

Analysis of CareFirst's Performance as a Charitable Not-for-Profit Health Insurance Company in the National Capital Area

Report to the DC Applesseed Center for Law and Justice

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Executive Summary

Introduction

The George Washington University School of Public Health and Health Services (“GWU”) and the Georgetown University Institute for Health Care Research and Policy (“GU”)¹ conducted this analysis on behalf of the DC Appleseed Center for Law and Justice in order to examine whether, in its operations and business practices, CareFirst BlueCross BlueShield (“CareFirst”) appears to be fulfilling its chartered mission for the National Capital Area.² The study began as an analysis of the coverage and access implications for the region of a proposal made by CareFirst and WellPoint Health Networks, Inc. (“WellPoint”) to convert CareFirst to for-profit status and permit its acquisition by WellPoint for a price of \$1.3 billion. Maryland’s Commissioner of Insurance rejected the proposal in March 2003. Upon the request of CareFirst and WellPoint, the insurance commissioners in the District of Columbia and Delaware suspended their review of the transaction.

Consideration of the CareFirst/WellPoint proposal (which ultimately was rejected) served to increase the region’s focus on CareFirst’s overall performance in its role as one of the region’s most important health insurers. CareFirst accounts for 1,061,000 privately insured residents in the Washington D.C. metropolitan area (an estimated 28% percent of all persons in the area with private coverage) and 3.2 million privately insured residents in its entire service area.³ Elevated population health risks in the Washington D.C. metropolitan region, as measured by certain key indicators, suggest the importance from a public health perspective of carefully considering the role of major health insurers such as CareFirst in the design of the health system, the accessibility, affordability and quality of health care, and ultimately, the health of the population as a whole.

The concept of broader population accountability on the part of health insurers may be particularly true in the case of insurers such as CareFirst, which are organized as non-profit corporations. A chartered not-for-profit insurance corporation, CareFirst (and its District subsidiary, Group Hospitalization and Medical Services, Inc. (“GHMSI”)) was chartered by Congress in 1939 as a “charitable and benevolent institution.”⁴ Not-for-profit institutions enjoy considerable tax advantages; the real-dollar value of this advantage in the case of CareFirst

¹ The George Washington University School of Public Health and Health Services (including the Department of Health Policy and its Center for Health Services Research and Policy) and the Georgetown University Institute for Health Care Research and Policy are completely independent from any health care provider entities at their respective universities that might contract with CareFirst/GHMSI.

² The National Capital Area is defined as the CareFirst/GHMSI service area, which the company states as the District of Columbia, suburban Maryland, and Northern Virginia. Suburban Maryland includes Prince George’s and Montgomery counties, and Northern Virginia includes the cities of Alexandria and Fairfax, the town of Vienna, Arlington County, and the areas of Fairfax and Prince Williams counties in Virginia east of Route 123 (see <http://www.carefirst.com/pages/coverage/ghmsi.htm> (accessed on October 20, 2003)). This analysis focuses particularly on the District of Columbia and Northern Virginia. The applicable regulators in Maryland commissioned analyses specific to that jurisdiction.

³ “CareFirst Supplemental Fact Sheet,” available at http://www.wellpoint.com/press_room/special_reports/cf/CFFacts.doc (accessed October 20, 2003).

⁴ See Current GHMSI Federal Charter at § 8 (Appendix A(2)).

(estimated at between \$12 and \$21 million per year in Maryland alone⁵) became publicly apparent during the company's negotiations with WellPoint. With these tax advantages come certain ethical, business and community obligations as suggested in both the literature and case law involving non-profit conversions and acquisitions.

Evidence drawn from numerous sources suggests that CareFirst's obligations can be conceptualized in two distinct ways. The first is a heightened obligation on the part of a company to conduct business practices in a manner that best serves the needs of the entire population of consumers who seek the product. How products are designed, marketed, and generally made available is important in this regard.

The second obligation extends beyond the marketing of a company's particular line of business products. It extends to the community as a whole in which the entity is located and entails the undertaking of activities designed to serve broader public purposes. In the case of health care entities such as CareFirst, this dimension of its community responsibilities can be thought of as activities that promote population health.

Background and Overview: Analyzing the Performance of Non-profit and Charitable Entities

The framework for analyzing the performance of CareFirst in the National Capital Area starts with the federal charter of GHMSI (its District subsidiary) and continues with principles from regulation, case law, and relevant literature.

GHMSI's federal charter declares the organization "to be a charitable and benevolent institution" and notes that "all of its funds and property shall be exempt from taxation other than taxes on real estate and unemployment compensation."⁶ Furthermore, the charter indicates that the company "shall not be conducted for profit."⁷ This federal charter and declaration of the organization as a charitable non-profit organization makes CareFirst/GHMSI unique among Blues plans, for none other operates under a federal charter.

The charter also indicates that GHMSI shall be "conducted for the benefit of [policyholders]."⁸ This provision suggests that the primary focus of the organization should be on its policyholders. GHMSI's status as a "charitable and benevolent" institution suggests a focus on the community. These two provisions do not necessarily conflict, however, because both can be satisfied. CareFirst/GHMSI can undertake activities that are consistent with its charitable and benevolent non-profit status while still operating for the benefit of its policyholders.

⁵ See M. W. Salganik, "State Allegedly Gave More to CareFirst Than It Got Back," *Baltimore Sun* (Jan. 31, 2003) at p. 1C (LEGC consulting firm analysis for Maryland tax breaks from 1997-2001 showed a value of \$12 to \$17 million per year); and M. W. Salganik, "CareFirst Is Told It Didn't Comply," *Baltimore Sun* (Nov. 28, 2002) at p. 1C (Maryland Insurance Commissioner analysis showed a \$21 million tax break for CareFirst in Maryland in 2001).

⁶ Current GHMSI Federal Charter at § 8 (Appendix A(2)).

⁷ *Id.* at § 3.

⁸ *Id.*

Regulation and case law in two primary areas (tax exemption and conversion) have developed standards for analyzing what kind of activities non-profit health care organizations such as CareFirst/GHMSI can pursue to benefit their communities in furtherance of their non-profit charitable status. These standards also provide a benchmark for evaluating how well a non-profit organization is fulfilling its charitable status.

With respect to tax exemption, regulation and case law surrounding the tax status of non-profit health care organizations led to the development of a “community benefit” standard. The Internal Revenue Service required a non-profit seeking tax exemption to demonstrate that it benefited the community through particular activities, and judicial decisions have extended this standard to health plans as well. These standards developed for organizations pursuing tax exemption under §501(c)(3) of the Internal Revenue Code. Although they do not directly apply to CareFirst/GHMSI, which is a §501(m) organization exempt from certain taxes because of its charter, these standards are a helpful guide in analyzing the community benefits provided by non-profit health care organizations.

Similarly, regulation and case law surrounding conversion of non-profit health plans to for-profit entities have developed standards for the evaluation of these transactions. Applying the *cy pres* doctrine, courts and regulators have required that the “charitable assets” of a converting plan remain in the non-profit sector (and not end up benefiting private parties). As a result, the assets of converting plans have typically been transferred to a charitable foundation, other non-profit organization, or the public sector for use in improving the community’s health and achieving the original non-profit mission of the converting organization.

From the legal guidance and judicial decisions regarding tax exemption and conversions, scholars have also identified ways in which a non-profit health plan might act to benefit the communities in which it operates. These include:

- Subsidizing care for individuals unable to pay for services;
- Providing services that have benefits beyond the immediate recipients of the services (such as treatment programs for substance abuse or disease prevention programs);
- Providing educational programs for the public and conducting research on health and health services;
- Allowing open access to services through implicit or explicit subsidization of prices for individuals and groups who otherwise would be charged premiums they could not afford; and
- Encouraging community influence in plan governance through representation of community groups in policymaking and efforts by the plan to respond to economically and politically disenfranchised groups.

Therefore, in analyzing the type of community benefits CareFirst/GHMSI could provide as a charitable and benevolent institution, and how well the organization is furthering its charitable non-profit mission in providing such benefits, policymakers and regulators in the National Capital Area can look to the standards developed through tax exemption and conversion regulation and case law, and the suggestions of scholars who study the performance of non-profit organizations under these standards.

Finally, another area of focus on non-profit health plans relates to the information gap (or asymmetry) between the plan and consumers (and the general community). Health plan consumers are generally not well-informed about what services might be medically necessary in any particular case and regarding managed care practices in general. Providers participating in a health plan may be unable to protect consumers because the providers themselves face information gaps in identifying how the managed care organization defines what services are medically necessary. As a result, the literature suggests that health plans adopt practices that better inform their own enrollees and the community generally, or support industry standards that reduce information gaps. Non-profit plans have adopted such information transparency policies.

Study Basis and Methods

Initial study approach and purpose: On behalf of the DC Appleseed Center for Law and Justice, GWU and GU initiated an analysis of the implications of the proposed conversion and acquisition of CareFirst/GHMSI on health care and health care access within the region. The purpose of this analysis was not to make the ultimate determination of whether (as required under applicable legal standards) the proposed transaction was in the public interest. Instead, its purpose was to assess and examine the implications of the proposed conversion and acquisition for the accessibility and affordability of health care coverage and health care services in the National Capital Area.

As originally designed, our analysis sought to examine the implications of the proposed transaction at both levels, i.e., with respect to area consumers of CareFirst coverage and in relation to broader population-wide “community benefit” principles. Examples of community benefits include cash or in-kind contributions, charity care, and health education or promotion programs. Our analysis focused on five distinct sets of individuals and activities, which we chose through an iterative consultation process with DC Appleseed and the community constituencies it represents. The five areas of focus were: (1) individuals seeking or receiving coverage through the individual market; (2) small employers and their employees and families; (3) Medicare beneficiaries in need of supplemental health insurance coverage; (4) individuals with disabilities or chronic illness who face particular difficulties securing coverage; and (5) health care providers now participating in CareFirst networks and safety net providers serving the uninsured. We concluded that the impact of the plan on health care providers as a group was important because given CareFirst’s size, its potential effect on providers’ business operations for all patients could be significant. We also determined that a focus on the “health care safety net” was important even though the prevalence of CareFirst members would be low at these sites. The clinics and organizations that make up the safety net and that provide extensive health services to the area’s low income, uninsured, and medically underserved populations were a separate and important

consideration because of the close association between the viability of these health providers and broader population health matters.

Our examination was conducted from three vantage points. The first vantage point was that of CareFirst “as is,” with no alteration in its current business practices. The second vantage point was following an acquisition and conversion. The third vantage point was a modified CareFirst business plan designed to operate with a greater community benefit orientation in terms of both treatment of product consumers and an expanded role in community and population health. For this vantage point, we considered the conduct and practices of Blue Cross/Blue Shield plans in other parts of the country.

Following the denial in Maryland and suspension of review in the District and Delaware, we refocused our analysis to consider both CareFirst’s current operations and practices and those that might be expected were CareFirst to adopt the types of operations and practices found in other jurisdictions served by not-for-profit Blue Cross/Blue Shield plans.

Methods: Our approach to the study included a mix of methods, including extensive analysis of data and interviews with key informants. Our data analysis began with an examination of key health status data for the District of Columbia and the surrounding region in order to ascertain the most significant health issues facing the population. We then collected and reviewed materials and documents relevant to CareFirst and other BlueCross/BlueShield plans (previously we also had reviewed extensive WellPoint documents). We also conducted more than 25 interviews with relevant stakeholders over a six-month time period. (Similarly, some of these interviews involved WellPoint). Interviews with relevant stakeholders (e.g., provider and community representatives, as well as WellPoint officials) were conducted in compliance with informed consent requirements of the George Washington University Non-Medical Institutional Review Board under approval # U112802ER.

During the period of this study, our requests for interviews with CareFirst officials were denied by the company, even though WellPoint officials were willing to be interviewed on their programs and activities related to the populations and issues we were covering. CareFirst’s refusal to consent to interviews continued on after the decision by the Maryland Insurance Commissioner to deny the acquisition and merger and the suspension of review by D.C.’s Insurance Commissioner.

Findings

Regional Demographics and Health Status

The National Capital Area is home to a population diverse in its background, its socioeconomic status, and its access to health care through insurance (public or private). As of March 2001, 13 percent of residents of the District of Columbia had no health insurance. Similarly, as of 2000, 14 percent of the residents in the parts of Northern Virginia within the CareFirst/GHMSI service area were uninsured.

The health status of District residents falls below the national average on a number of measures, including infant mortality, overall mortality, and mortality and morbidity related to cancer, diabetes, and heart disease. The District's AIDS case rate is the highest in the country.

CareFirst's Performance Compared to Other Not-For-Profit Health Plans for the Five Populations that Comprise the Focus of the Study

CareFirst's performance as a not-for-profit entity failed to reflect certain types of business practices and community service activities that could be readily identified among comparable non-profit Blue Cross/Blue Shield plans.

1. The small group and individual markets

Like other Blue Cross/Blue Shield plans, CareFirst offers a range of products of the type customarily found in other jurisdictions. However, unlike some other plans, CareFirst has done little to actively encourage growth in this aspect of its business through marketing and outreach, as measured by its marketing materials and its website. This is important because individuals and small groups face the most significant barriers to affordable insurance coverage and thus represent important constituencies for non-profit insurers. CareFirst appears to do the minimum expected under federal and state law; that is, it will issue coverage to individuals regardless of age, health history, medical history, or employment status. CareFirst's open enrollment period is year-round and it meets its legal obligation to advertise its program in newspapers of general circulation.

However, nothing requires CareFirst/GHMSI to market the guaranteed issue/open enrollment insurance program more aggressively, display it prominently on its website, or seek new ways of notifying individuals of this option. We saw no indication that CareFirst/GHMSI goes beyond the minimally required steps to market the program and enroll individuals. Furthermore, we could find no evidence to suggest that compared to its area competitors, CareFirst/GHMSI has attempted to design innovative products with respect to either coverage or access. Similarly, we could find no evidence to suggest that CareFirst had sought to distinguish itself from other insurers with respect to offerings in the small group market.

In contrast, we were able to identify Blue Cross innovations in the individual and small group markets in other jurisdictions. In particular, we found aggressive marketing to higher risk groups, innovation in design, and the provision of subsidies to make coverage more affordable.

2. Availability of MediGap coverage

While traditional fee-for-service Medicare covers part of the costs of hospital and physician care, it does not cover the costs of outpatient prescription drugs, eye care, dental coverage and other important medical services. In addition, Medicare requires beneficiaries to pay out of pocket for deductibles and co-payments. To assist Medicare beneficiaries in meeting the burden of gaps in coverage and out-of-pocket medical costs, some insurance companies offer Medicare Supplemental policies, including Medigap and Medicare+Choice, a managed care option. However, although CareFirst/GHMSI offers Medicare Supplemental (Medigap) plan

options, it does not offer a plan with prescription drug coverage. In addition CareFirst does not offer a Medicare+Choice plan, a limitation that disproportionately burdens lower income Medicare beneficiaries, who are disproportionately minority.

In contrast, Blues plans in other jurisdictions have expanded the range of available Medigap supplemental policies to include prescription drug coverage options. Indeed, WellPoint expanded its Medigap options in California and Georgia to include prescription drug coverage. Although WellPoint is a for-profit organization, its expansion of Medigap options in California and Georgia provides potential lessons for the National Capital Area.

3. Special Needs Populations

CareFirst/GHMSI has disease management programs for asthma, diabetes, cancer, and cardiovascular diseases (all of which occur in the District at rates that exceed national averages). However, despite the fact that the District has the highest AIDS case rate in the country, the company does not offer disease management or any other special programs for individuals with HIV/AIDS. In addition, and perhaps more significantly, CareFirst does not participate in the District's Medicaid managed care system.

In contrast, we found several other health plans that have addressed HIV/AIDS by initiating special programs, designing disease management programs, and providing grants to organizations serving those with HIV/AIDS. For example, Kaiser Permanente in California, a non-profit organization, formed a Consortium on HIV/AIDS Inter-regional Research with its regional divisions and Seattle-based Group Health Cooperative to focus on early diagnosis and treatment of HIV in its enrolled population. The organization has also targeted HIV/AIDS outreach efforts to African-American men, women, and children, and in a separate program, to all Kaiser-enrolled women in California who become pregnant. In addition, Kaiser has awarded community services grants to organizations in California that provide services for individuals who are HIV-positive or who have AIDS.

Non-profit health plans are not the only organizations taking steps to address HIV/AIDS. For-profit Oxford Health Plans in Connecticut offers a disease management program for HIV/AIDS.

Although these examples are not Blues plans, they provide examples of special programs and outreach efforts for individuals with HIV/AIDS that might be useful in the National Capital Area.

4. Health Care Providers, Including the Health Care Safety Net

With respect to network participation requirements for network providers, hospital interviewees indicated that CareFirst/GHMSI's credentialing process was typical of those used by other plans. With respect to compensation rates for network providers, those providers whose payer mix is predominated by public insurance and self pay indicated that CareFirst/GHMSI's payment rates were not out of line with other insurers. A larger group of providers, whose revenues are dominated by commercial insurance and CareFirst/GHMSI indicated that

CareFirst/GHMSI's rates are among the lowest offered by any insurer and lower than their costs providing care. CareFirst/GHMSI has used a "most favored nation" clause with some District hospitals that guarantees the lowest rate to CareFirst/GHMSI. In the case of appeals procedures for network providers, most interviewees reported that CareFirst/GHMSI was typical of all the plans in its utilization review and appeals processes. Some indicated difficulties in resolving appeals and obstacles to care created by the insurer's utilization management procedures. The experience of health care providers with other health insurers in other communities suggests that in areas such as payment, claims processing, contracting, case management, and community benefits, Blues plans in other jurisdictions that have partnered with providers have forged better working relationships.

With respect to relationships with the health care safety net and the provision of community benefits, few providers reported having received or even solicited support from CareFirst/GHMSI for community benefit activities in the past five years. CareFirst/GHMSI has not provided substantial grants or in-kind contributions to address the health needs of the National Capital Area's sizable low-income, underserved, and minority populations, many of whom have poor health status and face difficulties in accessing care. Just as CareFirst/GHMSI has not supported lower income residents through subsidized premiums, it also has failed to do what Blues plans in other communities have done, i.e., directly subsidize health care providers treating large numbers of uninsured patients.

According to its own documents and interviews with providers, CareFirst/GHMSI provides very few grants or in-kind contributions that could help address the health needs of the area's sizable low-income, underserved, and minority populations. For example, CareFirst/GHMSI reported contributions to District-based organizations of \$59,500 in 2000, \$233,000 in 2001 (of which \$125,000 was to the Washington Hospital Center and NBC-4 for a health fair), and \$61,000 as of August 2002. These sums do not compare favorably to the company's total surplus (approximately \$800 million in 2002), its quarterly surplus (\$40.8 million in the second quarter of 2003, a 66 percent increase over its surplus in the second quarter of 2002), or the compensation of its Chief Executive Officer (\$2.8 million in 2002).

Conclusions and Recommendations

Our yearlong examination of CareFirst/GHMSI and its role in the National Capital Area has led us to conclude that a number of changes should be considered, regardless of whether the company is ultimately converted and acquired. Learning from the lessons of other jurisdictions, policymakers in the National Capital Area might consider a number of options for strengthening the company's overall performance in relation to both the community it was established to serve and in consideration of the ongoing and considerable tax benefits it derives.

Improvements in the range of products and services offered: CareFirst's limited offerings are particularly noteworthy in light of the absence of such offerings by other local companies. Examples from other non-profit Blues plans and even from the for-profit WellPoint company's actions elsewhere demonstrate that innovation in the individual and small group market is possible and generally financially feasible. Options include inclusion of a Medigap policy with

prescription drug coverage, establishment of a Medicare+Choice plan, participation in Medicaid, the offering of subsidized benefits for lower income workers and their families without access to health coverage, and more active outreach to the individual and small group markets.

To the extent that CareFirst claims that innovation in product offerings is not financially viable, it is particularly important that this claim be closely scrutinized, given the substantial financial value of the preferential treatment the company enjoys as a result of its Congressional chartering and non-profit status.

More active product outreach and marketing: More active marketing of small group and individual products would potentially assist those consumers with heightened health risks and at greatest risk for lack of access to larger group health plans. While the company may meet minimum marketing standards, its product outreach support (as measured by its consumer-unfriendly Website) represents an important area for improvement.

Relationships with community health care providers: The magnitude of consumer dependence on CareFirst and the relationship between health care financing and ultimately, health quality, make improvements in its relationship with health care providers a matter of high importance. On issues such as payment, claims processing, denials, appeals procedures, and utilization management, our provider interviews indicated that relationships could be smoother. The frayed relationships CareFirst has with area providers was brought into sharp focus with the rate disagreement with Children's National Medical Center that took place during the time period covered by this study. A systematic study of CareFirst provider payment and management policies should be considered as part of an overall set of performance improvement actions.

Lack of Community Benefits: Although CareFirst/GHMSI has suggested that giving to the community is one of its goals, the evidence suggests that the company's allocation toward community benefits is strikingly low. Area policy makers may wish to consider the establishment of specific targets in relation to surpluses, which could take the combined form of premium subsidies for lower-income families, direct support to clinics serving the lowest income and most disadvantaged populations, and community support for health activities with broad population implications, such as cancer and chronic illness screening, additional care support for seriously ill patients, and other broadly conceived interventions. While we do not recommend a specific community benefit allocation level, this is a matter that merits active deliberation by area policy makers.

Transparency in community dealings: Throughout the course of our study, we were limited by the lack of information provided by CareFirst in response to our questions and requests for documents. Basic information (e.g., how many enrollees the company has by product line) was withheld as confidential or otherwise not provided. No CareFirst personnel were made available to explain the insurer's approach to its business operations in the National Capital Area. In this regard, CareFirst/GHMSI demonstrated a troubling lack of transparency, which persisted even after the proposed WellPoint deal ended and which stood in marked contrast to Well Point's willingness to supply information.

As policy makers consider possible long term reforms in CareFirst's operations, we believe that the company should be expected to demonstrate a level of transparency that one would expect from a corporation that enjoys such large commercial advantages as a matter of public policy. Regional lawmakers should reasonably be able to expect detailed answers to the following types of questions:

- What does CareFirst/GHMSI see as its obligations as a non-profit insurer chartered as a charitable institution?
- How is it fulfilling these obligations?
- How do its activities in the community (in the form of insurance products offered, health care services for members, provider relations, and broader community benefit activities) compare to those of other publicly chartered non-profit insurers?
- What specific plans for improvement can CareFirst/GHMSI identify in the areas highlighted by this analysis?
- What steps can the company take to improve its general standing among area health care providers?

Study Limitations

This study was limited by our ability to communicate with CareFirst and by the serious constraints on document access we faced as a result of the company's choices. The amount of available information about the performance of a publicly chartered health care company was strikingly low. To the extent that such limitations prevent careful consideration of a tax-advantaged corporation, we believe that reversing this situation may represent one of the first and most important steps area policy makers can take.

Our analysis does not address, and was never intended to reach, certain questions about the conversion and acquisition that include the valuation of CareFirst and specific questions of law related to whether the acquisition could be considered in the public interest. Our analysis does not address whether the proposed \$1.3 billion price was fair. It does not quantify the potential harms to the community for purposes of evaluating the proposed charitable foundation and how foundation funds should be used. We do not analyze the decision-making process CareFirst used to decide to convert to a for-profit company and the choice of WellPoint as the purchaser. Finally, we do not analyze the financial viability of CareFirst/GHMSI with respect to potential new product offerings or other potential improvements in the insurer's business practices vis-à-vis the region's consumers, purchasers, patients and health care providers. Those issues would properly be the subject of a comprehensive economic feasibility analysis of CareFirst/GHMSI in the National Capital Area by relevant experts.

Despite these limitations, our research yielded a significant amount of information regarding CareFirst and its performance. It is the overall picture of CareFirst that emerges that we

believe to be of special importance to longer-term efforts to address the company's performance for residents of the National Capital Area.

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Introduction

This analysis, conducted for the DC Applesseed Center for Law and Justice by The George Washington University School of Public Health and Health Services and the Georgetown University Institute for Health Care Research and Policy, examines the question of whether, in its operations and business practices, CareFirst BlueCross BlueShield (“CareFirst”) is fulfilling its chartered mission for the National Capital Area. This study began as an analysis of the coverage and access implications for the region of a business proposal made by CareFirst and WellPoint Health Networks, Inc. (“WellPoint”) to convert CareFirst to for-profit status and permit its acquisition by WellPoint for a price tag of \$1.3 billion. A similar proposal was rejected by Maryland’s Commissioner of Insurance in March 2003. Following that denial, CareFirst and WellPoint requested that the insurance commissioners in the District of Columbia and Delaware suspend review of the proposal. Those requests were granted.

For several reasons however, the rejection of the CareFirst/WellPoint proposal should not be viewed as resolving matters. First, there is the possibility that the two companies could revive and re-present a revised business plan, at which point an impact analysis would be both crucial and timely. Second, another company could present an offer for CareFirst.⁹ Third, the conditions recently identified by the Maryland Insurance Commissioner as key to CareFirst’s continued operations as a non-profit insurer mean that the company’s ongoing operations remain a major matter of concern for the National Capital Area’s health system. Finally, the CareFirst/WellPoint proposal served to turn greater public attention to the question of CareFirst’s performance in its role as one of the region’s most (if not the most) important health insurers. Accounting for 1,061,000 privately insured residents in the DC Metropolitan area (an estimated 28% percent of all persons in the area with private coverage) and 3.2 million privately insured residents in its entire service area,¹⁰ CareFirst exerts enormous influence over the accessibility, affordability, timeliness, and quality of health care in the National Capital Area. Furthermore, the company heavily influences access and quality as much by the people and health needs it chooses *not* to respond to with an offer of affordable insurance products of good quality.

As a chartered not-for-profit insurance corporation, CareFirst/GHMSI is subject to a high level of accountability for its products and services, as well as its dealings with the region’s residents, employers and health purchasers, health system, and government agencies involved in financing, delivering, and overseeing the quality of health care in this region. Specifically, GHMSI was chartered by Congress in 1939 as a “charitable and benevolent institution.”¹¹ The value of the company is a charitable asset, and the company receives significant tax breaks as a non-profit entity. Our yearlong examination of CareFirst and its role in the National Capital Area has led us to conclude that, regardless of whether it ultimately is converted and acquired, the

⁹ Maryland recently imposed a five-year moratorium on CareFirst’s conversion to for-profit status. See Maryland Senate Bill 772, § 7 (signed by Governor Ehrlich on May 22, 2003), available at <http://www.mlis.state.md.us/#bill> (accessed October 20, 2003).

¹⁰ “CareFirst Supplemental Fact Sheet,” available at http://www.wellpoint.com/press_room/special_reports/cf/CFFacts.doc (accessed October 20, 2003).

¹¹ See GHMSI Federal Charter § 8 (Appendix A).

company's performance as a regional health care leader merits serious and close attention from area lawmakers and regulators.

For these reasons, we believe that a close examination of CareFirst's performance as a premier insurer in the National Capital Area is warranted, regardless of whether a revised request for conversion and acquisition is ever submitted.

This analysis begins with a background and overview of the framework of analysis for non-profit and charitable corporations such as CareFirst. Following a description of our study basis and methods, we present our findings. We conclude with a discussion of recommendations and note the limitations of our research.

Background and Overview: Analyzing the Performance of Non-profit and Charitable Entities

The framework for analyzing the performance of CareFirst in the National Capital Area starts with the federal charter of GHMSI (its District subsidiary) and continues with principles from regulation, case law, and relevant literature.

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Regulation and case law in two primary areas (tax exemption and conversion) have developed standards for analyzing what kind of activities non-profit health care organizations such as CareFirst/GHMSI can pursue to benefit their communities in furtherance of their non-profit charitable status. These standards also provide a benchmark for evaluating how well a non-profit organization is fulfilling its charitable status.

Regulation and Case Law: The initial focus of regulatory activity regarding non-profit entities related to their tax status. In 1969, the Internal Revenue Service ("IRS") adopted the "community benefit" standard, which required a non-profit health care organization seeking tax

¹² Current GHMSI Federal Charter at § 8 (Appendix A(2)).

¹³ *Id.* at § 3.

¹⁴ *Id.*

exemption to demonstrate that it benefited the community.¹⁵ Although the IRS adopted the standard with hospitals in mind,¹⁶ a federal tax court ruled that the standard also applied to health maintenance organizations, which could provide community benefits and obtain tax exemption.¹⁷ These standards developed for organizations pursuing tax exemption under §501(c)(3) of the Internal Revenue Code. Although they do not directly apply to CareFirst/GHMSI, which is a §501(m) organization exempt from certain taxes because of its charter, these standards are a helpful guide in analyzing the community benefits provided by non-profit health care organizations.

A second area of regulatory focus surrounding community benefits is on conversions of non-profit managed care organizations to for-profit entities. Applying the *cy pres* doctrine, courts and regulators have required that the “charitable assets” of a converting plan remain in the non-profit sector (and not end up benefiting private parties).¹⁸ As a result, the assets of converting plans have typically been transferred to charitable foundation or other non-profit organization for use in improving the community’s health.¹⁹ Deviating from this norm, during the recent conversion of Empire Blue Cross, the State of New York appropriated the conversion assets and used them to subsidize health care organizations.²⁰ Despite this recent deviation, the reason for keeping the assets in the non-profit (or public) sector was to achieve the community benefit or social mission of the original non-profit plan.²¹

Relevant Literature: From the legal guidance and judicial decisions regarding tax exemption and conversions, Schlesinger, Gray, and Bradley have identified ways in which a non-profit health plan might act to benefit the communities in which it operates.²² These include:

- Subsidizing care for individuals unable to pay for services;
- Providing services that have benefits beyond the immediate recipients of the services (such as treatment programs for substance abuse or disease prevention programs);
- Providing educational programs for the public and conducting research on health and health services;

¹⁵ See Mark Schlesinger et al., “Measuring Community Benefits Provided by Nonprofit and For-Profit HMOs, *Inquiry* 40: 114-132 (Summer 2003).

¹⁶ See *id.* at 116.

¹⁷ See *Sound Health Ass’n v. Commissioner of Internal Revenue*, 71 T.C. 158 (Nov. 13, 1978).

¹⁸ See Schlesinger et al., *supra* note 15, at 116.

¹⁹ See *id.*

²⁰ See James C. Robinson, “The Curious Conversion of Empire Blue Cross.” *Health Affairs* 22:4 (July/August 2003): 100-118.

²¹ See Schlesinger et al., *supra* note 15, at 116.

²² See Mark Schlesinger, Brad Gray, and E. Bradley, “Charity and Community: The Role of Nonprofit Ownership in a Managed Health Care System.” *Journal of Health Politics, Policy and Law* 21(4): 697-752.

- Allowing open access to services through implicit or explicit subsidization of prices for individuals and groups who otherwise would be charged premiums they could not afford; and
- Encouraging community influence in plan governance through representation of community groups in policymaking and efforts by the plan to respond to economically and politically disenfranchised groups.

Therefore, in analyzing the type of community benefits CareFirst/GHMSI could provide as a charitable and benevolent institution, and how well the organization is furthering its charitable non-profit mission in providing such benefits, policymakers and regulators in the National Capital Area can look to the standards developed through tax exemption and conversion regulation and case law, and the suggestions of scholars who study the performance of non-profit organizations under these standards.

Another area of focus on non-profit health plans relates to the information gap (or asymmetry) between the plan and consumers (and the general community).²³ Health plan consumers are generally not well-informed about what services might be medically necessary in any particular case and regarding managed care practices in general.²⁴ Similarly, providers participating in a health plan may be unable to protect consumers because the providers themselves face information gaps in identifying how the managed care organization defines what services are medically necessary.²⁵ As a result, the literature suggests that health plans adopt practices that better inform their own enrollees and the community generally, or support industry standards that reduce information gaps.²⁶ Non-profit plans have adopted such information transparency policies.²⁷

Study Basis and Methods

Initial study approach and purpose: CareFirst, Inc. is a holding company for the non-profit BlueCross BlueShield plans of the National Capital Area, Maryland, and Delaware. On January 11, 2002, WellPoint, CareFirst, and CareFirst's National Capital Area subsidiary, Group Hospitalization and Medical Services, Inc. ("GHMSI"), filed an application with the D.C. Department of Insurance & Securities Regulation ("DISR") and the Office of Corporation Counsel ("OCC") seeking approval for the conversion of the non-profit CareFirst to a for-profit

²³ See Schlesinger et al., *supra* note 15, at 117.

²⁴ *Id.*

²⁵ *Id.* See also Sara Rosenbaum et al., *Medical Necessity in Private Health Plans: Implications for Behavioral Health Care*, DHHS Pub. No. (SMA) 03-3790. Rockville, MD: Center for Mental Health Services, Substance Abuse, and Mental Health Services Administration (available at <http://www.mentalhealth.org/publications/allpubs/SMA03-3790/default.asp>, accessed October 20, 2003).

²⁶ See Schlesinger et al., *supra* note 15, at 117.

²⁷ See D. Mechanic and M. Rosenthal, "Responses of HMO Medical Directors to Trust Building in Managed Care." *Milbank Quarterly* 77(3) (1999): 283-303.

company and its acquisition by WellPoint for \$1.3 billion. CareFirst and WellPoint filed similar applications in Maryland and Delaware.

On behalf of the DC Appleseed Center for Law and Justice, the George Washington University School of Public Health and Health Services (GWU) and the Georgetown University Institute for Health Care Research and Policy (GU) initiated an analysis of the implications of the proposed conversion and acquisition of CareFirst/GHMSI on health care and health care access within the region. Health impact is only one of a number of factors the respective insurance commissioners had to consider to determine whether the transaction was in the public interest.²⁸ Therefore, the purpose of this analysis was not to make the ultimate public interest determination, but to inform the DC Appleseed Center, the National Capital Area CareFirst Watch Coalition, and the responsible regulatory officials regarding the implications of the proposed conversion and acquisition for the accessibility and affordability of health care coverage and health care services in the District, suburban Maryland, and northern Virginia.²⁹

As originally designed, our analysis sought to address five identifiable groups for whom the potential impact of the acquisition was of particular concern, and whose needs should be considered in deciding whether it was in the public's interest to permit the conversion and acquisition: (1) individuals seeking or receiving coverage through the individual market; (2) small employers and their employees and families; (3) Medicare beneficiaries in need of supplemental health insurance coverage; (4) individuals with disabilities or chronic illness who face particular difficulties securing coverage; and (5) health care providers now participating in CareFirst networks and safety net providers serving the uninsured. We also sought to examine how a particular group or constituency would fare under CareFirst, WellPoint, and a BlueCross BlueShield plan that is dominant in its particular market and whose conduct is considered by experts to reflect that of a non-profit, insuring organization with a relatively well-recognized "community benefit" orientation. Such an orientation focuses on contributing to the local community in which the organization operates. Examples of community benefits include cash or in-kind contributions, charity care, and health education or promotion programs.³⁰ Thus, we sought to examine how the five identified groups would fare under CareFirst "as-is," CareFirst converted and acquired by WellPoint, and a CareFirst that operated with a community benefit orientation.

²⁸ Under District of Columbia law, the Commissioner of DISR and OCC must review and approve the conversion and sale of non-profit health and medical services corporations such as CareFirst/GHMSI. See D.C. Code §§ 31-3515 and 44-603 (2003). In order to approve the conversion and sale of CareFirst/GHMSI, the Commissioner of DISR must find that (1) the conversion and sale is in the public's interest; (2) the resulting for-profit company would be financially viable; and (3) GHMSI's policyholders and the insurance-buying public would not be harmed as a result of the conversion and sale. See D.C. Code § 31-3515 (2003). For the requirements applicable to OCC review, see D.C. Code § 44-603 (2003).

²⁹ This analysis focuses on the CareFirst/GHMSI service area, and particularly on the District of Columbia and Northern Virginia. The applicable regulators in Maryland and Delaware commissioned analyses specific to those jurisdictions.

³⁰ For an analysis of community benefits provided by managed care organizations, see Mark Schlesinger and Bradford Gray, "A Broader Vision for Managed Care, Part I: Measuring the Benefit to Communities," *Health Affairs* 17(3): 152-168 (May/June 1998) and Mark Schlesinger and Bradford Gray, "A Broader Vision for Managed Care, Part 2: A Typology of Community Benefits," *Health Affairs* 17(5): 26-49 (Sept./Oct. 1998).

The Maryland Insurance Commissioner's decision: On March 5, 2003, Maryland Insurance Commissioner Steven B. Larsen denied the WellPoint/CareFirst Maryland application for conversion and acquisition.³¹ In his order and accompanying 343-page report, Commissioner Larsen ruled, among other things, that: (1) the CareFirst board of directors had failed to consider its obligations as a non-profit; (2) consultants to the transaction had apparent conflicts of interest; (3) CareFirst hadn't negotiated to obtain the best price for the company; (4) the negotiated price did not constitute fair value; (5) there was no business need to convert; and (6) WellPoint had failed to produce documents that would have allowed him to consider the impact of the transaction on consumers.³²

WellPoint and CareFirst did not appeal the Maryland decision.³³ The Maryland legislature has reviewed and ratified Commissioner Larsen's decision. In light of the Maryland decision and based on a request from WellPoint and CareFirst, the insurance commissioners in the District and Delaware suspended review of the proposed transaction.

The denial in Maryland and suspension of review in the District had several implications for our proposed health impact analysis. First, a study focused on a comparison of CareFirst and WellPoint was no longer of central relevance. Much of our analysis had been aimed at documenting how, with respect to particular matters, the companies were similar, how they differed, and what it would be reasonable to expect from a converted CareFirst/GHMSI acquired by WellPoint. This line of inquiry assumed that there were lessons from WellPoint's other acquisitions of Blues plans (e.g., BlueCross BlueShield of Georgia) that would inform our expectations.

Second, to the extent some comparisons between the two companies were still relevant, we no longer had access to individuals or documents from the companies to answer our questions about their approaches and strategies. Finally, the Maryland decision and suspension of DISR review refocused our attention on CareFirst's operations and opportunities in the GHMSI market area regardless of any potential merger partner.

As a result, this analysis now presents our general findings for the five populations and offers a blueprint that may be useful in examining the potential health impact of any future proposed transactions. This analysis joins others that have examined CareFirst's current performance as part of the conversion and acquisition proposal,³⁴ collectively these studies will

³¹ The Maryland decision and background materials are available at <http://www.mdinsurance.state.md.us/jsp/CareFirst.jsp10?divisionName=CareFirst+Conversion+Information&pageName=/jsp/CareFirst.jsp10> (accessed on October 20, 2003).

³² See "Summary of Key Points" at <http://www.mdinsurance.state.md.us/documents/CareFirstdecision-SummaryKeyPointsrev.pdf> (accessed on October 20, 2003).

³³ See the press statements at http://www.wellpoint.com/xml/c_newsreleasetext.asp?REQID=398183&sd=20030000 (WellPoint) and http://carefirst.onlinepresskits.com/news_archive_32103.html (CareFirst) (each accessed on October 20, 2003).

³⁴ See the reports prepared for the Maryland Insurance Commission (e.g., Delmarva Foundation Impact Opinion Report, Wakely Consulting Fairness Opinion and Impact Report, and The Blackstone Group Analysis of CareFirst Inc. Business Case), available at <http://www.mdinsurance.state.md.us/jsp/CareFirst.jsp10?divisionName=CareFirst+Conversion+Information%5EEExp+Reports+and+Responses&pageName=/jsp/CareFirst.jsp10> (accessed on October 20, 2003).

contribute to an ongoing dialogue about the future of CareFirst/GHMSI and the state of health insurance and delivery in the GHMSI service area.

Methods: Our approach to the study included a mix of methods, including extensive collection and review of materials and documents relevant to CareFirst, WellPoint, and other BlueCross BlueShield plans, as well as more than 25 interviews with relevant stakeholders conducted over a six-month time period.³⁵ For each of the five study populations, we developed outlines and data requests for CareFirst and WellPoint. Interviews with relevant stakeholders (e.g., provider community representatives and WellPoint officials responsible for a particular study area) were conducted in compliance with informed consent requirements of the George Washington University Non-Medical Institutional Review Board under approval # U112802ER.

During the course of the study, the DC Appleseed Center became a formal party to the DISR insurance proceeding reviewing the proposed transaction. As a result, our document and interview requests were handled through DC Appleseed's counsel and treated by the parties as discovery in an administrative proceeding.

The Maryland decision halted any additional interviews with and production of documents by CareFirst and WellPoint. As a result, we completed this analysis without the benefit of any conversations with CareFirst officials or full responses to our data requests.

³⁵ The list of provider organizations interviewed is attached as Appendix B.

Major Findings

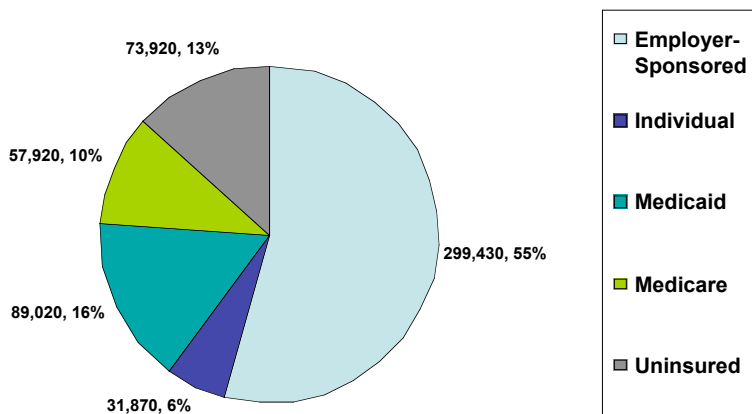
The District of Columbia

Health Care Insurance Coverage

As of March 2001, the District of Columbia had approximately 552,162 residents.³⁶ Of these, approximately 73,920 (13%) were uninsured.³⁷

Figure 1

Distribution of District of Columbia Population by Insurance Coverage (2001) N= 552,162



Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2001 and 2002 Current Population Surveys

As shown in Figure 1, over half (55%) of District residents have employer-based coverage, 16% are covered by Medicaid, 10% by Medicare, and 6% through individual health insurance coverage. These proportions mirror the distribution of coverage throughout the United States, except that the District has somewhat a lower percentage of its population enrolled in employer-based coverage (55% vs. 58% nationwide) and a higher percentage enrolled in Medicaid (16% vs. 11% nationwide).³⁸ At the same time, the District does have a greater

³⁶ Kaiser Family Foundation State Health Facts Online (“KFF SHFO”) (Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2001 and 2002 Current Population Surveys, available at <http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?> (accessed on October 20, 2003)).

³⁷ *Id.* Nicole Lurie and Michael Stoto estimated that there were approximately 50,600 adults aged 18-64 in the District without health insurance as of December 1999. See Lurie and Stoto, “Health Insurance Status in the District of Columbia” (October 22, 2002) (report commissioned by the District of Columbia Primary Care Association).

³⁸ KFF SHFO (Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2001 and 2002 Current Population Surveys), available at <http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?> (accessed on October 20, 2003)).

proportion of private sector employers that offer health insurance to employees (74% vs. 59.3% nationally as of 2000).³⁹

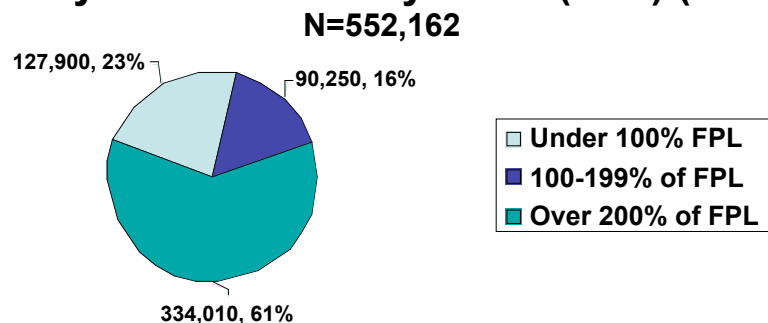
Health care insurance coverage for children under 18 either matches or falls below national rates. Children in the District are more likely to be covered by Medicaid (39% vs. 22% nationally), and less likely to be covered by employer-sponsored insurance (48% vs. 61% nationally). The percentage of uninsured children under 18 in the District (10%) is slightly better than the percentage nationally (12%).

Income

The data on income in the District reveals stark contrasts. Nearly a quarter (23%) of the District’s residents lived in poverty in 2001, defined as those who earn less than 100% of the federal poverty level (“FPL”).⁴⁰ This constitutes a higher rate of poverty than that of the United States as a whole (16%).⁴¹

Figure 2

Distribution of District of Columbia Population by Federal Poverty Level (FPL) (2001)



Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2001 and 2002 Current Population Surveys

Sixteen percent of District residents in 2001 were low income, with family incomes in the 100-199% of FPL range, which is less than the national figure of 19 percent. Combined, these numbers indicate that 40% of District residents are low-income (defined as 0-200% of FPL), which exceeds the national rate of 35%.

³⁹ KFF SHFO (Agency for Healthcare Research and Quality, Center for Cost and Financing Studies. 2000 Medical Expenditure Panel Survey - Insurance Component. Table II.A.2: <http://www.meps.ahrq.gov/MEPSDATA/ic/2000/Index200.htm>, accessed on October 20, 2003).

⁴⁰ The federal poverty threshold (100% FPL) for a family of three was \$13,738 in 2000 and \$14,128 in 2001.

⁴¹ KFF SHFO (Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2001 and 2002 Current Population Surveys), available at <http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?> (accessed on October 20, 2003)).

Despite the significant percentage of low-income and impoverished residents, there remains a substantial potential market for private health insurance coverage in the District. Over three fifths (60%) of the District's residents – some 334,000 – have incomes that exceed 200 percent of the FPL (\$30,040 per year for a family of 3 in 2002) or greater, which is viewed by many as the minimum amount needed to afford adequate health insurance coverage.⁴² The national figure is 65%.

The age of those in poverty differs when comparing the District to the rest of the nation. Twenty seven percent of District residents over 65 have incomes less than 100% of FPL (versus 13% nationally). Thirty six percent of children live in families whose incomes are below the poverty threshold (21% nationally). However, the difference for adults aged 19-64 below the poverty threshold is smaller; 18% of District residents and 14% nationally.⁴³

Race/Ethnicity

The District of Columbia is racially diverse. Nearly two thirds (64 percent) of the District's residents are black, about one third (27 percent) are white, seven percent are Hispanic, and two percent are categorized as other (which includes Asian-Americans, Pacific Islanders, American Indians, Aleutians, and Eskimos).⁴⁴

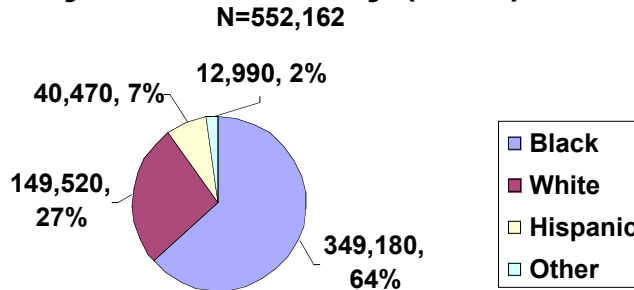
⁴² KFF SHFO, "Distribution of Total Population by Federal Poverty Level, 2000-2001," available at available at <http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?> (accessed on October 20, 2003)).

⁴³ *Id.*

⁴⁴ KFF SHFO, "D.C. Population Distribution by Race/Ethnicity, 2000-2001," available at available at <http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?> (accessed on October 20, 2003)).

Figure 3

Distribution of District of Columbia Population by Race/Ethnicity (2001)



Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2001 and 2002 Current Population Surveys

Among non-elderly District residents, 94% of all whites are insured and 81% have employer-sponsored coverage. Over four-fifths (83%) of all black residents have public or private insurance coverage and 55% have employer-sponsored coverage. Sixty-five percent of the District's Hispanic residents are insured, and 40% have employer-sponsored insurance coverage.⁴⁵

Health Status

The health status of District residents falls far short of the national averages on a number of measures. The District's infant mortality rate as of 1999 (15 deaths per 1,000 live births) was more than twice that of the U.S. (7.1 deaths per 1,000 live births). The District did improve its infant mortality rate from 20.1 in 1990 to 12.5 in 1998⁴⁶ due to numerous improvements in the health status of women and a decrease in teen pregnancy.

The District's overall mortality rate as of 1999 (1082.7 deaths per 100,000 residents) rate was 23 percent greater than the U.S. as a whole (881.9 deaths per 100,000). District residents are more likely to die of cancer (17 percent higher mortality rate), diabetes (54 percent higher mortality rate), and heart disease (9 percent higher mortality rate) than their fellow Americans. In each case, the mortality rates of District residents who are black substantially exceed that of white

⁴⁵ KFF SHFO "Rate of Nonelderly with Employer Coverage by Race/Ethnicity, 1999-2000;" "D.C. Rate of Nonelderly Uninsured by Race/Ethnicity, 1999-2000," available at <http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?> (accessed on October 20, 2003).

⁴⁶ Briefing Paper on the 1999 Infant Mortality Rate for the District of Columbia at http://dchealth.dc.gov/services/administration_offices/schs/pdf/main.shtm (accessed on October 20, 2003).

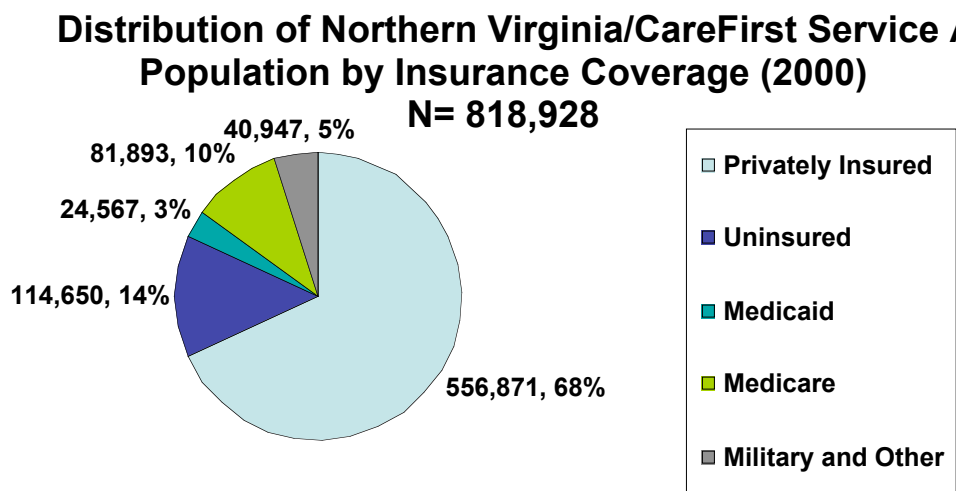
D.C. residents.⁴⁷ The District’s AIDS case rate is the highest in the country (152.1 per 100,000 population in 2001 vs. 14.9 nationally).⁴⁸

Northern Virginia⁴⁹

Health Care Insurance Coverage

As of 2000, the area of Northern Virginia within CareFirst’s service area had approximately 818,928 residents.⁵⁰ Of these, approximately 114,650 (14%) were uninsured.⁵¹

Figure 4



Source: Health Systems Agency of Northern Virginia

As shown in Figure 4, over two-thirds (68%) of Northern Virginia residents within CareFirst’s service area have private insurance (through employer-based or individual coverage),

⁴⁷ KFF SHFO, “District of Columbia, Health Status” (data derived from various tables, Deaths per 100,000 Population, 1999), available at <http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?> (accessed on October 20, 2003).

⁴⁸ KFF SHFO, “District of Columbia, Annual AIDS Case Rate,” available at <http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?> (accessed on October 20, 2003).

⁴⁹ The CareFirst Service Area in Northern Virginia includes the cities of Alexandria and Fairfax, the town of Vienna, Arlington County, and the areas of Fairfax and Prince Williams counties in Virginia east of Route 123. Source: <http://www.carefirst.com/pages/coverage/ghmsi.htm> (accessed on October 20, 2003). Total Northern Virginia is defined as the Northern Virginia Planning District, which includes Arlington, Alexandria, Falls Church, and Fairfax City (all in the CareFirst territory), Fairfax County (almost half the population is in the CareFirst area), and Loudoun County, Prince William County, Manassas, and Manassas Park (which are not in the CareFirst territory). More than half of those in the part of Northern Virginia area that is not CareFirst territory who are employed work in the CareFirst area. Source: Health Systems Agency of Northern Virginia.

⁵⁰ Data obtained from the Health Systems Agency of Northern Virginia.

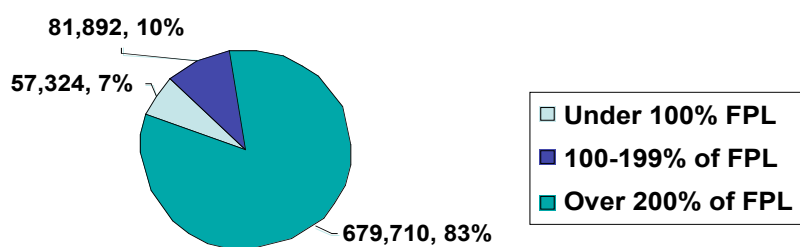
⁵¹ *Id.*

3% are covered by Medicaid, 10% by Medicare, 5% through the military or other insurance, and 14% are uninsured. Thus, Northern Virginia has a higher percentage of its population enrolled in private coverage (68% vs. 58% nationwide) and a lower percentage enrolled in Medicaid (3% vs. 11% nationwide).⁵²

Income

Figure 5

Distribution of Northern Virginia/CareFirst Service Area Population by Federal Poverty Level (FPL) (2000) N=818,928



Source: Health Systems Agency of Northern Virginia

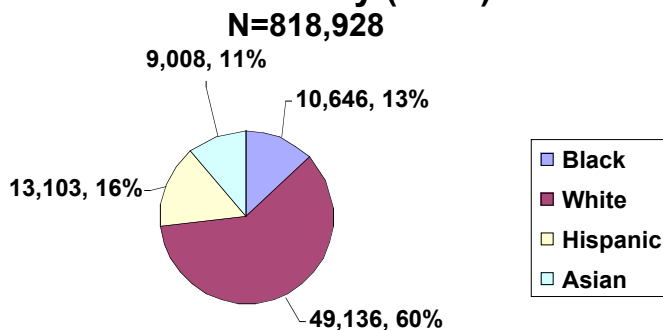
Seven percent of Northern Virginia residents in the CareFirst service area lived in poverty, with family incomes below 100% of poverty. Ten percent of Northern Virginia residents in the CareFirst Service area were low income, with family incomes in the 100-199% of FPL range, which is less than the national figure of 19 percent. Combined, these numbers indicate that 17% of Northern Virginia residents in the CareFirst service area are low-income (defined as 0-200% of FPL), which is less than half of the national rate of 35%.

⁵² Data on the Northern Virginia CareFirst service area obtained from the Health Systems Agency of Northern Virginia. National comparative statistics obtained from KFF SHFO (Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2001 and 2002 Current Population Surveys).

Race/Ethnicity

Figure 6

Distribution of Northern Virginia/CareFirst Service Area Race/Ethnicity (2000)



Northern Virginia is racially diverse, with over one-third (40%) of residents representing minority racial/ethnic groups. The region also has a significant immigrant population, with approximately 30% of residents born outside of the United States.⁵³

Regulatory Overview

DISR regulates health insurance products sold to individuals and employers (small and large) in the District, including supplemental policies sold to Medicare beneficiaries.⁵⁴ One of the Department's purposes is to protect the interests of District consumers by "ensuring that insurance companies . . . comply with the insurance or securities laws and regulations."⁵⁵ Part of DISR's stated mission is to ensure that insurers "conduct their business in a fair, equitable and reasonable manner."⁵⁶

A number of statutory and regulatory provisions applicable to non-stock, non-profit health insurers such as CareFirst/GHMSI are worth noting, both generally and in the context of analyzing future potential conversion/acquisition transactions, the current performance of CareFirst/GHMSI, and its potential performance as a more community benefit-oriented company. These include policy form⁵⁷ and rate approvals by DISR, mandatory coverage and benefits, open enrollment, and required reporting to DISR.

⁵³ Data obtained from the Health Systems Agency of Northern Virginia.

⁵⁴ The District's insurance laws are contained in Title 31 of the DC Code, and its insurance regulations are contained in Title 26 of the District of Columbia Municipal Regulations.

⁵⁵ See About DISR: Mission Statement at <http://disr.washingtondc.gov/who/index.shtm> (accessed on October 20, 2003).

⁵⁶ See *id.*

⁵⁷ Policy forms detail the coverage and other terms of an insurance policy or contract (e.g., restrictions, exclusions, and other limitations).

Policy forms and rates for insurance products (except for rates under experience-rated group plans) are subject to DISR review and approval prior to their use.⁵⁸ Under District law, rates may not be “excessive, inadequate, or unfairly discriminatory in relation to the services and benefits offered.”⁵⁹

DISR is also responsible for enforcing, among other requirements, statutory mandates for the inclusion of certain benefits in the individual and group products it regulates. These mandates include coverage for diabetes, newborns, mental health, drug and alcohol abuse, and breast, cervical, and colorectal cancer screening.⁶⁰ The District also mandates coverage of emergency services due to a medical emergency, and insurers cannot deny reimbursement based on an enrollee’s failure to obtain prior authorization.⁶¹ Finally, the District has an anti-discrimination provision for AIDS/HIV, which prohibits exclusions or limitations on coverage based on AIDS, HIV, or any related conditions.⁶²

District law requires non-profit insurers to offer a year-round open enrollment program that provides insurance contracts without regard to underwriting criteria that would otherwise deny or limit insurance because of an individual’s age, health status or history, employment status or job classification.⁶³ Insurers must advertise the open enrollment program quarterly in newspapers of general circulation throughout the District.⁶⁴

Insurers must file a series of annual reports with DISR, including loss ratio information (i.e., net premiums, amount of losses paid, and the amount of expenses incurred in the prior year), audited financial reports, and year-end financial statements.⁶⁵ These reports are available to the public and can be useful in analyzing the operations of an insurer operating in the District.

DC Metropolitan Area Health Care System Profile

In developing the provider study component of our original study, we focused on providers that would likely be most affected by a CareFirst/GHMSI conversion and acquisition: mainstream and safety net hospitals, safety-net ambulatory clinics, and, to a lesser extent, private physicians.⁶⁶ With the exception of a hospital for chronically ill children, the study did not address long-term care, pharmacies, or other health professionals. An overview of the DC Metropolitan area health care system in terms of health providers is essential in understanding the current situation and the potential effects of any future proposed transaction. We focused our

⁵⁸ DC Code § 31-3508(a) (2003).

⁵⁹ *Id.* at § 31-3508(e).

⁶⁰ See DC Code §§ 31-2902, 31-2931, 31-3002, 31-3102, and 31-3801.

⁶¹ DC Code § 31-2802 (2003)

⁶² DC Code § 31-1603 (2003)

⁶³ DC Code § 31.3514 (2003).

⁶⁴ See DC Code § 31-3514 for additional open enrollment criteria (e.g., premium tax requirements, required support services, etc.).

⁶⁵ See DC Code §§ 31-205, 31-302, and 31-1901 (2003).

⁶⁶ For the study’s limitations in addressing private physicians, see “Study Limitations” below.

analysis on the District and Northern Virginia components of CareFirst/GHMSI's service area and did not address the suburban Maryland counties (Prince George's and Montgomery) because Maryland commissioned impact studies for those jurisdictions.⁶⁷

The health professionals and institutional providers now serving the District and Northern Virginia represent their respective communities' histories and populations, which have in turn been influenced by more recent events. Similar to the wide variation in income, health, and insurance coverage status of the region's residents, the region's health care providers fall into certain categories that can best be characterized by the dominance of certain payers within their patient populations. Recent moves by the District to restructure its delivery of care to indigent District residents has affected most DC providers and is reconstituting the definition of the region's health care "safety net."

The District of Columbia: Health care services have tended to cluster around the major academic medical centers: Children's National Medical Center, George Washington University Hospital and Medical Center, Georgetown University Hospital, Howard University Hospital, and Washington Hospital Center. All have teaching faculty who also see patients as clinicians and run hospital-based specialty clinics. These medical centers have added satellite campuses to serve suburban locations and connect patients with specialists and advanced services within their systems. Several hospitals provide community-based ambulatory care services in the District, including Children's National Medical Center, which recently opened four clinics under a grant from the federal government. Community physicians also practice in these hospitals. Physicians have tended to cluster in nearby office buildings.

In addition to the major teaching hospitals, the District also has community hospitals, some of which have thrived (e.g., Sibley Hospital) while others struggle. Hadley Hospital, which converted to a long-term care only facility, and Greater Southeast Community Hospital are both at risk because of the recent bankruptcy filing of their for-profit parent company.⁶⁸ Providence Hospital is at risk because of the uncertain future of the D.C. Healthcare Alliance, the consortium of private healthcare providers that contracts with the District to offer care for the indigent.⁶⁹ Columbia Hospital for Women is now closed.

Until 2001, indigent residents received most of their care -- both inpatient and outpatient primary and secondary care -- at D.C. General Hospital. Private hospitals provided the remainder of uncompensated acute care, exceeding \$132 million or 54% of unsponsored care in the District for the year 2000.⁷⁰ 2001 saw a shift in the site of acute inpatient and specialty care for the uninsured as the District of Columbia Government closed D.C. General's inpatient acute care

⁶⁷ See, e.g., the Delmarva Foundation Impact Opinion Report at <http://www.mdinsurance.state.md.us/documents/DelmarvaFinalReport02-10-03.pdf> (accessed on October 20, 2003).

⁶⁸ Doctors Community HealthCare Corp. of Scottsdale Arizona, parent of both Greater Southeast Community and Hadley Memorial hospitals, filed for bankruptcy in late 2002. Under an agreement with creditors, the bankruptcy judge has approved funding for both hospitals that allow them to continue operations.

⁶⁹ Greater Southeast Community Hospital had been the primary contractor for the DC Healthcare Alliance until the hospital's parent company filed for bankruptcy in late 2002. The DC Department of Health took over the program and hired D.C. Chartered Health Plan, a private contractor, to jointly administer the Alliance. See Monte Reel, "D.C. Council Panel Blasts Health Program for Poor." *Washington Post* (June 26, 2003) at B5.

⁷⁰ DC Hospital Association Financial Indicators Survey (2001).

(including its trauma center) and much of its outpatient capacity. The District now manages the D.C. Healthcare Alliance to offer care for the indigent. For 2001, unsponsored care increased for the District's private hospitals to \$157.5 million. Five of nine acute care hospitals experienced increases, led by Howard University Hospital (whose unsponsored care increased by \$16 million) and the Washington Hospital Center (whose unsponsored care increased by almost \$10 million).⁷¹

Like hospitals, physicians have clustered in the Northwest quadrant where Howard University Hospital and Washington Hospital Center are located, and in downtown areas. These sites, which have parking and public transportation access, attract patients with health insurance. But few physicians can be found in poorer areas with more uninsured, Medicaid, and low-income Medicare patients, especially in the Shaw and Upper Cardozo neighborhoods of Northwest Washington, and East of the (Anacostia) River areas in Southeast Washington. The shortage of physicians there has prompted the growth of public interventions, in the form of clinics beginning as part of the public health department and later operated by the now defunct DC Health and Hospitals Public Benefit Corporation. These clinics now operate as Federally Qualified Health Centers (FQHC) within the Unity Health Care system. Privately funded clinics also grew, most in the form of "free clinics" started by charismatic leadership – often growing out of that nationwide movement in the 1960s. These free clinics were the "providers of last resort," who relied on volunteers and donated supplies to keep the clinic doors open in order to provide care to those who would otherwise not receive care. Most of these clinics still exist, although they now bill Medicare, Medicaid, and, in the District, the DC Healthcare Alliance. In the District, most of the not-for-profit clinics have banded together to begin participating in insurance programs, hiring a single vendor to process their claims. Clinics there are increasingly facing the need to change from a "free" clinic to one that bills payers. Most find this to be a wrenching cultural shift.

Northern Virginia. Until recently there have been no major teaching hospitals and no public general hospital. Rather, community hospitals, supplemented by several for-profit hospitals, have been the rule. While some physicians cluster around them, traditionally physicians have selected offices near their homes, or with attractive demographics, or both. Until recently there have been few large physician groups, and almost no large multi-specialty groups.

Northern Virginia providers are now changing rapidly. The non-profit owner of four of the hospitals serving the CareFirst/GHMSI area⁷² grew from a small community hospital into a large system with multiple services, including some teaching programs. Arlington Hospital tried to follow suit, partnering with a national for-profit chain, but that deal fell through over the ownership of the foundation. Physicians, too, are consolidating, especially single-specialty groups.

Northern Virginia has always had low-income residents, many of whom are uninsured and ineligible for public insurance. More recently, the area has had increasing numbers of the underserved. Although some have moved from the District while others are changing residence

⁷¹ *Id.*

⁷² CareFirst's Northern Virginia service area is east of Route 123, which winds along the Potomac River in McLean to bisect Fairfax City.

within Northern Virginia (e.g., from Alexandria to Fairfax County), a much larger number are new immigrants with a multiplicity of languages and cultures.

In addition to community hospitals, the other major providers of care for the underserved have been the public health departments, which offer preventive and primary care clinics, usually to the low-income uninsured who live in their jurisdictions. Their efforts are supplemented by the health professional education programs at George Mason University, Northern Virginia Community College, and The George Washington University.

CareFirst/GHMSI Profile

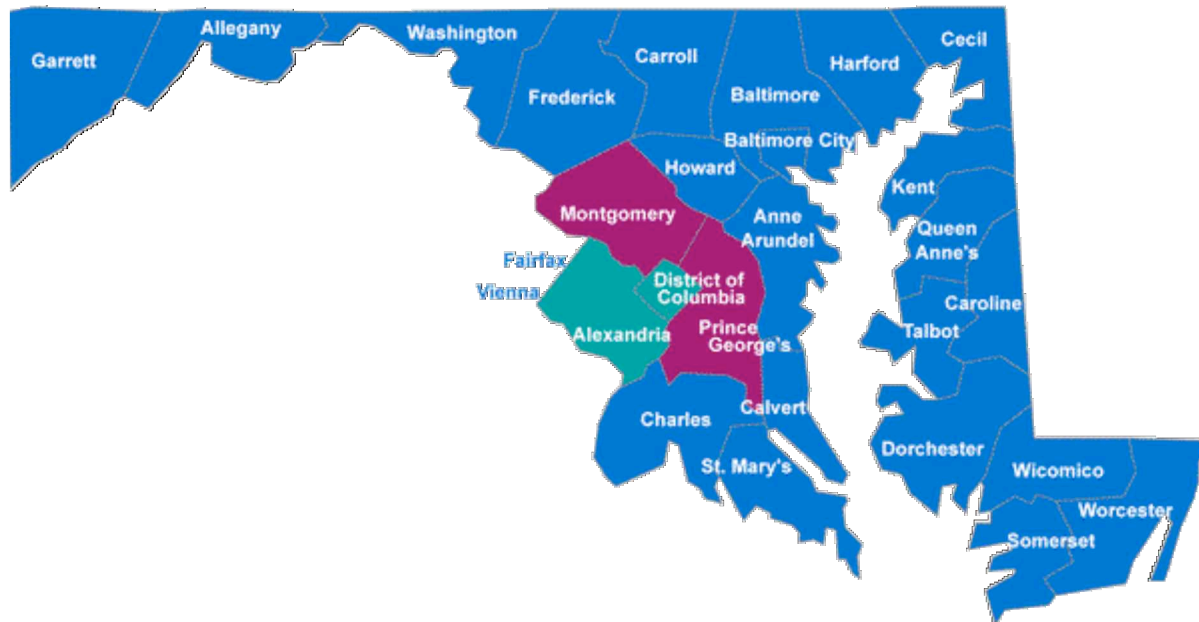
GHMSI is the District of Columbia BlueCross BlueShield subsidiary of CareFirst, Inc. GHMSI is a non-stock, non-profit entity and was chartered by Congress as a “charitable and benevolent” corporation in 1939.⁷³ GHMSI and CareFirst of Maryland, Inc. merged in 1998 to create the non-profit holding company CareFirst, Inc.

The CareFirst/GHMSI service area is stated as the District of Columbia, suburban Maryland, and Northern Virginia. Suburban Maryland includes Prince George’s and Montgomery counties, and Northern Virginia includes the cities of Alexandria and Fairfax, the town of Vienna, Arlington County, and the areas of Fairfax and Prince Williams counties in Virginia east of Route 123.⁷⁴

⁷³ See GHMSI Federal Charter § 8 (Appendix A).

⁷⁴ See <http://www.carefirst.com/pages/coverage/ghmsi.htm> (accessed on October 20, 2003).

Figure 7
Care First Blue Cross Blue Shield Service Area⁷⁵



GHMSI offers insurance products in the individual and group markets. In the individual market, GHMSI offers the following types of coverage:⁷⁶

- an indemnity comprehensive major medical plan with two deductible options and a \$1 million policy maximum;
- a PPO product called BluePreferred for District residents under 65. The policy has a \$2 million policy maximum and is available in a number of deductible and co-insurance levels. In addition, the PPO product is available in two forms:
 - as a medically-underwritten product and
 - as a HIPAA non-medically-underwritten product;
- an open enrollment PPO product pursuant to District requirements;
- a PPO conversion plan for individuals who leave group membership;

⁷⁵ The areas in blue are underwritten by CareFirst of Maryland, Inc. The northern Virginia area, shown in green, is underwritten by Group Hospitalization and Medical Services Incorporated (GHMSI). Both CareFirst of Maryland, Inc. and GHMSI operate in Prince George's and Montgomery counties, represented in magenta.

⁷⁶ For a more detailed description of GHMSI's products in the individual and group markets, see CareFirst, GHMSI, and WellPoint Amended and Restated Application, August 19, 2002, Supplement to Amended Form A Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer at pp. 23-28.

- an HMO product (BlueChoice) (which can be purchased by HIPAA-eligible applicants without medical underwriting)
- an HMO group conversion product for individuals who leave group membership; and
- three indemnity individual Medicare supplemental plans to District residents (all guaranteed issue).

In the group market, GHMSI offers the following types of coverage:

- indemnity comprehensive major medical (with first dollar coverage and a variety of benefits, deductibles, and out-of-pocket maximums);
- PPO products (BluePreferred PPO)
- HMO products (BlueChoice); and
- POS products (BlueChoice Opt-Out and Opt-Out Plus (subscribers are not responsible for charges above an established plan allowance))

GHMSI offers these products to groups through 25 standard packaged product combinations that provide employees with a choice of two to three health plans when they enroll.⁷⁷

As part of our data requests regarding the individual and small group markets, we asked CareFirst/GHMSI for enrollment information and financial performance information for each of these products (current and historical). CareFirst/GHMSI responded that this information was confidential and would be provided only pursuant to a confidentiality agreement and only for purposes of the DISR proceeding (rendering it unusable for this analysis once the DISR proceeding was suspended). However, the CareFirst, Inc. annual report lists a total of 3.2 million CareFirst members (MD, DE, DC, VA) and an information sheet about CareFirst on WellPoint's website indicates that approximately 1,061,000 of these enrollees reside in the District metropolitan area (not broken down by product, however).⁷⁸ Similarly, the GHMSI annual statements (filed in DC on National Association of Insurance Commissioner standard forms) do not break down enrollment by product.

Recent CareFirst/GHMSI Developments

⁷⁷ *Id.*

⁷⁸ See http://www.wellpoint.com/press_room/special_reports/cf/CFFacts.doc (accessed October 20, 2003).

After Maryland enacted legislation that gave the state authority over the selection of CareFirst's Board of Directors,⁷⁹ the National Blue Cross Blue Shield Association filed a federal lawsuit in Illinois seeking to stop CareFirst from using the Blue Cross and Blue Shield trademark.⁸⁰ The association claimed that the state control was a violation of CareFirst's licensing agreement. Maryland filed suit against the Blue Cross Blue Shield Association to prevent the termination of CareFirst's licensing agreement.⁸¹ CareFirst filed suit against Maryland claiming the legislation was unconstitutional.⁸² The parties negotiated a settlement of all three lawsuits that allowed CareFirst to retain its Blue Cross Blue Shield affiliation.⁸³ The settlement reduces the influence the state-appointed nominating committee will have over the CareFirst Board of Directors and the Maryland Insurance Commission's influence over compensation for CareFirst officers and directors.⁸⁴ The settlement does not affect the five-year moratorium on CareFirst converting to for-profit status.⁸⁵

Although the lawsuits are resolved, there remains a dispute between District Insurance Commissioner Lawrence H. Mirel and the Maryland Insurance Administration, now headed by Alfred W. Redmer (after Steven B. Larsen's departure). Commissioner Mirel has questioned the authority of the Maryland legislature and Insurance Administration to regulate CareFirst/GHMSI's operations in the District and has suggested that he will file suit to contest it.⁸⁶ On October 24, 2003, Commissioner Mirel issued an order directing CareFirst/GHMSI to disregard the Maryland reform legislation.⁸⁷ Commissioner Mirel issued the order after the CareFirst board took no action on a petition from GHMSI requesting the right to run its own affairs.⁸⁸ Commissioner Mirel has ordered CareFirst executives to appear at a November 21 hearing on the issue.⁸⁹

In addition, Maryland Insurance Commissioner Redmer announced plans to fine CareFirst and three executives (Chief Executive Officer William L. Jews, Executive Vice President David D. Wolf, and Chairman of the Board Daniel J. Altobello) for violations of Maryland's laws regulating non-profit organizations – allegations first made by former Commissioner Steven B. Larsen in his March 2003 report denying the proposed conversion and sale.⁹⁰ The fines range from a maximum of \$500,000 for the company and \$5-15,000 for the executives.⁹¹ Among other allegations, Commissioner Redmer alleges that the executives made willful misrepresentations to

⁷⁹ See Maryland Senate Bill 772, § 7 (signed by Governor Ehrlich on May 22, 2003), available at <http://www.mlis.state.md.us/#bill> (accessed October 20, 2003). The legislation gave Maryland greater control over selection of CareFirst's Board of Directors and the compensation of its officers and directors.

⁸⁰ See *Blue Cross and Blue Shield Association v. CareFirst Inc.*, N.D. Ill., No. 03C-3422.

⁸¹ See *Maryland v. Blue Cross Blue Shield Association*, D. Md., No. JFM 03-1510.

⁸² See *CareFirst Inc. v. Ehrlich*, D. Md., No. JFM 03-1521.

⁸³ See Bureau of National Affairs, "Judicial Accord Ends CareFirst Dispute," *Health Law Reporter* (June 12, 2003) at 924.

⁸⁴ *Id.* at 925.

⁸⁵ *Id.*

⁸⁶ Bill Brubaker, "CareFirst Oversight Questioned," *Washington Post* (July 7, 2003) at E1.

⁸⁷ Bill Brubaker, "D.C. Official Tells CareFirst to Ignore Md. Law," *Washington Post* (Oct. 25, 2003) at E2.

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ Bill Brubaker, "CareFirst, Officers Face Fines in Md.," *Washington Post* (July 9, 2003) at E1.

⁹¹ *Id.* at E4.

the CareFirst board to secure bonuses for themselves in the negotiations over the sale of the company to WellPoint.⁹² CareFirst and the executives will have the opportunity to respond during public hearings.

In addition, the U.S. Attorney's office in Maryland opened a federal criminal investigation that appears to focus on the company's actions related to the proposed conversion and sale to WellPoint.⁹³ The U.S. Attorney issued subpoenas requesting documents from CareFirst and WellPoint regarding the proposed transaction.⁹⁴

Our analysis of CareFirst/GHMSI does not address the possible criminal and civil liability of the incumbent management of the organization. This analysis focuses on the company's policies and practices vis-à-vis particular consumers and providers in the National Capital Area – issues that the organization must address regardless of the individuals with management responsibility for the company.

Although the resolution of the remaining disputes remains unclear, one thing is certain: the collective discussion about CareFirst/GHMSI will continue for the foreseeable future.

The Future for CareFirst/GHMSI

In this section, we address several scenarios regarding the future of CareFirst/GHMSI:

- Status Quo (our general findings regarding CareFirst/GHMSI with respect to our five original study populations); and
- Lessons from other non-profit Blues plans in other jurisdictions regarding our five original study populations that illustrate what other non-profits have been able to accomplish. Whether this region could expect similar initiatives would from CareFirst/GHMSI would be subject to an economic feasibility analysis of CareFirst/GHMSI in the National Capital Area..

⁹² *Id.* at E4.

⁹³ See Bill Brubaker and Lori Montgomery, "U.S. Probing CareFirst Over Attempted Sale," *Washington Post* (Aug. 15, 2003) at E1.

⁹⁴ *Id.* The U.S. Attorney's office also issued subpoenas to Indiana-based Anthem Blue Cross and Blue Shield (which acquired Virginia-based Trigon Healthcare Inc., another company that had sought to acquire CareFirst) and the Maryland Insurance Administration. *Id.* at E10.

Status Quo and Lessons Learned from other Non-profits

Individual/Small Group Markets

Status Quo

The focus of this study area was whether individual and small group coverage is available and affordable, and whether an insurer such as CareFirst/GHMSI offers product innovations that demonstrate a commitment to access.

To look at the general availability of GHMSI non-group policies across different areas of the District, we looked at whether various GHMSI non-group policies were available in different zip codes through www.e-healthinsurance.com. The website purports to be the largest web-based provider of health insurance products, and CareFirst accepts applications for coverage through this service as well as through other means of distribution. To determine if there were any differences in the products offered or the prices for non-group products across areas of the city, we queried which products were available from CareFirst/GHMSI for a number of different zip codes throughout the city. We saw no significant differences in the products that were available or the premiums for those products. Thus, it appears that CareFirst/GHMSI currently offers a range of typical products at competitive prices. CareFirst/GHMSI did not appear to offer any innovative products for the market compared to competitors.

Another indicator of an insurer's commitment to access to insurance is the presence of and growth in an open enrollment product. Under guaranteed issue/open enrollment laws in the District and Virginia, CareFirst/GHMSI must issue individual insurance policies to those who apply for them regardless of the individuals' age, health history, medical history, or employment status. The open enrollment program must be available year-round, and the company must advertise the program in newspapers of general circulation.⁹⁵ However, nothing requires CareFirst/GHMSI to market the guaranteed issue/open enrollment insurance program more aggressively, display it prominently on its website, or seek new ways of notifying individuals of this option.

On page 17 of their Third Response to DISR's First Request for Information, CareFirst/GHMSI indicated the following enrollment information for the Blue Preferred Open Enrollment product in the District:

<u>Date</u>	<u>Members</u>
11/1/1995	0
11/1/1996	116
11/1/1997	283
11/1/1998	408
11/1/1999	432

⁹⁵ See D.C. Code § 31-3514 (2003) and Va. Code Ann. §38.2-4216.1(2003).

<u>Date</u>	<u>Members</u>
11/1/2000	433

On p. 27 of their Amended and Restated application to DISR, CareFirst/GHMSI indicated that as of July 2002, there were 281 District residents covered by GHMSI's open-enrollment product. Thus, it appears that the open enrollment product is small and not growing (and, in fact, declining in enrollment). The product is not easily found, nor is it prominently advertised on CareFirst's website. We saw no indication that CareFirst/GHMSI goes beyond the minimally required steps to market the program and enroll individuals.

We had little information to assess whether CareFirst/GHMSI's offerings in the small group market were better or worse than any other insurer's. As with the individual market, we had no data that categorized enrollment by types of product, which would allow observations regarding the small group market and focus of the company's offerings. The policy forms we reviewed were not materially different than those of other insurers.

We could not discern from any documents CareFirst/GHMSI's strategies for or commitment to the individual and small group markets. For example, for purposes of this report, we had no historical CareFirst/GHMSI enrollment data by product line⁹⁶ or information about product innovations and when they came into the market, all of which we requested. Nor did we have information on which products have been discontinued over time, which we requested. Although this type of information is not conclusive, it illustrates an insurer's focus and market segmentation. By contrast, WellPoint personnel were willing to discuss this type of information to provide a picture of that company's activities in the individual and small group market segments.

Lessons Learned from Other Non-profits

There is some evidence that a WellPoint acquisition of CareFirst could have enhanced the availability of individual and small group products in the CareFirst/GHMSI service area. The type of products currently available in a market is one indicator of an insurer's commitment, but past history offers additional evidence of an insurer's strategy and approach to these market segments. In our discussions with WellPoint representatives in Georgia, we learned the effects on the individual/small group markets of the WellPoint acquisition of BlueCross and BlueShield of Georgia. Simply put, WellPoint was aggressive in these market segments and expanded the product offerings in both categories significantly beyond what BlueCross Blue Shield of Georgia had offered prior to the acquisition. In both the individual and small group markets, enrollment nearly doubled. Although such evidence is no guarantee that WellPoint would have pursued those market segments in the National Capital Area as aggressively, it demonstrates willingness by a for-profit insurer to innovate and respond to demand in the marketplace. In addition, such

⁹⁶ CareFirst/GHMSI responded that this information was confidential and would be provided only pursuant to a confidentiality agreement and only for purposes of the DISR proceeding (rendering it unusable for this analysis once the DISR proceeding was suspended).

historical evidence of increased numbers of products and enrollment in the Georgia market does not demonstrate that the new products were adequate or of high quality.⁹⁷

There are examples of approaches to the individual and small group markets by non-profit insurers that also illustrate a commitment to increasing access and fulfilling a social mission, including plans in Pennsylvania and New York. The regional non-profit Blues plans in Pennsylvania have managed to pursue innovative approaches to these market segments while remaining profitable – so much so that the Pennsylvania Insurance Commission held hearings to determine if the companies had excessive surpluses that should be returned to policyholders. Maryland Insurance Commissioner Larsen noted the testimony of the chief executives of these plans in some detail in his report,⁹⁸ but a few points are worth repeating here:

- The executives of these non-profit Blues plans explicitly acknowledge their social mission; and
- These companies subsidize insurance programs in the individual and small group markets to ensure their availability and affordability.

Highmark operates as Highmark Blue Cross Blue Shield in Western Pennsylvania and as Pennsylvania Blue Shield in the state's central, eastern and northeastern regions. In 1992, the company developed an individual market product called Special Care, specifically designed for uninsured, low-income Pennsylvanians whose incomes were at or below 185% of the poverty threshold. The product provides insurance coverage at about half the cost of traditional Blue Cross Blue Shield coverage. This cost differential is achieved through subsidization of the rates by the Blues plans, limiting the benefits,⁹⁹ and negotiating provider discounts. In addition to the Special Care program, Highmark subsidizes two insurance programs for children and the Children's Health Insurance Program for Pennsylvania.¹⁰⁰ The President and CEO summarized the obligation of a non-profit to both sell products and "pay for the care and administer the

⁹⁷ For a discussion of how insurers have introduced products with limited benefits and high cost-sharing, see Glied et al. "Bare Bones Health Plans: Are They Worth the Money?" http://www.cmwf.org/programs/insurance/glied_barebones_ib_518.pdf (accessed October 20, 2003). See also Lee and Tollen, "How Low Can You Go? The Impact of Reducing Benefits and Increased Cost Sharing", Health Affairs Web Exclusive 19 June 2002 (http://www.healthaffairs.org/WebExclusives/Lee_Web_Excl_061902.htm) (accessed October 20, 2003). We do not suggest that the new WellPoint products suffered from these defects – since we did not have an opportunity to examine those products in depth. We merely note the sufficiency and quality of insurance products as important considerations.

⁹⁸ Report of Maryland Insurance Commissioner Steven B. Larsen at 97, available at <http://www.mdinsurance.state.md.us/jsp/CareFirst.jsp10?divisionName=CareFirst+Conversion+Information&pageName=/jsp/CareFirst.jsp10> (accessed on October 20, 2003).

⁹⁹ Covered benefits include 21 days inpatient hospital care (per 90-day benefit period), emergency medical/accident, four doctor visits per year (with a \$10 co-pay), surgery, diagnostic X-ray and lab; chemotherapy and radiation therapy, annual mammogram after age 40, routine gynecological exams, pediatric preventive services including immunizations, and maternity/newborn care. The plan does not cover mental health, substance abuse, prescription drugs, dental, or vision. Highmark Special Care brochure; see also Barbara Dubs, Director of Community and Social Programs, Highmark, presentation to National Institute for Health Care Management's Private Sector Initiatives for the Uninsured working session, July 9, 2001, Washington DC; and generally www.highmark.com (accessed on October 20, 2003).

¹⁰⁰ Testimony of John S. Brouse, President and CEO, Highmark, Inc. before the Pennsylvania Insurance Commissioner, Wednesday, Sept. 4, 2002, at 4.

benefits of a population that many insurers will not, or are reluctant to, insure...For these groups and individuals, our products are often their only option.”¹⁰¹ For Highmark, the fact that many insurers do not include these individuals in their risk pools means that there is “even more demand for the Blues to uphold their commitment to small groups, individuals, and those who wouldn’t have insurance otherwise.”¹⁰²

Excellus, the BlueCross BlueShield plan that serves Rochester, Utica-Watertown, and central New York, has also developed innovative individual and small group products that are intended to expand access to low-income individuals, families, and workers. Offered to individuals and families whose incomes do not exceed 222% of the poverty threshold, Excellus’s ValueMed product provides a limited benefit package and is offered at rates below standard insurance products.¹⁰³ Excellus partnered with providers (who accepted lower rates) to enable the discounted rates. Similarly, the company works with the state of New York to offer Healthy NY, a state-sponsored program designed to allow small employers to offer health insurance coverage to their employees, dependents and other qualified individuals. The program offers a limited benefit package for eligible businesses with 50 or fewer employees. In addition, uninsured workers whose employers do not offer health insurance and sole proprietors can purchase the same benefits package that is available to small businesses participating in the Healthy NY program.¹⁰⁴

These are only a few examples of innovative approaches other insurers have taken in order to make health insurance accessible and affordable to low-income individuals and families. This analysis does not suggest that these products could somehow be immediately transplanted by CareFirst to the National Capital Area and succeed. A detailed financial analysis of whether these types of products would be feasible in the CareFirst/GHMSI market and whether CareFirst could afford to offer them is beyond the scope of this analysis. However, we provide these products as examples of innovation in addressing market needs. In our review of CareFirst/GHMSI’s products in the individual and small group markets, we saw no such innovation. We saw no aggressive marketing of the CareFirst/GHMSI open enrollment product (which has very low enrollment). In sum, the individual/small group products CareFirst/GHMSI offers are comparable to those offered by other insurers – which means that they do not address some fundamental needs in the National Capital Area.

Providers

Status Quo

One of the more critical issues in the acquisition of a not-for-profit Blue Cross Blue Shield plan by a for-profit insurer or the conversion of such a plan to for-profit status is the likely impact

¹⁰¹ *Id.* at 7.

¹⁰² *Id.*

¹⁰³ See http://www.bcbsra.com/guests/guests_home.htm (health plans link) (accessed October 20, 2003).

¹⁰⁴ *Id.*

on health care providers, especially those serving the poor, minorities, uninsured, and otherwise medically underserved residents of the CareFirst/GHMSI service areas.

The lack of documentation from CareFirst/GHMSI and WellPoint forced the study team to rely largely on the provider interviews for most information, which means that neither CareFirst/GHMSI's nor WellPoint's perspective can be represented in this document.

Only two CareFirst/GHMSI documents proved to be of even limited utility for the provider impact section of the study: 1) the Meyer and Waldman report, *Identifying Options for Using Charitable Assets to Improve Health in the District of Columbia*, prepared for CareFirst/GHMSI; and 2) Form A, *Amended Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer* (and supporting attachments), filed with the District of Columbia Department of Insurance and Securities Regulation and the Office of Corporation Counsel, August 19, 2002.

Participation Requirements for Network Providers: CareFirst/GHMSI's requirements for provider plan participation, the types of provider networks its policies induce (e.g., is there a different network for suburban customers than exists for the inner city?), and the credentialing process for actually becoming an in-network CareFirst/GHMSI participating provider are all important issues. Providers who are excluded from networks risk losing the CareFirst/GHMSI enrollees from their patient populations. Since CareFirst/GHMSI is the dominant commercial health insurance provider both in the region and for hospital providers, this indeed could be a substantial loss.

The hospitals studied all reported participating as CareFirst/GHMSI providers. Regardless of payer mix, CareFirst/GHMSI was reported as the largest commercial payer, with one exception: a Virginia market hospital for which CareFirst/GHMSI volume trails two other plans. The hospital interviewees said that the credentialing system that CareFirst/GHMSI uses is typical of that of other plans.¹⁰⁵ They reported that, to the best of their knowledge, they are included in all CareFirst/GHMSI's product lines, as appropriate.

None of the safety-net ambulatory care providers have historically billed CareFirst/GHMSI, either because the clinics have traditionally focused on the uninsured, or because CareFirst/GHMSI enrollees have represented such a small part of their patients that their managers have judged the administrative costs to outweigh any potential reimbursement from CareFirst/GHMSI.¹⁰⁶

Compensation for Network Providers: The hospital interviewees were of two opinions regarding CareFirst/GHMSI's payment levels: those who said that payments were comparable to

¹⁰⁵ One safety-net hospital did complain that CareFirst tried to keep the hospital's part-time physicians from billing under their own provider numbers in the physicians' private offices, thus limiting the physicians' ability to have private practices. This policy was successfully appealed.

¹⁰⁶ In the District, most of the non-profit clinics have banded together to begin participating in insurance programs, hiring a single vendor to process their claims.

those of other plans in the market, contrasted with a larger group who said that CareFirst/GHMSI's levels were significantly lower.

With one exception, the providers whose payer mix is predominated by Medicaid, self-pay/no-pay, DC Healthcare Alliance and Medicare (and who have minor penetration by commercial insurance patients) fell into the former group who felt that CareFirst/GHMSI rates were not out of line with other insurers. These providers were all located in the District. The Northern Virginia interviewees, whose systems care for a predominantly private, commercially-insured population, also fell into this group.

With one exception, the larger group of interviewees represented District providers for whom commercial penetration and CareFirst/GHMSI penetration is substantial. They fell into the latter group of hospital interviewees which said that CareFirst/GHMSI rates are the lowest - lower, some said, than Medicaid and Medicare, and well below providers' costs. The one safety-net hospital in this group reported that CareFirst/GHMSI rates were already below the hospital's costs, and that CareFirst/GHMSI's rates were "awful."

Some District hospital interviewees cited a "most-favored-nation" clause negotiated by CareFirst/GHMSI that in effect guarantees CareFirst/GHMSI the provider's best pricing. Also mentioned were CareFirst/GHMSI's market strength ("can't live with them, can't live without them"), which enables it to negotiate tough terms in its provider agreements. Also cited as contributing to relatively low payouts are high rates of denials ("one in five" according to one interviewee), delayed payments, and relatively high administrative overhead required of providers to successfully close claims.

Almost all the hospitals – those that stated that CareFirst/GHMSI was just like other insurers and those who said that CareFirst/GHMSI already paid the lowest rates -- worried that payments well below the hospitals' costs would negatively affect the institutions' ability to cost-shift and thus could threaten an erosion of care available for the poor and uninsured. However, one provider with high volumes of commercially insured patients said that CareFirst/GHMSI rates allow such cost shifting, and another said that its situation was on the brink of unfavorable cost shifting.

During our study period, CareFirst/GHMSI and Children's National Medical Center engaged in a fierce and very public battle over compensation rates, which was ultimately settled in January 2003 in an agreement that kept Children's in the CareFirst/GHMSI network.¹⁰⁷ This incident is notable not only for its ferocity and publicity, but also because both sides were willing to push the battle to the brink of disenfranchising thousands of the sickest children from their sources of affordable care.

Appeals Procedures for Network Providers: As network providers, most of the study's hospitals reported that CareFirst/GHMSI is "typical of all the plans" in its utilization management and appeals processes. However, several reported difficulties with CareFirst/GHMSI's utilization

¹⁰⁷ See Avram Goldstein, "Deal Set Between CareFirst, Children's; Patients Can Keep Doctors, Avoid Higher Fees" *Washington Post* (January 28, 2003) p. B01.

management and appeals. They stated that appeals were frequent but very few were successful. One complained that there is no external provider grievance mechanism in the District, with the only such relief being available for plan members. Several complained about the relative ineffectiveness of CareFirst/GHMSI's case management procedures, with one specifying that CareFirst/GHMSI's utilization management is more technologically unfriendly than other plans (CareFirst/GHMSI's utilization management is not web-based while other plans' are, and CareFirst/GHMSI's telephone system is inadequate). Since the ambulatory safety-net providers had little direct experience with CareFirst/GHMSI as a payer, this issue did not concern them.

Policies for Authorizing Payment for Covered Services Furnished by Out-of-Network Providers: Many – indeed, most – private insurers will authorize payments to duly licensed out-of-network providers, although such providers often receive lower payments than in-network providers (and the patients' share is substantially more). Referrals for specialty care or diagnostic procedures, as well as for post-hospital short-term rehabilitative care, are often the occasions where denial – or slowed insurer authorization -- for out-of-network providers occur.

Because all of the hospitals represented in the interviews are current CareFirst/GHMSI providers for all lines relevant to their services, few have a need to refer out of the network; they are typically on the receiving end of referrals. Thus, hospital interviewees reported few limitations by CareFirst/GHMSI on their referrals out of network, although one said that referrals to post-hospital rehabilitation services were problematic. Another said its ability to refer is affected by the declining number of private physicians who participate in CareFirst/GHMSI because of CareFirst/GHMSI's low payment rates. The safety-net ambulatory clinics had too little experience with CareFirst/GHMSI as an insurer to offer opinions on this matter.

Relationships with the Health Care Safety Net and Community Benefits: Providing grants or in-kind contributions could help to address the health needs of the area's sizable low-income, underserved, and minority populations, many of whom both have poor health status and face formidable barriers to accessing needed care. These barriers include the lack of health insurance or ability to pay for care out of pocket, distances from their residences to where providers are located -- a special trial in this metropolitan area with traffic gridlock and a lack of providers in the eastern sector of the District – as well as language and cultural barriers, which are increasing as the area becomes ever more diverse. Although many of the area's hospital and safety-net ambulatory providers either do not participate with CareFirst/GHMSI or else find the insurer's payment levels inadequate, CareFirst/GHMSI could become a bigger player in addressing these health issues by providing community benefits. Indeed, CareFirst/GHMSI's August 19, 2002 *Amended Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer*, filed with the District of Columbia in support of its merger with WellPoint states:

GHMSI has always made it a goal of the company to give to the community and to stay involved in community activities. Although charitable donations and community involvement are not part of its chartered purpose, GHMSI believes that

all corporations, profit and non-profit alike, should give back to the communities they serve.¹⁰⁸

According to the *Amended Statement*, CareFirst/GHMSI gave District-based organizations \$59,500 in 2000 (\$6,500 of that to direct service providers), \$233,000 in 2001 (\$132,500 to direct service providers, of which \$125,000 was to the Washington Hospital Center and NBC-4 for a health fair), and \$61,000 as of August 2002 (of which \$10,000 was to a direct service provider).¹⁰⁹ These sums do not compare favorably to the company's total surplus (approximately \$800 million in 2002),¹¹⁰ its quarterly surplus (\$40.8 million in the second quarter of 2003, a 66 percent increase over its surplus in the second quarter of 2002),¹¹¹ or the compensation of its Chief Executive Officer (\$2.8 million in 2002).¹¹²

Accordingly, the study team asked about the providers' receipt of such benefits, and few reported having received or even solicited support from CareFirst/GHMSI in the past five years. The few comments by interviewees reflected either their lack of expectation that CareFirst/GHMSI would make such donations or sense of frustration that CareFirst/GHMSI has not been a source of community benefits.

Except for one year's donation to support an annual hospital gala and the health fair noted above, none of the hospitals reported having received any type of community support from CareFirst/GHMSI. None of the safety-net ambulatory providers reported receiving a grant or in-kind contributions such as volunteer time, facilities, or equipment from CareFirst/GHMSI. One association reported receiving past support from CareFirst/GHMSI for its annual banquet. None of the provider interviewees reported knowing of any other organizations to which CareFirst/GHMSI made financial or in-kind donations, a response shared by all the trade associations.

Only three hospitals reported having solicited contributions from CareFirst/GHMSI in the past five years, but, except for the hospital gala support mentioned above, the requests were either refused or the hospitals received no response. One safety-net clinic had written two proposals for assistance. CareFirst/GHMSI did not acknowledge either proposal and finally responded that they had too many proposals and no money. Several interviewees reported receiving assistance from both Aetna and Kaiser Permanente's Community Benefit Fund as well as limited support from other corporations, mainstream hospitals, and public health departments.

¹⁰⁸ CareFirst, GHMSI, and WellPoint Amended and Restated Application, August 19, 2002, Supplement to Amended Form A Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer at 31.

¹⁰⁹ *Id.* at 31-32. CareFirst/GHMSI did not report contributions to organizations based in Maryland or Virginia in its filing.

¹¹⁰ Avram Goldstein, "Caught in A Hospital's Tug of War; Insurer, Children's Put Patients in a Bind," *Washington Post* (Dec. 15, 2002) at C01.

¹¹¹ M. William Salganik, "CareFirst's 2Q profit is up 66% to \$40 million," *Baltimore Sun* (August 16, 2003).

¹¹² Bill Brubaker and Lori Montgomery, "U.S. Probing CareFirst Over Attempted Sale," *Washington Post* (Aug. 15, 2003) at E10.

Any CareFirst/GHMSI initiatives focused on the region's substantial minority or low-income populations were unknown to any of the interviewees, including safety net providers. One said that CareFirst/GHMSI disease management programs (which some plans have used to impact conditions that are disproportionately experienced in minority populations) are not substantial. Nor did the interviewees believe that CareFirst/GHMSI participation has enhanced these providers' own ability to care for the uninsured. One hospital interviewee said that CareFirst/GHMSI participation had had a negative impact on its capacity to care for the uninsured because its rates are lower than those of both Medicare and Medicaid.

Lessons Learned from other Non-profits

With respect to relationships with mainstream providers on a variety of business issues (payment, claims processing, contracting, case management), we found a tense relationship reported by providers and significant room for improvement. CareFirst/GHMSI is not generally viewed as a favorable partner with providers in the delivery of care, and among other plans and jurisdictions (e.g., Excellus-NY, Highmark-PA), providers and insurers have partnered to address community health needs.

With respect to safety net providers, CareFirst/GHMSI has not been paying for care for DC's and Northern Virginia's poor and underserved through its payment rates or contributions to direct provider organizations. As one provider stated, "BCBS and other plans have never really supported care for the poor,"¹¹³ even though, according to another interviewee, "Non-profits should be addressing poor health status."¹¹⁴

Medigap

Status Quo

Medicare is a federally operated medical insurance program that primarily serves Americans over the age of 65. The purpose of the Medigap aspect of the study was to analyze the potential impact of the conversion of CareFirst to a for-profit company and its acquisition by WellPoint on Medicare beneficiaries. The analysis focused on the availability and access to Medicare Supplemental (hereinafter, "Medigap") insurance.

Fee-for-service Medicare requires beneficiaries to pay out of pocket for deductibles and co-payments. Moreover, while fee-for-service Medicare covers part of the costs of hospital and physician care, it does not cover the costs of outpatient prescription drugs, eye care, dental

¹¹³ This same interviewee gave CareFirst credit for "disseminating educational materials that target diabetes, HIV, high blood pressure, and obesity, which affect [minorities and low socio-economic status] populations disproportionately." When queried, no other provider cited such programs.

¹¹⁴ CareFirst's performance as the insurer of last resort (through, for example, open enrollment) could be a means of supporting care for the underserved.

coverage and other important medical services. To assist Medicare beneficiaries in meeting the gaps in Medicare coverage and the burden of out-of-pocket medical costs, some insurance companies offer Medicare supplemental policies, including Medigap and Medicare+Choice, a managed care option. Companies that offer Medigap coverage offer standard plans (except that some companies continue to offer older, non-standard plans that have been automatically renewed by plan beneficiaries).

CareFirst/GHMSI offers Medigap options, but like other plans in the market, it no longer offers Medicare+Choice, a product that can include prescription drug coverage and an important option particularly for low-income beneficiaries.

CareFirst/GHMSI's Role in the Medigap Market: The total number of Medicare beneficiaries for the market CareFirst/GHMSI operates in is 365,750.¹¹⁵ Note that the GHMSI market in Northern Virginia does not include parts of Fairfax and Prince Williams counties in Virginia lying west of Route 123. This number of beneficiaries represents a slight overestimate because we are not able to separate those areas of those counties.

Nationally, in 1999, 34.7 million non-institutionalized Medicare beneficiaries in 1999 received supplemental coverage.¹¹⁶ At the state level, 32% of District of Columbia Medicare beneficiaries use Medigap. Similarly, 32% of Maryland Medicare beneficiaries and 32% of Virginia Medicare beneficiaries are enrolled in Medigap.¹¹⁷

Types of Medigap Products Offered and the Scope of Benefits of these Products: Companies in the District of Columbia, Maryland, and Virginia have the option of offering a diverse range of Medigap plans. Nationally, there are 10 standard Medigap plans (A – J). Plans C and F are the most prevalent, constituting 26% and 37% of all standard Medigap policies in 1999. These policies are detailed below in Figure 8. The policies pay most of Medicare's cost-sharing requirements but do not cover outpatient prescription drugs.

CareFirst/GHMSI provides three standardized supplemental Medicare plans to Medicare-eligible individuals aged 65 and over: Plan A, Plan C and Plan F. First introduced in 1992, the plans follow federal benefit guidelines as adopted by each state and the District of Columbia. See D.C. Mun. Regs. tit. 26, Ch. 22 and Va. Regs. tit. 14.

¹¹⁵ Taken from the Medicare County Enrollment as of July 1, 2001, available at www.cms.gov (accessed on June 26, 2003). The enrollment in Medigap products for each region is as follows: District of Columbia – 74,701; Montgomery County, MD – 98,604; Prince Georges County, MD – 70,687; Alexandria City, VA – 19,946; Arlington County, VA – 17,554; Fairfax City, VA – 9,727; Fairfax County – 61,731; Prince William County – 12,800; Town of Vienna, VA – located in Fairfax County.

¹¹⁶ Taken from the Henry J. Kaiser Family Foundation, Medicare Chart Book (Fall 2001) (see Figure 30, p. 37).

¹¹⁷ The Henry J. Kaiser Family Foundation. *State Health Facts Online*, available at <http://www.statehealthfacts.kff.org> (accessed on June 26, 2003).

Figure 8

Medigap Policies, by Plan Type and Numbers of Policies Purchased, 1999¹¹⁸

PLAN	A	B	C	D	E	F ¹¹⁹	G	H	I	J
Percent of Standard Policies	4%	13%	26%	6%	2%	37%	2%	2%	2%	4%
Benefits										
Coverage for: - Part A coinsurance -365 additional hospital days during lifetime -Part B coinsurance -Blood products	X	X	X	X	X	X	X	X	X	X
Skilled nursing facility coinsurance			X	X	X	X	X	X	X	X
Part A deductible		X	X	X	X	X	X	X	X	X
Part B deductible			X			X				X
Part B balance billing ¹²⁰						X	X		X	X
Foreign travel emergency			X	X	X	X	X	X	X	X
Home health care				X			X		X	X
Prescription drugs								X ¹²¹	X	X
Preventive medical care				X						X

Among standard policies, only Plans H, I, and J include drug benefits. Together, they represent only 8% of the standard Medigap policies purchased. A small number of these plans are being bought because relatively few are marketed, the premiums for these plans are high, and beneficiaries are required to pay more than half their drug costs while not being covered for catastrophic drug expenses.¹²² CareFirst/GHMSI offers no supplemental plan that includes prescription drug coverage options.

¹¹⁸ Reproduced from Henry J. Kaiser Family Foundation, Medicare Chart Book, Second Edition, page 41, Figure 34, Fall 2001 (figures add up to 98% due to rounding).

¹¹⁹ “Plans F and J also have a high-deductible option that requires the beneficiary to pay \$1,580 before receiving Medigap coverage. This deductible is in addition to separate deductibles for prescription drugs in Plan J (\$250 per year) and foreign travel emergency (\$250 per year for plans F and J), which are required in these plans with or without the high-deductible option.” Footnote a - Henry J. Kaiser Family Foundation, Medicare Chart Book, Second Edition, page 41, Figure 34, Fall 2001

¹²⁰ “Some providers do not accept the Medicare rate as payment in full and “balance bill” beneficiaries for additional amounts that can be no more than 15 percent higher than the Medicare payments rate. Plan G pays 80 percent of balance billing; plans F, I, and J cover 100 percent of these charges.” Footnote b - Henry J. Kaiser Family Foundation, Medicare Chart Book, Second Edition, page 41, Figure 34, Fall 2001

¹²¹ “Plans H and I pay 50 percent of drug charges up to \$1,250 per year and have a \$250 annual deductible. Plan J pays 50 percent of drug charges up to \$3,000 per year and has a \$250 annual deductible.” Footnote c - Henry J. Kaiser Family Foundation, Medicare Chart Book, Second Edition, page 41, Figure 34, Fall 2001

¹²² General Accounting Office, *Medigap Insurance: Plans Are Widely Available but Have Limited Benefits and May Have High Costs* (July 31, 2001), available at <http://www.gao.gov/new.items/d01941.pdf> (accessed October 20, 2003).

The Number of Beneficiaries Enrolled in CareFirst/GHMSI Medigap Products and the Premiums and Cost Sharing They Pay: The total number of beneficiaries enrolled in CareFirst/GHMSI Medigap products is below in Figure 9.¹²³

Figure 9

CareFirst/GHMSI’s Medicare Over-65 Products: Name, Year Introduced, and Enrollment

Product Name	Year Introduced	Enrollment 1998	Enrollment 1999	Enrollment 2000	Enrollment 2001	Enrollment July 2002
Supplement 65 – Plan A, Plan C, Plan F	1992	3,604	3,424	3,249	3,305	3,210

Cost sharing is based on the plan type, since all Medigap plans are standardized. See Figure 8 above. The only difference is that some plans may offer Plans F and J with a high deductible.

Figure 10 below lists the monthly premium rates, annual deductible, and coverage levels of Medigap policies published by CareFirst for DC, MD, and VA as of June 2003.¹²⁴

Figure 10

Medigap Coverage by CareFirst in MD, VA, and DC

Region and Plan	Annual Deductible	Coverage Level	Monthly Premium
Maryland			
Medigap 65 MD Plan A	\$940.00	100%	\$86.04
Medigap 65 Plan B	\$100	100%	\$106.19
Medigap 65 Plan C	\$0	100%	\$123.49
Medigap 65 Plan F	\$0	100%	\$126.55
Northern Virginia			
Supplement 65 – VA Plan A	\$940.00	100%	\$200.15
Supplement 65 – VA Plan C – Underwritten	\$0	100%	\$121.74
Supplement 65 – VA	\$0	100%	\$122.25

¹²³ CareFirst’s Response to DCA’s Information Request Dated July 9, 2002 re: Data for Medicare Market Study (October 28, 2002) at page 4.

¹²⁴ Data obtained on June 26, 2003 at www.CareFirst.com by searching products and rates for a 65-year old individual (the rates are the same for males and females). The premiums increase as the individual’s age increases. As the figure illustrates, the monthly premium for Plan A in the District and Northern Virginia is \$200.15, while the monthly premium for the same product in Maryland is \$86.04. We were unable to determine the reason for the differential.

Region and Plan	Annual Deductible	Coverage Level	Monthly Premium
Plan F – Underwritten			
District of Columbia			
Supplement 65 – DC Plan A	\$940.00	100%	\$200.15
Supplement 65 – DC Plan C – Underwritten	\$0	100%	\$121.74
Supplement 65 – DC Plan F – Underwritten	\$0	100%	\$122.25

Recent and Projected Trends in CareFirst/GHMSI Product Offerings, Enrollment, Premiums, Cost Sharing, and Market Share: CareFirst/GHMSI’s market share for individuals over 65 grew from 4 percent to 8 percent during 1999 to 2000, 8 percent to 11 percent during 2000 to 2001, and declined slightly from 11 percent to 10 percent during 2001 to June of 2002.¹²⁵ Thus, the general trend appears to be one of increasing market share for individuals over 65.

Unless a beneficiary is low-income and eligible for Medicaid, Medigap and Medicare+Choice may be the only option for beneficiaries who need additional benefits and financial predictability. Nationally, supplemental coverage from employers and Medicare+Choice has eroded in recent years as health care costs have risen – particularly costs for prescription drugs.¹²⁶ Between 1991 and 2000, the share of large employers offering health benefits to their retirees declined from 80 percent to 62 percent.¹²⁷

Enrollment in Medicare managed care grew in the 1990s mainly because the plans offered benefits such as prescription drugs for little or no additional cost to beneficiaries. In 1998, 346 health plans contracted with the Medicare program to provide care to enrolled beneficiaries. The number of Medicare HMOs has drastically declined since, with only 179 participating plans in 2001 – with another 58 announcing their intention to withdraw from the Medicare market or reduce their service area beginning in 2002.

With employer-sponsored insurance and Medicare+Choice plans leaving the market and/or reducing benefits, access to prescription drugs and other needed benefits has declined.¹²⁸

¹²⁵ Funk and Bolton, CareFirst’s Response to DCA’s Information Request Dated July 9, 2002 Re: Data for Medicare Market Study, October 28, 2002

¹²⁶ Achman and Gold, *Medicare+Choice Plans Continue to Shift More Costs to Enrollees*, Commonwealth Fund, April, 2003, available at http://www.cmwf.org/programs/medfutur/achman_m+cshiftcosts_628.pdf (accessed on October 20, 2003).

¹²⁷ Figure 32: “Percentage of Large Employers Providing Retiree Health Benefits, 1991-2000” *The Medicare Chart Book: Second Edition, Fall, 2001*, Kaiser Family Foundation, page 39, available online at http://www.kff.org/content/2001/1622/Medicare_Chart_Book.pdf (accessed on October 20, 2003).

¹²⁸ Figure 46: “Prescription Drug Coverage among Non-Institutionalized Medicare Beneficiaries, 1998,” *The Medicare Chart Book: Second Edition, Fall, 2001*, Kaiser Family Foundation, page 59, available online at http://www.kff.org/content/2001/1622/Medicare_Chart_Book.pdf (accessed on October 20, 2003).

The local situation has been worse for Medicare beneficiaries, since all of the Maryland and District Medicare+Choice plans have withdrawn.¹²⁹

Lessons Learned from other Non-profits

One need look no farther than WellPoint's experience with the Medicare market in California, Georgia and elsewhere to make that case that CareFirst could do more to address the needs of local Medicare-eligible individuals, particularly those whose limited incomes are squeezed by the rising out-of-pocket costs of prescription drugs. A positive impact of Medicare Supplemental plans is on seniors who need assistance with the high cost of prescription drugs. WellPoint's experience and plan offerings demonstrate greater access to this benefit than CareFirst/GHMSI.

Georgia: Not-for-profit Blue Cross and Blue Shield of Georgia (BCBS of GA) marketed Medigap products to the senior markets statewide and Medicare+Choice to the eight counties comprising metropolitan Atlanta before for-profit WellPoint acquired it in 2001.¹³⁰ Prescription drug coverage was not featured in its Medicare plan offerings. According to a former BCBS of GA executive who remains in that capacity at WellPoint, BCBS of GA was wary of the risks of offering a plan that had pharmaceutical benefits.

These offerings have not changed substantially since WellPoint took over BCBS of GA in that it still offers Medicare Supplemental products statewide, and Medicare+Choice in metropolitan Atlanta (two options offered by a subsidiary company). However, because WellPoint had experience offering pharmacy benefits with BC of California and as Unicare with different plans, the previous BCBS of GA wariness was overcome, and it began offering a broad array of Medicare Supplemental plans in GA including some with pharmacy benefits. In spring 2002 WellPoint began offering two new products statewide with a pharmacy benefit:

1. Standard Plan J
2. A modification of Plan F, marketed as "the Advantage Plan," that includes a deductible and a generic pharmacy benefit.

A third plan that includes a pharmacy benefit awaits approval by the Georgia Insurance Commission, and if approved, will be introduced this year. As proposed, this plan is like Plan F, with a chronic care benefit attached. This plan has been marketed in California as the Smart Choice Plan; WellPoint has filed for permission to offer it in its St. Louis, Missouri market.¹³¹

Enrollment for BCBS of GA's Medicare+Choice plans declined in late 2001 to 2002. Part of the decline is attributed to competition from the United States Government, which introduced a *free* competing benefit for military retirees, resulting in many immediate lapses from BCBS of

¹²⁹ Figure 42: "Medicare HMOs and Other Private Health Plans Participating in Medicare, 1985-2001" *The Medicare Chart Book: Second Edition, Fall, 2001*, Kaiser Family Foundation, page 52, available online at http://www.kff.org/content/2001/1622/Medicare_Chart_Book.pdf (accessed on October 20, 2003).

¹³⁰ Interview of BlueCross BlueShield of Georgia executives.

¹³¹ *Id.*

GA plans. Another reason for this decline was a lack of marketing focus by the company, because the company rolled out a new marketing campaign for its individual and small group products. Those campaigns resulted in increased enrollment in those lines during the second half of 2002. The company is test marketing a similar media campaign for the Medicare Supplemental products, and based on its California experience (see below), expects to significantly increase enrollment in 2003.

California: Since its transition to WellPoint ownership, Blue Cross of California (BC of CA) has experienced robust membership growth and healthy net income compared to its non-profit predecessor.¹³² In California, WellPoint offers several Medicare Supplemental plans that feature prescription drug benefits: an innovative high deductible plan – Plan F with a generic pharmacy benefit was offered as well as Plans J and I and a Select plan with a J drug rider attached.

The availability of prescription drug benefits is explained only partly by California's historic managed care/HMO penetration. California's Medicare managed care experience is unique in that the whole movement to implement Medicare+Choice-style Medicare risk plans grew out of California and Florida. Managed care remains a strong trend in California generally and in WellPoint's Medicare Supplemental offerings in particular. After premium payments began to decrease in the late 1990s, plans withdrew from the California managed care market, but a small Medicare+Choice plan continues to operate in California. WellPoint responded to this void, offering the Smart Choice Plan as a reasonably priced product with a generic drug benefit. WellPoint asserts that the Smart Choice Plan has been very successful, and is WellPoint's second biggest product. Blue Cross of GA has filed for approval to market this plan in Georgia, and St. Louis is filing for permission to market it this year.¹³³

CareFirst/GHMSI could draw the following lessons from the experience of its former proposed acquirer, WellPoint, based on WellPoint's experiences in the larger California (3,837,080) and Georgia (897,503) markets (compared to 365,750 Medicare beneficiaries in the CareFirst/GHMSI market).¹³⁴ Offering a choice of Medigap plans that have prescription drug benefits similar to those marketed by for-profit WellPoint in California and Georgia should be explored given the relative lack of competition¹³⁵ for such plans in the CareFirst/GHMSI market (subject to an economic feasibility analysis for CareFirst/GHMSI in the National Capital Area market).

Individuals with Chronic Illness

¹³² Accenture, Nov. 16, 2001, Appendix, Binder 12, Tab 51 citing Interstudy, The National HMO Financial Database, 1994 – 2000; data from state Department of Insurance filings; Blue Cross membership figures include 125,000 members acquired through Omni Health Plan acquisition.

¹³³ Interview of Blue Cross Blue Shield of California and Unicare Brand executives.

¹³⁴ This number of beneficiaries represents a slight overestimate because we are not able to separate those areas of Fairfax and Prince William Counties, Virginia that are not included in GHMSI service area.

¹³⁵ The lack of competition is not absolute. The Federal Employees Health Benefit Plan (FEHBP) and the military offer Medigap policies.

Status Quo

The focus of this area of study was how CareFirst/GHMSI facilitates and manages care for individuals with chronic illnesses, and originally, whether its services for these individuals differed markedly from WellPoint's. CareFirst/GHMSI has disease management programs, which are generally developed with the goals of improving care, containing costs and assisting patients in self-management. Disease management programs provide a "prospective, disease-specific approach to delivering health care for chronic illnesses managed medically."¹³⁶ Programs are intended to augment a patient's visits to a physician with interim management through non-physician practitioners, and disease management programs seek to educate patients about self care and physicians about guidelines for the treatment and management of chronic illness.¹³⁷

Disease management differs from standard medical and hospital-based case management. Among other distinctions, disease management uses a care-giving team (instead of a physician-centered model). Non-physician caregivers provide much of the care (most of which is delivered in ambulatory settings), and guidelines and outcome measures are more disease-specific than body system-specific.¹³⁸ In addition, disease management programs focus on educating members about changes in behavior that will allow them to more easily manage their condition.¹³⁹

CareFirst/GHMSI has disease management programs for asthma, diabetes, cancer, and cardiovascular diseases (WellPoint has similar programs). Patients with these chronic health conditions are referred into the program based on medical and pharmacy claims, case managers and from enrollees themselves who request the programs.

Our analysis did not examine the quality of these programs, but instead looked at their availability and the company's strategy for disease management (we could not discern the latter in CareFirst/GHMSI's case). Given the prevalence of asthma, diabetes, cancer and cardiovascular disease in the National Capital area,¹⁴⁰ CareFirst/GHMSI has selected the appropriate diseases for such programs. One notable omission, however, from CareFirst/GHMSI is a disease management program for individuals with HIV/AIDS given the District's highest case rate in the country.

Lessons Learned from other Non-profits

As noted above, CareFirst offers disease management programs that cover the standard chronic illness conditions and that are found in the GHMSI service area, with the exception of HIV/AIDS. Development of such a program or initiatives should be considered.

We found several other health plans that have addressed HIV/AIDS by initiating special programs, designing disease management programs, and providing grants to organizations serving those with HIV/AIDS. For example, non-profit Kaiser Permanente in California formed a

¹³⁶ David W. Plocher, "Fundamentals and Core Competencies of Disease Management," in Peter Kongstvedt, ed., *Essentials of Managed Care*, Boston: Jones and Bartlett at pp. 281-292.

¹³⁷ *Id.*

¹³⁸ *Id.* at 282.

¹³⁹ *Id.*

¹⁴⁰ The prevalence of asthma, diabetes, cancer and cardiovascular disease in the District exceeds national averages.

Consortium on HIV/AIDS Inter-regional Research with its regional divisions and Seattle-based Group Health Cooperative to focus on early diagnosis and treatment of HIV in its enrolled population.¹⁴¹ The organization has also targeted HIV/AIDS outreach efforts to African-American men, women, and children, and in a separate program, to all Kaiser-enrolled women in California who become pregnant.¹⁴² In addition, Kaiser has awarded community services grants to organizations in California that provide services for individuals who are HIV-positive or who have AIDS.¹⁴³

Non-profit health plans are not the only organizations taking steps to address HIV/AIDS. For-profit Oxford Health Plans in Connecticut offers a disease management program for HIV/AIDS.¹⁴⁴

Although these examples are not Blues plans, they provide examples of special programs and outreach efforts for individuals with HIV/AIDS that might be useful in the National Capital Area.

Conclusions and Limitations

The rejection of the CareFirst/WellPoint proposal did not resolve questions about the future of CareFirst/GHMSI. The company's size and market share allow it enormous influence over the accessibility, affordability, timeliness, and quality of health care in the National Capital Area. As a chartered not-for-profit insurance corporation, CareFirst is subject to a high level of accountability for its products and services, as well as its dealings with the region's residents, employers and health purchasers, health system, and government agencies involved in financing, delivering, and overseeing the quality of health care in this region.

Our yearlong examination of CareFirst and its role in the National Capital Area has led us to conclude that, regardless of whether it ultimately is converted and acquired, the company has a variety of opportunities for improvement:

Range of Products: CareFirst/GHMSI has demonstrated no innovation in the development of products that would meet significant health insurance coverage and health status deficiencies in its service area. Examples from other non-profit Blues plans and even from for-profit WellPoint's actions elsewhere demonstrate that innovation is possible and generally financially feasible. Limitations in the CareFirst/GHMSI product line include its failure to offer a Medigap policy with prescription drug coverage, participate in Medicaid, or, at a minimum,

¹⁴¹ National Health Information, Disease Management Directory and Guidebook (2003): 418 (see <http://nhionline.net/products/products.htm>, accessed October 20, 2003).

¹⁴² Kaiser Permanente Press Release, "Kaiser Permanente Sees Shift in HIV Infections, Marks its Successes and Announces Outreach Against HIV/AIDS." November, 1998 (available at www.kaiserpermanente.org/locations/california/mod44/mod44-138.htm, accessed on October 20, 2003).

¹⁴³ Kaiser Permanente Press Release, "Kaiser Grants \$350,000 to California HIV/AIDS Organizations." July, 2000 (available at <http://www.kaiserpermanente.org/locations/california/newsroom/releases/ca071400.html>, accessed on October 20, 2003).

provide some alternative product to reach out to lower-income residents. Arguably, the limited offering of Medicare products is market-driven, but the impact is that much more acute since other local plans (which are not chartered charitable institutions) have also limited their offerings. Another glaring omission worth separate mention is the lack of a disease management program or other focus on HIV/AIDS, especially given that the case rate in the District is the highest in the country. If the company has not done more because of financial viability issues, those issues should be measured closely by relevant experts in a full economic feasibility analysis for CareFirst/GHMSI in the National Capital Area.

Better Marketing of Open Enrollment: There is room for improvement in the marketing of CareFirst/GHMSI's open enrollment insurance product. The product is not easily found, even on CareFirst's website. Although the company may meet minimum standards prescribed by law (e.g., advertisement in newspapers of general circulation), this product is important because it reaches out to those who would otherwise not have access to insurance products because of health status.

Relationships with Providers: While the relationship between insurers and providers is often tense, the providers we interviewed expressed an extreme dislike of CareFirst/GHMSI. On issues such as payment, claims processing, denials, appeals procedures, case management ease, and contributions to the safety net, providers sent a clear message that relationships could be much smoother. The relationship an insurer has with its provider network affects consumers' access to care and the quality of that care. The frayed relationships CareFirst has with area providers, brought into sharp focus with the rate disagreement with Children's National Medical Center, do not serve the region's consumers.

Lack of Community Benefits: Although CareFirst/GHMSI has suggested that giving to the community is a goal of the company,¹⁴⁵ there is little evidence to support progress toward this goal. According to its own documents and interviews with providers, CareFirst/GHMSI provides very few grants or in-kind contributions that could help address the health needs of the area's sizable low-income, underserved, and minority populations. For example, CareFirst/GHMSI reported contributions to the National Capital Area totaling \$59,500 in 2000, \$233,000 in 2001 (\$132,500 to direct service providers, of which \$125,000 was to the Washington Hospital Center and NBC-4 for a health fair), and \$61,000 as of August 2002 (of which \$10,000 was to a direct service provider).¹⁴⁶ These sums do not compare favorably to the company's total surplus (approximately \$800 million in 2002),¹⁴⁷ its quarterly surplus (\$40.8 million in the second quarter

¹⁴⁵ CareFirst, GHMSI, and WellPoint Amended and Restated Application, August 19, 2002, Supplement to Amended Form A Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer at 31.

¹⁴⁶ *Id.* at 31-32. CareFirst/GHMSI did not report contributions to organizations based in Maryland or Virginia in its filing.

¹⁴⁷ Avram Goldstein, "Caught in A Hospital's Tug of War; Insurer, Children's Put Patients in a Bind," *Washington Post* (Dec. 15, 2002) at C01.

of 2003, a 66 percent increase over its quarterly surplus in the second quarter of 2002),¹⁴⁸ or the compensation of its Chief Executive Officer (\$2.8 million in 2002).¹⁴⁹

Transparency: Throughout the course of our study, we were limited by the lack of information provided by CareFirst in response to our questions and requests for documents. Basic information (e.g., how many enrollees the company has by product line) was withheld as confidential or otherwise not provided. No CareFirst personnel were made available to explain the insurer's approach to its business operations in the National Capital Area. In this regard, CareFirst/GHMSI demonstrated a lack of transparency that is troubling for a non-profit chartered company that was proposing to convert to for-profit status and sell itself to WellPoint. This lack of information makes meaningful evaluation of the company and the proposed impact of its actions (conversion or not) difficult or impossible.

In the ongoing discussion of CareFirst's future, the company bears the burden of explaining how it is meeting the needs of residents of the National Capital Area, whose jurisdictions provide substantial tax breaks to the company. For example, the region's lawmakers should reasonably be able to expect CareFirst/GHMSI to answer the following types of questions:

- What does CareFirst/GHMSI see as its obligations as a non-profit insurer chartered as a charitable institution?
- How is it fulfilling these obligations?
- How do its activities in the community (in the form of insurance products offered, health care services for members, provider relations, and broader community benefit activities) compare to those of other publicly chartered non-profit insurers?
- What specific plans for improvement can CareFirst/GHMSI identify in the areas highlighted by this analysis?
- What steps can the company take to improve its general standing among area health care providers?

This list is by no means exhaustive, but is intended to contribute to the ongoing dialogue about the future of CareFirst/GHMSI and what the region's consumers, purchasers, patients, health care providers, lawmakers, and regulators should be able to expect from the company.

It is important to reiterate that our study's methods, findings, and conclusions were limited by incomplete responses to our data requests. In addition, following the suspension of review of the proposed transaction, we were further limited by a lack of access to CareFirst/GHMSI personnel for interviews.

¹⁴⁸ M. William Salganik, "CareFirst's 2Q profit is up 66% to \$40 million," *Baltimore Sun* (August 16, 2003)(accessed August 27, 2003).

¹⁴⁹ Bill Brubaker and Lori Montgomery, "U.S. Probing CareFirst Over Attempted Sale," *Washington Post* (Aug. 15, 2003) at E10.

Our analysis does not address, and was never intended to reach, certain questions about the conversion and acquisition that include the valuation of CareFirst and specific questions of law related to whether the acquisition could be considered in the public interest. Our analysis does not address whether the proposed \$1.3 billion price was fair. It does not quantify the potential harms to the community for purposes of evaluating the proposed charitable foundation and how foundation funds should be used. We do not analyze the decision-making process CareFirst used to decide to convert to a for-profit company and the choice of WellPoint as the purchaser. Finally, we do not analyze the financial viability of CareFirst/GHMSI with respect to potential new product offerings or other potential improvements in the insurer's business practices vis-à-vis the region's consumers, purchasers, patients and health care providers. Those issues would properly be the subject of a comprehensive economic feasibility analysis of CareFirst/GHMSI in the National Capital Area by relevant experts.

Despite these limitations, our research yielded a significant amount of information regarding CareFirst and its performance. It is this picture of CareFirst that emerges that we believe to be of special importance to longer term efforts to address the company's performance for residents of the National Capital Area.

Appendix A: GHMSI Federal Charter

(1) Original 1939 GHMSI Federal Charter

[Chapter 698]
AN ACT

Providing for the incorporation of certain persons as Group Hospitalization, Inc.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That Arthur C. Christie, doctor of medicine; Major General Charles R. Reynolds; Mrs. Joshua Evans, Junior; Joseph H. Himes; General Frank T. Hines; Frank R. Jelleff; Howard W. Kacy; Mark Lansburgh; Admiral Ross T. McIntire; George H. O'Connor; Sidney F. Taliaferro; Charles S. White, doctor of medicine; Roger J. Whiteford; Thomas W. Brahany; and E. Barrett Prettyman, and their successors to be selected in the manner hereinafter declared, be, and they hereby are, incorporated and made a body politic and corporate, by the name of "Group Hospitalization, Inc.", and by that name may contract and be contracted with, sue and be sued, plead and be impleaded in any court of law or equity of competent jurisdiction, and may have and use a common seal.

Sec. 2. Said corporation is hereby authorized and empowered (a) to enter into contracts with individuals or groups of individuals to provide for hospitalization of such individuals, upon payment of specified rates or premiums, and to issue to such individuals appropriate certificates evidencing such contracts; (b) to enter into contracts with hospitals for the care and treatment of such individuals, in accordance with the terms of such certificates; and (c) to cooperate, consolidate, or contract with groups or organizations interested in promoting and safeguarding the public health.

Sec. 3. Said corporation shall not be conducted for profit, but shall be conducted for the benefit of the aforesaid certificate holders. The business and affairs of this corporation shall be conducted by its board of trustees, who shall have full power and authority in the premises, including authority to provide for all expenses incident to the conduct and management of its business and affairs. The number of trustees shall be fixed by the bylaws, but shall be at least fifteen, and shall be maintained so as to be divisible in three equal classes. The incorporators are hereby declared to be the first board of trustees of this corporation, and their respective terms of office shall be as follows: General Frank T. Hines, Sidney F. Taliaferro, and Frank R. Jelleff, five years; Howard W. Kacy, Admiral Ross T. McIntire, and Arthur C. Christie, four years; Major General Charles R. Reynolds, Joseph H. Himes, and Charles S. White, three years; Mrs. Joshua Evans, Junior, Mark Lansburgh, and George H. O'Connor, two years; Roger J. Whiteford, Thomas W. Brahany, and E. Barrett Prettyman, one year. Upon the expiration of the respective terms of said trustees, their successors shall be appointed as follows: One by the Commissioners of the District of Columbia, one by the Medical Society of the District of Columbia, and one by a group consisting of the president or chairman of the boards of trustees or other designated individual of each hospital with which the corporation shall have contracts for hospitalization, at a

meeting called thirty days in advance by the president of Group Hospitalization, Inc. If either of the other two groups aforesaid shall fail to name their respective quotas of trustees at any time, then such trustees shall be selected by the Commissioners of the District of Columbia. If the number of trustees shall be increased, each of the appointing authorities heretofore designated shall increase, proportionately, the number of trustees to be appointed by such appointing authority. Each of the trustees to be appointed as aforesaid shall serve for five years.

Sec. 4. The first board of trustees shall meet within ten days after the approval of this Act and elect a president, vice president, secretary and treasury, and from time to time such additional officers as the bylaws may provide, and also transact such other business as may properly come before them, including the preparation for approval, from time to time, of the necessary bylaws for the proper conduct of the corporation. The treasurer shall give bond to the corporation with sufficient surety, in such penalty as the trustees determine, for the faithful discharge of his duty. Thereafter the meetings of the trustees shall be held at such time and place as provided in the bylaws. In case of vacancy in the board of trustees caused otherwise than by expiration of term of office, such vacancy shall be filled by the remaining trustees for the unexpired term of such former trustee.

Sec. 5. The corporation shall file with the superintendent of insurance of the District of Columbia a certified copy of this charter, of its bylaws, and copies of the forms of contract to be offered to the certificate holders, whereupon the company may commence operations under this charter. The corporation shall also file annually with said superintendent of insurance a statement disclosing the operations of the corporation for the proceeding year, and its financial position. If said superintendent shall have reason to believe that this corporation is not complying with the provisions of this charter, or is being operated for profit, or fraudulently conducted, he shall cause to be instituted the necessary proceedings to enjoin such improper conduct, or to dissolve the corporation.

Sec. 6. The funds of this company may be invested only in securities in which the funds of insurance companies may be invested, as provided by the laws of the District of Columbia.

Sec. 7. This corporation shall not be subject to the provisions of statutes regulating the business of insurance in the District of Columbia, but shall be exempt therefrom unless specifically designated therein.

Sec. 8. This corporation is hereby declared to be a charitable and benevolent institution, and all of its funds and property shall be exempt from taxation other than taxes on real estate.

Sec. 9. The corporation is hereby authorized and empowered to take over, carry out, and assume all contracts, obligations, assets, and liabilities of a corporation heretofore organized and now doing business in the District of Columbia under the name of Group Hospitalization, Inc.

Sec. 10. This Act may be altered, amended, or repealed at the pleasure of the Congress of the United States of America.

Approved, August 11, 1939 (Pub. L. 395, 53 Stat. 1412).

(2) Current GHMSI Federal Charter (as amended most recently in 1997)

[Chapter 698]

AN ACT

Providing for the incorporation of certain persons as Group Hospitalization and Medical Services, Inc.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That Arthur C. Christie, doctor of medicine; Major General Charles R. Reynolds; Mrs. Joshua Evans, Junior; Joseph H. Himes; General Frank T. Hines; Frank R. Jelleff; Howard W. Kacy; Mark Lansburgh; Admiral Ross T. McIntire; George H. O'Connor; Sidney F. Taliaferro; Charles S. White, doctor of medicine; Roger J. Whiteford; Thomas W. Brahany; and E. Barrett Prettyman, and their successors to be selected in the manner hereinafter declared, be, and they hereby are, incorporated and made a body politic and corporate, by the name of Group Hospitalization and Medical Services, Inc., and by that name may contract and be contracted with, sue and be sued, plead and be impleaded in any court of law or equity of competent jurisdiction, and may have and use a common seal. The District of Columbia shall be the legal domicile of the corporation.

Sec. 2. Said corporation is hereby authorized and empowered (a) to enter into contracts with individuals or groups of individuals to provide for hospitalization and medical care of such individuals, upon payment of specified rates or premiums, and to issue to such individuals appropriate certificates evidencing such contracts; (b) to enter into contracts with hospitals and other providers for the care and treatment of such individuals, in accordance with the terms of such certificates; (c) to cooperate, consolidate, or contract with individuals or groups or organizations interested in promoting and safeguarding the public health; and (d) to engage in any lawful business that is incidental to or supportive of the business and affairs of this corporation.

Sec. 3. Said corporation shall not be conducted for profit, but shall be conducted for the benefit of the aforesaid certificate holders. The business and affairs of this corporation shall be conducted by its board of trustees, who shall have full power and authority in the premises, including authority to provide for all expenses incident to the conduct and management of its business and affairs. The number of trustees, their terms of office, and the manner in which they may be elected shall be fixed by the bylaws.

Sec. 4. The first board of trustees shall meet within ten days after the approval of this Act and elect a president, vice president, secretary and treasury, and from time to time such additional officers as the bylaws may provide, and also transact such other business as may properly come before them, including the preparation for approval, from time to time, of the necessary bylaws for the proper conduct of the corporation. The treasurer shall give bond to the corporation with sufficient surety, in such penalty as the trustees determine, for the faithful discharge of his duty.

Thereafter the meetings of the trustees shall be held at such time and place as provided in the bylaws. In case of vacancy in the board of trustees caused otherwise than by expiration of term of office, such vacancy shall be filled by the remaining trustees for the unexpired term of such former trustee.

Sec. 5. The corporation shall be licensed and regulated by the District of Columbia in accordance with the laws and regulations of the District of Columbia.

Sec. 6. The funds of this company may be invested only in securities in which the funds of insurance companies may be invested, as provided by the laws of the District of Columbia.

Sec. 7. The corporation shall reimburse the District of Columbia for the costs of insurance regulation (including financial and market conduct examinations) of the corporation and its affiliates and subsidiaries by the District of Columbia.

Sec. 8. This corporation is hereby declared to be a charitable and benevolent institution, and all of its funds and property shall be exempt from taxation other than taxes on real estate and unemployment compensation.

Sec. 9. The corporation is hereby authorized and empowered to take over, carry out, and assume all contracts, obligations, assets, and liabilities of a corporation heretofore organized and now doing business in the District of Columbia under the name of Group Hospitalization, Inc.

Sec. 10. The corporation may have 1 class of members, consisting of at least 1 member and not more than 30 members, as determined appropriate by the board of trustees. The bylaws for the corporation shall prescribe the designation of such class as well as the rights, privileges and qualifications of such class, which may include, but shall not be limited to--

- (1) the manner of election, appointment or removal of a member of the corporation;
- (2) matters on which a member of the corporation has the right to vote; and
- (3) meeting, notice, quorum, voting and proxy requirements and procedures.

If a member of the corporation is a corporation, such member shall be a non-profit corporation.

Sec. 11. This Act may be altered, amended, or repealed at the pleasure of the Congress of the United States of America. The corporation may not be dissolved without approval by Congress.

Approved, August 11, 1939 (Pub. L. 395, 53 Stat. 1412; as amended on October 17, 1984 by Pub. L. 98-493; as amended on October 29, 1993 by Pub. L. 103-127, 107 Stat. 1336; as amended on December 16, 1997 by Pub. L. 105-149, 111 Stat. 2684).

Appendix B: Provider Organizations Interviewed

In the District of Columbia:

George Washington University Hospital
Washington Hospital Center
Greater Southeast Community Hospital
Hospital for Sick Children
Providence Hospital
DC Hospital Association
Children's National Medical Center
La Clinica del Pueblo
Planned Parenthood of Washington DC
Medical Society of the District of Columbia
Bread for the City and Zacchaeus Free Clinic
Unity Health Care
DC Primary Care Association
Whitman Walker Clinic
Washington Free Clinic
Non-Profit Clinic Consortium

In Northern Virginia:

INOVA Alexandria Hospital
INOVA Fairfax Hospital for Children
Affordable Health Care Program
Casey Clinic
Arlandria Health Center for Women and Children