



# Lessons learned from a failed conversion to for-profit.

## THE CAREFIRST BCBS STORY, PART 2

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*This article presents lessons for other states and all types of nonprofit health care organizations from the failure by nonprofit CareFirst Blue Cross Blue Shield to convert to for-profit status and be sold to the publicly traded Wellpoint Health Networks, Inc. The lessons relate only in part to conversions. More broadly they concern any kind of strategic decision making by nonprofit health care boards of directors and their executives that substantially affects the public interest. This article is a companion to one by this same author published in the Fall 2004 issue of Inquiry. That article chronicled the events and political environment surrounding the conversion proposal, the review process and decision, and the aftermath of actions and reactions by various parties, including state legislation to clarify CareFirst's mission and to reform its board.*

A companion article that appeared in the Fall 2004 issue of Inquiry (McPherson 2004 ) recounts the details surrounding the failed conversion of CareFirst Blue Cross Blue Shield, a nonprofit health insurer in Maryland, to for-profit status and sale to the publicly traded Wellpoint Health Networks, Inc., for \$1.3 billion. CareFirst formally announced its intent to convert and sell on November 20, 2001. Pursuant to the Maryland Conversion Act, CareFirst submitted its application to the Maryland Insurance Administration (MIA) on January 11, 2002, for review and approval. Under the act, the Maryland portion of the proceeds of such a conversion, if approved, would go to

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

In the following pages, I present the key lessons that can be derived from this interesting case study. Clearly, the merits of proposals by nonprofit health care organizations to convert and/or sell must be assessed on a case-by-case basis. Maryland has a unique political culture and traditions related to nonprofit versus for-profit health care and to health care regulation. Nonetheless, the CareFirst story illustrates important lessons for other states, as well as for all nonprofit health care organizations.

## Lessons for Other States

### *1. Proposed Conversions Should Be Subjected to Robust State Scrutiny and Action*

Nonprofit health care organizations, whether provider, insurer, or both, are typically significant public assets that exist under specific charters and have special tax privileges; arguably, they are the provider or insurer of last resort in many situations. Accordingly, it makes both common sense and sound public policy for major proposed conversions to be subjected to rigorous state scrutiny and action, irrespective of the mechanism used.

Maryland and about 30 other states have enacted conversion laws to achieve robust state scrutiny and action, specifying a review process and criteria and delegating the decision to an independent state insurance commissioner or state attorney general. In other states, elected leaders may prefer to keep such decisions in their own hands, with the nonprofit health care organization having to seek special legislation to convert. In still other states, a combination of state regulator and legislative scrutiny may be preferred.

### *2. States Should Promote and Require Due Diligence by Conversion Applicants, Placing the Burden of Proof of Justification on Them*

Maryland requires applicants to exercise due diligence in demonstrating that the proposed conversion is in the public interest. An applicant must:

- Demonstrate the need for the conversion.
- Assess the impacts of the conversion on the organization's mission, health care quality, access, and affordability.
- Ensure the fairness of the price/proceeds of the conversion or sale.
- Ensure reasonable terms in addition to the amount of the proceeds in the case of a sale.

Maryland's legislative action at the beginning of the process to shift the burden of proof to the applicant sent a clear message that changing one's nonprofit health care ownership status and mission can have a profound effect on the public welfare, and that it is incumbent on the applicant to justify why and how it has arrived at this decision and what the impacts will be on those served.

### *3. States Should Prohibit Inappropriate Compensation Incentives Linked to a Conversion to For-Profit*

Whether or not one agrees with the Maryland insurance commissioner that CareFirst's effort to convert and sell was "driven by its executives driven by greed," that was a common perception held by virtually all stakeholders. This was based on the proposal that substantial executive compensation bonuses were to be paid by CareFirst and Wellpoint. According to Jay Angoff, a consultant to the commissioner and a former insurance commissioner himself, "The merger bonus creates an incentive for the executives to prefer the bid of a suitor who agreed to pay the bonuses over the bid of a suitor who would not pay them, or who insisted on reducing them, and it creates an incentive for executives to choose consummating a transaction—any transaction—over not consummating a transaction at all, since the executives receive a bonus for any transaction, but receive no bonus for no transaction" (Salganik 2002). The compensation issue undoubtedly negated any chance of a favorable decision, and spurred the Maryland General Assembly to enact the drastic reforms described in my companion article.

#### *4. States Should Provide Significant Opportunities in the Review Process for Input by the General Public and a Variety of Stakeholders*

Maryland involved many groups and individuals around the state, including but not limited to a variety of community, consumer and health care groups. Also, the state insurance commissioner ensured that all relevant documents associated with the proceedings were made available in a timely and readily accessible manner to all interested parties.

#### *5. States Should Carefully Assess What the Proceeds of a Proposed Conversion and/or Sale Can and Cannot Accomplish in Relationship to Opportunities Forgone*

On the surface, the proceeds from a conversion and sale of a major health care organization—\$1.37 billion in the case of CareFirst—can appear to be a substantial “windfall” that can be used in many ways to benefit the public. Certainly those proposing to convert will emphasize this point of view, as will those organizations or individuals who feel that they can become direct or indirect recipients of such proceeds. But as one of the Maryland insurance commissioner’s consultants concluded following an extensive study, conversion foundations have a limited ability to make systemic changes or improvements in health care access, quality, or costs. The earnings from investment of the proceeds of such conversions and sales pale in comparison to the costs of providing coverage or care to the uninsured and underinsured in a state. Some politicians can be tempted to embrace conversions as quick fixes to short-term governmental budget problems. What then becomes lost is what the Maryland legislature would not allow—the demise of its nonprofit health financing mechanism. As several people interviewed for the companion article pointed out, if CareFirst had converted to for-profit, it likely would have been only a matter of time before the legislature sought to recreate it in another organization to help meet the needs of poor, high-risk, and other vulnerable people.

#### **Lessons for Nonprofit Health Care Organizations**

While there are undoubtedly some lessons that all nonprofit health care executives can learn from the CareFirst case study, the Maryland insurance commissioner and subsequently the Maryland General Assembly focused the bulk of their attention and harsh criticism on CareFirst’s governance. This is consistent with a national trend for the buck to stop at the

boardroom rather than at the chief executive officer’s desk.

It is perhaps too easy to cast stones at the CareFirst board members. Only they and the CareFirst executives involved in all of the board discussions starting a few years before the announced proposal really know what transpired. Abbreviated board minutes might have masked a great deal of the actual tone, breadth, and depth of discussions. Clearly, the board trusted and respected its CEO and his team, crediting them with bringing the organization from threatened insolvency to regional prominence. Moreover, the commissioner noted that the board had been told by its own attorney that the standard for due care was rather minimal, meaning that the board generally could rely on the advice of its expert executives and consultants.

Moreover, the board members were most likely being shown polished and convincing presentations on how the wave of Blue Cross Blue Shield conversions and sales in the 1990s represented the “new wisdom” of how to succeed in a highly competitive market. During the 1980s and 1990s it was not uncommon for some nonprofit hospitals and insurers to emulate for-profits—setting up holding companies and subsidiaries, adopting commercial language (e.g., “corporations,” “customers,” “market share”), and seeking for-profit compensation levels. The phrase “no money, no mission,” while absolutely true, was sometimes being distorted, intentionally or not, focusing all too narrowly on profits at the expense of mission.

Having said all that, however, the kind of yardstick that the Maryland insurance commissioner applied to the CareFirst board’s performance is symptomatic of broader demands for greater public accountability by all nonprofit health care boards. This pressure can be expected to grow from not only state regulators and legislators but also the Internal Revenue Service, donors, business partners, companies providing board liability insurance, voluntary accreditation bodies, institutional associations and professional societies, the media, the general public, and current and prospective board members themselves.

The CareFirst story provides some enlightening examples of the types of issues that nonprofit boards need to address effectively.

### *1. Nonprofit Health Care Boards Need to Be, and to Demonstrate That They Are, Fully Engaged and Acting Independently of Management*

From CareFirst's records, it is impossible to discern with any degree of certainty the level of engagement and independence of its board. At a very minimum, however, this experience should send a strong signal to all nonprofit health care organizations that minutes of board discussions and actions on major strategic issues should clearly document the diligence with which options are being identified, analyzed, and weighed in making decisions. Whether or not one agrees with the Maryland insurance commissioner's position that the boards of nonprofit health care organization should be subjected to a higher standard of due care than the business judgment rule (a matter that is likely to be tested in the courts over the next several years), a "best practice" appears to be emerging for virtually all boards, for-profit and nonprofit alike, to establish and apply specific standards that help to ensure board member independence and full engagement. As one of the interviewees for the companion article stated (while requesting anonymity), "While much or all of what was presented to the CareFirst board by management and consultants might have seemed rational and plausible, no one on the board appeared to have ever stepped back and asked the simple question: 'How will this play in the *Baltimore Sun*?'"

### *2. Nonprofit Boards Should Make the Organization's Mission Paramount—Guiding Strategic Decisions and Actions*

There can be little if any doubt that there was a serious "disconnect" between what the CareFirst board and executives perceived to be their mission and what various stakeholders believed. Had CareFirst been more explicit and in regular dialogue with its key stakeholders about its mission, and the progress and results that the organization felt it was making to pursue that mission, the chasm of misunderstanding might not have developed or been so profound. The Maryland insurance commissioner and legislative leaders were particularly critical of CareFirst's unilateral decisions to withdraw from participation in Medicare and Medicaid managed care programs and to change underwriting practices for individuals and small groups in ways that reduced coverage.

CareFirst now has a new mission statement, consistent with its legislative mandate. However, for CareFirst—or any

organization—a mission statement is only a piece of paper. To become real, it must be woven into the entire fabric of the governance process, including:

- Recruiting, selecting, and retaining only board members and executives who are fully committed to the organization's mission and basic values;
- Ensuring that key stakeholders are involved in identifying community needs and priorities, and approving plans and budgets for community benefit programs<sup>1</sup> that are consistent with those priorities and the overall mission;
- Routinely monitoring progress and results of community benefit programs and explicitly linking them to CEO performance assessments and compensation adjustments, as well as to board self-assessments;
- Approving regular reports to the public on progress and results in achieving the mission.

### *3. Nonprofit Boards Should Establish and/or Reinforce Standing Committees for Compensation, Audit, Nominations, and Governance Performance*

As a result of the Sarbanes-Oxley legislation and new stock exchange requirements to prevent future abuses such as the Enron scandal, for-profit companies are now required to have standing committees for auditing, compensation, and nominations and governance, composed solely of independent directors with the authority to hire and fire consultants if deemed necessary. These requirements can be expected to become best practices for many types of nonprofit organizations. While the CareFirst story did not include any potential auditing issues, compensation was a paramount issue. Also, CareFirst might have benefited from a standing committee that was charged not only with nominations of new board members but also with overall governance performance: development, assessment, and improvement. CareFirst hired a consultant in December 2003 to help it assess its "board structure." This individual may have focused on some or all of these aspects of governance performance.

### *4. Nonprofit Boards Should Ensure That Executive Compensation, and Any Board Compensation, Is Reasonable, Both in Fact and Perception*

It appears that compensation would have played little if any role in the failed CareFirst conversion had the CareFirst board,

executives, their consultants, and major stakeholders been in agreement on reasonable compensation for executives and board members, or at least on the yardsticks for determining reasonable compensation. This can be a controversial and complex issue that plays out differently depending on the locale, business sector, and organization. Defining and analyzing the experience of compensation peer groups may be helpful in setting compensation ranges. However, the only true test of what compensation package is necessary to attract candidates with the right knowledge, skills, and attitudes is the marketplace itself for that particular position, in that particular organization, in that geographic location, and at that particular time.

It is likely that in the future all nonprofit health care organizations will need to not only disclose regularly to the public executive and board compensation, but to do so more clearly and in a more accessible manner—and to be better prepared to justify it.

#### *5. Nonprofit Boards Should Approve and Regularly Review the Performance of a Code-of-Conduct Program, Including Those Components Related to Potential Conflicts of Interest*

The Maryland insurance commissioner found that in addition to the executives, three CareFirst consultants potentially had major conflicts of interest. Whether these potential conflicts were real or perceived, it seems reasonable that such possibilities should at least have been disclosed, with their consideration and disposition by the board well documented. While it is not known whether CareFirst is reassessing its policies and procedures on a code of conduct in general, or conflict of interest more specifically, this might well be one of the areas addressed by CareFirst's governance consultant.

#### **Conclusion**

The CareFirst story is in part about conversions, and what other states and nonprofit health care organizations can learn from that experience. More fundamentally, however, it is about the failure of governance, real or perceived, and should send a strong signal to all nonprofit health care organizations of where government intervention can lead when the public loses trust in the board.

#### **Notes**

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

<sup>1</sup> Community benefits might include programs, activities, and/or financial or in-kind contributions designed to provide needed services, improve access to needed services, achieve a single standard of care, and/or improve health status or quality of life, particularly for the poor, uninsured, underinsured, frail elderly, or other vulnerable population group. Additional community benefits include any subsidies for research and education programs benefiting society more generally.

#### **References**

- McPherson, B. 2004; The Failed Conversion of CareFirst BlueCross BlueShield to For-Profit Status: Part I, The Whole Story: Inquiry. 41:(3) 245–254.
- Salganik, W.M. 2002; CareFirst Action Tests Limits on How Far Board Can Go: Baltimore Sun (November 24): 1C.