this includes prescription drug coverage for the elderly and coverage for medically uninsurable individuals (high risk), etc.
  - **Affordability of insurance premiums**
  - **Research on insurance** - Research on issues related to public and private healthcare insurance.

[528] Baltimore Sun, January 29, 2003.

- **Service capacity and manpower availability:**

  - **Direct Medical Care** - Efforts to support clinics, hospitals or other entities providing medical care. This category includes the funding of buildings and equipment that is intended for the delivery of medical care. Preventative services are also included unless these services take the form of education or the provision of information.

  - **Improvements to Medical Care**

  - **Data** - Efforts to improve the collection and sharing of healthcare data

  - **Manpower** - The promotion of scholarships, mentoring programs, student loan reimbursement programs and programs to recruit, train, and support people pursuing careers in healthcare services.

- **Barriers:**

  - **Providing Medical Information** - This category includes several types of programs, such as the provision of information to the public on disease prevention and management, supporting case management and programs that connect people to services, such as subsidized drug prescription programs, informing healthcare professionals about medical treatment through seminars and conferences, etc.

  - **Public policy and advocacy** - Efforts to provide information to legislatures, policy makers, opinion leaders, and community leaders. In addition, it includes funding for advocacy groups and grass-roots organizations seeking to influence healthcare policy.

  - **Transportation**

  - **Reducing language and cultural barriers to healthcare access**.[529]

LECG used this framework in its evaluations of health care foundations and the contributions they make to the health care markets they serve.

LECG's analysis begins with the observation that the circumstances in states where BlueCross conversions have occurred and foundations have been established vary significantly. LECG looked at ten to 12 foundations at a high level and examined a smaller population in more detail. The foundations examined are in states that had Blue Cross/BlueShield plans acquired by WellPoint and Anthem, including Maine California, New Mexico, and Missouri. LECG observed that in at least four of the conversions, the converted plans were facing financial pressures and were considered failing plans by regulators. In addition, according to LECG, many of the converted plans are small both on an absolute basis and relative to CareFirst. The relative market share of Maryland's BlueCross plan is the second largest of any state observed by LECG. Of the 12 states reviewed, only Maryland's Blue plan and Missouri's had a market share

[529] LECG at 23 - 24.

of over 40%.[530] In four states the plans had less than 20%, in five states the market share of the plan was between 20% and 30%. In Connecticut, the market share of the plan was 36%.

LECG examined the missions of 14 Blue Cross conversion Foundations and found they all had similar missions. The general theme of all the foundations is improve the health of the citizens of the particular state, address unmet health care needs in the state, and improve access to quality care for all residents of those with limited access.[531]

As to the types of grants made by conversion foundation, about two third of these fund are made to grantees who specialize in the delivery or provision of health care services. This suggests that if a conversion were to result in the segments of the population being adversely affected in terms of access to health care, "the resulting conversion foundation is more likely to offset this decrease in access through the funding of programs that provide direct medical care than it is to offset this outcome through the funding of programs that provide insurance subsidies." Using the Access Framework developed by LECG, these grants fall into the "Service Capacity" function rather than "Insurance and Financing" function.

LECG cites several reasons for this:

Lack of resources: Generally, foundation resources are too small to make a significant impact subsidizing insurance. The largest healthcare foundations studied give no more than $50 million total in one year. This is a small percentage of the typical state Medicaid and other health-related department budgets.

Not self-sufficient: In most cases, when a foundation discontinues subsidizing an insurance program or product, the program either ceases or must be curtailed proportionately. This is because few alternative funding sources exist that would provide for continued provision. Thus, the program is usually only temporary at best.

Lack of experience: While some foundations have dabbled in the insurance provisions/subsidization area, most foundations generally feel that "insurance" is an area outside of their typical domain and experience of funding "innovative" stopgap programs, and are therefore reluctant to be involved.[532]

Typically these types of "direct care " grants are for less than $50,000 and are not intended to be long-term grants, but rather the grantees are expected to obtain longer term sources of funding in order to continue the program of care. The report concludes that " the typical conversion foundation may supplement (but will not supplant) the healthcare activities that are tasked as public sector obligations (such as Medicaid).

The larger California foundations, with endowments in the billions, make larger grants, sometime exceeding a million dollars or more. The appendix of the LECG report documents the types and amount of grants that are made by the various foundations. Grants have been made to recruit professional in rural areas lacking providers, recruit students into careers into human service professions, enhance translation abilities of bilingual staff who serve clients with limited English speaking ability, and assist senior in obtaining low cost prescription drugs. The California Healthcare Foundation provided a grant of almost $700,000 to translate a "consumer Assessment of Health Plans Survey" into Vietnamese, Mandarin Cambodian, and Korean.

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[530] See LECG page 16.
[531] Final report at 37 – 38.
[532] LECG at 43.

In testimony the authors of the study emphasized that because of the magnitude of health care spending in the states, conversion funds do not result in system change or broad changes in access to health care, but clearly can serve to increase access and address narrow problems in specific communities or populations.[533] One author of the Study, Robert Cameron of LECG testified that given the total spending devoted to health care, revenues from Foundations can be a "drop in the bucket."[534] Foundations usually view themselves as an incubator, to make grants so that programs or services can be self-sufficient. Id. However, based on Maryland receiving a $1 billion endowment, and assuming an 8% return on assets, LECG predicted between $40 and $47 million would be available over the next five years. That would allow for the following types of options to be funded:

Extended Medicaid Program to Decrease Uninsured: The projected FY 2003 average costs per person are $6,400 for Medicaid beneficiaries.[10] Since this figure represents an average of high (disabled, blind and indigent elderly) and low beneficiary costs, the typical expansion population beneficiary is likely to be less expensive. We estimate that expanded population Medicaid recipients cost between $2,500 and $4,500 annually. Thus, $40 million received annually ($80 million after the Federal match) would expand the Medicaid program to cover an additional 17,000 to 32,000 adults.

Provide Premium Subsidies to the Maryland Health Insurance Plan (MHIP): $40 million would cover an additional 12,075 medically uninsurable (*i.e.*, high-risk) individuals for one year.[11]

Expand Primary Care Coverage: $40 million of operational funding for a Maryland-Qualified Health Center (MQHC) in the State could accommodate between 80,000 and 133,000 adult primary care patients annually.[12]

Increase Dental Coverage: $40 million of operational funding for dental services in a rural area could potentially accommodate as many as 160,000 preventative care patients annually.[13]

Note: The above is for illustrative purposes only. We have used reasonable assumptions in developing these assessments; however, these assumptions have not been verified and in-depth program cost-analysis was outside the scope of this report.

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[10] Maryland's Department of Medicaid estimates.

[11] These are very preliminary estimates from MHIP and assume an eight to one PPO - HMO enrollment ratio. This projection also assumes that the preliminary "subscriber only" rate for MHIP is $273/month for the $1,000 calendar year deductible, $4,500 out-of-pocket maximum for the PPO plan and $376/month for the HMO plan.

[12] This figure assumes primary care costs range from $300 to $400 annually; this does not take into consideration any infrastructure costs.

[13] This figure assumes preventive dental costs range from $250 to $300 annually and includes approximately two visits, x-rays, dental screening and cleaning; this does not take into consideration any infrastructure costs.

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[533] 1/30/03, 67:8-14

[534] LECG at 56.

LECG also analyzed the Maryland Health Care Foundation and its governance. Attorneys that analyzed the governance of the Maryland Foundation and other foundations found Maryland's "very different" and unique. This distinction results from a multi-layered governance structure in which the Foundation is the trustee of any conversion proceeds, but such proceeds can only be expedited as a result of Legislative action. The mission of the Foundation is to "expand access" to health care services, while the statute establishing the Legislature's proceeds provides that expenditures from the proceeds from the conversion should be made to "improve the health status" of Maryland residents. Mr. Cameron stated that these concepts although not necessarily incompatible, were different, and could be interpreted in ways that supported "vastly different sets of activities or goal:[535]

LECG also identified the following potential problems with the current Maryland structure:

- It is not clear what constitutes the "governing body" in the Maryland model. In the typical conversion model this is the Board of Trustees. In Maryland it could be argued that the General Assembly fills this role by determining how the funds will be utilized. This role, however, is subject to the typical legislative process, including input from the Governor and potential veto power.
- If the General Assembly is viewed as the "governing body" its size is vastly larger than the typical foundation board, and its term and manner of action are different.
- Although the Maryland Health Care Foundation more closely resembles the typical conversion foundation, even its Board of Trustees (comprised of 19 individuals) is relatively large.

➢ In Summary, with respect to the foundations studied, LECG had the following observations:

- The overall problem-solving capacity represented by the capital assets is quite limited in the context of the healthcare economy; the larger the problem the less time the problem can be solved.
  - In this respect the assets may be more appropriately considered as a supplemental resource to help address specific and well-defined problems rather than as a replacement for public sector obligations or private sector healthcare cash flows.
  - The individual grants of a BCBS conversion foundation likely represent new revenue streams for community healthcare interventions that would otherwise not be available.
  - The foundation's grants are likely to emphasize community intervention in the form of direct service provision (as opposed to health insurance coverage or premium subsidies).
  - the effectiveness of these interventions will (in large part) not be demonstrable (at least in the short-term) given the current foundation performance measurement systems.

[535] Testimony of Robert Cameron, January 30, 2003, at 40.

- The efficiency with which the foundation's activities are delivered will likely vary considerably; for community intervention grants, the foundation's ability to be effective will largely depend on the specific grantee services and the grantee organization itself.

- Current performance evaluation systems will make it very difficult to evaluate the relative cost-benefit performance of competing pilot demonstration grants designed to identify a "best practice" solution for a given problem.

- Due to the enormous number of grants made by the healthcare philanthropic industry, it is unlikely that much of the foundation's activities will be truly unique or involve otherwise unstudied issues or untested models.

- However, the healthcare philanthropic industry appears somewhat fragmented (especially across state lines) and learning from the experiences of other foundations may not be easy.

- Foundations that devote significant portions of their assets to a pursuit of "truly unique" activities may experience "mission creep," and over time, risk developing an overly broad portfolio of unrelated grants and activities.

- Whether foundations represent the ideal vehicle (in terms of efficiency and effectiveness) for accomplishing their tasks is up for debate and highly sensitive to the specific types of activities examined.

- The closer a foundation focuses on the financing related aspects of "healthcare access" the more likely it becomes that other (non-foundation) options will be more effective and efficient than the foundation model.

- There are significant fixed expenses associated with operating a credible foundation; this implies that a certain critical mass in terms of foundation assets is needed to achieve a minimum acceptable level of performance.

- Within this universe of studied foundations, the overall attributes that most seem to correlate with operating efficiency include:

  - A relatively narrow geographic focus;

  - Independent or company-sponsored organization structure; and

  - A longer period of organizational experience.

- This evidence suggests there may be a tradeoff between the breadth of foundation efforts (both geographic and purpose-wise) and subsequent operating efficiency.

- There may be a further tradeoff between foundation operational efficiency and making the infrastructure investments (people, technology, etc.) to

improve the performance measurement systems needed to better assess grantee and foundation effectiveness.

- The structure of the philanthropic industry in Maryland is such that it may be difficult for a conversion foundation to significantly utilize intermediary organizations as a means for distributing grants.

XII. ADDITIONAL STATUTORY CONSIDERATIONS

A. Other Considerations Under The Conversion Statute

There are other issues that the MIA is required by the conversion statute to consider in deciding whether to approve the Proposed Conversion. Key among these is whether the proposed acquisition is equitable to CareFirst's enrollees, insureds, shareholders, and certificate holders.[536] In addition, the MIA must consider whether the transaction complies with Title 2, Subtitle 6 of the Corporations and Associations Article;[537] and whether it ensures that the transferee will possess the surplus (1) required under law, and (2) sufficient to provide for the security of CareFirst's certificate holders and policyholders.[538]

Of these three major considerations, the second and third require limited comment. MD. CODE ANN., STATE GOV'T § 6.5-303(2)(ii) requires compliance with the provisions of the Corporations and Associations Article governing charter amendments.[539] These provisions specify the method for adopting, and contents of, such amendments. It appears on initial review that the documents presented as part of the Application and Amended Application comply with these provisions. In light of the substance of the MIA's decision, further scrutiny of this aspect of the Proposed Transaction is unnecessary. Even if such scrutiny were to reveal technical deficiencies, they should be susceptible of relatively easy remedy. Section 6.5-303(2)(iii) requires that CareFirst have adequate surplus following the transaction. Nothing brought to the attention of the MIA as part of this process suggests that the company's surplus would be inadequate. Indeed, a stated objective of the transaction is to increase available capital.

The first requirement of this section, however, cannot be disposed of so easily. Section 6.5-303(2)(i) requires the Commissioner to consider whether the acquisition is equitable to CareFirst's enrollees, insureds, shareholders, and certificate holders. Putting aside the extent to which the inconsistency of the transaction with the public interest may itself preclude compliance with this requirement, there remain substantial problems. The interests of CareFirst's enrollees, insureds, and certificate holders are focused principally on availability, affordability and viability of coverage. Put another way, CareFirst's customers have a vital interest in assuring that the benefits they reasonably expect to receive under CareFirst coverages will not be affected adversely. If the transaction had the effect of reducing accessibility to health care services (such as by reducing access to providers or the scope of covered services), or resulted in rate increases attributable solely or principally to the transaction, these effects would be inequitable and compel a rejection of the proposed acquisition. Similarly, indications that the transaction might cause CareFirst to discontinue coverages for certain groups of customers (as by exiting or de-emphasizing certain lines of business), rejection of the deal would again be justified. These are matters of critical significance, affecting the very core of CareFirst's importance to this statewide community. Therefore, the MIA engaged in vigorous efforts to

[536] Md. Code Ann., State Gov't § 6.5-303(2)(a) (2002).
[537] Md. Code Ann., State Gov't § 6.5-303(2)(b) (2002).
[538] Md. Code Ann., State Gov't § 6.5-303(2)(c) (2002).
[539] Md. Code Ann., Corps. & Ass'ns § 2-601, *et seq.*

ascertain the probable consequences of WellPoint's proposed acquisition of CareFirst. See for example, the analyses by the Delmarva Foundation and by the Wakely Consulting Group, discussed above earlier in this report. However, these efforts were substantially frustrated by WellPoint's refusal to provide information critical to the analysis. Sadly, the MIA was left without the ability to conclude that the acquisition would not suffer from such deficiencies.

Given that the burden of demonstrating statutory compliance devolves upon WellPoint and CareFirst, this refusal to provide necessary information must result in a negative presumption. The public interest, and the need to protect insureds who lack the ability to protect themselves, bar a contrary presumption favoring the applicants in the naked and undocumented hope that their benevolence will restrain them from disadvantaging their customers.

Moreover, the analyses of the MIA's consultants do give rise to articulable concerns. For example, Delmarva's analysis expresses concern about WellPoint's provider relations. WellPoint's experience in California particularly, suggests an attitude of firmness in negotiations and willingness to sacrifice network breadth for economic interests. While this dynamic permeates the managed care universe, it seems particularly significant in WellPoint's case.

In its analysis, Wakely concluded that certain premium rates might be expected to increase due to the loss of the SAAC discount and premium tax exemption, though neither can be said to be solely the result of the conversion. But Wakely also noted that WellPoint's desire to improve CareFirst's performance may itself cause a premium rate increase.[540]

Furthermore, the proposed transaction would be unfair to the public, who as owners of the company can be viewed as the equivalent of shareholders. First, the company is being sold for a below market price. The final deal is for a purchase price of $1.37 billion. But the lowest point of the fair market value range identified by WellPoint is $1.45 billion. Moreover, there are many indications in the record that a higher price might have been available from Trigon. And it is clear that the "auction" was not conducted in a manner reasonably calculated to maximize price. In addition, the record is persuasive in demonstrating that management and the Board embarked on a predetermined course of for-profit conversion and sale to WellPoint, without nearly adequate consideration of the existence of viable alternatives, such as preservation of the status quo, or a combination with another entity, including nonprofit plans. On the whole, the interests of the public as owners received little or no consideration. The consequence is a deal contrary to the interests of the public as owners of CareFirst, *i.e.*, shareholders.

B. SUMMARY OF KEY POINTS:

The record does not indicate that the parties will fail to meet the statutory requirements governing charter amendments.

The record does not indicate that CareFirst would have inadequate surplus after the conversion to comply with legal requirements and provide for policyholder security.

Refusal by WellPoint to provide essential information has prevented sufficient analysis of whether the proposed transaction would be equitable to CareFirst's customers.

The limited information available to the MIA's consultants gives rise to concerns about potential impacts of the transaction on provider relations (and therefore access to health care services), as well as on premium rates.

[540] Wakely Report, page 45.

The proposed transaction would sell the company for a below-market-value price, without adequate consideration of alternatives. In these respects, it is inequitable to the public as the equivalent of Shareholders.

1. Conclusion

The conversion statute requires the Commissioner to consider the effect of the conversion on CareFirst's customers, but diligent efforts to do so were thwarted by WellPoint's unwavering refusal to provide essential information. Left to extract inferences from circumstantial and indirect observations, the MIA's consultants were unable to gain adequate comfort and, instead, identified at least some indicators of possible adverse consequences. On this record, it cannot simply be assumed that after the transaction "all will be well." Moreover, the proposed sale of the company would be inequitable to the public as the equivalent of shareholders, because it is for a price below fair market value, and insufficient attention was paid to what might have been far preferable alternatives.

C. Compliance with the Insurance Acquisition Statute

The Maryland Insurance Acquisitions statute promulgates seven conditions in the presence of which the Commissioner must deny reject the proposed transaction.[541] Of these, the first three, the fifth and the sixth seem to be of little concern in the context of the pending application. They inquire, respectively, about (1) entitlement to a certificate of authority, (2) effect on competition, (3) financial condition, (5) competence, experience and integrity of acquirer, and (6) a non-insurer acquirer. The MIA's review does not indicate the probability of adverse consequences from the transaction regarding any of these issues.[542]

The fourth statutory ground for disapproval would be triggered by WellPoint plans for CareFirst that would be unfair or prejudicial to policyholders.[543] As discussed at some length elsewhere throughout this report, try as they might, the MIA's consultants were unable to glean enough information about this subject. Specifically, WellPoint failed to provide the data necessary to evaluate the probable impact on CareFirst insureds of adoption of the "WellPoint Way." The record indicates that WellPoint has a plan to improve certain of CareFirst's operating ratios and margins.[544] No effort has been made to demonstrate specifically how these improvements will be accomplished without premium rate increases or reductions in benefits. WellPoint has also touted its wide variety of innovative products, many offering inferior benefit packages, admittedly at lower cost. But there has been no submission of specific plans regarding products to be offered in Maryland following the acquisition. The best that can be said is that WellPoint has a corporate strategy that is not inconsistent with overall reduction in benefits compared to the status quo. To be sure, Maryland's regulatory scheme will provide a safety net against excessive reductions in covered benefits. But the record does not permit the drawing of conclusions as to

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[541] MD. CODE ANN., INS. § 7-306(b) (2002).
[542] It is true that CareFirst has unabashedly proclaimed expansion of its already dominant market position as a key goal of the conversion. However, the record does not indicate that such expansion is possible, let alone probable. Moreover, a market-share increasing transaction facilitated by this conversion will itself be subject to independent scrutiny under the same statute. The combination of WellPoint and CareFirst does not by itself appear to create serious threats to what competition exists in this market.
[543] MD. CODE ANN., INS. § 7-306(b)(4) (2002).
[544] Wakely Report, page 45.

whether the array of products to be offered under the "WellPoint Way" would, in the aggregate, constitute a reduction of coverage.

Lamentably, these important issues did not prove susceptible of definitive conclusions, owing largely to a paucity of essential WellPoint information. Were this the only issue to be resolved in determining whether or not to approve the transaction, further analysis would have been indispensable. However, given the considerable analysis that was possible for other dispositive issues, it suffices on this point to suggest troubling uncertainty. Specifically, the record may not support a conclusive finding that WellPoint's plans for CareFirst would e unfair or prejudicial to policyholders. But there is enough in the record to prompt concern if the transaction were approved.

The seventh disapproval ground would be triggered by a finding that the interests of CareFirst's policyholders and stockholders might otherwise be prejudiced, impaired, or not properly protected. For all the reasons stated above, the record is, at best, inconclusive on this point as regards policyholders. But there are certainly reasons for concern. While it is entirely possible that an acquisition by WellPoint might leave CareFirst's customers no worse off than they are today,[545] the converse cannot be ruled out. In the end, the record in its current form might not support disallowance of the application solely on this basis. In the totality of the circumstances, this issue becomes less critical and might be characterized as a troubling, but not disabling, concern.

In contrast, the matter of stockholders compels a different conclusion. As noted, CareFirst has no stockholders. It is, however, owned by the citizens of this state, who can be viewed as the equivalent of stockholders for purposes of this analysis. In that vein, the record compels certain inescapable conclusions. The deal has been struck at a price below CareFirst's fair market value. That is to say, the selling public will receive less than the company's value if the deal is approved. That is contrary to their interests. Moreover, the record demonstrates conclusively that the transaction was partly, if not principally, motivated by improper considerations. Equally clear is that little attention was paid to alternatives less lucrative for management. For example, preservation of the *status quo* seemed to be out of the question without one iota of analysis. Similarly, alliance with another non-profit seemed fatally abhorrent to the disquietingly profit-motivated analytical methodology adopted by the Board and management. In short, the deal is unfair to the stockholders both, because CareFirst would be sold for too little, and because the Board and management simply failed to consider potentially preferable alternatives.

D. Summary of Key Points:

The record suggests that there is no reason to reject the transaction on account of (1) entitlement to a certificate of authority, (2) effect on competition, (3) financial condition, (5) competence, experience and integrity of acquirer, and (6) a non-insurer acquirer.

Owing in large part to lack of information sought unsuccessfully from WellPoint, the record is inconclusive as to whether the transaction would be unfair, prejudicial, or contrary to the interests of CareFirst's policyholders.

Despite the uncertainty of the record, there do exist bases for concerns about the effect of the proposed acquisition on CareFirst's policyholders.

[545] This is especially the case, given CareFirst's recent propensity for emulating its for-profit competitors.

In the context of the many other matters evaluated and addressed in this report, these concerns do not, by themselves, warrant rejection of the application. They are, at best, neutral.

Both because of a below market value price, and for failure to consider potentially preferable alternatives, the proposed transaction is unfair to the public as the equivalent of stockholders.

1. Conclusion

While the absence of information from WellPoint may preclude conclusions as to the effect of the proposed transaction on policyholders, the record is clear that the deal is bad for the public *qua* stockholders. Their asset would be sold for too little, and preferable alternatives were discarded without adequate analysis, in apparent deference to the pecuniary interests of management.

XIII. APPLICATION OF THE CONVERSION STATUTE TO GHMSI

The proposed conversion of CareFirst, Inc. includes the conversion of the three principal insurer subsidiaries, CFMI in Maryland, GHMSI in the District of Columbia, and BCBSD in Delaware.

Although domiciled in the District of Columbia, GHMSI is subject to the regulatory oversight and jurisdiction of the MIA because it is authorized to, and does, insure Maryland residents. As note previously, in an opinion dated November 12, 2002, the Honorable Joseph Curran, Attorney General for the State of Maryland, ruled that this regulatory authority extends to the pending conversion.[546] Specifically, General Curran found that the Commissioner of Insurance of this state has authority to review the proposed transaction as regards GHMSI under the Conversion Statute, the nonprofit health service plan statute, and the Insurance Acquisition Statute. The review encompasses the competitive impact of the transaction, its fairness to policyholders, preservation of GHMSI's financial stability, and protection of public or charitable assets. To be sure, the Commissioner may, but is not required to, defer to the District of Columbia Insurance Commissioner. The MIA has generally kept abreast of the work of the D.C. and Delaware regulators. Nonetheless, the breadth of GHMSI's operations in Maryland is such as to compel the conclusion that the MIA should include in its review the impact of the proposed conversion on that company.

The proposed conversion of GHMSI falls within the scope of Title 6.5 of the State Government Article. The provisions of that Title apply to the acquisition of nonprofit health service plans, which are defined as "a corporation without capital stock with a certificate of authority from the Insurance Commissioner to operate as a nonprofit health service plan."[547] GHMSI is a corporation without capital stock and holds a certificate of authority from the Insurance Commissioner to operate as a nonprofit health service plan. The conversion statute "*…does not apply to the acquisition of a foreign non-profit health entity operating in this State if the appropriate regulating entity determines, based on the standards set forth in this title, that any public or charitable assets of the nonprofit health entity that serve health care needs in this State will be adequately protected.*"[548]

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[546] 87 Opinions of the Attorney General __ (2002) [Opinion No. 02-019 (November 12, 2002)].
[547] Md. Code Ann., State Gov't § 6.5-101(h) (2002).
[548] Md. Code Ann., State Gov't § 6.5-307 (2002).

The question of whether those public assets of GHMSI that serve health care needs in this State would be protected adequately in the Proposed Transaction begins with an evaluation of whether those assets have been fairly valued. This report concludes that the proposed purchase price for CareFirst does not reflect the fair value of CareFirst and its assets, including GHMSI. Thus, one cannot conclude that those public assets of GHMSI that serve Marylanders are protected adequately.[549] Because those assets are not protected adequately, Title 6.5 does apply to the proposed conversion and acquisition of GHMSI.

The analysis of this transaction as it affects GHMSI, can be viewed from two perspectives: Impact on policyholders, and impact on the public. In the former are issues regarding availability, accessibility and affordability of health coverage. The latter includes effects on competition and safeguarding of public assets. Effects of the conversion anticipated for CareFirst and CFMI will inevitably impact GHMSI in much the same way, albeit with some limitation. It is important to note that the same Board and management team was responsible for the operations of GHMSI and for the rest of CareFirst. The accident of geographic location does not by itself insulate GHMSI from the transactional infirmities observed for CareFirst generally. For the reasons set out above in considerable detail, the Commissioner and MIA have concluded that the proposed transaction fails applicable statutory requirements as to CareFirst in both arenas; impact on policyholders and public impact. The same is true as to GHMSI.

The inability of MIA analysts to obtain vital information from WellPoint has precluded sufficient analysis of how becoming part of the WellPoint family of companies would affect availability, accessibility and affordability of health coverage for CareFirst insureds. No less true is this as applied to GHMSI. But as noted above there is basis for concern. Far more conclusive was the analysis regarding the process by which the companies have arrived at the proposed transaction. For all the reasons explore in the foregoing report, the decision to sell to WellPoint on the terms proposed is no less defensible as to GHMSI than it is as to CFMI or CareFirst as a whole. And the effect of the transaction in failing to protect public and charitable assets is no less important and relevant as to GHMSI than it is to CFMI and CareFirst. In short, the proposed deal is no better as to the D.C. subsidiary than it is as to CFMI or the company as a whole.

XIV. CONCLUSION: IS THE PROPOSED CONVERSION OF CAREFIRST AND ACQUISITION BY WELLPOINT IN THE PUBLIC INTEREST?

The Maryland Insurance Administration took a two-prong approach to evaluating whether or not the transaction was in the public interest. First, it evaluated the transaction under the criteria set out in the conversion statute. The MIA examined both the disqualifying factors and the mandatory considerations. This it must do as a matter of law. Second, although not necessarily required by statute, the MIA evaluated the so-called "Business Case" that CareFirst has put forward in support of its view that the transaction was in the public interest. Although not all the arguments presented by CareFirst as part of its Business Case relate directly to the statutory criteria, these arguments should be taken into consideration when determining whether the transaction is in the public interest.

[549] Additional grounds for this conclusion could exist, even if the transaction had been approved, depending on how the proposed purchase price were divided among the Maryland, Delaware and District of Columbia Foundations. The allocation of proceeds obviously impacts the determination of whether assets that serve health care needs in the State have been protected.

Taking into account all of the arguments advanced by CareFirst as part of its Business Case, along with the MIA's evaluation of the criteria, it is clear that this proposed transaction is not in the public interest, and CareFirst has not met its burden of persuasion.

To begin with, this deal does not ensure that the fair value of the public assets will be distributed to the Maryland Health Care Foundation as the conversion law requires. This compels a finding as a mater of law that the deal is not in the public interest. This report details the many ways in which the process employed by CareFirst to negotiate the terms of the sale, and achieve a purchase price was fatally flawed.

First, the Board never obtained a valuation before the bidding process began, so it had no independent basis for knowing whether the bids that were made approximated fair value for the company. The Board then relied on its investment banking firm, which brokered the deal, to render an opinion after the bids were received, on whether the price it had brokered was fair. However, the compensation of this investment banking firm largely depended on its reaching a conclusion that the price was fair. This situation created a clear potential conflict, where the firm's own interests in assuring that the deal would be consummated and ensuring a $13 million fee, could be at odds with its professional obligation to the Board only to issue a fairness opinion if, in fact, the price were fair and not inadequate. The risk of a "results oriented" opinion that would find the price fair is obvious. This circumstance alone precludes a determination that the deal has resulted in the fair value for the company.

This flaw is only the tip of the iceberg, and the other flaws exacerbate the consequences caused by the conflict of the investment bankers. The overwhelming evidence is that the Board treated the two bidders, WellPoint and Trigon, in materially different ways as regards their offers of consideration for CareFirst. First, Trigon was advised that an important consideration for CareFirst in evaluating the bids was the number of seats that CareFirst would have on the Trigon Board after the acquisition. After initial discussions with CareFirst, before formal bids were submitted, it offered three seats. Trigon then increased the number of Board seats to five when formal bids were submitted. Trigon was prepared to offer more money but believed, reasonably based on the evidence, that Board seats were more important to CareFirst. The testimony shows that this had the effect of reducing the price Trigon initially was willing to offer. In fact, Trigon's initial offering price was the price at which the company was sold. The evidence is clear that a significant reason for this is that Trigon was not asked to increase its purchase price after its initial offer. Conversely, WellPoin't initial bid was below that of Trigon, and it was given guidance to increase its price, which it did, ultimately matching Trigon's initial offer. This disparate treatment clearly served to suppress the purchase price of the company.

The weight of the evidence also shows that it was in fact a goal of CareFirst to get the prices "similar" because this facilitated negotiations over non-price factors, such as executive bonuses, the role for the CEO, and employee benefits. Negotiations over these items spanned many months, and eclipsed the level of negotiations held over the purchase price. Furthermore, the weight of the evidence shows that, not only were consideration of the many non-price factors inconsistent with the Board's fiduciary duties, but some of the factors were used as an *ex post facto* justification for the selection of WellPoint. To the extent that non-price factors were the subject of legitimate negotiation, the CareFirst Board never attempted to quantify the extent to which its demands for concessions on non-price factors was impacting the purchase price either party was willing to pay.

CareFirst also offered a rather significant concession that the auction was flawed when its CEO stated that CareFirst would rely on the regulatory process to ensure that the fair value for CareFirst would be obtained. While this concession might explain why CareFirst truncated the

price negotiations, it does nothing to ameliorate the flaws in the process. It was unreasonable for CareFirst to rely on the regulatory process to determine the fair value of CareFirst for the simple reasons that the regulatory process will not necessarily achieve the fair value of the company. The discussion of fair value earlier in this report identifies a basic precept of the idea, that fair value is what a willing buyer will pay to a willing seller. In other words, fair "market" value. There was no market at work here because there was not an effort to extract from two willing and competing buyers the highest price each was willing to pay. One bidder was not asked to increase its price, and it appears once WellPoint matched Trigon's bid it was not asked to increase its price. A market-based auction is the best way to capture whatever premiums, strategic or otherwise, two willing buyers may be willing to pay for a company. The fact that the conversion statute contemplates the hiring of a valuation expert by the regulator, does not reasonably give rise to a belief that the regulatory process will set the "fair value" of the company. The regulatory valuation can certainly serve as a check on whether an *inadequate* price has been achieved, based on the formulas that the investment bankers employ. The formulas used by the bankers cannot precisely measure whether the full market value had been obtained.

Finally, as mentioned, the Valuation Report prepared by Blackstone shows that even by the more formulistic valuation methodologies, the deal has not resulted in the payment of fair value for CareFirst. Certainly the ranges identified by Blackstone represent the minimum that could be viewed as fair value. The fact that Blackstone has identified a range of values might lead to the suggestion that the deficiency in the price can be cured merely by one party or the other offering a price within the ranges identified. But, for the reasons cited above, this may not necessarily result in a true "market value" because such an offer is not a substitute for a full and fair auction. The significant problem facing CareFirst now is that the opportunity to have a fair a full auction may be significantly diminished if not extinguished because the massive controversy over the bonus packages and pay-outs that have dominated the news and impacted the regulatory process may discourage further entrants to any subsequent bidding processes that might occur. Moreover, the acquisition of Trigon by Anthem has effectively eliminated one of a very small number of qualified potential buyers, indeed one viewed for quite some time as CareFirst's best strategic partner.

There is another basis to conclude as matter of law that the transaction is not in the public interest. As discussed earlier in this report, the retention bonuses that were negotiated as part of the revised compensation packages violate the anti-bonus provision of the conversion statute. Like the requirement in the conversion statute that disqualifies, as a matter of law, any deal that does not ensure fair value is received by the Maryland Health Care Foundation, a violation of the anti-bonus provision compels a determination that a transaction is not in the public interest. This section, along with the anti-inurement section, expresses an unequivocal legislative intent that management not profit from a transaction, except in the form of reasonable compensation for work actually performed for the acquiring company, paid fully from the assets of the acquiring company and not the public assets of the acquired company. The revised bonuses fail these tests, and, as this report points out, given that the executives have continued to demand a bonus in connection with this deal, one cannot say with certainty that WellPoint's price is not still discounted by the amount of the new bonuses.

While each of these violations of the conversion statute is alone enough to find the deal is not in the public interest, there are many other reasons that support this determination. The statute *requires* that the MIA consider, in determining whether the transaction is in not the public interest, the Board's due diligence at several points in the process. Did the Board exercise due diligence in the decision to convert? Did the Board exercise due diligence in the selection of a bidder, and in negotiating the terms and conditions of the transaction? Were all conflicts of

officers, directors and experts disclosed to the Board? These questions fall under the general rubric of whether the Board was guided by appropriate factors in its decision making, whether it acted in the best interests of the corporation as opposed to the interests of any particular individuals, and whether it discharged its duties of care and loyalty. These statutory questions suggest a clear legislative acknowledgement that improper motives or faulty decision-making on transactions falling within the conversion statute can be contrary to the public interest. Given the fact that these are mandatory considerations for the MIA, the most reasonable interpretation of the conversion statute is that failures by the Board in one or more of these areas can lead to a determination that a transaction is in the public interest, but do not always compel such a finding. One can imagine mistakes by a Board that may reflect, at some minimal level, a lack of due diligence, but that are not material to the outcome or do not serve to tarnish the decision-making process in a broad sense. However, in this case, the Board's actions were in many cases fundamentally flawed, and these flaws materially and negatively impacted the integrity of the process. In such an instance, these flaws justify a determination that the transaction is not in the public interest.

First, the Board's failure to recognize and abide by the corporate mission of the organization, as articulated in its bylaws, and its failure to consider how a conversion might impact its ability to further that corporate mission, is alone enough to find that this transaction is not in the public interest. This report documents that there are substantial differences in philosophies and objectives of non-profit and for-profit companies. The Boards of Directors of non-profits and for-profits owe their duties to two completely different set of constituents. It is undisputed that the Boards of Directors of for-profit companies owe their first allegiance to shareholders. Conversely, the Boards of Directors of non-profits owe their first duties to those who benefit from the mission of the company, its insureds. This difference can be easily seen in the contrasting testimony of the CEO of WellPoint, a for-profit company, and the CEOs of the non-profit companies cited in the report from the Pennsylvania BlueCross and BlueShield plans. The non-profit CEOs testified regarding the "social mission" of the company, and the fact that they subsidize products to enhance the affordability and accessibility of health care in their markets. In contrast, Leonard Schaeffer remarked that it was "unethical" to cross-subsidize products and that all products must be priced to be profitable. This comparison is not meant to serve as a criticism of WellPoint, nor of for-profit companies generally. But to suggest that there is no difference between non-profit and for-profit companies defies the record in this case. The Board should have considered these differences.

Second, the flawed process that led to the selection of WellPoint as the prevailing bidder again illustrates the Board's lack of due diligence and attention to its corporate mission. As outlined earlier in this report, that 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. 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. 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 reasons offered have little merit or are specious. In some cases, CareFirst has in fact misrepresented the nature of the offers from the two bidders. This also calls into question the veracity of other information provided to the MIA in connection with these applications.

This report outlines how the weight of the evidence supports the conclusion that the enrichment of the executive team was, if not the primary motivation, an important motivation for in selecting the prevailing bidder. This unfortunate fact means that the underlying arguments that give rise to the Business Case may be tainted by this improper motive. Whether or not improper bonuses and pay-outs can be limited by means of an Order approving the transaction conditioned on the

elimination of the bonuses, the fact is that the stain created by these bonuses soils the evidence that was presented in support of the transaction. The detailed analysis showing that the Business Case has little merit supports this conclusion.

Another of the mandatory considerations is whether the transaction would have a significant adverse effect on the availability and affordability of health care in the state. Like the due diligence considerations, the fact that the MIA is required to consider this issue leads to the reasonable conclusion that an affirmative finding could compel a determination that the transaction is not in the public interest. The Maryland Insurance Administration made its best efforts to investigate the potential risks associated with the WellPoint acquisition, and whether such a transaction would impact availability and affordability. Because WellPoint did not provide access to critical information regarding its pricing and underwriting practices, these efforts were frustrated. WellPoint should not be excused from scrutiny under these important criteria by virtue of its refusal to provide the information that permits their meaningful evaluation.

The MIA did, nonetheless, attempt to conduct the statutory inquiry without the operative data. It was forced to rely on secondary data, which in some cases was of limited use. Some of this data reveal a disturbing history of WellPoint antagonizing providers, and in particular, hospitals, in California. WellPoint presented data suggesting this antagonistic relationship has not impacted WellPoint's provider network in California negatively, at least as measured by the number of contracts signed with hospitals. However, WellPoint has in the past been ranked as the worst plan by California hospitals, and the California regulators said WellPoint's negotiations with hospitals have caused more disruption than have other HMOs.

We have seen the negative consequences of this type of relationship first hand in Maryland. Recent events involving the failure of CareFirst and Children's National Medical Center to reach a contract resulted in the potential disruption of care for some of Maryland's most vulnerable patients. Whether or not quality of care was compromised, the events caused considerable anguish and uncertainty on the part of the parents of patients at Children's, as evidenced by the hearings on February 5, 2003. One cannot help but be struck by how this episode falls on the heels of CareFirst's "for-profit" orientation. It raises the obvious question, as witnesses at the public hearings suggested, whether this episode is indicative of things to come under the management of a for-profit company. Theoretically state law provides some level of protection in such circumstances because the Department of Health and Mental Hygiene regulates the network adequacy of HMOs in the State. However, the reach and efficacy of such laws has not been proven, and in this case, although the MIA forwarded numerous complaints received by affected families to the Department, there is no evidence that any steps were taken to determine whether or not the law had been violated.

The fact that disputes over physician reimbursement may negatively impact quality and network adequacy is also illustrated by the testimony given at one of the public hearings in 2002. Witnesses referred the MIA to litigation involving GHMSI that is relevant.[550] That case involves claims that GHMSI, through the actions of a subcontractor utilized by GHMSI to deliver mental health services to GHMSI insureds, improperly reduced reimbursements to network psychologists by 30% in violation of the physicians' contracts. Public documents in that case show that this dramatic cut in reimbursement by GHMSI in the late fall of 1998 caused 80 practitioners to leave the GHMSI network, and 250 members had to be transitioned to other providers. Minutes from the Quality Improvement Committee at GHMSI show that "the

[550] Virginia Academy of Clinical Psychologists v. GHMSI, Civil Action No. 9400-98 (D.C. Superior Ct.)

committee concurred that this change impacted the quality of care for members". Ironically, this action came as the business combination between the D.C. and Maryland plans was being announced, and the press release issued by CareFirst in January 1999 promised that "physician and hospital networks will be available over a larger area".

This is not to suggest that only for-profit companies are likely to have contract disputes with providers. Non-profits can legitimately seek to contain costs through the negotiation process and may press for cost containment in their negotiations. But the evidence cannot be ignored that WellPoint has a particularly bad track record on this issue. Because disputes and schisms with providers can affect access to care in some cases, WellPoint's history must be included among the factors to be weighed in determining whether, on balance, the transaction is in the public interest, and this factor weighs against the public interest.

In defense of the concern over WellPoint's provider relationships, WellPoint and Accenture both argue that it is through "tough" negotiations with providers that costs are contained. Cost containment inures to the benefit of insureds in the form of lower rates, the argument goes. This argument has superficial appeal, and could be true. But it is not possible on this record to know whether the benefits obtained as a result of these tough negotiations are passed on in full or in part to subscribers in the form of lower rates or enhanced benefits. While WellPoint points out that it has grown market share in California by offering affordable products, the facts show many factors impact affordability. Mr. Hyers of Wakely pointed out that benefit levels have a significant impact on medical costs, and therefore rates. The MIA's analysis showed that, relative to Maryland products, WellPoint products in California are "thinner". No facts in the record verify that cost containment inures to the benefit of premium-paying customers as opposed to the corporation. WellPoint's pricing information might have shed light on this subject, but the MIA was not able to review it. One cannot help but notice that the most recent press reports on WellPoint earnings showed significant growth in net income and a strong financial performance. This certainly does not refute the possibility that the aggressive contracting is as much a benefit to shareholders as it is to insureds.

Also relevant to the consideration of potential impact on availability and affordability resulting from the transaction is the current CareFirst for-profit orientation. As explained in this report, CareFirst has adopted the strategies and objectives of many for-profit insurance companies and repudiated its corporate non-profit mission. Now CareFirst's corporate goals and objectives relate to achieving income targets and profitability goals. This report documents many examples of how CareFirst has emulated some practices of for-profit companies, at least in regards to efforts to maximize profits. These efforts have negatively impacted the availability and affordability in the state. 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. If other CareFirst products or lines of business were terminated because they were viewed unfavorably by the new owners, Maryland's high-risk program could yet again be flooded with applicants, clearly resulting on a significant impact on the availiablity and affordability of insurance. In such an event, it might be necessary to divert the income stream from Maryland's share of the proceeds of the conversion simply to provide insurance to this new uninsured population. CareFirst cannot argue that this scenario is unlikely, for in fact it has already occurred once. The conversion could hardly be viewed as a net "gain" for Maryland if the benefits of the sale of CareFirst were used simply to provide insurance to individuals who became uninsured as a result of the transaction.

One final point, regariding the impact analysis bears emphasis. Thie MIA viewed this as an important consideration in the overall analysis. The record shows that the Board did not view this as a point even worthy of consideration. 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 or availability in Maryland.

This report also analyzed in detail the Business Case presented by CareFirst. The Business Case is not compelling. CareFirst is the dominant health insurer in the State of Maryland and has strong market shares in both D.C. and Delaware. While CareFirst claimed that it could not compete with larger national companies operating in this market, the data developed by the MIA and its experts show that CareFirst has sufficient capital to make needed investments to maintain its competitiveness. It is currently outspending similar sized and even larger non-profit and for-profit health insurance companies. The data also show that for-profit companies do not typically access the capital markets through the issuance of stock to fund new infrastructure spending. And in presentations to the CareFirst Board and outside parties, CareFirst management has given no indication that its ability to invest in new products and technology has been constrained. No specific facts were provided illustrating how CareFirst lagged its competitors in Maryland in terms of investments, products, or technology. CareFirst's own experts concluded that it could satisfy its non-merger related capital spending needs.

The one area in which CareFirst may be lacking that was identified by its experts was capital to spend on mergers and acquisitions. But the Business Case in support of this objective is similarly weak. To begin with, CareFirst's own consultant, Accenture, placed great emphasis on the need to engage in merger and acquisition activity in order to concentrate and enhance CareFirst's current market share. Accenture cited the need for CareFirst to maintain its dominance in its current market, and viewed CareFirst's mergers and acquisition needs as relating to a necessity of making in-market defensive and offensive acquisitions. The MIA's analysis shows that such acquisitions are possibly prohibited under state and federal anti-trust laws, given CareFirst's already dominant position in the market, a fact not considered by the CareFirst Board. CareFirst has almost three times the share of its nearest competitor in Maryland. In some markets, it has almost 50%. CareFirst's expert, Accenture, found much less benefit to be derived from absolute scale as opposed to relative scale. Other data clearly support the notion that bigger is not necessarily better. There are risks associated with mergers, and many are not successful. In this vein, CareFirst has yet to achieve all the benefits that were promised in connection with the integration of the D.C., Delaware and Maryland plans.

CareFirst may also have a greater ability to fund its capital investments than was previously thought. The MIA's in-depth analysis of CareFirst's financial condition revealed that any perceived weaknesses in the performance of CareFirst, Inc., and in particular the Maryland plan, are due as much to unfortunate management decisions rather than competitive threats or over-regulation, as CareFirst argues. Curing these problems could further enhance CareFirst's ability to fund investments. More stringent Board oversight could help to remedy the problems. Notwithstanding these management deficiencies, CareFirst management, as well as MIA experts, agree that CareFirst is a viable, healthy plan, at least in the short and medium term, meaning the next three to five years. Trying to predict the various forces that will impact the marketplace more than five years in the future is pure speculation.

There is another factor which impacts the public interest analysis, and that relates to the spending of the proceeds of the conversion. The Maryland Health Care Foundation was established in 1997 to receive monies resulting from the conversion of non-profit health care entities in the State. Under the law establishing it, the Foundation’s purpose is to use the funds to "expand access to health care services for uninsured and underinsured Marylanders."

However, since the enactment of that law, the Maryland General Assembly has modified the role of the Maryland Health Care Foundation and given itself a role in the process. The General Assembly created the Maryland Health Care Trust to receive conversion proceeds, and although the Maryland Health Care Foundation serves as trustee of the Trust, money will be spent from the Trust only as determined by the General Assembly. In particular, according to current law, funds from the Trust would be expended to "implement acts of the General Assembly … that improve the health status of the residents of Maryland." While the goals of improving *access* to health care services for uninsured and underinsured Marylanders, and the goal of improving health *status*, are similar, they are not the same. The mission of improving health status can be read broadly. It is this broad Legislative directive that creates an element of uncertainty that impacts the public interest analysis.

Activities or projects that fall under the rubric of "improving health status" could include the construction of a gymnasium or pool for exercise, weight loss programs, drug and alcohol counseling, or stress reduction classes. In New York, a portion of the proceeds of Wellchoice's IPO will be directed to hospital worker salaries. In Wisconsin, conversion proceeds were directed to medical schools. All of these projects could be said to improve "health status" *albeit* indirectly in some cases.

If Maryland 's acquisition proceeds were spent on such projects, the foundation proceeds may not be available to fund coverage for new applicants to the state's high-risk pool that could result if, for example, WellPoint were to withdraw from a line of business or discontinue an unprofitable product. Put another way, if the Foundation proceeds are not spent or dedicated in a manner designed to correlate with the potential risks associated with an acquisition, some Marylanders may be substantially worse off after the acquisition. The current governance of the Trust creates such a risk. This risk clearly weighs against a finding that the transaction is in the public interest.

There are other factors that bear on whether the transaction is in the public interest that are not specifically set forth in the statute. One is the issue of local control. CFMI is a locally owned and locally controlled nonprofit health service plan. The holding company for CFMI, GHMSI, and the BCBSD, CareFirst, Inc., is also licensed as a Maryland nonprofit health service plan. The CareFirst Inc Board has 12 of 21 members nominated by the Maryland plan, CFMI. This structure provides a high level of local control over the operations of the plan. Decisions regarding the operations of the plan are made here. It is beyond dispute that a WellPoint acquisition would result in the diminution of that control because the holding company would be owned by an out of state entity. The Board of Directors of WellPoint would be the ultimate controlling authority, rather than the Board of CareFirst, Inc. The acquisition means that at least some decisions regarding the operation of the Maryland plan will be made out of state.

WellPoint and CareFirst both argue that WellPoint is committed to local control. This may be true, but only to a point. The record shows that key personnel in the WellPoint plans in Georgia and Missouri report directly to their supervisors in California. For example, the chief actuaries and medical directors in the Georgia and Missouri plans have a "straight line" reporting relationship to California, and a "dotted line" reporting relationship to the CEOs in Georgia and Missouri. Clearly this creates the reasonable impression that final supervisory authority for these functions is in California, not Georgia or Missouri.

It is admittedly difficult to quantify the benefits of local control, or the disadvantages of out-of-state control. Local control can translate into local accountability, and a corporate decision making process that is guided by local, rather than national considerations. Health care is clearly an enterprise that must be guided by local considerations. Large national health plans have

stutter-stepped when trying to superimpose national practices in local markets. In its filing with regulators in connection with its effort to become a for-profit company, Washington State's Premera Blue Cross asserted that "Premera believes it can best serve its customers and their interests by remaining an independent, locally managed plan". According to the filing, "Premera… rejected mergers or affiliations which would jeopardize local autonomy and in turn, jeopardize the plan's ability to properly respond to local market needs and expectations."

Perhaps one example of how local control creates greater accountability for a health plan can be seen in CareFirst's handling of its effort to negotiate Alternative Rate Arrangements (ARAs) with Maryland Hospitals in 1999. These arrangements, which were permitted by the HSCRC, were viewed as disruptive by the hospitals and an effort to do an "end-run" around the rate setting system in Maryland. Hospitals complained to political leaders that CareFirst was using its market power to muscle them into agreeing to the arrangement or risk being removed from the CareFirst provider network. CareFirst and the HSCRC responded to this concern and ended the effort. Would WellPoint be responsive to local regulatory or political concerns? Or would the national focus of a large multi-state plan override local considerations?

Maryland has already witnessed the consequences of the sale of another of its major insurance companies. The USF& G Corporation was a holding company for several Maryland based insurance companies located in Baltimore. Financial difficulties in the 1990's resulted in new management being installed to run the company. When turnaround efforts were unsuccessful, the company was sold to the St. Paul Company, and the chief executive left after he received a bonus of tens of millions of dollars. Over time, elements of the holding company system and lines of business, have been sold and employees relocated. Public ownership of CareFirst creates the possibility that this could again happen to a large Maryland-based insurer.

This discussion illustrates that although the issue of local control does not lend itself to a strictly quantitative analysis, it is properly an issue to be included in the overall balancing of whether the transaction is in the public interest. Notwithstanding WellPoint's efforts to assuage fears that it will usurp local decision making, it is simply a fact that final decisions regarding the fate of CareFirst and its operations will be in the hands of a Board and management team that have a higher responsibility than responding just to the concerns of Maryland stakeholders.

It is true that there may be some benefits resulting from a WellPoint acquisition of CareFirst. WellPoint appears to be a well managed for-profit insurance company with an impressive management team, and an impressive management track record in increasing membership, participating in state programs, and earning profits. The company has won numerous awards, and its CEO is widely regarded and respected in the industry. Unquestionably, certain elements of the "WellPoint Way," including the excellence of management, would be a benefit here. In other areas, purported benefits are not clear. The company has argued that it can bring product innovation to Maryland and its expertise in creating products for the small group and individual markets can provide purchasing options to Marylanders that are not currently available. However, the small group products that have contributed to WellPoint's success in California are not legal here. The individual products offered in California have fewer benefits than are permitted in Maryland. WellPoint's innovative products, which in some cases are less expensive possibly because they have more limited benefits, will not be the vehicle for growth here that they were in California.

For all the reasons expressed above and in the body of this report, it is therefore the conclusion of the Maryland Insurance Administration that the proposed acquisition of CareFirst by WellPoint is not in the public interest.

SCHEDULE A

DIRECTORS AND MANAGEMENT OF CAREFIRST DURING THE EVENTS DESCRIBED IN THE REPORT

DIRECTORS

Daniel Altobello
(Current Chairman)
Edward J. Baran
Max S. Bell, Jr. Esq.
Beverly B. Byron
William J. Byron, S.J.
Geneva Cannon
Dan A. Colussy
James M. Dale
Bernard J. Daney, C.P.A.
Anne Osborn Emery, Ph.D.
Ernest R. Grecco
Joseph Haskins
Sister Carol Keehan, R.N., M.S.
J. Richard Lilly, M.D.
Roger C. Lipitz
Patricia E. Lund, Ed.D., R.N.;
Robert H. Naftaly
Robert F. Rider
Charles W. Shivery
Hanan Y. Sibel
James C. Simpson
George B. Wilkes, III
Eddie N. Williams
Vincent A. Wolfington

SENIOR MANAGEMENT

William L. Jews, President & CEO
David D. Wolf, Executive Vice President, Managed Care & Strategic Planning
Leon Kaplan, Executive Vice President, Operations
Gregory A. Devou, Executive Vice President, Sales & Marketing
G. Mark Chaney, Executive Vice President, Chief Financial Officer & Treasurer
John A. Picciotto, Executive Vice President, General Counsel & Corporate Secretary
Sharon Vecchioni , Executive Vice President, Chief of Staff
Mike Felber, Senior Vice President, Sales

SCHEDULE B

Alphabetical Directory of Individuals Affiliated with the Proposed Transaction

Adams, Benjamin C.	Director, Credit Suisse First Boston, CareFirst Investment Banker Consultant
Allen, Andrea	Geriatrician and Eastern Shore Director of Maryland Academy of Family Physicians, Public Comment Speaker February 7, 2002
Altobello, Daniel J.	CareFirst Chairman of the Board.
Andrews, Steve	Subscriber, Public Comment Speaker February 7, 2002
Angoff, Jay	Roger G. Brown & Associates, Due Diligence and Fairness Consultant for MIA
Antoniewicz, Carol	Medical Social Worker, currently unemployed, Public Comment Speaker February 7, 2002
Aurand, Shirley	President of Chapter 306 of the NARF Association, but is speaking for herself, Public Comment Speaker February 13, 2002
Banker, Robert	Subscriber, Public Comment Speaker February 4, 2002
Barmer, Rebecca	Subscriber, does contract work for CareFirst, Public Comment Speaker February 7, 2002
Barnes, Donald G.	Vice President, Hay Group, Inc, Executive Compensation Consultant to CareFirst.
Barve, Kumar	Maryland general Assembly representing Gaithersburg, Rockville and Garrett Park, Public Comment Speaker February 11, 2002
Battista, Donald	President and CEO of Garrett County Memorial Hospital in Oakland, Public Comment Speaker February 13, 2002
Bauer, Gene E. Ph.D.	Managing Director Hay Group, Inc., Executive Compensation Consultant to CareFirst.

Beck, Larry	President of Good Samaritan Hospital, Public Comment Speaker February 4, 2002
Becker, Doug	Pediatrician, Public Comment Speaker February 13, 2002
Bell, Deidre	Chief Financial Officer of Shore Health System, Public Comment Speaker February 7, 2002
Berman, Richard	Subscriber, Public Comment Speaker February 11, 2002
Beusch, Christina G.	Former MIA Principal Counsel, Maryland Attorney General's Office
Bielenson, Peter	City Health Commissioner for Baltimore City, and President of the Maryland Citizens Health Initiative, Public Comment Speaker April 30, 2002
Birrane, Kathleen	MIA Principal Counsel, Maryland Attorney General's Office
Bodnar, Vicki	Subscriber, Public Comment Speaker February 13, 2002
Bowerman, Chuck	Chairman of the Board of Good Samaritan Hospital, Public Comment Speaker February 4, 2002
Brandenburg, Don	Chief Actuary, Maryland Insurance Administration
Brown, Dr. James	Physician, Public Comment Speaker February 11, 2002
Brown, Roger G.	Roger G. Brown & Associates, Due Diligence and Fairness Consultant for MIA
Bruning, Richard	Maryland University Health Care Action Network, Public Comment Speaker April 30, 2002
Bryden, Helen	Subscriber, Public Comment Speaker February 7, 2002
Burkey, Katherine	Chairman of the Board o9f the Western Maryland Health System in Cumberland, Public Comment Speaker February 13, 2002
Burkhart, Ronald	Wakely Consulting Group, Fairness Analysis and Impact Opinion Consultant to MIA
Burks, Michael	Vice President, Blue Cross Bblue Shield of Georgia, Operating Unit of WellPoint Health Networks, Inc.
Burt, Carol	Senior Vice President, Finance and Treasury, WellPoint Health Networks, Inc.

Callas, Peter	Sixteen years as elected official in Maryland, member of the Maryland Retired Teachers Association, legislative officer for Western Maryland and for the Washington County retired educational personnel, Public Comment Speaker February 13, 2002
Cameron, Robert H.	Director, LECG, LCC, Foundation Analysis, Consultant to MIA
Cantilo, Patrick H.	Managing Partner, Cantilo & Bennett, L.L.P., Conversion Consultant to MIA
Chaney, G. Mark	Executive Vice President and Chief Financial Officer, CareFirst, Inc.
Chase, Frank	Maryland Federation of the National Association of Retired Federal Employees, Public Comment Speaker April 30, 2002
Chenowitz, Ronnie	Member of Harford County Council, Public Comment Speaker February 4, 2002
Colby, David C.	Executive Vice President and Chief Financial Officer, WellPoint Health Networks, Inc.
Coleran, Jim	Insurance Broker, Public Comment Speaker February 11, 2002
Collier, Clay	Employed by Blue Cross Blue Shield Employee, Public Comment Speaker February 11, 2002
Colvin, Robert	Subscriber, Public Comment Speaker February 13, 2002
Conrad, Robert	Subscriber, Public Comment Speaker February 4, 2002
Corbett, Michaelyn	Economist, LECG, LCC, Foundation Analysis, Consultant to MIA
Cornwell, Martha	Subscriber, Public Comment Speaker February 13, 2002
Cruz, Lillian	President of Democratic Club of Montgomery County, Public Comment Speaker February 11, 2002
DeMarco, Vinny	Executive Director of Maryland Citizens Health Initiative, Public Comment Speaker February 4, 2002
Devou, Gregory A.	Executive Vice President and Chief Marketing Officer, CareFirst, Inc.
Dillan, Bob	Subscriber, Public Comment Speaker

Dorrin, Susan	Executive Director of the Cecil County Chamber of Commerce, Public Comment Speaker February 4, 2002.
Drummond, Jean	President, HCD International, Foundation Analysis, Consultant to MIA
Dwyre, Ruth	Pediatrician and represent the Western Maryland Region of the American Academy of Pediatrics, Public Comment Speaker February 13, 2002
Ellison, Dr. Rebecca PH.D.	Subscriber, Public Comment Speaker February 7, 2002.
Ewing, Councilman	Councilman for Montgomery County, Public Comment Speaker February 11, 2002.
Fagilla, Ms.	Subscriber, Public Comment Speaker February 4, 2002.
Farraq, Osama	Subscriber, Public Comment Speaker February11, 2002.
Feldman, Roger	Ph.D. Economics, Fairness, Consultant to MIA
Fennimore, Charles	Subscriber, Public Comment Speaker February11, 2002.
Fisher, Dr. Michael	Provider, Public Comment Speaker February 7, 2002.
Fletcher, Rita	President of Wicomico County Education Association, Public Comment Speaker February 7, 2002.
Foster, Robert Michael	Subscriber, Public Comment Speaker February13, 2002
Fouche, Bobby	Director of Education for the Central Maryland AFL-CIO Council, Public Comment Speaker February 13, 2002.
Friedman, Eugene	Hospital Trustee with Life Ridge, and member of Maryland Chapter of the American Association of Health Care Admin, Public Comment Speaker April 30, 2002
Funk, David M.	Managing Partner, Funk & Bolton, Counsel to CareFirst, Inc. and WellPoint Health Networks, Inc.
Gaisford, John	Principal, LECG, LCC, Foundation Analysis, Consultant to MIA
Geiser, Thomas C.	Executive Vice President, General Counsel and Corporate Secretary, WellPoint Health Networks, Inc.
Glaser, Robert	Vice President, Corporate Development, WellPoint Health Networks, Inc.

Glaser, D. Louis	Principal Gardner, Carlton & Douglas, Foundation Analysis Consultant to MIA
Glasscock, Larry	President and Chief Executive Officer of Anthem, Inc.
Goldman, Ralph	Subscriber, Public Comment Speaker February 11, 2002
Gordon, Arnold	Candidate for State House in the 19th Legislative District, Public Comment Speaker February 11, 2002
Gortz, Mason	Subscriber, Public Comment Speaker February 4, 2002
Gould, Rebecca	Representing League of Women Voters, Public Comment Speaker February 7, 2002
Grahe, Raymond	VP for Finance and CFO of Washington County Health System, Public Comment Speaker February 13, 2002
Grieb, Elizabeth	Partner, Piper Marbury Rudnick & Wolfe, CareFirst Outside Counsel
Hall, Diane	California Attorney which represented people in California, Public Comment Speaker February 7, 2002
Hamill, Jim	President of the Washington County Health System, Chairman of the Maryland Hospital Association's Task Force on the conversion of Blue Cross, Public Comment Speaker February 13, 2002
Hammond, Karen	Insurance Agent, Public Comment Speaker February 11, 2002
Hammond, Lee	State President for AARP, Public Comment Speaker February 7, 2002
Harrison, Lois	Board member of Washington county Health System and Chairman of the Board of the Washington county Hospital, Public Comment Speaker February 13, 2002
Haskins, Joseph	Chairman, CareFirst, Inc. Executive Compensation Committee
Haydun, Frederick	Hartford County Medical Society, Public Comment Speaker February 4, 2002
Hellawell, Jane	Representing League of Women Voters, Public Comment Speaker February 7, 2002
Herb, Jody	CareFirst employee, Public Comment Speaker February 7, 2002

Hoffman, Joe	Chief Financial Officer for Upper Chesapeake Health, Public Comment Speaker February 4, 2002
Howard, John	Employee of CareFirst, Public Comment Speaker February 4, 2002
Hyers, Dale D.	Wakely Consulting Group, Fairness Consultant to MIA
Hudak, James	Partner Accenture, CareFirst Strategic Consultant
Imhoff, Donna B.	Deputy Commissioner, Maryland Insurance Administration
Insgstrom, Fayette	Pediatrician, on Executive Committee of Maryland Chapter American Academy of Pediatricians, Public Comment Speaker February 7, 2002
Jackson, Bill	Representative of AARP statewide, Public Comment Speaker February 4, 2002
Jaffay, David	Physician, Public Comment Speaker February 4, 2002
Jenkins, Joe	President of HMS Financial Services, Inc., Public Comment Speaker February 4, 2002
Jews, William L.	President and Chief Executive Officer, CareFirst, Inc.
Kanter, Marvin M.D.	Chief Executive Officer Southern California-based Progressive Health Care Systems
Kaplan, Leon	Executive Vice President, Legal Services
Kelly, Robert A.	Vice President, Legal Services, WellPoint Health Networks, Inc.
Kissmiller, James	Subscriber, Public Comment Speaker February 4, 2002
Klein, Shirley	Member of Board of Directors of the Upper Chesapeake Health System, and Vice President of Klein Supermarkets, Public Comment Speaker February 4, 2002
Koplovitz, Jonathan	Managing Director, The Blackstone Group LP, Valuation Consultant for MIA
Knox, Jack	AARP, Public Comment Speaker February 13, 2002
Krauss, James	Subscriber, Public Comment Speaker February 4, 2002

Krantz, Harry	President of National Area Union Retirees Club, Public Comment Speaker February 11, 2002
Kube, Diane	Medical Practice Administrator, and represent the Montgomery County Medical Society, Public Comment Speaker February 4, 2002
Kulishek, Lisa	Staff Attorney Maryland Insurance Administration
Lachman, Deborah	Senior Vice President, Small Group, Blue Cross of California
Langere, Keith	Employee of CareFirst Blue Cross and Blue Shield, Public Comment Speaker February 4, 2002
Larsen, Steven B.	Maryland Insurance Commissioner
Lebray, Eugene	Physician, Public Comment Speaker February 11, 2002
Lefler, Rich	Subscriber, Public Comment Speaker February 7, 2002
Levine, Larry	Credit Suisse First Boston, CareFirst Investment Bankinger Consultant
Lighty, Lynn	Employee of CareFirst, Public Comment Speaker February 4, 2002
Limpson, Mr.	Subscriber, Public Comment Speaker February 11, 2002
Livy, Scott	Group Benefit Broker, Public Comment Speaker February 7, 2002
Long, Lucy	Subscriber, Public Comment Speaker February 7, 2002
Lowe, Ed	Northwestern Mutual Financial Network, Public Comment Speaker February 13, 2002
Magaziner, Iris	Assistant to Maryland Insurance Commissioner
Mallat, Veronica	Associated with AARP, Public Comment Speaker February 4, 2002
Marabito, Joseph	Partner, Accenture, CareFirst Strategic Consultant
Markey, Tim	Employed by CareFirst, Public Comment Speaker February 11, 2002
McCoy, Robert	President of Untied Seniors of Maryland, Public Comment Speaker February 11, 2002

McInnis, Miguel	CEO Mid-Atlantic Association of Community Health Centers, Public Comment Speaker April 30, 2002
McMullen, Patrick	Managing Director, Credit Suisse First Boston, CareFirst Investment Banking Consultant
McLoughlin, Dr. Ed	Rheumatologist, Public Comment Speaker February 7, 2002
Mendoza, Gary S.	Principal with law firm of Riordan & McKinzie, Counsel to CareFirst, Inc. and WellPoint Health Networks, Inc.
Miles, Bishop Douglas	Representative of Maryland Health Care for All, Public Comment Speaker April 30, 2002
Moller, Carolyn	Subscriber, Public Comment Speaker February 13, 2002
Monahan, John P.	Senior Vice President, State Sponsored Programs, WellPoint Health Networks, Inc.
Morriss, Annette	Subscriber, Public Comment Speaker February 4, 2002
Muedeking, Mark	Partner, Piper Marbury Rudnick & Wolfe, CareFirst Outside Counsel
Muldane, Rorry	Subscriber, Public Comment Speaker February 4, 2002
Muntner, Michael	Director, Credit Suisse First Boston, CareFirst Investment Banking Consultant
Myers, Woodrow A. MD	Executive Vice President, Chief Medical Officer, WellPoint Health Networks, Inc.
Nathan, Mark	Vice President of Compensation and Benefits, WellPoint Health Networks, Inc.
Nelson, Vicki	Subscriber, Public Comment Speaker February 13, 2002
Nessman, Alan	Special Counsel, with practice Director of the American Psychological Association, Public Comment Speaker April 30, 2002
Netherland, Bob	Vice President for Chesapeake Health, Public Comment Speaker February 4, 2002
Neuberger, Isaac M.	Newuberger, Quinn, Gielen, Rubin & Gibber, PA., Outside Counsel to William L. Jews, and CareFirst, Inc
Newby, John	Physician, Public Comment Speaker February 13, 2002

Newcome, Patrica Windsor	Delmarva Foundation, Fairness Analysis, Consultant to MIA.
Nolan, Timothy	Senior Vice President, Marketing & Corporate Development, Trigon
Nunez, Luis	Chair of the Montgomery County on Aging, Public Comment Speaker February 11, 2002
O'Rourke, John	President, WellPoint Central Region
Petty, Daren	President of United Auto Workers of State of Maryland, Public Comment Speaker April 30, 2002
Pham, Choung H.	Piper Marbury Rudnick & Wolfe, CareFirst Outside Counsel
Picciotto, John A.	Executive Vice President, General Counsel and Corporate Secretary, CareFirst, Inc.
Pierce, Wilbur	Subscriber, Public Comment Speaker February 4, 2002
Pierson, Cal	President, Maryland Hospital Association, Public Comment Speaker February 4, 2002
Polfray, Robert	Subscriber, Public Comment Speaker February 4, 2002
Pomisheski, Fred	Subscriber, Public Comment Speaker February 4, 2002
Pool, Alison	Wakely Consulting Group, Fairness Analysis Consultant to MIA
Porter, Robert	Subscriber, Public Comment Speaker February 4, 2002
Potee, Ms.	Subscriber, Public Comment Speaker February 4, 2002
Prettel, Michael	Subscriber and representing the Maryland Citizens Health Initiative, Public Comment Speaker February 4, 2002
Prettyman, Richard	Owns Brokerage firm in Easton, Public Comment Speaker February 7, 2002
Preston, Michael	Executive Director of Med Chi, the Maryland state Medical Society, Public Comment Speaker February 4, 2002.
Prouty, Keith	Maryland State Conference of the NAACP, Public Comment Speaker February 11, 2002.
Reynolds, Penny	CareFirst employee, Public Comment Speaker February 7, 2002.

Ricciti, Nicolas	Director of the Cecil County Department of Social Services, Public Comment Speaker February 4, 2002.
Riou, Pierre	Partner, Cantilo & Bennett, L.L.P., Conversion Consultant to MIA
Rogers, Kathy	Director of Community Relations for Western Maryland Health System in Cumberland, Public Comment Speaker February 13, 2002.
Rusnack, Andrew	Subscriber, Public Comment Speaker February 7, 2002.
Sack, Martin	President of the Infinity Health Alliance and Union Hospital, Public Comment Speaker February 4, 2002.
Schaeffer, Leonard D.	Chairman of the Board of Directors and Chief Executive Officer, WellPoint Health Networks, Inc.
Sczudlo, Ray	Vice President and Chief Legal Officer of Children National Medical Center in D.C., Public Comment Speaker February 4, 2002.
Seabout, Bobbi	Maryland Chapter of the American Academy of Pediatrics, Public Comment Speaker April 30, 2002.
Seeman, Isidor Sam	Metropolitan Washington Public Health Association, Public Comment Speaker February 11, 2002.
Shatz, Paul	President of Hartford County Education Association, Public Comment Speaker February 4, 2002.
Shorgren, Bruce	Director of financial reporting systems at CareFirst, Public Comment Speaker February 11, 2002.
Siegel, Mark	President of Montgomery County Medical Society, and also speaking on behalf of the State Medical Society, Public Comment Speaker February 11, 2002.
Simmons, William	Businessman and father, Public Comment Speaker February 4, 2002.
Sink, Doug	CEO of the YMCA of Talbot County, Public Comment Speaker February 13, 2002.
Slusher, Christopher	Roger G. Brown & Associates, Due Diligence and Fairness Consultant for MIA
Smith, Carl	Subscriber, Public Comment Speaker February 7, 2002.

Smith, Jay, Partner	Partner, Piper Marbury Rudnick & Wolfe, CareFirst outside Counsel.
Smith, Martin Alderson	Senior Managing Director, The Blackstone Group LP, Valuation Consultant for MIA.
Smith, Stuart	Managing Director, Credit Suisse First Boston, CareFirst Investment Banking Consultant
Smoot, Catherine	President elect of Med Chi, the Maryland State Medical Society, Public Comment Speaker February 7, 2002.
Snead, Thomas G. Jr.	President and Chief Executive Officer, Trirgon
Solomon, Steve	Independent health insurance agent and broker with Heritage Financial Consultants, Public Comment Speaker April 30, 2002.
Sorenson, Gregory L.	Managing Director Banc of America Securities, Financial Advisor to WellPoint Health Networks, Inc.
Surr, John	Subscriber, Public Comment Speaker February 11, 2002.
Taylor, James F.	Attorney, Funk & Bolton, Counsel to CareFirst, Inc.
Thomas, Jim	Insurance Agent, Public Comment Speaker February 11, 2002.
Thundermann, Ren L.	Attorney, Funk & Bolton, Counsel to CareFirst, Inc.
Tilman, Mike	CareFirst Associate, Public Comment Speaker February 7, 2002.
Town, Robert	Ph.D. Economics, Fairness, Consultant to MIA
Townsend, Howard	Delmarva Foundation, Fairness, Consultant to MIA
Vecchioni, Sharon J.	Executive Vice President and Chief of Staff, CareFirst, Inc.
Vollmer, Debra	Concerned citizen and speaking on behalf of Coalition for Universal Health care, Public Comment Speaker February 11, 2002.
Wallace, Steve	Speaking on behalf of mentally ill persons, Public Comment Speaker February 11, 2002.
Wallach, Harold	Chairman of the Coalition for Health Care Accountability, Public Comment Speaker February 11, 2002.

Wannemacher, Bob	President of the Western Maryland AARP Advocacy Council, Public Comment Speaker February 13, 2002.
Williams, Gene	Subscriber, Public Comment Speaker February 13, 2002.
Willis, Patty	Shore Health Systems, Public Comment Speaker February 7, 2002.
Weible, Brian	Wakely Consulting Group, Fairness Analysis Consultant to MIA
Weinhart, Carol	Director of Hartford County Office on Aging, Public Comment Speaker February 4, 2002.
Weiss, Martin	Maryland AARP, Public Comment Speaker February 11, 2002
Wielgost, John	General Manager of Syntex Systems corporation, Public Comment Speaker February 11, 2002
Wholey, Douglas	Ph.D. Business Administration, Impact Analysis, Consultant to MIA
Wilson, Brenda A.	Chief, Health Insurance and Managed Care, MIA
Wolf, David D.	Executive Vice President, Medical Services, CareFirst, Inc.
Zale, Jeffrey M.	Delmarva Foundation, Fairness Analysis, Consultant to MIA.
Zoldos, Steve	Wakely Consulting Group, Fairness Analysis Consultant to MIA

SCHEDULE C

Directory of Individuals By Affiliation to the Companies, Maryland Insurance Administration, Consultants and Advisors, and Other Interested Parties

Angoff, Jay,	Roger G. Brown & Associates, Due Diligence and Fairness Consultant for MIA
Beusch, Christina G.	Principal Counsel, Maryland Attorney General's Office
Birrane, Kathleen	Principal Counsel, Maryland Attorney General's Office
Brandenburg, Don	Chief Actuary, Maryland Insurance Administration
Burkhart, Ronald,	Wakely Consulting Group, Fairness Consultant to MIA
Cameron, Robert H.,	Director, LECG, LCC, Foundation Consultant to MIA
Cantilo, Patrick H.,	Managing Partner, Cantilo & Bennett, L.L.P., Conversion Consultant to MIA
Corbett, Michaelyn,	Economist, LECG, LCC, Foundation Consultant to MIA
Drummond, Jean,	President, HCD International, Foundation Consultant to MIA
Feldman, Roger	Ph.D. Economics, Fairness Consultant to MIA
Gaisford, John,	Principal, LECG, LCC, Foundation Consultant to MIA
Glaser, D. Louis,	Principal Gardner, Carlton & Douglas, Foundation Consultant to MIA
Hyers, Dale D.,	Wakely Consulting Group, Fairness Consultant to MIA
Imhoff, Donna B.	Deputy Commissioner Maryland Insurance Administration
Koplovitz, Jonathan,	Managing Director, The Blackstone Group LP, Valuation Consultant for MIA
Kulishek, Lisa	Staff Attorney Maryland Insurance Administration
Larsen, Steven B.	Maryland Insurance Commissioner
Magaziner, Iris	Assistant to Maryland Insurance Commissioner
Newcomb, Patrica Windsor	Delmarva Foundation, Fairness Consultant to MIA.

Pool, Alison,	Wakely Consulting Group, Fairness Consultant to MIA
Riou, Pierre,	Partner, Cantilo & Bennett, L.L.P., Conversion Consultant to MIA
Slusher, Christopher	Roger G. Brown & Associates, Due Diligence and Fairness Consultant for MIA
Smith, Martin Alderson	Senior Managing Director, The Blackstone Group LP, Valuation Consultant for MIA.
Town, Robert	Ph.D. Economics, Impact Analysis, Consultant to MIA
Townsend, Howard	Delmarva Foundation, Fairness Consultant to MIA
Weible, Brian,	Wakely Consulting Group, Fairness Consultant to MIA
Wholey, Douglas	Ph.D. Business Administration, Fairness Consultant to MIA
Wilson, Brenda A.	Chief, Health Insurance and Managed Care, MIA
Zale, Jeffrey M.,	Delmarva Foundation, Fairness Consultant to MIA.
Zoldos, Steve,	Wakely Consulting Group, Fairness Consultant to MIA

CareFirst, Inc., Executives, Consultants and Advisors:

Adams, Benjamin C.	Director, Credit Suisse First Boston, CareFirst Investment Banker Consultant
Altobello, Daniel J.,	CareFirst Chairman of the Board.
Barnes, Donald G.	Vice President, Hay Group, Inc, Executive Compensation Consultant to CareFirst.
Bauer, Gene E. Ph.d.	Managing Director Hay Group, Inc., Executive Compensation Consultant to CareFirst.
Chaney, G. Mark,	Executive Vice President and Chief Financial Officer, CareFirst, Inc.
Devou, Gregory A.,	Executive Vice President and Chief Marketing Officer, CareFirst, Inc.
Funk, David M.,	Managing Partner, Funk & Bolton, Counsel to CareFirst, Inc. and WellPoint Health Networks, Inc.
Grieb, Elizabeth	Piper Marbury Rudnick & Wolfe, CareFirst Outside Counsel
Haskins, Joseph	Chairman, CareFrist, Inc. Executive Compensation Committee

Hudak, James,	Partner Accenture, CareFirst Strategic Consultant
Jews, William L.,	President and Chief Executive Officer, CareFirst, Inc.
Kaplan, Leon,	Executive Vice President, Legal Services, CareFirst, Inc.
Levine, Larry	Credit Suisse First Boston, CareFirst Investment Banker Consultant
Marabito, Joseph,	Partner, Accenture, CareFirst Strategic Consultant
McMullen, Patrick,	Managing Director, Credit Suisse First Boston, CareFirst Investment Banker Consultant
Mendoza, Gary S.	Principal with law firm of Riordan & McKinzie, Counsel to CareFirst, Inc. and WellPoint Health Networks, Inc.
Muedeking, Mark	Piper Marbury Rudnick & Wolfe, CareFirst Outside Counsel
Muntner, Michael	Director, Credit Suisse First Boston, CareFirst Investment Banker Consultant
Neuberger, Isaac M.	Newuberger, Quinn, Gielen, Rubin & Gibber, PA., Outside Counsel to William L. Jews, and CareFirst, Inc.
Pham, Choung H.	Piper Marbury Rudnick & Wolfe, CareFirst Outside Counsel
Picciotto, John A.,	Executive Vice President, General Counsel and Corporate Secretary, CareFirst, Inc.
Smith, Jay,	Partner, Piper Marbury Rudnick & Wolfe, CareFirst outside Counsel
Smith, Stuart,	Managing Director, Credit Suisse First Boston, CareFirst Investment Banker Consultant
Taylor, James F.,	Attorney, Funk & Bolton, Counsel to CareFirst, Inc.
Thundermann, Ren L.,	Attorney, Funk & Bolton, Counsel to CareFirst, Inc.
Vecchioni, Sharon J.,	Executive Vice President and Chief of Staff, CareFirst, Inc.
Wolf, David D.,	Executive Vice President, Medical Services, CareFirst, Inc.

WellPoint Executives and Advisors

Burks, Michael	Vice President, Blue Cross blue Shield of Georgia, Operating Unit of WellPoint Health Networks, Inc.

Burt, Carol,	Senior Vice President, Finance and Treasury, WellPoint Health Networks, Inc.
Colby, David C.,	Executive Vice President and Chief Financial Officer, WellPoint Health Networks, Inc.
Geiser, Thomas C.,	Executive Vice President, General Counsel and Corporate Secretary, WellPoint Health Networks, Inc.
Glaser, Robert,	Vice President, Corporate Development, WellPoint Health Networks, Inc.
Kanter, Marvin M.D.	Chief Executive Officer Southern California-based Progressive Health Care Systems
Kelly, Robert A.,	Vice President, Legal Services, WellPoint Health Networks, Inc.
Lachman, Deborah	Senior Vice President, Small Group, Blue Cross of California
Monahan, John P.	Senior Vice President, State Sponsored Programs, WellPoint Health Networks, Inc.
Myers, Woodrow A. MD	Executive Vice President, Chief Medical Officer, WellPoint Health Networks, Inc
Nathan, Mark	Vice President of Compensation and Benefits, WellPoint Health Networks, Inc.
O'Rourke, John	President WellPoint Central Region
Schaeffer, Leonard D.	Chairman of the Board of Directors and Chief Executive Officer, WellPoint Health Networks, Inc.
Sorenson, Gregory L.	Managing Director Banc of America Securities, Financial Advisor to WellPoint Health Networks, Inc.

Additional Bidders for CareFirst, Inc.

Glasscock, Larry,	President and Chief Executive Officer of Anthem, Inc.
Nolan, Timothy,	Senior Vice President, Marketing & Corporate Development, Trigon
Snead, Thomas G. Jr.,	President and Chief Executive Officer, Trigon

Speakers at Public Comment Hearing

Allen, Andrea	Geriatrician and Eastern Shore Director of Maryland Academy of Family Physicians, Public Comment Speaker February 7, 2002
Andrews, Steve	Subscriber, Public Comment Speaker February 7, 2002
Antoniewicz, Carol	Medical Social Worker, currently unemployed, Public Comment Speaker February 7, 2002
Aurand, Shirley	President of Chapter 306 of the NARF Association, but is speaking for herself, Public Comment Speaker February 13, 2002
Banker, Robert	Subscriber, Public Comment Speaker February 4, 2002
Barmer, Rebecca	Subscriber, does contract work for CareFirst, Public Comment Speaker February 7, 2002
Barve, Kumar	Maryland general Assembly representing Gaithersburg, Rockville and Garrett Park, Public Comment Speaker February 11, 2002
Battista, Donald	President and CEO of Garrett County Memorial Hospital in Oakland, Public Comment Speaker February 13, 2002
Beck, Larry	President of Good Samaritan Hospital, Public Comment Speaker February 4, 2002
Becker, Doug	Pediatrician, Public Comment Speaker February 13, 2002
Bell, Deidre	Chief Financial Officer of Shore Health System, Public Comment Speaker February 7, 2002
Berman, Richard	Subscriber, Public Comment Speaker February 11, 2002
Bielenson, Peter	City Health Commissioner for Baltimore City, and President of the Maryland Citizens Health Initiative, Public Comment Speaker April 30, 2002

Bodnar, Vicki	Subscriber, Public Comment Speaker February 13 2002
Brown, Dr. James	Physician, Public Comment Speaker February 11, 2002
Bryden, Helen	Subscriber, Public Comment Speaker February 7, 2002
Bowerman, Chuck	Chairman of the Board of Good Samaritan Hospital, Public Comment Speaker February 4, 2002
Bruning, Richard	Maryland University Health Care Action Network, Public Comment Speaker April 30, 2002
Burkey, Katherine	Chairman of the Board o9f the Western Maryland Health System in Cumberland, Public Comment Speaker February 13, 2002
Callas, Peter	Sixteen years as elected official in Maryland, member of the Maryland Retired Teachers Association, legislative officer for Western Maryland and for the Washington County retired educational personnel, Public Comment Speaker February 13, 2002
Chase, Frank	Maryland Federation of the National Association of Retired Federal Employees, Public Comment Speaker April 30, 2002
Chenowitz, Ronnie	Member of Harford County Council, Public Comment Speaker February 4, 2002
Coleran, Jim	Insurance Broker, Public Comment Speaker February 11, 2002
Collier, Clay	Employed by Blue Cross Blue Shield, Public Comment Speaker February 11, 2002
Colvin, Robert	Subscriber, Public Comment Speaker February 13, 2002
Conrad, Robert	Subscriber, Public Comment Speaker February 4, 2002
Cornwell, Martha	Subscriber, Public Comment Speaker February 13, 2002
Cruz, Lillian	President of Democratic Club of Montgomery County, Public Comment Speaker February 11, 2002
DeMarco, Vinny	Executive Director of Maryland Citizens Health Initiative, Public Comment Speaker February 4, 2002
Dorrin, Susan	Executive Director of the Cecil County Chamber of Commerce, Public Comment Speaker February 4, 2002.

Dwyre, Ruth	Pediatrician and represent the Western Maryland Region of the American Academy of Pediatrics, Public Comment Speaker February 13, 2002
Ellison, Dr. Rebecca PH.D.	Subscriber, Public Comment Speaker February 7, 2002.
Elrich, Mark	City Council, Public Comment Speaker February 11, 2002.
Ewing, Councilman	Councilman for Montgomery County, Public Comment Speaker February 11, 2002.
Fagilla, Ms.	Subscriber, Public Comment Speaker February 4, 2002.
Farraq, Osama	Subscriber, Public Comment Speaker February114, 2002
Fennimore, Charles	Subscriber, Public Comment Speaker February11, 2002
Fisher, Dr. Michael	Provider, Public Comment Speaker February 7, 2002.
Fletcher, Rita	President of Wicomico County Education Association, Public Comment Speaker February 7, 2002.
Foster, Robert Michael	Subscriber, Public Comment Speaker February13, 2002
Fouche, Bobby	Director of Education for the Central Maryland AFL-CIO Council, Public Comment Speaker February 13, 2002.
Friedman, Eugene	Hospital Trustee with Life Ridge, and member of Maryland Chapter of the American Association of Health Care Admin, Public Comment Speaker April 30, 2002
Goldman, Ralph	Subscriber, Public Comment Speaker February 11, 2002
Gordon, Arnold	Candidate for State House in the 19th Legislative District, Public Comment Speaker February 11, 2002
Gortz, Mason	Subscriber, Public Comment Speaker February 4, 2002
Gould, Rebecca	Representing League of Women Voters, Public Comment Speaker February 7, 2002
Grahe, Raymond	VP for Finance and CFO of Washington County Health System, Public Comment Speaker February 13, 2002
Hall, Diane	Attorney which represented people in California, Public Comment Speaker February 7, 2002
Hamill, Jim	President of the Washington County Health System, Chairman of the Maryland Hospital Association's Task Force on the

	conversion of Blue Cross, Public Comment Speaker February 13, 2002
Hammond, Karen	Insurance Agent, Public Comment Speaker February 11, 2002
Hammond, Lee	State President for AARP, Public Comment Speaker February 7, 2002
Harrison, Lois	Board member of Washington county Health System and Chairman of the Board of the Washington county Hospital, Public Comment Speaker February 13, 2002
Haydun, Frederick	Harford County Medical Society, Public Comment Speaker February 4, 2002
Hellawell, Jane	Representing League of Women Voters, Public Comment Speaker February 7, 2002
Herb, Jody	CareFirst employee, Public Comment Speaker February 7, 2002
Hoffman, Joe	Chief Financial Officer for Upper Chesapeake Health, Public Comment Speaker February 4, 2002
Howard, John	Employee of CareFirst, Public Comment Speaker February 4, 2002
Insgstrom, Fayette	Pediatrician, on Executive Committee of Maryland Chapter American Academy of Pediatricians, Public Comment Speaker February 7, 2002
Jackson, Bill	Representative of AARP statewide, Public Comment Speaker February 4, 2002
Jaffay, David	Physician, Public Comment Speaker February
Jenkins, Joe	President of HMS Financial Services, Inc., Public Comment Speaker February 4, 2002
Kissmiller, James	Subscriber, Public Comment Speaker February 4, 2002
Klein, Shirley	Member of Board of Directors of the Upper Chesapeake Health System, and Vice President of Klein Supermarkets, Public Comment Speaker February 4, 2002
Knox, Jack	AARP, Public Comment Speaker February 13, 2002
Krantz, Harry	President of National Area Union Retirees Club, Public Comment Speaker February 11, 2002
Krauss, James	Subscriber, Public Comment Speaker February 4, 2002

Kube, Diane	Medical Practice Administrator and represent the Montgomery County Medical Society, Public Comment Speaker February 4, 2002
Langere, Keith	Employee of CareFirst Blue Cross and Blue Shield, Public Comment Speaker February 4, 2002
Lebray, Eugene	Physician, Public Comment Speaker February 11, 2002
Lefler, Rich	Subscriber, Public Comment Speaker February 7, 2002
Lighty, Lynn	Employee of CareFirst, Public Comment Speaker February 4, 2002
Limpson, Mr.	Subscriber, Public Comment Speaker February 11, 2002
Livy, Scott	Group Benefit Broker, Public Comment Speaker February 7, 2002
Long, Lucy	Subscriber, Public Comment Speaker February 7, 2002
Lowe, Ed	Northwestern Mutual Financial Network, Public Comment Speaker February 13, 2002
Mallat, Veronica	Associated with AARP, Public Comment Speaker February 4, 2002
Markey, Tim	Employed by CareFirst, Public Comment Speaker February 11, 2002
McCoy, Robert	President of Untied Seniors of Maryland, Public Comment Speaker February 11, 2002
McInnis, Miguel	CEO Mid-Atlantic Association of Community Health Centers, Public Comment Speaker April 30, 2002
McLoughlin, Dr. Ed	Rheumatologist, Public Comment Speaker February 7, 2002
Miles, Bishop Douglas	Representative of Maryland Health Care for All, Public Comment Speaker April 30, 2002
Moller, Carolyn	Subscriber, Public Comment Speaker February 13, 2002
Morriss, Annette	Subscriber, Public Comment Speaker February 4, 2002
Muldane, Rorry	Subscriber, Public Comment Speaker February 4, 2002
Nelson, Vicki	Subscriber, Public Comment Speaker February 13, 2002

Nessman, Alan	Special Counsel with practice Director of the American Psychological Association, Public Comment Speaker April 30, 2002
Netherland, Bob	Vice President for Chesapeake Health, Public Comment Speaker February 4, 2002
Newby, John	Physician, Public Comment Speaker February 13, 2002
Nunez, Luis	Chair of the Montgomery County on Aging, Public Comment Speaker February 11, 2002
Petty, Daren	President of United Auto Workers of State of Maryland, Public Comment Speaker April 30, 2002
Pierce, Wilbur	Subscriber, Public Comment Speaker February 4, 2002
Pierson, Cal	President, Maryland Hospital Association, Public Comment Speaker February 4, 2002
Polfray, Robert	Subscriber, Public Comment Speaker February 4, 2002
Pomisheski, Fred	Subscriber, Public Comment Speaker February 4, 2002
Potee, Ms.	Subscriber, Public Comment Speaker February 4, 2002
Porter, Robert	Subscriber, Public Comment Speaker February 4, 2002
Prettel, Michael	Subscriber and representing the Maryland Citizens Health Initiative, Public Comment Speaker February 4, 2002
Prettyman, Richard	Owns Brokerage firm in Easton, Public Comment Speaker February 7, 2002
Preston, Michael	Executive Director of Medci, the Maryland state Medical Society, Public Comment Speaker February 4, 2002.
Prouty, Keith	Maryland State Conference of the NAACP, Public Comment Speaker February 11, 2002.
Reynolds, Penny	CareFirst employee, Public Comment Speaker February 7, 2002.
Ricciti, Nicolas	Director of the Cecil County Department of Social Services, Public Comment Speaker February 4, 2002.
Rogers, Kathy	Director of Community Relations for Western Maryland Health System in Cumberland, Public Comment Speaker February 13, 2002
Rusnack, Andrew	Subscriber, Public Comment Speaker February 7, 2002.

Sczudlo, Ray	Vice President and Chief Legal Officer of Children National Medical Center in D.C., Public Comment Speaker February 4, 2002.
Seabout, Bobbi	Maryland Chapter of the American Academy of Pediatrics, Public Comment Speaker April 30, 2002.
Seeman, Isidor Sam	Metropolitan Washington Public Health Association, Public Comment Speaker February 11, 2002.
Shorgren, Bruce	Director of financial reporting systems at CareFirst, Public Comment Speaker February 11, 2002.
Siegel, Mark	President of Montgomery County Medical Society, and also speaking on behalf of the State Medical Society, Public Comment Speaker February 11, 2002.
Simmons, William	Businessman and father, Public Comment Speaker February 4, 2002.
Sink, Doug	CEO of the YMCA of Talbot County, Public Comment Speaker February 13, 2002.
Smith, Carl	Subscriber, Public Comment Speaker February 7, 2002
Smoot, Catherine	President elect of Med Chi, the Maryland State Medical Society, Public Comment Speaker February 7, 2002.
Solomon, Steve	Independent health insurance agent and broker with Heritage Financial Consultants, Public Comment Speaker April 30, 2002.
Surr, John	Subscriber, Public Comment Speaker February 11, 2002.
Thomas, Jim	Insurance Agent, Public Comment Speaker February 11, 2002.
Tilman, Mike	CareFirst Associate, Public Comment Speaker February 7, 2002.
Vollmer, Debra	Concerned citizen and speaking on behalf of Coalition for Universal Health care, Public Comment Speaker February 11, 2002.
Wallace, Steve	Speaking on behalf of mentally ill persons, Public Comment Speaker February 11, 2002.
Wallach, Harold	Chairman of the Coalition for Health Care Accountability, Public Comment Speaker February 11, 2002.
Wannemacher, Bob	President of the Western Maryland AAP Advocacy Council, Public Comment Speaker February 13, 2002.

Weinhart, Carol	Director of Harford County Office on Aging, Public Comment Speaker February 4, 2002.
Weiss, Martin	Maryland AARP, Public Comment Speaker February 11, 2002
Wielgost, John	General Manager of Syntex Systems corporation, Public Comment Speaker February 11, 2002
Williams, Gene	Subscriber, Public Comment Speaker February 13, 2002.
Willis, Patty	Shore Health Systems, Public Comment Speaker February 7, 2002

SCHEDULE D

SCHEDULE OF PUBLIC COMMENT HEARINGS

1.	Monday, February 4, 2002	Bel Air
2.	Thursday, February 7, 2002	Wye Mills
3.	Monday, February 11, 2002	Rockville
4.	Wednesday, February 13, 2002	Hagerstown
5.	Wednesday, February 27, 2002	Clinton
6.	Thursday, March 14, 2002	Catonsville
7.	Tuesday, April 30, 2002	Baltimore

SCHEDULE OF EVIDENTIARY HEARINGS

1.	Monday, March 11, 2002	University of Maryland, Baltimore County, Catonsville
2.	Wednesday, March 13, 2002	University of Maryland, Baltimore County, Catonsville
3.	Thursday, March 14, 2002	University of Maryland, Baltimore County, Catonsville
4.	Monday, April 29, 2002	Inner Harbor Marriott, Baltimore
5.	Tuesday, April 30, 2002	Inner Harbor Marriott, Baltimore
6.	Monday, December 16, 2002	Inner Harbor Marriott, Baltimore
7.	Tuesday, December 17, 2002	Inner Harbor Marriott, Baltimore
8.	Wednesday, December 18, 2002	Inner Harbor Marriott, Baltimore
9.	Tuesday, January 28, 2003	Inner Harbor Marriott, Baltimore
10.	Wednesday, January 29, 2003	Inner Harbor Marriott, Baltimore
11.	Thursday, January 30, 2003	Inner Harbor Marriott, Baltimore
12.	Friday, January 31, 2003	Inner Harbor Marriott, Baltimore
13.	Monday, February 3, 2003	Inner Harbor Marriott, Baltimore
14.	Tuesday, February 4, 2003	Inner Harbor Marriott, Baltimore
15.	Wednesday, February 5, 2003	Inner Harbor Marriott, Baltimore

LIST OF DEPOSITIONS

1. August 19, 2002: Deposition of Timothy P. Nolan, Senior Vice President, Marketing & Corporate Development, Trigon.

2. August 19, 2002: Thomas G. Snead, President and Chief Executive Officer, Trigon.

3. September 6, 2002: William L. Jews, President and Chief Executive Officer, CareFirst, Inc.

4. September 19,2002 and January 13, 2003: David D. Wolf, Executive Vice President, Medical Services, CareFirst, Inc.

5. October 10, 2002: Mark Muedeking, Partner, Piper Marbury Rudnick & Wolfe.

6. November 22 & 25, 2002: Stuart F. Smith, Managing Director, Credit Suisse First Boston ("CSFB"), CareFirst Investment Banker Consultant.

7. January 13, 2003: G. Mark Chaney, Executive Vice President and Chief Financial Officer, CareFirst, Inc.

SCHEDULE E

CATALOGUE OF INFORMATION REQUESTED BY MARYLAND INSURANCE ADMINISTRATION

SUMMARY OF REQUESTS

① On February 22, 2002, a Subpoena for Documents Was Served on Counsel for CareFirst, Inc. and WellPoint Health Networks Inc. Requesting the Following Documents

② On August 22, 2002, The Lewin Group Forwarded the Following Request for Documents and Information

③ On October 28, 2002, letter to counsel forwarding document requests from Wakely and Delmarva to WellPoint

④ On November 12, 2002, by Letter to Counsel for CareFirst and WellPoint Requesting Status on Document Requests Previously Propounded

⑤ On November 14, 2002, Additional Document Requests Made by Delmarva Foundation Were Handed to Sandy Beard at CareFirst as a Result of Reviewing Quality Management and Medical Management Plan

⑥ On November 15, 2002, the Following Additional Document Requests Were Forwarded to WellPoint by the Delmarva Foundation

DETAIL OF REQUESTS

① **On February 22, 2002, a Subpoena for Documents Was Served on Counsel for CareFirst, Inc. and WellPoint Health Networks Inc. Requesting the Following Documents**

Economies of Scale

1. Any analysis, report, projection or documentation of administrative expenses of CareFirst Entities and WellPoint Entities by product type, broken out by total dollars allocated or spent and also expressed as a percentage of premium, from 1998 to 2005. If available, the same information on a per-member-per-month ("PMPM") basis.

2. Any analysis, projection or other documentation relating to expected or possible savings or reductions in administrative expenses by CareFirst resulting from the proposed acquisition of CareFirst Entities by WellPoint (the "Proposed Transaction").

3. Documentation and detail of any other anticipated or projected synergies or economies of scale resulting from the Proposed Transaction, including those which might result in reduction of medical or claims costs, or reduction of other expenditures, for CareFirst. If available, the same information on a per-member-per-month ("PMPM") basis.

Investment Needs as Identified in the November, 2001 Accenture Report

4. All documents relating to expected or estimated actual costs incurred and expenditures required, or made, in connection with compliance by CareFirst Entities and WellPoint Entities with HIPAA's Privacy Rule and Electronic Transactions standards.

5. All documents relating to actual, estimated, or planned expenditures by CareFirst Entities and WellPoint Entities for e-commerce initiatives from 1998 to 2005.

6. All documents relating to actual, estimated or planned expenditures for consumer focused initiatives by CareFirst Entities and WellPoint Entities from 1998 to 2005.

7. All documents relating to actual, estimated, or planned expenditures for information technology infrastructure improvements by CareFirst Entities and WellPoint Entities from 1998 to 2005.

8. All documents relating to actual, estimated, or planned expenditures for Merger and Acquisition Activity by CareFirst Entities and WellPoint Entities in the next 3 to 5 years.

Due Diligence

9. Minutes of Board of Director meetings of all CareFirst Entities and WellPoint Entities, including all committees from January 1998 to present.

10. Copies of all written or electronic presentations, analyses, memos, reports etc., provided to the Boards of the CareFirst Entities or their committees regarding strategic planning, competitive analysis, conversion, acquisition or merger.

11. Copies of any internal reports or memoranda of CareFirst Entities discussing or analyzing conversion and acquisition or alternatives to conversion and acquisition.

12. Copies of any consultant or expert analyses, reports or other documents regarding strategic alliance, merger, acquisition or other restructuring alternatives.

13. Copies of any consultant or expert analyses, reports or other documents regarding potential partners for strategic alliance, merger, acquisition or other restructuring alternatives ("potential partners").

14. Copies of all correspondence by and between CareFirst Entities or their representatives and potential partners since January 1998 to present.

15. All correspondence, draft or proposed bids, final bids, originals revised or final merger agreements, or any other material received from potential partners or interested parties from January 1, 1998 to present.

16. Copies of all written or electronic documents prepared for, presented to, or considered by the Boards of the CareFirst Entities relating to executive and board member compensation, including bonuses, incentive programs, employee benefits, severance packages, benefits related to change in control, stock or stock option arrangements, expense allowances, memberships or the like, since January 1998, whether or not in connection with an acquisition or merger.

17. Copies of all executive compensation, incentive and benefit agreements executed or to be executed.

18. Copies of all written or electronic material provided to the Boards of the CareFirst Entities regarding their duties and obligations in evaluating strategic planning options and conversion, merger or acquisition options from January 1998 to present.

19. Copies of an analysis of, description, or justification for the amounts provided for in Section 8.2 of the Agreement and Plan of Merger.

20. To the extent that the following documents are in the possession of the WellPoint Entities - all expert reports, written testimony, transcripts of all meetings, hearings and depositions, statutory filings, and any other material submitted by anyone to the Insurance Departments in Georgia and Missouri in connection with the WellPoint acquisitions or strategic alliances in those states, as well as all reports and orders issued by or prepared on behalf of the Georgia and Missouri Departments of Insurance.

Fairness

21. All pro forma financial post-transaction projections by CareFirst or WellPoint Entities.

22. All pro forma financial post-transaction projections prepared or provided in connection with the Georgia or Missouri transactions.

23. All actuarial reports, projections or analyses prepared for or in connection with the Proposed Transaction.

24. Listing of all WellPoint and CareFirst Entities' health insurance and HMO products by product description, number of certificate holders, subscribers and covered lives, premium, medical expense, administrative expense, loss ratio, and underwriting margin.

25. Any and all documents comparing WellPoint Entities and CareFirst Entities product lines, underwriting guidelines, coverages, rates, UR criteria, or referencing changes to CareFirst Entities' product lines, coverages, rates, underwriting guidelines, or UR criteria in connection with or resulting from this transaction.

26. Any and all documents comparing WellPoint Entities and the Georgia and Missouri acquired plans product lines, underwriting guidelines, coverages, rates, UR criteria, or referencing changes to the Georgia and Missouri health plans product lines, coverages, rates, underwriting guidelines, or UR criteria in connection with or resulting from the Georgia and Missouri transactions.

27. All documents, analysis, or reports relating to CareFirst Entities' distribution system or potential or planned modifications to their distribution system resulting from the transaction.

28. Physician fee schedule by CPT code for participating network physicians and preferred provider network physicians for CareFirst Entities and WellPoint Entities from 1998 to 2002.

29. Copies of BCBSA required quarterly performance surveys for CareFirst, and all WellPoint Blue Cross plans since 1998.

30. Any analysis, comparison or discussion of “best practices” which may be shared between WellPoint and CareFirst or adopted by CareFirst from WellPoint as discussed the Accenture report.

31. Any analysis, or discussion regarding claims or IT Systems integration or sharing between WellPoint and CareFirst.

32. Copies of WellPoint’s and CareFirst’s manuals, handbooks or similar documents for claims, underwriting, case management, utilization review, marketing, policyholder or member services, provider contracting and provider relations.

Financial and Actuarial Information

33. Auditor's management letter with management response for the last three years.

34. Copies of all Management Representation letters or similar documents prepared by or for CareFirst in connection with independent audits during the last three years.

35. Accountants waive list in connection with most recent audit.

36. Summary listing of all internal audits conducted in 2000, and through June 30, 2001, and access to audit reports and work papers.

37. Access to independent auditors' work papers related to the 2000, 1999, and 1998 audits.

38. Detailed listing of, and supporting documentation for, estimated transaction costs that will be allocated to and paid by CareFirst Entities.

39. BCBSA Capital Benchmark calculations for CareFirst Entities for the years ended December 31, 1996 to December 31, 2001.

40. All rating agency (*e.g.*, Best's, Moody's, Standard & Poor's) presentations made by CareFirst Entities during the five years ended with the current date.

41. All rating agency (*e.g.*, Best's, Moody's, Standard & Poor's) reports issued in 1999, 2000, and through current date.

42. Planned versus actual income statement by business unit for the last six quarters and the last three years.

43. Detailed schedule of capital expenditures for the last three years and fiscal 2001.

44. Capital adequacy compared to BCBS National Association Standards for last three years and fiscal 2001.

45. At page 31 of the January 2002 Accenture Report, reference is made to WellPoint's target for a return on its investment in CareFirst. Please provide any documents that discuss WellPoint's target return on investment, and any documents that discuss how WellPoint and CareFirst plan to achieve that target.

46. All documents that relate, explain, support, or detail the statement attributed to WellPoint CFO David Colby at page 32 of the January 2002 Accenture Report that WellPoint "will achieve revenue synergies of $30 million within 3 years."

47. Audiotape and/or transcripts of all telephone or video conferences that were held for investors, the press, analysts, or others relating to the Proposed Transaction.

Claims/Underwriting

48. Product line information for the last three years and fiscal 2001 to include:

    a. Detail on pricing
    b. Detail on number of customers
    c. Detail for each major cost item

d. Detail on payroll expense
e. Overhead allocations
f. Margin analysis
g. Number of employees directly attributable and allocated to each product and function
h. Detail schedule of premium receivable and medical claims payable
i. Detail of reserve accounts
j. Detail of DPAC (deferred policy acquisition costs) and unearned premiums
k. Loss ratio

49. Total outstanding case reserves as of June 30, 2001, and for the last three years.

50. Underwriting criteria for both CareFirst Entities and WellPoint Entities.

51. For the last five years, premium rate history for CareFirst Entities and WellPoint Entities and competitor carriers.

52. For the last five years, the underwriting rejection percentage for WellPoint Entities and CareFirst Entities.

53. Detailed analysis of underwriting profit or loss for the last three years and fiscal 2001.

54. Development of loss and loss expense ratios from 1998 to the present.

Personnel and Management

55. WellPoint's and CareFirst current human resources manuals.

56. Copies of any analyses or projections regarding the projected impact of the Proposed Transaction on employment levels or benefits at CareFirst.

57. In the Agreement and Plan for Merger at page 26, the parties to the transaction have agreed to form a "Transition Team." Please provide the names of the team members, a schedule of meetings that have or will occur, minutes from the meetings, and any reports, memoranda, or other documents that have been presented or shared at the meetings.

Documents Required in connection with the Form A

58. The acquisition of control of CareFirst, Inc. will be effected by the merger of Congress Acquisition Corp. (CFAC) with and into CareFirst, Inc. Item 5 of the Form A indicates that at the time of the merger the Board of Directors of CFAC will become the Board of Directors of CareFirst, Inc. However, the Form A filing does not clearly identify the members of the CFAC Board of Directors (although Exhibit 1-A8 to the Form A was signed by two Directors of CFAC). Please advise us of the identity of the members of the Board of Directors of CFAC. In addition, please provide us with biographical affidavits and authorization for release of information forms for any CFAC Directors for whom these forms were not already provided.

59. The Form A filing did not clearly identify the individuals who will act as the officers of CareFirst, Inc. after the acquisition. In this regard, Item 5 of the Form A states that Mr. William Jews, CareFirst Inc.'s President and Chief Executive Officer, will become President of WellPoint's Southeast Business Region, and other CareFirst, Inc. officers will be assigned significant responsibilities with respect to the business of CareFirst, Inc. However, it was unclear if Mr. Jews will remain an officer of CareFirst, Inc., and exactly who will be the other officers of CareFirst, Inc. Please advise us of the identities of all of the individuals who will act as the officers of CareFirst, Inc. after the acquisition, and their respective positions. In addition, please provide us with biographical affidavits and authorization for release of information forms for any of these individuals for whom these forms were not already provided.

60. The Form A filing does not identify the individuals who will act as the Directors and officers of CFMI after the acquisition. Please advise us of the identity of the proposed Directors and officers of CFMI after the acquisition. In addition, please provide us with biographical affidavits and authorization for release of information forms for any of these individuals for whom these forms were not already provided.

61. The Form A filing did not include proposed revised Articles of Incorporation and By-laws of CFMI after the acquisition. Please provide these items. Your response should include any needed changes to the proposed Articles of Incorporation to meet CFMI's post-conversion capital and surplus requirements under Sections 4-103 to 4-105 of the Insurance Article.

62. Exhibits 2C-1 and 2C-2 of the Form A filing provided pre- and post-acquisition organizational charts for the WellPoint holding company system. However, the charts did not identify each insurer in the holding company system. Please provide us with a listing of each insurer in the holding company system. In addition, please advise us of the primary regulator of each of these entities.

② **<u>On August 22, 2002, The Lewin Group Forwarded the Following Request for Documents and Information</u>**

The following items are outstanding from our original data request of August 2, 2002.

1. Item 2: Additional documentation of competitive threats that CareFirst faces, such as information "debriefing" recent account losses and satisfaction surveys comparing CareFirst to competitors. Specifically, we would appreciate receiving this information by account type.

2. Item 4: Revenue and underwriting profit and loss information stratified similarly to the market share information as requested in item 3. Please see comments on next page regarding item 3.

3. Item 7: Follow-up and response regarding ability of CareFirst to share BCBSA performance measures and benchmarks from quarterly reports (how CareFirst compares to other Blues plans nationally). Also, follow-up regarding the ability of CareFirst and WellPoint to share NCQA accreditation survey findings.

Supplemental Information

To supplement the information you have already provided, we have listed additional items we would like to receive to assist us in our analysis.

4. In item 1 of our original request, we asked that you please provide a chronology of the transition of former FreeState HMO members to BlueChoice and other coverage options. In addition to the documentation we received from you, we would like further detail surrounding those who were disenrolled from FreeState HMO and did not enter another CareFirst product. Specifically, the submission should address the reasons these individuals did not enter another CareFirst product.

5. In item 3, we requested that you provide market share data along several dimensions for both CareFirst and its competitors. Specifically, we asked for market share data by market segment/account type, product type and territory. You provided market share data by individual (less than 65 and greater than 65), 1-50 (SEGO and non-SEGO), 51+/National and FEP. We did not receive any data by product type (*i.e.*, HMO, PPO, etc.). You provided market share by territory. However, we would like to receive these market share data not just by territory, but cross-tabulated along the other two dimensions, as well.

   For example, for each account type, the following table would be provided

		Territory	
Product	Central MD	Baltimore City	DC Suburbs
HMO			
PPO			
Indemnity			

6. In item 6 we requested information regarding WellPoint's innovative products, especially those offered to uninsured persons, individuals, small groups, and public payers. In addition, we requested that you indicate which of these products would not be eligible to be offered under Maryland's regulatory requirements. We received your descriptions of these products, however, we would appreciate your analysis of which of these innovative products would not be allowable under Maryland's regulatory constraints.

Items Received

7. In item 5, we requested that you provide contacts and introductions to the appropriate WellPoint staff that may assist us in comparing performance among WellPoint's plans in Georgia, California and Missouri and other Fairness Analysis issues. We appreciate your providing the name of Tom Geiser at WellPoint. We will work with him to arrange the appropriate meetings and interviews.

On-Site Meeting Request

8. As part of our "plan performance analysis," we would like to schedule interviews with you to assist us in understanding the key functional areas of your operations, specifically:

   · Sales and Marketing
   · Product Development

· Finance
· Underwriting/Actuarial
· Information Systems
· Provider Relations/Network Development
· Medical Management (Utilization and Quality)
· Claims Operations
· Member Services/Customer Relationship Management
· Human Resources.

③ **On October 28, 2002, letter to counsel forwarding document requests from Wakely and Delmarva to WellPoint**

List of Documents Requested by Wakely from Wellpoint

1. All California rate filings, rate manuals and renewal rating formulas for 1999 to present

2. All rate filings, rate manuals and renewal rating formulas of acquired companies for two years pre and post acquisition

3. Copy of all California underwriting guidelines

4. All underwriting guidelines of acquired companies for two years pre and post acquisition

5. California experience reports by line of business

6. Experience reports by line of business of acquired companies for two years pre and post acquisition

7. Lag triangles and work papers used in the development of Unpaid Claim liabilities for year end 1999, 2000 and 2001 by line of business in California

8. Lag triangles and work papers used in the development of Unpaid Claim liabilities for acquired companies by line of business for two years pre and post acquisition

9. NAIC Annual Statements 1999-2001 for California companies and for acquired companies

10. All projections with supporting worksheets and source data or information regarding projections of the number of insureds in the Maryland individual and small group market as a result of the proposed acquisition

11. Number of doctors and hospitals under contract with acquired companies for five years pre and post the acquisition

12. All current provider contracts in California

13. All provider contracts of acquired companies for five years pre and post acquisition

14. All statistical data that any other Team member requests

List of Documents Requested by Delmarva from Wellpoint

15. Quality Management Documents/Policies and Procedures

    a. Quality Management Plan for each product unless the QM Plan covers all product lines
    b. Any mandatory disease management guidelines used for physician profiles for quality measures or provider feedback.

16. Member Services/Consumer Affairs Documents/Policies and Procedures

    a. Staffing Ratios by product
    b. Member Service Performance Standards by product line
    c. Member Service Metrics (examples commonly measured include):
        i. Dropped calls/Abandonment rate
        ii. Minutes on hold
        iii. Percentage Calls answered with 30 seconds (or Corporate Standard) vs. seconds until call is answered
        iv. Average call time
        v. Average speed to answer
        vi. Percentage Issues resolved on 1st call
        vii. Average resolution time
        viii. Inquires per 1,000 MPM
        ix. Total complaints per 1,000 MPM
        x. Total grievances per 1,000 MPM
        xi. Total Appeals per 1,000 MPM
    d. Most common reasons for member inquiries, *i.e.*, claims/enrollment issues/benefits provider network/access issues/appeals on denial of payment/coverage
    e. Results of Satisfaction Surveys/CAHPS by product line
    f. Outreach Services by Product Line including ratio of staff to members
    g. Average complaint resolution time (days)
    h. Average grievance resolution time (days)
    i. Number of denials appealed provider/member
    j. Number of denials sent to external review
    k. Number of expedited appeals and number completed within timeframe

17. Benefits Documents/Policies and Procedures

    a. Carved out/restricted services by product line
    b. List and description of all products/product lines
    c. Benefit coverage descriptions (Range of Benefits/Services covered or excluded by product line) of all product lines including but not limited to:
        i. Covered /non-covered services and benefit limitations including dollar limits and any exclusions
        ii. Any carved out services including Behavioral Health, Vision, Dental, DME and other ancillary care providers

18. Payment Documents/Policies and Procedures

    a. Fee schedule for top 20 CPT codes by specialty if FFS payment method for product line
    b. Top E & M codes Fee schedule
    c. Information about Reinsurance or Stop Loss Coverage – if it is provided or must be purchased by physician/hospital provider including deductibles/coinsurance
    d. Use of withholds, risk pools or bonus pools for payment
    e. Services are covered and excluded under primary care or specialty care compensation
        i. All policies and procedures may be: product line specific or company specific

19. UM Documents/Policies and Procedures

    a. Utilization Management Plan for each product unless the UM Plan covers all product lines
    b. Process to Precertify
    c. Appeal process for Precertification
    d. Criteria used for Precertification and any policies for exceptions
    e. Criteria used for hospital length of stay
    f. Staffing ratios:
        i. Medical Directors for Precertification and Hospital LOS
        ii. Assignment/and # of Nurse Reviewers: Onsite, Telephonic
        iii. Assignment ratios by product
    g. Utilization Management Plan (submitted to Board annually - company wide and product line specific (if applicable)
    h. Any mandatory disease management guidelines used for profiles or incentive or withholds for all product lines.

20. PBM/Formulary Issues/Documents/Policies and Procedures

    a. Pharmacy management information including:
        i. Formulary Restrictions
        ii. Preauthorization requirements
    b. Pharmacy physician profiling (DUE)

21. Contract Documents/Policies and Procedures

    a. Payment methods for providers both physician and hospital for all product lines – to include:
        i. Capitation, FFS or blended rate where applicable
        ii. Detailing what services are included in each payment method
    b. Credentialing Policies including any limitations for example:
    c. Restrictions on being a PCP and also a specialist
    d. Board certification requirements
    e. Privileges at only participating hospitals
    f. Limitation of hospitals in network
    g. Termination clauses and categories, *i.e.*,

i. Quality of care
ii. Utilization issues
iii. Without cause

h. Appeal rights in all circumstances of termination including - time periods (days of notice, etc.), obligations to patients who are under their care at termination
i. Definition of medical necessity, emergency and urgent care and timeframes for types of appointments for access standards
j. Method for making referrals: paper, etc.
k. Evidence or lack of a multiple/all product agreement requirements
l. Contract expiration dates, *i.e.*, evergreen or expire on anniversary date
m. Fee-for-Service fee schedule for 20 most common CPTs by specialty (fee schedule based pricing)
n. Case rate pricing for hospitals (as allowed by HSCRC)

22. Network and Provider Relations Documents/Policies and Procedures

a. Standards by product line:
b. Member - physician ratios - for primary care and primary specialties, *i.e.*, Allergy, Cardiology, Neurology, Gastroenterology, General Surgery, Orthopedics, Dermatology, ENT, Ophthalmology, Cardiovascular Surgery, OB/GYN, Urology, Pulmonary, Nephrology, Hematology/Oncology, Neurosurgery, Infectious Disease, Endocrine and Rheumatology
c. Policies to allow members to go outside network if access issues or other exceptions
d. Policies to assess network adequacy based on above standards
e. Provider contracts and handbooks for all product lines (for both specialists and primary care physicians) for individual physicians, specialty group, and multi specialty groups
f. Policy/standards for travel: *i.e.*, PCP in X miles or min, specialists X miles or X minutes
g. Policy on how access varies based on rural/urban/suburban

23. Claims Documents/Policies and Procedures (samples of reports listed here may not correspond exactly to what is collected by CF or WP)

a. Turn around time standards for claims, including clean claims
b. Management reports on claims, *i.e.*, aged claims lists by categories of claims
c. Reports reflecting processing status of claims by age, for example: date of service, date received, processed date, paid date-partial vs. full, date adjustments made and reason codes
d. Claims operation management reports on inventory/productivity/quality
e. Pended/suspended claims report
i. By age and reason code
f. Claims lag reports
g. Claims status report by date of receipt, reason for rejection of claims, *i.e.*, eligibility, non participating provider or member not in system
h. Claims status by date of receipt sorted on types of claims
i. Glossary of adjustment reasons/codes

④ **On November 12, 2002, by Letter to Counsel for CareFirst and WellPoint Requesting Status on Document Requests Previously Propounded**

Information and Document requests made during hearings held on March 11, 13, 14, April 29, and April 30, 2002:

1. Provide the analysis used by WellPoint's investment banking firm to develop a value of 1.2 billion. See hearing day one March 11, 2002, witness - Leonard D. Schaffer - at page 58, line 13 through page 60, line 7.

2. With respect to the WellPoint Georgia transaction, provide information as to how the merger incentives were recorded on the balance sheets. In addition, provide the appropriate accounting method for the CareFirst incentive payments. See hearing day one, March 11, 2002, witness - Leonard D. Schaffer - at page 86, line 2 through page 87, line 11.

3. Please provide the chronology of advice received by the CareFirst Board of directors in the bidding process. See hearing day one March 11, 2002, witness Daniel J. Altobello - page 253, line 17 through page 255, line 9.

4. Provide a list of CareFirst, Inc. projects that were ramped down or put on hold as a result of the unexpected deadline for HIPPA. In addition provide a list of initiatives and budgets which CareFirst has not been able to pursue as a consequence of the need to allocate a set amount of money. See hearing day 2, witness - Bill Jews - page, 475 lines 2 through page 477, line 8.

5. Provide documents given to WellPoint or to any other potential bidder which informed them of the projected capital needs of CareFirst, Inc. See hearing day 2, witness - Bill Jews - page 478, line 14 through page 479, line 12.

6. With respect to hearing Exhibit 5, Project Chesapeake dated July 27, 2000, provide the analysis performed by DLJ to determine how much of the budgeted capital expenditures could be funded through external debt financing. Please provide the back-up for the $375 million number. See hearing day 2, witness - Stuart Smith, page 507, line 4 through page 509, line 9.

7. Provide a copy of the analysis performed in April 2001, which utilized three different valuation methodologies. See hearing day 2, witness - Stuart Smith, page 559, line 9 through page 560, line 21.

8. Provide the analysis, if any, of how much capital could be generated through an IPO approach. See hearing day 2 - witness Stuart Smith, page 566, lines 3-18.

9. Please provide information as to whether there was a regulatory discount rate used in the Cerulean transaction. See hearing day 2 - witness Stuart Smith - page 575, line 19 through page 578, line 5.

10. Please provide the cost of integration of the WellPoint coding system that allows back-end reporting to group claims in certain ways to allow for sorting in various

type of market segments. See hearing day 3- witness Michael Burks - page 79, line 17 through page 80, line 6.

11. Please provide the amount of administrative cost savings, if any, associated with the integration of the WellPoint coding system. See hearing day 3 - witness Michael Burks - page 81, lines 10-20.

12. Provide a list of services Accenture provided to WellPoint and how it was compensated for those services. See hearing day 4 - witness Joseph Marabito - page 25, line 12 through page 26, line 9.

13. Provide a copy of information reflecting where CareFirst ranks in level of customer as measured in the Blue Cross Blue Shield Association required quarterly performance surveys. See hearing day 5 - witness Joseph Marabito- page 85, lines 1 -13.

14. Please provide any supplemental list of inaccuracies found in the Trigon testimony pursuant to Mr. Jews statement to the Baltimore Sun. See page 36, line 3 through page 38, line 6.

15. Please provide any and all documents related to the valuation, if any, performed by First Boston prior to March 2001. See page 242, line 15 through page 243, line 2.

16. Please provide, to the extent not all ready produced, color copies of all minutes and attachments as they were presented to the board. See page 76, lines 9-19.

17. Please provide copies of all drafts of the definitive agreement and all documents associated with that agreement that have not been previously produced. See page 103, lines 4-10.

18. Please provide documents not previously produced because of the re-definition of the scope of the subpoena by Mr. Funk's letter which is Exhibit 199, and was retained by counsel. See page 267, line 7 through page 271, line 7.

Additional Requests from Delmarva and Wakely

List of Documents Requested by Delmarva from CareFirst

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    b. Any mandatory disease management guidelines used for physician profiles for quality measures or provider feedback.

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vii. Average resolution time
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x. Total grievances per 1,000 MPM
xi. Total Appeals per 1,000 MPM

d. Most common reasons for member inquiries, *i.e.*, claims/enrollment issues/benefits provider network/access issues/appeals on denial of payment/coverage
e. Results of Satisfaction Surveys/CAHPS by product line
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c. Benefit coverage descriptions (Range of Benefits/Services covered or excluded by product line) of all product lines including but not limited to:
   i. Covered /non-covered services and benefit limitations including dollar limits and any exclusions
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f. Staffing ratios:
    i. Medical Directors for Precertification and Hospital LOS
    ii. Assignment/and # of Nurse Reviewers: Onsite, Telephonic
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d. Board certification requirements
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f. Limitation of hospitals in network
g. Termination clauses and categories, *i.e.*,
    i. Quality of care
    ii. Utilization issues
    iii. Without cause
h. Appeal rights in all circumstances of termination including - time periods (days of notice, etc.), obligations to patients who are under their care at termination
i. Definition of medical necessity, emergency and urgent care and timeframes for types of appointments for access standards
j. Method for making referrals: paper, etc.
k. Evidence or lack of a multiple/all product agreement requirements
l. Contract expiration dates, *i.e.*, evergreen or expire on anniversary date
m. Fee-for-Service fee schedule for 20 most common CPTs by specialty (fee schedule based pricing)
n. Case rate pricing for hospitals (as allowed by HSCRC)

26. Network and Provider Relations Documents/Policies and Procedures

a. Standards by product line:
b. Member - physician ratios - for primary care and primary specialties, *i.e.*, Allergy, Cardiology, Neurology, Gastroenterology, General Surgery, Orthopedics, Dermatology, ENT, Ophthalmology, Cardiovascular Surgery, OB/GYN, Urology, Pulmonary, Nephrology, Hematology/Oncology, Neurosurgery, Infectious Disease, Endocrine and Rheumatology
c. Policies to allow members to go outside network if access issues or other exceptions
d. Policies to assess network adequacy based on above standards
e. Provider contracts and handbooks for all product lines (for both specialists and primary care physicians) for individual physicians, specialty group, and multi specialty groups
f. Policy/standards for travel: *i.e.*, PCP in X miles or min, specialists X miles or X minutes
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d. Claims operation management reports on inventory/productivity/quality
e. Pended/suspended claims report
    i. By age and reason code
f. Claims lag reports
g. Claims status report by date of receipt, reason for rejection of claims, *i.e.*, eligibility, non participating provider or member not in system
h. Claims status by date of receipt sorted on types of claims
i. Glossary of adjustment reasons/codes

Requests Addressed to CareFirst (as to all Maryland Companies):

28. All rate filings, rate manuals and renewal rating formulas for 1999 to present

29. Copy of all underwriting guidelines

30. Experience reports by line of business

31. Lag triangles and work papers used in the development of Unpaid Claim liabilities for year end 1999, 2000 & 2001 by line of business

32. All projections with supporting worksheets and source data or information regarding projections of the number of insureds in the Maryland individual and small group market as a result of the proposed acquisition

33. Current number of doctors and hospitals under contract

34. All current provider contracts

35. All statistical data that any other Team member requests

Requests Addressed to WellPoint:

36. While we appreciate that California does not require rates to be filed, we continue the need for the information that is typically included in such filings, *i.e.* WP must be able (albeit internally) to support their individual and small group rates.

37. CareFirst - NCQA accreditation history and results, CAHPS results, and HEDIS results for past 5 years (1997 - 2002)

38. WellPoint - NCQA accreditation history and results, CAHPS results, and HEDIS results for past 10 years (1992 - 2002)

39. Blue Cross Blue Shield of Georgia - NCQA accreditation history and results, CAHPS results, and HEDIS results for past 5 years (1997- 2002)

40. Blue Cross Blue Shield of Missouri - NCQA accreditation history and results, CAHPS results, and HEDIS results for past 5 years. (1999 - 2002)

41. With respect to the Experience Reports (Wakely Data Requests No. 5 and No. 6), we were advised that the information is in the 10-K filings with the SEC. While there is some breakout by "business segment" (Large Group, Small Group, etc) in Section 19 of the 10-K, the data is too broad and is missing important lines of information. Specifically, starting with the business segment information from Section 19 of the year 2001 10-K, we have the following request:

    a. First, we would like to see the segments split out into more detail. "Individual" medical shown separately from "Small Group" medical. "Individual" split into Senior (Med Supplement, Long-Term Care) and non-Senior medical experience; and "Small Group" medical shown separately from dental, life insurance, disability, etc.
    b. Secondly, please provide additional lines in the segment report for "Operating Expenses" (Incurred Claims, Selling Expense and G&A Expenses) so that we have a complete Income Statement for these lines of business.
    c. Finally, the experience report should be prepared separately for each geographic location (California, Texas Georgia, etc.) and for the calendar years originally requested.

Follow-up items pursuant to conference call with the Blackstone Group on November 8, 2002:

42. Revised forecast for the fourth quarter of 2002.

43. Revised 2003 forecast (as soon as its available).

44. "Run-rate" analysis for each of CareFirst's operating subsidiaries that was provided to CareFirst's auditors.

45. Please confirm whether the $300 million - $450 million of required investments (excluding acquisitions) that Accenture identified on page 11 of its November 23, 1999 presentation to CareFirst's Board of Directors was incremental to the capital expenditures in CareFirst's projections at the time.

46. An analysis of actual versus planned capital expenditures for 2002.

47. Please provide a copy of internal analysis regarding customer satisfaction of CareFirst and its competitors over time.

48. Additional detail on write-down of intangibles.

49. Additional detail on write-down of investments (as soon as its available).

Follow-up item from Delmarva Foundation:

50. Quality Management Plan, Policies and Procedures (Request #1). Well Point states that it is willing to provide all information regarding quality management, but it has not been made available to us. No deliverable time frames have been specified in the response. Please advise when it will be provided. We would like to obtain copies to allow us to review WellPoint's quality plan and procedures for the last 5 years. We also would like to review any quality committee minutes that would contain measures of performance in areas of healthcare and service delivery.

51. Member Services/Consumer Affairs/Documents/Policies and Procedures (Request #2). The information requested are customer service metrics. The letter notes "Internal customer service standards and guidelines are confidential and proprietary confidential information…." We are interested not only in the guidelines and standards but the actual results of performance of WellPoint's internal standards. Information provided to the State of California would give us some information but not sufficient detail to draw potential conclusions on how WellPoint applies those standards to reach their goals as set by the Member Service Committee that reports to leadership and to NCQA.

52. Benefits Documents/Policies and Procedures (Request #3). This request was not specifically addressed, and we were provided with promotional material that does not specifically answer our questions. We requested specific data that could easily be provided in a comparative spreadsheet. WellPoint states that "additional information is currently being gathered", but no deliverable date has been specified for their production. Please advise when it will be provided.

53. Payment Documents/Policies and Procedures (Request #4). We have asked for top 10 CPT and E & M fee schedules for all specialties for the last 5 years. Since state laws and regulations may effect benefits and coverage, Well Point could provide a summation of this information to help us better understand what information they have sent to us.

54. UM Documents/Policies and Procedures (Request #5). What is meant by WellPoint's response that it "... is determining whether it has additional documents responsive to this request that can be produced." When will this be provided?

55. PBM/Formulary Issues/Documents/Policies and Procedures (Request #6). Well Point can provide us any information as to how state requirements have shaped the pharmacy formularies.

56. Contract Documents/Policies and Procedures (Request #7). When will this be provided?

57. Network and Provider Relations Documents/Policies and Procedures (Request #8). Please explain what will be provided and when.

58. Claims Documents/Policies and Procedures (Request #9). Delmarva staff have requested to review the actual specifics or metrics as requested. The response summarizes applicable legal provisions and practices, but does not address the request. Nor is it obvious why the request requires disclosure of private medical information. In the main, the request inquires into procedural, statistical, and measurement data. This information is necessary for our review. Are you unwilling to provide all of the information requested?

⑤ **On November 14, 2002, Additional Document Requests Made by Delmarva Foundation Were Handed to Sandy Beard at CareFirst as a Result of Reviewing Quality Management and Medical Management Plan**

1. Modified Appropriateness Evaluation Protocol and procedure for amendments/approval of changes

2. Results of CareFirst Annual Customer Satisfaction Survey – 1997 through 2002

3. Results of Physicians and Office Administrator Satisfaction Surveys – 1997 through 2002

4. Care Management Committee Meeting Minutes and attachments 1997- 2002

5. Quality Improvement Committee Meeting Minutes and attachments 1997-2002

6. Results of Case Management Satisfaction Survey 2000-2001

7. Results of Hospitalist Program Satisfaction Survey 2000-2001

8. Longstanding Referral Process (was initiated in 1999)- provide written process.

9. Appeal volumes by line of business 2000 – 2001

10. Medial Necessity appeals 2000 – 2001

11. Non-medical necessity appeals 2000- 2001

⑥ **On November 15, 2002, the Following Additional Document Requests Were Forwarded to WellPoint by the Delmarva Foundation**

1. Results of Annual Customer Satisfaction Survey – 1997 through 2002
2. Results of Annual Physicians and Office Administrator Satisfaction Surveys – 1997 through 2002
3. Care/Case Management Committee Meeting Minutes and attachments 1997- 2002
4. Quality Improvement Committee Meeting Minutes and attachments 1997-2002
5. Appeal volumes by line of business 2000 – 2002 (HMO and federal program)
6. Medial Necessity appeals 1997 - 2002
7. Non-medical necessity appeals 1997- 2002

SCHEDULE F

DOCUMENTS GATHERED BY THE MIA

Source	BATE	BATES	DATE	DESCRIPTION
CF	1	12	05-Oct-00	Forwarding copy of Trigon Healthcare, Inc. Statement of Operations and Working Group list for Trigon and Merrill Lynch & Co. Trigon is nicknamed Turquoise
CF	239	291	13-Sep-02	State Comparison Analysis
CF	269	8	01-Aug-99	Invoice for Professional services re: General Matters dated from 8/1/99 to 12/1/00
CF	272	2901	13-Sep-02	State Comparison Analysis
CF	296	134		WellPoint Response to Document Request - Affidavits filed with other states, WellPoint products
CF	302		11-Jan-02	Transmittal letter for Application on behalf of CareFirst and WellPoint
CF	305	18	11-Jan-02	Form A Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer
CF	308	12	01-Oct-99	Invoices for professional services re: MAMSI dated 10/1/99 to 8/1/01
CF	315	90		Policy Considerations arising from a sale of the Maryland Plan
CF	329	25	01-Aug-99	Invoice for professional services re: Audit Responses dated 8/1/999 to 2/1/02
CF	333	28	18-Oct-00	CareFirst Financial Projections Combined Assumptions and Statements for years 1997 through 2003
CF	334	66	20-Nov-01	Exhibit 1-A-1 - Agreement and Plan of Merger by and Between WellPoint and CareFirst
CF	336	93	01-Oct-99	Invoices for professional services re: Reorganization dated 10/1/99 to 9/1/02
CF	342	88	21-Nov-00	Forwards copy of Confidential Bank Book "Draft Oxford Health Plans Senior Secured Credit Facilities Confidential Information Memorandum"
CF	342			Appendix A - Principal Terms of Plan of Conversion
CF	344	76		Appendix B - Definitions
CF	361	80		Appendix C - Articles of Merger between CareFirst, Inc. and Congress Acquisition Corp.
CF	369	87		Appendix D - Articles of Amendment and Restatement

CF	373	100		Appendix E - CareFirst Amended and Restated By-Laws
CF	381	123	22-Nov-00	Forwards copy of Board presentation "Project Chesapeake" prepared by Sand Beard
CF	387		01-Feb-00	Invoice for professional services re: DLJ Investment Bankers
CF	395		01-Jul-00	Invoice for professional services re: 100 S. Charles Street
CF	402	114	01-Aug-00	Invoices for professional services re: Genesis Health Ventures, Inc. dated 8/1/00 to 2/1/01
CF	409	2	15-Nov-02	Label and Index for Documents Responsive to Item One of Subpoena
CF	417	45	20-Nov-01	Draft CareFirst Merger Incentive Plans
CF	417	118		Appendix F - WellPoint Form Subordinated Note
CF	516	128	01-Dec-00	Invoices for professional services re: Sterling Health Care Group, Inc. dated 12/1/00 to 10/1/01
CF	875	121		Appendix G - Form of Affiliate Letter
CF	974	125		Appendix H - Indemnification Agreement
CF	974	292	01-Nov-00	Health Insurance/Managed Care Industry Overview & Investment Summary prepared by CSFB Health Care Research Group
CF	979		20-Nov-01	Attachment 9.10 - List of Executive Employees of CareFirst and Executive Employees of WellPoint
CF	979	128		Disclosure List of Schedules of WellPoint
CF	982	132	10-Jan-02	Schedule 5.1 - Organization, Qualification and Authorization
CF	1156	132	01-Mar-01	Invoices for professional services re: MPPI dated 3/1/01 to 6/1/01
CF	1159	166	01-Mar-01	Invoices for professional services re: Dimensions dated 3/1/02 to 8/1/02
CF	1261		10-Jan-02	Schedule 5.4 - No Violations; Consents and Approvals
CF	1333		10-Jan-02	Schedule 5.5 Capitalization; Valid Issuance
CF	1339	1345	16-Nov-01	Form A filed with Insurance Department of State of Missouri
CF	1341		10-Jan-02	Schedule 5.9 - Litigation; Judicial Proceedings
CF	1376		10-Jan-02	Schedule 5.11 - Employee Plans
CF	1391	138	20-Nov-01	CareFirst list of Disclosure Schedules
CF	1397	140	20-Nov-01	Section 4.1 - Organization, Qualification and Authorization

CF	1404	142	20-Nov-01	Section 4.4(a) No Violation; Consents and Approvals
CF	1415	146	20-Nov-01	Section 4.5(a) Financial Statements
CF	1447		20-Nov-01	Section 4.6(a)(ii) Reserves
CF	1452		10-Nov-01	Section 4.6(a)(iii) Reserves
CF	1453		10-Nov-01	Section 4.7(b) Taxes
CF	1475		20-Nov-01	Section 4.7(c) Taxes
CF	1542		20-Nov-01	Section 4.8(a), (b) Absence of Certain Changes or Events
CF	1547	153	20-Nov-01	Section 4.9(b) Litigation; Judicial Proceedings
CF	1549	160	20-Nov-01	Section 4.10(b) Compliance with Law
CF	1570	167	20-Nov-01	Section 4.11(a) Certain Contracts and Commitments
CF	1571	170	01-Jun-01	Invoices for professional services re: W.R. Grace
CF	1589		20-Nov-01	Section 4.11(b) Certain Contracts and Commitments
CF	1617	174	20-Nov-01	Section 4.12 Employee Plans; ERISA; Labor Matters
CF	1645		01-Nov-01	Invoice for professional services re: D.C. Building
CF	1649	180	01-Jan-02	Invoice for professional services re: Dimensions II dated 1/1/02 to 9/1/02
CF	1651		20-Nov-01	Section 4.12(f) Employee Plans; ERISA; Labor Matters
CF	1671		20-Nov-01	Section 4.12(h)(iii) Employee Plans; ERISA; Labor Matters
CF	1676		20-Nov-01	Section 4.12(j)(i) Employee Plans; ERISA; Labor Matters
CF	1687			Section 4.12(j)(ii) Employee Plans; ERISA; Labor Matters
CF	1695	180	20-Nov-01	Section 4.15(a) Environmental Matters
CF	1767	183	20-Nov-01	Section 4.15(e) Environmental Matters
CF	2138	187	01-Jan-97	Invoices for professional services re: General dated 1/1/97 to 5/1/02
CF	2303		20-Nov-01	Section 4.16 Non-competition Agreements
CF	2314	187	20-Nov-01	Section 4.18 Insurance Policies

CF	2322		01-Aug-99	Invoice for professional services re: Sale of Physicians Health Plan
CF	2335	203	20-Nov-01	Section 4.19 Intellectual Property
CF	2357	190	01-Jan-97	Invoices for professional services re: Patient Physicians dated 1/1/97 to 8/1/99
CF	2365		01-Oct-01	Invoice for professional services re: Audit Responses
CF	2367		01-Jul-02	Invoice for professional services re: Reorganization
CF	2370		01-Jul-00	Invoice for professional services re: Rouse Lease-Partnership/Owings Mills
CF	2385	197	01-Sep-00	Invoices for professional services re: Genesis Health Ventures, Inc. date4d 9/1/00 to 3/1/01
CF	2386		01-Mar-02	Invoice for professional services re: Capitation Recapture
CF	2394		01-Sep-01	Invoice for professional services re: Sterling Health Care Group, Inc.
CF	2480		01-Apr-01	Invoice for professional services re: Doctors
CF	2521	202	01-Mar-01	Invoice for professional services re: MPPI
CF	14008	206	01-Mar-01	Invoices for professional services re: Dimensions dated 3/1/01 to 4/1/02
CF	47	6332	10-Aug-01	Inquires as to availability for meeting prior to due diligence visit to Trigon
CF	61	6334	21-Feb-01	Letter informing Trigon of timing and procedures in pursuing possible transaction with CareFirst. Exhibit 102, Thomas Snead Deposition
CF	16333	6339	13-Aug-01	Informs that latest version of CareFirst document for WellPoint does include pricing mechanism in section 3.1(b) (note, all but one page of this email is blank)
CF-	1	205	20-Nov-01	Section 4.20 Real and Personal Property
CF-	2		21-Nov-01	Section 4.21 Affiliate Transactions
CF-	19		20-Nov-01	Section 6.1 Pre-Closing Operations
CF-	67	215	01-Dec-97	Invoices for professional services re: Employment Contract dated 12/1/97 to 7/1/00
CF-	68	211	20-Nov-01	Exhibit 1-A-2 - Certificate of Secretary and Resolutions of Board of Directors of CareFirst
CF-	77	214	20-Nov-01	Exhibit 1-A-3 Secretary Certificate and Resolutions of Board of Directors of Group Hospitalization and Medical Services, Inc.
CF-	81	217	20-Nov-01	Exhibit 1-A-4 - Secretary Certificate and Resolutions of Board of Directors of CareFirst of Maryland, Inc.
CF-	88	217	01-Jun-02	Invoice for professional services re: Sterling Investors

CF-	101	219	01-Jun-02	Invoice for professional services re: Personal
CF-	119	220	19-Nov-01	Exhibit 1-A-5 - Secretary certificate and Resolution of Board of Directors of BCBSD, Inc.
CF-	122	243	25-Sep-98	Draft of employment agreement between CareFirst and redacted name
CF-	126	322	10-Jan-02	Exhibit 1-A-6 - Community Impact Analysis of Proposed Conversion of CareFirst, Inc. to a For-Profit Business Entity and the Merger between CareFirst and WellPoint
CF-	127	273	14-Oct-98	Letter from Neuberger to Jews with attached employment contract and comments by Neuberger
CF-	129	331		Two draft copies of employment agreement between CareFirst and William Jews with comments by Neuberger firm
CF-	133	592	13-Sep-02	State Comparison Analysis: Information from State Departments of Insurance
CF-	133	592	13-Sep-02	State Comparison Analysis Information From State Insurance Departments Of Insurance
CF-	134	328		Executive Summary by DLJ discussing range of strategic alternatives available to CareFirst
CF-	135	42	20-Nov-01	Project Chesapeake, Presentation to Board of Directors
CF-	136	326	19-Nov-01	Exhibit 1-A-7 - Certificate of Secretary and Resolution of Board of Directors of WellPoint Health Networks
CF-	137	329	19-Nov-01	Exhibit 1-A-8 - Action taken by Unanimous Written Consent of Board of Directors of Congress Acquisition Corp.
CF-	139	363	27-Jul-00	"Project Chesapeake" presentation to CareFirst Strategic Planning Committee
CF-	141	423	31-Dec-00	Exhibit 2-B-1 - WellPoint Form 10-K for year ended 12/31/00
CF-	143	360		Draft employment agreement with hand written notes.
CF-	147	388		Draft of employment agreement with hand written notes re same
CF-	148	432	25-May-00	Forwarding final version of "Project Chesapeake" presentation to CareFirst Strategic Planning Committee dated 6/1/00
CF-	149	417		Draft of employment agreement with hand written notes re same
CF-	150			Employment agreement Section 19, Tax Reimbursement
CF-	151	438		Draft employment agreement between CareFirst and William Jews
CF-	152	518	31-Dec-99	Exhibit 2-B-2 - WellPoint Form 10-K for year ended 12/31/99
CF-	152	445	20-Nov-00	Forwards copy of "Project Chesapeake" presentation to Finance Committee & Strategic Planning Committee dated 11/21/00 with corrections made by Sandy Beard
CF-	154	460		Draft employment agreement between CareFirst and William Jews red lined copy

CF-	160	493	13-Oct-00	Forwards draft of "Project Chesapeake" presentation to Strategic Planning Committee dated 10/26/00
CF-	161	482		Draft employment agreement between CareFirst and unnamed executive red lined copy
CF-	164	487	30-Oct-98	Fax forwarding Jews contract with changes made which are acceptable to CareFirst
CF-	168	489	21-Oct-98	Ltr re: most recent employment agreement with questions and comments by Neuberger firm (note: contract not attached to letter)
CF-	169	510	30-Oct-98	Letter forwarding two copies of employment agreement with comments added from John Picciotto
CF-	175	495	24-Nov-00	Forwards copy of presentation page "Why not acquire another non-profit plan?" requesting that credit statistics presented on the page be confirmed
CF-	175	521	26-Nov-00	Forwards copy of Highmark ProForma Financials
CF-	176	531	04-Nov-98	Letter forwarding two copies of employment agreement to reflect changes in anniversary dates
CF-	177	608	31-Dec-98	Exhibit 2-B-3 - WellPoint Form 10-K for year ended 12/31/98
CF-	178	701	26-Nov-00	Forwarding Merger Models prepared by DLJ
CF-	179		19-Jul-01	One page fax re payment of severance, welfare benefits, out placement and merger retention bonus
CF-	179	536	05-Nov-01	Fax for conference call with Sharon Vecchioni and mark Muedeking
CF-	180	538		Chart reflecting benefits to WLJ in Trigon transaction
CF-	181		08-Nov-01	Chart reflecting duties of WLJ and TGS in Trigon transaction
CF-	184	542	23-Oct-01	Memorandum re: Geographic Expansion - Update
CF-	185		22-Oct-01	Chart reflecting titles and duties for Bill Jews and T Snead
CF-	188		30-Oct-01	Chart reflecting titles and duties for Bill Jews and T Snead
CF-	204		08-Dec-00	Draft of letter agreement between Trigon and CareFirst
CF-	206	553	13-Apr-00	Presentation CareFirst Trigon Plan Profile
CF-	207	556	18-Jul-01	Draft letter from T Snead to William Jews re: meeting and transaction with Trigon
CF-	208	559	14-Mar-01	Email re: Social issues chart reflecting comparison between Pacific and Atlantic
CF-	209	642	05-Mar-01	Facsimile forwarding copy of CareFirst/Trigon Term Sheet and draft Agreement of Merger
CF-	212	1653	13-Sep-02	State Comparison Analysis Individual State Research Part I Background documents
CF-	215	1653	13-Sep-02	State Comparison Analysis: Individual State Research Part I

CF-	218	686	31-Dec-97	Exhibit 2-B-4 - WellPoint Form 10-K for year ended 12/31/97
CF-	221	772	31-Dec-96	Exhibit 2-B-5 - WellPoint Form 10-K for year ended 12/31/96
CF-	221	733	04-Dec-00	"Project Chesapeake" presentation to Board of Directors
CF-	225	807	28-Nov-00	Forwards copy of WellPoint historical and financial projects
CF-	323	814	31-Dec-00	Exhibit 2-B-6 - WellPoint Annual Report for Year 2000
CF-	327	861	28-Nov-00	Forwards copy of CareFirst and WellPoint Merger Model
CF-	330	854	31-Dec-99	Exhibit 2-B-7 - WellPoint Annual Report for Year 1999
CF-	424	894	31-Dec-98	Exhibit 2-B-8 - WellPoint Annual Report for Year 1998
CF-	519	911	29-Nov-00	Forwards copy of "Project Chesapeake" presentation to Board dated 12/4/00 and directions and instructions for Board retreat.
CF-	609	930	31-Dec-97	Exhibit 2-B-9 - WellPoint Annual Report for Year 1997
CF-	687	120	01-Jan-00	Discussion of downstream risk issues.
CF-	773	967	29-Nov-00	Forwards copy of CareFirst and WellPoint merger model
CF-	815	993	31-Dec-96	Exhibit 2-B-10 - WellPoint Annual Report for Year 1996
CF-	855	982	29-Nov-00	Forwards copy of NewRun re: Anthem as of 11/00 prepared by CSFB
CF-	895	999	29-Nov-00	Forwards Cerulean analysis and CareFirst/WellPoint merger analysis.
CF-	931	1034	30-Sep-01	Exhibit 2-B-11 - WellPoint Form 10-Q for 9/30/01
CF-	994	24	02-Sep-99	Potential Synergies for meeting between TGS(Tom Snead) and WLJ (William Jews) Exhibit 101, Thomas Snead Deposition
CF-	1035	1141	30-Nov-00	Forwards copy of TGH Merger Model8
CF-	1037	1036		Exhibit 2-C-1 - Organizational Chart of WellPoint Corporate Structure prior to acquisition of CareFirst
CF-	1040	1039		Exhibit 2-C-2 WellPoint Organizational Charts after acquisition of CareFirst; after acquisition of CareFirst
CF-	1048	1047	18-Dec-01	Exhibit 3-A - Biographical Affidavit of Leonard David Schaeffer
Cf-	1054	1053	17-Dec-01	Exhibit 3-A - Biographical Affidavit of Woodson Toliver Besson
CF-	1059	1058	20-Dec-01	Exhibit 3-A - Biographical Affidavit of Roger Emil Birk
CF-	1066	1065	18-Dec-01	Exhibit 3-A - Biographical Affidavit of Sheila Patricia Burke

CF-	1072	1071	17-Nov-01	Exhibit 3-A - Biographical Affidavit of Stephen Lynn Davenport
CF-	1077	1076	19-Dec-01	Exhibit 3-A - Biographical Affidavit of Julie Anne Hill
CF-	1084	1083	21-Dec-01	Exhibit 3-A - Biographical Affidavit of Elizabeth Anne Weaver Sanders
CF-	1090	1089	18-Dec-01	Exhibit 3-A - Biographical Affidavit of Warren Yancey Jobe
CF-	1096	1095	20-Dec-01	Exhibit 3-A - Biographical Affidavit of Dennis Mark Weinberg
CF-	1102	1101	19-Dec-01	Exhibit 3-A - Biographical Affidavit of David Scott Helwig
CF-	1108	1107	18-Dec-01	Exhibit 3-A - Biographical Affidavit of Joan Elizabeth Herman
CF-	1114	1113	18-Dec-01	Exhibit 3-A - Biographical Affidavit of David Charles Colby
CF-	1120	1119	17-Dec-01	Exhibit 3-A - Biographical Affidavit of Thomas Christopher Geiser
CF-	1125	1124	18-Dec-01	Exhibit 3-A - Biographical Affidavit of Rebecca Ann Kapustay
CF-	1132	1131	18-Dec-01	Exhibit 3-A - Biographical Affidavit of Kenneth Casimir Zurek
CF-	1143	1142	18-Dec-01	Exhibit 3-A - Biographical Affidavit of Woodrow Augustus Myers, Jr.
CF-	1148	1201	01-Dec-00	Forwards copy of CareFirst/Trigon Merger Model
CF-	1150	1147	20-Nov-01	Exhibit 4-B - Opinion letter of Credit Suisse
CF-	1157	1149	20-Nov-01	Project Chesapeake Executive Summary
CF-	1161	1156	20-Nov-01	Project Chesapeake Process Review
CF-	1174	1160	20-Nov-01	Project Chesapeake Review of Pacific Proposal
CF-	1187	1173	20-Nov-01	Project Chesapeake Overview of Pacific
CF-	1404	1186	20-Nov-01	Project Cheeasapeake Valuation Analysis
CF-	1405	1403	20-Mar-01	Exhibit 4-C - Credit Agreement, 750 Million 5 Year Revolving Credit and Competitive Advance Facility
CF-	1445	1205	01-Dec-00	Forwards copy of announcement from First Union Securities re: Trigon offer to acquire BCBS Georgia's parent company Cerulean
CF-	1481	1208	02-Dec-00	Forwards copy of prudential Vector Healthcare Group's announcement that WellPoint had purchased Cerulean for $700 million
CF-	1483	1214	01-Dec-00	Forwards copy of Standard & Poor's Stock report on Trigon Healthcare
CF-	1531	171	14-Aug-00	Amednew.com articles re: BCBS plans see strength in consolidation.

CF-	1543	1226	01-Dec-00	Forwards copy of Prudential Vector Healthcare Group's announcement re: Trigon: the way a managed care company should be estimates and price target raised
CF-	1567	1230	01-Dec-00	Forwards copy of WellPoint Market Statistics spread sheet
CF-	1571	1288	01-Dec-00	Forwards copy of overview of WellPoint and CareFirst and Trigon merger model
CF-	1606	1298	01-Dec-00	Forwards copy of CareFirst Geographic Expansion Alternatives presentation to Board of Directors on 12//00
CF-	1608	1360	02-Dec-00	Forwards copy of CareFirst/WellPoint merger model
CF-	1609	3163	04-Nov-98	Form A Filing with Insurance and Safety Commissioner of Georgia
CF-	1610	1366	04-Dec-00	Forwards updated CareFirst Working Group List
CF-	1686	1372	05-Dec-00	Forwards financial statements of Trigon and WellPoint
CF-	1801	1384	05-Dec-00	Forwards copy of "Project Chesapeake" presentation to Board of Directors dated 12/4/00
CF-	1810	1386		Forwards WellPoint Financial Analysis spread sheet
CF-	1819	1395	05-Dec-00	Forwards copy of overview of WellPoint "Project Chesapeake" dated 12/6/00
CF-	1828	1484	06-Dec-00	Forwards copy of powerpoint presentation to S&P
CF-	1875			Exhibit 5-1 Biographical Affidavits of Proposed Directors and Executive Officers of CareFirst. None produced with Application. States will be produced at later date.
CF-	1878	1444	31-Dec-00	Exhibit 6-A-1 - CareFirst Annual Report for Year 2000
CF-	1881	1480	31-Dec-99	Exhibit 6-A-2 - CareFirst Annual Report for Year 1999
CF-	1884	1482	15-May-02	Transmittal letter with index of documents produced.
CF-	1891	1530	19-Nov-01	Project Congress Materials Prepared for Board of Directors
CF-	1898	1489	09-Dec-00	Forwards copy of Option Analysis - WellPoint
CF-	1905	1499	09-Dec-00	Forwards copy of Project Chesapeake Due Diligence Information Request List
CF-	1990	1521	12-Dec-00	Forwards copy of Due Diligence Outline Regarding Project Archer dated 2/1/00 with DLJ and Goldman Sachs
CF-	1998	1527	12-Dec-00	Forwards copy of Project Chesapeake Summary of Data Room Contents
CF-	2007	1529	14-Dec-00	Forwards list of missing items that may be identified in other tabs and requests clarification
CF-	2016	1536	14-Dec-00	Provides copy of CSFB Overview of CareFirst dated 12/00

CF-	2039	1542	01-Aug-97	Use and Abuse of the Medical Loss Ratio To Measure Health Plan Performance from Health Affairs
CF-	2044	1543	14-Dec-00	Forwards copy of CareFirst Working Group List as of 12/00
CF-	2050	1566	22-Apr-02	Piper Rudnick Advice to Board of Directors
CF-	2057	1550	15-Dec-00	Forwards copy of CSFB CareFirst Overview with suggested changes
CF-	2094	1552	15-Dec-00	Forwards copy of list of WellPoint as well as persons from Banc of America that will be attending meeting
CF-	2099	1561	15-Dec-00	Forwards copy of latest Project Congress Banc of America Securities Working Group List
CF-	2104		16-Dec-00	Provides list of additional legal items WellPoint request to see when the visit
CF-	2109	1570	16-Dec-00	Logistics and schedule for meetings with WellPoint
CF-	2172	1570		Due Diligence Data Room Contents
CF-	2177	1583	17-Dec-00	Provides copy of reconciliation of Financial Projections
CF-	2178	1605	26-Apr-01	Project Chesapeake Presentation to Board of Directors
CF-	2181	1592	17-Dec-00	Provides copy of Banc of America Project Congress Working Group List as of 12/16/00
CF-	2185	1599	17-Dec-00	Forwards final version of CSFB Overview of CareFirst dated 12/00
CF-	2186	1607	18-Dec-00	Forwards revised schedule for project congress visit
CF-	2189	1607	25-Apr-02	Affidavit of Gene E. Bauer
CF-	2193		23-Apr-02	Affidavit of John Picciotto
CF-	2194	1609	18-Dec-00	Working group list for Davis Polk & Wardwell
CF-	2197			Statement that CareFirst Strength Measure Reports have been placed in data room for review due to confidentiality
CF-	2226		18-Dec-00	Email addresses and phone numbers for Arthur Anderson contacts
CF-	2413	1685	22-Jan-98	CareFirst Organizational Meeting of Board of Directors, CareFirst Maryland, Group Hospitalization and Medical Services
CF-	2526	1622	21-Dec-00	CareFirst revised financial projections through 2003
CF-	2602	1624	22-Dec-00	Debevoise & Plimpton working group list
CF-	2722	1626	22-Dec-00	Steven Bloom contact information at Arthur Anderson
CF-	2793	1644	22-Dec-00	Forwards excel spread sheet re: IT discussion

CF-	2849	1718	22-Dec-00	Draft Stock Purchase Agreement with CareFirst
CF-	2888	2244	13-Sep-02	State Comparison Analysis: Individual State Research Part 2
CF-	3020	2244	13-Sep-02	State Comparison Analysis Individual State Research Part II Background documents
CF-	3052	1800	22-Jan-98	Organizational Meeting Orientation Book for Board Members of CareFirst, CareFirst of Maryland, Inc., and Group Hospitalization and Medical Services, Inc.
CF-	3074	1808	22-Dec-00	Forwarding copy of CareFirst Presentation to S&P
CF-	3143	245	31-Dec-01	California HMO annual report on complaints
CF-	3167	1799		CareFirst Presentation "Operations Quality"
CF-	3179	1809	26-Feb-98	CareFirst, Inc. Board of Directors Meeting Minutes
CF-	3216	1818	22-Dec-00	Forwarding copy of working group list and response to financial data requests
CF-	3243	1818	26-Feb-98	CareFirst of Maryland, Inc. Board of Director Meeting Minutes
CF-	3245	1826	22-Dec-00	Forwards timetable and working group list
CF-	3253	1827	26-Feb-98	Group Hospitalization and Medical Services, Inc. Board of Director Meeting Minutes
CF-	3255	1830	23-Dec-00	Response to Financial Data Requests
CF-	3263	1874	26-Feb-98	Handouts for Board of Director Meetings held 2/26/98 - Schedule of Meetings for 1998, Proposed Resolution for Telephone Participation Policy, CEO Report
CF-	3265	1830.1	27-Dec-00	Draft Definitions to Stock Purchase Agreement
CF-	3274	1844	29-Dec-00	Forwards spread sheet with membership breakdown used for the HMO Comps
CF-	3309	1845.47	29-Dec-00	Forwards draft of definitions and CareFirst Plan and Agreement of Merger, and memo from Piper Rudnick
CF-	3324	1925	02-Jan-01	Forwards copy of presentation to be made to WellPoint by CareFirst and requests that it be reviewed for fatal flaws
CF-	3337	1877	25-Mar-98	CareFirst, Inc. Board of Director Meeting Minutes
CF-	3348	1880	25-Mar-98	CareFirst of Maryland, Inc. Board of Director Meeting Minutes
CF-	3527	1883	25-Mar-98	Group Hospitalization and Medical Services, Inc. Board of Director Meeting Minutes
CF-	3529	1890	23-Apr-98	CareFirst Inc. Board of Director Meeting Minutes
CF-	3533	1897	23-Apr-98	CareFirst of Maryland, Inc. Board of Director Meeting Minutes

CF-	3535	1904	23-Apr-98	Group Hospitalization and Medical Services, Inc. Board of Director Meeting Minutes
CF-	3539	1989	23-Apr-98	Handouts for Board Meetings held 4/23/98 - Board Resolution re: Asset Allocation & Management Company, 1998 Combined Business Plan Overview
CF-	3541	1938	03-Jan-01	CSFB financial projections
CF-	3545	1961	03-Jan-01	Forwards external and internal only CareFirst Working Group Lists
CF-	3613	1967	03-Jan-01	Forwards copy of Desk Notes by CSFB on WellPoint Health Networks
CF-	3620	2091	04-Jan-01	Forwards copy of CSFB reports "Fundamentals of the Sector and how Health insurance works" and Accounting Primer 2000 Health Insurance/Managed Care
CF-	3627	1997	25-Jun-98	CareFirst, Inc. Board of Director Meeting Minutes
CF-	3634	2006	25-Jun-98	CareFirst Maryland, Inc. Board of Director Meeting Minutes
CF-	3666	2015	25-Jun-98	Group Hospitalization and Medical Services, Inc. Board of Director Meeting Minutes
CF-	3668	2038	25-Jun-98	Handouts for Board Meeting 6/25/98 - Biographical Summary of Anne Osborne, CareFirst Philosophy, Brand Excellence Success and Award
CF-	3673	2043	30-Jul-98	CareFirst, Inc. Board of Director Meeting Minutes
CF-	3675	2049	30-Jul-98	CareFirst of Maryland, Inc. Board of Director Meeting Minutes
CF-	3680	2056	30-Jul-98	Group Hospitalization and Medical Services, Inc. Board of Director Meeting Minutes
CF-	3682	2093	30-Jul-98	Handouts for Board Meetings 7/30/98 - Resolutions re: Pension Equity Plan of CareFirst, Mid Year Report to Companies
CF-	3687	2111	04-Jan-01	Forwards copy of research memorandum regarding executive compensation and graphs to show how CareFirst compares to other companies
CF-	3763	2098	22-Oct-98	CareFirst, Inc. Board of Director Meeting Minutes
CF-	3768	2103	22-Oct-98	CareFirst of Maryland, Inc. Board of Director Meeting Minutes
CF-	3773	2108	22-Oct-98	Group Hospitalization and Medical Services, Inc. Board of Director Meeting Minutes
CF-	3778	2171	22-Oct-98	Handouts for Board Meetings 10/22/98 - Resolutions Ins. Commissioner of Maryland appointed Resident Agent of company, Third Quarter Report to Companies
CF-	3823	2115	04-Jan-01	Provides power point slides on membership comparison, total revenue comparison net income comparison with Aetna, WellPoint, Pacificcare, Oxford, Trigon, CareFirst and Rightchoice
CF-	3829	2170	04-Jan-01	Provides draft of Agreement and Plan of Merger
CF-	3832	2449	04-Jan-01	Forwards spread sheets of September 2000 cash flow statements for CFI, CFMD and GHMSI

CF-	3837	2176	06-Dec-98	CareFirst, Inc. Board of Director Meeting Minutes
CF-	3840		06-Dec-98	CareFirst, Inc. Executive Session Meeting Minutes
CF-	3845	2180	07-Dec-98	CareFirst Minutes of Annual Planning Session of Board of Directors
CF-	3851	2184	06-Dec-98	Group Hospitalization and Medical Services, Inc. Annual Meeting of Board of Directors Minutes
CF-	3903		06-Dec-98	Executive Session of Group Hospitalization and Medical Services, Inc. Meeting Minutes
CF-	3928	2188	07-Dec-98	Group Hospitalization and Medical Services, Inc. Annual Planning Session of Board Meeting Minutes
CF-	3986	2192	06-Dec-98	CareFirst of Maryland, Inc. Annual Board of Director Meeting Minutes
CF-	4046		06-Dec-98	CareFirst of Maryland Executive Session of Board of Directors
CF-	4074	2196	07-Dec-98	CareFirst of Maryland, Inc. Annual Planning Session of Board Meeting Minutes
CF-	4076	2225	06-Dec-89	Handouts for Board Meetings 12/6/98 Agenda for annual meeting and Strategic Planning Conference, Executive Retirement Plans, Year End 1998 Report to Companies
CF-	4082	2412		Additional handouts for Board Meetings - Reaffirm Strategic Vision 2000, 1999 Operations/Systems Strategy, 1999 Financial Plan, 1999 Marketing Strategy
CF-	4084	2967	13-Sep-02	State Comparison Analysis: Individual State Research Part 3
CF-	4090	2967	13-Sep-02	State Comparison Analysis Individual State Research Part III Background documents
CF-	4092	2525	26-Feb-98	BCBS of Maryland Strategic Planning Committee Meeting Minutes - Presentations by Bear Stearns and Lewin Group
CF-	4098		08-Jan-01	request by Wendy Somera o Piper Rudnick to be added to working group list
CF-	4128	2452	10-Jan-01	Forwards updated CareFirstTimeline
CF-	4136	2455	12-Jan-01	Letter to CareFirst suggesting that they implement some form of management retention agreements in consultation with outside consultants.
CF-	4138	2463	12-Jan-01	Forwards copy of updated working group list
CF-	4145	364	30-Sep-02	WellPoint Form 10-Q (two copies)
CF-	4147	2473	12-Jan-01	CSFB financial projections based on final 2000-011 Combined Assumptions and Statements
CF-	4154	2498	12-Jan-01	Forwards copy of CareFirst 2001 Financial Plan
CF-	4156	2517	17-Jan-01	Forwarding copy of CareFirst 1999 S&P Rating Report
CF-	4200	2532	18-Jan-01	Forwards copy of presentation "Executive Summary" which has been revised

CF-	4202	2601	23-Apr-98	CareFirst, Inc. Strategic Planning Committee Meeting Minutes
CF-	4204	2577	18-Jan-01	Forwards copy of Bear Stearns reports on Trigon and WellPoint
CF-	4206	2585	18-Jan-01	Forwards copy of WellPoint Desk Notes prepared by CSFB Equity Research
CF-	4213	2598	18-Jan-01	Forwards copy of revised presentation "Executive Summary"
CF-	4219	2675	22-Jan-01	Forwarding revised versions of Agreement and Plan of Merger and Definitions
CF-	4226	2721	25-Jun-98	CareFirst, Inc. Strategic Planning Committee Meeting Minutes
CF-	4319	2678	22-Jan-01	Forwards list of Discussion topics for meeting regarding what representation on board, what organization will result after merger, relocating corporate headquarters, what is plan for name after transaction and what further employment levels to expect
CF-	4322	2682	23-Jan-01	Forwarding spread sheet of WellPoint and Trigon compensation analysis
CF-	4325	2694	23-Jan-01	Forwards proposed schedules for meetings
CF-	4328	2698	23-Jan-01	Forwards updated WellPoint and Trigon Compensation analysis
CF-	4336	2700	23-Jan-01	Forwards agenda for CareFirst visit to WellPoint
CF-	4343	2704	24-Jan-01	Forwards copy of CareFirst bidding procedure letter for review
CF-	4344	2708	25-Jan-01	Forwards templates for valuation
CF-	4351	2711	26-Jan-01	Provides copy of geographic expansion time line
CF-	4352	2742	26-Jan-01	Forwards copy of presentation to Trigon
CF-	4359	2792	30-Jul-98	CareFirst, Inc. Strategic Planning Committee Meeting Minutes
CF-	4360		08-Feb-01	Wants confirmation on Monday deliverables to include changes to key criteria matrix, if any, Interloper analysis, Anthem response and preparatory materials for meeting with Jews and Snead
CF-	4417	2747	26-Jan-01	Forwards bulleted review of Trigon meeting and attempt to respond to questions regarding how other constituents view Trigon and WellPoint
CF-	4422		26-Jan-01	Suggested changes to CareFirst Merger Agreement re: definition of CareFirst Material adverse effect; drop dead date of one year; reference to approval of Maryland Policyholders?; breakup fee
CF-	4427	2757	30-Jan-01	Meeting Agendas for WellPoint meetings with logistics
CF-	4431	2763	05-Feb-01	Forwards highlights of meeting with Trigon and power point presentation on stakeholder view of Trigon and WellPoint
CF-	4436	2771	08-Feb-01	Forwards coy of presentation "Key Transaction Issues"
CF-	4441	2775	12-Feb-01	Forwards draft letter to Larry Glasscock re: interest in bid process

CF-	4446	2788	13-Feb-01	Forwards agenda for conference call including Key Criteria document
CF-	4635	2790	13-Feb-01	Forwards copy of agenda for CareFirst and CSFB discussion on 2/13/01
CF-	4665		14-Feb-01	WellPoint EPS calculation in WellPoint model adjusts for adds back after tax interest costs from a convert issued in 1999.
CF-	4702	2796	14-Feb-01	Forwards copy of Sunspot article " CareFirst eyes shift to for-profit"
CF-	4792	2848	23-Sep-98	CareFirst, Inc. Strategic Planning Committee Meeting Minutes
CF-	4848	2829	14-Feb-01	Forwards copy of material for SPC 2/22/01 meeting and agenda for same.
CF-	4900	2831	14-Feb-01	Letter regarding response to letter to Anthem
CF-	5028	2882	16-Feb-01	Forwarding WellPoint Historical and Projected Quarterly Consolidated Statements of Income
CF-	5169	2887	22-Oct-98	CareFirst, Inc. Strategic Planning Committee Meeting Minutes
CF-	5176	2884	16-Feb-01	Summary of conference call on 2/16/01 by Elizabeth Grieb, Isaac Nueberger, John Picciotto, Sharon Vecchioni, David Wolf, and CSFB
CF-	5181	2890	19-Feb-01	Forwards revised version of articles of Merger and principal terms of plan of conversion
CF-	5186	3019	24-Nov-98	CareFirst, Inc. Strategic Planning Committee and Finance Committee Meeting Minutes
CF-	5191	2918	20-Feb-01	Provides copy of agenda SPC meeting, profile of Trigon and WellPoint, Key transaction issues list and Interloper analysis by CSFB
CF-	5234	2926	20-Feb-01	Provides revised Geographic Expansion Time Line for comments
CF-	5240	2929	20-Feb-01	Provides addendum to bidding procedures letter for Trigon and WellPoint
CF-	5242	2994	20-Feb-01	Forwards revised version of Agreement and Plan of Merger
CF-	5248	3028	13-Sep-02	Interview Findings
CF-	5250	3028	13-Sep-02	Interview Findings
CF-	5256	3126	20-Feb-01	Provides revised version of Agreement and Plan of Merger with change to section 6.10 second sentence
CF-	5258	3051	23-Feb-98	BCBS of Maryland Executive Compensation Committee Meeting Minutes
CF-	5264	3049	13-Sep-02	Maryland Market and Regulatory Environment
CF-	5266	3049	13-Sep-02	Maryland market and Regulatory Environment
CF-	5330	3093	13-Sep-02	Maryland's Hospital Rate Setting System

CF-	5334	3093	13-Sep-02	Maryland's Hospital Rate Setting System
CF-	5338	3073	26-Feb-98	BCBS of Maryland Executive Compensation Committee Meeting Minutes
CF-	5342	3142	23-Apr-98	BCBS of Maryland Executive Compensation Committee Meeting Minutes
CF-	5344	3296	13-Sep-02	Literature Review Findings
CF-	5346	3296	13-Sep-02	Literature Review Findings
CF-	5348	3192	20-Feb-01	Provides clean version of Agreement and Plan of Merger which includes appendices A and c
CF-	5394	3166	25-Jun-98	BCBS of Maryland Executive Compensation Committee Meeting Minutes
CF-	5401	3165		WellPoint Health Networks Inc. Holding Company System Listing of Insurers
CF-	5408	3271	12-Jul-02	Documents produced by WellPoint to the Blackstone Group on July 12, 2002 - including financials, and chronology of events re: bid for CareFirst
CF-	5415	3178	30-Jul-98	CareFirst, Inc. Executive Compensation Committee Meeting Minutes
CF-	5476	3215	22-Oct-98	CareFirst, Inc. Executive Compensation Committee Meeting Minutes
CF-	5485	3194	21-Feb-01	Provides revised version of Geographic Expansion time line
CF-	5493	3197	21-Feb-01	Provides addendum to bidding procedures for WellPoint and Trigon
CF-	5501	3222	23-Feb-01	Provides copy of CareFirst BCBS Merger/Conversion Communications packages which contains press release and contact list
CF-	5713	3242	03-Dec-98	BCBS of Maryland Executive Compensation Committee Meeting Minutes
CF-	5756	3267	26-Feb-01	Provides copy of "Project Chesapeake" presentations to Board of Directors dated February 2001
CF-	5785	3244	25-Feb-99	CareFirst Executive Session Meeting Minutes
CF-	5806	3254	22-Feb-99	CareFirst, Inc. Board of Director Meeting Minutes
CF-	5822	3254	25-Feb-99	CareFirst of Maryland, Inc. Executive Session Meeting Minutes
CF-	5852	3262	25-Feb-99	CareFirst of Maryland, Inc. Board of Directors Meeting Minutes
CF-	5902	3264	25-Feb-99	Group Hospitalization and Medical Services, Inc. Executive Session Minutes
CF-	5936	3273	25-Feb-99	Group Hospitalization and Medical Services, Inc. Board of Director Meeting Minutes
CF-	5966	3280	22-Mar-02	Transmittal letter enclosing documents responsive to document request dated 2/22/02. In addition, provides chart reflecting

CF-	5995	3308	25-Feb-99	Handouts for Board Meetings 2/25/99 - CEO Report, correspondence with Governor Glendening re: affiliation with BCBS Delaware
CF-	6005	3282	27-Feb-01	Forwards copy of Larry Glasscock's 2/26/01 letter to William Jews. Requests a draft response for William Jews by next day
CF-	6028	3328	19-Nov-01	Project Congress Materials Prepared for the Board of Directors (WellPoint)
CF-	6032	3292	05-Mar-01	Provides draft of summary of key terms of Atlantic and Pacific
CF-	6108	3295	07-Mar-01	Provides copy of CFI EBIT Analysis for 1998-2000
CF-	6166	3311	09-Mar-01	Provides copy of due diligence list
CF-	6242	3305	13-Sep-02	CareFirst and WellPoint "Plan Performance" Comparison
CF-	6313	L0003305	13-Sep-02	CareFirst and WellPoint "Plan Performance" Comparison
CF-	6315	3316	13-Sep-02	Analysis of the Financial Performance and Health of WellPoint and CareFirst
CF-	6316	3316	13-Sep-02	Analysis of the Financial Performance and Health of WellPoint and CareFirst
CF-	6318	3323	22-Apr-99	CareFirst, Inc. Board of Director Meeting Minutes
CF-	6320		15-Mar-01	Request material for meeting with Bill Jews and Isaac Neuberg on soft issues
CF-	6323		15-Mar-01	requests review of Wisconsin website regarding comparison of BCBS conversions at
CF-	6325	3316	15-Mar-01	Provides copy of corporate organizational chart for WellPoint and Trigon
CF-	6326	3368	19-Mar-01	Provides copy of WellPoint Historical & Projected Quarterly Consolidated Statements of Income
CF-	6327	3336	22-Apr-99	CareFirst of Maryland, Inc. Board of Director Meeting Minutes
CF-	6329	3334		Health Insurance Portability and Accountability Act (HIPAA)
CF-	6331	3343		IT 2002-2004 Strategic Plan IT Vision
CF-	6335	3347	22-Apr-09	Group Hospitalization and Medical Services, Inc. Board of Director Meeting Minutes
CF-	6339	3345	29-May-01	Minutes of WellPoint Health Networks Inc. Board of Directors Meeting
CF-	6343		01-Jun-01	Minutes of WellPoint Health Networks Inc. Board of Directors Meeting
CF-	6346		01-Nov-01	Minutes of WellPoint Health Networks Inc. Board of Directors Meeting
CF-	6347	3526	13-Apr-99	Handouts for Board Meetings for 2/22/99 - CEO Report, Final Assessment Report for NCQA Accreditation Survey of Capital Care, Statutory Financial Statements for 1998, 1997
CF-	6355	3351	19-Nov-01	Minutes of WellPoint Health Networks Inc. Board of Directors Meeting

CF-	6358	3373		Standard & Poor's Research re: WellPoint Health Networks for June 1999 through January 2002
CF-	6360	3370	20-Mar-01	Provides update for CareFirst working group to include R.W. Smith, Staci Dufour, and Celestin Kellam
CF-	6363	3419	20-Mar-01	Provides copy of Trigon Historical and Projected Consolidated Quarterly Statements of Income
CF-	6365	3394		FITCH and Duff & Phelps credit update for WellPoint
CF-	6366	3430		Best Ratings for BC Life & Health Insurance, BCBS Healthcare Plan of Georgia, Blue Cross of California, Greater Georgia Life Insurance Company
CF-	6367	3459	21-Mar-01	Provides paragraph by paragraph comment by Trigon and WellPoint to merger
CF-	6438	3563	16-Nov-01	WellPoint Policy Forms filed with state of Missouri
CF-	6475	3463	22-Mar-01	Provides updated "Summary of Major Issues"
CF-	6524	3487	22-Mar-01	Provides copies of material to be presented to Strategic Planning Committee on 3/23/ with includes financial performance
CF-	6580	3496	26-Mar-01	Provides files containing projected calculations for 2001 and 2002 tax rate
CF-	6623	3498	01-Apr-01	Provides copy of updated Geographic Expansion Board and Committee Timeline
CF-	6704	3504	02-Apr-01	Provides CareFirst Maryland Market Share by Competitor - Insurable Population
CF-	6792	3520	04-Apr-01	Provides copy of updated due diligence list and logistics. Request clarification on narrowing activities to the "preferred partner" but does not identify that partner
CF-	6878	3551	12-Apr-02	Provides copies of finance committee reports as requested
CF-	7060	3528	24-Jun-99	CareFirst, Inc. Executive Session Board of Director Meeting Minutes
CF-	7119	3532	24-Jun-99	CareFirst, Inc. Board of Director Meeting Minutes
CF-	7153	3534	24-Jun-99	CareFirst of Maryland, Inc. Executive Session Board of Director Meeting Minutes
CF-	7198	3538	24-Jun-99	CareFirst of Maryland, Inc. Board of Director Meeting Minutes
CF-	7238	3540	24-Jun-99	Group Hospitalization and Medical Services Executive Committee Meeting Minutes
CF-	7431	3544	24-Jun-99	Group Hospitalization and Medical Services, Inc. Board of Director Meeting Minutes
CF-	7472	3612	24-Jun-99	Handouts for Board Meetings 6/24/99 - Investment Resolution, CEO Report
CF-	7492	3553	12-Apr-01	Provides updated version of Geographic Expansion Board and Committee Timeline
CF-	7497	3558	12-Apr-01	Provides BCBS Delaware and Subsidiaries December Consolidated Operating Results for 2000

CF-	7525	3686	12-Apr-01	Provides clean and red line version of Pacific Agreement and Plan of Merger
CF-	7533	3626		Prefiled Written Testimony and Hearing Testimony before the MIA of Deborah Lachman
CF-	7580	3619	23-Sep-99	CareFirst, Inc. Board of Director Meeting Minutes
CF-	7596	3626	23-Sep-99	CareFirst of Maryland, Inc. Board of Director Meeting Minutes
CF-	7617	3633	23-Sep-99	Group Hospitalization and Medical Services, Inc. Board of Director Meeting Minutes
CF-	7654			Table of Contents of Binder 1
CF-	7668	3647	01-Jul-00	Blue Cross of California Prudent Buyer Plan
CF-	7672	3665	23-Sep-99	Handouts for Board Meeting held 9/23/99 - CEO report
CF-	7727	3704	13-Feb-02	California Carfe Medical Services Agreement
CF-	7797	369	31-Dec-01	CareFirst 5 year historical data from annual statement faxed to Jack Zale from Don Brandenberg
CF-	7943	3667	28-Oct-99	CareFirst, Inc. Executive Session of Board of Directors Meeting Minutes
CF-	7955	3672	28-Oct-99	CareFirst, Inc. Board of Director Meeting Minutes
CF-	8035	3674	28-Oct-99	CareFirst of Maryland, Inc. Executive Session Meeting Minutes
CF-	8110	3679	28-Oct-99	CareFirst of Maryland, Inc. Board of Director Meeting Minutes
CF-	8114	3681	28-Oct-99	Group Hospitalization and Medical Services, Inc. Executive Session Meeting Minutes
CF-	8118	3686	28-Oct-99	Group Hospitalization and Medical Services, Inc. Board of Director Meeting Minutes
CF-	8120	3762	28-Oct-99	Handouts for Board Meeting 10/28/99 - Executive Session, CEO Report
CF-	8122	3714	17-Apr-01	Provides 2001 Financial Plan for CFMI, GHMSI and BCBSD, Inc.
CF-	8263	371	27-Nov-02	Letter regarding Children's National Medical Center notification of no longer participating in CareFirst network.
CF-	8283	3766	19-Feb-02	Blue Cross of California Comprehensive Contracting Hospital Agreement for Comprehensive Hospital
CF-	8293	3718	18-Apr-01	Provides copy of Cash Flow Equipment Purchase Summary
CF-	8303	3722	18-Apr-01	Provides copy of CareFirst Risked Based Capital Summary
CF-	8524	373	31-Dec-01	Pages from CareFirst 2001 Annual Report showing enrollment by product and financial highlights
CF-	8528	3812	18-Apr-01	Provides updated copy of CFS Membership 3-01

CF-	8532	382		Response from California Department of managed health care to DelMarva general inquiries
CF-	8533	3767	23-Nov-99	CareFirst, Inc. Board of Director Meeting Minutes
CF-	8536	3798	29-Mar-02	California Care Hospital Services Agreement Direct Service Plan
CF-	8538	3772	23-Nov-99	CareFirst of Maryland, Inc. Board of Director Meeting Minutes
CF-	8544	3777	23-Nov-99	Group Hospitalization and Medical Services, Inc. Board of Director Meeting Minutes
CF-	8563	3822	23-Nov-99	Handouts for Board Meeting 11/23/99 - Strategy Implications Discussion, CEO Report
CF-	8565	3888	01-Jul-00	California Care Risk Professional and Institutional Services Agreement
CF-	8568		19-Apr-01	Advises that PPPA audited financials are not yet available
CF-	8587	3845	19-Apr-01	Provides list of items requested in due diligence and confirmatory due diligence data request list
CF-	8625	3828	05-Dec-99	CareFirst, Inc. Board of Director Meeting Minutes
CF-	8643	3831	06-Dec-99	CareFirst, Inc. Board of Director Planning Session Meeting Minutes
CF-	8662	384	11-Dec-02	Letter explaining WellPoint calculation of medical loss ration when comparing CareFirst with WellPoint
CF-	8681	3836	05-Dec-99	CareFirst of Maryland, Inc. Board of Director Meeting Minutes
CF-	8685	3839	06-Dec-99	CareFirst of Maryland Annual Planning Session Meeting Minutes
CF-	8690	3844	05-Dec-99	Group Hospitalization and Medical Services, Inc. Board of Director Meeting Minutes
CF-	8700	3850	06-Dec-99	Group Hospitalization and Medical Services, Inc. Annual Planning Session Meeting Minutes
CF-	8754	3857	19-Apr-01	Provides copy of presentation re: 2001 administrative expenses of CFMI and GHMSI
CF-	8757	410	01-Jul-02	Provides information relevant to community impact study
CF-	8759	3902	25-Feb-99	Executive Compensation Committee of BCBS
CF-	8884		19-Apr-01	Informs that FEP contract with BCBSA is renewed annually and there are no issues at this time.
CF-	8886	3860	19-Apr-01	Letter from Stuart Smith to David Platter regarding submission of Trigon bid and if there are changes to same, must be received by 4/23/01
CF-	8906	3862	19-Apr-01	Confirmatory diligence discussion re: contact names, Delaware information and indemnification and confidentiality agreements with M&R and Arthur Andersen
CF-	8918	3867	19-Apr-01	Provides copy of CFI stand-alone net, income statements

CF-	8921		19-Apr-01	Request email address for lawyers for Pacific
CF-	9048	3999	19-Apr-01	Provides clean and red lined versions of Agreement and Plan of Merger dated 4/19/01
CF-	9056	3917	04-Jun-02	Blue Cross of California Comprehensive Participating Provider Agreement
CF-	9074	3927	22-Apr-99	Executive Compensation Committee Meeting Minutes of BCBS
CF-	9199	3958	01-Jul-00	Blue Cross of California Comprehensive Participating Provider Agreement For Home Care Services
CF-	9201	3985	24-Jun-99	Executive Compensation Committee of BCBS Meeting Minutes
CF-	9266	3991	29-Apr-02	Blue Cross of California Medical Products and Services Agreement
CF-	9396	4045	23-Sep-99	Executive Compensation Committee of CareFirst BCBS Meeting Minutes
CF-	9475	4032	28-Sep-00	Blue Cross of California Transplant Network Agreement (centers for expertise)
CF-	9593	4042	20-Apr-01	Provides draft of representations and warranties section of merger agreement for review.
CF-	9595	4090	13-Feb-02	Blue Cross Senior Secure Medicare + Choice Medical Services Agreement
CF-	9597		20-Apr-01	Provides telephone numbers for contacts for weekend
CF-	9608	4046	20-Apr-01	Provides copy of CareFirst Financial Projection for 2001 - 2008
CF-	9727	4073	28-Oct-99	Executive Compensation Committee of CareFirst BCBS Meeting Minutes
CF-	9741	4086	20-Apr-01	Provides CareFirst Tax Calculations
CF-	9742	4075	22-Feb-00	CareFirst, Inc. Executive Session Meeting Minutes
CF-	9770	4081	22-Feb-00	CareFirst, Inc. Board of Director Meeting Minutes
CF-	9806	4083	22-Feb-00	CareFirst of Maryland, Inc. Executive Session Meeting Minutes
CF-	9857	4089	22-Feb-00	CareFirst of Maryland, Inc. Board of Director Meeting Minutes
CF-	9884	4091	20-Apr-01	Provides copy of Pacific Deal Improvement Points on Critical Issues
CF-	9917	4091	22-Feb-00	Group Hospitalization and Medical Services Executive Session Meeting Minutes
CF-	9953			Blue Cross of California Index of Provider Agreements
CF-	10008	4097	22-Feb-00	Group Hospitalization and Medical Services, Inc. Board of Director Meeting Minutes
CF-	10078	4128	01-Jul-00	Blue Cross Senior Secure Medicare + Choice Hospital Services Agreement

CF-	10130	4131	21-Apr-01	Provides copy of Revised Tax Calculation for CareFirst
CF-	10191	4217	22-Feb-00	Handouts for Board Meetings held 2/22/00 - Committee Structure/Appointments, Presidents Message, CEO Report
CF-	10271	428	02-Dec-02	DelMarva Foundation Audit
CF-	10332	4135	27-Apr-00	CareFirst, Inc. Board of Director Meeting Minutes
CF-	10388	4188	01-Feb-01	Blue Cross Senior Secure Medicare + Choice Professional Services Agreement
CF-	10420	4150	22-Apr-01	Providing comments on executive summary presentation
CF-	10439	4137	27-Apr-00	CareFirst, Inc. Executive Session Meeting Minutes
CF-	10500	4144	27-Apr-00	CareFirst of Maryland, Inc. Board of Director Meeting Minutes
CF-	10555	4146	27-Apr-00	CareFirst of Maryland, Inc. Executive Session Meeting Minutes
CF-	10625	4153	27-Apr-00	Group Hospitalization and Medical Services, Inc. Board of Director Meeting Minutes
CF-	10684	4158	23-Apr-01	Provides copy of Summary of Major Issues presentation
CF-	10722	4155	27-Apr-00	Group Hospitalization and Medical Services, Inc. Board Executive Session Meeting Minutes
CF-	10770	4199	27-Apr-00	Handouts for Board Meeting held 4/27/00 - CEO Report
CF-	10800	4174	23-Apr-01	Provides copy of due diligence request list
CF-	10810	4179	23-Apr-01	Provides copy of Summary of Major Issues to be presented to SPC meeting
CF-	10835	4183	23-Apr-01	Provides copy of 2001 Financial Forecast by Legal Entities
CF-	10879	4242	23-Apr-01	Provides electronic versions of CareFirst IBC materials
CF-	10937	4250	13-Mar-98	Blue Cross Senior Secure Medicare Risk Professional and Institutional Services Agreement
CF-	11086	4201	30-Jun-00	CareFirst, Inc. Special Meeting of Board of Directors Minutes
CF-	11104	4203	30-Jun-00	CareFirst of Maryland, Inc. Special Board of Director Meeting Minutes
CF-	11150	4205	30-Jun-00	Group Hospitalization and Medical Services, Inc. Special Board of Director Meeting Minutes
CF-	11187	4212	27-Jul-00	CareFirst, Inc. Board of Director Meeting Minutes
CF-	11230	4218	27-Jul-00	CareFirst of Maryland, Inc. Board of Director Meeting Minutes
CF-	11304	4225	27-Jul-00	Group Hospitalization and Medical Services, Inc. Board of Director Meeting Minutes

CF-	11357	4318	27-Jul-00	Handouts for Board Meeting held on 7/27/00 - Organizational Changes, CEO Report
CF-	11381	4254	24-Apr-01	Provides corporate overview of WellPoint and Trigon and 2000 financial performance comparison
CF-	11408	4273	03-Nov-97	Medi-Cal managed Care Program Participating Physician Agreement
CF-	11484	4258	24-Apr-01	Letter from WellPoint, among other things, increasing their bid to 1.3 billion
CF-	11531	4276	25-Apr-01	Provides copy of Hay Management consultants letter to Care First Compensation committee
CF-	11533	4292	21-Oct-02	Medi-Cal Managed Care Program Participating Physician Agreement for Emergency Room Physicians
CF-	11535	4336	25-Apr-01	Provides copies of electronic versions of CareFirst IBC materials.
CF-	11563	482	31-Dec-00	2000 HMO Performance Assessment Survey Report
CF-	11565	4335	17-Feb-00	AIM Medical Services Agreement
CF-	11626	44	15-Nov-02	CSFB List of Documents Produced in Annex 9A
CF-	11630	4321	28-Sep-00	CareFirst, Inc. Emergency Board of Directors Meeting Minutes
CF-	11634	4324	28-Sep-00	CareFirst of Maryland, Inc. Emergency Board of Director Meeting Minutes
CF-	11639	4327	28-Sep-00	Group Hospitalization and Medical Services, Inc. Emergency Board of Director Meeting Minutes
CF-	11644	4335	28-Sep-00	Handout for Emergency Board Meeting held 9/28/00 - Financial Review - Segment Performance and Medicaid Program Recommendation
CF-	11650	4376	30-Sep-00	Blue Cross of California Medi-Cal Managed Care Program Participating Hospital Agreement
CF-	11653	4342	26-Oct-00	CareFirst, Inc. Board of Director Meeting Minutes
CF-	11660		27-Apr-01	Provides 3 proposals for communications with Trigon. Also would be willing to sit down with Jews and Neuberger regarding compensation issues
CF-	11667		27-Apr-01	Discussion regarding message to Trigon as outlined before, not sure Jews is comfortable with compensation issue
CF-	11670	4340	27-Apr-01	Forwarding schedule of WellPoint participants
CF-	12058	4356	30-Apr-01	CFI Stated-alone net Income Statements
CF-	12071		26-Oct-00	CareFirst, Inc. Executive Session Meeting Minutes
CF-	12078	4350	26-Oct-00	CareFirst of Maryland, Inc. Board of Director Meeting Minutes
CF-	12178		26-Oct-00	CareFirst of Maryland, Inc. Executive Session Meeting Minutes

CF-	12270	4358	26-Oct-00	Group Hospitalization and Medical Services, Inc. Board of Director Meeting Minutes
CF-	12792	4395	01-May-01	Provides copy of Revised Tax Calculations for CareFirst
CF-	12971		26-Oct-00	Group Hospitalization and Medical Services, Inc. Board of Director Meeting Minutes
CF-	13184	4416	26-Oct-00	Handouts for Board Meeting Held 10/26/00 - 2001 Board and Committee Meeting Schedule, Board Compensation Recommendation, Investment Transactions
CF-	13273	4395	09-Feb-98	Healthy Families Program Participating Physician Agreement
CF-	13454	4435	01-May-01	Forwards CareFirst Tax Calculations CFI for 2001 - 2008
CF-	13752	4443	01-May-99	Blue Cross of California Medi-Cal Managed Care Medical Services Agreement
CF-	14001	4421	03-Dec-00	CareFirst, Inc. Board of Director Meeting Minutes
CF-	14376	4426	04-Dec-00	CareFirst, Inc. Annual Planning Session Meeting Minutes - Exhibit 129 Jews Deposition
CF-	14636	4430	03-Dec-00	CareFirst of Maryland, Inc. Board of Director Meeting Minutes
CF-	15011	4435	04-Dec-00	CareFirst of Maryland, Inc. Annual Planning Session Meeting Minutes
CF-	15269	4440	03-Dec-00	Group Hospitalization and Medical Services, Inc. Board of Director Meeting Minutes
CF-	15280	4447	03-May-01	Forwards latest version of CareFirst Financial Projection Revised 2001 - 2003
CF-	15288	4445	04-Dec-00	Group Hospitalization and Medical Services, Inc. Annual Planning Session Meeting Minutes
CF-	15306	4462		Blue Cross of California Dental Net Provisional Services Agreement
CF-	15308	4664	03-Dec-00	Handouts for Board Meeting and Planning Session - 4635 - 4664 - Exhibit 130 to Jews Deposition
CF-	15310		04-May-01	Request information regarding provider networks and contracts
CF-	15312	4530	07-May-01	Provides copy of Piper Rudnick memo re: draft of Agreement and Plan of Merger
CF-	15314	4477		Blue Cross of California Dental Net Specialty Services Agreement
CF-	15315	4491		Blue Cross of California Participating Dentist Agreement for Senior Secure Products
CF-	15335	4727	01-Jan-02	Blue Cross Blue Shield Healthcare Plan of Georgia HMO Primary Care Physician Office Manual
CF-	15638	68	04-Mar-02	Stuart Smith Prefiled Testimony with exhibits attached
CF-	16281	4538	07-May-01	Forwards updated due diligence request list

CF-	16284	4580	07-May-01	Provides copy of WellPoint Charter and Bylaws filed in Form 8-K filed on 5/7/97
CF-	16286	4594	08-May-01	Provides updated due diligence request list
CF-	16287	4608	09-May-01	Provides copy of revised CareFirst Free Cashflow Financial Statement
CF-	16290	4610	10-May-01	Request for market place expert from CSFB to make presentation CareFirst executives on current healthcare environment
CF-	16291	4614	10-May-01	Forwards Piper Rudnick memorandum re: CareFirst negotiations with WellPoint
CF-	16292	4624	10-May-01	Provides rough draft of presentation to be made to Lt Governor Kathleen Kennedy Townsend on 5/15/01
CF-	16299	4628	10-May-01	Forwards copy of "results of consolidation and conversion section of the case for change presentation.
CF-	16301		11-May-01	Request book, not identified, that supports the fairness opinion
CF-	16305	4633	11-May-01	Baltimore Business Journal article re: "CareFirst nears merger deal"
CF-	16307	4635	11-May-01	Provides copy of page titled "decade of change" presentation by CSFB
CF-	16313	4664	04-Dec-00	CSFB Presentation attached to 12/4/00 Minutes
CF-	16317	4642	11-May-01	Provides copy of CSFB presentation "Process Review" for comment
CF-	16320	4655	11-May-01	Provides copy of travel binder for meetings with WellPoint
CF-	16322	4781	15-May-01	Provides revised clean and red lined version of Agreement and Plan of Merger dated 5/15/01 along with Piper Rudnick memorandum re: same
CF-	16324	4701	22-Feb-00	CareFirst, Inc. Strategic Planning Committee Meeting Minutes
CF-	16325	60	14-Dec-01	Draft Letters to individual executives informing them of the Board's decision to be a participant in the CareFirst Merger
CF-	16329	4791	01-Jun-00	CareFirst Strategic Planning Committee Meeting Minutes
CF-	16330	4840	01-Jan-00	HMO Georgia PCP Office Manual
CF-	16338	4785	17-May-01	Request to provide chart per Bill Jews instructions for compensation issues. Trigon's reaction to news release is to still pursue a deal
CF-	16341	4904	18-May-01	Provides revised version of Agreement and Plan of Merger
CF-	16344	4847	11-Jul-01	CareFirst, Inc. Strategic Planning Committee Meeting Minutes
CF-	16346	493	16-Oct-02	Summary of hospital rate setting system prepared by Bob Murray at HSCRC provided by MIA to Delmarva
CF-	16347	4955	01-Jan-99	HMO Georgia PCP Office Manual
CF-	16349	4899	27-Jul-00	CareFirst, Inc. Strategic Planning Committee Meeting Minutes

CF-	16350	5027	26-Oct-00	CareFirst, Inc. Strategic Planning Committee Meeting Minutes - 4900 - 4901 Exhibit 127 Jews Deposition
CF-	16358	4910	21-May-01	Presentation regarding potential payments in connection with change of control
CF-	16359	4917	21-May-01	Forward presentation with updated numbers for potential payments in connection with a change of control
CF-	16360	4921	21-May-01	Provides copy of presentation with updated compensation analysis
CF-	16361	4923	22-May-01	Forwards copy of agenda for 5/24/02 SPC and Finance Committee meeting, request information on who will attend from CSFB
CF-	16366	4937	22-May-01	Forwards copy of proposed summary of Subordinated Notes prepared by Banc of America
CF-	16369	4939	22-May-01	Forwards revised page of agreement with change to definition of maximum note consideration
CF-	16372	495	06-Aug-02	The substantial available and affordable coverage program
CF-	16386	4941	22-May-01	Is disconnect with notes, the issue of notes should only be a limited approach for a limited period tied to WellPoint per share.
CF-	16387	4944	22-May-01	Isaac Nueberger is missing issues about notes. The notes kick in only if the stock falls below a floor. Should focus energy more on
CF-	16393	4947	23-May-01	Forwards copy of Executive Summary topics
CF-	16415	4951	25-May-01	Forwards copy of latest draft of open issues to be discussed with WellPoint
CF-	16549		28-May-01	Recounts meeting with WellPoint. CEO's met for entire day on compensation issues. WellPoint CEO wanted to know what dollars
CF-	16574	4954	28-May-01	Recounts meeting with Jews after meeting with WellPoint. Meeting went well, biggest issue is amount of time Jews will invest on board and staff meetings.
CF-	16575		28-May-01	Understanding is that WellPoint does not expect to have a condition to close the signing of an employment contract with Jews are any other senior manager.
CF-	16583	4972	04-Jun-01	Forwards latest version of presentation "Optimal Negotiated Position"
CF-	16588	5046	01-Jan-00	HMO Georgia Specialist Physician Office Manual
CF-	16671	497	04-Nov-02	Forwarding copy of Washington Post Article re: Children Hospital dropping HMO of CareFirst
CF-	16773	4977	04-Jun-01	Forwards list of material points of discussion regarding Trigon
CF-	16823	4979	06-Jun-01	Wants CSFB to participate in discussions with CareFirst executives regarding annual planning process
CF-	16937	503	27-Nov-02	Provides copy of S&P 11/12/02 report analyzing the conversion of BCBS plans
CF-	17038	4982	12-Jun-01	Trigon is working on separate letter to address issues
CF-	17144		12-Jun-01	Request that quarterly financials and press releases be obtained from BCBSKS website and have it added to managed care M&A comp.

CF-	17227	4986	13-Jun-01	Forwards copy of letter from Tim Nolan re: Trigon to prepare separate letter on issues
CF-	17289	5028	30-Jan-01	Benefit Manager Survey - Highlights of Findings of Annual CSFB Survey of Benefit Managers
CF-	17324	5168	21-Nov-00	CareFirst, Inc. Strategic Planning and Finance Committee Meeting Minutes 5119 - 5130 Exhibit 128 Jews Deposition
CF-	17356	5070	18-Jun-01	Updated transaction timeline, open items and recommended response, Maryland title 6.5.
CF-	17377	542		Various news articles re: conversion of blue cross plans
CF-	17402	5139	01-Jan-99	HMO Georgia Specialist Physician Office Manual
CF-	17423		19-Jun-01	Informing that WellPoint CEO will be at 7/26 board meeting.
CF-	17511	5220	20-Jun-01	CareFirst Historical Margin Analysis
CF-	17597	5204	01-Jan-01	Blue Cross Blue Shield Georgia PPO Physician Office Manual
CF-	17645	5175	22-Feb-01	CareFirst, Inc. Board of Director Meeting Minutes
CF-	17691	5180	22-Feb-01	CareFirst of Maryland, Inc. Board of Director Meeting Minutes
CF-	17744	5185	22-Feb-01	Group Hospitalization and Medical Services, Inc. Board of Director Meeting Minutes
CF-	17794	5190	22-Feb-01	BCBS of Delaware, Inc. Special Meeting of Board of Directors Minutes
CF-	17912	5233	22-Feb-01	Handouts for Board Meetings 2/22/01 - CEO Report, /Fiduciary Duties Executive Summary, Key Transaction Issues, Delaware 401(K) Plan
CF-	17997	5274	01-Jan-99	Blue Cross Blue Shield Georgia PPO Physician Office Manual
CF-	18081	5231	22-Jun-01	Forwards copy of Trigon 6/22/02 bid proposal
CF-	18155	5329	26-Apr-01	CareFirst, Inc. Board of Director Meeting Minutes
CF-	18207	5253	25-Jun-01	Forwards copy of Bill Jews response to BCBS Delaware concerns regarding transaction. A copy of the BCBS Delaware memo to Bill Jews attached.
CF-	18290	5241	26-Apr-01	CareFirst, Inc. Executive Session Meeting Minutes
CF-	18331	5247	26-Apr-01	CareFirst of Maryland, Inc. Board of Director Meeting Minutes
CF-	18448	5249	26-Apr-01	CareFirst of Maryland, Inc. Executive Session Meeting Minutes
CF-	18549	5255	26-Apr-01	Group Hospitalization and Medical Services, Inc. Board of Director Meeting Minutes
CF-	18655	5255	25-Jun-01	Submission to WellPoint for consideration new Section 7.1 Conditions to Each Party's Obligation

CF-	18736	5265	26-Jun-01	Forwards for review the chart reflecting potential change of control payments projected as of 4/1/02
CF-	18811	5257	26-Apr-01	Group Hospitalization and Medical Services, Inc. Executive Session Meeting Minutes
CF-	18864	5263	26-Apr-01	BCBS of Delaware, Inc. Board of Director Meeting Minutes
CF-	18951	5265	26-Apr-01	BCBS of Delaware, Inc. Executive Session Meeting Minutes
CF-	18997		26-Jun-01	Forwards draft of note to Bill Jews re: update of Trigon bid and status of same and requests that it be reviewed
CF-	19110	5329	26-Apr-01	Handouts for Board Meetings 4/26/01
CF-	19195	5271	26-Jun-01	Fax explaining role of Bill Jews in Trigon acquisition
CF-	19288	5342	26-Jun-01	Forwards for review CSFB Methodology, BCBSD Analysis, and process review. Has comparison of CSFB Process with Ellin & Tucker Snapshot
CF-	19373	5540	01-Jan-02	Atlanta healthcare Partners, Inc. Primary Care Physician Policy and Procedure Office Manual
CF-	19444	5333	25-Jul-01	CareFirst, Inc. Board of Director Meeting Minutes
CF-	19503	5337	25-Jul-01	CareFirst of Maryland, Inc. Board of Director Meeting Minutes
CF-	19597	5341	25-Jul-01	Group Hospitalization and Medical Services, Inc.
CF-	19707	5343	25-Jul-01	CareFirst, Inc. Executive Meeting Minutes
CF-	19710		27-Jun-01	Informs that Bob Kelly is not ready for conference call still looking through compensation data.
CF-	19714	5345	25-Jul-01	CareFirst of Maryland, Inc. Executive Session Meeting Minutes
CF-	19715	5348	03-Jul-01	Informs of 3 upcoming CareFirst meetings and forwards draft agenda for 7/16/01 meeting of SPC
CF-	19717	5347	25-Jul-01	Group Hospitalization and Medical Services, Inc. Executive Session Meeting Minutes
CF-	19721	5393	25-Jul-01	Handouts for Board Meetings held on 7/25/01 -Strategic Purpose, CEO Report
CF-	19725	5357	03-Jul-01	Forwards copy of Strategic Focus Analysis prepared by CSFB dated 6/25/01
CF-	19727	5362	04-Jul-01	Forwards copy of draft agenda for SPC 7/16/01 meeting.
CF-	19751		05-Jul-01	Informs as to who will be attending meeting on 7/9/01
CF-	19759	5510	06-Jul-01	Forwards copy of Health Insurance Managed Care Industry Overview and Investment Summary July 2001
CF-	19796	5400	25-Oct-01	CareFirst, Inc. Board of Director Meeting Minutes
CF-	19831	5407	25-Oct-01	CareFirst of Maryland, Inc. Board of Director Meeting Minutes

CF-	19858	5414	25-Oct-01	Group Hospitalization and Medical Services, Inc. Board of Director Meeting Minutes
CF-	19900	5475	25-Oct-01	Handouts for Board Meetings held 10/25/01
CF-	19947	560	30-Sep-02	Case Studies of 4 BC Conversions
CF-	19980	5484	20-Nov-01	CareFirst, Inc. Board of Director Meeting Minutes
CF-	20027	5492	20-Nov-01	CareFirst of Maryland, Inc. Board of Director Meeting Minutes
CF-	20039	5500	20-Nov-01	Group Hospitalization and Medical Services, Inc. Board of Director Meeting Minutes
CF-	20046	5712	20-Nov-01	Handouts for Board meetings held 11/20/01 - Summary of Key Proposed Terms, Draft agreement
CF-	20055	5521	10-Jul-01	Forwards comments on section 6.1, the new article and litigating closing condition
CF-	20060	5635	10-May-01	CSFB Desk Notes on Mid Atlantic Medical Services first quarter results beat expectations, focus remains on enrollment growth
CF-	20063	5829	01-Jan-01	Atlanta Healthcare Partners Inc. Primary Care Physician Policy & Procedures Office Manual
CF-	20071	567		duplicate copies of letter from WellPoint explaining calculation of medical loss ratio and fax forwarding CareFirst five year historical data
CF-	20136	5646	10-Jul-01	Comments re: section 6.1
CF-	20147	5650	11-Jul-01	Forwards copy of draft agenda for 7/25/01 of board of directors of CareFirst
CF-	20185	5654	11-Jul-01	Fax regarding meeting between Jews and Snead
CF-	20199	5675	12-Jul-01	Forwards copy of Due Diligence findings result for review of WellPoint
CF-	20239	577	22-Jun-01	Projected Pension, 501 (k) and FAS 106 Costs after purchase accounting
CF-	20275	5708	16-Jul-01	CareFirst Managed care Repositioning Presentation for 5/15/01
CF-	20326	684	01-Nov-02	Policy considerations arising from a sale of the Maryland Plan
CF-	20354	5713	16-Jul-01	Update on trip to New York
CF-	20387	5755	22-Jan-01	CareFirst, Inc. Strategic Planning Committee Meeting Minutes - Exhibit 133 Jews Deposition
CF-	20424	5730	18-Jul-01	Forwards copy of Black-Scholes Model that has not been tested
CF-	20479	5733	18-Jul-01	Draft memo re: compensation issues
CF-	20549	5738	19-Jul-01	Copy of 7/19/01 letter from Snead to Jews explaining his role after Trigon acquisition
CF-	20601	5749	20-Jul-01	Forwards list of significant framing legal issues as of 7/12/01 with WellPoint

CF-	20662	5753	23-Jul-01	Forwards copy of agenda for board meeting to be held on 7/25/01
CF-	20742	5755	23-Jul-01	List of key issues and response by WellPoint
CF-	20803	5784	22-Feb-01	CareFirst, Inc. Strategic Planning Committee Meeting Minutes 5756 - 5757 - Exhibit 137 Jews Deposition
CF-	20859	5776	24-Jul-01	Forwards revised copy of section 6.1 and articles of additional agreements
CF-	20891	5779	24-Jul-01	Forwards final version of memo re: compensation. States that Jews seems uninterested in substance of memo and recommendations for change.
CF-	20910	5782	25-Jul-01	Forwards process for determining cost of capital for CareFirst
CF-	20956	5786	25-Jul-01	Forwards copy of CareFirst Invoice for services
CF-	21012	5805	23-Mar-01	CareFirst, In. Strategic Planning and Finance Committee Meeting Minutes
CF-	21082	5788	27-Jul-01	Notes from Breakout discussions from Board of Directors meeting
CF-	21142		30-Jul-01	Agrees that WellPoints Subordinated Notes look ok but recommends a legal review
CF-	21180	5987	27-Jul-01	Forwards clean and red lined version of Agreement and Plan of Merger dated 7/27/01
CF-	21228	5821	26-Apr-01	CareFirst, Inc. Strategic Planning Committee Meeting Minutes
CF-	21253	5851	24-May-01	CareFirst, Inc. Strategic Planning and Finance Committee Meeting Minutes - Exhibit 152 Wolf Deposition
CF-	21297	6082	01-Jan-99	Atlanta Healthcare Partners, Inc. Physician Office Manual
CF-	21357	5901	25-Jul-01	CareFirst, Inc. Strategic Planning and Finance Committee Meeting Minutes
CF-	21508	5935	23-Aug-01	CareFirst, Inc. Strategic Planning Committee Meeting Minutes - Exhibit 153 Wolf Deposition
CF-	21526	5965	25-Sep-01	CareFirst, Inc. Strategic Planning Committee Meeting Minutes - Exhibit 155 Wolf Deposition
CF-	21572	5994	25-Oct-01	CareFirst, Inc. Strategic Planning Committee Meeting Minutes - Exhibit 157 Wolf Deposition
CF-	21609	5993	30-Jul-01	Forwards copy of Barron' online Article on Sunrise
CF-	21826	5997	30-Jul-01	Forwards proposed schedule for due diligence meeting with Trigon
CF-	21834	6004	05-Nov-01	Strategic Planning Committee Meeting Minutes - Exhibit 159 Wolf Deposition
CF-	21853	6003	01-Aug-01	Forwards copy of Due Diligence questions as of August 2001
CF-	21856	6139	01-Aug-01	Forwards clean and red lined version of Agreement and Plan of Merger with Trigon dated 8/1/01
CF-	21890	6027	05-Nov-01	Draft CareFirst, Inc. Strategic Planning Committee Special Meeting Minutes

CF-	21893	6031		CareFirst/Trigon Partnership Summary of Key Business Terms
CF-	21991	6107	02-Mar-01	Draft Agreement and Plan of Merger Between Trigon and CareFirst
CF-	22030	6196	01-Jan-02	Atlanta Healthcare Partners, Inc. Specialty Physician Policy & Procedure Office Manual
CF-	22038	132	24-Nov-98	Three copies of the Employment agreement between CareFirst and William L. Jews
CF-	22323	6165	01-Aug-01	Draft Agreement and Plan of Merger between Trigon and CareFirst
CF-	22476	6189	03-Aug-01	Forwards CareFirst and affiliates quarterly financials
CF-	22553	6241	01-Aug-01	Draft Agreement and Plan of Merger between Trigon and CareFirst
CF-	22559	6202	03-Aug-01	Forwards copy of press release re: 2 insures keep eyes on CareFirst
CF-	22565	6300	01-Jan-99	Atlanta Healthcare Partners, Inc. Specialty Physician Policy & Procedures Office Manual
CF-	22567	6205	03-Aug-01	Forwards project congress benefit comparison between CareFirst and WellPoint
CF-	22570	6313	03-Aug-01	Forwards revised version of Agreement and Plan of Merger with WellPoint dated 8/3/01
CF-	22571	6312	16-Oct-01	Draft Agreement and Plan of Merger between Trigon and CareFirst
CF-	22572	6367		Blue Choice PPO a Preferred Provider Organization Underwritten by Blue Cross and Blue Shield of Georgia
CF-	22574	6314	07-Dec-00	Letter expressing interest in exploring the possibility of Anthem and CareFirst affiliating - Exhibit 131 Jews Deposition
CF-	22584	6326	08-Aug-01	Forwards copy of memo to Jews re: summary of key issues with WellPoint to include legal, organization, associates benefits, and executive compensation
CF-	22586		03-Jan-01	Correspondence expressing interest to affiliate Anthem and CareFirst - Exhibit 132 Jews Deposition
CF-	22589	6317	05-Feb-01	Correspondence requesting Anthem be included in the transaction process - Exhibit 134 Jews Deposition
CF-	22590	6319	13-Feb-01	Correspondence expressing doubt about affiliation of CareFirst and Anthem - Exhibit 135 Jews Deposition
CF-	22591	6322	26-Feb-01	Correspondence expressing disappointment that Anthem is not being included in transaction process - Exhibit 138 Jews Deposition
CF-	22592	6324	20-Aug-01	Correspondence requesting Board to reconsider Anthem's participation in transaction process
CF-	22597		20-Sep-01	Letter expressing interest in discussing Anthem's interest after conversion is complete
CF-	22631		02-Oct-01	Correspondence informing that demutualization is on track and that Anthem will offer superior value to CareFirst in a potential combination.
CF-	22658	6328	02-Nov-01	Correspondence informing of Anthem's IPO and requesting that Anthem be allowed to participate in transaction.

CF-	22694	6330	08-Aug-01	Discussion regarding subordinated note with WellPoint
CF-	0016585A	6330	12-Nov-01	Correspondence expressing disappointment that Anthem is not being included in transaction and questions the Boards fiduciary obligation in excluding Anthem.
CSFB-	1	6338	02-Mar-01	Correspondence submitting Proposal on behalf of Trigon with Term Sheet and draft agreement
CSFB-	13	6342	15-Mar-01	Correspondence clarifying Proposal from Trigon
CSFB-	29	6342	14-Aug-01	Forwards copy of proposed schedule of due diligence with Trigon
CSFB-	89	6345	23-Apr-01	Correspondence stating pleased that Board is still considering Trigon offer.
CSFB-	124	6357	14-Aug-01	Forwards copy of WellPoint subordinated note and wants to discuss ranking of note, term of note, covenants and change of control provisions
CSFB-	293		12-Jun-01	Correspondence regarding series of issues that need to be resolved and that a letter is being prepared to address those issues regarding Trigon.
CSFB-	329	6354	22-Jun-01	Correspondence clarifying Trigon's key business terms and submitting revised term sheet.
CSFB-	364	6357	26-Jun-01	Correspondence explaining the role of William Jews in new organization with Trigon
CSFB-	433	6360	14-Aug-01	Provides copy of cost trend analysis
CSFB-	446	6359	11-Jul-01	Correspondence of encouragement for meeting between CEOs of Trigon and CareFirst Exhibit 109, Thomas Snead Deposition
CSFB-	494	6362	19-Jul-01	Correspondence with further explanation of William Jews role in combined Trigon and CareFirst organization
CSFB-	496	6381	15-Aug-01	Provides draft agenda for 8/23/01 SPC meeting and handout to members
CSFB-	522	6364	16-Oct-01	Correspondence conveying improved aspects of Trigon offer
CSFB-	702			CareFirst Diligence Visits to various government offices in Maryland, DC, Delaware and Virginia
CSFB-	734			CareFirst/Trigon Partnership Summary of Key Business Terms
CSFB-	808	6437	16-Oct-01	Draft Agreement and Plan of Merger between CareFirst and Trigon
CSFB-	830	6410		Individual Rate Increases for years 1998 through 2000
CSFB-	862	6391	15-Aug-01	Provides agenda and due diligence list for visit to Trigon
CSFB-	912	6393	16-Aug-01	Forwards copy of Baltimore sun article on CareFirst 2nd qtr
CSFB-	968	6395	16-Aug-01	Forwards copy of Chicago Tribune article re: BCBS Illinois pull plug on deal to buy Regence Group
CSFB-	983	6410	20-Aug-01	Forwards copy of subordinated note provided by WellPoint for discussion

CSFB-	1000	6413	22-Aug-01	Forwards copy of Glasscock 8/20/01 letter to Jews expressing continued interest of Anthem in affiliating with CareFirst
CSFB-	1142	6472		Group Conversion Rate Filings for years 1996 through 2002
CSFB-	1202	6416	08-Sep-01	Forwards copy of Jews response to Glasscock dated 8/29/01 re: Anthem attempt to enter bidding process
CSFB-	1206		18-Sep-01	Provides new contact information for home contact
CSFB-	1209	6419	18-Sep-01	Forwards copy of agenda for CareFirst SPC meeting 9/25/01
CSFB-	1215	6424	19-Sep-01	Forwards copy of memo to Jews with SPC meeting agenda attached as well as deal status and opens items with WellPoint
CSFB-	1227		21-Sep-01	Note regarding subordinated debt - Carol burt is flexible on some form of transferability, but worried about covenants. Wants
CSFB-	1231	6444	24-Sep-01	Forwards SPC meeting agenda and material for handouts for SPC meeting to be held on 9/25/01
CSFB-	1289	6474	25-Feb-99	CareFirst, Inc. Strategic Planning Committee Meeting Minutes
CSFB-	1299	6449	25-Sep-01	Forwards copy of 2001 Actual vs. Plan August YTD Net Income Operations
CSFB-	1361	6465	25-Sep-01	Forwards copy of 2002-2005 Strategic Planning Update presented at SPC meeting on 9/25/01
CSFB-	1367	6507	26-Sep-01	Forwards copy of CareFirst Financial Results as of 8/23/01
CSFB-	1373	6494		Mecidare Supplement Ads for years 2000 - 2002
CSFB-	1385	6523	22-Apr-99	CareFirst, Inc. Strategic Planning Committee Meeting Minutes
CSFB-	1387	6591		Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. Rate Filings for years 1997 - 2002
CSFB-	1396		26-Sep-01	Forwards Isaac Nueberger phone number
CSFB-	1485	6514	28-Sep-01	Forwards copy of Piper Rudnick May 15, 2001 Executive Summary of Merger Agreement
CSFB-	1490	6689	28-Sep-01	Forwards copy of the Kaiser Family Foundation Employer Health Benefits 2001 Annual Survey
CSFB-	1500	6579	18-May-99	CareFirst, Inc. Strategic Planning Committee Meeting Minutes
CSFB-	1522	6622	24-Jun-99	CareFirst, Inc. Strategic Planning Committee Meeting Minutes
CSFB-	1528	6647		Medicare Supplement Rate Filings for years 1997 - 2001
CSFB-	1530	6703	23-Aug-99	CareFirst, Inc. Strategic Planning Committee Meeting Minutes
CSFB-	1537	6749	31-Dec-01	Annual Statement of Blue Cross Blue Shield Healthcare Plan of Georgia
CSFB-	1544	6691	28-Sep-01	Bureau of Labor Statistics Survey of Medicad care benefits

CSFB-	1551	6696	28-Sep-01	Forwards updated draft of executive summary of merger agreement
CSFB-	1553	6715	30-Sep-01	Forwards draft of WellPoint Subordinated Note
CSFB-	1562	6791	23-Sep-99	CareFirst, Inc. Strategic Planning Committee Meeting Minutes
CSFB-	1563	6720	01-Oct-01	Forwards copy of Snead's 7/19/01 letter to Jews re: role after Trigon acquisition.
CSFB-	1571	6722	03-Oct-01	Forwards copy of transaction to date invoices paid
CSFB-	1584	6730	03-Oct-01	Forwards copy of memo to Jews from Dave Wolf providing WellPoint's best and final offer and height level summary of same
CSFB-	1593	6749	03-Oct-01	Forwards copy of WellPoint Subordinated note
CSFB-	1600	6756	03-Oct-01	Discussion regarding Subordinated Note
CSFB-	1608	6814	31-Dec-00	Annual Statement of Blue Cross Blue Shield Healthcare Plan of Georgia
CSFB-	1610		08-Oct-01	Discussion re: associate benefits and WellPoint's closing of all of CareFirst associate benefits
CSFB-	1611	6763	08-Oct-01	Forwards copy of two version of benefit comparison between WellPoint and CareFirst
CSFB-	1623	6765	15-Oct-01	Forwards copy of draft agenda for SPC 10/25/01 meeting
CSFB-	1625	6773	15-Oct-01	Asking for assistance with projected 5 year revenue growth rate for CareFirst
CSFB-	1627	6852	16-Oct-01	Forwards copy of Term Sheet, Due Diligence List, Letter from Snead and draft Agreement and Plan of Merger dated 10/16/01 from Trigon
CSFB-	1645	6877	28-Oct-99	CareFirst, Inc. Strategic Planning Committee Meeting Minutes
CSFB-	1719	6893	31-Dec-99	Annual Statement of HMO Georgia
CSFB-	1794	6858	17-Oct-01	Forwards chart reflecting exposure
CSFB-	1809	6946	18-Oct-01	Forwards copy of WellPoint Historical & Projected Quarterly Consolidated Statements of Income
CSFB-	1818.1	7059	23-Nov-99	CareFirst, Inc. Strategic Planning and Finance Committee Meeting Minutes
CSFB-	1827	6973	31-Dec-98	Annual Statement of HMO Georgia
CSFB-	1830.1	139	01-Jun-00	DLJ Presentation to the Strategic Planning Committee Project Chesapeake
CSFB-	1831		18-Oct-01	Forwards thoughts on current situation with each bidder. Concerned on Trigons requirement for meeting with politicians.
CSFB-	1832	6971	18-Oct-01	Forwards agenda and handout for 10/25/01 SPC meeting and request a review
CSFB-	1844.1	7016	19-Oct-01	Forwards copy of CSFB Equity Research departments review of RightChoice Managed Care Inc. dated 5/25/01

CSFB-	1846	7021	31-Dec-97	Annual Statement of HMO Georgia
CSFB-	1926	7019	20-Oct-01	Baltimore Sun article "Insurer held to put profit over patients"
CSFB-	1939	7023	21-Oct-01	CSFB Research report on WellPoint Announcing merger with RightChoice
CSFB-	1962	7199	31-Dec-01	Annual Statement of Blue Cross and Blue Shield of Georgia
CSFB-	1968	7055	22-Oct-01	Forwards copy of CareFirst Finance Committee meeting 10/25/01 handout
CSFB-	2093	7085	22-Oct-01	Forwards copy of agenda and handout for 10/25/01 SPC meeting
CSFB-	2112	7118	22-Feb-00	Executive Compensation Committee Meeting Minutes
CSFB-	2116	7091		Forwards copy of handout for 10/25/01 Finance committee meeting.
CSFB-	2171	7097	23-Oct-01	CFMI and GHMSI Plan of Income is CFMI $2m capital gains, $3m other income, GHMSI $2m capital gains, $.5m other income
CSFB-	2450	7100	24-Oct-01	Forwards list of material outstanding issues under the WellPoint merger agreement and subordinated note.
CSFB-	2451	7102	24-Oct-01	Forwards copy of alternative minimum tax worksheet for CareFirst Consolidated as of 12/31/00
CSFB-	2453	7113	24-Oct-01	Forwards updated copy of Project Chesapeek Process review dated 10/23/01 prepared by CSFB
CSFB-	2456		24-Oct-01	Forwards copy of WellPoint 8K (not attached)
CSFB-	2465	7127	24-Oct-01	Forwards copy of WellPoint's 3rd quarter earnings press release.
CSFB-	2474	7152	27-Apr-00	Executive Compensation Committee Meeting Minutes
CSFB-	2499	7129	26-Oct-01	Forwards copy of slide titled next steps involving WellPoint and Trigon
CSFB-	2518		26-Oct-01	Forwards article re: Constellation Energy Group
CSFB-	2533	7138	30-Oct-01	Forwards copy of agenda and memo to Bill Jews re: meeting with Trigon on deal issues
CSFB-	2578		30-Oct-01	Forwards notes on meeting with Atlantic
CSFB-	2586	7158	02-Nov-01	Forwards copy of WellPoint Subordinated Note
CSFB-	2599	7197	27-Jul-00	Executive Compensation Committee Meeting Minutes
CSFB-	2676	7173	02-Nov-01	Forwards copy of material for November 5 meeting to include SPC agenda and update
CSFB-	2679	7210	07-Nov-01	Forwards copy of WellPoint Subordinated Note for review
CSFB-	2683	7237	26-Oct-00	Executive Compensation Committee Meeting Minutes

CSFB-	2695	7295	31-Dec-00	Annual Statement of Blue Cross Blue Shield of Georgia
CSFB-	2699	7219	07-Nov-01	Forwards copy of WellPoint Confirmatory Due Diligence list
CSFB-	2701	7222	09-Nov-01	Forwards copy of transaction analysis comparing WellPoint's purchase of CareFirst and RightChoise on the basis of multiples and rationale
CSFB-	2705	7226	09-Nov-01	Forwards copy of financial plan by legal entity of CareFirst
CSFB-	2709	7232	14-Nov-01	Forwards copy of Executive Summary of Merger Agreement prepared by Piper Rudnick dated 11/13/02
CSFB-	2712		15-Nov-01	Provides call in numbers for Chesapeake IBC conference call
CSFB-	2722	7359	19-Nov-01	Forwards copy of revised Agreement and Plan of Merger with WellPoint
CSFB-	2743	7430	06-Dec-99	Handouts for Board meeting held 12/5/99 - 2000 Integrated Business Plan Summary, 2000 Marketing Plan, eCommerce Enablement at CareFirst
CSFB-	2748	7430	31-Dec-99	Annual Statement of Blue Cross Blue Shield Georgia
CSFB-	2749	7364	19-Nov-01	Forwards questions about CSFB opinion letter.
CSFB-	2758	7461		various news articles after announcement of merger
CSFB-	2764	7471	22-Feb-01	Executive Compensation Committee Meeting Minutes
CSFB-	2773	7563	31-Dec-98	Annul Statement of Blue Cross Blue Shield of Georgia
CSFB-	2776	7463	04-Dec-01	requests copy of the Abell Foundation report (not attached)
CSFB-	2789	7468	04-Dec-01	Forwards copy of CareFirst expense report as of 12/4/01
CSFB-	2791	7470	04-Dec-01	News article from Washington Post regarding Carl Schramm report and its fault with conversion of CareFirst
CSFB-	2792	7476	04-Dec-01	Provides reaction to Carl Schramm report.
CSFB-	2797	7491	23-Mar-01	Special Compensation Committee Meeting
CSFB-	2829	7488		Various news articles regarding conversion of CareFirst
CSFB-	2832		22-Jan-02	Request information on CSFB's latest benefit manager survey report.
CSFB-	2883	7763	22-Jan-02	Forwards copies of Health Insurance Managed Care Industry Overview and Investment summary prepared by CSFB and Bear Stearns
CSFB-	2885	7496	20-Apr-01	Special Compensation Committee Meeting Minutes
CSFB-	2891	7524	26-Apr-01	Executive Compensation Committee Meeting Minutes

CSFB-	2919	7532	24-May-01	Executive Compensation Committee Meeting Minutes
CSFB-	2927	7579	12-Jun-01	Executive Compensation Committee Meeting Minutes
CSFB-	2930	7695	31-Dec-97	Annual Statement of Blue Cross Blue Shield Georgia
CSFB-	2995	7595	09-Jul-01	Executive Compensation Committee Meeting Minutes
CSFB-	3127	7616	25-Jul-01	Executive Compensation Committee Meeting Minutes
CSFB-	3193	7653	25-Oct-01	Executive Compensation Committee Meeting (handout only, no minutes)
CSFB-	3195	7667	27-Nov-01	Agenda for Executive Compensation Committee Conference Call
CSFB-	3198	7671	01-Dec-01	Compensation Consultants Recommendations handout for Compensation Committee Meeting (no minutes attached)
CSFB-	3223	7726	01-Jun-01	Draft copy of CareFirst Schedules to the Agreement and Plan of Merger
CSFB-	3278	7708		Blue Cross of California PPO Prudent Buyer Plan Operations Manual
CSFB-	3283	7732	12-Sep-02	G&A Synergies Model
CSFB-	3293	7796	16-Nov-01	Comments to CareFirst draft Disclosure Schedules to Agreement and Plan of Merger
CSFB-	3296			Earnings Growth Model - Typical Premium pmpm CareFirst's Medical and Admin Ratios, Interest Expense
CSFB-	3312	7856	31-Dec-01	WellPoint Health Networks Form 10-K/A
CSFB-	3313	7767	22-Jan-02	Provides copy of Maryland hearing outline by witness.
CSFB-	3314	7775	21-Jan-02	Forwards copy of 1/18/02 Baltimore business journal article, wants appropriate response for Bill Jews regarding assertions made that $1.3 billion is low offer for CareFirst
CSFB-	3317	7810	05-Feb-02	News articles on advisors for MIA including background information on Patrick Cantilo
CSFB-	3369	7942	19-Nov-01	Clean copy of CareFirst Disclosure Statements to Agreement and Plan of Merger
CSFB-	3371	7816	06-Feb-02	Forwards copy of information on CSFB team members
CSFB-	3420	8007	07-Feb-02	Provides copies of reports written by Joe France - Survey of Benefit Managers 1/02, Anthem 11/11/01, and RightChoice
CSFB-	3460		01-Oct-02	Blue Cross of California brochure "Agent Agenda"
CSFB-	3464		01-Oct-02	Blue Cross of California News Brochure
CSFB-	3488			Blue Cross of California Brochure "Score Like a Big Leaguer with Small Group Signing Bonuses
CSFB-	3497	7866		Blue Cross of California Brochure "Win More Business with The Power of Blue in various different languages

CSFB-	3499	7862	01-Apr-02	Blue Cross California Brochure " You Choose Individual and Family Health Programs Featuring PlanScape"
CSFB-	3505	7864	01-Apr-01	Blue Cross of California Individual Enrollment Applications
CSFB-	3521		01-Jan-01	Blue Cross of California Brochure "Dental Select HMO Plans for Families and Individual of All Ages"
CSFB-	3552		01-Sep-01	Blue Cross of California Brochure "Blue cross Individual HMO Conversion Plan"
CSFB-	3554		01-Jan-01	Blue Cross of California Brochure "Don't Get Caught Uninsured"
CSFB-	3559	7876	01-Aug-02	Blue Cross California Brochure "FlexScape For Small Groups Sales and Enrollment Guide"
CSFB-	3687	7889	01-Jun-02	Blue Cross Brochures "Agent Quick Guide, The Premium Only Plan, Technical Tools for Agents"
CSFB-	3715		01-Oct-02	Blue Cross of California Brochure "You Choose FlexScape for Small Groups"
CSFB-	3719		01-Aug-02	Blue Cross of California Brochure "Making Your Pharmacy Benefits Work for You"
CSFB-	3723		12-Nov-02	Blue Cross of California Brochure "Vision Care Savings Program" 12/1/00
CSFB-	3813		01-Jan-01	Blue Cross of California Brochure "The Ready Access Program for Blue Cross HMO Members"
CSFB-	3814		01-Sep-02	Blue Cross of California Brochure "Keeping You and Your Family Well"
CSFB-	3846		01-Sep-02	Blue Cross of California Brochure "We're With You 24/7 & Wherever You Go"
CSFB-	3858		01-Jan-01	Blue Cross of California Agent Agreement Kit for Individual, Small Group, and Senior Services
CSFB-	3859		01-Apr-02	Blue Cross PPO Prudent Buyer Plan Directory of Health Care Professionals & Institutions - Northern Counties
CSFB-	3861			Blue Cross PPO Prudent Buyer Plan Directory of Health Care Professionals & Institutions - Central Counties
CSFB-	3863			Blue Cross PPO Prudent Buyer Plan Directory of Health Care Professionals & Institutions - Southern Counties
CSFB-	3868			Blue Cross HMO California Care Directory of Health Care Professionals & Institutions - Northern Counties
CSFB-	3869			Blue Cross HMO California Care Directory of Health Care Professionals & Institutions - Central Counties
CSFB-	4000			Blue Cross HMO California Care Directory of Health Care Professionals & Institutions - Southern Counties
CSFB-	4043			List of Blue Cross of California Individual and Small Group marketing/sales promotion material
CSFB-	4044	8223	14-Jun-02	Blue Cross of California Hospital Operations Manual
CSFB-	4047	7954	20-Nov-01	Marked up copies of CareFirst Disclosure Schedules to Agreement and Plan of Merger
CSFB-	4087	8033	28-Feb-02	Clean and red line versions of CareFirst Disclosure Schedules to Agreement and Plan of Merger

CSFB-	4093	8013	15-Feb-02	Forwards copy of news article "Governor oppose CareFirst Conversion
CSFB-	4132	8050	19-Feb-02	Forwards copy of CSFB 2001 Benefit Manager Survey
CSFB-	4151	8109	17-Dec-01	Red lined version of CareFirst Disclosure Schedules to Agreement and Plan of Merger for conference call
CSFB-	4159	8055	22-Feb-02	Forwards copy of agenda for SPC meeting and update on recent developments with WellPoint
CSFB-	4175		25-Feb-02	Wants help with questions from Maryland delegates such as at what point does a dip in WellPoint stock trigger a termination clause for CareFirst
CSFB-	4180	8068	25-Feb-02	Forwards list of items requested by MIA in preparation for hearing
CSFB-	4184	8103	28-Feb-02	Forwards copy of CSFB Health Care Conference Recap and 2002 Outlook
CSFB-	4243	8244	28-Feb-02	Forwards copy of Health Insurance Managed care industry overview and investment summary by CSFB dated 2/02
CSFB-	4255	8113	08-Jan-02	For confirmation schedule changes to 4.12(j)(ii) Employee Plans; ERISA; Labor Matters
CSFB-	4259	8117	08-Jan-02	Draft of letter from John Picciotto to WellPoint forwarding copy of CareFirst Schedules to Agreement and Plan of Merger
CSFB-	4277	8119	09-Jan-02	Draft of letter from John Picciotto re: former employee severance liabilities and other schedules
CSFB-	4337	8121	10-Jan-02	Revised version of John Picciotto letter re: former employee severance liabilities
CSFB-	4338	8262	10-Jan-02	Red lined and clean version of CareFirst Disclosure Schedules to Agreement and Plan of Merger
CSFB-	4339	8631		Blue Cross of California PPO Prudent Buyer Plan Operations Manual
CSFB-	4341	8337	28-Feb-02	Forwards copy of Accenture Impact Statement and Appendix dated 1/10/02
CSFB-	4357	8282	23-Jul-01	Revised version of section 6.1 for review
CSFB-	4395	8292	16-Nov-01	Revised versions of WellPoint Disclosure Schedules to Agreement and Plan of Merger
CSFB-	4436	8302	29-Nov-01	Drafts of WellPoint's Disclosure Schedules to Agreement and Plan of Merger
CSFB-	4448	8350	07-Mar-02	Forwards copy of various news articles re: conversion and amount of pay to executive.
CSFB-	4449	8523	20-Nov-01	Execution copy of Agreement and Plan of Merger with Schedules of CareFirst as well as Merger Incentive Plan and Severance Plan
CSFB-	4531	8339	07-Mar-02	Resume of Stuart Smith
CSFB-	4539	8358		Copy of engagement letter with Donaldson, Lufkin & Jenrette dated 6/15/00
CSFB-	4581	8365	11-Mar-02	Provides summary of witness testimony from Maryland hearings and what questions will be asked
CSFB-	4595	8372	14-Mar-02	Forwards copy of news paper article re: CareFirst being quised on finances

CSFB-	4609	8377	25-Mar-02	Forwards information on Bill Jews board memberships in preparation for meeting.
CSFB-	4611	8385	26-Mar-02	Forwards copy of news article "CareFirst has bad day in Assembly"
CSFB-	4615	8445	03-Apr-02	Forwards copy of CareFirst Billing spread sheet
CSFB-	4625	8457		Various news articles re: conversion of CareFirst
CSFB-	4629	8461		List of supplemental filing items emanating from Maryland hearing in March 02
CSFB-	4630	8464	22-Apr-03	Forwards copy of memo to Bill Jews from David Wolf providing brief background on each expert retained by Commissioner
CSFB-	4634	8469	24-Apr-02	Provides copy of WellPoint Financial press release for first quarter 02
CSFB-	4636	8471	25-Apr-02	Questions re: what costs are in monetizing WLP stake over time.
CSFB-	4643	8490	26-Apr-02	Forwards copy of transcript of WellPoint financial conference call re: first quarter 2002
CSFB-	4656		29-Apr-02	Request for analysis of Anthem/Trigon deal
CSFB-	4782	8503	29-Apr-02	CSFB Equity Research news release re: Trigon and Anthem merger.
CSFB-	4786	8507	03-May-02	CSFB Summary of key terms of Anthem and Trigon deal
CSFB-	4905	8519	08-May-02	Forwards copy of Baseline Synergies Unique to Mason-Dixon Combination and CareFirst Financial Projections Combined assumptions and statements as of 10/18/00
CSFB-	4911	8600	14-May-02	Forwards copy of CSFB Joe France's Quarter 1 2002 earning notes for publicly traded managed care universe.
CSFB-	4918	8527	02-Mar-01	WellPoint's response and proposal regarding potential transaction for 1.2 billion to a price not to exceed 2.0 billion - Exhibit 139 Jews Deposition
CSFB-	4922	8531	20-Feb-01	Letter informing WellPoint of timing and procedures for WellPoint pursuing a possible transaction involving CareFirst - Exhibit 136 Jews Deposition
CSFB-	4924		19-Mar-02	Letter obligating WellPoint to maintain the aggregate purchase price of 1.25 billion should the average purchaser stock price fall below the minimum of 75.00
CSFB-	4938	8535	15-Mar-01	WellPoint's response to issues - tax-exempt indemnification, definition of average purchaser stock price, minimum training EBIT and risk based capital
CSFB-	4940	8537	24-Apr-01	WellPoint response to issues - increase to 1.3 billion as purchase price, lower minimum share price to 70.00, higher purchase price should WellPoint's stock price improve
CSFB-	4942	8543	22-May-01	Proposed summary of terms for Subordinated Notes
CSFB-	4945	8562	28-Sep-01	Revised version of subordinated note
CSFB-	4948	8564	03-Oct-01	Clarification that Notes will not be transferable. Continue to believe foundation recipients should hold notes until maturity date.

CSFB-	4952	8567	09-Nov-01	Memorandum outlining dollar amount and transferability of notes
CSFB-	4953	8586	14-Nov-01	Copy of revised subordinated note
CSFB-	4955	8624	15-Nov-01	Revised and cumulative markup of subordinated note
CSFB-	4956	8608	12-Jun-02	Forwards copy of list of provider issues listing root cause, systemic fix, person responsible and timeline
CSFB-	4973	8617	12-Jun-02	Forwards copy of due diligence list and preparation for visit by Blackstone group.
CSFB-	4978	8621	12-Jun-02	Forwards revised copy of Provider issues
CSFB-	4980	8623	13-Jun-02	Provides summary of Blackstone meeting. Questions raised were, why 20% discount rate, and ask what value of company was, but CSFB did not answer.
CSFB-	4983	8763	14-Jun-02	Forwards copy of BCBSA Licensee directory as of 3/02
CSFB-	4984	8642	16-Nov-01	Clean copy of subordinated note
CSFB-	4987	9323		Blue Cross of California HMO Operations Manual (PMG)
CSFB-	5029	8661	28-Feb-02	Comments on subordinated note
CSFB-	5071	8680	20-Nov-01	Revised subordinated note marked to show most recent changes
CSFB-	5072	8684	14-Nov-01	Draft form of affiliate letter from foundations
CSFB-	5221	8689	16-Nov-01	Draft of tax indemnity agreement
CSFB-	5232	8699	20-Nov-01	Revised tax indemnification agreement
CSFB-	5239	8753	05-Nov-01	Markup of August 3, 2001 draft Agreement and Plan of Merger
CSFB-	5254	8756	06-Nov-01	Revised version of Article III Conversion of Shares; Purchase Price; Effects of the Merger
CSFB-	5256	8758	08-Nov-01	Revised language for sections 6.17 and 7.1a re: conversion
CSFB-	5266	8883	09-Nov-01	Revised draft of Agreement and Plan of Merger one clean copy and one red lined copy
CSFB-	5267	8766	17-Jun-02	Request for Joe France to make presentation to CareFirst executives about happenings in the managed care industry.
CSFB-	5272	8772	18-Jun-02	Forwards copy of memo to Bill Jews with summary of meeting with Blackstone Group. Also includes list of documents reviewed, and suggestion for meeting with Blackstone and talking issues.
CSFB-	5343		18-Jun-02	Notes from observation of Blackstone reviewing documents in data room and focus of review from individual named Spider
CSFB-	5344	8783	18-Jun-02	Forwards chart reflecting mergers and acquisitions from 1996 forward

CSFB-	5349		27-Jun-01	Forwards copy of memo summarizing meeting with Blackstone. (memo not attached)
CSFB-	5358		02-Jul-02	Obersaton and questions regarding Anthem Trigon deal. When would Anthem become viable acquirer of CareFirst after Trigon deal?
CSFB-	5363	8939	03-Jul-02	Forwards copy of memo to Bill Jews from Dave Wolf with summary of Blackstone visit and copy of and draft presentation to be given to Blackstone.
CSFB-	5364	8885	12-Nov-01	Memorandum outlining agreement on tax insurance issue, Pacific will pay for insurance if not over 5 million
CSFB-	5511	8905	12-Nov-01	Revised drafts of Agreement and Plan of Merger
CSFB-	5522	8917	13-Nov-01	Additional comments to Agreement and Plan of Merger
CSFB-	5636	8920	14-Nov-01	Revised version of section 6.14, Non-Solicitation
CSFB-	5648	9047	15-Nov-01	Latest draft of Agreement and Plan of Merger
CSFB-	5651	8987	09-Jul-02	Forwards copy of CareFirst Financial Results as of 5/02
CSFB-	5655	8991	10-Jul-02	Forwards copy of memo from David Wolf to Bill Jews re: advisor up date and status of meeting with each
CSFB-	5676	8993	12-Jul-02	Report on meeting between Blackstone and CareFirst senior management. Meeting went well
CSFB-	5678	8998	22-Jul-02	Forwards copy of SPC meeting agenda for 7/25/02 meeting
CSFB-	5709	8999	23-Jul-02	Forwards copy of financial projections through 2006, shows 15% net income annual growth, and are figures given to WellPoint and Blackstone
CSFB-	5714	9002	24-Jul-02	Informs that having a follow-up meeting with Blackstone to discuss 2002 re-forecast and 2003 financial plan
CSFB-	5731		25-Jul-02	Forwards question raised by DC department of insurance to detail any adjustment necessary to comply with the all cash requirement
CSFB-	5734	9006	26-Jul-02	Forwards copy of latest Negotiation Status on Key Deal Points for Atlantic and Pacific
CSFB-	5739		27-Jul-02	Will not give opinion on effect on WellPoint if all cash deal is required. CSFB comment would become public
CSFB-	5750	9019	09-Aug-02	Forwards copy of DC request for information. Is critical of questions that pre-suppose things that did not or will not happen
CSFB-	5754	9022	13-Aug-02	Forwards copy of CareFirst Income statements and projections out to 2006 showing 15% net income annual growth rate.
CSFB-	5756		15-Aug-01	Request to bill CareFirst for monthly retainer fees and expenses incurred to date. Total amount is $213,046 which include 4 months retainer fee.
CSFB-	5777	9025	15-Aug-02	Forwards copy of Barra Betas for the comps used in the CSFB's board presentation on 11/20/01
CSFB-	5780	9027	16-Aug-02	Forwards copy of Baltimore Sun article re: WellPoint withdrawing application to acquire Delaware CareFirst
CSFB-	5783		19-Aug-02	Forwards information on United health group

CSFB-	5787	9066	23-Aug-01	Forwards copy of presentations to SPC committee by CSFB during the evolution of the deal
CSFB-	5788	9055	16-Nov-01	Revised and agreed upon articles 2 and 6 to the Agreement and Plan of Merger
CSFB-	5789	9073	16-Nov-01	Revisions to Agreement and Plan of Merger
CSFB-	5989	9073		Baltimore Sun articles regarding CareFirst concern over layoffs by Trigon, Trigon testimony and bonus to be received by CareFirst executives
CSFB-	5994	9100	03-Sep-01	Forwards schedules and discussion topics for meeting between CareFirst executives and DC experts
CSFB-	5998	9198	19-Nov-01	Revised version of Agreement and Plan of Merger, one clean copy and one red lined copy
CSFB-	6004		10-Sep-02	Next meeting of SPC is 9/24/02, will discuss Anthem purchase and any bid Anthem might make for CFI
CSFB-	6140	9108		Baltimore Sun Articles - CareFirst worth more
CSFB-	6190	9114	13-Sep-02	Forwards copy of draft response to DC department re: fees to be paid to CSFB in connection with CareFirst deal
CSFB-	6203	9118	16-Sep-02	Forwards questions by DC experts Cain Brothers
CSFB-	6206	9121	19-Sep-02	Baltimore Sun article re: State's budge shortfall balloons
CSFB-	6314	9125	19-Sep-02	Forwards copy of presentation show Trigon deposition testimony which was inaccurate
CSFB-	6327	9157	25-Jul-02	Draft of Strategic Planning Committee Meeting Minutes
CSFB-	6331	9207	25-Sep-02	Draft responses to DC Department questions regarding transaction
CSFB-	6340	9200	19-Nov-01	Draft of proposed attachment 9.10 list of Executive Employees of CareFirst and Purchaser
CSFB-	6343	9265	02-Mar-01	Draft of Agreement and Plan of Merger with name Simpson Thatcher hand written on cover along with WellPoint
CSFB-	6358	9210	01-Oct-02	Baltimore Sun articles re: Officials trace accusations on CareFirst-Trigon deal
CSFB-	6361	9212	27-Sep-02	Affidavit of Stuart Smith
CSFB-	6382	9223		Pre-Filed testimony of Daniel L. Atobello
CSFB-	6392	9224.6	21-Oct-02	CareFirst Consolidated Financial reconcilliations
CSFB-	6394	9227	23-Oct-02	List of Regulatory Process to date from first round of hearings to appointment of advisors
CSFB-	6396	9234	03-Nov-02	Baltimore Sun article re: Commissioner Larsen
CSFB-	6411	10500		The documents that fall within this bates range are duplicates of documents dated August 2001 through November 2001
CSFB-	6414	9395	19-Apr-01	Revised version of Agreement and Plan of Merger, one red lined one clean copy;

CSFB-	6417	9349	01-Aug-02	Blue Cross of California Underwriting Guidelines Small Group Services 2-50 Employees
CSFB-	6418	9410	02-Oct-02	Assurance 90 Blue Cross Blue Shield Combined Evidence of Coverage and Disclosure Form
CSFB-	6420	9474	02-May-01	Draft of Agreement and Plan of Merger with comments by WellPoint as well as a Memorandum expanding on non-solicitation
CSFB-	6425	9473	02-Oct-02	Assurance Plus 90 Combined Evidence of Coverage and Disclosure Form
CSFB-	6426	9583		Blue Cross California Sample HMO Plan H2
CSFB-	6445	9592	18-May-01	Draft of Agreement and Plan of Merger one clean copy and one red lined copy
CSFB-	6450	9692	02-Oct-02	Blue Cross of California Sample HMO Plan H$
CSFB-	6466	9594	22-May-01	Replacement page with new definition of Maximum Note Consideration
CSFB-	6508	9596	25-Jun-01	Draft of section 7.1(j) Conditions to Each Party's Obligations re: No Litigation
CSFB-	6509	9607	09-Jul-01	Comments on Section 6.1 Covenants of the Parties
CSFB-	6515	9726	03-Aug-01	Draft of Agreement and Plan of Merger one clean copy and one red lined copy
CSFB-	6690	9822	02-Oct-02	Blue Cross of California Sample POS Plan ZF4
CSFB-	6692	9740	30-Aug-01	Comments regarding Subordinated Note
CSFB-	6697		01-Apr-02	Letter responding to First Subpoena Deuces Tecum
CSFB-	6716	9769	11-Feb-99	Correspondence requesting consultation services in formulation of a comprehensive 2000-2003 long-range strategy
CSFB-	6721	9805	22-Apr-99	Handout for CareFirst Board Strategic Planning Committee - Positioning for Industry Leadership
CSFB-	6723	9856	14-May-99	Handout for Board Strategic Meeting with main purpose to capture executives perspectives on industry scenarios
CSFB-	6731	9953	02-Oct-02	Blue Cross Plus Plan Sample POS Plan ZX1
CSFB-	6750	9883	27-May-99	Hand Out for Board - Industry Scenario Discussion - Interim Report to the Committee
CSFB-	6757	9916	18-May-99	Advisory Panel Meeting handout - Introduction to CareFirst
CSFB-	6758	9952	21-May-99	Handout - Strategy Options - Steering Committee Discussion
CSFB-	6764	10007	28-May-99	Handout - Environment and Strategy Options - CEO Discussion
CSFB-	6766	10062	02-Oct-02	Prudent Buyer Sample Preferred PPO - PF2
CSFB-	6774	10077	28-May-99	Handout - Industry Scenario Appendix Supporting Information

CSFB-	6853	10114	01-Oct-02	Blue Cross Blue Shield Sample Security 90 Policy
CSFB-	6859	10129	03-Jun-99	Handout - Strategy Options Discussion - CEO Discussion
CSFB-	6947	10222	01-Oct-02	Blue Cross of California Sample Senior Secure Plan 2
CSFB-	6948	10190	04-Jun-99	Handout - Strategy Options Discussion - Interim Report to the Steering Committee
CSFB-	6972	10207	11-Jun-01	Handout - Strategy Options Discussion - Meeting with Bill Jews
CSFB-	7017	10263	02-Oct-02	Blue Cross of California Sample Senior Select Plus
CSFB-	7020	10299	02-Oct-02	Blue Cross of California Sample Senior Select
CSFB-	7024	10331	15-Jun-01	Handout - Strategy Options Discussion - Advisory Panel Meeting
CSFB-	7056	10364	02-Oct-02	Blue Cross of California Sample Dental Net 2300
CSFB-	7086	10387	21-Jun-99	Handout - Strategy Options Selection - Discussion with Bill Jews
CSFB-	7092	10432	02-Oct-02	Blue Cross of California Sample dental SelectHMO - Plan B
CSFB-	7098	10419	24-Jun-99	Handout - Draft Strategy Discussion - Board Meeting
CSFB-	7101	10438	24-Jun-99	Handout - Strategy Discussion Board Meeting
CSFB-	7103	10535	02-Oct-02	Blue Cross of California Sample EPO - Plan E8
CSFB-	7114	10499	24-Jun-99	Handout - Strategy Options Discussion - Strategic Planning Committee Discussion
CSFB-	7115	10554	25-Jun-99	Handout - Strategy Discussion - Greg Devou's Direct Reports Meeting
CSFB-	7128	11200		Duplicate production of documents.
CSFB-	7130	10642	02-Oct-02	Blue Cross of California Sample PPO - Plan P2
CSFB-	7131	10624	30-Jun-99	Handout - Choosing a Strategic Direction - CEO Discussion
CSFB-	7139	10683	25-Jun-99	Handout - Strategy Options Selection - Strategic Planning Update
CSFB-	7140	10749	02-Oct-02	Blue Cross of California Sample PPO - Plan 3
CSFB-	7159	10721	15-Jul-99	Handout - Strategy Execution - CEO Discussion
CSFB-	7174	10769	23-Jul-99	Handout - Strategy Execution - Steering Committee Meeting
CSFB-	7211	10856	02-Oct-02	Blue Cross of California Sample PPO - Plan P

CSFB-	7220	10799	06-Aug-99	Handout - Strategy Execution - Integration Meeting
CSFB-	7223	10809		Handout - Preliminary Evaluation of acquisition of Kaiser Mid-Atlantic by CareFirst
CSFB-	7227	10834	09-Aug-99	Handout - Consumerism Sub Strategy Discussion Document - IBP Planning Process
CSFB-	7233	10878	23-Aug-99	Handout - Pursuing Geographic Dominance: M&A and Corporate Structure Implications - CEO Discussion
CSFB-	7234	10939	01-Oct-01	Blue Cross of California Small Group HMO 100% Plan
CSFB-	7360	10936	23-Aug-99	Handout - Strategy Selection Discussion - Strategic Planning Committee Discussion
CSFB-	7365	11085	25-Aug-99	Handout - Pursuing Market Leadership - Williamsburg Retreat
CSFB-	7462	11021	02-Oct-01	Blue Cross of California Small Group Saver HMO Plan 8977/8980
CSFB-	7464	11052		Blue Cross of California Senior Classic C Contract 7887 and 7912
CSFB-	7469	11083		Blue Cross of California Senior Classic F Contract 0535
CSFB-	7471	11122		Blue Cross of California Senior Classic J Contract 0536
CSFB-	7477	11103	29-Sep-99	Handout - SPC Meeting Implications Discussion - Meeting with CEO
CSFB-	7489	11149	11-Oct-99	Handout - Capability Assessment - Integration Team Meeting
CSFB-	7490	11167	14-Feb-02	Blue Cross of California 2002 Medicare health Benefits Brochure for 1/02 - 12/31/02
CSFB-	7764	11186	23-Nov-99	Handout - Strategy Implications Discussion - Board Meeting
CSFB-	7768	11237	01-Feb-02	Blue Cross of California Senior Secure Evidence of Coverage
CSFB-	7776	11229	29-Oct-99	eCommerce Enablement Phase 1: Executive Summary
CSFB-	7812	11900		Duplicate document production
CSFB-	7817	11303	29-Oct-99	eCommerce Enablement at CareFirst Phase 1: Final Deliverable: eVision Summary
CSFB-	8008	11274		Blue Cross of California Medicare Supplemental Coverage for Californians
CSFB-	8014	11323	01-Jan-01	Blue Cross of California Individual EPO (MSA Compatible) 7892
CSFB-	8051	11356	29-Oct-99	eCommerce Enablement at CareFirst Phase 1 Final Deliverable: eArchitecture Summary
CSFB-	8056	11403	01-Jan-01	Blue Cross of California Small Group High Deductible EPO Plan 8978/8979
CSFB-	8057	11380	29-Oct-99	eCommerce Enablement at CareFirst Phase 1 Final Deliverable: eRollout Summary

CSFB-	8069	11407	29-Oct-99	eCommerce Enablement at CareFirst Phase 1 Final Deliverable: eVision Appendix
CSFB-	8104	11451	01-Jul-00	Blue Cross of California Individual HIPAA PPO $1,000 Deductible 7902
CSFB-	8245	11483	29-Oct-99	eCommerce Enablement at CareFirst Phase 1 Final Deliverable: eArchitecture Appendix
CSFB-	8338	11499	01-Jul-00	Blue Cross of California Individual HIPAA PPO 40 % 7907
CSFB-	8351	11530	29-Oct-99	eCommerce Enablement at CareFirst Phase 1 Final Deliverable: eRollout Appendix
CSFB-	8359	11575	01-Oct-01	California Indian Health Care Program Federally Recognized California Indian Tribes PPO $30 Co pay Plan
CSFB-	8366	11532		Capital Bench Mark Calculations: Statement that various thresholds of capital bench mark are proprietary and can not be shared with parties pursuant to he Association guidelines.
CSFB-	8373	11534		Estimation of Costs
CSFB-	8378	11562	27-Oct-99	The CareFirst Service Transformation - The Road to Customer Delight
CSFB-	8386	11564	11-Nov-99	eCommerce Expenditure Documentation
CSFB-	8446	11625	21-Sep-00	Contact Center Strategy Blueprint for CareFirst
CSFB-	8458	11629	01-Jan-01	California Blue Cross Individual PPO Share $1000 1393
CSFB-	8462	11629	26-Jan-00	CareFirst Management Audit Letter
CSFB-	8465	11683	01-Jan-01	Blue Cross of California Individual PPO Share $2500 7891
CSFB-	8470	11633	26-Jan-00	Group Hospitalization and Medical Services Management Audit Letter
CSFB-	8472	11638	18-Feb-00	BCBS of Delaware Management Audit Letter
CSFB-	8491	11643	31-Jan-01	CareFirst Management Audit Letter
CSFB-	8492	11649	31-Jan-01	Group Hospitalization and Medical Services Management Audit Letter
CSFB-	8504	11652	31-Jan-01	BCBS of Delaware Management Audit Letter
CSFB-	8508	11659	26-Jan-02	CareFirst Management Audit Letter
CSFB-	8520	11666	26-Jan-02	Group Hospitalization and Medical Services Management Audit Letter
CSFB-	8601	11669	13-Feb-01	CareFirst Corporate Internal Audit Summary
CSFB-	8609	12057	26-Apr-01	HIPAA Assessment of CareFirst
CSFB-	8618	11738	01-Jan-01	Blue Cross of California Individual PPO Share $500 7895

CSFB-	8622	11828	01-Oct-01	Blue Cross of California Small Group Premier No Deductible PPO $20 Co pay Plan 5030
CSFB-	8624	11919	01-Oct-01	Blue Cross of California Premier No Deductible $10 Co pay 8982
CSFB-	8764	12600		Duplicate document production
CSFB-	8767	11945		Blue Cross of California Area 1 Prudent Buyer Plan Agreement Group Conversion
CSFB-	8773	12038	01-Oct-01	Blue Cross of California Small Group PPO $30 Co pay Plan 5031
CSFB-	8774	12130	01-Oct-01	Blue Cross of California Small Group PPO $40 Co pay Plan 5032
CSFB-	8784	12070	20-Dec-01	Draft CareFirst of Maryland, Inc. Amended and Restated By-Laws
CSFB-	8785	12077	20-Dec-01	CareFirst of Maryland, Inc. Articles of Amendment and Restatement
CSFB-	8786	12177	01-Jan-02	Community Impact Analysis of Proposed Conversion of CareFirst to a for-profit Business Entity and the Merger between CareFirst and WellPoint
CSFB-	8940	12159	01-Aug-02	Blue Cross of California Underwriting Guidelines Small Group Services 2 - 50 Employees
CSFB-	8988	12173		Blue Cross of California Web Site pages
CSFB-	8992	12205		Blue Cross of California Web site "Healthy Living"
CSFB-	8994	12269	01-Jan-02	An Assessment of Health Coverage Industry Trends and CareFirst's Strategic Response
CSFB-	8997	12247		Blue Cross of California website "Management Programs"
CSFB-	9000	12270		Blue Cross of California website "Health Care Resources, Information and Special Discounts
CSFB-	9003	12791	06-Mar-02	Pre-Filed Testimony of L Schaeffer, W. Jews, R Smith, D Altobello, G Mendoza, M Burks, D Lachman, J Marabito, S Smith and G Bauer
CSFB-	9004	12302		Blue Cross of California website "Breast Cancer Article
CSFB-	9007	12306		WellPoint website Healthcare Quality Assurance Medical Policy
CSFB-	9008	12313		Blue Cross of California website "Learn about our health plans and how to enroll
CSFB-	9020	12368	31-Dec-99	Blue Cross of California Annual Statement
CSFB-	9023	12424	31-Dec-01	Blue Cross of California Annual Statement
CSFB-	9024	12480	31-Dec-01	Blue Cross of California Annual Statement
CSFB-	9026	12572	31-Dec-99	BC Life & Health of Woodland Hills California Annual Statement
CSFB-	9028	12668	31-Dec-00	BC Life & Health of Woodland Hills California Annual Statement

CSFB-	9032	13806		CareFirst and Affiliates financials and models
CSFB-	9067	12793	31-Dec-01	BC Life & Health of Woodland Hills California Annual Statement
CSFB-	9074	12970	01-Oct-99	Briefing Book for Standard and Poor's Ratings Group 1999 Update
CSFB-	9101			Index of Documents contained in Binder 14
CSFB-	9102	12843		Blue Cross of California Formulary
CSFB-	9109	12858		Blue Cross Georgia Formulary
CSFB-	9115	12948		BCBS Georgia Product Information, BCBS Georgia Diabetes Information, BCBS Georgia Breast Cancer Information
CSFB-	9119	13116	01-Aug-99	Blue Cross Georgia HMO Provider Directory and Member Guide
CSFB-	9122	13183	01-Nov-00	Briefing Book for Standard and Poor's Ratings Group
CSFB-	9126.1	13286	01-Feb-00	Blue Cross Georgia HMO Provider Directory and Member Guide
CSFB-	9158	13272	20-Nov-00	Presentation to Standard and Poor's Ratings Group: 2000
CSFB-	9208	13453	15-Apr-99	ITBP Overview
CSFB-	9211	13463	01-May-00	Blue Cross Georgia HMO Provider Directory and Member Guide
CSFB-	9213	151	02-Sep-99	Employment Agreement between CareFirst and John A. Picciotto
CSFB-	9224	13751		CareFirst Technology Architecture Guidebook v0.9
CSFB-	9225	13647	01-Aug-00	Blue Cross Georgia HMO Provider Directory and Member Guide
CSFB-	9227	13836	01-Nov-00	Blue Cross Georgia HMO Provider Directory and Member Guide
CSFB-	9235	14000	13-Jan-99	CareFirst IT Blueprint Prepared by Ernst & Young LLP
CSFB-	10501	14700		Duplication document production
CSFB-	11201	14028	01-Feb-01	Blue Cross Georgia HMO Provider Directory and Member Guide
CSFB-	11901	186	01-Jul-00	DLJ Presentation to the CareFirst Board of Directors, Project Chesapeake
CSFB-	12601	14375	20-Feb-96	Current State Assessment Findings - Draft of Presentation for: Bill Jews in preparation for Strategic Planning Committee of the Board of Directors
CSFB-	13807	14234	01-May-01	Blue Cross Georgia HMO Provider Directory and Member Guide
CSFB-	14701	14453	01-Aug-01	Blue Cross Georgia HMO Provider Directory and Member Guide

CSFB-	14744	14635		CareFirst Technology Architecture Guidebook v0.9
CSFB-	15039	14646	01-Nov-01	Blue Cross Georgia HMO Provider Directory and Member Guide
CSFB-	15092	15010	12-Apr-00	Common CareFirst Terms and Definitions for subject areas of Member, Client, Provider, Product and Claims
CSFB-	15096	14880	01-Mar-02	Blue Cross Georgia HMO Provider Directory and Member Guide
CSFB-	15114	14743		Duplicate document production.
CSFB-	15117	15038	23-Aug-02	Forwards rough draft copy of deposition transcripts of Thomas Snead and Tim Nolan
CSFB-	15175	15121	01-May-02	Blue Cross Georgia HMO Provider Directory and Member Guide
CSFB-	15184	15268	16-Nov-99	Enterprise Structure and Approach Version 15.0
CSFB-	15186	15091		Duplicate document production
CSFB-	15434	15095	09-Sep-02	Forwards copy of MIA press release re: release of valuation report
CSFB-	15441	15113	10-Sep-02	Forwards copy of Stuart Smith pre-filed testimony
CSFB-	15444	15116	10-Sep-02	Baltimore Sun article "CareFirst worth more, analyst says"
CSFB-	15454	15174		Copy of pre-filed testimony of Stuart Smith and attached presentation Project Chesapeake dated 11/20/01 made to Board of directors
CSFB-	15501	15365	01-Aug-02	Blue Cross Georgia HMO Provider Directory and Member Guide
CSFB-	15606	15183	10-Sep-02	Forwards copy of WellPoint's response to Blackstone preliminary report and MIA press release
CSFB-	15611	15185	11-Sep-02	Forwards copy of CSFB's conflict letter to David Wolf dated 3/12/02
CSFB-	15613	15433	12-Sep-02	Forwards copy of SPC board presentations made by CSFB
CSFB-	16801	159	02-Dec-01	CareFirst Merger Incentive Plan
CSFB-	18283	15279	01-Apr-02	Chart reflecting Documents Provided by CareFirst in Response to MIA Document Request as of 4/1/02
CSFB-	18291	15287	01-Apr-02	Chart reflecting documents produced by WellPoint to MIA Document Request as of 4/1/02
CSFB-	18296	15305	16-Jan-01	Opinion from Piper, Marbury, Rudnick & Wolfe on Fiduciary Duties of Directors in Connection with Possible Business Combination
CSFB-	18297	15307	14-Feb-01	Letter recommending that CareFirst not pursue discussions with Anthem.
CSFB-	18315	15309	26-Jun-01	Letter explaining that Atlantic (Trigon) has improved their offer, there remain uncertainties relative to the Pacific (Anthem) offer.

CSFB-	18325	15311	30-Nov-01	Confirming that the Board received sufficient information to make an informed decision with respect to WellPoint proposal and satisfied its duty of care
CSFB-	18337	15313	07-Mar-01	Expresses appreciation for continued interest in a potential relationship with Anthem and CareFirst
CSFB-	18340		29-Aug-01	Corporate strategy is for CareFirst to merge with an entity that is converted.
CSFB-	18349	15334	29-Jul-02	CareFirst Presentation to the Blackstone Group
CSFB-	18355	15637		WellPoint and CareFirst's Pleadings/Discovery Binder of the District of Columbia
CSFB-	18359	15584	01-Feb-01	Blue Cross Georgia HMO & POS Provider Directory and Member Guide
CSFB-	18360	15440	13-Sep-02	Forwards copy of agenda and topic questions for meeting with DC experts the Cain Brothers
CSFB-	18365	15443	19-Sep-02	Forwards copy of Baltimore Sun article "State's budget shortfall balloons."
CSFB-	18366	15453	23-Sep-02	Forwards copy of Sun article "CareFirst Growing Pains"
CSFB-	18368	15500	23-Sep-02	Forwards copy of agenda and material for 9/24/02 SPC meeting
CSFB-	18371	15605	25-Sep-02	Forwards execution copy of Agreement and Plan of Merger with WellPoint
CSFB-	18374	15818	01-May-01	Blue Cross Georgia HMO & POS Provider Directory and Member Guide
CSFB-	18377	15610	01-Oct-02	Forwards copies of Sun articles "WellPoint going ahead on CareFirst" and Officials trade accusations on CareFirst-Trigon deal
CSFB-	18378	15612	17-Oct-02	Forwards copy of agenda for 10/24/02 SPC meeting
CSFB-	18382	16800		Duplicate document production
CSFB-	18587	16280	05-Sep-02	Binder of Documents produced by CareFirst at deposition of William Jews, which had previously been produced.
CSFB-	18595	16070	01-Nov-01	Blue Cross Georgia HMO & POS Provider Directory and Member Guide
CSFB-	18596	163	08-Jan-01	Letter forwarding for signature letter to Bill Jews acknowledging participating in merger incentive plan
CSFB-	18597	16333	01-Mar-02	Blue Cross Georgia HMO & POS Provider Directory and Member Guide
CSFB-	18599	16283	05-Sep-02	Index of Documents prepared by CareFirst that are responsive to August 29, 2002 Subpoena
CSFB-	18707	16285		Trigon proposed post-merger compensation package for William Jews
CSFB-	18709		08-Nov-01	Trigon Chart of post-transaction management structure for William Jews and Thomas Snead
CSFB-	18710	16289	23-Oct-01	Memorandum regarding Geographic Expansion Update
CSFB-	18713		22-Oct-01	Draft document with proposed post-transaction responsibilities for Jews/Snead

CSFB-	18716		30-Oct-01	Draft Document with proposed post-transaction responsibilities for Jews/Snead
CSFB-	18717	16293		CareFirst-Trigon preliminary due diligence proposed schedule
CSFB-	18721	16300	11-May-00	Joint opportunities meeting minutes
CSFB-	18722	16304	02-Oct-00	Merrill Lynch comments on Trigon
CSFB-	18726	16306	05-Oct-00	Financial improvement document for meeting between Wolf and Nolan
CSFB-	18732	16312	12-Nov-01	Medicare drug card program
CSFB-	18734	16316	23-Oct-01	News article by Blue Caucus
CSFB-	18736	16319	12-Oct-01	Minnesota Bulletin re AG action in conversions
CSFB-	18738	16321	10-Oct-01	Trigon Contribution to Historic Maggie Walker School
CSFB-	18740	16323	03-Jul-01	News Article re: reshuffling of Blue Cross of Georgia
CSFB-	18742		06-Jul-01	Letter re:Terms of Proposed Agreement
CSFB-	18750	16327	18-Mar-01	Letter clarifying proposal
CSFB-	18758		12-Mar-01	Email re: working together to serve northern Va Medicaid population
CSFB-	18760	16332	11-Jan-01	Addition to due diligence request list.
CSFB-	18762	16337	03-Jan-01	List of confirmatory due diligence
CSFB-	18765	16602	01-May-02	Blue Cross Georgia HMO & POS Provider Directory and Member Guide
CSFB-	18781	16340	23-Oct-00	Benefits to Constituents of Local Partnership
CSFB-	18787	16343	05-Oct-00	Direct response advertising campaign with attached draft Story Line
CSFB-	18794	16345	14-Sep-00	Framework for Merrill Lynch and DLJ to begin to evaluate the potential CareFirst/Trigon affiliation
CSFB-	18803		07-Nov-00	Request to view Trigon's document management area
CSFB-	18808	16348	01-Aug-00	Notes from meeting between Jews, Higins & Brouse
CSFB-	18811		29-Mar-00	Agenda for 3/29/00 Trigon e-Distribution Meeting
CSFB-	18812	16357	02-Jun-00	CareFirst, Inc. Organization Charts
CSFB-	18861		09-May-00	Draft agenda for 5/11/00 meeting

CSFB-	18862		11-Feb-00	Conversation with Dan Glaser
CSFB-	18909		10-Mar-00	Meeting with Tim Nolan
CSFB-	18912	16365	27-Apr-98	Confidential Trigon document re: discussions with Dave Wolf and Greg Devou titled Identifying Common Opportunities
CSFB-	18928	16368	23-Apr-98	Discussion agenda for 4/27/98 CareFirst/Trigon meeting
CSFB-	18982	16371	17-Apr-97	Clarification that Trigon did not state to newspaper that it was gobbling up Blue plans
CSFB-	19054	16385	25-Jun-99	Agenda for discussion for 6/25/99 meeting
CSFB-	19072		15-Jan-99	CareFirst internal memorandum re: double branding issues, facts and figures, and local strategy inclusive of physician issues
CSFB-	19094	16392	14-Jan-99	CEO Summit Issues Draft
CSFB-	19097	16414	13-Oct-00	CareFirst Trigon Business Case Validation Proposed Information Exchange and Meeting
CSFB-	19098	174	08-Jan-02	Letter forwarding for signature by Bill Jews a letter to various executives informing them of participating in merger incentive plan
CSFB-	19102	16548	01-Aug-99	Documents related to synergies of Trigon and CareFirst
CSFB-	19106	16573	13-Sep-00	North Carolina conversion statute
CSFB-	19108		08-Dec-00	Amendment to 9/21/00 Trigon/CareFirst agreement
CSFB-	19115	16582	13-Apr-00	CareFirst-Trigon plan profile
CSFB-	19481	16585	18-Jul-00	Marked draft of letter from Snead to Jews
CSFB-	19776	16587	14-Mar-01	Excerpt from CSFB presentation
CSFB-	19817	16670	05-Mar-01	Facsimile from CSFB to Isaac Neuberger with Trigon proposal
CSFB-	19852	16876	01-Aug-02	Blue Cross Georgia HMO & POS Provider Directory and Member Guide
CSFB-	19861	16772	31-Dec-01	Annual Statement of CareFirst of Maryland, Inc.
CSFB-	19891	16822	31-Dec-01	Annual Statement of CareFirst, Inc.
CSFB-	19912	18283		Duplicate document production
CSFB-	19935	16936	31-Dec-01	Annual Statement of Group Hospitalization and Medical Services
CSFB-	19948	17044	01-Nov-99	Blue Cross Georgia POS Provider Directory and Member Guide
CSFB-	19958	17037	31-Dec-01	Annual Statement of FreeState Health Plan, Inc.

CSFB-	19963	17143	31-Dec-01	Annual Statement of CareFirst BlueChoice, Inc.
CSFB-	19970	17224	01-Feb-00	Blue Cross Georgia POS Provider Directory and Member Guide
CSFB-	19977	17226	31-Dec-01	Annual Statement of Delmarva Health Plan, Inc.
CSFB-	19990	17401	01-May-00	Blue Cross Georgia POS Provider Directory and Member Guide
CSFB-	20006	17288	31-Dec-01	Annual Statement of First Care, Inc.
CSFB-	20053	17323	26-Jan-02	CareFirst, Inc. and Affiliates consolidated financial statements as of 12/31//01 and 12/31/00
CSFB-	20055	17355	31-Jan-01	CareFirst, Inc. and Affiliates consolidated financial statements as of 12/31//00 and 12/31/99
CSFB-	20057	17376	26-Jan-00	CareFirst, Inc. and Affiliates consolidated financial statements as of 12/31/99 and 12/31/98
CSFB-	20145	17401	22-Jan-99	CareFirst, Inc. and Affiliates consolidated financial statements as of 12/31/98 and 12/31/97
CSFB-	20222	17422		GAAP Quarterly Reports for last 2 years and 2002
CSFB-	20265	17583	01-Aug-00	Blue Cross Georgia POS Provider Directory and Member Guide
CSFB-	20315	17510	31-Dec-97	Annual Statement of BCBSD, Inc. filed in Delaware
CSFB-	63333	178	20-Nov-01	CareFirst Board Resolution approving the Plan Documents for Incentive Plans and designation of Plan Participants
DEL-	1	17596	31-Dec-97	Annual Statement of CareFirst of Maryland, Inc.
DEL-	91	17773	01-Nov-00	Blue Cross Georgia POS Provider Directory and Member Guide
DEL-	121	17644	31-Dec-97	Annual Statement of Columbia Medical Plan, Inc.
DEL-	172	17690	31-Dec-97	Annual Statement of Delmarva Health Plan, Inc.
DEL-	246	17743	31-Dec-97	Annual Statement of Free State Health Plan, Inc.
DEL-	365	17793	31-Dec-97	Annual Statement of Healthcare Corporation of the Mid-Atlantic
DEL-	370	17966	01-Feb-01	Blue Cross Georgia POS Provider Directory and Member Guide
DEL-	372	17911	31-Dec-98	Annual Statement of BCBSD, Inc. filed in Delaware
DEL-	374		19-Dec-01	Email re: salary continuation benefit, and whether this benefit is paid under a general severance plan already in place.
DEL-	383	17996	31-Dec-98	Annual Statement of CareFirst of Maryland, Inc.
DEL-	385	18186	01-Aug-01	Blue Cross Georgia POS Provider Directory and Member Guide

DEL-	411	18080	31-Dec-98	Annual Statement of CapitalCare, Inc. filed in DC
DEL-	429	208	14-Dec-01	Email forwarding letters of participation asking whether the letters should be signed by Jews or Picciotto
DEL-	483	18154	31-Dec-98	Annual Statement of Delmarva Health Plan, Inc.
DEL-	494	18206	31-Dec-98	Annual Statement of FirstCare, Inc.
DEL-	496	18424	01-Mar-02	Blue Cross Georgia POS Provider Directory and Member Guide
DEL-	498	18289	31-Dec-98	Annual Statement of FreeState Health Plan, Inc.
DEL-	504	18290	29-Oct-01	Forwards copy of material for meeting with Trigon including memorandum from Dave Wolf to Bill Jews
DEL-	543	18290	31-Dec-99	Annual Statement of CareFirst, Inc.
DEL-	561	18295	31-Oct-02	Project Evergreen
DEL-	568	18296	01-Nov-01	Chesapeake - Break up fee
FB-	1	18315	02-Nov-01	Pacific Subordinated Note
FB-	3	18324	19-Nov-01	06/15/2000 CareFirst Engagement Letter from DLJ
FB-	43	18336	24-Jan-01	CareFirst memo to Jews re: Valuation; article that questions 1.3 BN purchase price
FB-	45	18328	22-Jan-02	Maryland Hearing Outline
FB-	69	18447	31-Dec-99	Annual Statement of BCBSD, Inc. filed in Delaware
FB-	140	18339	25-Jan-02	CareFirst Response to Questions re: Valuation
FB-	187	18348	05-Feb-02	MIA consultant for CareFirst Merger (PHC bio)
FB-	225	18354	22-Feb-02	Meeting information
FB-	258	18358	06-Mar-02	Information on Hearings
FB-	305	18359	07-Mar-02	CareFirst
FB-	317	18364	20-Mar-02	CareFirst Liquidity Analysis
FB-	345	18365	20-Mar-02	William Jews of CareFirst, MBNA, Ryland Homes, Choice Hotels, EcoLabs, and MuniMae (trying to set up meeting with Adebayo Ogunlesi - head of Investment Banking with CSFB).
FB-	354	18367	25-Mar-02	Background Memo for Bill Jews meeting on 3/28/2002
FB-	361	18370	27-Mar-02	Jews Bio

FB-	362	18373	22-Apr-02	CareFirst Experts
FB-	368	18376	22-Apr-02	CareFirst Experts
FB-	375	18377	24-Apr-02	signed affidavit
FB-	379	18381	03-May-02	Anthem/Trigon Summary of Key Terms
FB-	384	18586	14-May-02	BCBS research
FB-	388	18664	01-May-02	Blue Cross Georgia POS Provider Directory and Member Guide
FB-	423	18548	31-Dec-99	Annual Statement of CareFirst of Maryland, Inc.
FB-	426	18654	31-Dec-99	Annual Statement of Group Hospitalization and Medical Services filed in DC
FB-	431	18594	06-Jun-02	Blackstone's request - working group list and due diligence request list.
FB-	439	18595	07-Jun-02	WLP stock prices
FB-	441	18596	07-Jun-02	Sellside Fee for WellPoint-Cerulean Del
FB-	476	18598	17-Jun-02	Joe France's visit
FB-	479	18706	03-Jul-02	Blackstone Management Discussion Presentation
FB-	483	18735	31-Dec-99	Annual Statement of CapitalCare, Inc.
FB-	487	18908	01-Aug-02	Blue Cross Georgia POS Provider Directory and Member Guide
FB-	562	224	27-Jul-00	DLJ Presentation to the CareFirst Board of Directors, Project Chesapeake
FB-	566	18708	09-Jul-02	Partner Performance Update
FB-	569	18709	16-Jul-02	Marilyn Maultsby - MD Healthcare Foundation
FB-	570	18712	22-Jul-02	SPC Info and Agenda
FB-	578	18715	23-Jul-02	CareFirst Projections
FB-	581	18716	25-Jul-02	DISR Question
FB-	583	18720	26-Jul-02	Agenda for Monday, July 29th 3:00 p.m. Blackstone Meeting
FB-	586	18721	15-Aug-02	Wellpoint pulls Delaware CareFirst bid for now (Reuters)
FB-	802	18725	09-Sep-02	MIA Releases Blackstone Report

FB-	804	18731	10-Sep-02	Wellpoint's Response to Blackstone's Report
FB-	808	18733	16-Sep-02	9/24/2002 Strategic Planning Committee Info
FB-	877	18735	25-Sep-02	CareFirst Editorial from Baltimore Sun
FB-	880	18810	31-Dec-99	Annual Statement of Delmarva Health Plan, Inc.
FB-	881	18737	25-Sep-02	CareFirst Editorial from Washington Post
FB-	1009	18739	28-Sep-02	Wellpoint going ahead on CareFirst
FB-	1011	18741	02-Oct-02	Smith Affidavit to MIA
FB-	1090	18749	10-Oct-02	Makik Hasan Bio
FB-	1207	18757	11-Oct-02	Biography of Masik Hasan
FB-	1209	18759	17-Oct-02	SPC Agenda
FB-	1215	18761	23-Oct-02	Timeline: Regulatory Process
FB-	1270	18764	23-Oct-02	Updated Schedule
FB-	1272	18780	15-Nov-02	Responsive documents produced by CSFB pursuant to the subpoena issued 11/8/2002
FB-	1283	18786	19-Nov-02	Fax from Carol Burt re: Cerulean valuation report
FB-	1303	18793		DISR's First Request for Information
FB-	1304	18802	04-Sep-02	CSFB Health Care Services Weekly Injection - 5/3/02
FB-	1422	18807	04-Sep-02	Affidavit of Stuart Smith
FB-	1440	18810	04-Sep-02	CareFirst Projections
FB-	1442	18863	31-Dec-99	Annual Statement of First Care, Inc.
FB-	1503	18811	06-Sep-02	DC Dept of Insurance Info Requests
FB-	1626	18860		Portions of Hearing Transcript (Stuart Smith)
FB-	1628	18861	10-Sep-02	Friday's conference call
FB-	1648	18900		Requests for Production of Information and Documents
FB-	1660	18950	31-Dec-99	Annual Statement of FreeState Health Plan, Inc.

FB-	1661	19162	01-Jun-98	BlueChoice PPO Preferred Provider Directory
FB-	1680	18911	12-Sep-02	Recent deals done for Wellpoint
FB-	1683	18927	26-Sep-02	More responses that reference CSFB (re: Value, Due Diligence)
FB-	1687	18981	26-Sep-02	Executive Summary of events taken place prior to 12/4/2000; Key Transaction Issues (side by side comparison between Trigon and Wellpoint); Strategic Rationale (analysis of pursuing transaction with either Trigon or Wellpoint); Key Transaction Issues (comp
FB-	1851	18996	31-Dec-00	Annual Statement of CareFirst, Inc.
FB-	1869	19053	26-Sep-02	Trigon Facing Falling Stock Price; Wellpoint Closes Cerulean Deal; 2000 Financial Performance Comparison (CareFirst, Trigon, Wellpoint); Key Deal Points: Side by Side Comparison (Atlantic v. Pacific); Trigon 2Q Results; Wellpoint 2Q Comparison; Meeting of
FB-	1888	19109	31-Dec-00	Annual Statement of BCBSD, Inc. filed in Delaware
FB-	1893	19071	26-Sep-02	2/28/2002 Carefirst Meeting of the Strategic Planning Committee (Agenda & Minutes, Plan: Initiative Review, Wellpoint Update, Legislative Update); 7/25/2002 Carefirst Meeting of the Strategic Planning Committee (Agenda & Minutes, Industry Update, Regulator
FB-	1903	19093	26-Sep-02	Carefirst Income Statements; Rollforward of Tax Attributes; Wellpoint Health Networks 3Q01 Results from Morgan Stanley
FB-	1973	19096	06-Sep-01	Discussion re: A Transaction between Anthem and Carefirst and Jews precluding at this time it is not in CareFirst's interest to pursue this matter
FB-	1981	19097	08-Oct-01	Associate Benefits
FB-	1999	19101	10-Nov-01	Selected Excerpts from CareFirst Contract Draft of 11/10/01
FB-	2124	19105	22-Jan-02	Maryland Hearing Outline
FB-	2125	19107	11-Mar-02	MD Insurance Administration Hearings Update
FB-	2127	19114	08-Nov-02	Subpoena for the deposition of Stuart Smith
FB-	2273	19194	31-Dec-00	Annual Statement of CareFirst of Maryland, Inc.
FB-	2283	19480	25-Sep-02	Final Merger documents
FB-	2302	19490	01-Apr-99	BlueChoice PPO Preferred Provider Directory
FB-	2312	19287	31-Dec-00	Annual Statement of Group Hospitalization and Medical Services, Inc. filed in DC
FB-	2324	19372	31-Dec-00	Annual Statement of CaptialCare, Inc.
FB-	2404	19443	31-Dec-00	Annual Statement of Delmarva Health Plan, Inc.
FB-	2477	19502	31-Dec-00	Annual Statement of First Care, Inc.

FB-	2481	19775	19-Aug-02	Rough draft transcripts of the testimony of Thomas Snead and Timothy Nolan
FB-	2485	19748	01-Aug-99	Blue Cross Blue Shield of Georgia PPO Provider Directory and Member Guide
FB-	2487	19596	31-Dec-00	Annual Statement of FreeState Health Plan, Inc.
FB-	2489	19706	31-Dec-01	Annual Statement of BCBSD, Inc. filed in Delaware
FB-	2629	19709		Transmittal memo and document titled History and Member Transition of FreeState HMO
FB-	2630	19713	31-Dec-01	CareFirst BlueCross BLueShield Market Share by Market Area as of 12/31/01
FB-	2640		01-Apr-02	Transmittal letter for response to first subpoena duces tecum
FB-	2667	19716	23-Aug-02	Transmittal letter for document request from Lewin Group
FB-	2668	19720	01-May-02	Customer Satisfaction Survey Results
FB-	2772	19724	23-Aug-02	CareFirst and Affiliates Underwriting Gain & Loss Report by Market Segment December 2001 Year To Date Actual
FB-	2774	19726		CareFirst Performance 2001 BCBSA Performance Measures
FB-	2775	19750		Maryland Health Care Commission Guide for Consumers
FB-	2777	20026	01-Feb-00	Blue Cross Blue Shield of Georgia PPO Provider Directory and Member Guide
FB-	2779	19758	01-Apr-02	Status of Document Production Chart
FB-	2781	19795	23-Nov-99	Strategy Implications Discussion (duplicate of CF-0011150-11186)
FB-	2784	19816	20-Nov-01	Project Chesapeake (presentation to the BOD)
FB-	2786	19830	04-Dec-00	Project Chesapeake (duplicate of CF-0004635-4664)
FB-	2787	19851	26-Apr-01	Project Chesapeake (presentation to the BOD)
FB-	2788	19857	26-Apr-01	Summary of Major Provisions (duplicate of CF-0005296-5322 and depo exhibit 145)
FB-	2790	19860	12-Mar-02	CareFirst Executive Summary
FB-	2792	19899	20-Nov-01	Summary of Key Proposed Terms (duplicate of CF-0005501-5661)
FB-	2794	19890	26-Apr-01	Project Chesapeake (presentation to the BOD)
FB-	2799	19911	06-Mar-02	Prefiled Written Testimony - Gene E. Bauer, PhD., Managing Director, Hay Group, Inc.
FB-	2800	19946	11-Jul-00	Project Chesapeake (duplicate of CF-0004800-4846)

FB-	2807	19934	06-Mar-02	Prefiled Written Testimony - Joseph Marabito, Partner, Accenture
FB-	2808	19947	04-Mar-02	Prefiled Written Testimony, Stuart F. Smith, Managing Director, Credit Suisse First Boston Corporation
FB-	2876	19979	27-Jul-00	Presentation to SPC Project Chesapeake (duplicate of CF-0004856-4888
FB-	2911	19957	01-Mar-02	Prefiled Testimony of Daniel J. Altobello, Chairman, Carefirst Inc., BOD
FB-	2912	19962	01-Mar-02	Prefiled Written Statement, Robert W. Smith Jr., Partner, Piper Marbury Rudnick & Wolfe LLP
FB-	2913	19969	01-Mar-02	Testimony of Gary S. Mendoza Before The Maryland Commissioner of Insurance
FB-	2914	19976	01-Mar-02	Prefiled Written Testimony of Deborah Lachman, Senior Vice President Small Group, Blue Cross of California
FB-	2915	19989	01-Mar-02	Prefiled Written Testimony of Leonard D. Schaeffer, Chairman and Chief Executive Officer, Wellpoint Health Networks Inc.
FB-	2916	20026	26-Oct-00	Presentation to SPC Project Chesapeake (duplicate of CF-0004933-5027)
FB-	2917	20005	11-Mar-02	Written Statement of William L. Jews
FB-	2918	20052		Requests for Production of Information and Documents from Funk & Boyton to CSFB
FB-	2919	20309	01-Aug-00	Blue Cross Blue Shield of Georgia PPO Provider Directory and Member Guide
FB-	2920	20038	21-Nov-00	Presentation to SPC and Finance Committee Project Chesapeake (duplicate of CF-0005119-5130)
FB-	2924	20045	22-Jan-01	Executive Summary (duplicate of CF-0005736-5742)
FB-	2925	20054	23-Mar-01	Summary of Key Terms (duplicate of CF-0005795-5799)
FB-	12724	20054	28-Sep-02	Baltimore Sun news article "WellPoint going ahead on CareFirst"
L-	1	20059	25-Jul-01	WellPoint Overview (duplicate of CF-00058645868)l
L-	1	20056	27-Sep-02	Affidavit of Stuart F. Smith
L-	292	201444		Michael A. Muntner notes re: Project Chesapeake (11/28/00 thru 1/23/01)
L-	292	20062	25-Oct-01	An assessment of Health Coverage industry trends and CareFirst's strategic response (duplicate of CF-0005973-5976)
L-	593	20070	20-Nov-01	Summary of Key Proposed Terms (duplicate of CF-0006020-6027)
L-	593	20135	01-Jun-00	Investment Banker Update presentation to SPC (duplicate of CF-0004710-4782)
L-	1654	20146	22-Feb-01	Key Transaction Issues (duplicate of CF-0005774-5784)
L-	1654	20221		Michael A. Muntner notes re: Project Chesapeake (1/24/01 thru 11/8/01)

L-	2245	20184	27-Jul-00	Project Chesapeake (duplicate of CF-0004281-4318)
L-	2245	20198	11-Feb-99	Request for Proposal (duplicate of CF-0009742-9755)
L-	2968	20238	06-Aug-99	Strategy Execution Integration Meeting (duplicate of CF-0010770-10799)
L-	2968	20264		Michael A. Munter notes re: Project Chesapeake (6/1/2001 thru 9/18/02)
L-	3029	20274	22-Apr-99	Positioning for Industry Leadership (duplicate of CF-0009770-9805)
L-	3029	20314	11-Mar-02	Notes taken during Maryland Hearings for the Carefirst conversion
L-	3050	20325	14-May-99	Strategic Planning Steering Committee Agenda (duplicate of CF-0009806-9856)
L-	3050	20602	01-Feb-01	Blue Cross Blue Shield of Georgia PPO Provider Directory and Member Guide
L-	3094	20346		Notes taken during Maryland Hearings for the Carefirst conversion
L-	3094	20353	18-May-99	Industry Scenario Discussion (duplicate of CF-0009857-9883)
L-	3297	20386	18-May-99	Advisory Panel Meeting (duplicate of CF-0009884-9916)
L-	3297	20423	21-May-99	Strategy Options (duplicate of CF-0009917-9952)
L-	3306	20478	28-May-99	Environment and Strategy Options (duplicate of CF-0009953-0010007)
L-	3306	20548	28-May-99	Industry Scenario Appendix Supporting Information (duplicate of CF-0010008-10077)
N	1	20600	03-Jun-99	Strategy Options Discussion (duplicate of CF-0010078-10129)
N	9	20771	04-Jun-99	Strategy Options Discussion (duplicate of CF-0010130-10190)
N	13	20910	01-Aug-01	Blue Cross Blue Shield of Georgia PPO Provider Directory and Member Guide
N	26	20741	11-Jun-99	Strategy Options Discussion (duplicate of CF-0010191-10270)
N	94	20802	15-Jun-99	Strategy Options Discussion (duplicate of CF-0010271-10331)
N	96	29858	21-Jun-99	Strategy Options Selection (duplicate of CF-0010332-10387)
N	97	20890	24-Jun-99	Strategy Discussion (duplicate of CF-0010388-10419)
N	115	20909	24-Jun-99	Strategy Discussion (duplicate of CF-0010420-10438)
N	129	220		Unexecuted CareFirst Merger Incentive Plan
N	133	20955	24-Jun-99	Strategy Options Discussion (duplicate of CF-0010439-10499)

N	167	21218	01-Mar-02	Blue Cross Blue Shield of Georgia State Wide PPO Provider Directory and Member Guide
N	171	21011	25-Jun-99	Strategy Discussion (duplicate of CF-0010500-10554)
N	172	21081	30-Jun-99	Choosing a Strategic Direction (duplicate of CF-0010555-10624)
N	181	21141	25-Jun-99	Strategy Options Selection (duplicate of CF-10625-10683)
N	188	21179	15-Jul-99	Strategy Execution (duplicate of CF-0010684-10721)
N	189	21227	23-Jul-99	Strategy Execution (duplicate of CF-0010722-10769)
N	191	21559	01-Aug-02	Blue Cross Blue Shield of Georgia PPO Provider Directory and Member Guide
N	192	21252	09-Aug-99	Consumerism Sub Strategy Discussion Document (duplicate of CF-10810-10834)
N	193	21296	23-Aug-99	Pursuing Geographic Dominance: M&A and Corporate Structure Implications (duplicate of CF-0010835-10878)
N	194	21356	23-Aug-99	Strategy Selection Discussion
N	198	21507	25-Aug-99	Agenda and Document Outline for Pursuing market Leadership (duplicate of CF-0010937-11085)
N	199	21525	29-Sep-99	SPC Meeting Implications Discussion (duplicate of CF-0011086-11103)
N	200	21571	11-Oct-99	Capability Assessment (duplicate of CF-0011104-11149)
N	201	21588	01-Jun-97	Blue Cross Blue Shield of Georgia Participating Dentists Directory
N	203	21608	23-Nov-99	Strategy Implications Discussion (duplicate of CF-0011150-11186)
N	207	21621	01-Jun-98	Blue Cross Blue Shield of Georgia Participating Dentists Directory
N	216	21825	01-Jun-02	CareFirst and all Affiliated Subsidiary and Related Companies Organizational Charts
N	218	21669	01-May-00	Blue Cross Blue Shield of Georgia Participating Dentists Directory
N	220	21721	01-May-01	Blue Cross Blue Shield of Georgia Participating Dentists Directory
N	244	21771	01-Sep-01	Blue Cross Blue Shield of Georgia Participating Dentists Directory
N	274	21822	01-Mar-02	Blue Cross Blue Shield of Georgia Participating Dentists Directory
N	332	21875	01-Aug-98	Blue Cross Blue Shield of Georgia Participating Pharmacy Directory
N	361	21833		Review of Competitive Environment
N	389	21852		Information on Products by Business Unit

N	418	21855	16-Jul-02	Market Research Showing Share by Segment, Product & Geography
N	419	21889		Rate Increases & Disenrollment Rate by Product/Network
N	439	21934	01-Jun-99	Blue Cross Blue Shield of Georgia Participating Pharmacy Directory
N	461	21892	12-Jul-02	Study of Enrollment over last 3 years
N	483	21990		Study of Claim Trends Over Last 2 Years
N	488	22345	01-May-00	Blue Cross Blue Shield of Georgia Participating Physicians and Pharmacies Directory
N	490	22029	16-Nov-00	Cost & Utilization Statistics
N	511	22037		IT Project Plan and Long Term Strategy
N	532	22322		Legislation/Regulation Pertaining to Operations
N	533	224	20-Nov-01	CareFirst Board Resolution approving Plan Documents for Incentive Plan and Designation of Plan Participants
N	537	22474	03-Dec-01	Handout for Board of Directors Retreat. (Document produced subject to confidentiality agreement signed on July 29, 2002)
N	539	22774	01-Mar-01	Blue Cross Blue Shield of Georgia Participating Physicians and Pharmacies Directory
N	540	22552	05-Mar-02	Standard & Poors Rating Reports for CareFirst as of January 2001. (Document produced subject to confidentiality agreement signed on July 29, 2002)
N	543	257	27-Jul-00	DLJ Presentation to the Strategic Planning Committee Project Chesapeake
N	544	268	16-Nov-01	Draft Merger Incentive Plan and Retention Bonus Plan
N	545	22558	20-Dec-02	Letter providing response to November 12, 2002 letter requesting information and documents requested during hearings and
N	546	22564		Chronology of Advice to CareFirst Board
N	554	22566	15-Jan-01	Confidential Forecast and 2002 Financial Plan and capital Budget of CareFirst and Affiliates
N	557	22569	19-Dec-02	Affidavit of Stuart F. Smith providing follow-up information requested during hearing.
N	560			CFI EBITDA Analysis attachment to 12/19/02 Affidavit
T	1			CSFB Fee Calculation Associated with CareFirst Engagement attached to Stuart Smith 12/19/02 affidavit
T	25	22573		Analysis of Recent Follow-on Offering (100% Secondary Shares) and Fee Calculation Associated with Foundations Distribution of Stock Portion of Merger Consideration attached to 12/19/02 Stuart Smith affidavit
T	26	22583	20-Dec-02	Responses to questions posed to Joe marabito of Accenture by Commissioner Larsen during the Maryland hearings on 4/29 and 30

T	30			Bullet point presentation regarding CareFirst and Trigon negotiations
T	115	22588	20-Dec-02	Affidavit of G. Mark Chaney providing additional information to Commissioner
T	118			CFMI Incurred Care Comparison, CFMI Expense Comparison, and GHMSI Expenses attached to Mark Chaney 12/20/02 affidavit
T	121			FreState Loss Incurred for Risk Providers 1998 through 2001 attached to Mark Chaney 12/20/02 affidavit
T	122			CFMI Non Risk Business effect on Underwriting gain attached to Mark Chaney 12/20/02 affidavit
T	123	22596		List of CareFirst Files not Originally produced pursuant to investigative subpoena dated 9/23/02
T	128	22630	01-Oct-02	Rate Manual, Formulas & Underwriting Guidelines for GHMSI, CareFirst Blue Cross Blue Shield
T	136	22657	31-Dec-02	Lag Triangles for GHMSI Total, BlueChoice Total, and CFMI Total
T	139	22693	31-Dec-01	Experience Reports by Product
T	142	22695		CareFirst Networks number of doctors and hospitals
T	220	23323	01-Mar-02	Blue Cross Blue Shield of Georgia Participating Physicians and Pharmacies Directory
T	239	23479	01-Aug-98	HMO Georgia BlueChoisce Platinum Provider Directory
T	252	23635	01-Jan-99	HMO Georgia BlueChoisce Platinum Provider Directory
T	256	23811	01-Jun-99	HMO Georgia BlueChoisce Platinum Provider Directory
T	258	23991	01-Jan-00	HMO Georgia BlueChoisce Platinum Provider Directory
T	263	252	10-May-01	CareFirst, Inc. Change of Control Incentive Compensation
T	269	24170	01-May-00	HMO Georgia BlueChoisce Platinum Provider Directory
T	271	24359	01-Sep-00	HMO Georgia BlueChoisce Platinum Provider Directory
T	289	24421	01-May-01	HMO Georgia BlueChoisce Platinum Provider Directory Green Network
T	320	24578	01-May-01	HMO Georgia BlueChoisce Platinum Provider Directory Blue Network
T	321	24771	01-Mar-02	HMO Georgia BlueChoisce Platinum Provider Directory
T	322	24999	01-Oct-02	HMO Georgia BlueChoisce Platinum Provider Directory
T	324		08-Nov-01	Chart reflecting shared and primacy duties of combined Trigon and CareFirst companies Exhibit 112, Thomas Snead Deposition
T	325	25670		Blue Cross Blue Shield of Georgia Participating Physicians Directory

T	326	25977	01-Nov-97	Blue Cross Blue Shield of Georgia Participating Physicians Directory
T	329	304	26-Oct-00	DLJ Presentation to Strategic Planning Committee Project Chesapeake
T	332	26252	01-Apr-97	BlueChoice Georgia Statewide Provider Directory
T	345	29	20-Sep-00	Transmittal of Confidentiality Agreement signed by Trigon and CareFirst
T	364	26529	01-Aug-97	BlueChoice Georgia Statewide Provider Directory
T	366	26863	01-May-98	BlueChoice Georgia Statewide Provider Directory
T	369	27263	01-Aug-98	BlueChoice Georgia Statewide Provider Directory
T	371	271	04-Apr-01	Executive Management five year wage history 1996 - 2000
T	387	295	19-Apr-01	Update of competitive pay levels for Trigon HealthCare and WellPoint Health Networks by Hay Management consultants
T	391	27547	01-Dec-00	BLueChoice Option POS
WP-	1	27861		Blue Cross Blue Shield Georgia Traditional Health Plan Certificate Booklet for years 2000 - 2002
WP-	135	27897	01-May-01	Blue Cross Blue Shield of Georgia Vision Benefit Program Submission Copy
WP-	1346	28146		Blue Cross Blue Shield of Georgia BlueChoice Certificate Booklet Submission Copies for years 2000 - 2002
WP-	3164	28216		Blue Cross and Blue Shield of Georgia Individual Participating Provider Dental Plan Policy
WP-	3166	28170		Blue Cross Blue Shield of Georgia Dental Benefit Program Submission Copies for years 2001 - 2002
WP-	3272	28416		Blue Cross and Blue Shield of Georgia Large Group Participating Provider Dental Plan Certificate of Coverage
WP-	3281	28695		Blue Cross and Blue Shield of Georgia BlueChoice Healthcare Plan Certificate Submission Copies of Booklets for years 2000 - 2002
WP-	3329	28703		Independent Medical Review Application Form
WP-	3335	29370		Prepaid and Periodic Charges for years 1999 - 2002
WP-	3344	29637		Blue Cross and Blue Shield of Georgia PDF
WP-	3346	301		Potential Change of Control Payments
WP-	3347	29826		Blue Cross of California Quarterly Reports filed with Health Care Service Plan Division for years 1999 and 2001
WP-	3348	31248		Blue Cross of California Large Group Sales Communications
WP-	3352	114	02-Mar-01	Proposal Letter with Term Sheet and Draft Agreement submitted by Trigon to CSFB Exhibit 103, Thomas Snead Deposition

WP-	3374	304	04-Jun-01	Executive Employment charts reflecting termination payments due to change of control
WP-	3395	307	17-May-01	Overview of Potential Change of Control Payments under existing agreements
WP-	3431	316	21-Nov-00	CSFB Presentation to the Finance Committee & Strategic Planning Committee Project Chesapeake
WP-	3564	314	08-May-01	CareFirst chart re: summary of change of control provisions under employment agreement and LTIP
WP-	3627	328	01-May-01	Chart reflecting payments to be made to executives upon change of control and merger incentives
WP-	3628	31590	02-Dec-02	NCQA's Health Plan Report Card
WP-	3648	31647	02-Dec-02	BCBSGA - Information from BCBS website regarding BCBSGA (including history, NCQA scores, HEDIS, HEDIS scores, customer service, claims processing, overall ratings)
WP-	3705	31649	02-Dec-02	BCBSGA - In the Community
WP-	3767	31670	14-Nov-02	Presentation by Max Brown (Senior VP, Network Svcs) re: Prudent Buyer Network to the Physicians Relations Committee
WP-	3799	31762	02-Dec-02	BCBSCA website information (including history, member rights); Blue Cross of California HEDIS 2002 Report to Employers
WP-	3889	344	04-Dec-00	CSFB Presentation to the CareFirst Board of Directors Project Chesapeake
WP-	3918	31837	08-Jul-98	Resubmission of Forms F-1681.742 (BCBSGA); Certificate Booklet F-1681.742 (BCBS New Chip)
WP-	3959	32012	02-Jun-99	BCBSGA New Chip Certificate Booklet F-1681.742 (Rev 1/99)
WP-	3992	32191	27-Jul-98	HMO Georgia Inc. Blue Choice Option Alternative Policy Certificate Booklet
WP-	4033	32377	02-Jun-99	HMO Georgia Blue Choice Option Certificate Booklet F-16814.722 (Rev 1/99)
WP-	4091	32574	27-Jul-98	BCBSGA Blue Choice PPO Alternative Policy Certificate Booklet F-1681-792-001 (Rev 2/98)
WP-	4092	32777	02-Jun-99	BCBSGA Blue Choice PPO Certificate Booklet F-1681.792-000 (Rev 1/99)
WP-	4129	32931	27-Jul-98	HMO Georgia Blue Choice Healthcare Plan Alternative Policy Certificate Booklet F-1681-782-001 (rev 2/98)
WP-	4189	332	18-May-01	CareFirst Potential Payments in connection with a change of control
WP-	4251	33104	02-Jun-99	HMO Georgia BlueChoice HealthCare Certificate Booklet F-1681.782 (rev 1/99)
WP-	4274	33186	09-Mar-01	BCBSGA 65 Plus Subscriber Contract (Plan A-Plan F) (rev 1/99)
WP-	4293	33292	13-Dec-01	BCBSGA 65 Plus Outline of Medicare Supplement Coverage

WP-	4336	33330	28-Mar-02	BCBSGA Resubmission 65 Plus Subscriber Contract (Subscriber Contract, Smart Choice Endorsement, Subscriber Application, Outline of Coverage)
WP-	4377		18-May-01	Chart re: Potential change of control payments for executives
WP-	4396	33507	23-Aug-01	BCBSGA Individual Flexplus Member Contract
WP-	4444	335	17-May-01	Preparation of chart reflecting the payment of incentive and change of control payments to executives.
WP-	4463	33676	21-Sep-01	BCBSGA Individual Flexplus Member Contract
WP-	4478	341		hand written notes re: incentive payments
WP-	4492	33695	15-Mar-99	BCBSGA Individual Hospital/Surgical Contract
WP-	4728	33709		BCBSGA Member Enrollment Application
WP-	4841	33725	24-Jan-01	BCBSGA Individual Markets Health Insurance Application
WP-	4956	33743		BCBSGA HEDIS 1997 Health Plan, Employer Data and Information Set
WP-	5047	33761		BCBSGA HEDIS 1997 Health Plan, Employer Data and Information Set
WP-	5140	33783		BCBSGA HEDIS 2000 - 1999 Health Plan Employer Data and Information Set
WP-	5205	33785		BCBSGA HEDIS 2001 - 2000 Health Plan, Employer Data and Information Set
WP-	5275	33787		BCBSGA HEDIS 2002 - 2001 Health Plan, Employer Data and Information Set
WP-	5541	33841	01-Oct-01	BCBSGA BlueChoice PPO Individual Saver
WP-	5830	33855		BCBSGA Amendment - Individual Flexplus Health Insurance Contract
WP-	6083	33861		BCBSGA Amendment - Individual Hospital Surgical Health Insurance Contract
WP-	6197	33862		BCBSGA Endorsement Smartchoice Plan Deductible Amount
WP-	6301	33941	23-Aug-01	BCBSGA BlueChoice PPO Individual PPO Member Contract (rev 5/01)
WP-	6368	33948	31-Oct-01	BCBSGA Resubmission of Individual Saver $2000 Policy
WP-	6411	34027	02-Nov-01	BCBSGA BlueChoice PPO - Individual PPO Member Contract (rev 9/01)
WP-	6473	34119	17-Dec-99	BCBSGA BlueChoice PPO - Individual PPO Member Contract
WP-	6495	34170	19-Nov-96	BCBSGA Conversion Individual Policy Forms

WP-	6592	34229	10-Aug-98	BCBSGA Assigned Risk Indemnity Outline of Coverage
WP-	6648	343	11-May-01	Forwards proposed modifications discussed regarding executive compensation
WP-	6750	343	11-May-01	Summary of proposed modifications to executive compensation and change of control payments
WP-	6815	34293	18-Nov-97	HMO Georgia Inc Group Medicare Risk Product
WP-	6894	34334	24-Apr-96	BCBSGA Basic Hospital/Surgical Policy Forms
WP-	6974	34494	01-May-01	BCBSGA Individual Hospital/Surgical Contract
WP-	7022	360	14-May-01	Presentation re: Proposed modifications to existing and proposed arrangements providing for payments to executives in connection with change of control.
WP-	7200	34559	01-Jul-02	BCBSGA Contract Specification Page; Individual Deductible Contract
WP-	7296	353	04-Dec-00	CareFirst Geographic Expansion Alternatives, Discussion of the Board of Directors
WP-	7431	34616	10-Aug-98	BCBSGA Enhanced Conversion Outline of Coverage
WP-	7564	34709	01-Apr-02	BCBSGA Resubmission of the High Deductible Plans
WP-	7696	34715	02-Aug-02	Blue Choice PPO MSA Eligible Rates
WP-	7709	34767	03-Jul-02	BCBSGA Limited Annual Benefit Plan
WP-	7733	34846	09-Mar-01	BCBSGA Dental Group Contract (rev 2/01)
WP-	7734	34965	01-Apr-02	BCBSGA Dental Benefit Program w/Orthodontics
WP-	7857	35396	01-Jan-97	Contract Templates (Participating Hospital Agreement; Participating Physician Agreement; Participating Certified Registered Nurse Anesthetist; Participating Optometrist Agreement; Preferred Physician/Provider Agreement; Preferred Physician Group Provider
WP-	7858	35858	26-Sep-94	NCQA Amended Final Assessment Report - CaliforniaCare Health Plans
WP-	7859	360	18-Nov-01	Executive Summary prepared for Strategic Planning Committee on 1/22/01
WP-	7860	35979	16-Dec-96	NCQA 1996 Final Assessment Report - CaliforniaCare Health Plans
WP-	7861	26599	19-Oct-00	Amended Final Assessment Report - Blue Cross of California
WP-	7863		18-Nov-01	Next Steps prepared for Strategic Planning Committee Meeting on 1/22/01
WP-	7870	368	30-Apr-01	Payments made in connection with Cerulean change of control

WP-	7871	367	22-Feb-01	Key Transaction Issues prepared for CareFirst Board Meeting on 2/22/01
WP-	7872	36709	11-Aug-99	Blue Cross of California - Report of Results of HEDIS/CAHPS 2.0H Member Satisfaction Survey (For Commercial Members Continuously Enrolled in 1998 and Age 18 or Over as of 12/31/1998)
WP-	7873	36891	01-Jul-00	Blue Cross of California - Commercial Adult HEDIS/CAHPS 2.0H Member Satisfaction Research (July 2000)
WP-	7879	374	22-Feb-01	Key Transaction Issues prepared for the Strategic Planning Committee Meeting on 2/22/01
WP-	7880	37031	01-Jun-01	Blue Cross of California - Commercial Adult HEDIS/CAHPS 2.0h Member Satisfaction Research (June 2001)
WP-	7883	372	10-May-01	Summary of current and proposed payments under change of control agreements
WP-	7884	37208	01-Jun-02	Blue Cross of California - Commercial Adult (June 2002)
WP-	7885	37286	01-Jan-02	Wellpoint 2002 Human Resources Associate Handbook
WP-	7886	380	08-May-01	CareFirst Summary of Severance and Incentive Payments
WP-	7887	378	22-Feb-01	Interloper Analysis prepared for Strategic Planning Committee Meeting on 2/22/01
WP-	7890	383	21-Mar-01	Summary of Key Terms prepared for Strategic Planning Committee Meeting 3/32/01
WP-	7891	386	08-May-01	Summary of change of control provisions under employment agreements and LTIP
WP-	7892	387	25-Apr-01	Summary of Major Provisions prepared for CareFirst Board Meeting 4/26/01
WP-	7893	394	08-May-01	Summary of severance and incentive payments showing changes made upon netting out non-compete consideration
WP-	7894	422	26-Apr-01	Presentation to CareFirst Board Project Chesapeake
WP-	7895	401	02-May-01	Change of control provisions under employment agreements and LTIP
WP-	7896	408	01-May-01	Hays equity based compensation for each executive
WP-	7897	416	04-May-01	Email forwarding Hays group calculations for executive payments
WP-	7898	431	01-May-01	Draft of Memorandum re: Reasonable compensating under Golden Parachute Rules
WP-	8224	431	01-May-01	Draft of Reasonable Compensation under Golden Parachute Rules memorandum
WP-	8632	425	26-Apr-01	Summary of Major Provisions prepared for Strategic Planning Committee Meeting
WP-	9324	430	20-Jul-01	WellPoint Overview prepared for Strategic Planning Committee and Finance Committee Meeting on 7/25/01

WP-	9350	438	05-Nov-01	Summary of Key Proposed Terms prepared for Strategic Planning Committee Meeting on 11/5/01
WP-	9411	440	20-Nov-01	Summary of Key Proposed terms prepared for CareFirst Board Meeting on 11/20/01
WP-	9474	475	20-Nov-01	Presentation to CareFirst Board Project Chesapeake
WP-	9584	77	20-Nov-01	CSFB Opinion Letter
WP-	9693	482	20-Feb-01	Request for Proposal
WP-	9823	486	02-Mar-01	Trigon's submission of proposal
WP-	9954	561	02-Mar-01	Draft Agreement and Plan of Merger
WP-	10063	523	01-Jun-01	Discussion piece re: compensation presentation
WP-	10115	565	15-Mar-01	Letter clarifying proposal of Trigon
WP-	10223	568	23-Apr-01	Letter in response to request to revise proposal
WP-	10264		12-Jun-01	Letter regarding informing of separate letter regarding social issues.
WP-	10300	577	22-Jun-01	Letter clarifying proposal by Trigon
WP-	10365	580	26-Jun-01	Letter explaining role of Bill Jews after merger
WP-	10433	582	11-Jul-01	Regards meeting between Bill Jews and Tom Snead
WP-	10536	585	19-Jul-01	Letter regarding role of Bill Jews after merger with Trigon
WP-	10643	801	01-Aug-01	Clean and Red Lined versions of Agreement and Plan of Merger between Atlantic and CareFirst
WP-	10750	803	15-Nov-02	Label for binder 2 of 6
WP-	10857	807	20-Feb-01	Letter to WellPoint requesting Proposal
WP-	10940	876	02-Mar-01	Submission of proposal and draft Plan of Agreement and Plan of Merger with hand written notes
WP-	11022	973	23-Mar-00	WellPoint Schedule 14A Information
WP-	11053	879	15-Mar-01	WellPoint's response to issued raised by CSFB
WP-	11084		19-Mar-01	Letter responding to concern by CareFirst of lower minimum share price of WellPoint stock
WP-	11123	1008	19-Apr-01	Email Memo from Piper Rudnick and redline and clean versions of Agreement and Plan of Merger
WP-	11168	978	23-Jul-01	Draft of Memorandum regarding Compensation plans for CareFirst Executives

WP-	11238	978	23-Jul-01	Revised draft of memorandum re: compensation issues
WP-	11275	981	23-Jul-01	Draft of Memorandum regarding Compensation plans for CareFirst Executives
WP-	11324	979	23-Jul-01	Draft memorandum re: compensation issues
WP-	11404	1155	27-Apr-01	Transmittal letter forwarding employment Contracts for CEO, six Executive Vice Presidents, and Senior Vice President of Sales of CareFirst
WP-	11452	1010	24-Apr-01	Letter increasing WellPoint's purchase price to $1.3 Billion
WP-	11500	1089	02-May-01	Memo with draft agreement attached to show WellPoint comments.
WP-	11576	1206	18-May-01	Email forwarding memo from Piper Rudnick reflecting changes and providing a clean and marked up copy of agreement for review.
WP-	11630	117	18-Mar-01	Letter clarifying Trigon Proposal that was submitted on 3/2/01, Exhibit 104, Thomas Snead Deposition
WP-	11684	1158	27-Apr-01	Executive Management Five Year Wage History 1996 - 2000
WP-	11739	1260	21-Dec-00	Cerulean Companies Inc. Schedule 14A
WP-	11829	120	23-Apr-01	Letter revising aspects of Trigon Proposal Exhibit 105, Thomas Snead Deposition
WP-	11920	1208	22-May-01	Email forwarding replacement page which changes the definition of maximum note consideration.
WP-	11946	1214	22-May-01	Forwards proposed summary of terms for subordinated notes.
WP-	12039		12-Jun-01	Fax cover page
WP-	12131	1269	01-Jun-01	Forwarding draft of CareFirst schedules that are subject to change
WP-	12160		12-Jun-01	Letter to acknowledge a series of issues that need to be resolved which include a series of business and social issues. Exhibit 106,
WP-	12174	127	12-Jun-01	Fax confirmation pages for Tim Nolan letter to David Wolf
WP-	12206	1332	19-Mar-01	Executive Compensation in Comparative Transactions
WP-	12248	1271	25-Jun-01	Email submitting proposal for change to section 7.1(j) "No litigation"
WP-	12271	1282	09-Jul-01	Forwarding WellPoint's comments on Section 6.1 "Pre-Closing Operations.
WP-	12303	1850	15-Nov-01	Clean and red lined copy of merger agreement
WP-	12307	135	22-Jun-01	Points of Clarification and Improvement from Prior Offer Letters, Exhibit 107, Thomas Snead Deposition
WP-	12314	1302	23-Jul-01	Email forwarding revised Section 6.1 which discuss objectives to be accomplished after merger.
WP-	12369		15-Nov-02	Label for Binder 3 of documents

WP-	12425	1421	03-Aug-01	Draft of Agreement and Plan of Merger between Pacific and CareFirst
WP-	12481	1338	25-Apr-01	Facsimile forwarding Iowa journal of Corp law re: Blue Cross Ohio deal and payment to inside counsel for noncompete agreement
WP-	12573	1340	19-Jun-01	Email concerning payments to executives in BCBS Ohio case
WP-	12669	1375	01-Jul-98	University of Iowa Journal of Corporation Law article - Checkpoints on the Conversion Highway: Some troupe spots in the conversion of non-profit health care organizations to for-profit status
WP-	12794	138	26-Jun-01	The Role of William Jews in a CareFirst/Trigon merger, Exhibit 108, Thomas Snead Deposition
WP-	12795	1390	25-Apr-01	Facsimile forwarding articles re: failed BCBS Ohio deal and problems with executive payment.
WP-	12844	141	19-Jul-01	Further explanation as to the role of William Jews in new CareFirst/Trigon Company Exhibit 110, Thomas Snead Deposition
WP-	12859	1396	26-Oct-98	Chart reflecting payment to various executives from various corporations
WP-	12949	1403	11-Nov-97	Cerulean Form 8-K
WP-	13117	1414	29-Jan-01	Chart reflecting pay of other Insurance executives and stock options
WP-	13287	1407	02-Feb-01	Free Edgar publication re: payments to management resulting from merger
WP-	13464	1446	01-Sep-98	Premium Pay II Corporate Compensation in America's HMOs
WP-	13648	219	16-Oct-01	New Term Sheet, list of leaders to interview and draft agreement, Exhibit 111, Thomas Snead Deposition
WP-	13836	1439	28-Sep-01	Revised version of Subordinated Note marked to show changes
WP-	14029	1441	03-Oct-01	Email explaining that WellPoint has not agreed to allow the notes to be transferable.
WP-	14235	1502	05-Nov-01	Markup of 8/3/01 draft agreement.
WP-	14454	1450	02-Feb-01	FreeEdgar article re: payments to management resulting from merger
WP-	14647		30-Nov-01	Email requesting copies of final letters of participation
WP-	14881	1474	26-Nov-01	Email forwarding copy of Retention Bonus Plan and Merger Incentive Plan
WP-	15122	1541	20-Nov-01	Email providing marked and clean copies incentive plan
WP-	15366	1625	09-Nov-01	Redlined and Clean version of Agreement and Plan of Merger between Pacific and CareFirst
WP-	15585	1546	20-Nov-01	Slides prepared by Piper Rudnick re: changes in incentive plan as requested by WellPoint
WP-	15819	1548	17-May-01	Overview of Potential Change of Control Payments under existing Agreements

WP-	16071	1569	19-Nov-01	Request copies of retention plan, incentive plan and term sheet for retention bonus be printed for meeting with CareFirst
WP-	16334		19-Nov-02	Comments by Bill Kirk regarding concerns over officer employment agreements, associate benefits and gap between protections of 7.5 in BCBSD CareFirst agreement and protections in 6.17 of agreement with Pacific
WP-	16603	1588	16-Nov-01	Marked up pages from merger agreement
WP-	16877	1616	16-Nov-01	Copy of incentive plan, retention plan, term sheet for merger retention, term sheet for bonus plan board resolution and memo to board
WP-	17045	1644	16-Nov-01	Forwarding copies of agreements, forwarded same to WellPoint requesting comments on incentive plan, term sheet and retention bonus plan
WP-	17225	1627	12-Nov-01	Memo re: merger agreement on tax insurance issue, and modification to definition of Purchaser Material Adverse Effect.
WP-	17402	1647	12-Nov-02	Facsimile forwarding marked up versions of merger agreement
WP-	17584	1648	15-Nov-01	Forwarding term sheet for incentive plan and proposal by WellPoint dated 7/19/01 for purposes of conference call with Sharon Vechioni and Isaac Nueberger
WP-	17774	1659	13-Nov-01	Follow-up comments to markup of merger agreement
WP-	17967	1650	15-Nov-01	Forwarding copy of 7/19/01 terms of incentive plan and CIC plan
WP-	18187	1670	15-Nov-01	Forwards copy of retention bonus plan and merger retention incentive plan
WP-	18425		15-Nov-02	Label for Binder four
WP-	18665	1679	14-Nov-01	Revised Subordinated Note
WP-	18909	1675		WellPoint Restricted Stock Program
WP-	19163	1686	06-Dec-00	WellPoint 1999 Stock Invective Plan as amended through 12/6/00
WP-	19491	1682	14-Nov-01	Revised section 6.14 with definition of Superior Proposal with cover memo from Piper Rudnick
WP-	19749	1686	14-Nov-01	Draft form of Affiliate letter
WP-	20027	1694	27-Oct-98	WellPoint Officer Severance Plan as adopted 10/27/98
WP-	20310	1732	15-Nov-01	Marked up copy of subordinated note
WP-	20603	1753	06-Nov-01	Forwards final definitive set of comments from Simpson Thacher and WellPoint.
WP-	20911		13-Jun-01	Pacific's concern with respect to compensation payments

WP-	21219	FB01868	16-Nov-01	Clean copy of Subordinated Note
WP-	21560	1887	16-Nov-01	Comments to Subordinated Note
WP-	21589	1892	16-Nov-01	Draft Tax Indemnity Agreement
WP-	21622	1902	16-Nov-01	Disclosure Schedules of WellPoint
WP-	21670	1972	16-Nov-01	Comments to CareFirst Disclosure Schedule
WP-	21722	1980	16-Nov-01	Comments on section 2.6 Headquarters, and covenants of parties
WP-	21772	1998	16-Nov-01	Comments regarding Merger
WP-	21823	2123	19-Nov-01	Clean and red lined versions of merger agreement
WP-	21876		15-Nov-02	Label for binder 5
WP-	21935	2126	19-Nov-01	Proposed attachment 9.10 listing employees of CareFirst and purchaser
WP-	22346	2272	19-Nov-01	Marked and clean versions of CareFirst Disclosure Schedules
WP-	22775		13-Apr-01	Board needs to determine a sale bonus based on sale amount CEO will receive under company's long term plan. Board should then decide whether the plan payments would be in addition or netted out.
WP-	23324	238	17-Oct-00	Revised Business Case Discussion, Exhibit 115, Tim Nolan Deposition
WP-	23480	2282	20-Nov-02	Revised Tax Indemnification Agreement
WP-	23636	2301	20-Nov-01	Revised Subordinated Note
WP-	23812	2311	20-Nov-01	WellPoint Disclosure Schedules
WP-	23992	2306	26-Mar-01	Equity Based Compensation in Comparative Transactions draft memo
WP-	24171	2323	20-Nov-01	Marked up CareFirst Disclosure Schedules
WP-	24360	2317	22-Mar-01	Providing charts reflecting top 5 payout based on comparison to ECAS Survey and top 5 payout based on constant % = merger consideration
WP-	24422	2324	20-Mar-01	Email re: comparative transactions worksheet revised to add information about cash payments
WP-	24579	2403	11-Dec-01	Redlined and clean version of Disclosure Schedules
WP-	24772	2336	13-Feb-01	Fiduciary Duties Executive Summary
WP-	25000	2364	19-Feb-01	Analysis of market trends and executive contract

WP-	25671	2366	19-Feb-01	Retaining Key Executives
WP-	25978	2369	12-Feb-01	Facsimile of draft letter to Bill Jews re: incentive pay
WP-	26253	2378	05-Feb-01	Facsimile of draft letter to Bill Jews re: market trends for executive contract provisions
WP-	26530		01-Feb-01	Memorandum regarding management incentive plan
WP-	26864	2388	26-Jan-01	Draft of proposed letter to Bill Jews from Don Barnes to Mark Muedeking
WP-	27264	251	14-Nov-00	Due Diligence list of document and information requests from Trigon to CareFirst, Exhibit 116, Tim Nolan Deposition
WP-	27548	2403	31-Jan-01	Draft of Proposed letter to Bill Jews
WP-	27862	2476	17-Dec-01	Redlined version of Disclosure Schedules
WP-	27898	2480	08-Jan-02	Changes to Disclosure Schedule 4.12(j)(ii) Employee Plans; ERISA; Labor Matters
WP-	28171	2482	31-May-01	Corrections to Compensation and Benefits Discussion
WP-	28174	2484	08-Jan-02	Draft letter to WellPoint enclosing CareFirst disclosure schedules
WP-	28217	2486	09-Jan-02	Comments on draft letter to WellPoint re: CareFirst Disclosure Schedules
WP-	28281	2488	10-Jan-02	Revisions to letter to WellPoint re: CareFirst Disclosure Schedules
WP-	28417	2628	10-Jan-02	Clean and redlined versions of disclosure schedules of CareFirst
WP-	28695	255	17-Jan-01	List of Virginia General Assembly Bills
WP-	28704	2538		Handwritten Notes re: Executive Compensation
WP-	29371	257	14-Nov-00	Email message forwarding Due Diligence list of document and information requests from Trigon to CareFirst (duplicate of email, no list attached)
WP-	29638	262	12-Jan-01	Virginia 2001 Session Bill Summary
WP-	29827		15-Nov-02	Label for Binder 6
WP-	31584	268	05-Aug-02	Vision of Partnership - Foundation for a Regional Blue Rough Draft Exhibit 117, Tim Nolan Deposition
WP-	31591	2639		Pre-Filed Testimony of Daniel J. Altobello
WP-	31648	2666	04-Mar-02	Pre-Filed Written Testimony of Stuart F. Smith
WP-	31650		15-Nov-02	Index of documents responsive to Item 2 of subpoena

WP-	31671	2771	20-Nov-01	Execution copy of Agreement and Plan of Merger
WP-	31763	270	22-Jan-01	Proposed Diligence Discussion and Tour Schedule Exhibit 118, Tim Nolan Deposition
WP-	31838	288	24-Jan-01	BCA Brand Strength Reports forwarded by Tim Nolan Exhibit 119, Tim Nolan Deposition
WP-	32013	2773	07-Dec-00	Letter from Glasscock to Jews re: merger with Anthem
WP-	32192		03-Jan-01	Letter from Glasscock to Jews re: possible merger with Anthem
WP-	32378	2776	05-Feb-01	Glasscock letter reiterating interest in merger with Anthem
WP-	32575	2778	13-Feb-01	Letter addressing issues that CareFirst has with Anthem
WP-	32778	2780		Letter addressing
WP-	32932	2783	26-Feb-01	Letter expressing disappointment regarding possible merger with Anthem.
WP-	33105	2785	20-Aug-01	Anthem still has strong interest in affiliating with CareFirst
WP-	33187		20-Sep-01	Anthem IPO will be achieved on timeline as discussed. Wants to discuss interest more specifically.
WP-	33293		02-Oct-01	Anthem's demutualization is continuing on schedule. Anthem can offer superior value to CareFirst
WP-	33331	2789	02-Nov-01	Anthem priced its initial public offering and the demutualization is compete
WP-	33508	2791	12-Nov-01	Disappointed that Anthem is excluded.
WP-	33677	2793	14-Feb-01	Does not believe that CareFirst should pursue discussions with Anthem
WP-	33696	2798		Pre-Filed written statement of Robert W. Smith
WP-	33710		15-Nov-02	Listing of items responsive to request Item 3
WP-	33726	2806	15-Jun-00	Engagement letter between DLJ and CareFirst
WP-	33744		12-Mar-02	CSFB update to engagement letter
WP-	33762	2875	01-Jun-00	Project Chesapeake presentation to CSFB
WP-	33784	28280		Blue Cross and Blue Shield of Georgia Small Group Participating Provider Dental Plan Certificate of Coverage
WP-	33786	2910	27-Jul-00	Project Chesapeake presentation to SPC
WP-	33788	319	25-Jan-01	Slide Presentation used by Thomas Snead for CareFirst and Trigon discussion between senior teams. Exhibit 120, Tim Nolan Deposition

WP-	33842		15-Nov-02	Listing of documents produced responsive to Item 4
WP-	33856		15-Nov-02	List of documents produced responsive to Item 6
WP-	33862		15-Nov-02	List of documents produced responsive to Item 7
WP-	33863		15-Nov-02	List of documents produced in response to Item 8
WP-	33942		15-Nov-02	List of documents produced responsive to Item 9
WP-	33949		15-Jan-02	List of documents produced responsive to Item 10
WP-	34029		15-Nov-02	Label for binder containing confidential material
WP-	34120		15-Nov-02	List of documents produced responsive to Item 1
WP-	34171		15-Nov-02	CareFirst Income Statements for years 2000 - 2006 (marked as confidential)
WP-	34230	2923		CareFirst, Inc. Roll forward of Tax Attributes (marked as confidential)
WP-	34294		15-Nov-02	List of documents responsive to Item 3
WP-	34335	2930		CareFirst CFI Consolidated Financials. Company projections as of 12/00 (marked as confidential)
WP-	34495		31-Jan-01	Communications Process Exhibit 121, Tim Nolan Deposition
WP-	34560		09-Feb-01	Trigon Special bonus and Thrift Match
WP-	34617	323	03-Jul-01	Atlanta Journal news release re: BCBS of Georgia could eliminate 85 jobs due to merger with WellPoint
WP-	34710		08-Aug-01	Spending against plan ISD/OPS (email only, not attached document)
WP-	34716		08-Aug-01	CSFB Fees and any other advisors with compensation contingent upon transaction.
WP-	34768	328	10-Sep-01	Partnership Frame Work Meeting Summary of meeting between Tim Nolan John Picciotto, and David Wolf, discussion re: Trigon's objection to incentive pay to executives. Exhibit 122, Tim Nolan Deposition.
WP-	34847	331	04-Oct-00	Draft of Business Case Discussion
WP-	34966	344	14-Nov-00	List of topics for due diligence discussions
WP-	35397	363	23-Oct-00	Revised Business Case Preliminary Synergies
WP-	35859	365		duplicate documents of emails re: Spending against plan ISD/OPS and CSFB fees
WP-	35980	368	23-Oct-00	Benefits to Constituents of Local Partnership

WP-	36600	370	20-Oct-00	Additional Unique Admin Line Items
WP-	36710	386	20-Oct-00	Updated Business Case Study
WP-	36892	390	07-Apr-00	Schedule of Statistics Exhibit 113, Tim Nolan Deposition.
WP-	37032	403	02-Oct-00	Follow Up data for Market Share, Hospital Revenues, Physician Network breakdown Exhibit 114, Tim Nolan Deposition.
WP-	37209	5238	22-Jun-01	Forwards revised version of 6.1 of agreement and proposed new article reflecting additional agreements dealing primarily with management, social and compensation related issues.

SCHEDULE G

DEPOSITION AND HEARING EXHIBITS

EXHIBIT#	BATES RANGE/ DATE/DESCRIPTION	AUTHENTICATION
March and April, 2002 Hearing Exhibits		
1	Prefiled Written Testimony in Connection with the Maryland Public Hearing on the Proposed Conversion of CareFirst and its Acquisition by WellPoint CF-0012270 - CF-0012791	
2	State Government Article Title 6.5	
3	Board Meeting June 24, 1999 CF-0003527 - CF-0003612	
4	Board Discussion October 28, 1999	
5	Presentation to Project Chesapeake July 27, 2000	
6	Presentation to Board of Directors Project Chesapeake December 4, 2000	
7	CareFirst, Inc. Experts	
8	Supplemental Filling in Accordance with Title 6.5, Subtitle 3 of State Government Article	
9	Letter filed pursuant to Ins. Article ' 14-106 dated March 1, 2002 from John A Picciotto to Commissioner Larsen	
10	Presentation to Starndard and Poor=s Ratings Group: 2001 November 13, 2001	
11	Preliminary Planning Document Regarding Future Investments in Information Technology without Having Access to Additional Capital	
12	Minutes of the SPC August 23, 2001 CF-0005902 - CF-0005935	

13	Sumamry packet of Information Supplied by CareFirst with 6 Sub-Exhibits	
14	SPC Meeting Minutes 6/24/99 CF-0006580 - CF-0006622	
15	SPC Meeting Minutes 9/23/99 CF-0006704 - CF-0006791	
16	SPC Meeting Minutes 10/99 CF-0006792 - CF-0006877	
17	SPC Meeting Minutes 6/1/00 CF-0004702 - CF-0004791	
18	Board Minutes 10/28/99 CF-0003666 - CF-0003762	
19	Standard & Poor=s Outlook for 2002 - Submitted by CareFirst	
20	Standard & Poor=s Presentation on 11/13/01	
Deposition of Thomas Snead 8/19/02		
100	Deposition Subpoena to Thomas Snead and Tim Nolan	Page 12, L 14-18
101	T0001 - 0024; 9/2/99; Synergies table and supporting documents.	Pages 18-20, L 22-7 Has seen, hand writing is Identified by Nolan
102	CF0006331 -6334; 2/2/01; CSFB letter to Snead to request bid	Pages 53-54, L 8-2
103	T0030-0114; 3/2/01; Trigon term sheet and draft merger agreement	Page 60, L 1-8
104	T0115 -0117; 3/18/01; Trigon bid clarification letter	Page 86, L 10-22
105	T0118-120; 4/23/01; Trigon bid clarification letter	Page 92, L 16-22
106	T0122; 6/12/01; Nolan to Wolf re: issues	Snead has seen Identified by Nolan Pages 61-62, L 19-4
107	T0128-0135; 6/22/01; Snead to Jews re: roll for Jews	Pages 98-99, L 16-13
108	T0136-0138; 6/26/01; Snead to Jews re: roll clarification for Jews	Page 113, L 3-15

109	CF0006358-59; 7/11/01; Platter letter to Snead and Jews re: meeting	Pages 118-119, L 12-11
110	T0139-141; 7/19/01; Snead to Jews	Page 122, L 6-16
111	T0142-0219; 10/16/01; Trigon draft agreement	Page 123, L 7-16
112	T0025; 11/8/01; flow chart for responsibilities of Snead and Jews	Pages 130-131, L 15-11
	Deposition of Tim Nolan 8/19/02	
113	T0387-0390; 4/7/00; Byrd to Chaney re: schedule of statistics	Page 17, L 20-14
114	T0391-0403; 10/2/00; Gosselin to Thompson re: followup data	Pages 19-20, L 22-1
115	T0220-0238; 10/17/00; Bear to Nolan re: business case	Page 26, L 4-13
116	T0239-251; 11/14/00; Nolan to Wolf re: due diligence list	Pages 35-36, 21-5
117	T0263-0268; 1/22/01; Nolan Wolf re: reverse due diligence presentation	Pages 38-39, L 22-1
118	T0269-0270; 1/22/01; Nolan to Wolf re: revers due diligence schedule	Page 43, L 2-8
119	T0271-0288; 1/24/01; Nolan to Devou re: brand strength	Page 52, Lines 6-18
120	T0289-0319; 1/26/01; Nolan to Wolf re: Snead presentation slides	Page 53, L 3-10
121	T0320; 1/31/01; Nolan to Devou re: announcement	Page 92, L 10-20
122	T0326-0328; 9/10/01; Beard to Nolan re: 9/7/01 meeting summary	Pages 79-80, L 19-5
	Deposition of William L. Jews September 6, 2002	
123	Deposition Subpoena	
124	ACareFirst may have sold for too little@ Baltimore Sun 8/22/02	Pages 13-14, L 11-3
125	ACareFirst says it feared layoffs despite pledge of losing bidder@ Baltimore Sun 8/23/02	Pages 14-15, L 11-3

126	ACareFirst chief accuses Trigon over Testimony@ Baltimore Sun 8/24/02	Page 15, L 10-19
127	CF-0004900-4901; 10/26/00 SPC Meeting Minutes	Pages 82-83, L 21-4
128	CF-0005119-5130; CSFB Presentation attached to 11/21/00 SPC Meeting Minutes	Page 82, L 4-20
129	CF-0004422-4426;12/04/00 Annual Planning Session of the Directors of CareFirst	Page 87, L 6-15
130	CF-0004635-4664; CSFB Presentation attached to 12/04/00 Annual Planning Session	Page 93, L 8-18
131	CF-0006313-6314; 12/7/01 Glasscock to Jews	Pages 98-99, L 21-9
132	CF-0006315; 1/3/01 Glasscock to Jews	Page 104, L 6-22
133	CF-0005713-5755; 1/22/01 SPC Meeting Minutes	Pages 111-112, L 12-1
134	CF-0006316-6317; 2/5/01 Glasscock to Jews	Page 122, L 14-21
135	CF-0006318-6319; 2/13/01 Jews to Glasscock	Pages 143-144, L 18-4
136	CF-0008528-8531; 2/20/01 Adams to Schaeffer soliciting bid	Pages 145-146, L 20-21
137	CF-0005756-5757; 2/22/01 SPC Meeting Minutes	Pages 157-158, L 22-5
138	CF-0006320-6322; 2/26/01 Glasscock to Jews	Page 161, L 13-17
139	CF-0008524-8527; 3/2/01 Schaeffer to Adams, WellPoint Offer	Page 186, L 18-21
140	CF-0015312-15313; 3/7/01 Jews to Glasscock	Page 192, L 2-11
141	CF-0008533-8535; 3/15/01 Colby to Adams re: WellPoint Offer	Page 197 L 2-11
142	CF-0008532; 3/19/01 Colby to Adams, WellPoint Bid Enhancement	Page 201, L 14-22, does not recall ltr
143	CF-0005785-5805; 3/23/01 SPC and Finance Committee Meeting Minutes	Page 206, L 10-20
144	CF-0008536-8537; 4/24/01 Colby to Adams re: Bid	Page 210-211, L 19-9
145	CF-0005234-5329; 4/26/01 CareFirst Board of Director Meeting Minutes and Exec. Session	Page 212, L 14-18

146	CF-0005806-5821; 4/26/01 SPC Meeting Minutes	Page 225, L 13-18
147	outline of proposed compensation for Jews	Page 280, L 7-17
148	chart reflecting Trigon propose job duties after merger	Page 288-299, L 8-1
149	10/23/01 Wolf to Jews re geographic expansion update	293-294, L14-19
150	7/18/01 ltr to Jew re: Jews role	Pages 390 - 391, L 2 -22 does not recall
151	10/22/01 draft of role of Jews	393-394, L 13-14
Deposition of David Wolf September 19, 2002		
152	CF-0005822 - 5851; 5/24/01 SPC and Finance Committee Meeting Minutes	
153	CF-0005852 - 5901; 7/25/01 SPC and Finance Committee Meeting Minutes	
154	Key Deal Points: Side by Side Comparison from 7/25-26/01 Board Meeting	
155	CF-0005936 - 5965; 9/25/01 SPC Meeting Minutes	
156	Color version of Key Deal Points Chart form 9/25/01 SPC Meeting	
157	CF-0005966 - 5994; 10/25/01 SPC Meeting Minutes	
158	Color version of Negotiation Status on Key Deal Points Chart from 10/25/01 SPC Mtg	
159	CF-0005995 - 6004; 11/05/01 SPC Meeting Minutes	
Deposition of Mark Muedeking October 10, 2002		
160	Long Term Performance Incentive Plan between key employee and BCBS Maryland	
161	CareFirst, Inc. Executive Retirement Plan	
162	Jews Employment Agreement dated 11/24/98	

163	CF02386 - CF02388; 1/26/01 draft of proposed letter to Bill Jews from Don Barnes to Mark Muedeking	
164	CF02394 - CF02403; 1/26/01 draft of proposed letter to Bil Jews	
165	CF02385; 2/1/02 memo Grieb to Jews re: Management Incentive Plan	
166	CF02370 - CF02378; fax of draft letter to Bill Jews 2/5/01	
167	CF02367 - CF02369; 2/12/01 fax of draft letter to Bill Jews re: incentive pay	
168	CF02335 - CF02336; Fiduciary Duties: Executive Summary	
169	CF02357 - CF02364; 2/19/01 ltr Don Barnes to Joseph Haskins re: analysis of market trends and executive contract	
170	CF02365 - CF02366 2/19/01 ltr Don Barnes to Joseph Haskins re: retaining key executives	
171	CF02322 - CF02324; 3/20/01 fax Pham Chuong to Muedeking re: comparative transaction worksheet	
172	CF02314 - CF02317; 3/22/01 fax Bill Jews to Muedeking re: payout chart comparison to ECAS survey	
173	CF02303 - CF02306; 3/26/01 memo Choung Pham to no addressee re: equity based compensation in comparative transactions	

Continuation of Exhibits to Deposition of William Jews September 6, 2002

174	6/24/99 ECC meeting minutes	Page 298-299, L 17-2
175	2/22/00 Vecchioni memo re: 2/22/00 ECC meeting	Pages 302-303, 19-8
176	7/27/00 ECC meeting minutes	Page 306, L 6-18
177	3/23/01 Special ECC Meeting	Page 307, L 13-19
178	4/20/01 Speicial ECC Meeting	Page 316, L 13-20
179	4/26/01 ECC Meeting Minutes	Pages 324-325, L 21-1

180	5/24/01 ECC Meeting Minutes	Page 326, L 6-10
181	6/12/01 ECC Meeting Minutes	Page 340, L 15-20
182	7/9/01 ECC Meeting Minutes	Page 346, L 2-6
183	7/25/01 ECC Meeting Minutes	Page 350, L 3-8
184	11/20/01 Special Board Meeting Minutes	Page 373, L 4-9

Continuation of Deposition Exhibits of Mark Muedeking October 10, 2002

185	4/12/01 memo Kanter/Timmerman to Muedeking/Thomas re: sale incentive Amount for CareFirst CEO	
186	CF02138; 4/13/01 memo Kanter to Meudeking/Thomas re: board determination on sale bonus	
187	4/20/01 Special Compensation Committee Meeting	
188	4/26/01 Executive Compensation Committee Meeting Minutes	
189	CF02521 - CF02538; hand written notes re: executive compensation	
190	CF00239 - CF00252; CareFirst, Inc. Change of Control Incentive Compensation Agreement	
191	CF00342 - CF00343; 5/11/01 ltr Muedeking to Stuart Smith re: proposed modifications to executive compensation	
192	5/24/01 Executive Compensation Committee meeting minutes	
193	CF02480 - CF02482; 5/31/01 email Muedeking to Thomas compensation and benefits discussion chart	
194	CF00417 - CF00431; draft 5/01 memo re: reasonable compensation under golden parachute rules	
195	CF00516 - CF00523; 6/1/01 email Stuart Smith to Muedeking re: discussion piece re: compensation	

196	CF01767; 6/13/01 memo R Smith to Grieb, Muedeking, Taylor; re: Pacific concern about compensation payments	
197	CF00979 - CF00981; 7/23/01 email Hooder to Thomas re: draft Smith memo re: compensation	
198	CF00974 - CF00978; 7/23/01 email Thomas to Smith re: revised CareFirst memo on compensation	
199	retained by Counsels to BCBS Maryland	

Deposition Exhibits to Stuart Smith Deposition November 11, and 22, 2002		
200	Why Can=t we Fund Our Capital Needs Internally?	
201	Page from Accenture 2001 report addressing what the average large health plan=s investment needs will be for the next 3 to 5 years.	
202	4/26/01 Presentation to Board of Directors AProject Chesapeake@	
203	Investigative Subpoena	
204	7/11/00 Minutes of the Strategic Planning Committee	
205	2/22/01 Minutes of the Strategic Planning Committee	
206	Page from July 27, 2000 DLJ Report regarding Secondary Recommendation	

Hearing Exhibits December 2002		
207	CF02386 - CF 02403; 1/24/01 HayGroup letter to Bill Jews	
208	4/22/02 Piper Rudnick Memorandum to John A. Picciotto re: Advice to Board of Directors	
209	Annotated Code of maryland 6.5-101 - 6.5-307	
210	12/23/97 Order in the Matter of Proposed Business Combination of BCBS of Maryland and Group Hospitality and Medical Services, Inc.	

211	4/22/96 Order in Insurance Commissioner of Maryland v. Consumer Dental Care Co	
212	3/19/01 Findings fo Fact, Conclusion of Law and Order from State of Wisconsin in the Matter of Application for Conversion of BCBS United of Wisconsin	
Deposition Exhibits to Deposition of Mark Chaney January 13, 2003		
213	CareFirst Capital Expenditure Overview	
214	CF-0022377; Expanding Interactive Capabilities of Providers and Members	
215	CF-0022383; HIPAA Board Handout	
216	12/26/02 ltr Mark Chaney to Commissioners of Maryland, Delaware and DC, re: Notice of proposed transaction.	
Deposition Exhibits to Deposition of David Wolf January 13, 2003		
217	Provider Network Management 2001 Update	
218	3/4/01 letter B Edwards to Practitioner re: CareFirst expanding NCA provider networks	
219	6/8/99 letter D Hiller to William Jews re: Alternative Rate Arrangements	
220	Daily Record article ABig Health Insurer Rattles Hospitals@	
221	6/15/99 letter David Wolf re: maintaining relationship with participating hospitals.	
January and February 2003 Hearing Exhibits		
230	Testimony of Blue Cross of Northeastern PA	
231	Statement of James Mead B Capital Bluecross	
232	Remarks of John Brouse, Highmark	
233	Remarks of John Brouse, Highmark	
234	BCBS of Maryland Articles of Amendment and Restatement	

235	CFI Board Minutes October 25, 2001	
236	Neuberger Bills N0000026 B N0000039, N0000042, N0000046 - N0000095, N0000192	
237	Letter from Neuberger to Jews, Oct. 21, 1998. N0000488 B N0000489	
238	Letter from Neuberger to Jews, Oct. 30, 1998, with Employment Agreement attached. N0000490 - N0000510	
239	Neuberger Bill N0000207 - N0000210	
240	Neuberger Bill N0000211 - N0000215	
241	Letter from Neuberger to Jews, Oct. 14, 1998, with attachment. N0000244 - N0000273	
242	Fax from Neuberger to Picciotto Oct. 30, 1998 with attachment. N0000483 - N0000487.	
243	Letter from Neuberger to Jews, Nov. 4, 1998, with Employment Agreement attachment. N0000511 - N0000531.	
244	Exhibit Number Not Used	
245	Income Statements for all Holdco and all subsidiaries	
246	Arthur Anderson audit of Potomac Physicians, P.A., Jan. 26, 2002	
247	Report on Examination of FreeState, Dec. 31, 2000	
248	Letter from William Stack to Les Schott, Dec. 30, 2002	
249	Affidavit of Mark Chaney, Dec. 20, 2002	
250	CareFirst Disclosure Schedule, Agreement and Plan of Merger, Nov. 20, 2001	
251	CareFirst Press Release, March 1, 2001	
252	CareFirst Press Release, Nov. 15, 2002	
253	Cain Brothers Valuation Report, Page 24	
254	CareFirst chart of Medical products, networks, and systems	

255	Overview Extract from KPMG Audit of the NASCO Processing System, 2001	
256	Slide showing Core Systems Integration, (CF B 0022381)	