

**BEFORE THE COMMISSIONER OF INSURANCE  
OF THE STATE OF KANSAS**

<b>In the Matter of the Conversion and Acquisition of Blue Cross and Blue Shield of Kansas, Inc.</b>	) ) )	<b>Docket No.: 3014-DM</b>
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**INTERVENORS KANSAS MEDICAL SOCIETY’S AND KANSAS HOSPITAL  
ASSOCIATION’S LEGAL MEMORANDUM IN OPPOSITION TO THE  
APPLICATION FILED BY BLUE CROSS AND BLUE SHIELD OF  
KANSAS AND ANTHEM INSURANCE COMPANIES, INC.**

Intervenors Kansas Medical Society (“KMS”) and Kansas Hospital Association (“KHA”) submit this legal memorandum in opposition to the application for approval filed by Blue Cross and Blue Shield of Kansas, Inc. (“BCBSKS”) and Anthem Insurance Companies, Inc. (“Anthem”). The Intervenors (KMS and KHA) submit this legal memorandum along with the testimony of Carl Schramm and Marvin Fairbank, including appropriate exhibits, to support their position.

KMS and KHA assert that the applicants BCBSKS and Anthem have provided an insufficient basis for the Commissioner to conclude that they have carried their burden of proof to obtain approval of the proposed acquisition and there is ample evidence presented by these Intervenors (and as part of the KID Testimonial Team presentation) to conclude that approval would be hazardous and prejudicial to the Kansas insurance-buying public.

**I. INTRODUCTION AND SUMMARY**

BCBSKS and Anthem admit BCBSKS is a successful company in a strong financial position. No one argues that this take-over is necessary to save BCBSKS from an existing financial crisis. The transformation proposed by the applicants would drastically change the health care environment for all providers and thousands of Kansas citizens. This would directly

impact one out of every two Kansas citizens outside of Johnson and Wyandotte counties. To propose such a drastic upheaval for so many hospitals, physicians, and patients when there is no apparent problem to be fixed puts a heavy burden on the applicants to justify the proposed transaction.

This Memorandum discusses at some length the track record of Anthem in other states, and, as troubled and alarming as that history is, it is not the indicator of Kansas' future that one might surmise. Instead, the future under an Anthem regime is much less favorable because Anthem is now (as of November 2001) a publicly-held company and must maximize profit to satisfy the investors that have poured \$2.1 billion of dollars into Anthem over the last two months. These investors expect, and will require, a return on that investment. Anthem's need to meet these investors' expectations could lead to significant marginal increases in premiums, increases in claim denial rates, reduced provider networks, and an overall degradation of the quality of health care for a huge number of Kansas citizens.

The KID Testimonial Team, while adopting a narrow and deferential approach to its task, nevertheless concludes that the likely premium increases, above those that will be required even without this transformation, mean that the acquisition will not be fair and equitable to policyholders and may be hazardous or prejudicial to the insurance-buying public.

The testimony of Marvin Fairbank, Director for Contracted Care at Stormont-Vail Healthcare, recounts his professional experience with Anthem and its application of Milliman & Robertson care guidelines and how Anthem's approach to medical necessity determinations has caused problems for providers and patients.

Carl Schramm's report addresses the supposed advantages of this proposed transaction and exposes them as myths unsupported by the facts. Mr. Schramm demonstrates that the

pressures exerted by shareholders to achieve earnings lead to reduced claim payouts and higher administrative expense. These factors require the conclusion that the takeover will threaten access to the ability of providers to sustain quality healthcare and will prejudice the health insurance buying public.

The Schramm report, authored by a former professor of health management and policy at The Johns Hopkins University School of Hygiene and Public Health and president of the Health Insurance Association of America as well as the president of Fortis Healthcare, a commercial health insurance company, argues that larger health insurance carriers are not more efficient or more competitive, as the applicants suggest to the Commissioner. In fact, Mr. Schramm argues, there is substantial evidence that the conversion of a non-profit Blue Plan to a for-profit, investor-owned company will mean a significant reduction in the percent of total revenue spent on healthcare claims. It seems apparent that a substantial reduction in the medical claims cost ratio will be hazardous or prejudicial to the insurance buying public.

## **II. DISCUSSION OF SCHRAMM AND FAIRBANK REPORTS**

### ***A. Carl Schramm's Report Explains The Lack Of Merit In The Asserted Reasons For The Takeover And How The Resulting Company Will Spend Less, As A Percentage, On Healthcare.***

Carl Schramm has prepared a report that is submitted with the pre-hearing filings made on behalf of KMS and KHA. Mr. Schramm is an economist and lawyer by training who lives in the Baltimore, Maryland area. He formerly served as a professor of health management and policy at The Johns Hopkins University School of Hygiene and Public Health and founded The Johns Hopkins Center for Hospital Finance and Management. Mr. Schramm is experienced in the non-profit and for-profit sectors. He has also been active in the regulatory area. Mr. Schramm served as chairman of the Maryland Health Services Cost Review Commission, and he

currently serves as a member of the Maryland Health and Higher Education Facilities Authority. Mr. Schramm has served as president of the Health Insurance Association of America and as president of Fortis Healthcare, a commercial health insurance company. He is presently vice-chairman of the board of Patient Choice Healthcare, Inc., in Minneapolis, and chairman of Greenspring Advisors, a consulting and economic research firm specializing in healthcare.

Mr. Schramm's report challenges the theories used by the applicants to support their proposed transformation. Mr. Schramm argues that there will not be "economies of scale" obtained as a result of this conversion, but that the true effect will be to create a less efficient organization and there will be a substantial reduction in the medical claims cost ratio if this transaction is approved. Mr. Schramm's report includes information suggesting that the percent of total revenue spent on healthcare claims in non-profit Blue Plans is approximately 83.7%. For commercial carriers it is 80.1%. However, investor-owned Blues, which is what the applicants are seeking, pays only 73.5% of total revenue on health care claims. This 10% difference is crucial to Mr. Schramm's analysis suggesting that the change from a non-profit blue plan to an investor-owned blue plan is problematic for policy holders, healthcare providers and the public.

Mr. Schramm's report reaches the following conclusion:

The founders of the state's Blue Cross and Blue Shield plans were not naive. They were business people who understood the importance of a non-profit organization to deal with a private market for a public good. They also understood that in healthcare the laws of the market do not always work and that, in some instances, unchecked market forces would produce results that were unacceptable to a compassionate community . . .

Today, it is appropriate to have the same concerns about markets that do not work to make healthcare available to all citizens. The ethos that characterize the Kansas Blue Plan should not be lightly dismissed. Providers are appropriately concerned that the intrusion of the pressure for shareholder returns, without any clear evidence that the for-profit form that the Blue Plan seeks will benefit the citizens of Kansas, may be a very bad bargain and one that is, in the end, transitory. A stable, mixed system of insurance has served this State and its providers well. It should not be abandoned without an

abundance of evidence that the good that will come to the health system will overcome the risks to the State's providers and its citizens.

Schramm report at 23.

***B. Marvin Fairbank's Report Explains the Negative Effects Created By Medical Care Guidelines Utilized By Anthem.***

Anthem utilizes a restrictive set of criteria to evaluate length of stay and medical necessity. BCBSKS utilizes a Kansas-based experience and guideline approach. Anthem utilizes the Milliman & Robertson Guidelines. These guidelines are "efficiency" based goals to health care. Milliman & Robertson Guidelines are also very controversial resulting in litigation. Physicians have sued to have their names removed from the guidelines. Patients have sued because of care denials. In Topeka, Anthem has a disproportionate share of denials resulting in the need for providers or consumers to resort to appellate processes.

Milliman & Robertson's efficiency standards penalize consumers who utilize rural providers. Due to size, provider mix, and other variables, rural health care institutions cannot meet criteria. Care at such institutions will be denied. Even the "100 Top Hospitals" are not efficient enough for Milliman & Robertson's pediatric guidelines.

The criteria utilized by Anthem and the method of application is not in the public interest.

**III. ANALYSIS OF APPLICABLE LAW**

***A. The Proponents Must Establish Every Element Required Under Kansas Law By Substantial Competent Evidence That Is Clear And Convincing***

As the proponents of the acquisition, BCBSKS and Anthem have the burden of proof to convince the Commissioner that each and every required element prerequisite to approval has been established. BCBSKS and Anthem both seemingly suggest by their submissions that the Commissioner should approach this mechanically as if it were nothing more than a proposed

merger between two ordinary insurance companies. Such an approach would be entirely inappropriate.

BCBSKS provides some form of coverage to approximately 67% of the eligible service area population. It is the insurer of last resort throughout its service area. It has provider contracts with 99% of Kansas hospitals and 98% physicians in its service area along with numerous other health care providers. It also provides administrative services to a number of self-insured groups whose member participants receive BCBSKS cards. In short, with the exception of government, it is quite likely that no other institution within the State of Kansas touches the lives of Kansans as frequently and as significantly as does BCBSKS. A change of this magnitude is thus not one to be addressed mechanically or lightly.

One prominent authority has noted the following with regard to the concept of burden of proof:

“The term ‘burden of proof’ often contemplates what the litigating proponent must establish in order to persuade the trier of the facts of the validity of his claim or affirmative defense, and, at times, is referred to as the ‘burden of persuasion,’ or as the ‘risk of non-persuasion.’

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“Implicit in this concept of the burden of proof is the problem of the quantum of proof necessary to carry the proponent’s burden of persuasion. This standard varies with the issue at hand, such as in a criminal trial, which calls for proof beyond a reasonable doubt, and in a civil trial (including an administrative adjudicatory proceeding), which demands either a preponderance of evidence (the most common situation) or clear, unequivocal and convincing evidence.”

4 J. Stein, G. Mitchell and B. Mezanines, *Administrative Law* 24.01, at 24-5 through 24-8 (2001).

This concept is carried forward in the Kansas Judicial Review and Enforcement of Civil Agencies Act, K.S.A. 77-601 *et seq.* That act effectively requires that a decision of a state agency be supported by substantial evidence and not be arbitrary and capricious. K.S.A. 77-621(c). Substantial evidence is evidence that possesses both relevance and substance and furnishes a substantial basis of fact from which the issue can reasonably be resolved. *E.g., State Department of Social and Rehabilitation Services v. Paillet*, 270 Kan. 646, 16 P.3d 962 (2001). It is such legal and relevant evidence as a reasonable person might accept as being sufficient to form a conclusion. *In re Broce Construction Co., Inc.*, 27 Kan. App. 2d 967, 970, 9 P.3d 1281 (2000). An agency decision unsupported by substantial evidence is arbitrary and capricious. *U.S.D. N. 461 v. Dice*, 228 Kan. 40, 50, 612 P.2d 1203 (1980).

This case does not present an ordinary transaction that should be evaluated merely by a preponderance of evidence that is conclusory in form and short on specifics. It is nothing at all like a typical transaction in which, as an example, one life insurance company acquires another and the standards of review utilized by the Commission in that type of acquisition should not be utilized in this case. The reason is that BCBSKS has monopoly market power. Assuming that the Commissioner even has authority to approve the proposed transaction, and the Intervenors contend that she does not as noted in the following section of this brief, the proponents should be required to provide clear, unequivocal and convincing evidence with regard to all required elements.

K.S.A. 40-3301(b)(2) expressly states, in pertinent part, that the public interest and the interests of policyholders are or may be adversely affected when acquisition of control of an insurance company would substantially lessen competition or create a monopoly in the insurance business in the state. That would seem to be doubly true if the insurer being acquired is a mutual

company with monopoly market power that is being acquired by an even larger company beholden not to its policyholders but to Wall Street and shareholders. Kansas law explicitly prohibits contracts, combinations or arrangements that may be in restraint of trade. *E.g.*, K.S.A. 50-101, 50-112. Assuming that the Commissioner has authority to do anything other than deny the requested acquisition, the Intervenor would suggest that these clear statements of policy by the Kansas legislature necessitate that the review by the Commissioner be much more searching and detailed than might ordinarily be the case and that incomplete data or opinions offered by those with a conflict of interest be rejected as support for this transaction.

***B. BCBSKS And Anthem Have Not Satisfied The Statutory Elements***

Before the acquisition may be approved, BCBSKS and Anthem must establish that the transaction is fair and reasonable to policyholders and in the public interest and not likely to be hazardous or prejudicial to the insurance-buying public. K.S.A. 40-3304(d)(1)(C) and (E). BCBSKS and Anthem must also establish that the experience of Anthem is such that the interest of policyholders is served by allowing the acquisition. K.S.A. 40-3304(d)(1)(D). They will not be able to sustain this burden. Indeed, they cannot do so as a matter of law because the transaction is not one that the Commissioner has authority to approve.

As noted previously, Kansas law explicitly prohibits practices that are or may be anti-competitive. For example, K.S.A. 50-112 explicitly prohibits any agreement that may “tend” to control the cost or rate of insurance. The Kansas statutes are replete with other references prohibiting anti-competitive practices. The legislature was cognizant of its long-standing policy prohibiting such practices when it adopted the Insurance Holding Company Act and expressly stated that the interest of the public and the interest of policyholders would be adversely affected if acquisition of control of an insurer would substantially lessen competition or create a

monopoly in the insurance business in this state. Nothing in the language of the Insurance Holding Company Act suggests that the legislature contemplated that an outside company might attempt to acquire an existing monopoly or that the legislature intended to allow such an acquisition to occur.

The filings in this proceeding by both Anthem and BCBSKS recognize the dominant position of BCBSKS in the health insurance market in this state. It has market or monopoly power. *Reazin v. Blue Cross and Blue Shield of Kansas*, 899 F.2d 951 (10th Cir. 1990). To reiterate what has already been said, the acquisition of a monopoly by an even larger company that is obligated not to its policyholders but to Wall Street is by definition hazardous or prejudicial to the insurance-buying public and, as a matter of law, the proponents of this transaction cannot carry their burden of proof as to K.S.A. 40-3304(d)(1)(E).

Anthem and BCBSKS are also unable to sustain their burden as to other elements of K.S.A. 40-3304(d)(1). Subparagraph (D) requires that the Commissioner evaluate whether the experience of those persons who will control the acquired company is such that the interests of the policyholders and of the public would be served by permitting the merger.

Anthem suggests that the information provided as Exhibit D to its Form A demonstrates that its directors and executive officers possess outstanding competence, experience and integrity. That may in fact be true but Anthem's statement is not responsive to the statutory test prescribed by K.S.A. 40-3304(d)(1)(D). The word "person" is defined in K.S.A. 40-3302(f) to encompass individuals, corporations, or other forms of entity and "any combination of the foregoing acting in concert." Thus, the "experience" of Anthem, as the acquiring entity, must be fully and carefully evaluated. That experience is virtually nonexistent.

The Anthem corporation that proposes to acquire BCBSKS in fact has no experience because it has never before functioned as a publicly-owned and publicly-traded corporation. No one can say for certain what impact will be caused by the pressure that Anthem management will feel to satisfy Wall Street. There is no “experience” on the part of Anthem as it presently exists sufficient to evaluate a transaction of this magnitude and significance to the state of Kansas.

That conclusion is supported by the track record of Anthem when it functioned as a mutual company. Substantial questions can be raised with reference to its conduct in other states and, to the extent the report of PricewaterhouseCoopers might suggest a different conclusion, that report is open to serious question. (*See* Section IV of this brief following.) However, the conduct of Anthem when it was owned by its policyholders is not necessarily reflective of its conduct when it is beholden to Wall Street. Anthem in its present form cannot establish the experience required to justify approval of this transaction.

In addition, K.S.A. 40-3304(d)(1)(C) requires that the Commissioner determine, before approving the transaction, that the plans or proposals of Anthem to make any material change in the business of BCBSKS are not unfair and unreasonable to policyholders and are in the public interest. The problem with the application of this particular requirement is that Anthem has not explained its plans to make changes in the operations of BCBSKS. (*See* Section IV of this brief following.) Anthem generally suggests that BCBSKS will continue to function as it has in the past and that all decisions of material significance to the public will continue to be made locally. It in fact goes to some lengths to emphasize the local nature of its operations in each state. This approach presumably allows it to suggest that its problems in other states are localized in each of those states and that these problems will not recur in Kansas. It has also produced a document showing that the total projected savings over a five-year period as a result of this transaction will

be less than \$8 Million. (Log A007375.) One may then validly ask how this transaction will be anything other than unfair and unreasonable both to policyholders and to the public, especially given the price admitted by a key management official of BCBSKS to be \$35 Million. *Topeka Capital Journal*, December 15, 2001 at 10A. The policyholders and the public are entitled to substantially more specifics than have been presented to this point and what has been presented is not adequate, in the circumstances of this extraordinary transaction, to justify its approval.

In that regard, the Intervenors would note two items of particular concern. One involves medical necessity criteria utilized by Anthem to evaluate whether care is to be authorized, particularly with regard to hospitalization, and the other focuses on use of so-called most-favored nations clauses in contracts with providers.

At the present time, neither policyholders nor the public, to include provider groups, have any assurance that medical necessity criteria will continue to be developed and utilized as they have in the past by BCBSKS. If Anthem's present practices in this state are used as an indicator, medical necessity will be evaluated using much different criteria. Those criteria have been condemned across the health care community and have generated litigation because of their abuse by large insurance companies. This is more fully addressed in the testimony of Marvin Fairbank.

In addition, Anthem has publicly stated its intention to utilize a form of most-favored nations clause. Such a clause generally requires that a health care provider not agree to a lower price from other payors than that paid by the payor instituting the clause without granting the same lower rate to the payor instituting the clause. When the insurance company utilizing such a clause contracts with a substantial percentage of providers in a market area and revenues from that insurer constitute a substantial percentage of those providers' revenues, such a clause "can

raise the price paid for health care services, raise entry barriers to new health plans attempting to enter the market, and facilitate oligopoly pricing.” 2 J. Miles, *Health Care & Antitrust Law: Principles and Practice*, § 15:23, at 15-142. Use of a most favored nations clause was introduced as evidence of and contributing to the market or monopoly power of BCBSKS in *Reazin v. Blue Cross and Blue Shield of Kansas*, *supra*, 899 F.2d at 971. BCBSKS has generally not attempted to enforce the clauses in its present provider contracts in recent years. However, Anthem leaves no doubt as to its intention as stated in its registration statement for its public stock offering:

We believe our market share enables us to negotiate favorable provider reimbursement rates. In some markets, we have a “modified favored rate” provision in our hospital and ancillary contracts that guarantees contract rates at least as favorable as those given to our competitors with an equal or smaller volume of business.

This effectively means that Anthem intends to utilize its market power to keep any smaller competitor from gaining market share. Such tactics would unquestionably be unfair and unreasonable to policyholders and not in the public interest.

#### **IV. ANALYSIS OF SUBMISSIONS BY BCBSKS, ANTHEM AND KID**

##### ***A. BCBSKS’s Presentation Ignores The Major Issues***

While impugning the motives of the Intervenors, BCBSKS provides no concrete information and ignores economic common sense in its brief supporting the proposed takeover. Vague references to “economies of scale” and the burden of future technology costs do not satisfy its burden of proof to demonstrate that the proposed change, directly affecting nearly half of the citizens in Kansas, will not be hazardous to existing or future policyholders or hazardous or prejudicial to the insurance buying public. *See generally*, K.S.A. §§ 40-3304(d)(1)(E); 40-4004(a).

The BCBSKS submission does little more than express conclusions. For example, on page 4 of its brief, BCBSKS suggests that Anthem is providing \$190 Million in cash consideration for the stock of BCBSKS without discussing the numerous challenges to this figure that have repeatedly been made at the public hearings. Mike Mattox, a BCBSKS Executive Vice President, is quoted as saying that the actual investment made by Anthem is \$35 Million. *Topeka Capital Journal*, December 15, 2001, at 10A. The failure of the BCBSKS brief to candidly discuss these issues reflects a pattern in the submission made to the Commissioner.

The same unwillingness to address the controversy issues that lead to overflow crowds protesting this takeover is seen in the BCBSKS discussion of whether this plan is hazardous or prejudicial to the insurance buying public. The salient point of this entire controversy is the impact of the obligation of Anthem to create value for its shareholders that will exist if this takeover is approved yet that is not directly addressed by the BCBSKS brief. Even though BCBSKS acknowledges that it is “financially sound and enjoys a strong in-market share . . .” it nevertheless suggests that this transaction is necessary. BCBSKS’s brief does not address the exact nature of how this takeover will affect the day-to-day lives of BCBSKS policyholders. The brief simply states that competition will protect the policyholders and the change in their organizational form will not alter this point. How can acquisition of a monopoly by a large publicly-traded company from outside Kansas possible protect policyholders?

***B. Anthem’s Presentation Makes No Commitment About Future Operations and Ignores Basic Issues***

The Anthem submission to the Commissioner follows the BCBSKS approach of conclusory statements with little detail or analysis. The Commissioner will find it difficult to locate any specific statements about the exact methods that Anthem will employ if it is permitted

to take over Kansas' largest health insurance company. Although Anthem's submission is sensitive to the question of whether the proposed successor entity to BCBSKS is actually run locally, the prefiled testimony of Dr. Nussbaum makes it clear that "medical policy" will be decided by a national committee and imposed upon the Kansas company. Prefiled Direct Testimony of Samuel R. Nussbaum, M.D., at 2 ("a medical policy group comprised of medical directors from all Anthem states . . . . engages the viewpoints of academic and community specialist physician experts in Anthem states to determine Anthem's national policy." (emphasis added)). In response to the next question, Dr. Nussbaum states that "locally based medical directors" are "involved" in complex clinical decisions as opposed to indicating that such medical directors "decide" or "control" such decisions. *Id.*

Dr. Nussbaum's direct testimony, as well as the direct testimony of all the other Anthem witnesses, fails to mention the issues that are crucial to a fair analysis of the proposed transaction. For example, as set out in the Kansas Medical Society Motion to Intervene, a number of specific conditions were placed upon Anthem as part of the approval by the Maine Bureau of Insurance. Some of the conditions pertinent to the issues to be addressed by the intervenors include the following:

21. AHPM [Anthem affiliate] shall utilize all commercially reasonable efforts to maintain a network of providers throughout the State of Maine that is comparable in size, geographic scope, and types of providers (including, without limitation, primary care physicians, specialists, nurse practitioners, all levels of hospitals, ancillary providers, and rural health centers) to the existing BCBSME network of providers. AHPM shall immediately notify the Superintendent if a Maine hospital or physician hospital organization (PHO) terminates its contractual relationship with AHPM.

23. If, at any time, AHPM decides to cease offering a product currently offered by BCBSME, or to withdraw from a geographic service area, it must file a plan of withdrawal with the Superintendent six months in advance of terminating the product, unless law specifies

another time period. There shall not be any degradation of the provider network supporting this product or geographic service area until the product is completely withdrawn from the market or the geographic service area limitation has been approved by the Superintendent. The plan shall specify the number and location of subscribers to be affected; any similar benefit offerings that would remain available and the rates therefore; the reasons for such termination; the affect on the solvency of AHPM; the methods to be used to notify subscribers and providers; and such other information as may be required by the Superintendent.

30. Anthem and AHPM shall assure that AHPM's local medical director is a medical provider licensed by the State of Maine Board of Licensure in Medicine or by the State of Maine Osteopathic Board. Additionally, Anthem and AHPM shall assure that AHPM's medical director for mental health services is a psychiatrist licensed by the State of Maine Board of Licensure in Medicine.

31. AHPM shall not reduce its service area in any manner without first filing a plan of withdrawal with the Superintendent for his review and approval. The plan shall include, at a minimum, those items set forth in Condition 23, above.

Kansas Medical Society Petition to Intervene.

In New Hampshire, the Department of Insurance approved a transaction similar to the one proposed here but added 18 separate conditions. A number of those conditions address issues directly concerning physician providers and the issues that KMS and KHA seek to examine. The following conditions were included in the New Hampshire Department of Insurance approval:

### **3. Local Advisory Board**

a. Anthem NH shall establish a Local Advisory Board ("Advisory Board") within ninety days of Closing. The Advisory Board shall meet at the call of the Chair or at the request of a majority of its members. The Advisory Board shall consist of at least nine members to be appointed by Anthem NH, after consultation with both the Intervenors and the former Board members of BCBSNH with respect to the initial appointment of such members. The members of the Advisory Board shall possess

knowledge and experience in dealing with the health care needs of the citizens of New Hampshire. In addition, one or more of such members shall have demonstrated expertise in at least one of the following: (i) the health care needs of medically under-served areas of New Hampshire, (ii) mental health, and (iii) medical needs of persons with disabilities and chronic health conditions.

b. The Board of Directors of Anthem NH and executive officers, including, without limitation, the Chief Executive Officer, Chief Financial Officer and Medical Director, shall consult with the Advisory Board in person or by telephone conference call at least once quarterly during the first twenty-four months following the establishment of the Advisory Board and, thereafter, at a reasonable time in advance of any decisions to make any material changes in operations, including, without limitation, significant changes in (1) product portfolio; (2) employment levels; (3) community benefits; (4) medical management, (5) network access, (6) provider contracting, (7) benefit offerings, and (8) any drug formulary. Prior to the implementation of any such operational change, Anthem NH shall submit a detailed communication plan to this Department and the Advisory Board for notifying affected policyholders, enrollees, health care providers, employees and members which shall explain in lay terms the impact of such change: and provide clear information as to whom the affected constituent may contact for more information about their options, rights and alternatives. Anthem NH shall include with its notice any plans of action it may anticipate implementing; to avoid or minimize its disruption in patient care.

7. Until July 1, 2000 Anthem NH shall not enforce any provisions in any existing contracts or enter into any new contracts with providers of health care in New Hampshire requiring, by their terms or in effect, such providers to offer Anthem NH “most favored” terms or “equally favored” terms, except that the foregoing prohibition shall not apply if prior to July 1, 2000 a competing health insurer (i) has or obtains, singly or in combination with affiliates, at least 20% of the market for health insurance in New Hampshire and (ii) enforces or seeks to enforce such provisions. This Condition shall not impair or supersede or in any way affect any contract with a provider of health care entered into by BCBSNH or MTHP or MT Insurance for periods prior to the date of this Order.

11. Anthem NH shall utilize all commercially reasonable efforts to maintain, for thirty-six months following the Closing, a network of providers throughout the State of New Hampshire that is comparable

in size, geographic scope, and types of providers (including, without limitation, nurse practitioners) to the existing network of BCBSNH providers. This requirement shall be subject to minimum credentialing standards adopted by Anthem NH. Beginning six months following the Closing and continuing every six months thereafter for a period of thirty-six months, Anthem NH shall provide a written report to (i) the Insurance Department and (ii) the Advisory Board detailing the number and geographic location of its current providers and such information as the Department shall require reasonably in advance of such report. Anthem NH shall also provide reasonable technical support to such studies as are undertaken by the Department in respect of statewide network access.

[Findings and Final Order, New Hampshire Insurance Department - Paula T. Rogers Insurance Commissioner, Docket No. INS. 99-003-AP \(October 26, 1999\), at 12-15.](#)

Although these problems are well known to Anthem and Dr. Nussbaum, there is no mention of any of these questions in the submission by Anthem or in Dr. Nussbaum's prefiled testimony.

It is apparent that Anthem seeks the unrestricted discretion to transform BCBSKS in any manner it chooses. There are no commitments. There are no enforceable promises. There are only vague allusions, coupled with descriptions of "emphasis" and "focus". Even assuming that these statements are accurate and made in good faith, they provide no reliable assurance for the insurance-buying public in Kansas that what Anthem will do a year after this transaction is closed will not be hazardous or prejudicial.

***C. PwC Report Fails To Provide a Reliable Description Of Anthem***

As part of its evaluation, the Testimonial Team retained PricewaterhouseCoopers (PwC) to, in its words, "address questions related to potential changes in insurance coverage in Kansas resulting from the transaction." PwC Report at i. Its report suggests that "[t]o assess the potential effects of the transaction, we compared results of similar marketplace activities to those

anticipated in the State of Kansas after the proposed transaction.” *Id.*<sup>1</sup> Unfortunately, the PwC Report is a mass of factual information, much of it incomplete or unverifiable, without significant analysis or insight.<sup>2</sup>

The worst example of incomplete or unverifiable information appears on pages 49 and 50 in which PwC reports that interviews were conducted with representatives of hospital and medical associations in six states and that the reports were generally favorable. These Intervenor have been unable to verify who was interviewed, what was asked or what exact responses were provided. Representatives of associations in these states have not been complementary of Anthem in their discussions with the Intervenor.

In any case, this type of presentation by PwC, assuming it is entitled to any weight at all, overlooks a crucial point. The plans acquired by Anthem to this point have been unsuccessful standing on their own. They have generally had low market share and in some instances were teetering on the edge of bankruptcy. In effect, they could only improve or collapse. That they may be seen as improving says nothing about what will happen in Kansas, which has the good fortune of a Plan that is one of the best in the entire Blue Cross Blue Shield system with a huge market share and nearly 100% of the providers under contract in its network.

The PwC Report also notes a report that Anthem would not forgo its most-favored nation clause in its provider contracts. PwC Report at 49. Yet the Report is devoid of analysis of the implications of this in a state such as Kansas. As noted previously in this brief, use of such a

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<sup>1</sup> Of note is that the Report, at Table 3-6, purports to report statistics with regard to Kansas physicians. Interestingly, the PwC Report does not even reference the official numbers available from the Kansas State Board of Healing Arts at [www.ksbha.org/statistics.html](http://www.ksbha.org/statistics.html).

<sup>2</sup> The Intervenor would note that this is not in any way the fault of the Testimonial Team, which received the report only within days of the filing of this brief. The Intervenor do not question the direction provided to PwC but they do question the PwC result.

clause by a company with the market share of BCBS has substantial implications for the insurance-buying public and for health care in this state.

The Report also identifies a number of lawsuits and attempts to describe pending litigation involving Anthem. Report at 44-47. However, much of this information is incomplete or inaccurate.

One example is the Report's reference to *State of Connecticut v. Anthem Blue Cross and Blue Shield of Connecticut, Anthem Health Plans, Inc., et al.*, (Report at 46) relating to alleged violations of the Employee Retirement Income Security Act of 1974 (ERISA). The language of the Report almost mirrors exactly the language selected and used by Anthem in its S-1 filing and in its prospectus for its public stock offering. But an independent review of the actual complaint indicates a much broader allegation and therefore a much broader concern associated with the actions of Anthem. The Connecticut Attorney General brought an action against Anthem Blue Cross Blue Shield of Connecticut plus six other defendants as a class action on behalf of all persons in Connecticut who are members in HMO or POS plans operated by the defendants. The Attorney General alleges that (1) the defendants breached their obligations under ERISA by failing to disclose, concealing and misrepresenting the nature and extent of the coverage provided by the plans including material facts concerning how defendants determined whether proposed or ongoing care is medically necessary and hence covered under those plans, (2) that the defendants breached their obligations under ERISA by obstructing and/or denying their members access to medically necessary medications that are not included in lists of preferred medications; (3) that defendants breached their obligations under ERISA by providing inadequate and inadequately trained staff to handle inquiries from members and/or providers making it difficult to have such claims addressed in a reasonably timely manner; (4) that

defendants breached their obligations under ERISA by routinely and unjustifiably failing to make timely payments to providers thereby threatening enrollees with the loss of necessary care, and (5) that defendants breached their obligation under ERISA by using inappropriate and arbitrary coverage guidelines as a basis of coverage denials. The very fact that the Attorney General of a sister state would make such a claim against Anthem, even though also made against other insurers, is cause for extreme caution in evaluating this transaction. Anthem may be no better or worse than other large for-profit companies. But BCBSKS is better and should remain so.

The PwC Report also purports to discuss litigation in Ohio. On page 47 it references *Dardinger v. Anthem Blue Cross and Blue Shield, et al.*, which resulted in a huge punitive damage verdict against Anthem for its inadequate claims handling practices and notes a reversal of that award by the Ohio Court of Appeals. It fails to note, however, as described in the Anthem prospectus, that on “. . . October 10, 2001, the Supreme Court of Ohio agreed to hear the plaintiff’s appeal, including the question of punitive damages, and denied the cross-appeal of Anthem and CIC [Community Insurance Company].”

In addition the Report does not note that there are two other cases pending in Ohio similar to *Dardinger*. *Kemp Allemange v. Anthem Insurance Companies, Inc.*, Court of Common Pleas, Clinton County, Ohio, C.V.H. 20010140, alleges breach of contract and bad faith arising out of the defendant’s refusal to authorize, approve, and pay for necessary medical treatment for the plaintiff. *Joseph Robert Evans v. Anthem Insurance Companies, Inc., et al.*, Court of Common Pleas of Pike County, Ohio, Case No. 122CIV01, also alleges breach of contract and bad faith arising out of the defendant’s refusal to authorize, approve, and pay for necessary

medical treatment for the plaintiff. These and other similar suits raise the issue of Anthem’s ongoing business practices in the area of “ medical necessity” decision making.

The Anthem prospectus (page 131) also references *Connecticut State Dental Association, et al. v. Anthem Health Plans, Inc.*, filed in Superior Court, Judicial District of Hartford, Connecticut on October 10, 2001. The suit alleges that the Connecticut affiliate of Anthem violated the Connecticut Unfair Trade Practices Act by unilaterally altering fee schedules without notice or a basis to do so, instituting unfair and deceptive cost containment measures and refusing to enroll new providers unless they agreed to participate in all available networks. There does not appear to be any detailed explanation of this suit in the PwC Report. See Appendix A for a summary of this lawsuit.

The PwC Report also addresses complaints to state insurance departments. (Report at 43-44.) The Report compares the states of Colorado, Indiana, Kansas, Kentucky, Ohio and Maine in table 5-9, page 44. This type of limited presentation is hardly sufficient as evidentiary support for the transaction proposed in this proceeding.

For example, an analysis of complaints in Colorado reflects the following (statistical data taken from [www.dora.state.co.us/insurance](http://www.dora.state.co.us/insurance)):

- Anthem purchased Blue Cross Blue Shield in November 1999.
- In 1999 Anthem Blue Cross Blue Shield of Colorado had slightly over \$213 million in premiums. In 2000 the premiums dropped to slightly below \$150 million. During the same time market share dropped from 11.3% in 1999 to 8.04% in 2000.
- During the time period of 1999 to 2000, the complaint ratio increased as follows:

INSURANCE CO. *	COMPLAINT RATIO	PREMIUM (\$ MILLION)	MARKET SHARE
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<b>INSURANCE CO. *</b>	<b>COMPLAINT RATIO</b>	<b>PREMIUM (\$ MILLION)</b>	<b>MARKET SHARE</b>
Anthem Blue Cross Blue Shield of Colorado	2000: 1.39	\$149.89	8.04%
Anthem Blue Cross Blue Shield of Colorado	1999: 0.63	\$213.01	11.30%
Colorado Dental Service, Inc.	2000: 0.04	\$144.86	7.77%
Colorado Dental Service, Inc.	1999: 0.04	\$113.16	6.00%
Connecticut General Life Ins. Co.	2000: 0.18	\$109.32	5.86%
Connecticut General Life Ins. Co.	1999: 0.19	\$76.94	4.08%
Employers Health Insurance Co.	2000: 0.34	\$268.94	14.42%
Employers Health Insurance Co.	1999: 0.41	\$227.81	12.09%

\* Only selected companies used for illustration on these tables – please see entire web site chart for all companies.

- The average complaint ratio for year 2000 for the above four companies was .4875. Excluding Anthem from the average, then the average for the three remaining companies for year 2000 was .186.
- The 2000 complaint ratio for all 37 companies in the Colorado survey was 1.00. Excluding the highest and the lowest number of complaints leaving 35 companies produced an average complaint ratio of .885.
- Additionally, a review of Anthem Blue Cross Blue Shield HMO in Colorado (HMO Colorado, Inc.) shows that the HMO complaint ratio in the year of purchase, 1999, was 0.55 after being 0.33 in 1998 and 0.32 in 1997. This complaint ratio increased in 2000 to 0.62.
- A comparison for any company having an HMO market share of 5% or greater shows the following:

<b>INSURANCE CO.</b>	<b>2000 COMPLAINT RATIO</b>	<b>PREMIUM (\$ MILLION)</b>	<b>MARKET SHARE</b>
Aetna US Healthcare of Colorado	0.27	\$212.59	10.51%
HMO Colorado, Inc. (Anthem)	0.62	\$149.6	7.39%
Kaiser Foundation Healthplan of Colorado	0.13	\$497.31	24.58%
PacifiCare of Colorado, Inc.	0.31	\$434.09	21.45%
Rocky Mountain HMO, Inc.	0.23	\$158.30	7.82%
Sloans Lake Health Plan, Inc.	0.21	\$100.88	4.99%
United Healthcare of Colorado, Inc.	0.16	\$158.06	7.81%

Publicly-accessible information published for 1999 by the Kentucky Department of Insurance also shows poor performance by Anthem ([www.doi.state.ky.us/kentucky/search/complaint](http://www.doi.state.ky.us/kentucky/search/complaint)):

<b>COMPANY NAME</b>	<b>JUSTIFIED COMPLAINTS</b>	<b>PREMIUMS WRITTEN</b>	<b>RATIO</b>
Anthem Health Plans of Kentucky, Inc.	530	\$912,247,130	0.58
Denta Dental Plan of Kentucky, Inc.	10	\$21,928,167	0.46
Employers Health Insurance Company	0	\$5,711,583	0
Prudential Health Care Plan, Inc.	6	\$18,129,923	0.33
United Health Care Insurance Company	23	\$71,164,111	0.32
United Health Care of Kentucky, Ltd.	57	\$195,959,819	0.29
United Health Care of Ohio, Inc.	1	\$3,528,669	0.28

The PwC Report suggests the complaint ratio for Anthem in Ohio is “above average” but provides no further information or definition. (Report at 44.) The Ohio Department of Insurance

complaint ratio information may be obtained at [www.ins.state.oh.us/consumserv/ocs/OSCRatios.htm](http://www.ins.state.oh.us/consumserv/ocs/OSCRatios.htm). The Anthem complaint ratio for 1998 was 22.84 and the complaint ratio for 1997 was 15.98. For the 32 listed insurance companies, only one other company was in double digits for 1998. The next closest complaint ratio was then 2.92. For 1997, Anthem Insurance Company was the only company with a double-digit complaint ratio. Anthem's Ohio complaint ratio performance might thus be better characterized as horrible rather than above average.

The PwC Report does not reference Connecticut or note that the Connecticut Insurance Commissioner has published "A Comparison of Managed Care Organizations in Connecticut," dated October 2001. The "guide", as it is referred to in the document, is designed to help compare managed care organizations. It contains data from all health maintenance organizations (HMOs) and the 15 indemnity insurers with the highest premium volume for managed care plans in Connecticut. It includes on page 13 a table entitled "Health Maintenance Organizations Utilization Review Measures" that lists eight companies, including Anthem Blue Cross Blue Shield. Anthem ranked as the highest in the percentage of utilization review requests denied at 24.81%. The next closest was 16.01% and then 11.52%. The remaining five were all in single digits. Anthem, however, was the fifth highest in "percentage of denials that were reversed on appeal" with 35.50%. In the "Indemnity Managed Care Organizations Utilization Review Measures" found at page 31 Anthem Blue Cross Blue Shield was again highest in percentage of utilization review requests denied at 27.61%. The next closest figure was 9.52%. Of the six companies which reported percentage of denials that were reversed on appeal, Anthem was fourth highest with 26.62%. This suggests that Anthem places a number of hurdles in the way of its policyholders who seek payment for needed care. The data contained in the Connecticut

Insurance Commissioner's report also strongly suggests the reason that the Connecticut Attorney General determined to take legal action against Anthem.

The Report also leaves out other important public information. Connecticut state regulators also fined Anthem \$53,000 in 1999 because the company failed to settle some emergency room complaints fast enough and improperly paid commissions to its agents. (see [www.insure.com](http://www.insure.com) [June 11, 1999]).

Additional information is contained in Appendix A to this Brief as to litigation involving Anthem and its issues with various commissioners of insurance. Health care providers may legitimately ask why a company with this type of record should be allowed to acquire BCBSKS, which has a much different history, and why there is any reason to expect anything other than a worse record from an Anthem that must take the reaction of Wall Street into account. The PwC Report answers neither question.

The PwC Report also notes that conditions of approval have been imposed in other states as a means of protecting the public interest. (Report at 56.) Oddly, however, PwC only reviewed orders from three other states and admits that none is analogous to Kansas. The Report simply lists various conditions imposed in the three states that PwC reviewed without comment as to their potential applicability to Kansas. The Intervenors would suggest that this is simply not adequate. More should be expected than a mere laundry list of possible conditions without analysis as to why such conditions were imposed in a particular state and whether that reason has application in Kansas.

The bottom line is simply that the PwC Report is inadequate to provide an evidentiary foundation for action by the Commissioner to approve this transaction. The Report provides virtually no analysis of the marketplace impact of the transaction and does not address signifi-

cant considerations relevant to that issue. It also does not even attempt to address the impact of the transaction on the day-to-day health care issues affecting thousands of Kansans.

***D. Bear Stearns' Fairness Opinion Is Clouded By Promotion Of Anthem Stock***

The Intervenors are also compelled to comment on the Report and fairness opinion prepared by Bear, Stearns & Co., Inc. (Bear Stearns). While this is outside the scope of the issues as to which the Intervenors may present direct testimony, the Intervenors, as policyholders and representatives of the health care community, believe they have the same right as others to comment on this aspect of the transaction.

The Intervenors find it objectionable and inappropriate that Bear Stearns has rendered its opinion while at the same time touting Anthem stock to its clientele as “one of the most compelling new stories to emerge in the publicly traded managed care world in years.” *See* Appendix B to this Brief. Bear Stearns issued a “new purchase recommendation” for Anthem stock on November 7, 2001. According to its Report, this was but one day after its last meeting with BCBSKS concerning its opinion on this transaction. (Bear Stearns Report, p. 11.)

On November 1, 2001 issued a report available to its clientele entitled “Anthem Inc.: The Power of Blue.” That report essentially assumed that the acquisition of BCBSKS would be approved. After touting the Anthem stock, at least in part with reference to the Kansas acquisition, Bear Stearns could do nothing but reach an opinion that this transaction is fair to policyholders.

Also of note is that the Bear Stearns Report states that Anthem is purchasing BCBSKS for \$190 million (p. 3) and makes references to this as the purchase price throughout the report. Yet a table in its report to its clientele, under the heading “Amount Paid”, contains the amount of \$370 million with reference to the acquisition of BCBSKS by Anthem. This is shown to be a

price per member of \$517 for BCBSKS as compared to an average across 23 acquisitions of \$607 per member. Neither of the tables in the Bear Stearns report prepared for the Testimonial Team matches up with the \$517 per member shown in its report to its clientele and neither approaches the \$607 per member average.

Bear Stearns was retained as a representative of the policyholders and public of Kansas. Its report should not be tainted by any hint of conflict of interest and in the context of a transaction of this magnitude should be rejected as inadequate evidentiary support for any finding or decision.

## **V. CONCLUSION**

For all of the reasons set forth in this memorandum, the Kansas Medical Society and Kansas Hospital Association assert that the application made by BCBSKS and Anthem should be denied because the applicants have not met their burden of establishing the appropriateness of this transaction and there is ample evidence that suggests that the proposed takeover is not in the best interest of policyholders and the insurance buying public.

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**CERTIFICATE OF SERVICE**

The undersigned hereby certifies that a true and correct copy of the above and foregoing pleading was served by e-mail and by U.S. Mail this \_\_\_\_ day of \_\_\_\_\_, 2001, to:

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# APPENDIX A

TO

INTERVENORS KANSAS MEDICAL SOCIETY'S AND KANSAS HOSPITAL  
ASSOCIATION'S LEGAL MEMORANDUM IN OPPOSITION TO THE  
APPLICATION FILED BY BLUE CROSS AND BLUE SHIELD OF KANSAS  
AND ANTHEM INSURANCE COMPANIES, INC.

## LITIGATION AND REGULATORY ISSUE SUMMARY

	ISSUE/ITEM	DESCRIPTION	NOTES/DISCUSSION
1	Litigation: Ohio	“Report of examination of the Community Insurance Co. as of December 31, 1997:” A final order and judgment was issued on April 8, 1998, by the United States District Court, Southern Dist. of Ohio, Western Div. and the Hamilton County Court of Appeals. The settlement allowed for \$2.7 million to the class and \$1.5 for plaintiffs’ attorney’s fees and expenses plus \$2 million in administrative costs. The order required the company for a period of 5 years from its effective date to calculate co-payments and lifetime and maximum benefits, on the basis of the actual amounts paid to the providers by the company or the provider’s billed charges for covered services or products, whichever amount is less. The order also allowed the company 2 years to make necessary system changes to meet the order’s conditions.	“Report of examination of the Community Insurance Co. as of December 31, 1997:” See p.2 of report under “Co-payment Litigation.” [A007001]
2	Litigation: Kentucky	“The Kentucky Department of Insurance is in litigation with both administrators, Plan Source and United Chambers, concerning the status of the state of Kentucky Alliance business placed with various carriers.”	See page 92, Market Conduct Examination Report, August 2, 1999, Kentucky Insurance Commissioner report. [A008956]
3	Litigation: Kentucky	<i>The Kentucky Department of Insurance v. SMIC, SUMI, SGI, and AICI.</i> This lawsuit relates to the merger of SMIC and AICI in July 1993. The Department of Insurance seeks unspecified relief, including payments to certain former policyholders, arising out of alleged misrepresentation of	See page 10 of Department of Insurance “Annexed Copy of Report on Examination of Anthem Health Plans of Kentucky, Inc. [formerly Southeastern Group, Inc., report dated as of December 31, 1998].” [A00844]

		operational efficiencies that the merger would achieve. According to AHPKY, the outcome of this lawsuit cannot be determined at this time.	
4	Litigation: Kentucky	<i>The Kentucky Attorney General v. SMIC, AICI, SCI and SUMI</i> . This lawsuit also arises from the merger of SMIC into AICI. The Kentucky Attorney General is pursuing an action to recover certain of SMIC's assets. The primary issue is whether the merger invoked a charitable trust on the assets of SMIC.	See page 10 of Department of Insurance "Annexed Copy of Report on Examination of Anthem Health Plans of Kentucky, Inc. [formerly Southeastern Group, Inc., report dated as of December 31, 1998]." [A00844]
5	Litigation: Kentucky	<i>Kentucky Health Purchasing Alliance v. AHPKY</i> . This 1999 case is brought by this former Kentucky statutory entity to resolve issues and amounts owed by the third-party administrator and/or the HMOs and other insurers participating in the health insurance purchasing group. AHPKY reported an estimate of \$7,992,202 as net premiums due from the Kentucky Health Purchasing Alliance as of December 31, 1998. Although the amount was considered an admitted asset as of year end, it has been reflected as an asset not admitted in recent financial statements due to the aging requirements of statutory accounting principles.	See also the report of examination of AHDS as of December 31, 1998 for more information regarding this operation and litigation. [A00844]
6	Litigation: Connecticut	Class action lawsuit filed by State of Connecticut by Attorney General of Connecticut: Attorney General has brought an action against Anthem Blue Cross Blue Shield of Connecticut plus six other defendants as a class action on behalf of all persons in Connecticut who are members in HMO or POS plans operated by	[See Connecticut complaint]

		<p>the defendants. Allegations include whether defendants breached their obligations under ERISA by failing to disclose, concealing and misrepresenting the nature and extent of the coverage provided by the plans including material facts concerning how defendants determined whether proposed or ongoing care is medically necessary and hence covered under those plans, whether defendants breached their obligation under ERISA by obstructing and/or denying its members access to medically and necessary medications that are not included in its list of preferred medications; whether defendants breached their obligations under ERISA by providing inadequate and inadequately trained staff to handle inquiries from members and/or providers making it difficult to have such claims addressed by defendants in a reasonably timely manner; whether defendants breached their obligations under ERISA by routinely and unjustifiably failing to make timely payments to providers thereby threatening enrollees with the loss of necessary care; whether defendants breached their obligation under ERISA by using inappropriate and arbitrary coverage guidelines as a basis of coverage denials; whether defendants have breached their contractual obligations to plaintiffs (State of Connecticut class members).</p>	
7	Litigation: Ohio	Information from "Central Ohio Source" posted August 29, 1997	

		indicates that several Cincinnati, Ohio specialists have sued Anthem Blue Cross Blue Shield after it dropped them from its provider network in several plans.	
8	Litigation: Maine	<p>Maine Department of Professional and Financial Regulation, Bureau of Insurance. September 28, 2001 filing relating to Anthem Blue Cross Blue Shield and Maine, Partners Health Plan 2002 rate filing.</p> <p>Information filed indicates that Anthem is in the process of implementing “a more accurate cost allocation system” as it relates to administrative cost by product line and that other refinements are scheduled for 2002. Additionally, the filed information indicates Anthem states that the individual HMO rate increase will average 31.7%.</p>	
9	Litigation: Maine	<p>Maine Department of Professional and Financial Regulation, Bureau of Insurance. Maine Attorney General files designation of issues for a hearing to be held October 17, 2001:</p> <p>1. The reasonableness of the proposed rate increase in light of the fact that recent years’ financial performances have been considerably more favorable than expected, specifically the reasonableness of the following:</p> <p style="margin-left: 40px;">A. Claims trend assumptions. B. The administrative expense component. C. The underlying rate development methodology.</p> <p>2. The reasonableness of</p>	

		<p>Anthem’s allocation of its administrative expenses.</p> <p>3. The reasonableness of the investment income credit, given that it does not include a component for interest income on long-term investments.</p> <p>4. The appropriateness of Anthem’s level of marketing effort for individual products.</p>	
10	Litigation: Maine	<p>Maine Department of Professional and Financial Regulation, Bureau of Insurance. Prefiled testimony of Paul T. Swobota, Health Policy and Health Finance Consultant, consultant to Maine Department of Attorney General and former manager, program development unit and Hospital Bureau of the Massachusetts Race Setting Commission.</p> <p>Mr. Swobota is of the opinion that the use of administrative expenses in its rate filing has not been justified by Anthem because, in part, the addition “to the failures of Anthem and Blue Cross, . . . use of those rates involve both inappropriate incentives to Anthem as well as equity issues to non-group subscribers.” Additionally, his testimony was that the proposed average 13.5% increase requested by Anthem for its Health Choice products is excessive because, in part, Health Choice products have actually performed considerably better financially than projected by the company in prior filings submitted in support of rate increases.</p>	
11	Corporate Integrity Agreement (CIA)	<p>CIA between OIG and Anthem Health Plans, Inc., doing business as Anthem Blue Cross Blue Shield of Connecticut: In December 1999</p>	

		<p>Anthem entered into a CIA with obligation to comply with the CIA for five years from the effective date of the CIA. Obligations include the preparation of a code of conduct, Anthem Blue Cross Blue Shield of Connecticut's commitment to full compliance with all statutes, regulations and written federal governmental directives applicable to federal health care programs, required training and education, obligation to perform annual assessments through an outside entity to assess Anthem Blue Cross Blue Shield of Connecticut performance under its Medicare + Choice contract relating to enrollment data submission, encounter data submission, adjusted community rate data submission, claims procession and selective marketing/disenrollment practices plus an additional engagement to determine whether it is in compliance with the CIA.</p>	
12	Corporate Integrity Agreement (CIA)	<p>In July 1999 a CIA was entered into between United States Department of Health and Human Services and Rocky Mountain Hospital and Medical Service, dba Blue Cross Blue Shield of Colorado.</p> <p>The content of this CIA is similar to the above CIA between Health and Human Services and Anthem Blue Cross Blue Shield of Connecticut.</p>	The Rocky Mountain Health Corporation CIA is carried on the HHS OIG web site as a CIA with Anthem Blue Cross Blue Shield of Colorado.
13	Litigation: Connecticut	<p>1. <i>Edward Collins, M.D. et al v. Anthem Health Plans, Inc.</i>, No. CV-99-0156187 S, filed December 14, 1999 in Superior Court, Judicial District of Waterbury, CN.</p>	See SEC filing Form S-1

		<p>2. <i>Steven R. Levinson, M.D., et al v. Anthem Health Plans, dba Anthem Blue Cross Blue Shield of Connecticut</i>, filed February 14, 2001 in Superior Court, Judicial District of New Haven, Connecticut.</p> <p>3. <i>State Medical Society v. Anthem Health Plans, Inc.</i> filed February 14, 2001 in Superior Court, Judicial District of New Haven, Connecticut.</p> <p>These suits (<i>Collins, Levinson</i> and <i>State Medical Society</i>) allege that the Connecticut affiliate has breached its contracts by, among other things, allegedly failing to pay for services in accordance with the terms of the contracts. Additionally, the suits allege violation of the Connecticut Unfair Trade Practices Act, breach of the implied duty of good faith and fair dealing, negligent misrepresentation and unjust enrichment.</p> <p>4. On October 10, 2001 the Connecticut State Dental Association along with five dental providers filed suit against the Connecticut affiliate in which it alleges violation of the Connecticut Unfair Trade Practices Act by allegedly unilaterally altering fee schedules without notice or a basis to do so, instituting unfair and deceptive cost containment measures and refusing to enroll new providers unless they agree to participate in all available networks.</p>	<p>Reference: <i>State Medical Society</i>: Information from <a href="http://www.insure.com">www.insure.com</a>, Vicki Lankarge, indicates the following: the lawsuits identify specific common practices that the HMOs are alleged to have employed to breach their contract with physicians including.</p> <ul style="list-style-type: none"> <li>• arbitrarily reducing a physician's payment for medically necessary care by "downcoding," or changing claims and billing codes to indicate a doctor should be paid less (for example, a doctor conducts an extensive office visit with a patient who has a number of health problems, but is reimbursed only for a simple office visit that is far shorter and less complicated.</li> <li>• arbitrarily overruling a physician's determination of medical necessity without conducting a proper analysis or review.</li> <li>• failure to pay physicians in a timely fashion.</li> <li>• failure to provide a proper explanation when a claim has been denied payment.</li> <li>• failure to pay interest on claims according to the state's prompt payment law.</li> <li>• failure to properly staff clinical departments.</li> <li>• engaging in improper claims review by</li> </ul> <p>RE: <i>Connecticut State Dental Association, et al v. Anthem Health Plans, Inc.</i>, Superior Court, Judicial District of Hartford: <i>Connecticut State Dental Association</i></p>
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			<p>Connecticut State Dental Association Summary of Allegations: Anthem has “deceived Connecticut’s dentists and pays unfairly low fees”, Anthem “unilaterally stopped paying dentists the contractually” required “usual, customary and reasonable” fees, Anthem uses a so-called “utilization management” system including downcoding where “Anthem rejects a claim for payment under the procedure code that represents the procedure actually performed, and pays for a less expensive procedure,” bundling, “Anthem substitutes its judgment for that of the treating dentist, paying only for what Anthem considers to be a ‘less costly alternative’ service, even when the less costly alternative really isn’t the same,” and “Anthem refuses to pay for medically necessary procedures.”</p>
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14	Litigation: Maine	An additional lawsuit was brought by the Attorney General of Maine following the purchase of Blue Cross Blue Shield Maine by Anthem. The Maine Attorney General and a consumer's group filed a petition for administrative review seeking a decision by the Superintendent (Insurance) in regard to application by Blue Cross Blue Shield of Maine to convert.	From company's SEC filing Form S-1.
15	Litigation: Ohio	On March 11, 1998 the lawsuit of <i>Dardinger v. Anthem and Community Insurance Company</i> (Anthem's Ohio subsidiary) was filed. This matter is currently before the Ohio Supreme Court based on a trial court verdict and subsequent review by the Ohio Intermediate Appellate Court. The jury returned a verdict for plaintiff awarding \$1,350 for compensatory damages, \$2.5 million for bad faith in claims handling and appeals processing and \$49 million for punitive damages. The Ohio Court of Appeals affirmed the jury award of \$1,350 for breach of contract and affirmed the award of \$2.5 million for bad faith but dismissed the other judgments against Anthem.	From company's SEC filing form S-1.
16	Kentucky Department of Insurance Market Conduct Examination Report:	Kentucky Department of Insurance (KDI) uses a 10% error criteria for all operations of analysis of Anthem Blue Cross Blue Shield of Kentucky. The exception to this 10% error criteria is a 7% error criteria that is applied to claims matters. KDI is of the position any operation with an error ratio in excess of these thresholds indicate	

		<p>a general business practice. (Page 2 of KDI examination report “as of August 2, 1999”).</p> <p><b>CLAIMS PRACTICES:</b>  “Examples of errors include, but are not limited to, any unreasonable delay and the acknowledgment, investigation, payment, or denial of a claim; the failure to correctly calculate the claim benefits, or the failure of the company to comply with Kentucky statutes and regulations regarding claim settlement practices. (Page 55).</p> <p>The examiners requested a total of 3,600 “paid and denied claims” for review. Anthem only provided 387 claims which equals 10.75%. (Page 56) [On page 57 of the examination report KDI notes that it has taken almost five months to furnish the examiners with only 10.75% of the claims requested and therefore the company is not in compliance with Kentucky law which was cited.]</p> <p>As it relates to the “1998 paid claims - group accident and health – SGI” review KDI found there was an error ratio of 20.5% (almost 3 times the acceptable level).</p> <p>On page 73 of the examination report it is noted that approximately 10% of the 346 complaint files reviewed by the examiners were not paid in a timely manner and therefore a violation of Kentucky law.</p> <p>A specific notation of the</p>	
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		<p>examiner from page 74 is “this matter [of paying interest on claims] was discussed with the company, and it was determined that it was not the practice of the company to pay interest on claims unless requested by the claimant.”</p> <p>Under an examiner comment starting on page 77 that continues over to page 78 the comment addressed the “infertility services” that were paid by the company. Note the comment states in part “However, the legal services department [of Anthem Blue Cross Blue Shield of Kentucky] determined that benefits for the infertility services should be reimbursed at 90% instead of 50% for the remainder of the contract year (January 1, 1996 through December 31, 1996). . . .The company reported that there were 2,776 infertility claims paid in 1996. Not all of those received the improper schedule of benefits. The following inter-company memorandum was included in one of the complaint files reviewed.</p> <p>“Subject: State group - - infertility.</p> <p>“As many of you know, when States Group reopening took place, wrong information was given on the infertility benefits. The benefit summaries indicated for Enhanced High that infertility was payable at 90%. They should have indicated this benefit is payable at 50%.</p> <p>“I recently met with the legal and the project managers, and the following procedure was approved.</p>	
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		<p>“* Pay these claims at 90% only on a complaint basis. Acordia Lexington may want to put a policy in place to help identify these members.</p> <p>“* Continue to pay all other claims at 50%, as the benefits should correctly be paid. Certificate language indicates 50%.” (Anthem memo)</p> <p>Page 84 of the Kentucky examination report indicates that 29 out of the 50 complaints/inquiries reviewed by KDI appeared to be in violation of Kentucky insurance statutes and regulations.</p>	[A006858+]
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## APPENDIX B

TO

INTERVENORS KANSAS MEDICAL SOCIETY'S AND KANSAS HOSPITAL  
ASSOCIATION'S LEGAL MEMORANDUM IN OPPOSITION TO THE  
APPLICATION FILED BY BLUE CROSS AND BLUE SHIELD OF KANSAS  
AND ANTHEM INSURANCE COMPANIES, INC.