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104TH CONGRESS, 1st Session | SENATE | REPORT 104–92

# FOURTH INTERIM REPORT

ON

# UNITED STATES GOVERNMENT EFFORTS TO COMBAT FRAUD AND ABUSE IN THE INSURANCE INDUSTRY: PROBLEMS IN BLUE CROSS/BLUE SHIELD PLANS IN WEST VIRGINIA, MARYLAND, WASHINGTON, DC, NEW YORK, AND FEDERAL CONTRACTS

PREPARED BY THE

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

OF THE

COMMITTEE ON GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

JUNE 1995

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JUNE 5, 1995.—Ordered to be printed

Mr. ROTH, from the Committee on Governmental Affairs, submitted the following

## REPORT

### I. INTRODUCTION

For the past several years, the Senate Permanent Subcommittee on Investigations has been examining fraud, abuse, and inadequate regulation in the insurance industry. During this investigation, a number of regulators described problems they had encountered in trying to regulate and oversee the operations of Blue Cross/Blue Shield Plans in their states. Many of them noted that they spent a disproportionately greater amount of time regulating their "not-for-profit Blues" than they did on any "for-profit" insurance companies. Other regulators said that they knew little about their Blue Cross/Blue Shield Plans, and that when they attempted to find out more about their operations, they were either denied access or were otherwise barred by their own State law from requiring full disclosure. Some regulators expressed concern that the philosophy guiding many of these Plans had changed from that of a non-profit organization primarily concerned with the subscribers' interests to that of a large corporation out to maximize short-term profits.

In October, 1990, for the first time in the history of the Blue Cross/Blue Shield System one of its members—the West Virginia Plan—was declared insolvent and was seized by the West Virginia Insurance Department, leaving more than 51,000 individuals with unpaid claims and thousands more with reduced or non-existent coverage. In the aftermath of this Plan's failure, press reports raised serious questions about its management and the regulatory oversight of its operations.

In 1991, the National Association of Insurance Commissioners (NAIC) formed a Special Committee on Blue Cross Plans.[1] The Special Committee's charge was to "identify solvency issues related to Blues organizations, and review current regulatory oversight of these issues." This was the first time the NAIC had deemed it necessary to form such a committee on the Blue Cross/Blue Shield Plans.

Set against a backdrop of spiraling health care costs and growing public debate over the future of the American health care system, these concerns prompted then Subcommittee Chairman Sam Nunn to launch a specific inquiry regarding the nation's Blue Cross/Blue Shield Plans. This inquiry focused on allegations of mismanagement and misconduct on the part of several of these Plans and the ability of state insurance regulators to oversee their operations, as well as those of the other Plans in the Blue Cross/Blue Shield system. It led to a series of hearings, the first of which took place on July 2, 1992, examining the Blue Cross/Blue Shield Plans of West Virginia, Maryland, the District of Columbia, and New York (Empire) and Blues contracts with the Federal government.

At the July hearing, then Chairman Nunn noted that when the Senate last undertook a comprehensive review of the Blue Cross/Blue Shield system in the early 1970s,[2] it found evidence of mismanagement, excessive billings, exorbitant salaries and perks for Plan officials, as well as conflicts of interest and fraud. Then Chairman Nunn described the framework for the Subcommittee's subsequent efforts in its updated examination of the Blues, including the following issues:

—the financial integrity of the Blue Cross/Blue Shield Plans;
—the role of the Blue Cross/Blue Shield Association in ensuring that its member Plans are financially sound and well managed;
—the propriety of not-for-profit Blue Cross/Blue Shield Plans creating and operating "for-profit" subsidiaries, and the impact these subsidiaries or affiliates may have on the former's financial integrity and stability;
—the effectiveness of State regulators in overseeing their domiciled Blue Cross/Blue Shield Plans and their subsidiaries and affiliates;
—the Plans' management style and philosophy, and whether these have become inimical to effective State regulation;

[1] The NAIC consists of the heads of the insurance departments of each of the 50 States, the District of Columbia and the four U.S. territories. For the last 120 years it has served as the primary vehicle for coordinating insurance regulatory activities and as a catalyst for developing a national program of insurance regulation.

[2] The Senate Judiciary Committee, Subcommittee on Antitrust and Monopolies, Chaired by Senator Philip Hart.

—the propriety of salaries and fringe benefits received by Plans' officers and directors; and,

—the role of the Federal government in monitoring and supervising the Federal employee programs administered by the various Blue Cross/Blue Shield Plans.

This investigation was conducted by the Subcommittee's Majority Staff at the direction of then Chairman Nunn, with the concurrence and support of then Ranking Minority Member, Senator William V. Roth, Jr. It was authorized pursuant to Senate Resolution 62, adopted February 28, 1991, and Senate Resolution 71, adopted February 25, 1993, which empower the Subcommittee to investigate "all other aspects of crime and lawlessness within the United States which have an impact upon or affect the national health, welfare, and safety; including but not limited to investment fraud schemes, commodity and security fraud, computer fraud, and the use of offshore banking and corporate facilities to carry out criminal objectives."

## II. THE BLUE CROSS/BLUE SHIELD SYSTEM

### A. History of the Plans

The Blue Cross/Blue Shield organization is the largest and oldest provider of prepaid health care coverage in the nation. It is a nationwide federation of individual corporations, or Plans, each of which serves its community as a non-profit organization. Each Plan is a member of the national Blue Cross and Blue Shield Association, which serves as a coordinating agency for the Plans.

Blue Cross and Blue Shield were originally two separate organizations. Blue Cross Plans were founded primarily to cover hospital expenses, though over time they have expanded into other areas, such as outpatient and home care. Blue Shield Plans were established primarily to cover physicians' services, though over time they also have expanded into other areas, such as dental, vision, and outpatient coverage. The Blue Cross Association and the Blue Shield Association began operating under one president in 1978 and merged into a joint corporation in 1982. Today, Blue Cross and Blue Shield Plans either cooperate closely, are joint corporations, or are separate entities whose benefits may overlap. At the end of 1991, the system's 73 Plans totaled approximately 94.3 million subscribers. Of these, 68.1 million were private subscribers (26.5 percent of the market share), and 33 million were Government subscribers.[3]

### B. Unique Status of Blue Cross/Blue Shield Plans

Ever since their establishment in the 1930s, Blue Cross/Blue Shield Plans have been organized and regulated pursuant to special statutes in their various states of domicile. This special status is based on a number of considerations, including their: not-for-

[3] About 6.8 million subscribers—Medicare recipients with supplemental Blue Cross/Blue Shield coverage—are counted as both Government and private subscribers.

profit nature;[4] presumed commitment to providing health care coverage at the lowest possible cost to the largest possible population; and, in some states, status as the health insurer of last resort. Unlike their for-profit counterparts, Blue Cross/Blue Shield Plans are looked on as having an intrinsic fiduciary responsibility to protect the interests of their subscribers. In line with their special role and responsibilities, Blue Cross/Blue Shield Plans are often accorded significant advantages not available to commercial insurers, such as being exempt from certain tax and other regulatory requirements.

### C. The Blue Cross and Blue Shield Association

The Blue Cross and Blue Shield Association (the Association or BCBSA) is a trade association and as such is neither the parent of the individual Plans nor a guarantor of their debts or other contractual and financial obligations. According to its articles of incorporation, the Association's purposes are to:

—promote the betterment of public health and security, and to secure wide public acceptance of the principle of voluntary, non-profit prepayment of health service;
—protect the Blue Cross and Blue Shield service marks;
—develop and maintain the Association's membership standards;
—cooperate with federal, state, and local governments for the provision of health services to the needy and aged;
—establish and maintain support and other services to Members through the exercise of authority delegated by the Members; and,
—conduct its affairs, to have offices within and without the State of Illinois, and to exercise the powers granted by the General Not-For-Profit Corporation Act of the State of Illinois.

A significant Association activity is to coordinate health care coverage for national employers with offices in more than one region of the country including, for example, the Federal Employee Health Benefits Program (FEHBP). Under that program, Blue Cross/Blue Shield Plans insure 3.5 of the 9 million participating Federal workers, retirees, and their families throughout the country. In addition, the Association is the prime contractor for the Blue Cross/Blue Shield organization's administration of Medicare (Part A). Under this program, the Association contracts with member Plans to perform a wide range of functions, such as claims processing, audits, utilization reviews, and other administrative tasks.

### D. Association Structure

The Association is governed by a Board of Directors, which consists for the most part of the Plan CEOs. The Board holds at least four regular meetings each year, in addition to any special meetings that may be called. Between meetings, its authority is vested

[4] In recognition of changing market conditions and the special need to access capital markets, the Blue Cross/Blue Shield Association's Board of Directors has recently authorized Member Plans to change their organizational form to "for-profit."

in a 26-member Executive Committee. The Executive Committee Chairman also serves as the Chairman of the Board of Directors. Another Executive Committee member is the President of the Association, while the remaining 24 represent the 12 districts into which the member Plans are divided.

## E. Financial Information

In 1990, the Association reported systemwide total assets of $118,857,345, liabilities of $106,054,671, and equity of $12,811,674. In the same year, it reported total revenues of $109,129,527 and total expenses of $106,866,512. In terms of systemwide revenues, the Association maintains it is the same size as the fifth ranked corporation on the list of Fortune 500 companies.

Based on aggregated data derived from member Plan balance sheets, the Association reported total Plan assets of $30.1 billion and reserves of $9.8 billion as of December 31, 1991. It should be noted, however, that the financial strength of any individual Plan relies not on these total figures but, rather, on the strength of its own assets and reserves.

## F. Oversight of Member Plans

At the outset of the Subcommittee's investigation, all Plans had to adhere to seven membership standards as a condition of membership.[5] However, partly in response to the Subcommittee's investigation, as of June 1993 these standards had been revised and/or expanded to: clarify Plan Boards' oversight responsibilities; inform state regulators about Plan subsidiaries' activities; assure that subscribers' claims are paid and their coverage continued in the event of a Plan insolvency (effective December 31, 1994); inform the public on Plans' financial condition; and, assure that Plans are able to meet their inter-Plan program financial obligations.

These standards apply to all regular member Plans and membership renewal is contingent upon their compliance with them. Based on the degree of compliance with the standards, the Association has a range of options it can pursue.[6] It can monitor Plans experiencing financial and/or operational difficulties, using authority it has to require records and other relevant data to be submitted. In the event that a Plan fails or is expected to fail to meet one or more of the membership standards, the Association can contact the Plan's Board or the concerned state insurance regulators to seek their input in this regard. If these efforts prove unsuccessful, the

[5] These standards provided that Plans: be organized and operated on a non-profit basis; have a Board not controlled by any special interest group and which is comprised of a majority of persons other than health care providers; furnish reports and records to the Association to indicate compliance with these standards; maintain adequate financial resources to protect customers and meet long-term business obligations; use their best efforts to contract with cost-effective health care providers; operate in a manner responsive to customer needs; and participate in each national program adopted by the Association.

[6] At the outset of the Subcommittee's investigation, Plans were subject to a somewhat different regime: they could be in substantial compliance with all seven membership standards; they could receive comments on specific issues where they were not in full compliance; they could fail to be in substantial compliance with any one membership standard, which would prompt their being placed on conditional status (being required to develop a rehabilitation plan and being subject to continuous monitoring by the Association); and, in the event that they failed to meet the membership standards, failed to meet terms agreed upon pursuant to conditional membership status, or failed to apply for renewal, their membership could be subject to non-renewal.

Association can seek judicial enforcement of the license agreement or, with a majority vote of the membership, move to terminate the Plan's license.

## III. FINDINGS

The Subcommittee's examination of the West Virginia, Maryland, District of Columbia, and New York (Empire) Plans, and Blue Cross/Blue Shield's Federal employee and Medicare contracts, has revealed a pattern of gross mismanagement, ineffective oversight, and regulatory failings strikingly similar to that uncovered by the Senate Judiciary Committee in its investigation of the Blues more than twenty years ago. With the exception of the Federal contracts, these problems caused severe financial impairment in all of the Plans examined and, in the case of the West Virginia Plan, helped to bring about its demise.[7] These problems also adversely impacted the Plans' ability to fulfill their responsibilities to policyholders, providers, and other health care industry interests. In the case of the Federal employee and Medicare contracts, these problems resulted in wasted taxpayers' dollars, unnecessary costs to the Federal government, and questionable charges and poor service to subscribers.

## THE WEST VIRGINIA, MARYLAND, DISTRICT OF COLUMBIA, & EMPIRE PLANS

### A. MISMANAGEMENT

1. The Plans' CEOs created corporate cultures inimical to Blue Cross/Blue Shield's historical mission and non-profit status. These executives operated their Plans in an irresponsible and unsafe manner that ill befitted their status as non-profit health insurers whose primary mission was to provide affordable, quality health care to their policyholders and, in some cases, serve as the health insurer of last resort.

2. Top managers failed to operate their Plans in accordance with their fiduciary responsibilities to the policyholders by making unsound business decisions and, in at least two instances (Empire and West Virginia), engaging in highly questionable, if not improper, conduct. The Subcommittee found that these managers at times acted for their own self-interest and/or enrichment and, in three of the four Plans examined, set up for-profit subsidiaries that had little to do with the Blues' primary mission and ended up losing hundreds of millions of dollars.

3. The Plan CEOs and their management teams generally succeeded in resisting and/or evading duly constituted authorities—State Insurance Departments, Plan Boards of Directors, and the

[7] While this investigation focused on the West Virginia, Maryland, District of Columbia, and Empire Plans, the Subcommittee also received information on other Blue Cross/Blue Shield Plans that have experienced some of the same problems discussed herein. For example, according to an April, 1994 GAO report, *Blue Cross and Blue Shield: Experiences of Weak Plans Underscore the Role of Effective State Oversight* (GAO/HEHS–94–71), Plans in Vermont, New Hampshire, Maine, Massachusetts, New Jersey, New York, and West Virginia (Mountain State, successor to the failed West Virginia Plan) have experienced such problems. In addition, the Subcommittee notes that the Colorado Plan's CEO was recently removed for misconduct and that the former CEO of the Louisiana/Mississippi Plan pled guilty in Federal Court to charges of having bribed the State Insurance Commissioner in an attempt to quash an audit critical of the Plan.

Blue Cross/Blue Shield Association—in the exercise of their oversight/regulatory functions.

4. Top Plan managers abused their positions by obtaining exorbitant salaries and other fringe benefits and by incurring millions of dollars in unnecessary and/or unjustified travel and entertainment expenses, at a time when their Plans were in dire financial straits and subscriber premiums were being increased dramatically.

5. All the Plans examined had extensive and recurring accounting, financial reporting and/or internal control deficiencies, which significantly impaired their operations and financial integrity. In the Maryland and Empire Plans, these deficiencies helped create circumstances that enabled major frauds to be perpetrated against them, resulting in tens of millions of dollars in losses.

6. All the Plans examined had serious problems in their underwriting policies and practices, resulting in tens of millions of dollars in losses. In large part, these problems were caused by management decisions to systematically underprice their lines of business in order to gain market share.

7. The Plans' problems had serious consequences for policyholders, providers, and other health care industry interests. The lives of thousands of West Virginia Plan policyholders and providers were thrown into turmoil as a result of its failure. In the Empire, Maryland and District of Columbia Plans, policyholders experienced poor service, a diminution in and/or loss of coverage, and dramatically increased premiums, while providers encountered ever-increasing problems in obtaining reimbursement for services rendered.

B. INADEQUATE OVERSIGHT BY THE BOARDS OF DIRECTORS

8. The Plans' Boards of Directors failed to perform their requisite oversight functions, ignoring their responsibility to the policyholders whose interests they were charged with protecting. The Subcommittee found that:

a. management was able to gain effective control of Boards by circumventing and/or altering rules regarding the process by which members were selected. As a result, over time Boards tended to become unquestioning "rubberstamps" for management decisions.

b. many Board members failed to understand Plan policies and procedures, were ignorant of the serious problems and/or abuses occurring within the Plans, and were easily manipulated and misled by management. This was particularly evident in the case of the Maryland and Empire Plans, where the CEOs used their dual roles as Board Chairmen to control the information made available to Board members.

c. many Board members failed to understand their fiduciary obligation to protect the policyholders' interests and their responsibility to oversee management's actions. Indeed, the West Virginia Plan's Board Chairman was involved in an incident that constituted a conflict of interest with his Board responsibilities, and he also served as Board Chairman for a number of the Plan's for-profit subsidiaries that were designed for his benefit and that of other Plan officials and Board members.

C. INADEQUATE REGULATION BY STATE INSURANCE DEPARTMENTS

9. State Insurance regulators were hesitant, reluctant, and even afraid to take decisive action against a Plan for fear of the effect such action might have on the large number of policyholders involved. In effect, the Plans examined became too-big-to-fail and/or to be effectively regulated, as reflected in the following:

a. regulators overseeing the Plans examined often accorded them special treatment and made forebearances for them. The Subcommittee found instances where assets of questionable value were allowed to be counted toward meeting statutory reserve or other important reporting requirements; official decisions were reversed when such action accrued to a Plan's benefit; premium increases were readily granted; and, Plans were allowed to ignore regulations, directives, and remedial recommendations with impunity.

b. regulators in some cases ignored or failed to fully utilize examination results and other information available to them, which described the Plans' problems and set forth specific recommendations for further action.

c. regulators in the concerned States failed to use available means to enforce their authority over the Plans.

d. regulators in the concerned States were often unaware of or not fully informed about significant Plan activities, such as the establishment of for-profit subsidiaries and the major problems they subsequently caused.

e. regulators in some cases were subject to political pressure exerted on behalf of the Plans, which undermined and/or negated oversight and enforcement efforts.

f. regulators in the concerned States were hampered in their oversight efforts by inadequate staff, resources, and/or statutory authority, and the Plans' ability to evade and resist such efforts.

10. As a result of a Federal statutory exemption from District of Columbia insurance regulation, oversight of the D.C. Plan rested on limited efforts by Maryland and Virginia regulators to oversee that portion of the Plan's business underwritten in their jurisdictions.

D. INADEQUATE OVERSIGHT BY THE BLUE CROSS/BLUE SHIELD ASSOCIATION

11. While being aware of these Plans' serious problems, the Blue Cross/Blue Shield Association failed to act decisively to correct those problems. For example, the Association failed to enforce its membership standards, even after long-term monitoring had shown that a Plan was not meeting specified reserve and liquidity requirements.

12. Association officials were extremely reluctant to act against the Plans, fearing that their only effective means of enforcement—i.e., the "ultimate weapon" of revoking the Blue Cross/Blue Shield trademarks—would seriously injure the image of the Blue Cross/Blue Shield system and leave them with the difficult task of having to find substitute coverage for the affected policyholders.

13. The Association failed to systematically share in a timely manner the important information it had concerning the Maryland, District of Columbia, and Empire Plans' problems with the appropriate State insurance authorities and Plan Boards, even after the West Virginia Plan had failed and the other Plans had become seriously impaired.

## FEDERAL CONTRACTS

### A. MISMANAGEMENT

14. Blue Cross/Blue Shield's mishandling of its Federal contract responsibilities has resulted in millions of dollars in unnecessary, wasteful, and/or questionable costs incurred by the Federal government and, in some instances, subscribers.

a. excessive layers of bureaucracy involved in the Federal Employee Program (FEP) contract—i.e., the Blue Cross/Blue Shield Association, the FEP Director's Office, the FEP Operations Center, and the 67 participating Plans—have added unnecessarily to the Federal government's FEP program costs.

b. Blue Cross/Blue Shield Plans participating as FEP and Medicare contractors have billed the Federal Government for tens of millions of dollars in charges that have been questioned and/or disallowed. In the FEP, since 1988 the Office of Personnel Management, Office of Inspector General (OPM/OIG), has questioned more than $78 million in contract charges and disallowed $51.6 million (66%) of that amount. Since 1992, the Department of Health and Human Services, Office of Inspector General (HHS/OIG) has recommended disallowing more than $40 million for improper charges by Blues Medicare contractors.

c. Blue Cross/Blue Shield Plans have withheld millions of dollars in hospital and provider discounts from the Federal government and some FEP subscribers. In the case of the subscribers, this has resulted in higher and unfair out-of-pocket expenses.

d. reflecting the same irresponsible management outlook and disregard for cost-containment uncovered in the West Virginia, Maryland, District of Columbia, and New York (Empire) Plans, the Blue Cross/Blue Shield Association has billed the Federal Government for millions of dollars in questionable and/or unnecessary charges for FEP conferences and meetings, promotional items, and executive compensation.

15. Poor performance on the part of some Blue Cross/Blue Shield Medicare contractors has resulted in their being placed on a "watch list" and/or being terminated by the Health Care Financing Administration (HCFA). Eight of the 41 Blue Cross/Blue Shield Plans participating as Part A intermediaries in 1993 were on the watch list and one of these was scheduled to be terminated at the end of the 1994 contract year. Seven of the 27 Blue Cross/Blue Shield Plans participating as Part B carriers were on the watch list in that same year and another three will not be renewed at the end of the 1994 contract year.

16. Extensive and recurring internal control weaknesses among Blue Cross/Blue Shield Plans involved in the FEP have resulted in duplicate payments, coordination of benefits problems, and discrepancies in enrollment data that have caused erroneous premiums to be collected and benefits to be paid. These internal control deficiencies constitute an invitation to fraud, particularly since anti-fraud efforts have generally received minimal attention from the Blue Cross/Blue Shield Association and the individual Plans.

### B. Inadequate Regulation

17. Regulation by OPM and HCFA, the agencies responsible for overseeing the Blue Cross/Blue Shield contracts with the FEHBP and Medicare, has been marked by many of the same inadequacies that the Subcommittee found in connection with the West Virginia, Maryland, District of Columbia, and New York (Empire) Plans, including:

a. uncooperative attitudes and evasive tactics on the part of the Blue Cross/Blue Shield Association and the individual participating Plans;

b. a tendency by regulators to treat the Blues in an unquestioning and deferential manner, owing to their size and market share,—i.e., the "too-big-to-regulate" dilemma; and,

c. a serious lack of regulatory resources; resulting, for example, in an inability to audit the participating Plans on a timely basis.

### C. Inadequate Oversight by the Blue Cross/Blue Shield Association

18. The Association's performance regarding its Federal contract responsibilities exhibited most of the same shortcomings identified in its failed oversight of the West Virginia, Maryland, District of Columbia, and New York (Empire) Plans. For example, OPM officials indicated that a lack of guidance and oversight by the FEP Director's Office is the biggest problem in FEP operations and subscriber service. In the Medicare program, the Association does not monitor the performance of Blue Cross/Blue Shield contractors and is thus largely unaware of any problems they may be having in carrying out their functions.

## IV. CONCLUSIONS

### A. Gross Mismanagement, Ineffective Regulation/Oversight Raise Concerns About Blues' Ability to Serve Basic Purpose

Based on its investigation, the Subcommittee is concerned about the ability of Blue Cross/Blue Shield Plans to continue to serve their basic purpose of providing quality health care coverage at an affordable price. In the cases we examined, the accountability triad of oversight by Plan Boards of Directors and the Blue Cross/Blue Shield Association, and regulation by State insurance authorities (and OPM and HHS in the case of the Federal contracts) did not ensure that the Plans performed efficiently and effectively. Plan executives were able to operate in a grossly inept and unsound manner, while deliberately blocking and evading the efforts of those

charged with regulating and overseeing their activities. The evidence also highlighted the inability and/or unwillingness of regulators, Plan Boards, and the Blue Cross/Blue Shield Association to effectively carry out their responsibilities regarding the Plans and their policyholders.

Accordingly, the Subcommittee believes that major improvements are needed across-the-board in response to the problems uncovered by its investigation. The management of Blue Cross/Blue Shield Plans has to be improved substantially and Plan operations have to be carried out in accordance with the Blues' mission. In addition, State insurance authorities (and OPM and HHS in the case of the Federal contracts), Plan Boards, and the Blue Cross/Blue Shield Association have to substantially improve their regulation and/or oversight of Plan management and operations. The Subcommittee notes that should States fail to improve their regulatory performance regarding the Blues, this may prompt the need to consider a Federal role beyond the narrow one maintained in terms of the FEHBP and Medicare contracts.

### B. Implications for Health Care Reform

The Subcommittee also believes that the serious problems revealed regarding the Blues Plans examined and those charged with their regulation and oversight may have implications for the current debate on health care reform. Specifically, the Subcommittee is concerned about the role Blue Cross/Blue Shield Plans can and/or should play in any new or substantial revision of the existing health care delivery system. They must correct their operational problems, lack of accountability, and inadequate performance in containing costs, to function effectively as part of a revised health care delivery system. Similarly, in considering the idea of a significant Blues role in a reformed health care delivery system, the Subcommittee notes that there is sufficient reason to question the ability of State insurance authorities, Plan Boards, and the Blue Cross/Blue Shield Association to effectively carry out whatever regulatory and/or oversight responsibilities they may be given in this regard. Indeed, one of the key dilemmas facing those concerned with health care reform is how to resolve the apparent problem posed by any potential role the Blues might play in our health care system and the Subcommittee's findings that the existing mix of State regulation and Association/Plan Boards oversight are inadequate. The essential question remains, if these entities cannot be counted on to do the job, to whom will these essential functions be assigned?

## V. RECOMMENDATIONS

In setting forth its recommendations,[8] the Subcommittee intends that they serve the dual purpose of providing a blueprint for correcting the serious problems it has identified in the Blue Cross/Blue Shield system, while at the same time constituting an important reference point for the health care reform debate. The pivotal

[8] The Subcommittee notes that in response to its investigation, remedial actions reflecting the findings and conclusions are under consideration and/or have already been instituted by the Maryland legislature and Insurance Division, the District of Columbia Superintendent of Insurance, the New York Insurance Department, the National Association of Insurance Commissioners (NAIC) and the Blue Cross/Blue Shield Association.

issues raised in this Blue Cross/Blue Shield investigation—i.e., corporate performance and accountability, cost containment and protecting policyholders' interests, and regulatory capability—are clearly among those that will have to be addressed effectively for any proposed health care reform effort to succeed.

With these thoughts in mind, the Subcommittee makes the following recommendations:

## A. Plan Performance and Accountability

### 1. ELIMINATE MANAGEMENT DEFICIENCIES AND ABUSES

The Subcommittee received overwhelming evidence showing that the problems—mismanagement, exorbitant salaries, wasteful travel and entertainment expenses, internal control deficiencies, and faulty underwriting—experienced by the Plans examined were a reflection of a corporate culture and operational approach that were inconsistent with Blue Cross/Blue Shield Plans' non-profit status and special responsibility to their policyholders. Indeed, the Blue Cross/Blue Shield Association has already responded to some of the Subcommittee's findings in this regard by providing for its assessments of Plan performance to be communicated directly to the Boards rather than through Plan CEOs, and by requiring that the Boards adopt a code of conduct that shows that they are committed to the highest level of business ethics.

While these measures are clearly steps in the right direction, the Subcommittee believes that additional remedial actions are needed and recommends that the Association:

—establish cost containment guidelines and develop related incentives to assure compliance;
—develop minimum standards regarding accounting and internal control procedures and require that Plans comply with them;
—require that compensation packages, i.e., salaries, bonuses, and other benefits for corporate officers and senior managers be a matter of public record;
—establish guidelines to curtail waste and abuse in travel and entertainment expenses;
—develop a policy regarding compensation of Board members that helps to assure their independence;
—prohibit a Plan CEO from also serving at the same time as Board Chairman;
—require Plans to develop and implement detailed programs to deter and detect fraud; and,
—closely monitor the performance of the Blue Cross/Blue Shield Plans participating in the FEP and Medicare.

In addition, in light of the mismanagement and extensive operational problems found in the Plans examined, and the Blues preeminent position in the health insurance industry, the Subcommittee is concerned that such problems may also exist among other health insurers. These concerns reflect testimony by Blue Cross/Blue Shield officials in which they attempted to justify questionable entertainment, travel, and marketing expenses by asserting that they were necessary in order to remain competitive and that

others in their industry were doing the same thing. The Subcommittee believes that the possibility that such practices—and the underlying corporate culture that aids and abets them—may be more widespread needs to be examined, both in terms of their immediate effects and longer term health care reform implications. Such an undertaking should involve, but not necessarily be limited to, state insurance regulators, the NAIC, Congress, and concerned Executive Branch agencies.

### 2. PLANS MUST BE ACCOUNTABLE

As non-profit corporations, the Plans of the Blue Cross/Blue Shield system have no shareholders to whom they must answer and are not fully subject to the rigors of marketplace competition. In the cases examined by the Subcommittee, the Boards of Directors charged with holding Plan officials accountable failed to fulfill their responsibilities in this regard. While State insurance regulators are supposed to serve as the ultimate authority to whom an insurer must answer, the testimony presented demonstrated that they too failed to carry out their responsibilities.

In light of these findings, the Subcommittee believes that the critically important question—to whom are Blue Cross/Blue Shield Plans accountable—needs to be examined, both in terms of correcting the problems revealed by this investigation and in the wider context of the current debate on health care reform. Every effort must be made to improve the performance of Boards of Directors and State insurance regulators in holding Plan officials accountable and protecting the policyholders' interests. For example, consideration should be given to mandating the establishment of voluntary subscriber watchdog groups, to monitor Plan performance and represent subscribers' interests before Plan Boards of Directors, State legislatures and regulatory bodies, and other relevant entities.[9]

The Subcommittee also notes that the NAIC has recently formed a Special Committee to look at issues relating to the Blue Cross/Blue Shield Plans, and thus strongly recommends that the question of accountability be placed high on its agenda. In considering health care reform, this question of accountability must be carefully addressed by the President, Congress, as well as other interested parties.

### 3. INSOLVENCY SAFEGUARDS

The disastrous effects of the West Virginia Plan's failure—in unpaid claims and diminution in and/or loss of coverage—emphasized the need for measures to provide added protection for other Blue Cross/Blue Shield Plan subscribers in the event of an insolvency. At the time of our investigation, only 25 of the more than 70 Blue Cross/Blue Shield Plans were participating in state guaranty funds. The Subcommittee notes that the Blue Cross/Blue Shield Association has moved to require its member Plans to either participate in a state guaranty fund or institute some other acceptable type of financial safeguard (e.g. creating a special reserve). In addition, the

[9] Similar consumer advocacy organizations were established in the late 1970s and early 1980s to represent the interests of utility ratepayers. These advocacy organizations, known as "Citizens' Utility Boards" (CUB), currently exist in states such as Wisconsin, California, Illinois, and Oregon.

National Association of Insurance Commissioners (NAIC) is presently considering whether and how Blue Cross/Blue Shield Plans can and/or should be integrated into state guaranty fund systems.

While the Subcommittee is encouraged by the Association's action in this regard, we believe that State regulatory authorities also need to be involved to assure that concrete action to protect policyholders is undertaken as quickly as possible. Accordingly, we recommend that the NAIC expedite its efforts along these lines and that, in addition to these efforts, individual State legislatures and insurance departments act to ensure that Blue Cross/Blue Shield Plan policyholders in their jurisdictions are afforded protection against an insolvency.

### 4. UNIFORM SOLVENCY STANDARDS

A number of witnesses discussed the absence of uniform solvency standards and financial reporting requirements regarding the Plans of the Blue Cross/Blue Shield system. For example, the District of Columbia Superintendent of Insurance indicated that the dramatically different solvency standards in effect in the District, Maryland, and Virginia were not in the policyholders' best interests. The clear implication is that while the D.C. Plan might reach a stage where it would be considered insolvent in one State, it could theoretically still continue to operate in another State whose solvency requirements it had not violated.

The Subcommittee recommends that the NAIC and Blue Cross/Blue Shield Association, jointly or separately, develop specific solvency standards, financial reporting requirements, and other additional measures as needed, to apply uniformly to all Plans. The Subcommittee notes that both the NAIC and Association have already begun to consider such questions and urges them to make this effort a high priority and bring it to a successful conclusion as quickly as possible.

The Subcommittee further recommends that the NAIC and State regulatory authorities mandate the use of Generally Accepted Accounting Principles (GAAP) for the reporting of financial information by insurers. As stated in the Subcommittee's Third Interim Report on efforts to combat fraud and abuse in the insurance industry,[10] statutory accounting principles—the other accounting methodology used in the reporting of financial information—are too flexible to provide an accurate picture of an insurer's financial soundness.

### 5. INFORMATION SHARING

The Subcommittee found that a great deal of important information regarding the financial problems and management abuses in the Plans examined was in the hands of the Blue Cross/Blue Shield Association and the concerned State regulatory authorities before

[10] *Third Interim Report on United States Government Efforts to Combat Fraud and Abuse in the Insurance Industry: Enhancing Solvency, Regulation and Disclosure Requirements—A Case Study of Guarantee Security Life Insurance Company*, Senate Report 103–29, March 23, 1993. The other two reports issued by the Subcommittee pursuant to its investigation of the insurance industry are: *Interim Report on Combatting Fraud and Abuse in Employer Sponsored Health Benefit Plans*, Senate Report 102–262, March 12, 1992; and, *Second Interim Report on U.S. Government Efforts to Combat Fraud and Abuse in the Insurance Industry: Problems with the Regulation of the Insurance and Reinsurance Industry*, Senate Report 102–310, July 1, 1992.

the Plans became impaired. Such information, according to the Subcommittee staff and other witnesses, was not shared between or among these various entities, with clearly adverse effects. Without such information, state insurance authorities were not fully aware of the severity of the problems at a given Plan, nor did they have sufficient information upon which to make the most informed and timely regulatory decisions.

In response to this situation, the Subcommittee recommends that:

—the Blue Cross/Blue Shield Association in a timely manner share all relevant information regarding both itself and the individual Plans with the appropriate state and federal regulatory authorities;

—state insurance authorities improve and expand their procedures to share information concerning a Plan operating simultaneously in several jurisdictions, such as the instant case of the D.C. Plan and its activities in the District of Columbia, Maryland, and Virginia; and,

—agencies of the U.S. Government involved in some official capacity with Blue Cross/Blue Shield Plans, such as the Department of Health and Human Services and the Office of Personnel Management, develop procedures to make available to the appropriate state insurance authorities all reports and reviews of Plan operations.

## B. REGULATION/OVERSIGHT

### 6. MORE EFFECTIVE STATE AND FEDERAL ROLE

The Subcommittee received testimony conclusively showing that in the cases examined State insurance regulators, as well as OPM and HHS regarding the FEHBP and Medicare, were unable and/or unwilling to deal effectively with the Plans operating in their jurisdictions and/or areas of responsibility. The Subcommittee strongly believes that regulatory authorities can and should do more in their efforts to oversee the Plans of the Blue Cross/Blue Shield system and recommends that States:

—provide increased staff, training, and resources to their insurance regulatory bodies;

—establish cost containment guidelines and develop related incentives to encourage compliance;

—require that the information used as the basis for granting rate increases be made available to the public;

—utilize existing subpoena and/or investigatory authority and, where none exists, seek such powers from their legislatures; and,

—seek enactment of statutory authority to:

* prohibit the creation or alteration of subsidiaries and affiliates without prior written notice;
* establish specific reporting requirements including, but not necessarily limited to, audited financial statements for all wholly-owned subsidiaries or affiliates, detailed consolidated financial statements, and internal and external audits or studies;

* examine all books and records of affiliates and subsidiaries at any time deemed necessary;
* require that a Plan get prior written approval for a sale or liquidation of any significant assets;
* institute administrative fines applicable to the Plan, as well as its Officers and Directors, for failure to respond on a timely basis to lawful orders;
* remove Officers and Directors if, after due process, a determination is made that members of either and/or both groups have failed to comply with lawful orders; and,
* make health insurance fraud a felony and enhance existing criminal and civil penalties for violation of relevant insurance laws and regulations.

Regarding the FEHBP and Medicare, we recommend that:

—Congress and the Administration consider giving both OPM and HHS the authority to openly and competitively bid the FEHBP and Medicare Parts A and B contracts, and to contract directly with the Blue Cross/Blue Shield Plans, rather than the Association, in connection with the FEHBP and Medicare Part A contracts;

—the appropriate Congressional Committees review and consider providing additional resources for OPM's Contracting Office, the OPM Office of Inspector General and HHS Office of Inspector General to enable them to better perform their regulation and oversight functions;

—OPM and HHS establish cost containment guidelines and develop related incentives to encourage compliance;

—Federal contracts policies and procedures be revised as appropriate to:

* require Plans to collect, utilize, and maintain standardized information before paying claims;
* allow easier termination of a contractor for repeated violations of the contract or regulations and for failing to: cooperate with the Government in an audit or investigation; promptly provide access to files and records; and, resolve audit findings in an expeditious and reasonable manner; and,
* in the case of the FEHBP, establish a centralized enrollment system.

—The appropriate Committees of Congress should carefully review the annual amount of individual compensation health care contractors can charge the Federal government in combined salary and benefits.

### 7. INTERMEDIATE ENFORCEMENT MEASURES

The Subcommittee found that State insurance regulators and officials of the Blue Cross/Blue Shield Association were severely hampered in their efforts to respond to the abuses and problems found in the Plans examined because they felt that the only enforcement tool available to them was in the form of "an ultimate weapon." For State regulators, this meant declaring a Plan insolvent and placing it into receivership; for the Association, it meant

acting to remove a Plan's Blue Cross/Blue Shield trademarks. The Subcommittee recommends that the Association, the NAIC, and/or individual State insurance authorities act expeditiously to develop and institute intermediate enforcement measures, including fines against the Association and/or its officers. Efforts along these lines might be undertaken by the NAIC and the Association jointly.

8. FEDERAL CRIMINAL/CIVIL SANCTIONS FOR INSURANCE FRAUD

To ensure that health benefits and insurance premiums are adequately protected from internal fraud and abuse, Congress and the Administration should consider establishing Federal criminal and civil sanctions for the violation of fiduciary responsibilities within the insurance industry. The health insurance industry is entrusted with billions of dollars of subscribers premiums and, as such, has a fiduciary duty to see to it that those funds are not squandered or misappropriated. The Subcommittee believes that its Blue Cross/Blue Shield investigation highlights the need for such sanctions, for example, as indicated by the possibility that in certain cases involving hospital/provider discounts and coinsurance payments some Blues Plans may have violated prohibited transaction requirements stipulated by the Employee Retirement and Income Security Act (ERISA). Indeed, the Subcommittee further recommends that these potential ERISA violations be reviewed by the Department of Labor, the agency responsible for overseeing the activities carried out pursuant to this law.

9. REVIEW OF PLAN NON-PROFIT TAX BENEFITS

The Subcommittee found that the Blues Plans examined abused their non-profit status, e.g., West Virginia Plan managers engaged in a highly risky type of investment trading that its auditors said was not appropriate for a company of its type. In addition, top managers of these Plans operated them in a grossly irresponsible manner, for example, by using policyholders' premiums for excessive executive compensation packages, lavish parties and entertainment, luxury travel and transportation, and charitable contributions. Given these abuses, the Subcommittee recommends that the Administration review the Federal tax status of the Blue Cross/Blue Shield Association and the individual Plans of the Blue Cross/Blue Shield system, to ascertain whether they continue to warrant the special tax advantages accorded them as non-profits.

10. ENHANCING DISTRICT OF COLUMBIA INSURANCE AUTHORITY

The Subcommittee believes that the District of Columbia should continue its efforts to swiftly enact and implement the legislation and regulations necessary to enable its Superintendent of Insurance to effectively oversee GHMSI's operations. Toward this end, the Subcommittee recommends that the Congress provide all necessary support, including, but by no means limited to, enacting legislation to dissolve GHMSI's Congressional charter.

# VI. APPENDIX: CASE STUDIES
# THE WEST VIRGINIA PLAN

## A. Background/Organization

Blue Cross/Blue Shield of West Virginia, Inc. (the West Virginia Plan) was incorporated as a non-profit health service corporation in West Virginia in 1983. Headquartered in Charleston, it employed approximately 700 employees over the seven years it was in existence and, at its peak in 1983 had some 379,000 subscribers. It was formed as a result of a merger between Blue Cross/Blue Shield of Southern West Virginia (Charleston) and Blue Cross/Blue Shield of Northern West Virginia (Wheeling). In 1984, the Blue Cross/Blue Shield Plans of Morgantown merged with the West Virginia Plan, completing the consolidation of Blue Cross and Blue Shield operations in the State with one exception—West Central Blue Cross/Blue Shield (Parkersburg).

During its seven-year existence, the West Virginia Plan's organizational structure consisted primarily of three types of entities: those involved in underwriting and servicing its core lines of Blue Cross/Blue Shield insurance business; a for-profit stock holding company; and, a number of for-profit joint ventures with the Blue Cross/Blue Shield Plans of Maine, New Hampshire, and Vermont. The for-profit external business activities were deeply involved in the West Virginia Plan's rapid financial decline and ultimate collapse.

## B. Financial Profile

The Plan, according to its financial records, incurred losses in all but two years of its existence. Total losses amounted to approximately $69 million, while about $13 million was made in 1984 and 1985.[11] By 1987, the Plan was insolvent and its reserves (or net worth) continued to decline drastically, so that by the end of 1989 they had reached a negative balance of $31 million. Ironically, while the number of subscribers dropped from a high of 379,385 at the end of 1983 to 273,695 in 1989, during the same period the premium income increased from $213 million to $252 million. However, despite this increase in premium income, the Plan still lost money.

## C. Problem Areas

The Plan's decline, insolvency, and ultimate seizure by the West Virginia Insurance Department in 1990 were primarily caused by a combination of: mismanagement; inadequate Board of Directors' oversight of management policies and actions; and, inadequate regulation and enforcement by the West Virginia Insurance Department.[12] While not found to be a factor that directly contributed to

[11] Although Plan gains exceeded losses in 1984 and 1985, the Blue Cross/Blue Shield Association noted that the entire system experienced similar profitability trends at that time, influenced by an upturn in the underwriting cycle and a nationwide drop in health care claims.

[12] Plan officials James Heaton (President and Chief Executive Officer), Salvatore Torrisi (Executive Vice President and Chief Operating Officer), and Donald Wagenheim (Chairman of the Board of Directors) maintained that the Plan's problems and collapse were not a consequence of their mismanagement, but the result of factors beyond their control, including cost shifting from West Virginia hospitals and a general decline in the West Virginia economy. While such

the Plan's failure, inadequate oversight of Plan operations and activities on the part of the Blue Cross/Blue Shield Association was also a problem area.

1. MISMANAGEMENT

*a. Flawed Management Approach*

Regulatory officials, Plan employees, Board members, consultants, and outside accountants provided testimony on management's questionable actions and decisions. The Plan's Labor Consultant from 1985-1990 said that the management was so bad he could only assume that the Plan was being "managed to fail." A former Plan Executive Vice President, with 20 years of experience working at various Blue Cross/Blue Shield organizations resigned in 1986 after having concluded that Jim Heaton's policies and actions were leading the Plan to a "significant downward turn [and] turbulent financial ride." In addition, a management consultant with years of Blue Cross/Blue Shield experience, hired by Heaton in 1984 to head the Plan's planning staff, advised the Subcommittee Staff that upon becoming familiar with Heaton's management style and major policy decisions, he concluded that the Plan was doomed and resigned.

Fred E. Wright, the former Insurance Commissioner for the period 1985-1988, said the Plan's 1984 decision to buy the old Sears Building in South Charleston to turn into its new corporate headquarters was "a crazy idea." He called the purchase "puffery...an edifice to the glory of management," which was not justified by the Plan's needs, made at a time when the Plan had serious financial problems (e.g., in 1983, the Plan had $2.4 million in underwriting losses and, at the end of the same year, had a surplus sufficient to cover only one week's claims).

*b. Proliferation of Subsidiaries*

Heaton and other Plan officers established a number of for-profit subsidiaries and affiliates that were essentially for their personal gain rather than for the benefit of the subscribers. This scheme, which was part of a reorganization launched by Heaton in 1984, violated management's fiduciary responsibility to the subscribers. Though funded by Blue Cross/Blue Shield money, the potential profits from these ventures would not have benefitted the Plan or its subscribers. Heaton said that he saw nothing wrong with establishing these for-profit affiliates and subsidiaries, further underscoring his apparent lack of appreciation for any fiduciary responsibility to the Plan's subscribers.

These for-profit external businesses also violated the "corporate opportunity doctrine," which holds that a director or officer of a corporation may not take advantage of a business opportunity that rightly belongs to the corporation. In a 1984 letter, for example, one of the Plan's legal advisors warned:

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factors may have contributed to the Plan's problems in some small way, the overwhelming evidence accumulated by the Subcommittee shows they cannot explain the Plan's dramatic decline and ultimate failure. If controlling, such factors logically should have also affected the Parkersburg Blue Cross/Blue Shield Plan. However, there was no evidence of any major adverse effects on the Parkersburg Plan, which was profitable until its merger with Blue Cross/Blue Shield Mutual of Ohio (the Cleveland Plan).

> The plan of reorganization * * * raises several areas of concern dealing with the 'corporate opportunity doctrine'. * * * [A] sale of all of the stock of the subsidiary of Blue Cross/Blue Shield to the individual members, or a corporation controlled by the members, even at fair market value, might raise concerns as to whether the members were taking a 'business opportunity' from Blue Cross/Blue Shield. * * * In the present situation, corporate officers and directors might be considered to be taking personal advantage of an enterprise already profitable to Blue Cross/Blue Shield. Although the motive for splitting-off the subsidiary corporation is bona fide, the fact that future profits may be diverted from the parent corporation to individual directors or members raises at least the specter of impropriety.

Finally, these external ventures diverted millions of dollars (at least $1.8 million in start-up costs alone, according to Insurance Department figures) from other areas of activity at a time when the Plan was experiencing serious financial problems. As one Insurance Department auditor explained:

> The problem with the subsidiaries was especially serious since it would appear to aggravate the already shaky financial condition of the West Virginia Plan. It is one matter to create subsidiaries, but it was particularly troubling to find the Officers and Board considering to diversify and create a multitude of affiliates and subsidiaries when the parent Plan was losing money. Our question was where the money would come from to pay for these new ventures.

*c. Internal Control Deficiencies*

In a 1987 examination, the Plan's outside accountants, Ernst & Young, identified numerous deficiencies in the Plan's internal system of controls, recordkeeping, and accounting practices. It took 68 pages in their report to detail the weaknesses found and to list the extensive improvements needed. Most significantly, Ernst & Young cited five material weaknesses in the Plan's internal accounting controls for accounts receivable and investment activity.[13]

During this same internal control examination it was also discovered that the Plan was engaged in a highly risky type of investment trading—hedging and speculating in stock price fluctuations—which the auditors believed was neither appropriate for a company of its type nor permissible under the West Virginia Insurance Code.[14] Records indicate that Plan management had only a limited knowledge of how the market for these investments actually worked or the potential for significant losses. While the Plan

[13] A material weakness is a deficiency in an entity's internal control structure so significant that there is more than a relatively low risk that errors or irregularities may occur and not be detected within a timely period.

[14] The Insurance Department subsequently determined that the Plan's participation in these investments was, in fact, a violation of the West Virginia Insurance Code because borrowed money was used to finance the transactions. The Department filed a $2.3 million suit against Shearson Lehman Brothers and E.F. Hutton, the firms that advanced loans for the transactions and advised the Plan on the specific investment strategy utilized. This suit was settled in August 1993 for $775,000.

subsequently ceased this investment activity, its involvement still resulted in more than $2.3 million in losses.

*d. Questionable/Poor Underwriting Practices*

Numerous sources said that the Plan was consistently undermined by ill-advised underwriting decisions. The Vice President for Finance, for example, said that the Plan took on new clients without properly underwriting that business, in order to generate more cash through premiums and recapture lost market share. This decision, he added, resulted in the Plan assuming more liabilities than it could handle.

In a 1990 document, Blue Cross/Blue Shield Association auditors reported that the Plan's financial predicament was, in part, a result of its tendency to "focus on enrollment rather than profitability." An analysis by the West Virginia Hospital Association concluded that one of the major factors that contributed to the Plan's failure was "terrible underwriting decisions * * * throughout the 1980's which found Blue Cross acquiring business and then losing millions of dollars as they gambled to expand marketshare."

*e. Excessive Salaries*

While salaries hardly increased for the Plan's 700 or so employees, those for Heaton and the other nine highest paid officers rose precipitously. These increases occurred most pointedly between 1984-1989, when the Plan was in serious financial difficulty. For example, while total salaries for the Plan's top ten officers was approximately $575,000 in 1984, by 1989 that figure had risen to more than $900,000. During this same timeframe, Heaton's salary nearly doubled, from $85,000 to $160,000.

2. INADEQUATE OVERSIGHT BY THE BOARD OF DIRECTORS

The Subcommittee received considerable testimony on the Board of Directors' failure to perform its requisite oversight of management policies and performance. Instead of protecting the subscribers' interests, the Board was routinely manipulated and misled by management and, in some instances, became intertwined with the latter in questionable activity.

In January, 1984 Heaton moved to create a new governing body within the existing Board, which effectively undermined the Board's ability to properly perform its responsibilities. This new governing body, the "Board of Voting Members," came to be known as the "Super Board," and was comprised of Heaton, Board Chairman Don Wagenheim, and a group of their hand-picked associates. The new Board of Voting Members was the only body empowered to: change the corporation's by-laws; elect the directors on the Board; and, nominate new voting members. In Heaton's words, "control of the voting members allows for control of the board." [15] Among other things, this ability to control the Board enabled Heaton to establish and operate the Plan's highly questionable for-

[15] In a July 14, 1988 letter to the President of the District of Columbia Blue Cross/Blue Shield Plan.

profit external ventures with virtually no opposition from the Board.[16]

In an affidavit submitted to the Subcommittee, one longtime Board member described the effect of the Super Board:

> This special creation of a "Super Board" caused some full Board members to resign. * * * Members became much, much less involved * * * [and] soon, the Board just went along with whatever management suggested, and questions were not asked at Board meetings. The Board was controlled and silenced.

The evidence also established that management routinely misled and/or failed to inform the Board:

—regarding the Plan's involvement in the risky investment activity—i.e., speculating in future stock price fluctuations—described above, Board Chairman Wagenheim told the Subcommittee Staff that "he didn't understand it then and * * * wouldn't understand it today";

—the Board was unaware that the Plan incurred more than $240,000 in expenses in settling a lawsuit brought by a female Plan employee in relation to her long-running affair with President Heaton; and,

—although the Board was informed in early 1988 that the Plan was in a "negative reserve" condition, a Board member noted that the word "insolvent" was never mentioned (even though the Plan was insolvent at that time). She noted that:

> * * * Mr. Torrisi would continue giving optimistic forecasts for recovery. He would flash slides on viewgraphs, but not give us copies of the information. The graphs only gave limited snapshots of the financial condition of the Plan. Financial forecasts were handed out, but no one ever explained that the forecasts were just based on management's opinion.

Questionable conduct on the part of Board Chairman Wagenheim may also partly explain the Board's failure to adequately carry out its responsibilities. In a number of instances while serving as Chairman and Board member, Wagenheim, at best, used very poor judgment or, at worst, behaved unethically and/or knowingly involved himself in an unlawful business transaction. Most notably, Wagenheim became deeply enmeshed in the process by which his firm, H.E. Neumann Construction Company, was awarded a $723,000 contract from the Plan to do work in connection with the renovation of its Charleston headquarters building.

In the Insurance Department's 1986 examination of the Plan, the auditing team learned that Wagenheim's firm received the contract even though it had not submitted the low bid and had not been recommended by the architectural and design firm that oversaw the bid process. The auditors felt that this was a "sweetheart deal," in

[16] After discovering the creation of the Super Board in their 1984 audit of the Plan, Insurance Department examiners concluded that it violated state-mandated requirements regarding the Board's appropriate composition and directed that it be dissolved. The Department's subsequent 1986 examination found that the Plan had not complied with the earlier directive and the Super Board was still in existence.

violation of West Virginia law and recommended that Wagenheim be removed as Board Chairman.[17]

When deposed by the Subcommittee Staff, Wagenheim admitted that he appointed the Building Committee that determined which contractors would be solicited for bids and what bids would be accepted. He also admitted that the Plan did not publicly advertise bids for the rehabilitation of the new headquarters renovation; instead, the Building Committee sent out invitations to a limited number of companies—including H.E. Neumann—to submit bids. In his deposition, Wagenheim saw no problem with his actions in connection with the contract award and no mention was made regarding it during Board and Executive Committee meetings at that time. Indeed, one member expressly said that she first heard about this situation only when informed by the Subcommittee Staff. Chairman Wagenheim, it should be noted, also served as Board Chairman of a number of the for-profit enterprises the Plan's management established during the 1980s, which were intended to benefit certain Plan officials and Board members.

### 3. INADEQUATE REGULATION BY THE INSURANCE DEPARTMENT

The West Virginia Insurance Department's efforts to oversee the Plan and protect the interests of its subscribers were inadequate. While the regulators knew about the Plan's problems almost from its merger-based inception in 1983, they did not move against it until 1990, by which time it had been insolvent for almost three years and was essentially beyond any hope of recovery. This inaction resulted from both the Plan's ability to evade regulatory efforts and the Department's own inability and/or unwillingness to take appropriate action in a timely manner.

Past and present senior Department officials testified that they had neither sufficient staff nor budget resources to properly oversee the Plan's operations and the other insurance companies under their jurisdiction. Former Commissioner Wright testified that when he took over, the Department was "a mess," i.e., it had few experienced employees, was suffering from high turnover, and had no comprehensive management policy in place. In an affidavit provided to the Subcommittee, the Counsel to the Insurance Commissioner from 1982 to 1989 stated that:

> In 1982, the Department had a small number of employees, approximately 25 to 30. Only a handful of those employees were professionals and I was the only in-house attorney. We were charged with regulating the activities of approximately 20 to 25 domestic insurers, overseeing the business practices of over 1000 non-domestic insurers and regulating the activities of several thousand insurance agents and brokers. * * *

The former Counsel also notes that although resources increased over time, during her tenure the Department still never had suffi-

[17] West Virginia law (Chapter 33, Sec. 4–17 and 33–24–4) strictly bars officers and directors of an insurance company and/or Blue Cross/Blue Shield Plan from profiting from their position in transactions with the company. As explained below (see p. 24), the audit report containing this recommendation was never filed and, therefore, no action was taken to remove Wagenheim.

cient staff or budget to be able to fully carry out its regulatory functions.

The Department's ability to do its work was also hampered by a lack of expertise and turn-over in the ranks of senior employees. During the Plan's short-lived existence (1983–1990), for example, there were three Commissioners and three Chief Examiners. One of the Chief Examiners was removed for incompetence and two of the three had no prior field examination experience. Shortly after the completion of the Department's 1986 examination of the Plan, the Chief Examiner left to take a job with the Plan.

The Subcommittee also received testimony indicating that the Department's failure to act against the Plan was also a matter of its apparent unwillingness to do so. In 1984 and 1986, Department examiners reported the Plan's financial decline, as well as questionable conduct on the part of management and directors. In the 1986 report, the examiners recommended that the Department seek to remove Heaton, Torrisi, Wagenheim and most of the other Directors for violating their fiduciary duty.

However, the Department did little if anything about either of these reports and their findings and recommendations. For reasons that remain unexplained, nearly a year intervened from the time the 1984 report was submitted to the Commissioner and when it was finally filed in 1985. The 1986 report was never filed and, therefore, remained unavailable to the public.

In his deposition, former Commissioner Wright testified that the main reason that the 1986 report was never filed or acted upon was because "there were just too many other more important and pressing things to do at the time," including the status of three financially distressed domestic insurers. Nevertheless, the point remains that the Department's failure to act on the report was to some considerable degree a matter of choice. Indeed, in his deposition former Commissioner Wright conceded that, in retrospect, he perhaps should have been more aggressive and followed up on his examiners' recommendations.

The present Insurance Commissioner, Hanley C. Clark, told the Subcommittee Staff that in part he did not act sooner because he did not have the regulatory tools to do so.[18] He said that when he obtained the needed additional regulatory authority in March, 1990, with the passage of West Virginia House Bill 4195, he started to proceed against the Plan. Some legal experts, however, informed the Staff that even from a cursory reading of the Code, the Insurance Commissioner clearly had the discretionary authority to refuse to renew, suspend or revoke the license of the Plan for being "in an unsound condition or in such condition as to render its further transaction of insurance in West Virginia hazardous to its policyholders or to the people of West Virginia."[19] Indeed, Department representatives, such as current General Counsel, Keith Huffman, and former Commissioner Wright, testified that they did not use regulatory tools available to them, such as public hearings and subpoena power, because of concerns about litigation:

[18] Prior to being named Commissioner in January, 1989, Mr. Clark was either the Deputy or acting Commissioner for much of the Plan's existence.

[19] West Virginia Insurance Code, Sec. 33–3–11 (4).

> Senator NUNN. But you had subpoena power, did you not?
>
> Mr. HUFFMAN. He [Commissioner Clark] had subpoena power, Senator, but * * * if the department would have issued subpoenas to * * * garner evidence * * * [from] the National [Blue Cross/Blue Shield Association or from] * * * E & Y [Ernst & Young], I guarantee you what would have happened is that those entities would have called down the street to their 200- or 300-lawyer firm and tied the department up [for] so long * * * that those subpoenas would not have been very effective at all. * * *
>
> Senator NUNN. Were you afraid to subpoena Blue Cross/Blue Shield of West Virginia * * * because of their lawyers?
>
> Mr. WRIGHT. Senator, everything we did at that time involving what I would call the bad insurance companies or organizations developed into a war with lawyers. * * *

Former and current officials also testified that the Plan quite literally fought the regulators at every turn. Former Commissioner Wright's Counsel, for example, stated that:

> The relationship between Blue Cross and the Department was rocky, full of contention and far from pleasant. My perception of Blue Cross was that it made little effort to cooperate with the Department and seemed to almost automatically take a position in opposition to suggestions or recommendations of the Department. I questioned Blue Cross' willingness to deal openly and fairly with the Department.

Both the former and current Commissioners echoed the Counsel's remarks. In his testimony, for example, Commissioner Clark stated that:

> The relationship between the management of BCBSWV and the Department could be characterized, at a minimum, as very poor. In nearly every encounter with the BCBSWV management, the Department staff came to expect misinformation, deceit, arrogance, and defiance.

Commissioners Wright and Clark indicated that nothing ever came easy in dealing with this Plan. Both described how they would have to threaten litigation before the Plan would voluntarily comply with a simple request that would be handled pro forma by any other insurance company.

The Department's lead examiner on the 1986 exam, had this to say about his dealings with the Plan:

> Throughout this examination, the Plan's officers and employees exhibited an arrogance to the law and an unwillingness to cooperate with the examination. We quickly learned that the Plan's Officers felt they were 'above the law,' and were very well connected politically. The Plan's officers did not even attempt to hide their displeasure that we were there.

4. INADEQUATE OVERSIGHT BY THE BLUE CROSS/BLUE SHIELD ASSOCIATION

The Blue Cross/Blue Shield Association's role regarding the Plan, indicates that it had sufficient information about the Plan's problems and authority to take decisive action, but failed to do so in a timely manner. In addition, the Association failed to adequately convey its knowledge of and concerns about the Plan's problems to the West Virginia Insurance Department.

Beginning in 1987, a year after the Plan's financial problems had led to a loss of nearly $3 million, the Association took the serious step of placing it on conditional status for failing to comply fully with a membership standard involving financial responsibility, i.e., failing to have sufficient reserves on hand to meet at least 1.5 months of potential claims. Conditional status was renewed in 1988, after Association staff made an on-site visit to the Plan to examine its 1987 performance results. In the March, 1988 report summarizing the results of their visit, the Association staff found that: the Plan's forecast of a $1.5 million gain in 1988 was unlikely and, instead, that significant losses could occur; the Plan could be out of operating cash by late summer of that year; and, because of the Plan's deteriorating financial condition, there could be intervention by the State Insurance Department.

In 1989, conditional status was again renewed, when the Plan failed to meet the same reserve and liquidity requirements it had not met in 1988, and also failed to satisfy a requirement that financial reports be submitted in an accurate and timely manner. The conditional status for 1989 reflected the Association's April, 1989 review of the Plan, which found that it had experienced four years of enrollment and market share decline, in addition to net losses of $22 million and $19 million in 1987 and 1988, respectively. The April review also pointed out that it was the Plan's "precarious financial condition" that forced it to be placed on conditional status in 1987 and 1988, and that management's response to these problems had been largely unsuccessful.

Finally, in the spring of 1990, the Association's Plan Performance and Monitoring Committee voted for non-renewal of the Plan's license, the most serious sanction available to it. However, a non-renewal recommendation could have been made at least a year earlier, after the Plan had experienced three consecutive years of declining financial performance and two consecutive years of noncompliance with the financial responsibility membership standard. At the very least, an earlier threat of non-renewal of the Plans's membership by the Association might have prompted an affiliation or some other action that could have helped avert the Plan's ultimate seizure and liquidation.

According to Association officials, action was not taken sooner because of a series of promising developments, all of which, however, eventually "fizzled." In 1988, the West Virginia Plan and the District of Columbia Plan (GHMSI) had begun affiliation negotiations. In addition, at the end of 1988 the Plan's accountants, Ernst & Young, projected a $6.8 million gain for 1989. Although this projection did not materialize and West Virginia's problems continued in 1989, the Association officials noted that the talks with GHMSI

were ongoing and Ernst & Young had again forecast positive results for 1990—a projected gain of $8.9 million.[20] Then, in early 1990, hopes were again raised when Commissioner Clark approved a significant rate increase for the Plan and affiliation talks began with the Cleveland Plan. The Association officials also stated that they did not move earlier to rescind the Plan's membership status because that is a drastic measure they only use as a last resort.

According to the Insurance Department, the Association concealed the true nature and extent of its concerns regarding the Plan's problems and, by so doing, effectively contributed to delays on the regulator's part to act against the Plan before it became irreparably impaired. As early as 1986, the Association was fully aware of the Plan's deteriorating financial condition and had placed it on conditional status in 1987. The Association, however, failed to notify the Department of this action and also failed to do so again in 1988 and 1989, when the Plan's conditional status was continued.[21]

Commissioner Clark testified that in meetings from May 17–23, 1988, Association representatives told Department staff that the Plan was not experiencing more financial difficulties than any other Plan in the Blue Cross/Blue Shield system, and that these problems were related to a normal downturn in the insurance cycle being experienced by all health insurers. According to this testimony, Department staff were told that the situation would improve in 1989. Commissioner Clark also testified that the Association representatives advised the Department that drastic action was not needed, although at the same time they said that the Department ought to continue to monitor the Plan.

The Commissioner explained the Department's "huge dilemma" in this regard as follows:

> Under laws in existence in the State of West Virginia, if the Department sought rehabilitation or liquidation of the plan, it would be faced with a full adversarial hearing * * * in which it would be necessary to demonstrate (over the strenuous objections of management) that [such action] was in the 'interest of the policyholders, creditors, stockholders, members, subscribers, or the public'. * * * As a practical matter, the Department needed the support of * * * the National [Association] against BCBSWV management in order to take affirmative action. * * * There would have to be expert testimony that the plan was insolvent and would not recover on its own * * *, as well as a workout plan to help retire the liabilities of BCBSWV * * * and provide a solvent merger or affiliation partner.

[20] The Subcommittee staff were surprised to learn that Association officials were unaware that the Ernst & Young forecasts were compilations, rather than examinations. The officials told the staff that since the West Virginia Insurance Commissioner had requested and relied upon the forecasts, it never occurred to them that the forecasts were not independently audited or verified.

[21] In his deposition, Plan President Heaton said that as a former member of the Association's Board of Directors and with his more than 20 years of experience in the Blue Cross/Blue Shield system, he found that the Association uses three techniques to stave off a Plan's failure. It will first approach the regulators to get rate increases. If that doesn't work, it will put political pressure on the regulators—including, for example, going as far as threatening to pull a Plan's trademark and service marks, which Heaton said he saw done in the case of the New Jersey Plan. Finally, if all else fails, a merger with another Plan will be pursued.

> * * * However, * * * the National [was] aligned against such measures."[22]

D. EFFECTS

For thousands of West Virginia subscribers, providers, and others, their lives and/or businesses were thrown into turmoil as a result of the Plan's failure. The Plan's demise left subscribers with more than $40 million in unpaid claims. An administrator of and participant in his small company's employee health benefits plan, testified that he personally lost $23,000 due to non-payment of benefits. The financial pressure placed on him and his family as a result of his unpaid medical bills became so great that at one point he seriously considered declaring bankruptcy.

Another subscriber, who was left with more than $37,000 in unpaid medical bills for services rendered in treating her serious cancer condition, described the difficulties she faced:

> To stop the harassment from the medical providers for payment that they had been denied by the failed Blue Cross Plan, and to prevent creditors from putting a judgment against my home, I had to start making monthly payments. * * * Not only do I have to worry about having cancer, I now have to worry about the bills. * * *
>
> This constant worry about the medical bills and where the money is going to come from to pay them has put me under a lot of additional stress, as I worry about the possibility of losing our home.

At the time of the Subcommittee's hearings this individual had no health insurance at all.

Some West Virginia Plan subscribers were also dramatically affected by premium increases. For example, one of the witnesses who testified about the impact of the Plan's failure explained that in the wake of its demise many firms were unwilling to trust the successor plan, Mountain State Blue Cross/Blue Shield. When some of these firms signed up with other health insurers, Mountain State increased premiums for its high-risk subscribers by more than 60%. This action, he said, "hit home" for him because the pastor of his church had to drop his family's coverage when his premiums increased from $500 to over $800 a month. In their testimony, the Subcommittee Staff confirmed that many West Virginia Plan subscribers lost their coverage as a result of this staggering premium increase.[23]

Lastly, the Subcommittee also found that the Plan's failure had major consequences for providers. Testimony submitted by the West Virginia Hospital Association states that the more than $40

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[22] In its role as Receiver, the Insurance Department filed a civil suit against the Association in January 1992, alleging that its conduct in connection with the Plan's failure was "willful, wanton, and malicious" and in violation of the West Virginia Unfair Trade Practices Act. The suit called for $34 million to cover outstanding claims resulting from the Plan's failure; $10 million in extra contractual damages for annoyance, inconvenience, hardship, and mental anguish; and, another $10 million for punitive damages. This suit was settled in March 1992, with the Association agreeing to pay the Department $8.6 million.

[23] Generally speaking, the Plans examined by the Subcommittee had little difficulty in obtaining desired premium increases.

million in unpaid medical bills for services already provided to Plan subscribers had a "substantial" effect on providers.

## THE MARYLAND PLAN

### A. BACKGROUND/ORGANIZATION

Tracing its roots back to predecessor organizations formed in the late 1930s, the Blue Cross/Blue Shield plan of Maryland (BCBSM) was established as a result of the 1985 merger of the State's separate Blue Cross and Blue Shield plans. Headquartered in Owings Mills, BCBSM was serving approximately 1.4 million Marylanders (nearly 30% of the State's population) in 1992. In addition, at the time of the Subcommittee's hearing, BCBSM employed approximately 4,500 individuals and in 1991 took in $1.7 billion in total revenue.

From the mid-1980s onward, BCBSM's organizational structure included three types of operational entities: those involved in underwriting and servicing its core Blue Cross/Blue Shield insurance business; for-profit subsidiaries with some health-related purpose; and, for-profit subsidiaries with no health-related purpose. In 1985, BCBSM's structure was fairly simple, consisting of the parent company and two subsidiaries. By 1991, however, it had become extremely complicated by the addition of another 29 subsidiaries and three limited partnerships.

### B. FINANCIAL PROFILE

From 1986 through 1988, BCBSM incurred operating losses of $110 million and its net worth declined dramatically from $67 million to $17 million.[24] Reflecting these losses and reduced net worth, a 1987 Maryland Insurance Division examination found that BCBSM had achieved a deficit position of $1.2 million.[25] Between 1985 and 1989 the Plan's reported reserves declined precipitously from $122 million to $16 million.

In a July 17, 1992 letter to the Governor, the Maryland Insurance Commissioner, John A. Donaho, observed that, "in broad terms, BCBSM may be 60-65 percent weaker at December 31, 1991 than it was at December 31, 1984." On the basis of its April, 1992 business performance review of BCBSM, the Blue Cross/Blue Shield Association concluded that the Plan's reserve position was "low and tenuous."

Since 1986, the Plan's subsidiary companies had incurred total losses of $120 million. During this same timespan the Plan made capital infusions of more than $170 million to its HMO and non-insurance subsidiaries. Between 1987 and 1990, BCBSM's external auditors refrained from issuing a "going concern" audit opinion on

[24] Since 1989, BCBSM has reported operating gains of $121 million and an increase in net worth of $85 million as of June 30, 1992. However, according to the Subcommittee staff, these figures may be substantially overstated because accepted accounting rules and asset valuation procedures have not been strictly followed by BCBSM. See related discussion below, p. 42.

[25] This examination was never formally completed. See related discussion below, p. 39.

its HMO subsidiaries, but only after Plan officials said that they would guarantee the latters' solvency.[26]

## C. Problem Areas

Some of the same key factors associated with the demise of the West Virginia Plan were present in varying degrees at BCBSM.[27] Specifically, the testimony established four broad problem areas: mismanagement; inadequate oversight by the Board of Directors; inadequate regulation by the Maryland Insurance Division; and, inadequate oversight by the Blue Cross/Blue Shield Association.[28]

### 1. MISMANAGEMENT

As in the West Virginia Plan, mismanagement and questionable management decisions were inextricably bound up in BCBSM's financial difficulties. An August 11, 1992 letter from Commissioner Donaho to the Governor seriously questioned BCBSM's management decisions:

> The Blue's generally poor financial condition is a result of years of a combination of mismanagement and inadequate rates. By mismanagement, I am not suggesting anything illegal just poor planning and execution, a malady that frequently strikes managers in positions where profit, that is return to investors, is not a question.[29]

#### *a. Proliferation of Subsidiaries*

In reviewing the 29 subsidiaries and three limited partnerships that BCBSM purchased or formed between 1985 and 1991, the Subcommittee found a pattern of disjointed and confused management decisions surrounding their establishment and operation. There was no clearly stated long-term management strategy regarding these ventures and some of them were established but never became operational.

When a subsidiary was having financial problems, BCBSM funds were routinely, and generally without question, used to bail them

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[26] A going concern opinion indicates that the auditors have substantial doubt that the entity examined will be in business one year from the date of the audit.

[27] In their testimony the Subcommittee staff offered two cautionary notes on this point. First, they explained that while there were major similarities in the problems at the West Virginia and BCBSM Plans, there were also a number of important differences, including: no evidence was uncovered that top BCBSM officers or Board members had engaged in self-dealing or created subsidiaries for their personal enrichment; and, BCBSM's President did not create a "Super Board," consisting of himself and certain hand-picked associates, in an effort to control the Plan and circumvent existing regulatory requirements. Second, the Staff cautioned that the similarities in the Plans' problems did not mean that BCBSM was on the verge of imminent failure. Rather, they suggested that BCBSM could ultimately become as impaired as the West Virginia Plan, if its problems were not addressed in a timely manner.

[28] BCBSM officials did not dispute the Subcommittee's findings, although in their testimony they did cite other factors—e.g., the 1986–1988 downturn in the health insurance industry, increased competition from for-profit insurance companies, and dramatic changes in health care industry products and services—to explain the situation that confronted the Plan from the time of its establishment in 1985. However, within a week of the hearings, the Board met and removed Carl Sardegna as its Chairman and appointed a special committee to examine the issues raised by the Subcommittee. The results of this special committee's review corroborated virtually all of the Subcommittee's findings regarding BCBSM's management and operations.

[29] Commissioner Donaho's concerns about BCBSM's management are shared by a number of his predecessors. In interviews with the Staff, for example, one former Commissioner called BCBSM's management structure "awful," while another said that when it comes to the Plan's management, "you don't know what they're doing as a regulator, then you realize that they don't know what they're doing, and what they do most of the time is wrong."

out. According to documents subpoenaed from BCBSM, the subsidiaries lost nearly $72 million between 1986 and 1991. BCBSM officials subsequently acknowledged that total subsidiary losses were in excess of $120 million. Again, comments by Commissioner Donaho in his August 11, 1992 letter to the Governor are revealing:

> Rather than approaching a new scheme conservatively with careful estimates, they [BCBSM management] plunge ahead without concern as to when or if the investment will be returned. The Smart Card [LifeCard International] and Health Credit Card [HealthLine] are perfect examples of the drain of cash caused by mismanagement of our Blues.[30]

*b. Internal Control Deficiencies*

As in the West Virginia Plan, major problems for which management was ultimately responsible were also found in BCBSM's accounting and internal control procedures. Numerous audits by external and internal auditors, management consultants, and former employees between 1985-1991 disclosed recurring problems, including:

—in 1985, 1986, 1989, and 1990 external auditors expressed concern that weaknesses in the Plan's information security procedures were allowing access to the Plan's computer system by unauthorized persons. In 1987, auditors noted that data security responsibilities were not fully defined or adequately staffed and suffered from a lack of technical expertise. In 1989, the auditors expressed the concern that unauthorized persons could change program or data files without being detected in a timely manner and, in 1990, it was noted that "virtually all employees (authorized and unauthorized) have access to the claims processing system."

—audits in 1986, 1989, and 1990 found numerous and repeated claims processing problems at one of the Plan's subsidiaries. These various audits found that claims control procedures were weak and processing staff were untrained, inexperienced, and inadequately supervised. The auditors also reported ongoing problems in claims processing timeliness, accuracy, and recordkeeping.

—a former BCBSM Supervisory Auditor described an incident wherein a former employee of the Plan's Willse subsidiary embezzled over $4 million by writing checks to fictitious entities. Although BCBSM auditors had previously identified serious weaknesses regarding access to Willse's checks and check writing procedures, management had failed to correct these deficiencies.

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[30] According to the Subcommittee staff's analysis, between 1987-1991 total losses from HealthLine operations were $15.4 million; between 1985-1991, LifeCard International losses were $30 million. Examples of BCBSM mismanagement involving these subsidiaries include: the pilot program for BCBSM employees to acquire HealthLine's Medcash card (a credit card for charging medical bills, weight loss clinic and fitness center expenses, and medical products) had no credit standards, which resulted in significant delinquencies and defaults; and, fitness centers were known to be risky businesses for credit card purposes and, by 1992, nearly half of Medcash's charges (about $3.3 million) were from transactions at these concerns.

In one of BCBSM's recent cost-saving moves, the Corporate Audit Department's budget was reduced from $1.07 million to $857,000 (about 20%) and the staff was cut from 16 to 12 employees. Plan documents indicate that this budget cut will significantly reduce the Internal Auditors' ability to cover known problem areas, such as subsidiary operations, corporate staff activities, and claims and billing system functions. At this reduced level of coverage, the Subcommittee staff estimated that it could take from 10 to 20 years before the Internal Auditors would be able to audit these areas completely.

*c. Blunders and Misjudgments: CARE, Project W, and Corporate Downsizing*

The Subcommittee received evidence of a long list of major management blunders and misjudgments, which ended up costing the Plan tens of millions of dollars in unanticipated expenses and diminished its financial strength. For example, the Plan experienced serious problems with the development, cost-effectiveness and ultimate functional advantages of the CARE claims processing system. While the system was to have been fully operational by mid-1990, at an estimated cost of $9 million, it was not yet in full operation as of late 1992, and had already cost more than $25 million. According to one consultant's analysis, an additional $20–$30 million may be needed for the system to become fully operational. Worse yet, according to an October, 1991 consultant's study, the CARE system "is unlikely to ever be as efficient" as two other readily available systems and, in terms of computer resource utilization, will not likely "ever equal that of the systems being replaced."

There are similar concerns about a little-known internal unit of BCBSM, Division W (Project W). Division W was created in January, 1991 to help management to "rethink how BCBS of Maryland provides products and services to customers and to develop and implement new approaches from the basis of a 'clean sheet of paper'." Division W purportedly has been developing a claims adjudication and payment processing system that would link physicians and other providers to the Plan electronically.

Although Division W had spent about $12 million by late 1992, it had produced little, if anything of significance by the time of the Subcommittee's hearings. A consultant's study described this organization as "too ambitious" and "very futuristic," and concluded that it was "off track and a muddle" and "would not become operational until the end of the decade at the earliest."

Another costly management blunder was described by the former Plan Supervisory Auditor in testimony regarding a "corporate downsizing" instituted by BCBSM management in 1986. While her testimony indicates that some cuts in BCBSM's 2,500 employee workforce may have been in order, she explained that the way that management carried them out resulted in total costs of "a staggering $10 million." As implemented, the downsizing included expensive severance packages for senior executives, overpayments of pension benefits, eight weeks of severance pay for a large number of employees, two weeks of pay for others who were laid off, and health care coverage for all through the end of the year. A decision was made immediately following this downsizing to reorganize the

Plan into so-called Strategic Business Units. Over the next five years, this reorganization resulted in a dramatic increase in the size of the workforce to 4,500 employees; prompting yet another severe staff cutback in 1991.

*d. Questionable/Poor Underwriting Practices*

The testimony also confirmed management misjudgments in BCBSM's underwriting practices on so-called non-risk business, i.e., business in which the Plan only performs administrative functions, such as claims processing and customer service, while employers assume the health-related financial risk. This issue surfaced in the following exchange:

> Senator NUNN. Could you explain what you mean by non-risk underwriting loss?
>
> Commissioner DONAHO. * * * as this trend is developing away from people purchasing insurance from the Blues, * * * large employers * * * including the State of Maryland, Baltimore City, Baltimore Gas & Electric Company and others, * * * [are] engag[ing] the Blues as administrators of their own so-called self-insurance plans. * * * Blue Cross, in effect, charges a fee for administering a company's plan, and this is the most amazing thing to us, because how can you lose money on a business which you are charging a fee to run?
>
> Senator NUNN. That is what I was going to ask you. * * *
>
> Commissioner DONAHO. Well, my offhand conclusion, until we research it, * * * is that their bids have been cut in order to get the business, so that actually the bid is based upon a loss. In other words, the organization is emphasizing * * * keep[ing] its cash flow going, * * * the reason most Blues survive is because of their cash flow, not because they are accumulating large amounts of surplus.

In a subsequent October, 1992 letter submitted for the Record, the Commissioner pointed out that between 1986–1990, $100 million of BCBSM's total underwriting losses of $115.7 million "surprisingly" came from non-risk business, suggesting a "systematic problem in underpricing" on the part of the Plan to gain marketshare. He concludes that "maintaining market share may have been a primary concern of BCBSM even to the point of absorbing losses from inadequate expense charges," and cites BCBSM's account with Maryland as an example:

> The State of Maryland account, recently awarded $945 million ($85 million for administration), is obviously perceived to be critical by BCBSM management. The bewildering concept is whether the State account is more critical due to its high visibility, "flagship" marketing value and not due to its underlying profit potential.

*e. Excessive Salaries and Business Expenses*

Testimony before the Subcommittee also established a pattern of excessive administrative expenses. These excesses are important

for two primary reasons: 1) they reveal management's profound misunderstanding of and/or insensitivity to BCBSM's status as a non-profit organization intended to provide "access to quality care at an affordable price and to be the health insurer of last resort;" and, 2) they took place at a time when the Plan was in dire financial straits and subscriber premiums were being increased significantly. These excesses occurred in two broad categories of expenses—executive compensation packages (salaries, bonuses and other benefits) and corporate marketing efforts (entertainment, charitable contributions, and travel).

In the area of executive compensation, the Staff's testimony highlighted the following examples:

—between 1986-1991, Plan President and CEO, Carl Sardegna's total compensation (i.e., salary plus bonuses) nearly quadrupled, from $221,130 to $850,193. According to the BCBS Association, Sardegna's 1991 compensation was more than double the average total compensation for all BCBS Plan CEOs ($388,000) and placed him well above the 98th percentile figure of $710,000.[31]

—while total compensation for BCBSM's top ten executives increased by more than 180 percent between 1986-1991, the increase for the Plan's employees in general was just 28 percent during the same timeframe.

—between 1986–1992, the number of BCBSM employees paid $100,000 or more jumped from 11 to more than 40, with nine of the 40 earning over $200,000 and five $300,000 or more.[32]

Mr. Sardegna attempted to justify the Plan's executive compensation levels by explaining that they were based on studies done by independent consultants. In one such study, however, the Staff found that in trying to compare BCBSM executives' salaries with those of other companies, the consulting firm's sample focused on 1,700 enterprises, the vast majority of which were for-profit and only one-quarter of which were insurance companies. The Staff testified that:

—there was no information on the tenure of the executives at the companies used in the comparison. The number of years an executive has served a company is likely to be reflected in his or her compensation level and thus a failure to include such information could skew the study's results. Underscoring the potential significance of this deficiency, the Staff point out that Mr. Sardegna's compensation increased nearly 300% in just four years.

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[31] BCBSM officials told the Staff that their high salaries were commensurate with the size of their plan. In fact, however, the BCBS Association has noted that BCBSM's 1.4 million subscribers place it just above the average Plan size of 1.2 million. Furthermore, BCBS Association data shows that of the 26 BCBS Plans with more than one million subscribers, the average total compensation for CEOs was $458,000; which places Sardegna well into the 90th percentile of all these Plan CEOs as well.

[32] The Staff's testimony also highlighted excessive financial benefits available to BCBSM executives. One such example, the Plan's policy on moving expenses, resulted in reimbursement costs of $1.8 million between 1986–1988 for the relocation of just 32 employees (an average of more than $56,000 per employee). In addition, the Staff was told that the Plan paid for an employee to transport a horse pursuant to his relocation and, in at least two instances, stated in writing that employees would be reimbursed for the transport of their boats as part of their moving expenses.

—the names of the 1,700 companies used in the study were not available, according to the consulting firm, because their work was based on information collected from other studies. In addition to questioning the inherent validity of an analysis based on so many unknown companies, the Staff note that without such information, the relative affect of cost-of-living differentials between BCBSM and the other companies used in the comparison cannot be determined.

The Staff also described questionable expenses in the area of corporate marketing activities:

—documents subpoenaed from the Baltimore Orioles baseball organization show that BCBSM leased a skybox at the new Oriole Park at Camden Yards, at a cost of $300,000 for the years 1992-1995 ($75,000 per annum). The skybox suite includes 14 seats, two color televisions, private bathrooms, heating and air conditioning, a wet bar with bar stools, a refrigerator, private elevator access and an internal telephone to call caterers. The skybox fee was exclusive of food or drink, which cost the Plan anywhere from several hundred dollars to over $1,400 per game.

—in 1990–1992, BCBSM or one of its subsidiaries sponsored hospitality tents for the Preakness horse race at Pimlico Race Course in Baltimore. In 1992, BCBSM paid $32,500 to rent two tents adjacent to the Preakness Winner's Circle, complete with astroturf, dining tables and chairs for 150 guests, and four closed-circuit television monitors displaying the races of the day. More than $32,000 in additional expenses were incurred on this occasion for catering, printing, flower arrangements, gifts, and a photographer.

—at Plan expense, five senior executives—the CEO, the General Counsel, the Corporate Counsel, the Director of Community Relations, and the Chief Operating Officer—held memberships in one of Baltimore's most exclusive restaurants, The Center Club. The restaurant charges an initiation fee of $1,250 per member, plus annual dues of $650 per member. These five BCBSM executives, according to subpoenaed records, spent a total of almost $9,000 at The Center Club on lunches, dinners, flowers, and guest fees in 1992 alone.

—BCBSM purchased a corporate membership in the Cave's Valley Golf Club in Owings Mills, Maryland. The initiation fee was $75,000 and annual dues for 1991 and 1992 were $2,800 and $3,300, respectively.

—in 1988, BCBSM paid $182,000 for 64 all-expenses-paid packages to the Olympics in Calgary, Alberta and, in 1992, at a cost of $21,000, four all-expenses-paid packages to the Barcelona Olympics were purchased. The four Barcelona packages were purportedly given to a major Plan account, Baltimore Gas and Electric Company, when BCBSM's CEO decided not to make the trip.

BCBSM's response to the above was expressed in Mr. Sardegna's statement for the Record as follows:

> These types of activities * * * provide BCBSM a vehicle to market products to its customers and conduct other business activities. As one of Maryland's large employers, BCBSM has a corporate responsibility to enhance the business climate. Both the Orioles and the Preakness represent significant revenue to the State.

BCBSM also made sizeable charitable contributions to Baltimore area organizations with no apparent healthcare-related purpose. In recent years, for instance, BCBSM has made large donations to the Baltimore Symphony ($125,000), the National Aquarium ($53,000), the Center Stage ($37,000), the Walters Art Gallery ($18,000), and the Baltimore Museum of Art ($17,000).

Mr. Sardegna also expressly indicated that BCBSM is involved in these kinds of activities because its competitors do the same thing, a point which was disputed by Commissioner Donaho:

> Senator NUNN. Commissioner, what about the argument that this is a competitive world, that they [BCBSM] are basically competing, * * * [and] if they do not compete for entertainment and that kind of thing, they will lose business and the policyholders will suffer?
>
> Commissioner DONAHO. * * * I regulate 108 other domestics and 1,400 licensees, and I know of only one other insurance company that has a skybox. * * * I do not know of any company offhand * * * that exceeds the Blues in similar activities.

Moreover, regarding the contributions to the Baltimore Symphony, Symphony officials told the Staff that Sardegna declined to have BCBSM's name appear on a marble wall in the lobby of Symphony Hall in Baltimore, even though it was entitled to do so for having donated more than $100,000. Regarding a $25,000 corporate gift, Sardegna wrote the Symphony Society's President in August, 1991 insisting that "this contribution is not to be mentioned in any printed material." These requests for anonymity appear to be inconsistent with Sardegna's claim that BCBSM makes charitable contributions because their competitors do and because the company wants to be recognized in the community as a supporter of the arts.

The Subcommittee believes that the key question that arises in connection with BCBSM's entertainment expenses and charitable contributions is how they benefit the policyholders. In 1987, for example, Mr. Sardegna accompanied the Baltimore Symphony on a trip to Russia at the Plan's expense—an occurrence which prompted the following pointed exchange at the hearing:

> Senator NUNN. Did the Plan pay for you to accompany the Baltimore Symphony to Russia?
>
> Mr. SARDEGNA. Yes, it did, Senator.
>
> Senator NUNN. What was the business purpose of that trip * * *?
>
> Mr. SARDEGNA. The business purpose was that there were a significant number of businessmen who went with the Baltimore Symphony and I went along with them.

> Senator NUNN. And all those business people had their companies pay for it and deducted the expenses?
>
> Mr. SARDEGNA. * * * I do not know, Senator. * * *
>
> Senator NUNN. But you do not have any trouble justifying that as a business purpose? I do not mind you going to Russia with the Baltimore Symphony, but you make a pretty good salary * * * [so] why could you not pay for it out of your own pocket?
>
> Mr. SARDEGNA. Senator, in hindsight, I probably * * * should have made a different decision.

In the area of travel, in 1991 alone BCBSM spent over $2.8 million. Though BCBSM conducts business solely within the State of Maryland, this included trips by its executives to Singapore, Hong Kong, London, Tokyo, Osaka, Seoul, Amsterdam, Brussels, and Bangkok. BCBSM travel expenses also included corporate functions held outside Maryland. For example, while special events to honor outstanding marketing division employees were held at a local restaurant in earlier years, in 1991 and 1992 the ceremony was held at the Hilton Head resort in South Carolina. Subpoenaed documents included receipts for $10,000 in expenses for ground transportation and some $46,000 for air transportation.

2. INADEQUATE OVERSIGHT BY THE BOARD OF DIRECTORS

BCBSM's Board of Directors displayed an apparent unawareness of and/or insensitivity to its primary fiduciary responsibility to the Plan's subscribers. Arguably most important among the Board's problems in this regard are the inherent questions raised by Carl Sardegna's having served simultaneously as the Plan's CEO, President and Chairman of the Board. In a July 29, 1992 letter to the Governor, Commissioner Donaho stated:

> I am quite aware of your confidence in those Board members of BCBSM with whom you have had long experience. * * * The binder I gave you on July 3rd last demonstrates, however, the many instances in which Blue Cross management has not only failed to comply with regulation and to notify us, but also failed to keep the Board informed.

Mr. Sardegna's successor as Board Chairman, Frank Gunther, in a letter to then Chairman Nunn following the Subcommittee's hearings formally acknowledges that the Board had not been fully apprised of many of the actions taken by Mr. Sardegna and his management team. He points out that "while the Board knew the bottom line financial condition of the company, the method of presenting the results was always 'spun' to highlight the positive and ignore the negative." Concerning BCBSM's poor provider and consumer service record, he concedes that although the Board understood that there were problems in these areas, it was not aware how "acute" they were.

Management also failed to fully inform the Board of the BCBS Association's concerns about and actions regarding BCBSM's operations and financial condition, as confirmed by Mr. Gunther:

> Of most concern to the Board members was the fact that until the second week in November, when I received a copy of a letter from the Blue Cross and Blue Shield Association regarding their monitoring of the Blue Cross of Maryland, the Board was not aware that Mr. Sardegna had submitted a plan to the Association to improve the company's surplus, liquidity and service with specific goals and timeframes. While we had been told that the Association was monitoring Blue Cross, we were led to believe that that monitoring was business as usual. We were not aware of the specifics of the plan of recovery with the Association or even that it existed.[33]

To their discredit, Board members did participate in BCBSM's successful effort to forestall a 1991 management audit ordered by Commissioner Donaho. Three BCBSM Board members visited him in an attempt to persuade him to allow the Plan to substitute its own study. They justified their request by suggesting that a study initiated by the Insurance Division "would be an embarrassment and harmful to the image of the Blues." Some Board members also participated in BCBSM's efforts to circumvent the Commissioner by going directly to the Governor's staff and the Governor himself. According to the Commissioner, the study substituted by BCBSM failed to address seven of the eleven key concerns in his original proposal.[34]

The Board also failed to adequately oversee the Plan's operations and protect the subscribers' interests in its handling of salary and compensation issues. For example, the Board played a direct role in approving the excessive executive salaries and bonuses described above. Indeed, the Board determined Sardegna's $850,000 compensation package for 1991, as well as the package for the more than 40 top-level executives earning more than $100,000. The Board's actions in this regard were at best irresponsible, given the fact that the Plan was experiencing severe financial problems and subscribers' premiums were being increased substantially.[35]

### 3. INADEQUATE REGULATION BY THE INSURANCE DIVISION

The testimony presented to the Subcommittee regarding the regulation of BCBSM reveals a pattern of problems similar to those described in connection with the failed West Virginia Plan. While the Maryland Insurance Division was generally informed about BCBSM's financial and management difficulties, its actions in response were at various times insufficient and/or wholly ineffective. As in West Virginia, these failings were essentially the result of BCBSM's ability to block and evade regulatory efforts and/or the Division's inability or unwillingness to take appropriate action when necessary.

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[33] Reliable sources advised the Subcommittee staff that the Board's discovery of this apparent deception on the part of Mr. Sardegna was the ultimate act that led to his "resignation" on December 4, 1992.

[34] See related discussion below p. 39.

[35] At the time of the hearing BCBSM Board members were annually receiving total compensation of almost $20,000 (an $8,000 stipend, plus $800 each for 12 monthly Board Meetings, and an additional $400 for Board Subcommittee Meetings). This amount, according to the BCBS Association, is more than double the average ($9,600) for directors of all BCBS Plans.

For example, according to documents cited by the Subcommittee staff, a partially completed 1988 financial examination of BCBSM was suspended, "as a matter of courtesy to BCBSM." This examination had been ordered by the then-Commissioner in response to the huge losses reported by the Plan for the previous two years. The Commissioner had briefed the Governor on the examination in a March, 1988 memo in which the possibility was raised that if BCBSM's losses continued at the same rate, the Plan would be insolvent by the coming Fall. The examination's preliminary results in fact showed that, as of the end of 1987, BCBSM was already statutorily insolvent by virtue of having achieved a deficit position of $1.2 million. The decision to postpone the examination was made by the successor to the Commissioner who originally ordered it, over "the strong protestations" of an Assistant Commissioner.

Similarly, BCBSM successfully used its considerable political influence to see that a review of Plan operations being conducted by its own consultant was substituted for the independent management audit called for by the Commissioner in January, 1991. The call for this latter audit was in response to BCBSM's unremitting management and financial problems and, moreover, was expressly authorized by language in a bill passed by the Maryland Legislature.[36]

According to documents cited by the Staff, after the Commissioner issued a Request for Proposals in 1991 regarding the management audit of BCBSM, "Carl [Sardegna] subsequently worked hard to head off that audit, in part by hiring Booz Allen to do its own management audit of the Plan." Plan officials and representatives met with the Commissioner in an attempt to convince him to allow the substitution of their own study for the Division's proposed audit. On a number of occasions Plan officials and representatives tried to circumvent the Commissioner by taking their case directly to the Governor's then-Chief of Staff and the Governor himself. BCBSM President Sardegna, for example, had discussions with the Governor in which he argued that the Insurance Division's proposal was beyond the Commissioner's authority.

As a result of these activities, the Governor first began to question the Commissioner's proposal and then, despite the latter's strong arguments in opposition, ultimately sided with BCBSM. According to the Commissioner, "he [the Governor] was of the view that Blue Cross should be given the opportunity to undertake its own study." Based on the Governor's position, the Commissioner decided not to award the contract for the management audit.

The Subcommittee has several concerns regarding this episode. First, it underscored the Commissioner's vulnerability to outside interference and weakened his ability to respond to future challenges to his legitimate authority. Second, not only was the Commissioner compromised, but the Legislature's intent in authorizing him to require such audits was also circumvented. Finally, the substitution of BCBSM's study for the State audit negatively affected

[36] In a May 13, 1991 letter to Commissioner Donaho, State Representative Timothy F. Maloney, Chairman of the Budget Subcommittee that was the source of the relevant language in this regard, affirmed that BCBSM was in fact a proper subject of an Insurance Division-sponsored management audit as follows: "John, I'm glad you're going full steam ahead with the management audit and hope you'll keep me posted on its progress. Blue Cross/Blue Shield needs a major overhaul."

the regulatory objectives that had prompted the Commissioner to order the audit in the first place. As the Staff noted:

—there were major differences in approach between the Plan consultant's study and the Commissioner's proposed management audit; e.g., the former was based on a top-down, strategic planning approach that would fail to generate sufficient information on BCBSM's day-to-day operations and management's involvement therein.

—on a number of key issues, such as executive compensation and valuation of subsidiary business, the Plan's study relied on work by other consultants that had been performed for purposes unrelated to those stipulated in the Commissioner's proposed audit.

—there is reason to suspect the objectivity of the Plan's study, since one of the consultants involved has admitted that he has known Carl Sardegna for years and has done numerous other reports for a company where Mr. Sardegna was formerly employed. In addition, while this same consultant claimed that his firm's work in behalf of BCBSM was the result of a competitive bid process, there was no evidence of this and the consultant could not produce any evidence of an actual bid (including price) by his firm.

—to the extent that the usefulness of BCBSM's substitute management review depended upon the timely receipt of a finished product, it is notable that the Commissioner did not receive a copy until nearly a year (July, 1992) after the study was completed in September, 1991. In the intervening period, the Commissioner made at least two requests to obtain the study and only finally received it after testifying before this Subcommittee and after a Committee of the Maryland Legislature determined to hold its own hearing on BCBSM.

The Subcommittee received testimony on other problems encountered by the Insurance Division in its efforts to oversee the Plan's activities. For example, all five of the Commissioners who headed up the Division between 1981 and 1992 confronted problems with the establishment and operation of for-profit subsidiaries. The Acting Commissioner for the period late-1987 to mid-1988 stated that it was only by chance that one of her examiners happened on a BCBSM flowchart that listed a number of subsidiaries about which she had no knowledge. The Acting Commissioner became so frustrated by this situation that she issued an Order on March 30, 1988, which required all non-profit health service plans to provide the Division with 30 days advance written notice of any new transactions, ventures, or acquisitions.

However, even with this 1988 Order in effect, the Plan failed to comply. The Subcommittee reviewed charts which compared organizational information provided by BCBSM in annual financial statements submitted to the Insurance Division, with flowcharts obtained by the Subcommittee pursuant to its subpoena of Plan documents. The information received by the Subcommittee was clearly more detailed than that provided to the Division and, indeed, revealed subsidiary operations that were not listed on the financial statements filed with the regulators. In effect, more than

three years after the Order's issuance, the Division was still in the dark about some BCBSM subsidiary operations—a point underscored by Commissioner Donaho's acknowledgement that it was not until he saw the Subcommittee's charts that he fully realized that there were entities that he had neither heard of nor approved.

Despite the regulators' constant concerns about BCBSM's management and financial problems, their actions display a pattern of hesitancy, reluctance, and even a fear of taking the difficult, but necessary, actions to deal with them. A former Commissioner who, in referring to his concerns upon having received BCBSM's disastrous 1986 year-end results stated, "the last thing we needed was for Blue Cross Blue Shield to go belly up." This type of attitude apparently was the basis for a general reluctance on the regulators' part to take decisive action.

For example, the Commissioner who suspended the 1988 financial examination, even though the preliminary findings had shown BCBSM to be statutorily insolvent by $1.2 million, testified in deposition that:

> * * * I thought that the position of Insurance Commissioner was three-fold. One was to look at the solvency of the insurance companies, one was to protect the consumers, and one was to implement legislation. Sometimes those three things came into conflict, as it did in this case, where solvency and consumers * * * couldn't [be] serve[d] simultaneously.
>
> Secondly, $1.2 million is just not a lot of money in insurance parlance. * * * The bottom line appeared that the financials were turning around and my job was to serve and protect the consumers of the State of Maryland, and how do I best do that. I didn't see that there would be any service to them, shutting down the Blues, so I didn't. It really wasn't a complicated decision.
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> * * * * *
>
> Now, if you think about it, a company whose financials are improving, who within a year or two is going to break even, it doesn't make sense to take them down when, in fact, the situation is turning around, and * * * they were doing what they should have been doing. * * * They were willing to be monitored closely. It would have been foolish to shut them down. You would have shut them down and three weeks later or six months later started them up again, with what? They would have lost a lot of their membership by then. That's not good strategy, either for the consumers or the company.

Finally, in an August 11, 1992 letter to the Governor, Commissioner Donaho explained:

> * * * I think it would be doing our citizens a disservice if, at this time we declared Blue Cross/Blue Shield insolvent and put them into some kind of conservatorship.
>
> As a clear contrast to the ease of replacing both property and casualty and life coverage in the event of insolvency

> * * *, a Blue insolvency would create a significant market shortage, as there would not be health insurance capacity in this State to cover the number of citizens who would be out of insurance. * * * There is not current capacity in this State to insure those people, nor is there guaranty fund capacity.
>
> * * * * *
>
> In addition, the cash flow would severely decrease as the non-risk business would be easily moved elsewhere. * * * It could be expected that many providers would stop accepting a citizen's Blue Cross/Blue Shield cards, as they would not think they would get paid for services. We would see a significant increase in expenses as attorneys, accountants, auditors, actuaries and other consultants would be brought in to look at various aspects of the operation. Considerable Division time and energy would be spent on the issue detracting from our overview of other companies. While this was happening, a continual deterioration of the Blues would take place lessening its value to an outside source who will be willing to take it over. I do not see any positive purpose the above scenario would have for our citizens.

The Division's attitude, as reflected in the statements cited above, suggests that BCBSM has become too large a presence in the State for the regulators to treat it as they would any other domiciled insurer. The prevailing attitude seemed to be that BCBSM was either too big to fail and/or too big to be taken down. This may have unwittingly resulted in the masking or perpetuation of certain Plan weaknesses. For example, the Staff mentioned decisions by several Commissioners to allow favorable consideration of BCBSM financial transactions which, if treated otherwise, could have negatively impacted its overall financial position, including:

—in 1988, BCBSM was allowed to increase the value at which it carried its Joppa Road headquarters on its books from about $6 million to $12 million;

—in 1988, BCBSM was allowed to increase the value at which it carried its Columbia HMO by $23 million;

—in 1989 or 1990, in connection with the resumption of the suspended 1988 financial examination, the regulators recognized as an admitted asset a questionable $5 million receivable from BCBSM's Willse subsidiary. This action, in turn, was one of the primary factors that helped to turn the preliminary examination finding of a $1.2 million deficit into a surplus;

—in 1992, despite their own stated "reservations," the regulators accepted a valuation of $29 million on BCBSM's Carefirst HMO; and,

—in 1992, BCBSM was allowed to carry as admitted assets some $42 million in questionable receivables due from its

subsidiaries and $24.2 million in questionable Pertek subsidiary assets.[37]

4. INADEQUATE OVERSIGHT BY THE BLUE CROSS/BLUE SHIELD ASSOCIATION

The testimony received regarding the BCBS Association's oversight of BCBSM shows a pattern of activity similar to that encountered in the case of the West Virginia Plan. On the one hand, the Association carried out a variety of evaluation and monitoring functions that effectively tracked the Plan's operations and performance. For example, reflecting its serious problems, beginning in 1988, BCBSM was placed on conditional status because of its failure to meet the Association's reserve and liquidity requirements. The Plan remained under this status until 1990, and then, pursuant to a change in the Association's monitoring system, was continued at a new "concern" stage because of its ongoing failure to meet certain financial and marketplace membership requirements. At the time of the Subcommittee's hearing, BCBSM was still being monitored under this new system. Also, the Association determined that BCBSM has been at or near the bottom of all BCBS Plans in claims processing and subscriber service since 1988.

On the other hand, the Association did not share any of its considerable knowledge on BCBSM operations and deficiencies along these lines with the Insurance Commissioner. The Insurance Division needs to have access to all necessary documentation and material to help it make fully informed regulatory decisions. In this sense, the Association was remiss in failing to share the important information it had concerning BCBSM's operations and financial condition, even if the latter's problems were demonstrably less severe than those of the West Virginia Plan.

## D. Effects

As a result of the Plan's problems, BCBSM subscribers were confronted with diminished coverage and/or a denial of promised benefits. Commissioner Donaho testified that in 1991 alone his office received about 1,000 complaints from subscribers, the majority of which concerned inefficient claims handling, delays in payment, or unjustifiable denial of benefits. The Subcommittee Staff examined some of these complaints, focusing on those involving benefits denials, and found that the Plan was, at best, conservative and, at worst, irresponsible in its decisions in this regard.

In addition to problems with coverage and benefits, BCBSM subscribers saw their premiums increase dramatically as a result of the Plan's overall difficulties.[38] Under BCBSM's most popular op-

[37] As a result of these and other exceptions from accepted statutory accounting rules approved by the Commissioner, BCBSM's reported net worth, i.e., the excess of its assets over its liabilities, may have been overstated by as much as $103 million at year-end 1991. Closer scrutiny of these exceptions might have raised questions about their validity and, in turn, BCBSM's true financial condition.

[38] The Subcommittee found that to some extent these rate increases were a result of the Plan's mismanagement and operational problems. For example, according to press reports cited in the Staff's testimony, BCBSM executives admitted that they raised premiums in order to cover the $120 million in losses by their Plan's subsidiaries. Indeed, in one article, BCBSM's chief legal officer confirms the practice of placing the burden of such losses on the subscribers by saying, "the only way you can get it back is through rates. * * * the money has got to come from some-

Continued

tion, the Group Conversion Comprehensive plan, a subscriber with a $250 deductible who paid $3,000 for a policy in 1988, was paying over $5,800 in annual premiums for the same coverage in 1992. In a letter received by the Subcommittee, one subscriber expressed his outrage at such increases:

> "These people are operating as a non-profit insurance company with multi-purpose goals for profit. This is an ideal business arrangement because they can always obtain new capital simply by requesting the Insurance Department of Maryland for an increase in their rates and the money comes rolling from their subscribers. The increases that have been granted for my premium 65 Policy since October 1982 are obscene."

Extensive problems with BCBSM were also described by a primary care physician, who testified on his own behalf and in his capacity as President of the 600-member Maryland Society of Internal Medicine. In his testimony, this physician provided detailed accounts of ways BCBSM made it difficult for providers to receive prompt payment for services and/or placed burdensome and unnecessary administrative requirements on them. Another provider, the Director of a Maryland visiting nurses agency, described "coverage * * * reimbursement and other associated problems" with BCBSM, concluding that "* * * it has reached the point that this whole process makes me reluctant to accept patients for care, once I find out they have Blue Cross and Blue Shield of Maryland."

Finally, the Subcommittee also learned that some providers and subscribers have for years been routinely denied interest owed them as a result of BCBSM's failure to pay claims within State-mandated timeframes.[39] According to a 1991 Market Conduct examination of BCBSM by the Maryland Insurance Division, in numerous instances the Plan did not meet the specified payment timetable and failed to pay interest on claims that were not resolved within the stipulated 30 days.[40] An interoffice memorandum written by the Plan's Corporate Audit Division Director indicates that of $234 million in total claims paid in 1991, almost 25 percent were subject to the interest calculation for having taken over 30 days to process. Since the Plan has been required by law to calculate and pay such interest as of July 1, 1986, the chief market conduct examiner estimated that through December 31, 1991, BCBSM has failed to pay interest on more than one million such claims.

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where." Similarly, in their January 31, 1991 letter to Commissioner Donaho, "A Silent Majority of BCBS Employees" point out that "the management practices of our company have driven rates through the roof. * * *"

[39] Maryland law requires an insurer to acknowledge receipt of a claim within 10 working days, and to make payment on it within 15 working days of receipt of all necessary forms and information. The law also requires a non-profit health service plan to pay interest on the amount of a claim that remains unpaid 30 days after it has been filed.

[40] Previous Market Conduct examinations turned up similar problems in BCBSM's claims processing and customer service. For example, an October 1986 report for the period December 1, 1984 to June 30, 1986 stated that, "the company's claim of processing claims within 15 days is a distortion." According to the examiners, the Plan's practice was to assign several different identification numbers to the same claims thereby masking the true processing time for the claims.

# THE NATIONAL CAPITAL AREA PLAN

## A. BACKGROUND/ORGANIZATION

Group Hospitalization and Medical Services, Incorporated (GHMSI), doing business as Blue Cross and Blue Shield of the National Capital Area (BCBSNCA) was established pursuant to the 1985 merger of Group Hospitalization Inc. and Medical Services of the District of Columbia. This merger was accomplished under the auspices of the U.S. Congress and the new entity retained the exemption from insurance regulation by the District of Columbia that Congress had granted its predecessor in 1939. GHMSI/BCBSNCA serves over one million subscribers in the District of Columbia, Prince Georges and Montgomery Counties in Maryland, and Arlington, Alexandria and part of Fairfax County in Virginia. As of 1991, it had annual revenues in excess of $1.5 billion, employed over 3,300 people, and ranked thirteenth among the BCBS system's 73 Plans in annual premium income.

Like its West Virginia and Maryland counterparts, from the time of its establishment in 1985, GHMSI/BCBSNCA's corporate structure embraced three kinds of operational entities: those involved in underwriting and servicing its core Blue Cross/Blue Shield insurance business; for-profit subsidiaries with some health-related purpose; and, for-profit subsidiaries with no health-related purpose. By December 1992, the company was responsible for the operations of a total of 45 wholly owned and/or majority-owned or controlled subsidiaries. From the time of the 1985 merger until mid-1992, effective control of GHMSI's decision-making apparatus and overall operations rested in the hands of its President and CEO, Joseph P. Gamble.

## B. FINANCIAL PROFILE

For the eight-year period, 1985–1992, GHMSI incurred net losses of about $182 million and its net worth declined drastically from more than $180 million at the end of 1985 to a projected negative $25.1 million as of December 31, 1992. During this period, losses were reported in five of the eight years, as follows: $42 million (1986); $66 million (1987); $58 million (1988); $7 million (1991); and, a projected $38 million for 1992. In the three years where gains were made, either the amounts earned were comparatively small—$2 million and $3 million for 1989 and 1990, respectively—or, in the case of 1985, the $25 million amount reflected the fact that the Plan's newly established subsidiaries had not yet incurred the sizeable and continuous losses they subsequently experienced.

A review of GHMSI financial data also established that:

—the Plan's reserves declined $166 million between year-end 1985 and year-end 1988 and, from 1991 to 1992, according to projections, will decline again by some $57 million (from $32 million to -$25.1 million).

—the Plan's losses between 1985-1991 occurred despite the fact that premium income from its core BCBS business almost doubled (from $808 million to $1.5 billion), while the total number of subscribers covered increased by only 100,000 (from 1.1 million to 1.2 million).

—GHMSI's more than $100 million in cumulative losses from its subsidiary operations have offset operating gains from its BCBS core business; e.g., projected 1992 financial results show the latter's $8.1 million gain being overwhelmed by nearly $50 million in subsidiary losses. Financial data for 1989, 1990, and 1991 show the same pattern of positive core business operating results being offset by subsidiary losses.

## C. Problem Areas

Many of the same key factors associated with the West Virginia Plan's failure and BCBSM's serious financial decline were present in GHMSI and helped to bring it to the brink of financial disaster. Specifically, the Subcommittee found evidence of the four broad problem areas that were identified in connection with the West Virginia and Maryland Plans: mismanagement; inadequate oversight by the Board of Directors; inadequate regulation by the Virginia, Maryland, and District of Columbia Insurance Departments; and, inadequate oversight by the Blue Cross/Blue Shield Association.[41]

### 1. MISMANAGEMENT

#### *a. A Proliferation of Subsidiaries*

A significant part of GHMSI's management problems were a direct result of what one of the latter's former executives referred to as a "frenzy of investments" in a far-flung and highly complex network of for-profit subsidiary operations. Two years before the 1985 merger that established GHMSI, its predecessor, Group Hospitalization Inc., had just two subsidiaries. By 1992, in accordance with a strategic plan instituted by GHMSI's President and CEO, Joseph Gamble, the number of subsidiaries had grown to 45. Over the years, GHMSI has incurred cumulative losses in excess of $100 million from these subsidiaries.

These enormous losses can be attributed largely to extensive mismanagement on the part of GHMSI and subsidiary officials. In a written statement for the record accompanying the testimony of GHMSI's President and CEO, Benjamin Giuliani, the following observations are made:

> In less than five years, GHMSI was transformed from an organization focused on D.C. with a single basic business to one with multiple subsidiaries and business interests around the world. As the result of the critical self-examination in which GHMSI has been engaged for almost a year, it now must be conceded that GHMSI simply did not

[41] GHMSI did not dispute the Subcommittee's findings in this regard. In its prepared remarks, GHMSI testified that "turn-around efforts initiated * * * in early 1992, in combination with the subsequent scrutiny of the Permanent Subcommittee on Investigations, has helped GHMSI to refocus its mission of fulfilling the interests and needs of its subscribers." This testimony goes on to say that:

"The process by which GHMSI has come to chart a new course has been a chastening experience for the enterprise and its trustees, officers and employees. Some of the facts that have come to light have been embarrassing. * * * In this testimony, GHMSI acknowledges responsibility for many of the problems that confront it today. Mistakes unquestionably were made."

> have in place a management structure capable of operating such a far-flung undertaking.
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> * * * * *
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> A number of observations can be made concerning the subsidiaries, particularly those that did not directly complement the core business. Too often, GHMSI embarked upon subsidiary ventures without a comprehensive understanding of the business, a clearly defined business strategy or objective management criteria for measuring whether the subsidiary was meeting its purpose.
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> * * * * *
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> The deficiencies in management were further exacerbated by the absence of adequate management controls.

The Subcommittee found a long list of specific management deficiencies that contributed to the dismal performance of most GHMSI subsidiary and affiliate operations. For example, inadequate analysis was performed before subsidiaries or affiliates were created and, in some cases, limited or no "due diligence" examinations were made before sizeable financial and human resources were committed to their development. In the July, 1987 affiliation with the Blue Cross Plan of Jamaica (BCJ), GHMSI provided BCJ with $5 million in capital without having performed the kind of in-depth, on-site review warranted by an investment of this size. It was not until 1990 that an in-depth audit was conducted, revealing dozens of instances—including some that preceded the 1987 affiliation—of gross mismanagement and questionable legal practices by former and then-current BCJ employees. GHMSI sustained losses of about $4 million from its operations between 1989-1991, and lost $3.5 million of its $6.5 million capital investment.

In addition, after companies had been established, in many cases GHMSI subsidiary and affiliate managers focused almost entirely on efforts to generate revenue—particularly via clients with large numbers of actual or potential enrollees—while paying little, if any, attention to rising overhead, increased liabilities, and mounting losses. Many subsidiaries' poor performance also reflected the fact that they were ventures in which the management had little or no experience. As one executive stated, "they flew by the seat of their pants and utilized the deep pockets of GHMSI to support their exuberant inexperience." GHMSI's record statement bluntly conceded that:

> * * * it is now apparent that Mr. Gamble experienced difficulty in selecting the right people to operate the subsidiary businesses. People often were transferred from a Blue Cross and Blue Shield job to start up one of the subsidiaries or, in a few instances, they were hired from the outside without the requisite business expertise and management skills to operate a new business.

The Subcommittee also found that no matter how poorly run or unprofitable a subsidiary was, its senior executives operated with the attitude that they could always rely on continued funding from GHMSI. A former Vice-President of the National Capital Administrative Services (NCAS) subsidiary, for example, stated that when

he raised questions about company expenditures, its President often responded with words to the effect—"Don't worry, it's the Plan's money." This attitude toward GHMSI's seemingly endless deep-pocket—"rubber money," as the former Vice President referred to it—was well-known within NCAS, according to other former employees. In a number of subsidiary financial statements, the auditors noted that the continued existence of the subsidiary depended on GHMSI's financial backing.

*b. Internal Control Deficiencies*

The testimony also confirmed extensive accounting and internal control problems in GHMSI and its subsidiaries and affiliates. GHMSI's own statement for the record acknowledges that:

> Financial reporting for the subsidiaries was inadequate for an enterprise of GHMSI's size. Particularly in 1990 and 1991, reports to the Board indicating that the subsidiaries had "turned the corner" were later amended at year end to show dramatic losses. The need to improve accountability for variances between actual and projected operating results became clear. The inability to resolve that problem continued to plague the enterprise [i.e., GHMSI], however, until as late as the first quarter of 1992.

The Staff testified to specific accounting and internal control problems in the subsidiaries' operations, including:

—EMTRUST (a joint venture between BCBSNCA and the Fairfax Hospital holding company): management failed to reconcile its corporate and trust accounts on a regular basis, because internal controls were lacking. Among other things, this facilitated the questionable practice of paying one client's claims with funds provided by other clients to cover their insured's claims.

—The International Division: the exact amount of losses incurred by the subsidiaries operating under it was hard to calculate, since the International Division did not keep even the most rudimentary records until five-and-a-half years after it started. The Division's Chief Financial Officer told the Staff that even the most basic financial control function—the tracking of premiums received and claims paid—applicable to its subsidiaries' joint ventures with foreign insurance carriers "was not standardized or well thought out from the beginning." The deficiencies in this regard continue to haunt GHMSI today, since lacking such complete and/or accurate information, no one has been able to determine precisely what has happened to these lines of business and the extent of GHMSI's liability therein.

—NCAS: audits in 1990 and 1991 found overly complicated, confused, and/or wholly deficient accounting systems for billing and calculating actual costs of work performed and services provided. The latter finding became especially problematic when, using inaccurate and faulty data traceable, in part, to this cost accounting deficiency, NCAS filed a claim for hundreds of thousands of dollars in added reimbursement beyond a U.S. Agency for International Development con-

tract's fixed-price stipulations. Also, in response to a written question from the Staff on these problems, NCAS' former Director of Finance and Administration simply said that "there were too many examples of bad accounting to detail."

—PROTOCOL (an entity established to sell health insurance to foreign embassies and businesses in Washington, D.C.): a 1991 GHMSI internal audit revealed serious problems including: lack of written policies and procedures; lack of written contracts; problems with accounts payable and receivable, and journal entries; three different billing systems used for the B'nai B'rith account; and the inability to accurately assess underwriting gains and losses for paid claims. The auditors concluded that Protocol's accounting procedures were not in keeping with GHMSI intercompany practices and did not provide a clear understanding of the company's financial position.

*c. Excessive Salaries and Business Expenses*

The Subcommittee's review of the corporation's salary structure, fringe benefits, and other administrative expenses yielded results much the same as those encountered in the West Virginia and BCBSM Plans. In brief, excessive spending and outright waste were rampant throughout GHMSI, including: excessive salaries and substantial fringe benefits for executives; exorbitant and questionable travel and entertainment expenses; and, unnecessary charitable contributions. These expenses occurred at a time when GHMSI/BCBSNCA subscriber rates were increasing,[42] benefits were decreasing, and the Plan's overall financial condition was deteriorating dramatically.

In the area of executive compensation, President and CEO, Joseph Gamble's total salary and benefits increased by more than 100% between 1987–1991, from $264,487 to $533,589. According to a 1991 BCBS Association survey, Mr. Gamble's salary was greater than 80% of the 60 Plan CEOs that responded, even though GHMSI/BCBSNCA, with only 1.1 million subscribers, was of average size for a BCBS Plan. From 1988–1991, in contrast to the 13% increase other Plan employees received, salaries and benefits for GHMSI's top eight executives (including Gamble) rose nearly 85%. For the most part, these major increases in salaries and benefits were approved at a time when GHMSI was losing millions of dollars annually.

The Subcommittee also received evidence of questionable domestic and international travel by top executives and other GHMSI employees. While reasonable travel and entertainment may be a legitimate cost of doing business, the regular use of first-class or Supersonic air transportation by some of its executives was clearly inappropriate for a not-for-profit entity during a time of financial crisis. Equally disturbing was GHMSI's use of deluxe accommodations, along with allowances for seemingly limitless dining and entertainment expenses. Examples of these types of questionable expenditures include:

[42] From 1988 to 1991, premium rates for a family of non-group subscribers more than doubled, from $194 to $410 per month. During this same period, rates also nearly doubled for a family covered under one of GHMSI's group policies, from $82 to $156 per month.

—over an approximate six-year period (1987-1992), three top GHMSI executives alone incurred a total of more than $1 million for their domestic and international travel. Nearly $450,000 of this amount was for trips by the Plan's President and CEO, Joseph Gamble.[43]

—top GHMSI executives flew first-class routinely and at least four of them used the Supersonic Concorde. In terms of frequency, Mr. Gamble was by far the heaviest user, with at least 22 trips over the years.[44]

—there were numerous instances of unnecessarily expensive hotel or lodging costs. For example, Mr. Gamble stayed at the Grand Barbados Beach Resort in 1990 and 1992, at a charge of $450 per night and, in 1992, a GHMSI/BCBSNCA Vice President spent $635 a night at the Loews Ventana Canyon Resort in Tucson, Arizona.

—GHMSI executives went on business trips in which golf, dining or other leisure activities constituted a larger portion of the trip than business activities. On these trips entertainment and leisure activities, such as tours and golf, were often paid for by the Plan.

—GHMSI also absorbed unnecessarily large expenses in Plan-sponsored marketing incentive trips to reward employees for superior job performance. Such trips, which took place in each of the last six years, were all-expenses-paid and cost the Plan $1,540,749.

—as a fringe benefit to many of its officers, GHMSI paid their initiation fees and partial dues for membership in area golf and other clubs. In some instances, this fringe benefit was taken to extremes, as in the case of the BCBSNCA Vice President who, between 1988 and 1992, submitted $10,573 for golf and golf-related items to the Plan as local business expenses.

Finally, on the matter of charitable activities, while it is difficult to criticize the Plan's good intentions, one questions the appropriateness of a non-profit company making such contributions at a time when it was losing millions of dollars. Indeed, several of the for-profit subsidiaries that were making the most generous contributions had continuously operated in the red and were in severe financial distress. For example, in 1988, the year in which it sustained its most serious financial loss (more than $10 million), CapitalCare (the Plan's Health Maintenance Organization) made $348,000 in charitable contributions. Similarly, while Protocol lost some $4.7 million in 1991, it spent $72,000 for charitable purposes.

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[43] The sheer amount of Mr. Gamble's travel also raises some concerns about the affects of his being away from his office for such extended periods of time. For example, according to Mr. Gamble's date book and expense reports, he traveled extensively for the years 1988 to 1991. In 1991, the year in which his travel began to decline, records indicate that he was away from the home office either on business travel or leave for 160 days (44% of the year). In 1990, he had his most extensive travel year, wherein he was away 202 days (55% of the year). In 1989 and 1988, he was away from the office for 173 and 193 days, respectively.

[44] Based on their review of GHMSI executives' travel records, the Staff determined that when first class or Supersonic travel was used, the difference between their cost and the coach fare was charged to a separate "Corporate Account." The Staff believe that the creation and use of this separate account amounted to a subterfuge by senior GHMSI managers to avoid close scrutiny of the excessive costs associated with the first-class or Supersonic travel. See also related discussion below pp. 52–53.

Overall, between 1988 and 1992, GHMSI and its subsidiaries sponsored events and made charitable contributions amounting to nearly $1.8 million.

2. INADEQUATE OVERSIGHT BY THE BOARD OF TRUSTEES

As in West Virginia and Maryland, GHMSI's Board of Trustees failed to adequately oversee the Plan's operations and management. The Board allowed itself to become an unquestioning and compliant rubberstamp body, effectively controlled by fellow trustee and Plan CEO, Joseph Gamble. The Board's failure along these lines often was a function of the fact that it was being misinformed, misled, and/or manipulated by Mr. Gamble.

The evidence confirmed that the Board was co-opted by the management it was charged with overseeing and was negligent in the performance of its duties.[45] With Mr. Gamble's active encouragement, the Board typically took a very broad policy approach to its job, rarely got involved with the details of the company's business dealings, and tended to accept without question management's projections, explanations, and decisions. For example, Chairman Nunn asked the former Chairman of the Board of Trustees, Charles P. Duvall, about the Board's involvement in reviewing expenditures:

> Senator NUNN. * * * Dr. Duvall, did you know about * * * the expenditures, lavish dinners and corporate sponsorship * * *?
>
> Dr. DUVALL. I didn't know about them at all, Senator.
>
> * * * * *
>
> Senator NUNN. Did the Board have any policy about [these] expenditures at all? Did you give any guidance whatsoever to the executives of the company?
>
> Dr. DUVALL. The Board would have felt [that] this is part of management's prerogative and [the] corporate culture.
>
> Senator NUNN. So, if management wanted to fly first-class all over as a matter of policy, that wasn't a matter for the Board to be concerned with?
>
> Dr. DUVALL. We didn't concern ourselves with it.[46]

The Board's approach and attendant effects are readily apparent in its flawed performance regarding GHMSI's affiliates and subsidiaries. With the Board's approval, between January, 1988 and December, 1992, GHMSI management formed or acquired controlling interests directly or indirectly in 28 subsidiaries and affiliates. However, while the Board approved these actions, it did so without consideration of such basic issues as the funding necessary to reach a break-even point or to achieve profitability.

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[45] Once the Board finally became aware of the Plan's alarming financial condition in February 1992, one of their first actions in response was to seek advice regarding their own liability. Pursuant to the advice they received, their liability insurance was subsequently increased from $15 million to $20 million.

[46] According to some Board members, they were also not always aware of other important expenditures, such as compensation. In the case of Mr. Gamble, for example, they told the Staff that they did not actually know the exact amount of his total compensation, since they typically just voted on a percentage increase each year. It is also worth noting that Mr. Gamble's compensation increases were based on studies done by outside consultants who were hired by and reported to him. Only after Gamble received the results of these reports, was the Board's Compensation Committee informed of the findings.

Indeed, based on remarks by Dr. Duvall, it appears that until early 1992, the Board was content to merely accept management's continual assurances that even though losses had been sustained, profits were always just around the corner. Regarding the subsidiaries, the Board failed to assure that management had: established adequate internal controls to monitor and administer their operations; obtained credible actuarial data prior to conducting business in foreign countries; and hired experienced personnel to operate certain ventures.

In January 1985, at Mr. Gamble's suggestion, the Board voted to compensate itself. One trustee who refused this compensation said that he felt it was wrong for a non-profit corporation to pay its Board, because the Board then "gets too close" to management. This same trustee observed that after the Board members started to receive this compensation, over time they stopped acting as individuals and became Gamble's "yes men."

Some of the Board's problems were a result of misinformation from and/or manipulation by Mr. Gamble. According to Dr. Duvall, Mr. Gamble would usually brief the trustees on an idea and then insist on a vote that same night. As a result, another former member complained, the Board never had any time to think things over. Dr. Duvall also said Gamble periodically asked him to show up a few minutes in advance of a scheduled meeting to review the Corporate Account. Under these circumstances, there was no time for him to examine the supporting documentation, and thus he just reviewed the summaries and approved them.

Mr. Gamble often failed to provide complete information to the Board. Although Dr. Duvall said that he saw documentation on the proposed affiliation with Blue Cross of Jamaica (BCJ), other former trustees said that there were no figures or documentation presented at the meeting where it was approved. One former trustee remarked that all he remembered about this venture was Gamble saying that "the possibilities (in Jamaica) are endless." In many cases, Gamble had already established a subsidiary or was well on his way to purchasing it before the Board was aware or could protest. Likewise, Dr. Duvall noted that when subsidiary operations were discussed, Mr. Gamble usually focused on the "big picture" rather than the finances involved.

Finally, Dr. Duvall did not become aware that GHMSI was being monitored by the BCBS Association until Mr. Gamble's successor informed him in the Spring of 1992. In fact, Dr. Duvall expressed considerable surprise when he learned from the Staff that the Association had been monitoring the Plan since 1988.

In other situations, Mr. Gamble deliberately misled the Board. For example, Gamble told Board members that the Plan withdrew from the Medicare Part A contract because it was "not profitable." In fact, the Plan had tried very hard to keep this Federal contract, but had been removed against its wishes for poor performance. As late as May 6, 1990, some three years after the loss of this contract, Gamble was still telling the Board that the Plan "got out of the Medicare business in an attempt to save money."

Gamble also apparently failed to inform the Board of the nature of the Plan's Corporate Account:

Senator NUNN. Did you know about this corporate account where the Concorde charges and other charges * * * were basically accounted for * * *?

Dr. DUVALL. I knew very little as to the exact nature of the account. * * * I had no idea, Mr. Chairman, that there was any Concorde in there once. That did not come to my attention.

### 3. INADEQUATE REGULATION BY DISTRICT OF COLUMBIA, MARYLAND, AND VIRGINIA INSURANCE AUTHORITIES

With one notable addition—the adverse affects resulting from GHMSI's unique status of being exempt from regulation by District of Columbia insurance authorities [47]—the regulatory difficulties regarding GHMSI are much the same as those described in connection with the West Virginia and Maryland Plans. Specifically, GHMSI was adept at evading and staving off appropriate regulatory efforts directed at it, and the insurance authorities with jurisdiction—i.e., Maryland and Virginia—were unable and/or unwilling to adequately oversee its operations.

As a result of its Federal exemption from regulation by the District of Columbia, GHMSI was subject to a patchwork system of State regulation that was inherently inadequate. Essentially, pursuant to their authority to license insurers, Maryland and Virginia regulators have applied their rules to that portion of GHMSI's business underwritten within their respective States.

Generally, reliance for the primary oversight of an insurance carrier rests with the authorities in the company's "State of domicile." However, this was not the case with GHMSI, as indicated in the testimony of the District of Columbia's Superintendent of Insurance, Robert M. Willis, at the Subcommittee's July 2, 1992 hearing:

Superintendent WILLIS. * * * If we can imagine that a raft is floating down a river and on the shoreline stands the Commissioner * * * from the State of Maryland, who has a gaff hook and has the ability to snag the raft before it goes over Niagara Falls. That is the nexus that he has through licensing the Blues relative to the Maryland situation.

The District of Columbia is situated beyond the edge of the fall, in fact, at the bottom of the fall, and can only report the result of the raft having gone over the falls. * * * By law, I have the statutory duty to tell the Corporation Counsel that I believe that GHMSI—and I am not saying that is the case, but were that the case—has reached the point where the financial condition of the company is impaired. So I am simply in a role of having to report what has happened, that an insolvency has, in fact, occurred. * * *

[47] It was not until September, 1992, as a direct result of testimony presented to the Subcommittee by the District of Columbia's Superintendent of Insurance, that Congress acted to amend GHMSI's charter to provide such regulatory authority. The legislation was signed into law on October 5, 1992 and, since then, the D.C. Insurance Department has been developing the necessary policies and procedures to implement it.

As a result of this situation, GHMSI has adeptly played Maryland, Virginia, and D.C. insurance regulators against one another.[48] For example, Superintendent Willis observed:

> A recent example is the treatment of GHMSI investments by Virginia in its examination process. Under the Virginia laws certain investments are not permitted, but may arguably be permitted under District investment laws. GHMSI has taken the position that District laws apply, irrespective of the language in the Charter stating that GHMSI shall not be subject to District statutes regulating the business of insurance.

In his testimony, the Virginia Insurance Commissioner, Steven Foster, added:

* * * there have been problems in the past trying to understand the extent to which GHMSI was or was not subject to the District's insurance laws. GHMSI would hire outside counsel and would make those kind of assertions

Neither Virginia nor Maryland authorities undertook strong regulatory action against the Plan until late 1992. In the intervening years (1987–1991), GHMSI lost nearly $120 million. A 1988 joint Maryland/Virginia quadrennial examination of GHMSI for the period 1984–1987 (the last two years of which saw losses of nearly $110 million), called for just minor adjustments to the Plan's reported financial statement. For example, the Plan was not permitted to claim as an asset the $5 million investment in Blue Cross of Jamaica, and $1.5 million in uncollected premiums that could not be substantiated was disallowed.

GHMSI's relationship with State insurance authorities was characterized by its ability to evade efforts to oversee its operations. Virginia's Insurance Commissioner testified that:

> Commissioner FOSTER. * * * I have never had a company more difficult than GHMSI in trying to get straight factual data regarding the financial condition of that * * * company.
>
> Senator NUNN. In other words, they have been the worst?
>
> Commissioner FOSTER. No question. In fact, I have never told any other CEO that I would not meet with that company's CFO [Chief Financial Officer] and general counsel. I told that to this CEO [Mr. Gamble].
>
> Senator NUNN. When was that?
>
> Commissioner FOSTER. About three years ago. * * * In the end, Mr. Gamble himself finally came to my office to see if he could help straighten things out a little bit, because his lieutenants, prior to that, just simply were not dealing with us in a straightforward manner.

[48] According to Superintendent Willis, three separate solvency standards are applicable to GHMSI: the District of Columbia requires life and health companies to maintain a surplus of $1.5 million; Maryland requires a minimum of $75,000 surplus or a maximum reserve equal to two months of claims and operating expenses; and, Virginia requires a minimum contingency reserve for up to 45 days of anticipated operating and incurred claims expenses.

A former Maryland Acting Insurance Commissioner said that she faced continual problems with GHMSI, the most serious being they would never tell her the full truth about their activities in her State. She eventually issued an order requiring GHMSI to cease subscribing operations in Maryland unless it obtained prior written approval from her office. A former D.C. Insurance Superintendent observed that any time she asked for even the most basic information from the Plan, her requests were "politely ignored."

GHMSI also used existing requirements to undermine regulatory efforts. In one case, GHMSI dramatically increased its 1988 year-end reserves from $8.2 million to more than $103 million by the end of 1989, because of a loophole in the Virginia Insurance statute. This loophole, which allowed the Plan to carry its headquarters at market value, rather than at cost, enabled the company to list the building at $80 million more than the value it had reported just a few months earlier. Although the law was eventually changed to close this loophole, prior valuations conducted pursuant to it were unaffected, and thus the Plan continues to carry its headquarters—a highly illiquid asset—at market value. The higher valuation also effectively masked critical reserve problems:

> Senator ROTH. But it was that reevaluation of the value of the [headquarters] building that really postponed the day of reckoning?
>
> Commissioner FOSTER. No question. * * * it is no question, Senator, [that] their being able to admit the full market value of the building is what kept them * * * back in 1988, arguably, [from] being under * * * [Virginia's minimum] 45-day [reserve] requirement.

*4. Inadequate Oversight by the Blue Cross/Blue Shield Association*

The BCBS Association's dealings with GHMSI suggest problems almost identical to those described concerning the West Virginia and Maryland Plans. Regarding GHMSI, the Association did not:

—obtain the financial information needed to enable it to effectively monitor the Plan after it had been placed on "conditional" membership status;
—determine the financial condition of GHMSI's subsidiaries and its attendant impact on the Plan as a whole;
—enforce its internal standards regarding GHMSI's conduct and operations; and,
—share information with regulators and GHMSI's Board of Trustees.

The Association's failure to obtain adequate information partly reflected GHMSI's negative approach to Association requests. A member of the Association's Business Performance Review office—the entity responsible for plan monitoring—stated that three words best described GHMSI management's behavior in this respect: "uncooperative, difficult, and non-disclosure." This attitude began with GHMSI's merger-based establishment in 1985, in contrast to the positive relationship that had existed with its predecessors.

Prompted by concerns about GHMSI's financial condition, the Association in 1988 renewed the Plan's membership on a conditional basis. GHMSI's continuing financial problems necessitated this on-

going Association scrutiny through the Fall of 1992. According to Association officials, their monitoring efforts met with incomplete and/or misleading information, repeated requests for extensions, and postponements of scheduled site visits.

In January, 1992, the Association developed a "specific monitoring program" for GHMSI, which was more intensive than the normal process and included on-site visits. However, Association staff were still denied access to subsidiary managers and the information available on their activities, as one Association representative put it, was nothing more than "what they thought everyone wanted to see." Disclosure improved after Mr. Gamble's successor, Mr. Giuliani, took control of GHMSI's daily operations in July, 1992. Even so, a representative of the Association's monitoring team was not able to obtain a full understanding of the extent of GHMSI's subsidiary activity until December, 1992.

Despite the Plan's prolonged obstructionist behavior, the Association was unwilling and/or unable to force more thorough compliance. The Association only began to move toward action in the Fall of 1992, more than four years after it had first learned of GHMSI's serious financial problems. The Association's actions in late 1992, moreover, were not entirely self-generated, but rather were in part a response to the fact that the Virginia Insurance Bureau had initiated its joint quadrennial examination of GHMSI. As GHMSI's Board Chairman, Peter O'Malley, stated:

> The National Association is acting under pressure of the regulatory environment we are in and wants to be in a position of moving against GHMSI, if required, before the Virginia Commissioner does.

Lastly, the Association failed to adequately inform the concerned insurance regulators and the GHMSI Board of Trustees about the Plan's continuing problems. During the hearings, the Virginia Insurance Commissioner emphatically addressed this point:

> Senator NUNN. The National Association has a unique relationship with the 73 Blue Cross/Blue Shield Plans that it franchises, but I am told they do not keep the insurance commissioners informed of the restrictions they place on any kind of troubled Plans. Is that your understanding?
>
> Commissioner FOSTER. * * * I have never been informed of such restrictions. * * *
>
> Senator NUNN. Does the NAIC [National Association of Insurance Commissioners] have any kind of position on that? Are you advocating or are you requesting that the National Association begin to be more cooperative with * * * [the NAIC]?
>
> Commissioner FOSTER. Yes, sir. One of the charges that we are suggesting be given to our [Executive] Committee * * * is to look at the appropriate oversight role of the National Blue Cross/Blue Shield Association.

Similar views were expressed by GHMSI's former Board Chairman:

> Senator NUNN. What do you mean by that, if somebody had picked up the phone?

Dr. DUVALL. If I had heard about many of the things we have discussed in the course of this hearing, some segment of it from a credible witness our source, I think things would have turned out differently. * * *

I think if the Board could have seen how other Plans ranked through the Association, they might have known earlier what I learned later—that we stick way out like a sore thumb in terms of liquidity. We are not even close, and we are scrambling to make that benchmark.

## THE EMPIRE PLAN

### A. BACKGROUND/ORGANIZATION

As of June 1993, with more than 8.2 million subscribers, Empire Blue Cross and Blue Shield was the Nation's largest not-for-profit health insurer and largest of the Blue Cross/Blue Shield system's Plans. In 1992, Empire collected about $6.6 billion in premiums from its policyholders and paid out some $6.3 billion in claims. In that same year, it employed more than 10,000 people and had an annual payroll exceeding $300 million.

Reflecting its longstanding corporate mission—to provide affordable health insurance to as large a segment of the population as possible—Empire's organizational structure consists almost entirely of operational entities involved in underwriting and servicing its core Blue Cross/Blue Shield insurance business. Empire has historically relied on two key operational concepts: open enrollment and community rating. Under open enrollment, all who desire insurance are afforded access to it, regardless of their age, sex, health status, or where they live and/or work. Community rating denotes the outcome of the process whereby an average premium rate is determined for purchasers of insurance through open enrollment. The average premium, which is the same for all subscribers, is derived by placing the latter in "risk pools" and using their total, aggregated health care costs as the basis for calculating the rate.

In his roles as Chief Executive Officer and Chairman of the Board of Directors, Albert A. Cardone effectively controlled Empire's management and operations from April, 1987 until his resignation in May, 1993. Prior to coming to Empire as the Plan's Deputy Chairman in July, 1985, Mr. Cardone was a partner at the public accounting firm, Deloitte, Haskins and Sells and held the position of National Industry Director for the firm's national health care practice.

### B. FINANCIAL PROFILE

The Subcommittee found Empire's financial condition to be precarious, at best. Between 1986 and 1992, the Plan incurred underwriting losses of $617 million, more than two-thirds ($444 million) of which came in 1991 and 1992. Reflecting offsets of $421 million from investment income and smaller amounts from other sources, total operational losses for this same period amounted to $210 million. As a result of these losses, the Plan has had to rely on extraordinary measures to stay in business, including: rate increases of up to 20%; the receipt of $93.5 million in a March, 1993 settle-

ment of a lawsuit against the New York State Medical Malpractice Fund; and, the release of a reserve by New York State insurance regulators in August, 1992 that contributed $80 million to the Plan's surplus.

Empire's reserves also decreased dramatically in recent years. In 1991 and 1992, its reserves declined steeply from $295 million at December 31, 1990 to $40 million at December 31, 1992.[49] This $40 million reserve figure was $485 million below the statutory requirement prescribed by New York State. Indeed, from 1991 through April, 1993, the Plan has been consistently below 50% of the State's minimum statutory reserve requirement.

The $40 million Empire had on hand in 1992 to protect its more than 8 million subscribers, was less than that required for the far smaller District of Columbia Plan (GHMSI) and its 1.1 million subscribers. While GHMSI's reserves amounted to $49.64 per policyholder, the comparable figure for Empire policyholders was just $4.84. Even though Empire is the largest of the Blue Cross/Blue Shield Plans, its reserves at the end of 1992 were higher than only 14 other Plans.

In both 1992 and 1993, Empire's external auditors were sufficiently concerned about the Plan's ability to stay in business to seek assurances from State Insurance Department officials that there would be no regulatory takeover of the Plan. In 1992, four days after receiving these assurances, the auditors issued an unqualified opinion on the Plan's financial statements. In 1993, the auditors again refrained from issuing a going concern qualification, only after Insurance Department officials expressly indicated they did not intend to take control of the Plan and affirmed their practice of granting the Plan "substantially all" requested rate increases.

## C. Problem Areas

With the notable exception of subsidiary-inspired difficulties, the testimony regarding Empire established the same serious problem areas experienced by the West Virginia, Maryland, and District of Columbia Plans: mismanagement; inadequate oversight by the Board of Directors; inadequate regulation by the State Insurance Department; and, inadequate oversight by the Blue Cross/Blue Shield Association.[50]

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[49] Had it not been for the ruling by the New York Insurance Department in August, 1992 to release $80 million in supplemental reserves for hospital reimbursement, Empire's reserves would have fallen below zero.

[50] Some witnesses, such as Empire's former and acting CEOs and the Superintendent of Insurance, testified that the Plan's problems were largely, if not entirely, the result of outside factors beyond its control. This testimony emphasized the adverse effects of selective underwriting ("cherry-picking") and "dumping" of poor risks by competitor commercial carriers, intensified competition for large-group business, and the high cost of health care in downstate New York and New York City. While the Subcommittee acknowledges that these factors may have played a role in Empire's difficulties, the overwhelming evidence accumulated regarding this Plan and those of the other three Plans examined, shows a clear and strikingly similar pattern of problems that helped bring them to the state in which our investigation found them.

1. MISMANAGEMENT

*a. Misrepresentation of Loss/Gain Figures*

The Subcommittee examined the role of Empire's CEO, Albert Cardone, and CFO, Jerry Weissman, in knowingly providing State insurance regulators with information on underwriting gains/losses that misrepresented the Plan's performance in its Community-Rated and Experience-Rated market segments. This information was contained in statutorily required Interim and/or Annual Statements filed by Empire with the State Insurance Department for the years 1989-1992.[51] In each of these years, the periodic filings contained loss figures that differed significantly from that which was discovered on the same subject in other contemporaneous Plan financial records known as the "Black Books."[52] While it is not clear why the figures were altered, the changes made were to Empire's benefit.[53]

Two former Empire employees—a Vice President/Executive Assistant to the CEO, and her associate, a Director in the CEO's Office—provided pointed testimony in this regard. The former Executive Assistant explained that her associate brought these discrepancies to her attention on February 3, 1992 and that she confronted the CFO, Mr. Weissman, about it. Mr. Weissman, she said, explained that the Black Book figures were for internal purposes and the other set of figures, which had been developed by the Plan's actuarial department, were for external purposes. Mr. Weissman also told her that "the Black Book figures were right and that the other figures were 'more politically acceptable.'" He added that the latter, which she said he referred to as the "manipulated" figures, were the ones that were used in the Annual Statement filings and that Mr. Cardone was aware of this. The former Executive Assistant testified that she was very disturbed by these responses and expressed her concern accordingly, whereupon Mr. Weissman told her to talk to Mr. Cardone about it.

As a result, the next day she and her associate met with Mr. Cardone, who appeared to be surprised about this situation and said that he did not know anything about it. At one point, responding to the former Executive Assistant's observation that the Black Book figures were always relied upon as being accurate, Cardone said that:

> * * * nobody knows what figures are right. * * * I can't rely on any numbers coming out of [the] actuarial [depart-

[51] The Interim and Annual Statements are commonly referred to as the "Blanks" or "Statutory Blanks." At Empire, the Actuarial Department is responsible for preparing the sections of the Annual Statements pertaining to this discussion.

[52] The Black Book is an internal management report prepared by Empire's Accounting and Financial Reporting Department. It consists of a number of individual reports, many of which are generated monthly by the Plan's budget, accounting, and actuarial departments. The latter are based on primary source records and cover key areas of underwriting activity, including premiums earned, claims incurred, and expenses. The Black Book derives its name from the color of the binders into which the various reports are placed, and is neither a secret document nor part of a so-called "separate set of books" designed to conceal Plan financial problems.

[53] The Subcommittee staff expressed the belief that Empire was shifting results from its experience-rated accounts to its community-rated accounts to avoid casting the Plan in an unfavorable light and to support a bill then pending before the Legislature. This bill, which was subsequently passed in July, 1992, was designed to spread the higher risk and associated costs incurred from community-rated accounts among other insurers and health maintenance organizations operating in New York State. Another possibility was that overstating community-rated losses could be valuable in the event that the Plan wanted to obtain a rate increase.

ment]. They're jelly. Neither you nor I know which figures are accurate.

The two former employees added that to the best of their knowledge nothing was done to address their concerns about the discrepancies and, most particularly, the very serious questions they posed regarding the accuracy of the figures used in the Annual Statements for 1989 and 1990. Within a matter of weeks of having brought this matter to Cardone's attention, they were removed from their positions and placed in sales-related jobs in another building. Both witnesses noted that nothing in their experience qualified them for these new jobs. The Executive Assistant testified that after the February 5, 1992 meeting Cardone excluded her from meetings to which she had previously been invited and, in general, treated her "coldly." [54]

Empire's Vice President in charge of the Audit Division testified that when she asked Mr. Weissman and his staff about the discrepancies, she was "stonewalled" for a couple of weeks by being given explanations that did not bear up under further scrutiny. However, as noted in an affidavit she provided to the Subcommittee, she ultimately had a conversation with Mr. Weissman on June 16, 1993 in which he stated that "there were no supportable reasons for these differences in 1991 and that Mr. Cardone had told him to change the figures in the annual statement for 1991 to show a lower level of losses in the experience-rated market segment." When asked about this statement, Weissman disagreed, saying that it "mischaracterized" what he had said.

There was also conflicting testimony regarding CEO Cardone's role in this matter. For example, while the Audit Division Vice President's affidavit states that Weissman had changed the figures in the Annual Statements for 1991 at Mr. Cardone's direction, when asked at the hearing, both Cardone and Weissman denied that Cardone had ordered the changes. Mr. Weissman, however, did testify that he had discussed the situation with Cardone and had changed his initial figures as a direct result of that discussion:

Senator NUNN. In your [Subcommittee] staff deposition, * * * you stated, 'I think I was upset that he [Cardone] had questioned my numbers. That really had not happened the 2½ years since I became CFO. I felt extreme pressure that I better make sure that our numbers are right. I don't know how you could do that when you are dealing with some fairly sizable projections, but you know he was a tough guy and this was the way he dealt with us. I went back and took a look at the reserves, and my recollection is that whatever adjustments that I had recommended initially between the internal accounting report [Black Books] and the statutory report [Annual Statement], that I increased the adjustment between the experience and the community-rated business.' Is that correct?

Mr. WEISSMAN. Yes, sir.

Senator NUNN. Do you stand by that statement?

[54] Shortly after moving to her new position, the former Executive Assistant left Empire to assume the position of Executive Vice President and Chief Operating Officer at another insurance company, and six months later, her associate likewise left the company voluntarily.

Mr. WEISSMAN: Yes, sir, I do.[55]

The discrepancies and the conflicting testimony regarding them go to the heart of perhaps the key question that surfaced in the Subcommittee's investigation of Empire—the credibility of the Plan's management. Indeed, the contradictions in the testimony presented lead to the unavoidable conclusion that someone in Empire's top management was either lying or mistaken in their statements to the Subcommittee.[56]

In addition, subsequent to the Subcommittee's hearings, the question of the discrepancies and their relationship to the Interim and Annual Statements filed for 1989–1992 was examined by a Special Counsel, former United States Attorney Otto G. Obermaier. This investigation's findings, which were set forth in a report issued on September 21, 1993,[57] confirmed the existence of $83 million in discrepancies between the figures listed in the Annual Statements and those contained in the Black Books for the four-year period examined. Of this $83 million, the report states, "no contemporaneous documentation or explanation could be found or may not have existed" for $63 million of it.[58] The effect of this $63 million in unexplained discrepancies, the report continues, was to overstate the Plan's losses in its Community-Rated market segment and understate its losses in its Experience-Rated business. In light of these findings, the Special Counsel recommended that Empire file amended Annual Statements for the years 1989–1992, eliminating the "unexplained adjustments" and making certain other related corrections.

*b. Internal Control/Information Systems Deficiencies*

As with the West Virginia, Maryland, and District of Columbia Plans, the Subcommittee found that inadequate internal control procedures were a serious problem at Empire. Internal control problems, coupled with major information system difficulties, made Empire highly vulnerable to both internal and external fraud and, in turn, helped bring about higher overall premiums for subscribers and some of the dramatic losses incurred by the Plan over the last few years.

The Subcommittee reviewed 100 Internal Audit Reports performed by Plan auditors between 1987 and 1992. These reports revealed extensive system access and security problems involving the claims, purchasing, and other key corporate databases, including:

—purchasing system data files are subject to unauthorized and excessive access;

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[55] In his deposition with the Subcommittee staff Weissman stated that he did not think the new numbers were his best judgment because, in his own words, "I think I went into Cardone with my best judgment early on, and he told me: you'd better take another look at it." Similarly, when he was later asked if he thought his original numbers were more accurate than the new numbers, Weissman answered, "Obviously I thought they were more accurate. That was the basis on which I went in to Cardone in the first place."

[56] On October 18, 1994 Jerry Weissman was indicted by a grand jury sitting in the Southern District of New York on three counts of perjury in testimony given before the Subcommittee and one count of obstructing the Subcommittee's investigation of Empire.

[57] *Report of Special Counsel to the Audit Committee of the Board of Directors of Empire Blue Cross and Blue Shield.*

[58] Several Empire employees told the Special Counsel that in 1993 Mr. Weissman instructed them to destroy documents pertaining to the differences between the Black Books and the company's periodic filings.

—Plan employees can make unauthorized claims submissions or changes;
—computer IDs were found for a terminated employee and in the name of another unknown individual; and
—system files were not protected by security software and inappropriate staff were authorized to modify files.

In almost 50 percent of the Internal Audits examined by the Staff, the problems found in the earlier audits were cited more than once. The Audit Reports often contained remarks indicating that management had failed to take action in response to their findings and recommendations; e.g., "of the eight issues originally reported to senior management, none have been fully addressed" and "these problems were identified two years ago and were discussed with management * * * [but] corrective action was not taken. * * *"

Empire's information systems problems are long-lived and deep-seated, and to a large extent are a result of the numerous mergers of separate Blues Plans that ultimately led to Empire's establishment in 1985. This situation did not improve very much over the years, even after intensive efforts were undertaken in the late 1980s to eliminate the duplication and develop one or more interoperable systems. A recent management audit described Empire's current systems environment as still consisting of a number of disparate systems, many of which were built 15 to 20 years ago with now outdated technologies.[59].

The adverse effects of these combined internal control and information systems problems were most obvious in two areas: the use of so-called "dummy codes" to pay providers for services rendered to Plan subscribers; and, the failure to monitor the membership of its community-rated small group clients to ensure that claims were being paid for valid subscribers.

*Dummy Codes*

For years Empire has been routinely paying claims to doctors, dentists, pharmacies, hospitals and durable medical goods providers without verifying their status as valid Plan participants. In response to serious claims processing backlogs and delays caused by absent provider identification information, Empire managers authorized the use of dummy codes, i.e., data entries that allowed its computers to process claims without this essential information.[60]

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[59] The Subcommittee staff's Statement details several examples of Empire's information systems problems, including: the Sigma Imaging System—a costly and yet-to-be-completed project to reduce claims processing costs; CS–90—a system, scheduled for completion in 1995 (at a projected cost of as much as $50 million), that will attempt to eliminate the redundant, non-integrated systems inherited from the various pre-Empire mergers; and, the InterPlan Data Reporting System—the Blue Cross/Blue Shield Association's "national" claims payment system, established to facilitate reimbursement for claims paid by one Plan for another Plan's policyholder.

[60] When an Empire subscriber submits a claim, the information is eventually entered into a computer, where it goes through a number of edit checks. These checks determine if the person submitting the claim is a valid subscriber, that the procedure is proper, and that the provider is an approved one. If any of these checks fail to meet Plan specifications, the computer is programmed to stop processing the claim. When this occurs, an Empire employee must manually continue the procedure.

In the case of the provider, if that person or firm is listed in the database, the system will automatically enter the appropriate identification number on the claim and continue on. If the provider is not listed in the database, a Plan employee must provide the number or use a dummy identification number in order for the claims process to proceed.

The use of dummy codes made it difficult to verify that a service had been performed or provided by a licensed and credentialed physician, making the Plan exceedingly vulnerable to claims processing errors and fraud. In a September 26, 1991 internal audit report, Empire's Vice President of Auditing concluded that:

> The potential for fraud and abuse and operational errors, including duplicate claim payments, exists because of the failure to restrict the assignment of dummy codes to process claims from out-of-area physicians, pharmacies, durable medical equipment vendors, and registered private nurses. The use of dummy codes limits management's ability to track utilization trends and to detect fraudulent practices.[61]

In an April, 1993 interview, Acting Empire CEO, Donald Morchower, told the Subcommittee staff that in 1990 alone dummy code payments to non-credentialed physicians had amounted to some $219 million. Plan estimates indicate that for 1991 and 1992, the total amount of dummy code-based payments was $723 million.[62] Empire's Director of Program Security during the period 1987–1993 testified that he had been deeply concerned about the potential for fraud from the use of dummy codes ever since his arrival at Empire. He cited a case wherein a Plan employee defrauded the company out of tens of thousands of dollars by entering dummy codes for a fictitious provider and a fictitious patient.

*Community-Rated Small Groups*

Until recently Empire did not audit its small, community-rated groups and as a result knew little about them.[63] For instance, Empire management did not know their claims ratio (the difference between premiums collected and claims paid), whether they were meeting Plan underwriting standards, or if the groups actually existed.

Prompted by reports of a major fraudulent scheme perpetrated by some of these small groups,[64] in July, 1991 Plan officials di-

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[61] The audit report also concluded, more broadly, that the Plan's system of internal controls was inadequate to ensure an accurate, complete, and valid physician database. Among the concerns cited in this regard were failures to: establish minimum credentialing criteria; validate physicians' credentials against independent sources (e.g., the American Medical Association); and, purge the Provider File (last done in 1984). Despite Empire officials' claims to the contrary, the Subcommittee is informed that there may be electronic data systems available that can address these internal control issues in a timely and cost-effective manner.

[62] In the April, 1993 interview, Mr. Morchower also said that, as of that time Empire officials had found 8,000 physicians who had received payment for services that could not be verified. He further indicated that they would have an approximation of the improper payments in this regard within a few weeks, but despite repeated requests from the Subcommittee staff, such figures were never provided.

[63] The reason for this, according to CFO, Jerry Weissman, lay in the nature of community-rated business, wherein Empire had to provide coverage for individuals and groups regardless of their health status. The Plan never concerned itself with a particular group's gains or losses, since it was assumed that any losses incurred could be recovered through premium increases applicable to the community-rated pool as a whole.

[64] This case—known as the Finkelstein case, after one of the alleged perpetrators—involves a long-lived scheme, in which, among other things, foreigners were brought to the U.S. to receive treatment whose costs were covered by Empire. One Empire official estimated the total amount of the suspected fraud from the scheme at nearly $29 million—by far, the biggest fraud in the Plan's history. Law enforcement officials have only recently initiated a criminal investigation of this case, even though both the Plan and the New York Insurance Department were alerted about it in 1986.

Continued

rected that a special task force be established to examine the implications this scheme might have for other community-rated small groups. Initially, the task force visited nearly 500 such groups with high dollar losses, and found that more than 60% of them had some sort of significant problem; e.g., non-existent members, a failure to meet underwriting standards, or being fictitious entities.

These initial findings prompted a larger and more intensive review, the results of which were summarized in a 1992 Year-End Status Report[65] The Report notes that audits conducted on just over 2,000 of the Plan's 60,000 small groups resulted in the cancellation of 377 of them. The latter were cancelled, according to the Report, either because they failed to meet the Plan's underwriting requirements, denied the auditors access to their files and records, or could not be found. These 377 cancelled groups accounted for $25 million in losses to the Plan for the years 1990–1991.[66]

*c. Questionable/Poor Underwriting Practices*

As in the West Virginia, Maryland, and District of Columbia Plans, the Subcommittee found that substantial mismanagement had occurred in Empire's underwriting practices. An internal management review, which was performed during the early part of 1993, found that managers did not know the true administrative and operational costs of many of the products being marketed by the Plan. The review revealed that cost information was not consistently used in the sales/marketing decision process, either because the actual cost was unknown or such information was not communicated to the right persons. Cost allocations often did not accurately reflect the true expense of a product, thereby constraining Empire's ability to tailor its prices in order to either make a profit and/or meet a customer's specific service requirements.

According to some Plan officials, such poor underwriting practices caused Empire to become involved in unprofitable contracts and/or lines of business. For example, in an interview with consultants, then Chief Operating Officer, Donald Morchower, stated that Empire had decided to "buy Merrill Lynch business" with low retention rates for the first three years—admittedly losing money on the contract for that period—in hopes of being able to recoup the losses by raising premiums in the fourth year. The Plan's CFO, Jerry Weissman, told the consultants that no one could deny that Empire had made "bad deals" like the Merrill Lynch contract. Indeed, in the area of "National Accounts,"[67] since 1988 the Plan has

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The Subcommittee staff also found that after being briefed by Plan officials on this matter in 1991, U.S. Postal authorities expressed interest in undertaking a criminal investigation regarding it. However, Plan officials never pursued this option, instead deciding to proceed against the alleged perpetrators in a civil action. While the Plan initially sought $22.5 million in damages in this suit, it recently agreed to a settlement of just $250,000.

[65] Before the task force embarked on this second audit, any small group that had membership problems was given a month-long amnesty to admit their problems, in return for which the Plan would attempt to help them convert their coverage. This amnesty resulted in the cancellation of 1,229 groups, with some 19,000 subscribers.

[66] In 1993, the task force's institutional successor, the Group Integrity Department, scheduled audits for 1,603 small groups, which, in the previous year, had lost more than $115 million in 1992. At the time of the Subcommittee's hearings, 876 (55%) of the groups had been audited, resulting in the cancellation of 201 (23%) of them. Losses attributable to these 201 cancelled groups are estimated at $14.5 million.

[67] National Accounts are primarily large companies, like Merrill Lynch, headquartered in New York City, for whom Empire controls and services employee health benefit claims on a nationwide basis.

lost contracts with 78 firms and other organizations, representing 350,000 employees.

*d. Excessive Salaries and Business Expenses*

In the case of Empire, the Subcommittee also found extravagant salaries, fringe benefits, and other administrative expenses incurred at a time of increased premiums, reduced benefits, and serious financial losses. For example, compensation for Empire's top 10 executives rose 56% between 1987-1992, while in the same timespan, the Plan was sustaining $617 million in underwriting losses and $210 million in overall operating losses. CEO Cardone's salary rose from $325,000 in July, 1985 to $600,000 in 1992, and between 1990 and 1992—when the Plan lost some $217 million—total compensation for the Chief Operating Officer, Donald Morchower, increased from $363,527 to $427,141.

In comparison to executive incentive programs operated by other large New York City firms, Empire's was exceedingly generous, especially in view of the Plan's serious financial problems at the time. When informed that some senior Empire executives had received average incentive payments ranging from 11 to 13 percent in 1991 and 1992, a New York corporate benefits expert said:

> It would be highly unusual to give someone that size bonus even every other year, especially if you're losing money. You could do it once, maybe, but no Board would let you do it every year.

Empire executives also have received special allowances and benefits. For example, for the five-year period 1988–1992, the Plan paid more than $270,000 for officers' health and lunch club memberships, parking, and physical examinations. During this same period Empire purchased 82 automobiles (with a current market value of more than $1 million) for its officers to use for both personal and business purposes. (Some of these vehicles were used more for personal than business reasons.) Also, despite the availability of these 82 cars and another 41 "pool" vehicles, Empire still incurred sizeable expenses for limousines.[68]

Other unnecessary and/or excessive Plan expenses include those incurred for:

EMPLOYEE AWARDS/GIFTS: from 1988 through 1992, Empire spent more than $1.1 million to recognize employee performance, attendance, and/or service accomplishments. Among the gifts/awards provided for these purposes were jewelry, gold wristwatches, clocks, crystal glassware, flatware, and cash sums up to $2,500. After a company-wide Employee Recognition Program was established in 1992, in the first eight months of its existence it gave more than 7,000 awards to Empire's 10,000 employees, at a cost of more than $250,000.

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[68] Over the past six years, for instance, the Plan spent $226,000 for this purpose; indeed, while Empire was losing $150 million in 1991, costs incurred for limousine service exceeded $90,000. This figure includes $11,000 for limousines used by CEO Cardone for a two-month period to ride to and from his home in Connecticut to Plan headquarters in New York City. Mr. Cardone told the Staff that this expense was justified because his corporate car was being repaired at that time. When Staff asked if he considered using one of the Plan's "pool" vehicles instead of the limousine, Cardone responded indignantly, "I was recruited by this company and I was promised a car."

CATERING/MEALS: between 1989-1992, Empire subsidized its cafeteria costs to the tune of more than $7 million. The Plan also paid for food and beverage catering service which was routinely used for almost daily staff meetings. The costs incurred for such meetings typically ran into the hundreds of dollars.

CEO CARDONE: throughout his tenure, Mr. Cardone continually expended Plan funds without regard for the restraint one would expect from the head of a non-profit enterprise, let alone one that was experiencing major financial losses. Examples of such expenditures include:

—first-class air travel, which he almost always used, and which other Plan officers and employees often used when they accompanied him on trips;
—a corporate apartment maintained for his use from 1985 through 1989, at an annual cost of $48,000;
—a luncheon membership at The Sky Club, which in addition to annual dues ($1,800 in 1992), cost the Plan more than $50,000 over the past five years. Empire's food services group also provided meals delivered to Mr. Cardone's office, at a cost of $26,000 for 1992, alone;
—a renovation of the Plan's executive offices and boardroom, at a cost of $118,000. Not included in this figure are an additional $84,000 in approved but not expended funds for a breakfront, conference table, and oriental rug. Mr. Cardone also purchased a $20,000 Chippendale desk for his own office;
—a $30,000 Lincoln Town Car and a chauffeur to drive it; and,
—a $27,000 telecommunications system installed at his home to provide a direct link with Empire headquarters.

2. INADEQUATE OVERSIGHT BY THE BOARD OF DIRECTORS

As in the case of the West Virginia, Maryland, and D.C. Plans, Empire's Board failed to provide the necessary checks and balances over the Plan's management, thereby abdicating their responsibility to protect the interests of the subscribers. Specifically, the Subcommittee's examination of Empire found a Board that was self-perpetuating, ill-informed, lacking in expertise, and dominated by management.

Empire's by-laws provide for a Board consisting of 18 to 20 Directors, to be elected by a separate body of 78 so-called "voting members." The vast majority (55) of the voting members are selected by the Directors themselves, the net effect of which has been to create a self-perpetuating process by which the Board selects those very individuals whose job it is to select the Board.[69]

In his capacity as both CEO and Chairman of the Board, Mr. Cardone was able to exert undue influence on the Board's selection and composition. While the Board was comprised of 44 Directors when Cardone assumed the positions of CEO and Chairman, over time he was able to drastically downsize it to 19 members. A

[69] Further reinforcing this self-perpetuating process, the Directors selected by the voting members come from a list of candidates developed by the Nominating Committee of the Board. While the by-laws provide that the voting members may independently place a name in nomination with the support of twenty members, this has never been done.

former Empire officer stated that virtually every Board member who might question Cardone's actions was removed, leaving only those who could be counted on to "rubberstamp" his actions.

Another major Board shortcoming was the Directors' admitted lack of technical expertise and the resultant hesitancy to question management proposals and actions. One Director, for instance, stated that the Board failed to delve deeply enough into issues, instead accepting surface answers. A former Empire Vice President stated that "the Board didn't know what to ask even if they wanted to find out what was going on."

The Board's performance was also heavily influenced by management's ability to manipulate and control the flow of information to it. Long-time Director and newly appointed Board Chairman, Harold Vogt, admitted in an interview with the Staff that he knew little or nothing about such key matters as major lawsuits that had been filed against Empire,[70] the controversy surrounding a multimillion dollar information systems contract, and the serious problems that had led to the decision to recredential all of its small group clients. Vogt told the Staff, "I'm learning a lot here talking to you."

Some of the sharpest criticism of the Board came from several former Empire executives and other employees. One of these stated that the Board "provided no checks on management," and that no one in the Plan had much confidence in the Board. Another characterized the Board as being "asleep at the switch," and stated that it did nothing more than rely on Cardone. Several said that the Board was merely a rubberstamp for senior management, and Cardone in particular. One former employee commented that the latter description was probably too kind because "at least a rubberstamp leaves an impression."

### 3. INADEQUATE REGULATION BY THE INSURANCE DEPARTMENT

The Subcommittee found that the New York Insurance Department's performance in overseeing Empire's activities was woefully inadequate, primarily because of a pattern of regulatory forbearance which, at times, bordered on favoritism. At times, the Department reversed itself when such action accrued to Empire's benefit, failed to exercise its regulatory authority over the Plan, and allowed Empire to ignore its recommendations and/or regulations with impunity.

The Subcommittee also found that the Department's actions regarding Empire, which insured nearly 45% of New York State's citizens, reflected the same "too-big-to-fail" approach that helped explain the Maryland Insurance Division's inability to deal effectively with BCBSM. As Insurance Superintendent, Salvatore Curiale, stated:

> You have asked whether certain of the Blues Plans, and now specifically Empire, are "too big to fail?" Under the law as it existed in New York prior to April 1, 1993, the

[70] One of these was a March, 1993 lawsuit filed against Empire by AT&T, in which the latter claimed that the Plan had improperly withheld hospital differentials obtained in its behalf. Mr. Vogt did not learn about this matter until a meeting with the Superintendent of Insurance a month-and-a-half later.

effective date of health insurance reform legislation, I would agree, Empire was too big to fail.[71]

Among the cases that best represent the Department's failed regulation of Empire is Healthnet, the Plan's HMO operation. In this case, the Department reversed itself to Empire's benefit, allowed it to ignore State regulations governing HMOs, and failed to exercise and/or follow through on its authority over HMO operations. As a result, Healthnet has been able to continue in business, even though it has had only one year of modest profitability during its seven-year existence and has drained more than $115 million from the Plan's surplus.

The Department's handling of important issues relating to Empire's Board of Directors is another area in which it performed inadequately. In 1989, the Department determined that the process for selecting Directors did not provide for subscriber participation, and accordingly recommended that the Board "undertake a study of the election process and propose a method * * * which would evidence greater accountability * * * to the subscribers." The Department, however, chose not to force this issue and thus the same process remains in effect today.

Also during 1989, the Department expressed concerns that under Mr. Cardone, Empire's by-laws had been changed to allow him to simultaneously hold the positions of CEO and Board Chairman. The Department's General Counsel determined that the arrangement under which CEO Cardone was serving on the Board, as a member representing Plan subscribers, was not in conformance with existing statutory requirements.[72]

As a result, the Department recommended that the Board "furnish a formal description of the process by which the change was made and its justification therefor." Empire's response attributed the change to a 1981 Nominating Committee recommendation (even though the change was made in 1987), and justified it on the tenuous grounds that the company had "grown to be a multi-billion dollar enterprise with complex and important functions and operations...." Upon receipt of this reply, the Department dropped the matter and at least until May, 1993, Cardone continued to hold the position of Chairman of the Board under the newly-created category, "officer-employee."[73]

The evidence suggests that the Department allowed Empire to ignore its regulatory actions with virtual impunity, despite the fact

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[71] Elaborating on this point, Superintendent Curiale offered some critically important additional remarks, which place Empire and BCBS Plans in general in the wider context of the current debate on health care reform: "Senator, in your opening statement you asked the question, can we build a health care system relying extensively on huge non-profit organizations. I think the answer is clearly no. We must devise a way to control health care costs and to share the burden of financing them not only through not-for-profit insurers, but also through for-profit, commercial insurers, self-insured employers and organizations, and whatever financing vehicles may be fashioned in the coming months and years."

[72] Because of its status as a non-profit insurer, the composition of Empire's Board is set by statute. In 1989, this statute required that the Board be comprised of representatives of three distinct categories: 1) the provider community; 2) the subscriber community; and, 3) the public interest. Empire had listed Cardone as falling under the subscriber category.

[73] It was not until 1993—apparently after the Subcommittee had commenced its inquiry into Empire—that Superintendent Curiale decided that perhaps these combined CEO/Board Chairman positions were not such a good idea. For example, in a May, 1993 interview with *The New York Times*, Mr. Curiale stated that he reached his decision "in hindsight, with three years of experience." Likewise, in an interview with the Staff, he stated that his concern was that "Cardone may have been dominating the Board."

that it has a broad array of enforcement powers.[74] The Department's examination report of Empire, for the period ending December 31, 1983, noted that three of the Department's four previous recommendations had not been complied with. Likewise, the report for the period ending December 31, 1987 listed five recommendations from the 1983 report with which the Plan had not complied. No penalties for this non-compliance were assessed by the Department against Empire.

Other examples of this regulatory failure include:

—Empire's refusal to comply with a recommendation made by the Department in 1989 that it change its external auditors because a number of the Plan's officers had formerly been associated with that same firm;[75]

—the Department allowed Empire to invade reserves on a number of occasions, even though it was failing to comply with regulatory requirements that made this contingent upon the establishment and execution of a plan to restore and add to these reserves;

—Empire's failure in 1990 and 1991 to make required contributions from its experience-rated business to subsidize its community-rated business and, for 1992, contributing a substantially lower amount than the specified minimum; and,

—in a 1992 meeting with BCBS Association officials, Superintendent Curiale was told that Empire was in danger of losing the Blue Cross/Blue Shield trademarks, if its reserves declined into a negative status. Shortly thereafter the Department declared "redundant" certain reserve funds held by the Plan to pay hospital claims. This adjustment effectively made $80 million available for Empire's reserves, saving them from falling to a level of minus $40 million for 1992.

The Department's inadequate performance regarding Empire to some extent reflected its lack of knowledge about important matters affecting the Plan. Department officials said that they were unaware of the large number of National Accounts that Empire had lost. The Superintendent told the Staff that until 1992 he was unfamiliar with the Association's NMIS system and had no knowledge of the Plan's poor performance ratings therein.[76] The Superintendent also stated that while he was aware of the dummy codes issue, he had no idea that it involved such enormous sums, e.g., $219 million in payments to non-credentialed physicians in 1990 alone. Finally, he did not know that the Plan had already identified more than $25 million in payments made to ineligible groups in 1990–91.

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[74] Included among these are the power to: 1) issue, suspend and revoke licenses; 2) require reports; 3) make investigations and examinations; 4) regulate finances and business operations; 5) establish rates; 6) provide for the protection of consumers; and, 7) impose penalties.

[75] While the Department seemed content to allow Empire to disregard this recommendation for four years, in an April 30, 1993 meeting with the Board, Superintendent Curiale again suggested that the external auditors be rotated.

[76] The National Management Information Service (NMIS) quantitatively measures service levels for all BCBS Plans on a quarterly basis.

### 4. INADEQUATE OVERSIGHT BY THE BLUE CROSS/BLUE SHIELD ASSOCIATION

As in the West Virginia, Maryland, and D.C. Plans, the testimony confirmed that the Association, while long concerned about Empire, failed to respond effectively to its problems.[77] For example, as long ago as 1987, the Association recognized that Empire's reserves were unacceptably low and put the Plan on conditional status in four of the next five years. Yet, the Association failed to take decisive action and as late as November 1992, was still being fended off by management's refusal to cooperate fully with its legitimate oversight requests. For instance, after the Association asked Empire for certain internal audit reports on accounts receivable, HMO operations, and systems implementation, Plan staff, at the direction of CEO Cardone, refused the request. Cardone only relented after months of phone calls, significantly delaying the Association's ability to act on the information requested.

Moreover, during the preceding months, the Plan's condition grew sufficiently worse to prompt significant additional downgradings. In May, 1992, its conditional status was moved to the "concern" level—the next to the highest level of monitoring available. The Association also directed that CEO Cardone develop a detailed recovery program for presentation in September of that year.[78] In August, 1992, Empire's problems reached the stage where the Association placed it on the highest level of monitoring, "contingency protocol."

In addition to its monitoring efforts, the Association also had access to numerous reports and other information on Empire, which should have prompted more forceful and immediate action in response to its problems. Notable in this regard is a National Account Performance Review (NAPR), completed in December, 1991:

> Significant operational deficiencies were identified Planwide for national accounts and the Federal Employee Program (FEP). Performance levels for most functions deteriorated during 1990 and 1991 * * * [and] were below the National Account Performance Standards in two thirds of the categories * * * [the FEP] index score of 73.9 points * * * ranked the Plan 20 [out] of [the] 26 monitored. * * *

## D. Effects

Empire subscribers and providers experienced problems much the same as those found in the West Virginia and Maryland Plans. In 1992, for example, the New York Insurance Department closed 4,200 complaints against Empire, while the Plan itself received some 13,000 additional complaints from other sources, such as the

[77] To its credit, and in marked contrast to its actions along these lines regarding the other Plans examined by the Subcommittee, the Association did discuss its concerns about Empire with both the Board of Directors and New York insurance regulators. However, it did not do so until 1992, when the Plan's long-lived and deep-seated problems had already caused hundreds of millions of dollars in losses and dramatically weakened its overall financial condition.

[78] When Cardone made his presentation, Association officials found it unacceptable. They instructed him that they intended to conduct site visits at the Plan and again warned that the Plan would lose its BCBS membership status if it did not meet the operative reserve requirements.

New York City Office of Consumer Affairs.[79] These complaints, once again, involved claims problems, payment delays, and denial of benefits.

Complaints, and the poor customer service that prompted them, played a substantial part in causing Empire's national accounts to leave the Plan. The Subcommittee staff testified that 18 of the 42 largest companies (those having between 1,100 and 57,000 employees enrolled) that have terminated their contracts with Empire since 1988, did so because of poor service involving claims processing, slow payment, and/or a failure to respond to complaints. Representatives of these former national accounts described the chronic service problems at Empire:

—dealing with Empire was like dealing with a black hole. You could never get anyone to deal with your problems * * *;
—difficult to get through to customer service and poor follow-up on complaints * * *;
—claims processing was slow and sloppy; and,
—the billings were often wrong, the employees hated it and we got fed up with it.

Empire subscribers also experienced excessive premium increases. For instance, the cost of basic medical coverage (Matrix II) for subscribers in the Plan's community-rated groups increased 350% between 1989 and 1993—from $29.55 to $138.90 monthly for individuals and $73.90 to $318.55 monthly for families. During the same timeframe, community-rated group subscribers with major medical coverage (Wraparound Plus) saw their premiums rise by 230%—from $97.90 to $323.95 monthly for individuals and $226.80 to $752.35 monthly for families.[80]

Lastly, Empire providers encountered problems similar to those described in connection with the West Virginia and Maryland Plans. For example, hospital administrators stated that Empire often loses claims or denies ever having received them, even when the latter have been transmitted electronically or with a return-receipt requested. Officials at one hospital stated that Empire does not respond to any inquiry concerning the status of a claim until 30 days have passed since its submission. At that point, Plan representatives have often responded that they did not receive the medical records, whereupon the whole cycle must begin again.

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[79] Not included in these figures are an undetermined, but potentially large number of additional complaints that may have been contained in the five million telephone contacts recorded by Empire during this same period.

[80] As in the case of BCBSM, these rate increases were also to some extent a result of the Plan's mismanagement and other related problems. One former Empire executive, who held the position of Director of National Accounts, stated that "the rank and file's attitude, supported by management was, 'I don't care what it costs—we'll just pass it on.'" Likewise, a senior vice president said that management's attitude in the face of the huge losses Empire was experiencing prior to his recent departure was that this was "no problem since in the end the community will cover it with increased premiums."

## FEDERAL CONTRACTS

### A. BACKGROUND/ORGANIZATION

Blue Cross/Blue Shield Plans are the single largest health care service provider to the Federal Government.[81] In a unique set of Federal contracts, the Blue Cross/Blue Shield Association (BCBSA) arranges for the individual Plans to provide coverage for Medicare Part A (Hospital) and the Federal Employees Health Benefits Program (FEHBP).[82] The Blue Cross/Blue Shield system insures about 40% of all Federal employees, dependents, and annuitants covered by the FEHBP, and administers over 90% of all Medicare Part A claims and 65% of Medicare Part B (Medical) claims for elderly beneficiaries nationwide.

The Blue Cross/Blue Shield Service Benefit Plan, which is commonly referred to as the Federal Employee Program (FEP), is the largest FEHBP participant. FEP operations involve four separate Blue Cross/Blue Shield entities:

—the Chicago-based BCBSA, which acting on behalf of the 67 independent Plans, contracts directly with the Office of Personnel Management (OPM) to provide health benefits to Federal employees who enroll in the FEP. The BCBSA charges the Federal government for these services, which between 1989-1993 averaged about $3.3 million annually.

—a Director's Office in Washington, D.C. that provides centralized management of the FEP contract by coordinating its administration with the BCBSA, individual Blue Cross/Blue Shield Plans, and OPM. In recent years the Director's Office has employed as many as 119 "staff equivalents" to work on the FEP contract. Between 1989–1993, the annual expenses of the Director's Office averaged about $26 million.

—an Operations Center at GHMSI in Washington, D.C. The Operations Center carries out certain administrative functions and centralized record keeping. It is linked with all the Plans via a telecommunications and computer network, through which it verifies subscriber eligibility, processes claims, and maintains historical claims files. Annual charges billed to the Federal contract for the Operations Center averaged nearly $15.5 million between 1989–1993.

—the 67 local Blue Cross/Blue Shield Plans that actually provide the benefits to the Program participants. Last year they paid out some $5.2 billion in benefits and incurred $344 million in administrative expenses.

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[81] Federal spending for health care in the United States accounts for approximately one third of the estimated trillion dollars to be spent in 1994 for this purpose.

[82] The FEHBP was established by the Federal Employees Health Benefits Act of 1959 (P.L. 86–382). Its purpose is to provide health insurance benefits for Federal employees, annuitants, and dependents. In 1960, 1.7 million Federal employees were enrolled in 36 participating FEHBP plans. Since then, it has grown enormously, encompassing about 300 plans today (with a peak of over 440 in 1988) providing coverage for some 9 million enrollees. FEHBP participants receive health care coverage through either fee-for-service plans (those that reimburse the claimant or provider for covered services) or prepaid plans (those that provide comprehensive medical services through their own doctors and hospitals). The FEHBP is financed through premium payments made by the enrollee and the Government. Currently, the Government pays about 70% and the enrollee pays 30%.

Blue Cross/Blue Shield Plans also collectively serve as the largest contractor for administering the Medicare program. Medicare provides hospital insurance (Part A) and supplementary medical insurance (Part B) for the aged and disabled.[83] Part A contractors are referred to as "intermediaries" and by law are nominated to administer the Medicare contract by hospitals in the community in which they serve. In many states, the local Blue Cross/Blue Shield Plan is the only insurer large enough to be considered for nomination and, thus, as of 1993, 41 of the 46 participating Part A intermediaries were Blues Plans. Medicare Part B contractors are referred to as "carriers" and, in 1993, 25 of the 37 participating insurers were Blue Cross/Blue Shield Plans.

The agency responsible for Medicare administration and oversight, the Health Care Financing Administration (HCFA) of the Department of Health and Human Services (HHS), contracts with the BCBSA to administer the Part A program.[84] The individual Blues Plans serve as subcontractors to the Association. The BCBSA is reimbursed for performing various functions pursuant to this contract and in 1993 received about $7.4 million for its efforts in this regard.[85] In the case of Medicare Part B, HCFA contracts directly with the individual participating Plans.

## B. Financial Profile

A major difference between the Federal contracts and the individual Blue Cross/Blue Shield Plans discussed previously is that there is no concern about a possible insolvency affecting subscribers, since the FEHBP and Medicare are backed by the Government and are essentially self-insured. As a result, in its review of the Federal contracts, the Subcommittee focused on the alleged waste of taxpayer dollars and the correspondingly adverse impact on the Federal budget.

In 1992, for the FEP's more than 1.7 million enrollees, $5.16 billion in premiums were collected and $4.81 billion in claims were paid. For that same year, FEP administrative costs were $363 million and income from service charges was $38.4 million. Referring to the FEP in a March 1990 memorandum to Blue Cross/Blue Shield Chief Executives, the BCBSA President stated that, "by a wide margin [the FEP] is the Blue Cross and Blue Shield system's largest and most valuable single account."

Of the approximate $170 billion in total claims processed annually by all Blue Cross/Blue Shield Plans, over 60% are Federal

[83] Medicare Part A provides hospital insurance for the aged and disabled, including medical services furnished by hospices, skilled nursing facilities, and home health agencies. It is financed primarily through Medicare's share of the FICA (Federal Insurance Contribution Act) payroll tax and in 1993 covered an estimated 35.1 million individuals. Medicare Part B provides supplementary medical insurance for the aged and disabled for physician care, outpatient services, durable medical equipment, and a variety of other non-institutional services. Enrollment in Part B is voluntary and anyone enrolled in Part A may enroll in it by paying a monthly premium ($41.10 in 1994). Premium payments cover about 25% of Part B costs, with the remainder being paid by Federal tax dollars. In 1993, Part B covered an estimated 34.3 million individuals.

[84] HCFA was formed in 1977 to place responsibility for the Medicare and Medicaid programs in a single Federal agency. It contracts with private insurers to process claims and is responsible for administering and overseeing Medicare and Medicaid program operations.

[85] These functions include: determining whether services provided are covered; receiving, disbursing, and accounting for funds in making payments to service providers; auditing records of service providers; assisting service providers in developing procedures regarding utilization practices; assisting institutions, facilities, or agencies interested in becoming a service provider; and, serving as a communications link between service providers and HHS.

claims—$106 billion for Medicare and $5.2 billion for the FEHBP. Figures for 1993 show that the Plans of the Blue Cross/Blue Shield system received the largest share of Medicare's overall administrative costs—$1.1 of the total $1.54 billion—and the largest portion of the FEHBP's total administrative costs—$402 million of the total $702 million. Federal funds constitute a significant portion (about 40%) of the BCBSA's annual revenues; in 1992, for instance, revenue from the FEHBP and Medicare amounted to $53.9 million of the Association's $136.8 million in total revenue.

A large portion of the Blue Cross/Blue Shield Plans' total overhead and fixed costs are paid for by the Government, which some have suggested is most helpful to the Blues when they compete for private business. As one health care analyst told the Staff, the Federal contracts also tremendously increase Blue Cross/Blue Shield's subscriber market share and, thereby, improve their bargaining position with local hospitals and doctors.

## C. Problem Areas

The Subcommittee found that the relationship between Blue Cross/Blue Shield and the Medicare and FEHBP contracts is marked by some of the same problems uncovered in its previous hearings. Specifically, as with the West Virginia, Maryland, District of Columbia, and Empire Plans, the Subcommittee found evidence of mismanagement; inadequate oversight by the Blue Cross/Blue Shield Association; and inadequate regulation by responsible regulatory authorities.

### 1. MISMANAGEMENT

#### *a. Excessive Bureaucracy*

The Subcommittee staff testified that the Blue Cross/Blue Shield system has generated a multi-layered, complex organizational structure that has resulted in additional and unnecessary expenditures by the Federal government. The FEP contract involves the BCBSA, an FEP Director's Office, an Operations Center, and the 67 independent Plans nationwide. As a result, the Federal government pays a substantial amount for the direct and indirect costs of not just one insurance company, but those of 67 separate insurers; i.e., 67 CEO's salaries, 67 computer systems, 67 payroll offices, 67 building expenses, etc.[86] The Associate Director of OPM's Retirement and Insurance Group commented that "the Blues have the worst bureaucracy; they * * * make the Federal government look good."

For example, while the Operations Center performs almost all claims and payments processing, it does not actually pay the claims. That step is performed by the 67 individual Plans, because only they know what the actual discounted hospital and provider charges are in their respective territories. These charges are negotiated by each Plan with its local hospitals and providers and are viewed as business proprietary information.

[86] Total costs incurred by the Government between 1989-1993 for the BCBSA, FEP Director's Office, and FEP Operations Center amounted to $224.1 million. During the same timeframe, the total cost for the 67 participating Blue Cross/Blue Shield Plans was nearly $1.5 billion.

*b. Administrative Costs*

In terms of administrative costs per $100 of benefits paid, GAO reported that the FEP ranked second highest among 17 FEHBP fee-for-service plans in 1988 and fifth among 15 plans in 1990. For 1991 and 1992, data compiled by OPM showed that the FEP's administrative costs were third and sixth highest, respectively, among the FEHBP's 11 largest fee-for-service plans. According to health benefits experts the Subcommittee staff interviewed, taking into account the Blues' size and experience it would be expected that they would have done much better than the other FEHBP plans, since economies of scale play a significant part in lowering administrative costs. These same sources also said that the FEP administrative cost ratio was exorbitant and should have been about half the 8% to 9% range cited by GAO and OPM in their recent analyses of the FEHBP fee-for-service plans.

*c. Questionable/Poor Business Practices*

The Staff testified that the 43 audit reports regarding the FEP issued by the OPM/OIG since 1988 show that more than $78 million in contract charges were questioned and, of that amount, $51.6 million (66%) was disallowed. Items questioned and/or disallowed include: marketing charges (commissions, awards, and bonuses); advertising costs; charitable contributions; meals, entertainment, and travel expenses; promotional costs; lobbying and legal fees; and, membership in country clubs and other social organizations. For example:

—the BCBSA charged the FEP $2.6 million between 1985 and 1990 for commissions, awards, and bonuses paid to employees for efforts resulting in the acquisition and retention of subscribers. The OIG's previous audit had identified similar charges of $568,217 for 1983 and 1984, which were also disallowed.

—Blue Shield of California charged the FEP more than $48,000 for entertainment and promotional costs associated with its 50th anniversary observance and $148,000 in leasing costs for vehicles Plan employees used for personal purposes.

—Blue Cross/Blue Shield of the National Capital Area charged the FEP nearly $600,000 for lost investment income, $80,000 for lobbying activities, and $26,000 for promotional items.

Questionable charges were also identified among Blue Cross/Blue Shield Medicare contractors audited by the Department of Health and Human Services, Office of the Inspector General (HHS/OIG). The OIG audits have recommended disallowing more than $40 million since 1992 for improper charges, including first-class airline tickets, golf course fees, alcoholic beverages, tickets for sporting and cultural events, and family travel.[87]

The Subcommittee also received testimony that Blue Cross/Blue Shield Plans have withheld millions of dollars in hospital and provider discounts from the Federal government and FEP subscrib-

[87] At the Subcommittee's request, the HHS/OIG audited some expenses that had been questioned during its investigation of the Maryland and Empire Plans and found almost $1 million in unallowable salary charges.

ers.[88] OPM first discovered that Blues Plans were not complying with requirements that they credit the FEP for hospital "differentials" (the difference between the provider/hospital billed charge and the discounted amount actually reimbursed) during a 1975 audit of the Illinois Plan. Despite this audit finding and testimony provided by Blue Cross/Blue Shield officials insisting that the differential problem had been taken care of, some Plans have continued to abuse this requirement:

—a 1992 OPM/OIG audit of the North Dakota Plan found that it had overcharged the Government $585,000 by paying hospitals a negotiated rate and then billing the FEP for the full amount; and,

—an audit of Blue Cross/Blue Shield of the National Capital Area reported that the Plan owed OPM $1.4 million in interest alone for failing to credit the Government on a timely basis for funds received from hospital settlements.

In the case of FEP subscribers, the Subcommittee found that for years many Blue Cross/Blue Shield Plans have been using the higher, non-discounted billed amount to determine coinsurance (the percentage of a bill for which the insured is responsible), resulting in unfair and higher out-of-pocket costs for thousands of Federal employees. For example, the Empire Plan told a subscriber that he owed more than $6,000 in coinsurance for hospital services that cost $16,000. However, after the hospital and the subscriber complained to OPM, it was determined that he actually owed about half the amount the Plan had charged him and, equally important, that the Plan owed more than twice the $1,700 it had paid pursuant to its obligations.

The Subcommittee found that in other cases the Plan ended up paying nothing on a claim, while the Federal employee's coinsurance amounted to thousands of dollars. For instance, after calculating their discounts and deductibles, Blue Cross/Blue Shield of Colorado had determined that the total covered charges for an $11,500 hospital bill was $3,700. The Federal subscriber's coinsurance was calculated using the $11,500 amount and he was advised to pay the hospital $4,600. Since this latter amount exceeded the total charges owed by the Plan after its discounts had been factored in, the Plan ended up paying nothing to the hospital. The Federal employee, it should be noted, did not know this until after he complained about the size of the original bill. OPM subsequently determined that his actual coinsurance payment should have been about $1,500, instead of the $3,700 called for by the Plan.[89]

Serious problems were also identified in Blue Cross/Blue Shield's Medicare program involvement. Out of the 41 Plans operating as

[88] Hospital and provider discounts are a long-lived Blues practice, resulting from their tremendous purchasing power and the way hospital bills are paid. Individual Plans negotiate discount prices with hospitals and providers in return for sending patients to them. The discounts vary from 2% to 75%.

[89] OPM now prohibits the practice of calculating the coinsurance payment on the billed versus the discounted amount, and Blue Cross/Blue Shield officials testified that they are complying with this new policy. While the effects of this practice have not been fully assessed, OPM has determined that tens of millions of dollars are owed thousands of Federal subscribers for certain mental health and outpatient expenses incurred from 1990 to the present. In his testimony before the Subcommittee, OPM's Associate Director for Retirement and Insurance stated that he expects about $25 million in "rebates" to be refunded to these FEP enrollees.

Part A intermediaries in 1993, eight had been placed on a "watch list" for failing to meet basic performance requirements—e.g., claims payment controls, timeliness of claims processing, and customer service—established by HCFA. One of these Plans, Blue Cross/Blue Shield of Michigan, will be eliminated from the Medicare program at the end of the 1994 contract year because HCFA discovered that it had submitted false statements to cover up poor performance.[90] Likewise, seven of the 27 Blue Cross/Blue Shield Part B carriers had been placed on the watch list by HCFA for poor performance and another three will not be renewed at the end of the 1994 contract year. It should also be noted that two of the Part B Plans on the watch list have additional problems with broader implications: the Justice Department has filed suit against the Florida Plan, alleging that it incurred $10 million in unwarranted Medicare program costs as a result of trying to resolve computer generated backlogs in claims payments;[91] and, the Massachusetts Plan is under investigation by the HHS/OIG and the FBI for allegedly manipulating performance data to comply with the timeliness requirements of the Medicare contract.

In addition to these Part A and Part B problems, some Blue Cross/Blue Shield Plans have mismanaged their Medicare Secondary Payer Program (MSP) responsibilities, causing hundreds of millions of actual and potential losses to the Federal government.[92] In the case of the Empire Plan, the HHS/OIG found that it had billed the Federal government for $85 million in improper MSP payments.[93] HCFA officials, moreover, stated that they believe that the total amount owed by Blue Cross/Blue Shield contractors for improper MSP payments is more than $500 million.

*d. Internal Control Deficiencies*

As with the individual Plans discussed above, the Subcommittee found that inadequate internal controls exist in a significant number of the Blue Cross/Blue Shield Plans participating in the FEP. A 1989 OPM/OIG audit report, for example, lists a number of weaknesses found regarding the Massachusetts Plan, including:

—inadequate controls over coordination of benefits with other carriers;
—inadequate procedures for investigating duplicate payments; and,
—inadequate segregation of allowable and unallowable administrative costs.

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[90] The HHS/OIG and the FBI are conducting a criminal investigation of this case, which has already resulted in the firing of 21 Michigan Plan managers.

[91] According to officials of the Florida Plan, it has agreed to pay the Federal government $10 million. Of this amount, $9.5 million will come from GTE Data Service, Inc., the company whose deficient computer system caused the Medicare claims payment backlog.

[92] The MSP covers individuals 65 or older, who are still employed and have private health insurance coverage through their employers. Under the MSP, the private health insurer is supposed to pay the insured's medical claims as the primary carrier, with Medicare serving as the secondary carrier responsible for charges not covered by the former. In July 1990, the Subcommittee's Ranking Minority Member, Senator William V. Roth, held hearings on the MSP, which found that the Federal government may have erroneously paid between $400 million and $1 billion annually in benefits to providers who should have been paid by the primary carrier.

[93] The HHS/OIG audit confirmed $85 million. However, Empire failed to provide justification for another $118 million and HCFA has indicated it expects to recover this additional amount if such justification is not received from the Plan.

OPM/OIG reports issued in 1992 and 1993 regarding the FEP operations of the Florida, Virginia, and Arizona Plans cite similar findings:

—claims processing system weaknesses;
—duplicate payments;
—failure to properly coordinate benefits with other carriers;
—weaknesses in accounting systems for administrative expenses; and,
—inadequate procedures to ensure that refunds were properly credited to the contract.

As was the case in the Maryland, District of Columbia, and Empire Plans, the weaknesses listed above have been recurring; e.g., the OPM/OIG's December 1992 audit report on the Massachusetts Plan cited the same problems described in the report issued three years earlier. In their review of the 43 OPM/OIG audit reports issued since January 1988, the Subcommittee staff found that 34 cited problems with duplicate payments, 12 mentioned coordination of benefits difficulties, and 12 made reference to unsupported charges.

Internal control weaknesses can constitute an open invitation to fraud. Throughout the Subcommittee's Blue Cross/Blue Shield investigation, the evidence has indicated that anti-fraud efforts receive inadequate attention from the individual Plans, the BCBSA, and regulatory authorities.[94] As noted previously, for example, in its examination of the Empire Plan, the Subcommittee found that one small criminal group was able to defraud the Plan of about $29 million owing to faults in its subscriber enrollment system.

Subscriber enrollment system problems in the FEHBP in general and the FEP in particular were identified as long ago as December, 1979 in a GAO report, *Errors in Health Benefits Enrollment Data Push Up Health Insurance Costs* (FGMSD–80–8). In that report, GAO stated that discrepancies in the enrollment data kept by the Federal agencies and insurance carriers caused erroneous premiums and benefits to be collected and paid, respectively. GAO noted that a 1976 audit of FEP files found a 10% overall discrepancy rate among the Blue Cross/Blue Shield Plans and that half of these showed employees listed on the carriers' rolls as being eligible to receive benefits when they were not listed in the records of the Federal agency for which they presumably worked. GAO estimated that the Federal government was losing more than $1.5 million in premiums annually as a result of these discrepancies, but did not attempt to determine losses that may have occurred from fraudulent claims filed by ineligible individuals.[95]

Enrollment system problems were also identified in almost yearly findings by outside accountants hired to audit the FEP Director's Office. For example, in 1979, the auditors noted that:

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[94] See related discussion below p. 85.

[95] The OPM Inspector General testified that in recent years his office has investigated several cases where, because of the lack of enrollee reconciliations by Blue Cross/Blue Shield, individuals have continued to receive health benefits for years after leaving Federal service. In some cases, these individuals received benefits to which they were not entitled worth more than $200,000 and in one case a former Federal employee received health benefits from Blue Cross/Blue Shield for 17 years after she had been fired from her job with the Navy Department.

> reports of the previous audit firm noted there was no reconciliation of the FEP enrollment system master files, the various payroll offices' subscriber files, and the various transmittal forms for subscriber input and enrollment changes.

Inexplicably, it was not until 1989 that the Director's Office and OPM agreed to examine the enrollment system issue.

*e. Questionable Business Expenses*

The Subcommittee's review of the FEP revealed the same irresponsible management outlook and apparent disregard for cost containment uncovered in the West Virginia, Maryland, D.C. and Empire Plans. Specifically, questionable and/or unnecessary charges were found in several areas, including conferences and meetings, promotional items, and executive compensation.

Among the most questionable expenses charged to the Federal government are those associated with FEP National Conferences. Hundreds of employees and their spouses attend these events, which in recent years have been held at various resort and/or luxury hotels located in Scottsdale, Arizona (1990), New Orleans (1991), Palm Springs, California (1992), and Atlanta (1993). The Conferences consist of a mixture of lavish stage productions, informational speeches and workshops, and entertainment. One of the largest conference expenses is for the private production companies, which are retained to "design, produce, direct and stage" the conference.[96] For the 1990-1993 Conferences, the total cost of these production contracts was more than $1.1 million, all of which was billed to and paid by the Federal government.[97]

The extent to which these costs are chargeable to the Government is based on a Federal Acquisition Regulations (FAR) standard of "reasonableness." Section 31.201–3 of the FAR states that:

> A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person in the conduct of competitive business * * * [and if] it is the type of cost generally recognized as ordinary and necessary for the conduct of contractor's business or the contract performance.

Then Chairman Nunn asked the HCFA Bureau of Program Operations Director, Carol J. Walton, and the OPM Associate Director for Retirement and Insurance, Curtis J. Smith, whether they considered these conference expenses to be appropriate Federal charges:

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[96] The production company is required to develop a theme that is carried on throughout the conference and must also provide "speech preparation and support, audio visual and teleprompter speaker support for presentations, speaker rehearsal, * * * talent, props, costumes, sets, studio, editing suites equipment, duplication and delivery of finished 1/2″ VHS tape cassettes for duplication."

[97] The Government paid an additional $850,000 for food, beverages, meeting facilities, and other miscellaneous expenses incurred at these four conferences.

Senator NUNN: * * * from what you have seen here,[98] would HCFA permit those kinds of expenses on conferences to be charged to the Federal government?

Ms. WALTON: I would say that the video on the conference to be financed by Federal funds is offensive, and we would not permit that to be paid with Medicare trust funds.

Senator NUNN: Where do you draw the line?

Ms. WALTON: I think conferences are totally business affairs when they are financed by Government funds.

Senator NUNN: And anything that goes beyond business ought to be paid for outside of public funds.

Ms. WALTON: * * * Yes, sir.

Senator NUNN: Mr. Smith, do you generally agree with that?

Mr. SMITH: Yes. * * *

Blue Cross/Blue Shield officials told the Subcommittee staff that these production costs—i.e., the value of "Super Plan" (an entertainer dressed in a Superman-like costume) at the 1991 conference and "Dr. FEHBAR" (creator of futuristic robots that had traveled back in time to study the success of the FEP) at the 1992 conference—were appropriate because they "didn't want people falling asleep." These officials also asserted that many U.S. companies hold similarly elaborate meetings. However, when the Staff asked the other 13 participating FEHBP fee-for-service, not-for-profit plans about their conferences, none of the nine that responded indicated that they held such elaborate and expensive events.

The FEP also holds annual Marketing Meetings, with about 200 marketing representatives from the 67 participating Plans usually attending. Staging and production are part of the meeting format and are paid for by the Federal government. These costs amounted to about $180,000 in 1992 and 1993 respectively, with the Government's total share being nearly $330,000.[99]

In addition, the BCBSA has hosted more than 200 meetings since 1990, including quarterly Board of Directors meetings that also have been held at luxury hotels or resorts, such as The Breakers in Palm Beach, Florida, the Colonial Williamsburg Inn in Virginia, and Westcourt in the Buttes in Tempe, Arizona. These meetings, which last two or three days and are attended by 80 directors and their spouses, cost as much as $60,000, one-third of which is typically charged to the Federal government. The Government also routinely pays a portion of the cost of entertaining the spouses, including items such as dinner theater performances, a tour of Victorian homes, and a champagne lunch and private tour of Liberace's estate.

Promotional items have also been charged to the Federal government. In recent years the Government was charged for Customer Service Motivational Kits, including $23,000 for 10,000 coffee mugs, $59,260 for 8,200 liquid paperweights, and $87,300 for 200

[98] Then Chairman Nunn was referring to a videotape shown during the Subcommittee staff's testimony, in which highlights of the 1991 and 1992 conferences were depicted. The videotape showed lavish, Broadway-style productions, complete with costumes, singing, dancing, etc.

[99] These are the only years for which the Subcommittee was able to obtain information from Blue Cross/Blue Shield.

kits containing mirrors, buttons, memo pads, banners, balloons on sticks, and mobiles. Regarding such expenses, in an audit report dated October 20, 1992, OPM stated that:

> The Association charged the FEHBP for unallowable advertising costs related to premium items and giveaways that were used to enhance [its] * * * overall image and to assist the marketing sales force during annual open season campaigns. * * * [W]e determined that the FEHBP was charged $224,399 in [such] unallowable costs from 1985 through 1990 * * * [for] * * * items * * * [including] * * * pocket calendars, tote bags, ceramic, mugs, lapel pins, biofeedback cards, and key chains.

The Subcommittee's investigation also questioned executive compensation and miscellaneous personal expenses that were charged to the Federal government. The Government pays a portion of the salaries for 122 BCBSA management positions, including the President/CEO, the Chief Operating Officer, four Senior Vice Presidents, 10 Vice Presidents, 15 Executive Directors, 36 Directors, and 55 Managers. This included, in 1993, $274,000 of the President/CEO's $866,000 total compensation; $143,504 of the Chief Operating Officer's $451,155 total compensation; and, $154,175 of the Senior Vice President of Business Services' $236,075 total compensation.

In the case of Medicare, the HHS Inspector General testified that her office found unreasonable salary increases charged to the program by the Empire, Maryland, and Pennsylvania Plans. The OIG reported that top executives at these three Blues contractors received increases in their compensation packages that were greatly in excess of the Department of Labor's Employment Cost Index (ECI). For the period examined (1989–1992), while the ECI increased 14.6 percent, the average compensation of the 12 top BCBSM executives rose 107.7 percent; for the eight top Pennsylvania Plan executives, the increase was 56.6 percent; and, for Empire's top four executives, the increase was 89 percent.[100]

The Subcommittee questioned the appropriateness of other BCBSA expenses that were charged to the Federal government:

—the Government paid $400 of the $1,200 cost of two folding wardrobe bags for the President/CEO;
—the Government paid $700 of the $2,275 bill for preparing the President/CEO's income tax returns;
—the Government paid $8,000 of a $40,000 annual contract that provides fitness training to BCBSA employees;
—the Government paid $600 of a $2,000 gift certificate for a retiring member of the Board of Directors; and,
—the Government provided tuition reimbursement for FEP employees, including one that was attending law school.[101]

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[100] The Empire figures are based on a six-year period, 1987–1992. As a result of these findings, the OIG has recommended that HCFA establish a ceiling on executive compensation increases that contractors can allocate to the Medicare program. According to the Inspector General's testimony, HCFA officials have agreed in principle that Medicare should not be charged unreasonable or excessive increases in executive compensation.

[101] The Subcommittee asked the OPM/OIG to examine similar expense items that had surfaced in the investigation of the Maryland, D.C., and Empire Plans. The OIG found that each of these Plans had improperly charged the Government for portions of their limousines, chari-

Continued

2. INADEQUATE REGULATION

The regulatory agencies responsible for overseeing the Blue Cross/Blue Shield contracts with the FEHBP and Medicare—OPM and HCFA, respectively—have encountered problems similar to those experienced by their State counterparts in connection with the West Virginia, Maryland, D.C., and Empire Plans. Both OPM and HCFA have dealt with uncooperative attitudes and evasive tactics on the part of the BCBSA and individual participating Plans, and OPM, in particular, has encountered considerable difficulty in being able to regulate them effectively.

For example, in interviews with the Subcommittee staff, OPM contract officers referred to the FEP Director's Office and many of the individual participating Plans as being "arrogant," "obstructionist," and "uncooperative" in their responses to legitimate regulatory requests and/or actions. OPM/OIG staff described similar problems, explaining that one of the reasons why it takes so long to finalize a draft audit report is that the BCBSA takes an inordinate amount of time to provide its comments. In reviewing some two dozen of the 43 audit reports issued by the OPM/OIG regarding the FEP since 1988, the Subcommittee staff found that BCBSA took an average of nearly 9 months to comment; in two cases nearly two years elapsed before the comments were received and, in another, it took nearly two-and-a-half years.

These regulatory inadequacies can be attributed to limited resources as well as the problems inherent in trying to regulate entities as large as Blue Cross/Blue Shield Plans:

*a. The "Too-Big-To-Regulate" Dilemma*

The Subcommittee staff testified that because Blue Cross/Blue Shield Plans have about 40% of the FEHBP market share, regulators are forced to tread lightly, for fear that they might decide to pull out of the program. The Staff said they found evidence in the past, such as the early 1980s, that Blue Cross/Blue Shield officials made such threats prior to obtaining large increases in their service charges from OPM. A former OPM Assistant Director stated that "one of OPM's worst nightmares was having the Blues drop out of the program," adding that they had threatened to do precisely that "a couple of times." The present Assistant Administrator of OPM stated: "what would we do with the people [i.e., the subscribers] if we got rid of the [Blues] contract? It is impossible to terminate them because of their size."

This attitude, and the unquestioning and deferential treatment it has engendered, have undermined OPM's ability to regulate Blue Cross/Blue Shield effectively. It has made it difficult for OPM to take strong action when required and has led to unnecessary and wasteful expenditures, as demonstrated by the following:

—spurred by criticism from GAO,[102] OPM made a concerted effort in 1992 to reduce administrative costs in the FEHBP by

table contributions, country club memberships, first-class airfare, and/or salaries. In the case of the Maryland Plan, the unallowable costs that resulted from this review were $21,000; for the D.C. Plan, $15,000; and, for Empire, $132,000.

[102] In May 1989, GAO testified (GAO/T–GGD–89–26) before the Subcommittee on Compensation and Employee Benefits of the House Post Office and Civil Service Committee, that OPM's cost control efforts were inadequate to contain excessive administrative expenses. A subsequent

5%. Blue Cross/Blue Shield adamantly opposed this initiative and it was not until almost a year after it was announced that an agreement was reached. The agreement provided for a reduction of only 1% per year spread over a three-year period, which for 1993 meant that Blue Cross/Blue Shield's administrative savings decreased from the proposed $17 million to $10.2 million. Other FEHBP carriers did not object as strongly as Blue Cross/Blue Shield did and, in fact, most accepted the initial request without much complaint,

—although a not-for-profit, the BCBSA is paid a service charge by the Federal government for its role in administering the FEP contract.[103] From 1960, when the contract first became operative, the amount of this charge has grown almost every year and between 1981 (when a new formula was instituted) and 1993, it rose from $6.4 million to $39.4 million (more than 500%).[104] The Staff testified that in the eyes of many OPM officials this new formula was flawed from the start because, if applied correctly, it would result in lower service charges unacceptable to the carriers. As a result, OPM has basically "force-fitted" the formula to produce the profits the Blues have requested. Indeed, the Staff found that no one at OPM had focused on this matter very much before 1992. Typically, all the file contained was a handwritten note from someone in the Insurance Group stating that the service charge proposed by BCBSA "looks good" or "ok to me." Moreover, the Staff found that the process used to determine the service charge has become an incentive for BCBSA to increase costs, rather than to reduce them as provided for in the formula's cost containment criteria, since the higher the amount of claims paid and administrative costs for processing them, the greater the potential service charge.

—as part of indirect costs, OPM is billed for a portion of the membership dues individual Blue Cross/Blue Shield Plans pay to support the BCBSA. Between 1988–1992, the Federal government paid $11.7 million for such membership dues. In 1975, when the current OPM Inspector General's predecessor ruled that such charges could not be billed to the Government, the BCBSA fought to overturn this ruling, successfully accomplishing a reversal in 1988. OPM officials could not provide the Subcommittee with any justification for this pay-

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report in February 1992 (GAO/GGD–92–37) confirmed that stronger controls were still needed to reduce administrative costs in the FEHBP.

[103] At the time of the FEHBP's inception, Blue Cross/Blue Shield insisted on a "risk charge" as a condition for participating in the program. According to OPM, since the original statute was written so that the Blues were the only real candidate able to administer the Government-wide Service Benefit Plan, "* * * we had to allow the risk charge BC/BS was insisting on." As early as 1966, OPM's predecessor, the Civil Service Commission, proposed to do away with the risk charge because the original reasons behind it had been effectively eliminated by the establishment of reserves, Medicare, and experience rating. Indeed, reflecting the decreased risk to FEHBP carriers, the risk charge was renamed "service charge" in 1971.

[104] The formula developed in 1982 continues in effect today essentially unchanged, with the exception of a 1987 alteration that allows carriers to receive up to 1.1% of a combination of administrative expenses and claims incurred. The profit, i.e., "that element of potential remuneration that contractors receive for contract performance over and above allowable costs," is determined by multiplying a number of weighted factors with the Plan's administrative costs and claims paid. The factors are: contractor performance; contract cost risk; Federal socio-economic programs; capital investments; cost control and other past accomplishments; and, independent development.

ment and said that they have continued it because of the difficulty they knew they would encounter should an attempt be made to exclude it.

*b. Inadequate Resources*

Limited resources are among the more serious problems faced by OPM in trying to administer the FEHBP and oversee Blue Cross/Blue Shield's involvement therein. Funding for OPM, for example, has been widely recognized as being inadequate for years. While 1% of the total FEHBP premium is allotted for administering the program, the actual amount received by OPM is only 1/8 of 1% because the funds must be appropriated by Congress and the Office of Management and Budget has allowed OPM to only request that amount.

In 1993 OPM had 166 employees, including 36 OPM/OIG staff, available to operate and oversee the $15 billion FEHBP; in contrast, there were 300 staff employed by the BCBSA's Director's Office to "coordinate" its Federal contract responsibilities. OPM's Contracts Division III, the group directly responsible for the FEP and 94 other contracts, had only $4,000 in travel funds for FY 1993 and none for FY 1994. As a result, the staff has not gone on a site visit to any of the participating Blue Cross/Blue Shield Plans for a number of years. Likewise, the Division's training budget is almost non-existent; for 1993, the entire Insurance Group, of which Division III is a part, spent only $47,000 for conferences, seminars, and training, and only $2,000 has been budgeted for these purposes for the first six months of 1994.

Given their limited resources, OPM officials admitted that there "is no way for OPM to conduct the oversight and auditing necessary to make sure the contractors are properly administering the program and holding costs to a minimum." They rely substantially on the OPM/OIG for such audits and oversight—a situation which is itself problematic, since the OPM/OIG's goal of auditing all carriers, including Blue Cross/Blue Shield Plans, on a three-year cycle has slipped to more than nine years, in some instances, as a result of the latter's own resource problems. Indeed, according to OIG officials, the last year in which an audit was performed on 47 of the 67 participating Plans was 1986 or earlier and, in at least four of those, audits had not been done since the 1970s. Since FEHBP contracts have a five-year record retention requirement, this means that there are years that will never be audited because a carrier can simply say that records are no longer available for years outside the specified limit.

The sizable intervals between audits also inhibit the probability of corrective action. One frustrated OIG auditor told the Subcommittee staff that the Blues feel comfortable in the knowledge that there will not be another audit for years ahead. OPM/OIG officials expressed similar frustration, observing that the Plans know that they will be audited only every five years or longer and, therefore, take risks. At worst, these officials added, even if certain charges are disallowed, the Plans will have had the benefit in the interim of the interest-free use of the questioned funds.

Resource limitations force OPM to rely on Blue Cross/Blue Shield for essential information and to accept whatever they provide with-

out verifying its accuracy. For example, OPM officials "took it on faith" that the Blues' calculations of subscriber refunds for improper coinsurance payments were accurate. Blue Cross/Blue Shield's original refund estimate of $160.5 million in November 1993, shrank markedly to slightly more than $80 million by May 1994. By the time of the Subcommittee's August hearings, this amount had declined even further to just $25 million, with apparently little concern on OPM's part as to accuracy:

> Senator NUNN: What happened to get [the estimate] down from $160 million to $25 million?
>
> Mr. SMITH: I do not know the answer to that. The estimate came from Blue Cross, and * * * as they did more and more data collection and data analysis, the number kept dropping and has ended up today at $25 million.
>
> Senator NUNN: So you are relying on basically a Blue Cross computation here?
>
> Mr. SMITH: That is correct. They have the claims data upon which the payments will be made and upon which the calculation will be made.

Finally, the Staff initially found a paucity of publicly reported internal or external fraud cases concerning the FEHBP and after examining the issue more closely concluded that the simple reason why there had been such few cases is because no one, outside of the understaffed OPM/OIG, was seriously looking for fraud. In 1989, GAO criticized OPM's anti-fraud efforts and concluded that OPM could not reasonably assure that FEHBP funds are adequately protected from fraud and abuse. More recently, the persistence of these weaknesses in anti-fraud efforts has resulted in the Office of Management and Budget placing the FEHBP among those programs classified as being at "high-risk" to fraud and abuse.

### 3. INADEQUATE OVERSIGHT/PERFORMANCE BY THE BLUE CROSS/BLUE SHIELD ASSOCIATION

The Subcommittee found inadequacies in BCBSA's ability to effectively oversee its Federal contract responsibilities. For example, the Staff testified that almost every OPM official with whom they spoke complained about the fact that the more than sixty participating Blue Cross/Blue Shield Plans do not have to answer to the FEP Director's Office.[105] One official commented that the biggest problem she sees in FEP operations and subscriber service is the need for greater guidance and oversight by the Director's Office. She cited several areas where the Director's Office has performed inadequately, including: initial review of claims disputes between subscribers and individual Plans; keeping the FEP contract manual up to date, and cooperating with the OPM Contracts Office and OIG. She cited the example of a major fraud case involving a medical lab, in which the Director's Office failed to provide adequate data on a timely basis. She explained that "if all other carriers

[105] The FEP Director's Office is part of the BCBSA and thus throughout this discussion its actions are treated as being the Association's ultimate responsibility.

were as bad as the Blues * * * OPM would not have recovered anything in the case." [106]

From 1989 through 1993, the Federal government paid $500,000 annually for audits by the Director's Office intended to uncover mismanagement, fraud, and/or violations of the contract. Even though the Federal government had paid for these audits, prior to 1992 OPM could not get a copy, being restricted to just an "on-site review" by OIG staff. The OPM Inspector General also testified that the Director's Office was not reporting any internal fraud cases and few external fraud cases to his office. He added that even after being formally directed to do so in March 1994, "they have not been responsive."

Similar problems exist in the Association's oversight of the Medicare contract. BCBSA officials expressly believe that monitoring of Medicare contracts is HCFA's responsibility, not the Association's. As a consequence, BCBSA is generally unaware of problems at the participating Plans until HCFA takes some type of action. For example, the Association was completely in the dark until after HCFA had notified Blue Cross/Blue Shield of Michigan in March 1994 that it was being terminated as both a Medicare Part A and Part B contractor, for allegedly falsifying data to enhance its Contractor Performance Evaluation Program (CPEP) scores.[107] At the time of the Subcommittee's investigation nearly a dozen other Blue Cross/Blue Shield Part A and/or Part B Plans had been placed on HCFA's watch list. If nothing else, the poor performance reflected in the significant number of Plans terminated and/or on the watch list should have generated considerable concern on the Association's part.

### 4. RESPONSE TO BLUE CROSS/BLUE SHIELD'S TESTIMONY

In their testimony and submissions for the Record, Blue Cross/Blue Shield officials asserted that the Subcommittee staff's Statement contained "serious misunderstandings or errors." In support of their contentions, they cited reports and other data, which in their view refuted some of the Staff's findings regarding FEP costs, the FEP service charge, the discount/co-payment issue, Medicare oversight, and the Medicare Secondary Payer Program. For example, they cited a Towers, Perrin study as evidence that FEP administrative costs are "reasonable in comparison to the administrative expenses of other health benefit plans." Also emphasized was a Miller and Chevalier study, which purportedly refutes the Subcommittee staff's testimony regarding lavish, unwarranted costs charged to the FEP by Blue Cross/Blue Shield.

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[106] In their review of OPM internal files and correspondence, the Subcommittee staff came across other items that corroborate these observations, including the BCBSA's failure to: educate local Plans regarding changes in the FEP; submit financial statements in a timely manner; establish adequate procedures for the communication of appeals; and, resolve inconsistencies about who in Washington is responsible for handling various aspects of the FEP.

[107] HCFA uses CPEP to assess a Plan's compliance with Medicare program requirements and as a means of ranking its performance in relation to other contractors. Plans whose CPEP scores fall below the 20th percentile of all other participating contractors can be dismissed from the program. Such removal of a contractor, according to HCFA officials, is a rare occurrence, with only three Part B carriers having been terminated in the past three years. Notably, all three of these have been Blues Plans; i.e., the King County Plan in Washington State (May, 1993), Blue Cross/ Blue Shield of Michigan (March, 1994), and Blue Cross/Blue Shield of Maryland (May, 1994).

However, the Subcommittee notes that these reports were admittedly commissioned in response to its investigation and were not mentioned before the hearings. As then Chairman Nunn observed:

> I find it very strange and somewhat frustrating that these studies are taking place during the same period that we were having [this] investigation and you chose not to share them with us or to even tell us about them. * * * It looks like to me * * * [that] you hired your own consultants, paid them * * * out of your own funds and basically attempted to preempt the findings without telling us about it.

Moreover, only one of the reports was actually produced after the hearings and only at then Chairman Nunn's insistence. The other (the Miller and Chevalier study) the Subcommittee was informed, was a "legal analysis" performed by Blue Cross/Blue Shield's lawyers, not a report. Despite Mr. Tresnowski's testimony that he "would be glad to submit that," this document was withheld on grounds that it was subject to attorney/client privilege, which Tresnowski refused to waive. Blue Cross/Blue Shield's refusal to produce this analysis makes it impossible for the Subcommittee to accurately evaluate Mr. Tresnowski's testimony based on it that disputes some of the Staff's findings.

In addition, portions of Blue Cross/Blue Shield's testimony and use of these studies purportedly refuted "statements" or "conclusions" that were mischaracterizations of what the Subcommittee staff said in their Statement. For example, the officials maintained that the Subcommittee staff had said that: "Blue Cross and Blue Shield shouldn't earn a profit;" "it is improper to use portions of the service charge to pay unallowable expenses;" and, "Blue Cross Blue Shield got the benefit of [the billed versus the discounted amount of coinsurance]." In each case, the statements had not been made, prompting then Chairman Nunn to observe:

> Mr. Tresnowski, you have again set up a straw man. I don't think you will find anything where the staff says that. * * * What you are doing here is setting up one exaggerated staff finding after another and knocking them down. It is a very skillful job, but you are quoting things from the staff study without putting quote marks on it. You are deducing your own [conclusions] and you are implying things and then knocking them down. That is just not accurate.

The following Senators, who were members of the Permanent Subcommittee on Investigations at the time of the hearings, have approved this report:

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| William V. Roth, Jr. | Sam Nunn |
| Ted Stevens | John Glenn |
| William S. Cohen | Carl Levin |
| Thad Cochran | David Pryor |
| John McCain | Joseph Lieberman |
| | Byron L. Dorgan |

The following Senators who are currently Members of the Subcommittee but were not Members at the time of the hearing and did not participate in the hearing on which the report was prepared have taken no part in the preparation and submission of the report except to authorize its filing as a report made by the Subcommittee:

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|---|---|
| Fred Thompson | Daniel K. Akaka |
| Charles Grassley | |
| Bob Smith | |

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