S. Hrg. 103-212

OVERSIGHT OF THE INSURANCE INDUSTRY: BLUE CROSS/BLUE SHIELD—EMPIRE PLAN (NEW YORK)

HEARINGS

BEFORE THE

PERMANENT
SUBCOMMITTEE ON INVESTIGATIONS

OF THE

COMMITTEE ON
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

JUNE 25 AND 30, 1993

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* Retained in the files of the Subcommittee.

OVERSIGHT OF THE INSURANCE INDUSTRY: BLUE CROSS/BLUE SHIELD—EMPIRE PLAN (NEW YORK)

FRIDAY, JUNE 25, 1993

U.S. SENATE,
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS,
OF THE COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 9:04 a.m., in room SD-342, Dirksen Senate Office Building, Hon. Sam Nunn, Chairman of the Subcommittee, presiding.

Present: Senator Nunn.

Staff Present: Eleanore J. Hill, Chief Counsel; John F. Sopko, Deputy Chief Counsel; Mary D. Robertson, Chief Clerk; Alan Edelman, Counsel; Eleni P. Kalisch, Counsel; David B. Buckley, Chief Investigator; Harold B. Lippman, Investigator; R. Mark Webster, Investigator; Scott E. Newton, Investigator; Cynthia Comstock, Executive Assistant to Chief Counsel; Mariea Wilt, Staff Assistant; Daniel F. Rinzel, Minority Chief Counsel; Stephen H. Levin, Minority Counsel; Mike Maloney, GAO Detail; John Forbes, Investigator (Customs); Gene Richardson, Investigator (AID); Liza Lanier, Intern; Jeff DiSantis, Intern; and Jee Hun Nam, Intern.

OPENING STATEMENT OF CHAIRMAN NUNN

Chairman NUNN. The Subcommittee will come to order.

Today, the Permanent Subcommittee on Investigations holds the fifth in a series of hearings to examine the management and operations of the Blue Cross and Blue Shield insurance network. This inquiry began last year when the Subcommittee first received testimony concerning the problems that the State regulators were having overseeing the operations of their respective Blue Cross plans. As a result of that initial testimony, the Subcommittee began an in-depth review of several particularly troublesome plans.

The Subcommittee's review first focused on Blue Cross and Blue Shield of West Virginia. In 1990, that plan became the first, and so far the only, Blue Cross plan to fail. As a result of that failure, over 51,000 individuals were left with outstanding unpaid medical claims. The Subcommittee's review found that the failure of the West Virginia Plan was due in large part to waste and mismanagement on the part of the plan's management combined with inadequate oversight of the plan on the part of the board of directors, the State Insurance Department, and the National Blue Cross and Blue Shield Association.

Following the West Virginia Plan, the Subcommittee examined the operations of the Blue Cross and Blue Shield plans in Maryland as well as the District of Columbia. Once again the Subcommittee found the same pattern—management run amok, while the board of directors, the State regulators, and the Blue Cross Association seemed either unwilling or incapable of doing anything to stop them. As a direct result of the Subcommittee's inquiries, both the Maryland plan and the D.C. plan replaced their chief executives, brought in new management teams, and committed themselves to refocusing their operations on their core business.

This morning, the Subcommittee's focus shifts to Empire Blue Cross and Blue Shield of New York. With over eight million subscribers and more than $7 billion in premiums, Empire is the largest of the 71 Blue Cross and Blue Shield plans in the Nation. In fact, it is this country's largest non-profit health insurer. It is also, as of today's hearing, a very troubled health insurance plan.

Indeed, one need only look at the front page of the *New York Times* for the past 2 weeks in order to realize the timeliness of these hearings. As a result of this Subcommittee's efforts and the increased press scrutiny of Empire, serious questions have been raised in the past few weeks as to whether Empire may have falsified the financial statements it has provided over the years to the State Insurance Department. In addition, it has now been alleged that Empire may have knowingly used false data in order to convince the New York Legislature to pass landmark legislation in 1992. This legislation radically changed the insurance market in New York, much to Empire's benefit. These issues have been addressed in our investigation, and this morning we will hear from the staff, as well as two former employees of Empire, as to these serious allegations.

Last month, Empire's chief executive officer and chairman of the board, Albert Cardone, was ousted from his positions. Last week, Empire's chief financial officer, Jerry Weissman, was placed on a leave of absence by the plan. His office was sealed, and he reportedly is no longer allowed entrance into the Empire building. Also last week, Empire's acting chief executive officer, Donald Morchower, and its new board chairman, Harold Vogt, agreed to step down in order to allow a new outside management team to attempt to turn the plan around.

Today's hearing comes at a time when Empire is a plan in turmoil. Questions have been raised as to whether the State Insurance Department will seek to take over the operations of Empire and as well as to whether the National Association will seek to withdraw Empire's right to use the Blue Cross and Blue Shield trademarks. Of course, either step would have very significant ramifications. The fact that these questions are raised and the circumstances under which they have been raised underscores the importance of the Subcommittee's efforts in undertaking this review of the Blue Cross network.

At the outset of this investigation, Empire's then chief executive officer, Albert Cardone, welcomed the Subcommittee's efforts, telling the Subcommittee staff that he was sure that they would find that Empire was different from the previous plans examined. This

attitude was reinforced, I am told, in other meetings with Empire's top officers.

In one sense, Mr. Cardone was right. The Subcommittee's investigation did uncover some differences between Empire and previous plans examined, particularly in Empire's lack of significant subsidiary activity, which had been a very prevalent and destructive practice in the other plans we examined. For the most part, however, the Subcommittee staff found, as they will testify this morning, that Empire fit into what has now become a very disturbing pattern among Blue Cross plans which we have examined: mismanagement on the part of the plan's top executives; ineffective oversight of the plan by the board of directors; ineffective regulation of the plan by the State Department of Insurance; and inadequate response by the Blue Cross and Blue Shield Association to problems with the plan until significant damage had already been inflicted.

Of course, one major difference between Empire and the plans previously examined by the Subcommittee is what now appears to be the possibility that Empire kept two sets of books: one for internal purposes and one for public consumption. If this turns out to be true, if the largest Blue Cross plan in the country intentionally misled State regulators and State legislators, then, of course, the implications are very severe.

These hearings are, thus, not only timely but I think very important. Moreover, the issues they raise go to the very heart of the debate on health care reform. As we consider proposals to move to greater consolidation and regionalization in health care, this Subcommittee's work on Blue Cross underscores some very basic policy questions. And I don't pretend to have all the answers here this morning, but they are very important questions:

What mechanism assures accountability for large, non-profit insurers that are not subject to the disciplines of the marketplace? There are no stockholders to complain. There are no markets to value the worth. There are no profits to measure efficiencies. We are left with regulators and policyholders.

What options are available to a regulator facing a large regional insurer such as Empire? How does a State regulator balance the public interest in tough regulatory enforcement against the risk of jeopardizing the insurance needs of large segments of the State's population? And I hope we will all think through these questions together, and certainly we will be hearing from the insurance regulator next week.

Are tough sanctions appropriate when there is a real risk of economic collapse? And in some cases, the sanctions could precipitate or make worse the likelihood of that collapse.

Has the system created health care giants that, as inefficient as they may be, are too big to regulate?

These are questions that not only are with us now, but they are questions that are very important as we consider how to restructure the health system in this country.

Under those circumstances, where you have non-profits with no stockholders, with no market to govern in any way or reflect the value, and with no bottom line in terms of profits to show any kind of efficiencies, what guarantees do we have that health care costs,

whether justified or not, will merely be passed on again and again and again and again to the taxpayers and to the policyholders?

If this Nation is ever to truly reform its health care system, we must find a way to hold insurers accountable to their subscribers, to regulators, and to the public at large. As to the health care reform debates, these hearings have raised a crucial question in my mind. Can we reform our health care system by relying extensively on huge non-profit corporations? If so, we must devise a system that is capable of overseeing huge entities like an Empire Blue Cross. We must develop a system in which regulators have the authority, the resources, and the confidence—by that I mean confidence that not only they are making the right substantive decision, but confidence that they will be backed up in the overall governmental and political system? Will they have the confidence to make the difficult regulatory decisions which are sometimes required for the protection of the policyholders, of the taxpayers, and of the public interest?

In closing my statement this morning, I would like to thank Senator Roth and the minority staff, Dan and others, for their support and cooperation we have had in complete form, as usual, since we undertook this investigation. We look forward to working together continually with the minority in this and other investigations of importance.

I would say at the outset that originally we had scheduled the representatives of Empire Blue Cross and Blue Shield, including Donald Morchower, acting chief executive officer, and Harold Vogt, chairman of the board, to appear and testify this morning. Yesterday, Subcommittee staff had the opportunity to speak to former Empire employees, and we will have two of them testifying this morning. In light of those discussions, the Subcommittee has asked those two individuals to appear this morning and give their testimony. And given that fact and the time constraints, I have asked our previously scheduled panel of Empire witnesses to reschedule their appearance until next Wednesday, June 30th.

I want to make it absolutely clear, however, that representatives of Empire were prepared to testify and respond to the questions this morning at the hearing. They made that very clear, and I want to make it clear that this was our call of postponing it, not in any way a request of theirs. They were fully prepared to come forward and testify.

Mr. Morchower has asked that we release his written statement this morning, and in accordance with his request, his written statement is being made available to the public and to the news media this morning.[1]

Chairman NUNN. I want to thank all the staff this morning for what has been a very diligent effort, a very tedious effort, a very detailed effort. It consumed many, many, many hours, and all of you have done a splendid job. So we appreciate the hard work you have put forth in bringing this report to us this morning.

I am going to ask all of you who are going to testify to please stand and raise your right hand. We swear in all the witnesses

[1] The prepared statement of Mr. Morchower appears on page 235.

before the Subcommittee. Do you swear the testimony you will give this morning before the Subcommittee will be the truth, the whole truth, and nothing but the truth, so help you God?

Mr. SOPKO. I do.

Mr. EDELMAN. I do.

Ms. KALISCH. I do.

Mr. MALONEY. I do.

Mr. WEBSTER. I do.

Chairman NUNN. The first panel this morning will be members of the Subcommittee staff who have spent the past 6 months investigating Empire's operation. Staff Counsel John Sopko, Alan Edelman, and Eleni Kalisch will testify regarding their findings and will be accompanied by investigators Mike Maloney and Mark Webster. Thank you all for being here, and we will ask you to lead off.

TESTIMONY OF JOHN F. SOPKO, DEPUTY CHIEF COUNSEL; ALAN EDELMAN, COUNSEL; ELENI P. KALISCH, COUNSEL; ACCOMPANIED BY MIKE MALONEY, INVESTIGATOR, AND MARK WEBSTER, INVESTIGATOR, PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

Mr. SOPKO. Thank you, Mr. Chairman.

Mr. Chairman and members of the Subcommittee, almost exactly a year ago, this staff first appeared before this Subcommittee on July 2, 1992, and testified before you about our inquiry into the ability of State regulators to oversee the operations of the 71 Blue Cross/Blue Shield plans. This morning the staff is prepared to report for the fourth time the results of its investigation of a specific Blue Cross/Blue Shield plan, in this case Empire Blue Cross/Blue Shield plan, the largest plan in the Blue Cross/Blue Shield system.

In sum, the staff found, based upon its 6-month investigation, the following serious problems with the management, operations, and regulations of the Empire plan; an inability to properly execute the most basic functions of an insurance company, resulting in abysmally poor service to subscribers and providers; a severe lack of internal controls, leading to a high degree of vulnerability to fraud; excessive expenditures for the benefit of senior officers and members of the board of directors; a propensity on the part of the plan management to blame external factors for the plan's failings and to rely upon external sources of relief to keep it afloat; inadequate oversight of management activities by the board of directors and ineffective regulation of the plan by the State Department of Insurance.

As you alluded to, Senator, we have a very lengthy staff statement of approximately 200 pages. The staff today will summarize those conclusions in its testimony today.

Today, the Subcommittee is faced with a patient that, for all accounts, has been in the intensive care unit for several years. Gross mismanagement, wasteful expenditures, fraud, and a history of inattentiveness and non-action by its board of directors and the State Insurance Department have left it critically ill.

In some respects, the staff found Empire to be very similar to the three other plans, as previously alluded to by the Chairman.

As was true in the case of Maryland, Empire's senior officers and board of directors appear to be in a state of self-delusion and denial. They refuse to accept ultimate responsibility for the current financial and management crisis within the plan. Even after the forced termination of the long-standing CEO and chairman of the board, Albert Cardone, on May 19, 1993, the new chairman of the board, Harold E. Vogt, told the staff that there was no serious problems with the way the plan was operated. He opined that any problems it had were the result of outside sources.

The New York Insurance Department is apparently in agreement with the plan and its board of directors. In a May 27th interview with Salvatore Curiale, the superintendent of insurance for the State of New York, he placed nearly all of the blame for the plan's financial predicament on external sources, such as the economy, inflation, unfair competition, and commercial insurers.

On the basis of its 6-month investigation, the staff disagrees with both the plan and the Insurance Department. The plan's current illness is, for the most part, the result of its own making and cannot be easily shifted to others, such as the economy, inflation, or commercial competitors. To understand what went wrong with Empire, one must look within its operations. Although external forces to some extent exacerbated its internal problems, the staff concludes that the sine qua non of this plan's financial crisis was and continues to be gross mismanagement.

One additional factor that the Chairman has alluded to has recently come to light which needs to be addressed and which underscores the timeliness of this hearing. From the outset of this investigation, the staff has sought to understand the reasons behind Empire's dramatic losses in 1991, particularly its dramatic losses in the community-rated lines of business. In light of what appeared to the staff to be a huge aberration in underwriting results, the staff has continuously pressed Empire's chief financial officer and other top Empire officials for an explanation.

In particular, the staff has had concerns that several of Empire's community-rated lines of business showed a strange anomaly in 1991: a steady decline in enrollment combined with a precipitous rise in both number of claims filed and amount of claims incurred.

It now appears that the staff's concern over this issue may have been justified. In the deposition of Jerry Weissman on June 11, 1993,[1] the staff questioned Mr. Weissman, who is the chief financial officer of the plan, about the accuracy of information filed by Empire with the Insurance Department. One of the questions asked was:

"Are you aware of any discussions within Empire pertaining to falsifying information on filings with the department or presenting them in a light that would not be truly reflective of the actual financial condition of the company?"

Mr. Weissman answered, "Yes. Recently there has been an inquiry from the press and from, I think, one of the assemblymen

[1] Exhibit No. 11 is retained in the files of the Subcommittee.

that information was given to them that showed an internal document that had different numbers within it what we call the market segments for the internal reports versus the external reports, what we file with the Insurance Department."

Mr. Weissman went on to say that, "The actuaries, when they do the statutory blanks or the statutory annual statements, they do what we call a top-down."

"The actuaries' data does not include information on an individual account basis, so we could not use that information to develop what we call in-house the brick-by-brick analysis that holds the salespeople accountable."

He went on to further say that, "Basically, by having"——

Chairman NUNN. Could you put quotes around what he is saying so there won't be any question about what you are saying versus what he is saying?

Mr. SOPKO. Certainly, Mr. Chairman. And in the staff statement, it is clearly reflected by quotations.

He went on to say, and I quote, "Basically, by having the brick-by-brick information I mean, that was the basis on which we got out of the association business in 1991. . . . And the numbers don't tie. I mean, my recollection is that in 1991, for example, there was about a $30 million difference between the internal report and the external report that we sent to the Insurance Department."

Mr. Weissman went on to say, "So, yes, I'm aware of it. We have explained it to the press. We explained it to the press; we explained it to the assemblyman's office."

On June 16, 1993, counsel for Empire informed the staff that Empire had discovered discrepancies in certain information filed by Empire with the Department of Insurance. Counsel stated that the effect of these discrepancies may have been to understate the losses incurred by Empire in its experience-rated lines of business.

On June 22, 1993, the staff re-deposed Mr. Weissman.[1] During the course of this deposition, Mr. Weissman again explained the reasoning for keeping the internal set of financial records, which he referred to as the "black books." He also explained the process by which Empire generated the set of financial figures reported to the Insurance Department on the Annual Statement, and the reasons why these figures were not always identical to those reflected in the internal records. According to Mr. Weissman, the internal records formed the initial basis for generating the figures for the Annual Statement. Adjustments, known as reallocations, were then made.

Under questioning by the staff, Mr. Weissman admitted that these reallocations were subjective and, in fact, somewhat discretionary.

Mr. Weissman subsequently related to the staff one instance in which one might question whether the reallocations were made, in fact, and were they appropriate. According to Mr. Weissman, in early 1991 he informed Empire's CEO, Albert Cardone, of anticipated large losses in Empire's experience-rated business. Mr. Weissman testified that this conversation took place at the time Empire

[1] Exhibit No. 11 is retained in the files of the Subcommittee.

was preparing to file its quarterly report with the Insurance Department. Mr. Weissman stated that the projections he provided to Mr. Cardone during that conversation were based on figures he had derived after making the customary allocations.

Mr. Weissman related that Mr. Cardone was concerned with these projections, and told Mr. Weissman that "this is not a time for me to be super-conservative and show losses that were greater than we expected the actual results to be, and that I had better make sure that if we were showing losses that, in fact, those losses did occur."

The staff then questioned Mr. Weissman as to the effect of this adjustment.

"Question: Do you recall whether the impact of these new adjustments were to raise the community-rated claims and lower the experience-rated claims?"

Mr. Weissman's response: "My recollection is that the additional adjustments were intended to reduce the experience-rated claims."

"Question: Now previously you said that your recollection was that he"—referring to Mr. Cardone—"didn't . . . really differentiate what kind of losses he was talking about. So why did you come away with the impression that he was most concerned with the experience-rated losses?"

Mr. Weissman answers, "I mean, because, you know, the community-rated losses . . . you know—those could easily be blamed on cherrypicking, on increased enrollment in the non-group, losses in the Medigap, on the fact that the superintendent had cut back on the rate increase request."

Mr. Weissman goes on to say, "I didn't think that he"—meaning Mr. Cardone—"took that as really his problem. However, if we were going to show losses on the unregulated business or the experience-rated business, that that would show the company in an unfavorable light."

Mr. Weissman went on to testify 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."

A further question was asked of Mr. Weissman: "Did you think your original numbers were more accurate than the new numbers?"

Mr. Weissman answered, "Obviously I thought they were more accurate. That was the basis on which I went in to Cardone in the first place."

It thus appears from this colloquy with Mr. Weissman and further investigation by the staff that in 1991, the year in which Empire suffered massive losses which it blamed on cherrypicking and other outside factors——

Chairman NUNN. Why don't you define "cherrypicking"? It seems to be at the heart of a whole lot of this, and some people following it may not know what that means.

Mr. SOPKO. Certainly, Mr. Chairman. "Cherrypicking" basically is an argument that the Empire plan has been making that in the community-rated pool, the commercial insurers would offer below-market or low-priced insurance to take the best risk, the cherries, from the community-rated groups that Empire had, leaving the

worst risks, the sick, the elderly, who would be then dumped back into the Empire community-rated pools, therefore increasing their costs. And since their premiums were set by the Insurance Department, Empire would then incur further losses.

Chairman NUNN. And, therefore, if the community-rated losses appeared to be bigger, it lends strength to the argument that cherrypicking was the heart of the financial problem.

Mr. SOPKO. Absolutely, Mr. Chairman. And what we believe this shows is that the plan shifted claims from its experience-rated accounts to its community-rated accounts in order to avoid casting the plan in an unfavorable light and in order to make their cherrypicking argument look better before the State legislature, which at that time was debating whether to pass the community-rated bill. The staff is not passing any judgment on the community-rated bill, we are just stating that it appears Empire, in testifying, and explaining its case, in justifying, was using data that may not have been accurate.

We will have two new witnesses that the staff just discovered within the last few days—who, Mr. Chairman, you have referred to—will testify today after the Subcommittee staff finishes about these discrepancies. We believe it will put those discrepancies in a new light.

Mr. Chairman, one of the key issues I want to touch on briefly that the staff has focused on is the financial state of Empire. We have a number of charts[1] which I believe will graphically illustrate the fact that Empire's financial condition is precarious at best.

The plan has had underwriting losses of $444 million over the past 2 years and $617 million since 1987. The first chart dramatically shows Empire's underwriting losses during that time.

Its overall losses since 1987 have been most severe in the last 2 years, as depicted in this chart, which shows Empire's net gain and loss.

If you will note, in 1991 there is a slight upward movement. It looks like they are losing less. That, in part, is because of an infusion of funds they received from the Insurance Department of approximately, I believe——

Mr. MALONEY. $80 million.

Mr. SOPKO. $80 million at that time.

Chairman NUNN. When you say funds from the Insurance Department, really that was the Insurance Department permitting them to reallocate reserves; is that right?

Mr. SOPKO. If I am not mistaken, that is correct, Mr. Chairman. It wasn't exactly money from the Insurance Department.

Chairman NUNN. It wasn't taxpayers' money. It was Empire money that was reallocated from a reserve account to an operational account.

Mr. SOPKO. Yes, which then reflected the positive increase, or, I would say, the decrease in their losses for the 1992 period. As a result, Mr. Chairman, its reserves decreased from $295 million at December 31, 1990, to $40 million at December 31, 1992, or $485 million below the statutory limit.

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[1] See Appendix C of Staff Statement on page 218.

The next chart shows three lines. The green line is the New York law or New York required reserves, the blue line is the actual reserves that Empire has, and the orange line is the deficit between those two.

Empire is required by New York State insurance law to maintain a reserve for the protection of its customers. That reserve consists of admitted assets less liabilities. New York State insurance law does not recognize or admit certain assets referred to as non-admitted assets. Non-admitted assets would include receivables aged more than 90 days, prepaid expenses, leasehold improvements, and notes receivable.

We have prepared another chart because the staff found that Empire's non-admitted assets have increased greatly over the past few years, from $83.2 million in 1987 to $124.2 million in 1992. The primary reason for this, the staff found, was an increase in uncollected premiums and an increase in miscellaneous accounts receivable. Basically they weren't finding and collecting the money that was owed to them.

New York law also allows for the invasion of reserves up to 50 percent, provided that a 3-year plan of restoration is approved by the Insurance Department.[1] Empire first invaded its reserves in January of 1987, and then went below the 50-percent statutory minimum during 1991. Therefore, since 1991 and through April of 1993, Empire has been below 50 percent of the statutory reserve requirements. Although the Insurance Department has decided not to take it over or to put it into receivership, the staff found it has had to rely on large rate increases, which drive away subscribers, and various cash infusions such as the release of $80 million in reserves in 1992, and $93 million from settlement of a lawsuit in 1993.

Just to put it in context, Senator, basically if you refer back to the hearing we had on the Washington, D.C., plan, the Empire plan's, which is a far bigger plan, has less reserves than the D.C. plan did.

One other issue that the staff looked at when looking at the financial arena was the plan's administrative expenses. The staff found that Empire's administrative expenses have increased steadily since 1987. We have prepared a chart that graphically describes that. I will ask Mark to then go through the next series of charts which show increases in some of the expenses, such as salaries, that have caused this increase in administrative expenses.

Now, the plan says that in comparison to commercial insurers and other Blue Cross plans, their administrative expenses are quite low. The staff determined that such a comparison isn't quite accurate. It is like comparing apples and oranges because commercial insurers have different expenses than the Empire plan does. For example, commercial insurers pay taxes, Empire doesn't, commercials pay for bonuses and payments to brokers, Empire doesn't. Even the National Blue Cross/Blue Shield Association told us that it was an unfair comparison. They said that if we wanted to make a correct comparison to other Blue plans, we should look at plans

[1] Exhibit No. 69 is retained in the files of the Subcommittee.

that have similar lines of business. Empire is basically a hospital-oriented business, which is very cheap to administer.

The National Association said look at the three Pennsylvania Blue Cross plans and compare them. We did that, and we found out that Empire's administrative expenses are far higher than those other plans. So the argument that Empire has low administrative expenses is also, we feel, invalid.

Let's quickly go to some of those other Empire expenses. We see that Empire's payments to consultants dramatically increased over the time frame; and also Empire's expenses as related to external legal counsel; and Empire's expenses as relating to rent increased dramatically; and, they all go to that increase in overall administrative expenses.

Chairman NUNN. Was that more space, more square footage, or was that higher rent? What were the circumstances there?

Mr. SOPKO. I believe, Mr. Chairman, it was a combination of both, if I am not mistaken.

Yes, there was a new facility put up in Middletown, New York, to process claims during that time frame, plus they have very expensive locations in Manhattan where they have offices, and the rent is very high down there.

In addressing the issue of its financial decline, Empire has consistently sought to place the blame for its predicament on outside parties. Indeed, in a recent interview with the *New York Times*, when asked, Mr. Cardone said, "Empire has done nothing wrong."

Probably Empire's biggest source of blame for its financial woes is what we call the cherrypicking argument, which I have mentioned or alluded to before. Although Empire has consistently blamed the commercial carriers for stealing all of its best risks, Empire's own small-group cancellation study, dated January of 1992, using data provided by the Gallup company, show that less than half of those groups that canceled the Empire coverage in 1991 went to commercial carriers.

Indeed, in Gallup's separate report dated February of 1992,[1] Gallup found that 36 percent of those that canceled their Empire coverage no longer maintained health insurance coverage at all.

The staff also is concerned about Empire's reliance on a second study conducted by Milliman and Robertson.[2] The Milliman study reached its conclusion on the basis of information and data provided by Empire itself, without doing any independent verification.

Another bit of evidence raised in favor of the plan's argument has been the recent study, a $1.9 million study done by Arthur Andersen.[3] This was commissioned by the State of New York and paid for by the State of New York.

From the inception of the Subcommittee's investigation of Empire, the staff was told that this legislatively mandated management report would support the plan's position.

The staff's review raises a series of questions about the validity of the Arthur Andersen report. The staff believes the report may be fatally flawed and questions the overall objectivity of the Arthur

[1] Exhibit No. 40 is retained in the files of the Subcommittee.
[2] Exhibit No. 70 is retained in the files of the Subcommittee.
[3] Exhibit No. 16 is retained in the files of the Subcommittee.

Andersen report; the thoroughness of the Insurance Department's contracting process for the Arthur Andersen contract; the accuracy, completeness, and independence of the report; and the undue reliance upon representations of the plan without any independent verification.

Briefly, Mr. Chairman, in July of 1992, the Community Rating Bill [1] required, among other things, that a special independent management and financial audit of Empire be conducted. The New York Legislature only placed one condition on the Insurance Department's ability or authority to grant that contract. The legislation specifically barred any organization from performing the audit if they were found to have done work for Empire within the last 5 years, unless there was an affirmative showing of independence and objectivity.

The Staff discovered that at the time Arthur Andersen was awarded the contract,[2] they had a significant business arrangement with Empire. They were paid $371,000 in 1992 and $447,000 in 1991. The size of those contracts made Arthur Andersen one of the highest-paid consultants listed on documents submitted by the plan to the Insurance Department.

The Subcommittee staff interviewed Eric Edelstein, the project director of Arthur Andersen, and Paul Anello of Andersen Consulting to determine what, if anything, was done or what, if anything, did they do to assure the Insurance Department that their consulting contracts wouldn't influence their work.

We were told that basically the only thing they had to do was tell the Insurance Department that their contractual relationship wouldn't influence their work. They also admitted that their contract with the Insurance Department was discounted from normal rates, and when asked, they said that the reason they wanted to get the contract was "to be helpful, improve our credentials, and to also get more business from the Blues!"

When asked, they said they were not specifically hoping to get more business from Empire as a result of its contract, but certainly they were hoping to get more business from other Blue Cross/Blue Shield plans.

When we questioned Salvatore Curiale, the Superintendent of Insurance, about this contract, he indicated that he recalled the bid addressed the issue of their independence. However, at the time of the bidding process, the Superintendent was not aware that Andersen or any of its subsidiaries had done or was doing work for Empire. When directly asked, he admitted that he did not know that Andersen Consultants was one of the highest-paid consultants for the plan in 1991 and 1992. He also did not know what steps his own office had taken to verify Andersen's independence.

The staff did review the files of the Insurance Department concerning this contracting, and we found that these files do not evidence any independent verification of Andersen's competency or independence. There is no evidence that the Insurance Department reviewers who looked at this contract, even knew the full extent of Andersen's contractual relationship with the plan.

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[1] Exhibit No. 12 is retained in the files of the Subcommittee.
[2] Exhibit No. 20 is retained in the files of the Subcommittee.

None of the material provided would indicate that any overt steps were taken by the Insurance Department to verify Andersen's independence.

Chairman NUNN. Was anything in writing on this, Mr. Sopko? Was there any kind of waiver or any kind of certification by the Insurance Department to indicate a consciousness of the law that had been passed by the legislature?

Mr. SOPKO. Well, there were some notes from the five reviewers that they were aware of the law, and there actually was a document which had a checklist for each of the various contracting companies who were applying to see if they complied with the law.

Now, we found four of those checklists. One noted there was a conflict with Andersen. One didn't. One was illegible; we couldn't read it. And one had a question mark.

There was one reference to the fact that Arthur Andersen did have a contract with the plan, but it apparently was just that. It stated they had done business with the plan, but did not list how much the business was, or how significant it was. As far as we could tell, no one in the Insurance Department made any inquiry to determine its extent, to talk to people, to review the work, even talk to the Empire people about what work Andersen did.

Chairman NUNN. Did you find any evidence that there was any testimony by the Insurance Department before the State legislature as to why they chose Arthur Andersen or any report by the Insurance Department to the legislature?

Mr. SOPKO. I don't know of any testimony before the legislature, Mr. Chairman. We found it unusual that there was actually no document provided us by the Insurance Department recommending Arthur Andersen to Salvatore Curiale, the Superintendent. There was a group of five people who reviewed the contracts, and as far as we know, it was an oral recommendation to Mr. Curiale, and he orally—or I don't know how—indicated to sign up Arthur Andersen, give them the contract.

About 6 months or 3 months after the fact, we found a document saying the contract was granted to Arthur Andersen for certain reasons. That was not, I believe, prepared by Mr. Curiale, but it was prepared by somebody else. But we found no contemporaneous document from the superintendent or from anybody in the Insurance Department recommending Arthur Andersen. All we found were some checklists.

In addition to the problem we found with the way the Insurance Department granted the contract to Arthur Andersen—we discuss this in more detail in the staff statement, and I will just briefly summarize it now—we found an inherent problem with the way the Arthur Andersen team did their work. They basically didn't question anything the plan told them. Based upon the interviews with the Arthur Andersen employees and a review of their own files—and we subpoenaed all of their interview notes and reviewed them—the staff noted the following areas where the Andersen report evidenced an undue reliance upon the plan's representations and other poor accounting practices. I will briefly just hit some of the highlights.

We found that Arthur Andersen never interviewed the National accounts that left. Arthur Andersen never interviewed any sub-

scribers. Arthur Andersen never interviewed former board members.

Chairman NUNN. What do you call national accounts? I think you need to define that term. That was the first item.

Mr. SOPKO. Mr. Chairman, there are some large accounts—these are large corporations like IBM, CBS, AT&T, even the accounting firm, Deloitte and Touche—which have national business beyond the State of New York. Those are termed national accounts. Those are not community-rated. Those are competed for with other insurance companies using actuarial tables and regular underwriting practices. Those are termed national accounts.

Before, when we were saying that we found evidence that Empire was shifting the losses, they were shifting the losses from the National accounts and other types of competitive accounts to the community-rated accounts.

Chairman NUNN. So when Empire takes on a national account and the National account has employees all over the United States, like AT&T, then they would be insuring people not only in New York State but also in other States around the country. Is that right?

Mr. SOPKO. Sometimes yes. Sometimes they are doing it through other Blue Cross plans. This is related to other Blue Cross plans. I don't know, Alan, if you want to add anything on that. But they would be doing that. There is nothing illegal about that. That is perfectly legal.

Chairman NUNN. But the distinction is this was competitive business and it was not based on any kind of community rate.

Mr. SOPKO. That is correct, Senator. And one of the arguments the plan——

Chairman NUNN. So they could actuarially price that for whatever they want, do whatever they thought was good business, either get the deal or not get it, right?

Mr. SOPKO. Oh, absolutely. That is what Empire should have done. We found that they didn't. And one of the arguments they made to Arthur Andersen was that they lost their national account business because the commercials were doing what they call "loss leading." By "loss leading," they meant and the plan has argued that a commercial company would sell their line of business, their insurance, at a loss, their health insurance line, so they could get in the door to CBS or AT&T or NYNEX, and then sell them other lines of business—dental, directors and officers, life, you name it—and then make the profit on the other lines of business.

Now, what we found when we asked Arthur Andersen about this, we said, "Did you do any independent research to verify that?" And they said no. Like everything else, they relied upon Empire. The plan told them there was loss leading; they accepted it.

That is one of the main criticisms we have of the Arthur Andersen report.

Chairman NUNN. OK. Why don't you back up? I interrupted you. Start over on that list.

Mr. SOPKO. OK. In addition, we found that the Andersen team did not actually review the National Blue Cross/Blue Shield documents. The Andersen team did not verify the cherrypicking argu-

ment, merely accepted that there was cherrypicking and concluded accordingly in the report.

They did not, as I said before, verify the loss-leader argument. They did not analyze the segments of the community-rated market. The Arthur Andersen team, surprisingly, did not even review the minutes of the board of director meetings prior to 1991. The Arthur Andersen team did not know about medical bills paid to uncredentialed physicians. They did not know that HHS, Health and Human Services, was contemplating suing Empire.

They did not talk to the OPM, Office of Personnel Management, or HHS IG's. They did not know about the AT&T lawsuit until it was in the newspapers. They did not know about the officers' deferred compensation plan or the supplemental employment plan, known as SERP I. They did not independently study or verify the plan's compensation program.

They did not test management assertions regarding paying high compensation to retain officers. They did not analyze potential contingencies. They did not even look at the Deloitte and Touche work papers. Those are the outside auditors who did the independent financial statements for the last few years. They never reviewed the work papers.

And it is also possible, Mr. Chairman, that they did not even review the Deloitte annual financial statements since the project manager, when he was interviewed by us, could not recall looking at the annual financial statements prepared by Deloitte and Touche. He said, "I guess we did."

Chairman NUNN. What did they do?

Mr. SOPKO. Mr. Chairman, they produced a 200-, 300-page report, and it basically repeated the assertions and arguments of the plan.

Chairman NUNN. After reading the statute and talking to people and conducting this investigation, what is your personal judgment about what the legislature of New York really expected in this audit? What were they looking for?

Mr. SOPKO. The legislative history was a little bare on that, but from talking to a number of staff and reviewing some of the legislative history, they were concerned—I mean the New York Legislature was concerned about the cherrypicking argument, about a lot of these arguments, and was concerned about mismanagement. They also did not apparently trust Deloitte and Touche to tell them about plan problems. So they appropriated up to, I think it was $3.6 million to have the Insurance Department hire a credible management consulting or auditing team to go in there and to determine if there was a factual basis for cherrypicking, a factual basis for mismanagement or not.

I think that was their intention. As one staffer told us who worked for the State legislature, "Our biggest fear was that Deloitte would get the contract. We wanted somebody independent, really independent and not in any way tainted by prior dealings or current dealings." That is why they put that clause into the statute.

Chairman NUNN. The taxpayers actually paid for this audit?

Mr. SOPKO. Yes, $1.9 million. Or I think it may be $2.2 million.

Chairman NUNN. $2.2 million. They appropriated more than was spent, right?

Mr. SOPKO. That is correct. That is correct. And one of the reasons we didn't find——

Chairman NUNN. So, clearly, the legislature was looking for an independent, objective, and analytical product, not simply something that took Empire's word. They wanted to go behind that. That was what they were asking for, right?

Mr. SOPKO. That is our understanding.

Chairman NUNN. It was an audit that was based on the skepticism of the State legislature?

Mr. SOPKO. That is correct, and I believe they wanted the auditors, whatever auditing firm it was, to have that professional skepticism. And we did not find that based upon our review of Arthur Andersen's work product.

Chairman NUNN. Now, you gave all of these findings about the Arthur Andersen report, but where did you arrive at those judgments? Was that based on interviews with the Arthur Andersen staff? What was the basis on which you made your findings?

Mr. SOPKO. We reviewed the report. We talked to other experts in the field who had also reviewed the report. We talked to other current and former employees of Empire, current and former employees of the Insurance Department, and we also interviewed the project leaders of the Arthur Andersen team, I believe on three separate occasions. We also interviewed the Insurance Superintendent, I believe, in a lengthy, 3- or 4-hour interview about this and other subjects. And, we also reviewed the work papers, including every interview done by Arthur Andersen in the course of their study.

Chairman NUNN. Did you find people either within or without the Empire Blue Cross plan that were critical of the Arthur Andersen study?

Mr. SOPKO. Yes, Mr. Chairman.

Chairman NUNN. For instance?

Mr. SOPKO. Well, I think we alluded to, in the staff statement, I think one former Empire vice president who actually told us that it was a whitewash, it was going to be a whitewash. And, based upon his review, he noted that the report itself had some criticisms in it, but the conclusions didn't seem to be related to the report. It is almost a schizophrenic report. You have conclusions which adopt the Empire's argument, but the body of the report has a lot of negative statements that contradict the conclusions.

I think one other vice president told us that his prediction was that they would come up with a few recommendations which would easily be dealt with, without addressing the significant management problems at the Plan. He referred to the Arthur Andersen report, I believe, as a "bone to be thrown to the State legislature and the *New York Times* to make them go away."

Chairman NUNN. Who was that?

Mr. SOPKO. That was a former employee, vice president of the Empire plan. So we did receive other criticisms.

Chairman NUNN. In the statement Mr. Morchower filed this morning, which is being made part of the record, he says on page 10, "In fact, the thorough management audit carried out by Arthur Andersen found no evidence to substantiate the charges of exces-

sive spending, salaries and perquisites or mismanagement leveled against the company."

Do you believe that the Arthur Andersen report went into these areas and gave any kind of thorough analysis?

Mr. SOPKO. No, we do not, Senator. In essence, Mr. Morchower is absolutely correct. If you look at the report, it does say that there was no mismanagement. It does say no excessive compensation, et cetera. So he is accurate about that. But what we are saying is they never really asked the right questions and didn't know enough to make that judgment.

One example, Senator—and I don't want to dwell on it because of the time constraint—deals with something called a Supplemental Employee Retirement Program, SERP, and this gives you an example. The Arthur Andersen team found a document that said SERP II, SERP with two Roman numerals, was adopted but then not implemented. We asked the Arthur Andersen team, well, did you know about SERP I? And they said no. And our thought was—if you found a SERP II document, didn't you ask is there a SERP I? And they never even asked that. So we are a bit critical of Arthur Andersen for these types of inadequacies.

Mr. Chairman, I want to briefly just state—and, again, the staff statement goes into great detail—that we did find that there was mismanagement. The staff reviewed the management practices of Empire, and what the staff found was a plan that appeared incapable of effectively carrying out the most basic functions of an insurer. They couldn't price, they couldn't collect, they couldn't pay. They couldn't adequately price their product, they couldn't adequately and efficiently collect their premiums, and they couldn't efficiently and timely pay their claims.

As a result, as detailed in the staff statement, they couldn't compete. And when they had to compete against other insurance companies, they lost. So, Mr. Chairman, I would ask that the whole staff statement, which is over 200 pages, with documents, be introduced into the record, and I will now turn to Eleni Kalisch.

Chairman NUNN. I fully realize how long it is. [Laughter.]

Mr. SOPKO. And the staff fully realizes that you fully realize how long it is. I will turn to Ms. Kalisch, who is going to continue on some of the other issues.

Chairman NUNN. Ms. Kalisch?

Ms. KALISCH. Thank you, Mr. Chairman.

An area of review in all of the staff's investigations of Blue Cross/Blue Shield plans has been customer service and consumer complaints. In interviewing the chief of the Consumer Service Bureau of the New York Insurance Department, the staff learned that the department closed only 4,200 complaints against Empire last year.[1] Given the fact that Empire insures over eight million people, the staff was impressed by this seemingly low number of complaints. A closer look, however, revealed this number to be misleading.

A large number of the 4,200 complaints was reviewed by the staff and found to be almost exclusively from subscribers with individ-

[1] Exhibit No. 63 is retained in the files of the Subcommittee.

ual, direct-pay policies. This figure did not account for the thousands of complaints of hospitals, complaints lodged with Empire directly, nor complaints registered by employees of Empire's large national accounts.

The primary complaint the staff heard from the hospital administrators was that Empire often loses claims or denies ever receiving them. This is true even when the claims are sent return receipt requested or transmitted electronically.

Another large problem associated with the hospital business is Empire's use of dedicated service centers for its large accounts. The DSC's are formed to service specific accounts such as IBM and the State of New York. The hospitals cannot send their claims directly to the DSC's, but must route them through Empire. Again, a problem arises regarding lost claims. The DSC's say they never got them from Empire; Empire says they never got them from the hospitals.

One hospital administrator told the staff that his sister submitted a claim to Empire for $2,600 and received four checks, each for $2,600. She called Empire Customer Service to explain the mistake and was told it "was her lucky day" and to just keep the checks. Uncomfortable with this, the woman actually took the checks to Empire's offices and attempted to return them to the customer service reps. She was told the system couldn't handle returned checks and that she should just keep them.

Representatives of the Greater New York Hospital Association told the staff that "there is an appearance of cordiality with Empire but nothing gets resolved."

The hospital administrators denied that cherrypicking is Empire's problem. They maintain that subscribers are leaving Empire because of service. "The Guardian provides better service at a higher price," one said, "and people are willing to pay for it. That's not cherrypicking."

When asked to compare Empire service to that of the commercial insurers, the hospital administrators agreed that the commercials are much more efficient. They cited very few instances of lost claims and much less frequent requests for medical records. They also felt that electronic claims submissions had streamlined operations for both Empire and the commercials, but felt that Empire simply "had no desire to pay what they owe."

In addition to the hospital complaints, Empire itself received over five million complaints and telephone inquires last year directly from subscribers and over 13,000 complaints which had been forwarded to the plan from outside agencies, such as the Office of Consumer Affairs and U.S. Senate offices such as yours.

As for the individual complaints against Empire, the subscribers represented by the 4,200 cases closed by the Insurance Department first attempted to resolve their problems by contacting Empire directly. After repeated efforts to convince customer service reps that a claim was incorrectly processed, the subscriber often turned to the Insurance Department for help.

In 1990, an Empire subscriber gave birth to triplets, each of whom required intensive care hospitalization. Empire made partial payment on one of the claims but refused to acknowledge the claims of two of the triplets. The subscriber found that Empire's

computer system could not process the three claims separately because each of the babies had the same date of birth and were, therefore, processed as only one birth. The subscriber told the staff that the babies are almost 3 years old now, but the claim with Empire is still not resolved.

In 1991, one subscriber actually had to sell her home to pay $20,000 in medical bills for her father-in-law, which should have been paid by Empire. After the father-in-law died in 1987, Empire made several payments to the hospital but failed to pay an outstanding hospital bill of $20,000 until February 1991. By that time, the hospital had received a judgment against the woman and her husband who sold their home to pay the bill. When Empire eventually reimbursed the couple, they included a letter apologizing for "taking so long to resolve this issue, particularly since it was Empire's error in the first place."

The position of Empire officials regarding its reputation for poor customer service is that it is merely a "perception" problem. The staff's interviews have clearly indicated that Empire's poor treatment of customers is much more than a perception problem. Empire officials need to acknowledge that this is an earned reputation and that serious steps must be taken to improve relations with unhappy subscribers.

The staff has also accumulated substantial evidence that Empire cannot meet the competition when it comes to servicing its large national accounts. They continue to lose major accounts, not because of cherrypicking but because they are providing poor service.

Empire serves as the control plan for numerous national accounts. Currently the number of national accounts totals 51. However, since 1988, 78 organizations involving nearly 350,000 employees and retirees have terminated their contracts with Empire.[1] The staff contacted 42 of the largest national accounts that have left Empire and found that for most of the companies poor service was the primary reason for moving to a new contractor. Slow payment and failure to follow up on complaints were the main areas of concern.

A sampling of the comments made by representatives of some of the National accounts who have left Empire includes:

"Let me put it this way: I have a full crop of gray hair, and every one of them came as a result of my dealings with Empire."

"Dealing with Empire was like dealing with a black hole."

"I have been involved with the Blues twice in my professional life, and both were the worst experiences of my life."

Finally, "One thing you can say about Empire is that they did not show favoritism in their screw-ups. They were non-discriminatory. They screwed up everyone's claims."

During the course of our investigation, we noted that the warning signs were everywhere relating to systems problems, failed management oversight, and poor communications. Numerous private companies, well-known hospitals, universities, governmental organizations, and the Blue Cross/Blue Shield national organization performed their own audits of Empire's performance and came

[1] See Exhibit No. 73 on page 332.

to the same conclusions. The staff statement contains a sampling of these negative audit findings.

As previously mentioned, the Arthur Andersen study commissioned by the State concluded that Empire should maintain its national account business. The Arthur Andersen team leaders noted that much of the Empire business was lost to other companies because of the loss-leader issue, as previously discussed. Staff disagrees with that finding.

We interviewed several brokers who had dealt with Empire and with commercials, and we were told some of the following:

"When I go to the customer service counter, I feel I am in a combination of a zoo and a deli counter. I would only place business with Empire if there were no other choice."

Another broker told us that, "Being big didn't save the dinosaur."

The Federal Employees Health Benefit Program was created to provide health benefits to Federal employees, annuitants, and dependents by way of a contract with the National Association. As another indication of widespread management problems at Empire, the staff noted negative findings in the most recent audit of the Federal Employees Health Benefit Program, which found questionable costs of over $6 million. The staff also found that the Medicare Secondary Payor Program may cost Empire over $143 million.

The Health Care Financing Administration, or HCFA, within the U.S. Department of Health and Human Services, pays contractors to process bills and claims and otherwise administer the Medicare program. Empire is under contract with HCFA and is the largest Medicare contractor in the United States.[1]

With the increase in the number of people actively working past the age of 65 and covered by employer-sponsored insurance or by an employed spouse's policy, the Medicare program should experience less of a burden as the primary payor of health benefits on persons still employed. This is not necessarily the case with Empire, as the Inspector General's Office of HHS has discovered in an ongoing audit of the Medicare Secondary Payor Program.

Based on statistical sampling in its audit, the IG estimates that improper payments may total as much as $143 million. While these are considered estimates at this time, HHS auditors are confident that the final figures will be very significant.

The staff also found that the Medicare contract with Empire was put on probation for not meeting Government-wide standards for the past 2 years.

In 1992, Empire dropped to a ranking of 46 out of 51 intermediaries on a nationwide performance rating scale.

On April 26, 1993, Albert Cardone was notified that the regional office of HCFA would be closely monitoring Empire's performance and that if progress was not made the Medicare contract would not be renewed.

Should it not be renewed, Empire stands to lose nearly $100 million in costs it receives annually from HCFA and approximately

[1] See Exhibit No. 28 on page 310.

1,500 full-time equivalent positions designated to serve the Medicare population.

Ironically, the current chairman of the board, Harold Vogt, was interviewed by the staff, and he told us that he did not know about this problem with the Medicare contract until he read about it in the *New York Times.*

In addition to customer service complaints, the staff also found Empire's large executive salaries to be of utmost concern to subscribers. This chart depicts the corporate organization of Empire Blue Cross/Blue Shield as of September 1992.[1]

According to the chart, which was provided to the Subcommittee by Empire, the corporate structure includes 20 assistant VP's, 39 VP's, three corporate VP's, one executive VP, and one corporate secretary.

Chairman NUNN. How many VP's is that?

Ms. KALISCH. Well, around 60. It is a total of 65 executives overall, although there have been some changes, obviously, since the chart was provided. Mr. Cardone is no longer CEO, and the COO, Mr. Morchower, is now acting as CEO.

The next chart lists the total cash compensation of Empire's top six executives for the past 3 years.

In 1991, the Blue Cross and Blue Shield National Association conducted a study of all 72 plans in order to prepare executive compensation schedules. According to the study, Al Cardone's compensation of $600,000 placed him within approximately the 85th percentile of CEO's within the 60 plans responding to the survey. Given that Empire is the largest Blue Cross/Blue Shield plan, the staff finds this reasonable. We contend, however, that CEO's earning these impressive amounts should at least be operating financially sound plans.

According to Empire's corporate policy, each year's incentive payment is based on performance of the plan in the previous year. Thus, the incentives based on 1991's business performance, the year in which Empire experienced the $150 million in losses, were awarded in 1992. As the chart shows, these figures were significantly greater than the previous year, with the exception of the general counsel position, which had a slight decrease.

Despite Empire's poor performance, they were awarded these incentives. Empire officials explained that this was possible because incentive payments also incorporate divisional and personal goals; thus, even though the plan may have done poorly, the individual officers may have done well.

The staff is uncertain how the plan could do poorly in 1991 if all but one of the officers was performing so well.

Chairman NUNN. Well, which officer didn't get the bonus?

Ms. KALISCH. Mr. Drewsen, the general counsel. He received a bonus, but it was only 11 percent, $22,000; whereas, the previous year he had gotten a 13 percent incentive bonus of $27,000.

Chairman NUNN. So you said all but one got a bonus.

Ms. KALISCH. No, all but one got an increase over the prior year's bonus.

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[1] See Appendix C of Staff Statement on page 218.

Chairman NUNN. Got an increase. I see.

Ms. KALISCH. Yes, sir.

Chairman NUNN. So what you are saying is the plan lost how much money?

Ms. KALISCH. $150 million in 1991.

Chairman NUNN. And that was the year on which this chart was based, the bonuses?

Ms. KALISCH. All 3 years are shown there.

Chairman NUNN. OK. So the——

Ms. KALISCH. But the bonus for 1991 was awarded in 1992.

Chairman NUNN. So what you are saying is, with this chart, the year they lost $150 million, all the top officials got a bonus?

Ms. KALISCH. An increase in the bonus from the prior year.

Chairman NUNN. Not only a bonus, but an increase in the bonus.

Ms. KALISCH. Right. Yes, sir.

When informed of Empire's average incentive payment of 11 to 13 percent, a benefits expert that the staff interviewed said, "It would be highly unusual to give someone that size bonus even every other year, especially if you are losing money. You could do it once maybe, but no board would let you do it every year."

Al Cardone initially joined Empire with an employment contract, but was working pursuant to three board resolutions for the past several years.[1] The board minutes reflect that these resolutions were approved by the board without any question as to how much it would actually cost the plan.[2] Estimates since Mr. Cardone's resignation place his severance payment at between $1.4 and $2 million.

In 1987, when Edwin Werner stepped aside as CEO of Empire, he was retained by the company on a consulting basis. The staff found that in the year following his retirement, Werner received $105,000 in consulting fees for his assistance in the transition of administrations. Several other Empire officers also left Empire's payroll, only to be immediately rehired on a consulting basis at an average fee of $120,000 a year.

Mr. Cardone maintains that the consulting work performed by these officers involved assisting in the transition period for their successors. The staff has some question, however, as to whether these officers actually served as consultants or whether this was actually some type of severance payment to these officers.

In addition to complaints about excessive salaries and incentive payments, the staff also received complaints concerning perquisites Empire officials enjoy. The figures presented on the compensation chart do not include the value of fringe benefits provided to these and other officers. The plan paid for health club memberships, luncheon club memberships, physical examinations, and parking costs for many of its executive officers.

Perhaps the most costly of all corporate perks at Empire is the fleet of corporate automobiles.[3] Empire has purchased 82 automobiles for its officers ranging in model years from 1988 to 1992, at a current fair market value of over $1 million. Corporate policy for

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[1] Exhibit No. 42 is retained in the files of the Subcommittee.
[2] Exhibit No. 38 is retained in the files of the Subcommittee.
[3] Exhibit No. 43 is retained in the files of the Subcommittee.

employees to whom these cars are assigned provides that the cars may be used for both business and personal reasons. Interestingly, the staff that some officers actually reported using the vehicle for more personal use than business.

In addition to the fleet of 82 assigned vehicles, Empire also owns a feel of 41 pool cars, or cars which are available for employees for specific Empire-related purposes. This fleet of cars also has a fair market value of approximately a half-million dollars.

The staff found it remarkable that despite 82 officers having vehicles assigned to them and 41 pool cars being available for use for Empire business, the company still engages the services of several limousine companies.

Last year, Empire spent over $50,000 on limos, while in 1991 the company spent over $91,000 for limos. The staff found that during the past 6 years, despite its own extensive fleet of cars, Empire spent a staggering quarter of a million dollars on limousine services for officers, employees, and guests.

Chairman NUNN. Now, are these the same people using the limo service that have the automobiles?

Ms. KALISCH. In many instances, yes, sir.

Chairman NUNN. So it is not a whole group of other people out there. There is a lot of overlap there.

Ms. KALISCH. Yes, sir, there is. One example of the overlap is Mr. Cardone. There was almost 2 months of steady limousine rides for Mr. Cardone, and he explained that his car, his assigned car and driver were out of commission. So he had the limousine, and the staff asked why he didn't use a pool car instead of paying $11,000 for a limousine. He was very indignant and said, "I was recruited by this company, and they promised me a car, and I got a car." And that was $11,000 of subscriber monies. He could have gone out and almost bought a new car rather than use a limo for 2 months.

The staff finds that these types of expenditures of subscribers' hard-earned money typifies the blue-chip mentality of Empire executives. Throughout this investigation, the staff has been told that we would be hard-pressed to find extravagant overseas travel upon the Concorde or $300,000 skyboxes or lavish country club membership, as we found in previous investigations. That much is true. What we did find, however, is that Empire operates as if it is a profitable Fortune 500 company rather than a non-profit health insurer.

In addition to the corporate perks described above, Empire also lavishes its staff with numerous gifts and rewards at subscriber expense. Last year, Empire created a company-wide "Employee Recognition Program" to reward employees for specific achievements. One of these awards is a service award which Empire employees, when they work 5 years, 10 years, 15 years in the company, are allowed to select a gift of their choosing from an Empire catalogue,[1] which I believe you have with you. Some of the items in that catalogue—this is a display of what they are allowed to choose—include diamond and sapphire jewelry, Waterford crystal, pearl necklaces, gold wrist watches engraved with the Empire logo,

[1] Exhibit No. 44 is retained in the files of the Subcommittee.

binoculars, wall clocks, carriage clocks, grandfather clocks, and some of the other awards include $2,500 in cash. Last year, these gifts to employees cost Empire subscribers $255,000. Over the past 5 years, these gifts have totaled over $1 million.

Chairman NUNN. Is that given pretty much across the board to an awful lot of people, or are those awards based on specific achievement and performance?

Ms. KALISCH. They are very generously bestowed. I believe one of the awards is called Circle of Stars, which is awarded if you do something above and beyond the call of duty. I believe in one month 2,500 employees received the Circle of Stars award.

Meanwhile, as all these gifts are being bestowed, the premium rates charged to subscribers have been skyrocketing. This chart shows the history of rate increases granted for some of Empire's community-rated contracts.[1] This shows that an employee of a small group that had basic medical coverage has seen a 350 percent increase. In 1989, he would have been paying $29.55 for individual coverage, and this year he is paying $138. And if he has major medical coverage, he saw a 230 percent increase. In 1989, he would have been paying $97.90 a month, and this year he would be paying $323 a month.

The staff also learned that Empire bestows even more gifts upon its employees for participating in such worthy causes as the United Way Campaign, March of Dimes fundraiser, and Red Cross Blood Drives.

During the 4-year period 1989 to 1992, Empire spent an additional $264,000 in "rewards" for employees who participated in these events. The staff is concerned about the propriety of a non-profit health insurer spending subscribers' premium monies in order to reward employees for such acts as contributing to charity or donating blood.

In 1987, the board of directors established the Edwin R. Werner Scholarship Fund in honor of the plan's former CEO. Since this scholarship was established in 1987, the plan has awarded over $400,000 to 12 students. These scholarships are not funded by Mr. Werner, nor by the executive officers or the board of directors. It is funded directly by Empire subscribers.

Another example of Empire's Fortune 500 attitude can be found in its catering and meal expenses. Empire contracts with several catering companies to provide food and beverage services to the plan. In reviewing the company's catering bills, the staff found routine, almost daily staff meetings at which hundreds of dollars of food and beverage is served.

Empire also subsidizes the cost of its cafeteria expenses in an effort to offer convenience and affordable food to its employees. The amount of this subsidy totaled $1.3 million in 1989, $1.6 million in 1990, and over $2 million in 1991 and 1992. According to its food service contracts, Empire is responsible for pricing their food, and given the size of their subsidy, the staff things perhaps they should look at their pricing mechanism.

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[1] See Appendix C of Staff Statement on page 218.

Empire also subscribes to a rather lenient overtime policy for its employees. In reviewing expense reports, the staff found that this policy is abused. The majority of Empire employees who claim to be working late are not ordering in sandwiches from the corner deli, but are rewarding themselves with expensive meals at New York restaurants.

In January 1991, an internal audit of Empire's overtime policies was conducted and revealed that employees often received overtime pay for days when they were out sick or on vacation.

Another area of expenditure which the staff reviewed was travel. Staff found a large expenditure for 12 Empire officers to attend a seminar at Disney World in Orlando, Florida, in July and October of 1990.[1] The seminar was entitled "The Disney Approach to Quality Service" and was available at a registration fee of $1,700 per person, or over $20,000 for Empire's 12 officers to attend.

This $20,000 covered the cost of hotel rooms and seminar registration for the officers, but did not cover the cost of transportation. Staff found that 10 of the 12 Empire officers who attended the seminar flew to Orlando at a reasonable coach airfare. Two of the officers, CEO Al Cardone and Vice President of Corporate Quality Control, Beverly Palmer, flew first class at a cost to the plan of $1,700. When questioned by the staff, both Cardone and Palmer maintained that they were working and therefore had to sit together in first class.

CEO Al Cardone accompanied the first group of six officers who attended the Disney seminar. However, he made a special request for a two-room villa at a cost of $725 a night rather than stay in the room which was included in the $1,700 seminar fee. The total bill for Mr. Cardone's attendance at the 3-day Disney seminar was over $5,000, paid for by the subscribers.

The staff found numerous other instances of the Fortune 500 mentality of Empire officers and employees, including the following:

Empire paid $300,000 to be one of the eight major sponsors of this book, "The Power to Heal, Ancient Arts & Modern Medicine." [2] The staff notes that none of the other major sponsors of the book—Eastman-Kodak, Parke-Davis, United States Surgical Company, Pan Am World Airways, Apple Computer, Nikon, and the San Francisco Marriott—are non-profit organizations.

Last year, Empire spent over one-half million dollars to lobby lawmakers in the State Capitol. This was more than any other organization in the State except one. The staff questions such excessive spending on lobbying fees by a non-profit company which is raising its premium rates and receiving an infusion of funds from the State.

Also, Empire officers appear to be unwilling to incur the slightest personal expense associated with their jobs. For example, Maroa Velez, vice president of auditing, making over $166,000 a year, charged an 11-cent phone call to the plan. Bernard Schoen, vice president of experience-rated sales, making over $268,000 a year, charged $2.50 to the plan for tolls he had to pay to attend the

[1] Exhibit No. 47 is retained in the files of the Subcommittee.
[2] Exhibit No. 48 is retained in the files of the Subcommittee.

funeral of a co-worker's mother. Michael Blumenfeld, vice president of public and governmental affairs, making over $161,000, received reimbursement for a 40-cent newspaper. And Alan Drewsen, Empire's general counsel, making over $227,000, charged the plan for lead for his mechanical pencil.

In 1990, Empire spent $7,600 to install a hidden camera in the office of an employee suspected of drug use and to hire an undercover agent to pose as an employee and monitor the suspect's activity for a 3-week period. When questioned about the surveillance, Alan Drewsen, general counsel, stated that he acted on a tip from an employee who Mr. Drewsen could not identify for the staff. The suspected employee had been with Empire for over 10 years at the time surveillance was commenced. The surveillance revealed no drug activity. In addition to Mr. Drewsen, only four other employees were aware of the surveillance: two security officials, a former human resources employee, and Donald Morchower, the now-acting CEO. Mr. Drewsen told the staff he did not feel it necessary to inform Mr. Cardone.

Chairman NUNN. What do you find wrong with that if they really believe somebody has got a drug problem? Were they suspecting selling, or were they suspecting use?

Ms. KALISCH. Empire officials couldn't recall the exact nature of the tip that they received. They believed that it was a tip that the person was using drugs on the premises.

We did talk with law enforcement, and they said that they do believe individuals have a reasonable expectation of privacy in their own office, which this was a private office with a door, but that as long as Empire was just watching and not listening to the employee, it was not illegal.

The staff questions the expense of $7,600 when there was no evidence that they did anything to confirm the credibility of this tip.

Mr. SOPKO. Could I just add this, Mr. Chairman? I spoke with a former vice president who left recently, and he also described this instance. He said his understanding was the entire tip included the fact that some employees saw a brown paper bag next to the employee in question's desk. Based upon that, they decided to put a hidden camera in and then hired an undercover agent, and they didn't discover anything.

Ms. KALISCH. Mr. Chairman, when Al Cardone became CEO of Empire in 1985, the board of directors was comprised of 44 directors, including Cardone himself as chairman. Over the next 6 years, Cardone drastically downsized the board of directors, primarily through attrition, to 19 members.

A former Empire officer told the staff that Cardone removed every board member who might question some of his actions and kept only those who were "rubber stamps" for Cardone's actions. Although neither the 44-member board nor the 19-member board received financial compensation from Empire, they were extravagant in spending subscriber funds for board meetings, receptions, seminars, and gifts.

In addition to its regularly scheduled meetings, the board also treats its members and their spouses to annual seminars held at conference centers outside of New York City. Anywhere from 20 to 30 Empire officers and spouses also attend.

In reviewing documents subpoenaed from Empire,[1] the staff found that each of the board seminars incorporated a theme into its extravagant decorations and floral arrangements. For example, in 1990, the theme of the board seminar was "Amadeus," as depicted by a masquerade motif. Empire purchased 147 masks on sticks such as this at a cost to subscribers of approximately $3,000.

In addition to the masquerade motif, there was a board seminar with an art deco theme, and in 1988 there was a Broadway theme for which posters such as this one of "Les Miserables" were purchased. Over $9,000 was charged to subscribers for those posters.

In addition to the decorative themes at the board seminars, Empire management also took this opportunity to bestow gifts upon its board members for their——

Chairman NUNN. I am not sure I follow that. What was purchased? Posters?

Ms. KALISCH. Various Broadway posters, over $9,000, just for decoration——

Chairman NUNN. Did they give them to each person who came or they were decorations?

Ms. KALISCH. Just for decorations for their parties, yes, sir.

In 1990, at the board seminar, the year of the "Amadeus" seminar, the board received exclusive Ghurka luggage. The staff has a piece here to show what they received. Over 2 years, they each received two pieces, and the subscribers paid over $24,000 for that luggage. That particular piece, I believe, was given in 1989, and it cost $450.

When we asked the chairman of the board about that, he didn't recall receiving gifts such as the luggage, but said that he didn't really pay much attention to it.

The staff found that each seminar costs subscribers an average of $142,000 in food, drink, accommodations, and gifts. Although Mr. Vogt refused to comment on whether the $142,000 expenditure was appropriate, he did acknowledge that he would not recommend such an expense and would not approve of it in the future.

The board seminars held in September or October of each year——

Chairman NUNN. The time these gifts are being purchased is during the same time they were losing an awful lot of money and raising fees to policyholders?

Ms. KALISCH. Yes, sir. Last year was the first year that they did not have a board seminar, and Mr. Vogt explained that it was because of the financial situation at Empire. But he felt that the seminars were necessary to get away from "the ringing phones" at Empire, despite the fact that it cost subscribers $142,000.

Chairman NUNN. You are not saying there is anything improper about the seminars; what you are saying is they didn't have to spend all that money, right?

Ms. KALISCH. The cost, yes, sir.

The Christmas holidays also present another opportunity for board members to receive gifts. Both current and retired board members receive Christmas gifts at subscribers' expense. In 1991,

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[1] Exhibit No. 52 is retained in the files of the Subcommittee.

subscribers paid $3,700 for ginger jars to be given to the retired directors and over $14,000 for silver punch bowls.

Chairman NUNN. For what?

Ms. KALISCH. Ginger jars. A type of vase.

Chairman NUNN. OK.

Ms. KALISCH. That was for the retired board members. The active board members received silver punch bowls. This is the punch bowl that was ordered from the Smithsonian Institution. They ordered 19 of them, and when we contacted the Smithsonian, we found that Empire had paid $14,000 for these bowls, yet did not receive delivery of them. Empire has asked that the Smithsonian keep them in storage, where they have been since 1991. You can see the bowl is starting to tarnish in some places. And when we asked the Smithsonian why Empire paid for them in full, over $14,000, and then didn't accept delivery, they said they had two different answers: First what Empire told them was that it didn't look good and for the Smithsonian to just hold on to them; then more recently Empire has said that their building isn't secure, and they can't keep something of that expense in their building. Both Smithsonian and the staff wonders why that is important if these are meant for the board members. In fact, the Christmas card is even in the box, which says, "Happy Holidays from Empire." So we don't understand why they have refused to accept delivery.

All told, the annual board of directors Christmas parties cost subscribers over $40,000 in food, beverage, decorations, and gifts.

Chairman NUNN. That was for what? For one year, or are you talking about for 2 years?

Ms. KALISCH. The $40,000 is each year, each Christmas party. And, again, they didn't have one last year for financial reasons.

Chairman NUNN. How many years did you cover that?

Ms. KALISCH. $40,000 for the past 5 years, each year for the last 5 years.

Chairman NUNN. Each year for the last 5 years, so about $200,000 total.

Ms. KALISCH. Yes, sir.

In addition to the annual board of directors seminar and the board of directors Christmas party, gifts are also bestowed upon board members when they retire. The typical retirement gift package includes a framed copy of the board resolution acknowledging the director's retirement. These resolutions cost $450 each and have totaled $10,000 in the past 5 years. Board retirees also receive framed portraits, framed caricatures, costing over $8,500 in the past 5 years; $600 Tiffany clocks are also given to board members. Finally, retired board members receive free health coverage for themselves and their spouses for life.

Chairman NUNN. Do you have a value on that?

Ms. KALISCH. No, sir. I wouldn't begin to guess what that is worth. But, of course, as they retire, they tend to be the older board members, as do their spouses, I would imagine. And I would think the cost at that time in their lives would be higher than average.

Edwin Werner, Empire's former CEO, received numerous retirement gifts as well as a party in his honor when he retired. A $2,500 glass Excalibur paperweight was presented to Mr. Werner along

with a $500 Steuben Glass eagle. A $6,000 silver tray with an inscription to Mr. Werner was also given to him in honor of his retirement. The staff asked Mr. Vogt whether any retirement gifts or receptions were going to be held for Mr. Cardone, and he responded that, to his knowledge, there were no such plans.

As the staff's investigation progressed, we learned more and more about the manner in which Al Cardone ran Empire. The staff found that Mr. Cardone, until his resignation, was enjoying all the accouterments of a chief executive of a profitable Fortune 500 company, while failing to show the restraint in spending which one would expect of a non-profit CEO.

For example, travel documents reviewed by the staff revealed that Mr. Cardone virtually always traveled first class. Additionally, as we discussed before, Mr. Cardone had one of the assigned cars—his particular car was a Lincoln Town Car—and an assigned chauffeur. The staff interviewed the chauffeur, and he said that Mr. Cardone had death threats made against him, and that is why he needed the protection. He was an armed driver assigned to Mr. Cardone. The driver did tell the staff that he has been with Mr. Cardone for 2½ years and there has not been a death threat in that time.

Also, in response to the alleged death threats, Mr. Cardone had a security system installed at his home in 1990 at a cost to subscribers of $17,000, plus $2,000 annual maintenance. In 1991, Mr. Cardone decided he also needed a telecommunications system installed at his home which would provide a direct link from his home to Empire. That cost subscribers an additional $27,000.

In another effort to maintain his direct link with the office, Mr. Cardone had a cellular phone installed on what he called his "larger boat." The installation cost of $1,000 to $2,000 was also paid by Empire.

From 1985 through 1989, Empire maintained a corporate apartment at the Dumont Plaza in New York City at a cost of $48,000 a year. Documents revealed that when the lease expired in 1989, Empire decided not to renew primarily because "Mr. Cardone prefers accommodations offering 24-hour food service."

The food services group at Empire provides a monthly accounting for what it terms "Cardone Services." The staff was told that these figures represent meals Mr. Cardone has had the Empire food service staff deliver to his office. Many of the items listed on "Cardone Services" simply state "Meal for one" or "Meal for two." Last year, these "Cardone Services" meals cost Empire subscribers over $26,000. Mr. Cardone maintains that each of these meals was business related.

In 1989, Mr. Cardone initiated a sweeping design and construction overhaul of the executive offices and board room on the 26th floor of Empire headquarters.[1] After spending $118,000 on this project and countless hours choosing fabric samples, furniture styles, and color schemes for presentation to Mr. Cardone, Rochelle Vella, the employee assigned to oversee the project, was suddenly informed the project was on hold.

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[1] Exhibit No. 49 is retained in the files of the Subcommittee.

The staff reviewed the proposals for which Mr. Cardone gave his preliminary approval and found such items as a $50,000 breakfront, a $22,000 conference table, and a $14,000 Oriental rug.

Of particular note is a $20,000 mahogany Chippendale desk which Mr. Cardone had requested for his office. According to Ms. Vella, Mr. Cardone selected this desk on one of their outings to a furniture warehouse, and Empire did, in fact, purchase the desk for him. When the staff visited Empire headquarters and asked to see Mr. Cardone's office, we were struck by the absence of the Chippendale desk. Ms. Vella confirmed that even though the $20,000 desk had been paid for in full by Empire, the desk was being stored off-site in a warehouse. When asked why the desk would be kept in storage even after it had been paid for, Cardone told the staff it would have "stuck out like a sore thumb" without the other items he had envisioned as part of the redecorating project.

Another purchase instigated by Cardone was a set of china and glassware from Tiffany's. Shortly after Mr. Cardone became CEO, he hosted a meeting with IBM at which drinks were apparently served. Embarrassed by the quality of glassware available for the meeting, Cardone placed a $1,400 order for Tiffany china and glassware bearing the Empire logo.

In fact, the staff has discovered that Empire established a corporate account with Tiffany's [1] in 1986 which it has used to purchase over $45,000 in giftware. Empire also maintains a corporate account with Cartier's and has purchased similar gift items during the past 5 years at a cost to Empire subscribers of over $13,000.

In fact, when the staff contacted Cartier's and Tiffany's, representatives made a comment about the fact that Empire was a nonprofit health insurer and was maintaining corporate accounts at such exclusive stores, and they wished us luck in our investigation.

As mentioned earlier, Mr. Cardone received a luncheon membership at The Sky Club in New York City, courtesy of Empire subscribers. In addition to the $1,800 annual dues, Cardone incurred over $17,000 in meal expenses last year and over $50,000 in the past 5 years.[2]

Mr. Cardone also has a luncheon membership at the Windows on the World restaurant atop the World Trade Center. According to Empire documents, however, Mr. Cardone has only dined at Windows on the World three times: 1990, 1991, and 1992. Each of these expensive luncheons were with the representatives of the Health Care Financing Administration, the agency responsible for oversight of the Medicare program.

While Al Cardone no longer serves as Empire's CEO, the staff finds that Empire's problems are too complex to resolve by merely removing an individual officer. At this point Mr. Edelman will address some of those complex problems.

Chairman NUNN. Thank you, Ms. Kalisch.

Mr. Edelman, talk right into the mike now because these mikes have to be direct.

Mr. EDELMAN. Senior Empire officials, in an interview with the staff, admitted that one of the causes for their losses in 1991 was

[1] Exhibit No. 45 is retained in the files of the Subcommittee.
[2] Exhibit No. 50 is retained in the files of the Subcommittee.

fraudulent activity related to some of their union accounts and association business. However, these officials have downplayed its significance in relationship to the overall losses of the plan in 1991 and 1992. The plan's losses, they have consistently argued, are primarily due to cherrypicking and other unfair competition from commercial insurers in the community-rated market, as well as rate suppression by the Insurance Department.

In view of these arguments, recent revelations of fraudulent activity by just one broker in this market, potentially costing the plan up to $25 million, raises serious questions as to whether cherrypicking is, in fact, a valid explanation for Empire's community-rated losses.

Based upon its review of not only this case but the entire fraud prevention environment at Empire, the staff concludes that Empire is extremely vulnerable to fraud, waste, and abuse because of a long history of shortcomings in its computer systems and fraud-detection capabilities. As a result, Empire has suffered major losses due to fraud, waste, and abuse which the company itself in internal documents has admitted totals over $64.5 million in 1991 and 1992 alone, representing approximately 25 percent of the plan's net losses for those 2 years.

Furthermore, the community-rated small-groups market is particularly susceptible to potential fraud, and up to mid-1991 Empire had never attempted to determine the extent to which possible fraud contributed to the plan's losses in that market.

The staff discovered that Empire has routinely been paying claims to doctors, dentists, pharmacies, hospitals, and durable medical goods providers without verifying whether any of these providers even exist. This practice, which includes the use of so-called dummy codes,[1] is significant and amounts to over $500 million every year in claims paid by Empire.

Chairman NUNN. That $500 million is not necessarily fraudulent claims or claims that shouldn't have been paid, but these are claims that are improperly documented and do not fit into the normal checklist on the computer code. Is that right?

Mr. EDELMAN. That is correct, sir. The staff is not saying that all of these claims are fraudulent. These are merely claims which have been paid for which Empire has not established the necessary existence of the providers, but has instead used a generic code rather than the precise code which the doctors or the hospitals, or whoever the provider may be, would normally be assigned.

Chairman NUNN. Is that what we call or have seen in the paper described as a "dummy code"?

Mr. EDELMAN. Yes, sir.

Chairman NUNN. Now, give a definition. Give your best definition of a dummy code.

Mr. EDELMAN. Normally, when a subscriber would file a claim, he would file the bill from the doctor, and on that bill there would be a provider number which is assigned to a doctor. Every licensed physician would have a certain provider number which is given to him by State authorities. And on the basis of that number, Empire

[1] Exhibit No. 24 is retained in the files of the Subcommittee.

would process the claim, and it would be recognized by Empire's computer systems.

In instances where a claim comes in and Empire does not have the provider number for that particular physician or the particular provider, what it would do, rather than suspending the claim at that point and having to manually go through the records and establish what the exact provider number is, they would instead give that particular claim a generic number; in essence, a made-up number within the plan so that the computer would then recognize it and not suspend that claim; in other words, not stop payment on that claim. Then the claim could continue to be processed.

Chairman NUNN. The dummy code is a way of bypassing, then, the normal checklist to certify, in effect, that the claim is valid?

Mr. EDELMAN. That is correct, sir. I presume the theory would be that at some point in time the plan would go back and check on these numbers and establish that, in fact, those claims for which they were attaching generic codes were, in fact, valid claims. But our review has shown that the plan has not done that very well over the years.

The staff learned that the inherent problem with the use of these dummy codes is that their usage prevents subsequent verification that the service was provided by a licensed, credentialed physician or even if the service was performed at all. Equally significant, the usage of these dummy codes opens the door for fraud.

As it was described to the staff, the system currently permits someone in the claims processing area of the plan to submit a completely fictitious claim, utilizing a dummy code to fraudulently pay a claim to him- or herself or to a confederate.

The staff deposed Thomas J. Ward [1] who, until shortly before his deposition with the Subcommittee, had been the director of program security at Empire. He verified that he has been concerned about the potential fraud from the use of dummy codes and other corporate shortcomings since he joined the plan in 1987. He testified that as a fraud investigator, he would "want to eradicate them"—meaning the dummy codes—"from the face of the Earth."

When asked if anything was ever done in the plan to effectively deal with the dummy-code issue, Mr. Ward said that there have been some incremental improvements and that committees were formed to look into the issue; but overall, dummy codes remained, in Mr. Ward's words, "a window of vulnerability that needs to be shut very quickly."

In fact, Mr. Ward told the staff that the practice of paying claims when the provider could not be identified most accurately totaled approximately $504 million in 1991 alone. Furthermore, Mr. Ward informed the staff of the existence of a January 13, 1993, memorandum from Ms. Maroa Velez, Empire's vice president for internal audit, which cited the $504 million figure. [2]

Chairman NUNN. Let me ask this question, Mr. Edelman. You may get to it later in your testimony, but the dummy code is set up to go ahead and pay claims that are not properly validated.

Mr. EDELMAN. Correct.

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[1] Exhibit No. 10 is retained in the files of the Subcommittee.
[2] Exhibit No. 24 is retained in the files of the Subcommittee.

Chairman NUNN. According to the normal computer program. Does this mean that every claim that is not properly documented goes through the dummy code, or is there a discriminating method so that some of them are kicked out and not paid and thereby checked further? Or is the dummy code a way of basically validating everything?

Mr. EDELMAN. Well, in the process of processing a claim, there are a number of what are called edits within the computer system, which makes sure that appropriate information is included on the claim. That would go to everything from the subscriber's Social Security number and address to a description of the services the claim is being made for, to the identification of this necessary information concerning the providers. I believe from our understanding that the usage of the dummy codes went primarily to instances in which verification information concerning the providers was missing. And I don't believe it was used to any great extent when other pieces of information were missing.

Chairman NUNN. So there is a certain amount of information here that was allowed to go through the system, a certain number of claims allowed to go through the system and be paid that were not properly validated?

Mr. EDELMAN. That is correct.

Chairman NUNN. And those were primarily claims that did not have adequate information regarding the provider; that is, the doctor or the hospital or so forth?

Mr. EDELMAN. That is correct.

Chairman NUNN. All right. What I am asking now is: Did that mean that all the claims that came in that were not properly validated or verified with the normal computer code, were all of those claims paid with a dummy code, or was there a discrimination between some that were paid and some that were not paid?

Mr. SOPKO. I don't know if we know for certain, Senator, about that. We do know that there are other editing problems with the computers there which don't relate to dummy codes. We have heard the term "dummy code" used in reference to, as Mr. Edelman said, the providers, but we also were told by Mr. Ward and other people that people were actually making up—and I don't know if they used the dummy code for that or not. I am not an expert on it. But people were actually making up patients out of thin air.

There was one case, which I think Mr. Edelman will allude to, which was called the "claim of horrors," where a claims processor made up everything: the provider, the doctor, children being born, hospitals, everything. And I don't know if it all used dummy codes, if that is your question. There may be another term that we are not aware of, but the computers have significant problems beyond dummy codes in paying proper claims.

Chairman NUNN. OK. Go ahead.

Mr. EDELMAN. With respect to this January 13, 1993, memorandum citing the $504 million figure relating to the usage of dummy codes, Mr. Ward testified in his deposition that Ms. Velez attempted to hide the details of this report from not only the Subcommittee, but also from the New York regulators, from the Arthur Andersen team doing the management and financial audit, and from

Towers Perrin, a management consultant firm hired by Empire itself. She did so, Mr. Ward testified, because she didn't want the adverse information in that memorandum to get out.[1]

No one knows what percentage of the total amount of dummy coding is fraudulent. Neither the Insurance Department nor the plan itself has ever bothered to inquire into the question of potential fraud until this Subcommittee started its investigation.

The staff also uncovered a second and equally troubling systems and internal control problem that may have resulted in significant losses to Empire due to the improper and sometimes fraudulent payment of claims. This concerns the plan's ability to monitor the membership of many of its small groups to ensure that only eligible subscribers are permitted to submit claims to the plan.

The staff's review points to grossly inadequate controls and the potential for millions of dollars of improper claims having been paid by the plan. The staff discovered that, until recently, Empire did not perform any audits of its small community-rated groups. The reason for this, as explained by Jerry Weissman, Empire's chief financial officer, was in part due to the nature of the community-rated business. Since the plan had to take individuals and groups regardless of their health risk, the plan never bothered to concern itself with the particular group's profit or loss. Rather their focus was always on the community pool as a whole.

Until 1991, Empire knew little about its small-group market. For specific groups, Empire did not know the claims ratio. They did not know if they met underwriting standards or even, as it later came out, if a particular group insured by Empire really existed in the first place.

Mr. Ward told the staff that in the summer of 1991 the plan set up a task force to look at the groups in the community area to see if they were real groups. When asked the reason for this, Mr. Ward responded, and I quote, "My recollection is because of the massive losses taking place in the community-rated area. I also think they were looking to see what evidence of cherrypicking was taking place, too, if I remember correctly."

The staff has reviewed the 1992 year-end status report of that task force, which is called the Group Integrity Department.[2] It shows significant problems with the integrity of the plan's small groups and lays the basis for the staff's concern about significant fraud having been perpetrated upon the plan through the small-group market.

Based on the latest report from the Group Integrity Department, which covered April 1992 to December 1992, the special task force conducted audits on 2,004 groups. Each of the groups experienced losses ranging from $35,000 to $1 million. This resulted in an overall loss to the plan from these groups of $149 million. The audits resulted in the cancellation of 377 groups that did not meet Empire's underwriting requirements or groups that refused access to the auditors or groups which Empire was unable to even locate.

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[1] Subsequent to the Subcommittee Staff's June 25, 1993 testimony, Mr. Ward corrected his affidavit to clarify that Ms. Velez attempted to hide the details of the report from *only* the Insurance Department and state regulators and not Towers Perrin and the Subcommittee Staff.

[2] See Exhibit No. 3 on page 286.

This report indicates that from the 377 groups that were canceled, Empire lost $25 million from 1990 to 1991.

According to the Group Integrity Department, between April 1992 and May 1993, it audited 2,880 groups and found only 1,173, or 41 percent of those groups, to be qualified. For example, more than half the groups which this department audited were found to be unqualified.

Chairman NUNN. OK. What is causing that? Is that a mistake in the very beginning? Where is the mistake taking place to get into those kind of unqualified groups being covered and getting those kind of losses. Where is the mistake being made?

Mr. EDELMAN. As Empire's internal reports have documented, the procedures over the years have been lacking at the time that Empire signs up these groups to determine whether the individuals who comprise the group are eligible for insurance, and even after the group has been signed up, to monitor the group to make sure, again, that the individuals continue to be eligible or that new individuals are not added to the group who may be ineligible.

Chairman NUNN. Well, what group in the Empire plan, what division is responsible for determining proper eligibility? Is that the underwriting function? Is that the marketing function? What function is that that is supposed to address that?

Mr. EDELMAN. Well, we have been told that Empire throughout the years has maintained an underwriting manual, which the underwriters have, which the salesmen are given, which is supposed to contain many, if not all, of the underwriting standards which are applicable to groups before they are signed up. In many instances, we have been told the salesmen are supposed to be aware of these standards and check them before they sign up a particular group.

Chairman NUNN. Well, does this indicate a pattern of getting business no matter what the quality of the business is, simply from the point of view of getting bigger and bigger? I mean, what is the mentality that causes this?

Mr. EDELMAN. It very well could be. We have been told by employees and we have seen in some of the interviews that were done by some of the management consultant teams that many people in the sales area have said that the emphasis has always been placed on quantity and not necessarily quality of groups.

Chairman NUNN. Now, this is not the community basing where Empire is basically taking in all people who are seeking insurance?

Mr. EDELMAN. Actually, Mr. Chairman, this is the community-rated pool. These small groups are a large part of this community pool for which Empire needs the approval of the insurance commission in order to raise rates.

Chairman NUNN. All right, but does Empire have a choice about whether to take these groups then into the plan? Do they have a way of turning them down, or are they compelled to take them?

Mr. EDELMAN. Well, they can turn them down if they do not meet the eligibility standards that Empire itself has. In other words, one of the standards would be that for a small group the individuals who comprise the group reside within the 28-county area that Empire covers within New York State. One of the problems in one of the frauds which was perpetrated against Empire in

this small-group market was that phony businesses were being established with addresses in New York, but most, if not all, of the so-called employees of these businesses turned out to be individuals who resided in Israel, not even in the United States. These individuals were coming into the United States for the purposes of obtaining oftentimes expensive operations, operations such as liver transplants, billing Empire as an "employee" of this so-called business, and then, upon completion of their operations, returning to their home in Israel. So in that instance, these were people who never in the first place would have been eligible to be insured by Empire.

Chairman NUNN. So the fact you are dealing with community-based business does not mean per se that all comers are taken in? There are certain eligibility requirements and certain thresholds that have to be met?

Mr. EDELMAN. That is correct.

Chairman NUNN. You are basically saying in some instances you had an umbrella group here that was not eligible to begin with that were bringing in people from other jurisdictions, even out of the country, and getting basic medical payments and service in a way that was totally illegitimate?

Mr. EDELMAN. That is correct, sir.

Chairman NUNN. And there wasn't a mechanism to detect this at the outset or even a monitoring system to detect it as they went along?

Mr. EDELMAN. No, not up until the last year or so.

Chairman NUNN. Have they improved now?

Mr. EDELMAN. The plan has stated that it is attempting to place more checks within the system and do better monitoring of the system to ensure that these types of problems do not continue to take place in the future. We take the plan at its word. However, we have been told by some employees of the plan that even though Empire is saying this, the situation today is just as bad as it has been in the past few years.

Chairman NUNN. Do you know of other insurance companies who are having these kind of fraudulent claims? Is this unusual? Is this standard in the insurance business?

Mr. EDELMAN. We have not done a review or a survey of other insurers, but I would just note that in the three Blue Cross plans that we have reviewed up until today, I don't believe that these types of problems or issues have surfaced in any of those.

Mr. SOPKO. Senator, I would just add along that line, I think Mr. Ward and other individuals in the plan said that the commercial insurers are far more aggressive in determining that these groups are legitimate and looking at the losses of a group. If they see a group and they are selling insurance to a group, let's say XYZ Manufacturing Company, and they are reporting large losses, they will go back in again, and the next year change the premiums to cover the costs.

Since these groups were all community-rated, I think Mr. Edelman has indicated that the CFO of the plan told us no one ever cared about the individual losses of an individual group. It was just buried in the pool of community rating. And that is one of the unforeseen and maybe subtle problems of community rating is that

nobody really looks at the cost of care and the cost of insurance, therefore, to the individual group.

Chairman NUNN. In other words, it just raises the whole community rating, and everybody's premium goes up.

Mr. SOPKO. That is right. If Aetna, for example, or a commercial saw one of these companies, it would skyrocket. They would send their underwriters out, their investigators out, to see what is going on. Mr. Weissman, the CFO, told us up until 1991, when they had the first case of a major fraud and they uncovered it, they had never looked.

Chairman NUNN. So there are some warning bells here in terms of community rating if there is any kind of national health insurance reform coming. I mean, that one had better be noted, correct? It lends itself to fraud.

Mr. SOPKO. Correct.

Chairman NUNN. Very large fraud.

Mr. SOPKO. It doesn't mean the staff is opposed to community rating. We are not making a judgment on that. What we are saying is this is an inherent problem with community rating, so let's be prepared if it does become a national agenda.

Chairman NUNN. If it does, you are going to have to have a monitoring system to make sure that everybody in the community is not basically the victim of some very widespread abuse that would simply be absorbed through the community rate.

Mr. EDELMAN. We should also note that it is this very group, this small-group market within the community pool, that Empire has used to make its argument of cherrypicking, claiming that the heavy losses that they have suffered in that particular line of business have been due to the fact that their best risks have been taken by the commercial insurers leaving them with the oldest and sickest people to insure, when, in fact, in some of these cases we have seen as a result of frauds committed by some of these ineligible groups, you had instances of just one group within the first couple of weeks of being insured by Empire running up hundreds of thousands, if not millions of dollars in claims. And these were claims which never should have been paid in the first instance.

At this point, Mr. Chairman, the staff would like to turn to an examination of the three organizations which provide primary oversight over Empire. These are the National Blue Cross and Blue Shield Association, Empire's own board of directors, and the New York State Department of Insurance.

Our review of the files subpoenaed from the Blue Cross and Blue Shield Association revealed its steady concern about Empire's performance and the Association's efforts to bring those concerns to the attention of Empire management and the superintendent of insurance. [1] However, it also shows a lack of action strong enough to thus far reverse the downward trends detected by the Association's own oversight.

The National Association has recognized that Empire's reserves have been low since 1988 and has put Empire on conditional status in 1988, 1989, 1991, and 1992. The plan has had a low liquidity posi-

[1] Exhibit No. 76 is retained in the files of the Subcommittee.

tion since 1988, and in early 1993, that position reached "early warning levels."

In May 1992, the Association's Plan Performance and Membership Committee, the PPMC, renewed Empire for one year and put them on the concern level, which is the next to the highest level of monitoring, and told Empire that it needed a recovery program. They requested that Mr. Cardone present the program personally in September so they could ask him questions.

In August 1992, the Association put Empire on contingency protocol, which is the highest level of monitoring. Association officials met with the insurance superintendent that month and told him that Empire needed to have positive reserves in order to keep the Blue Cross/Blue Shield trademarks and that the plan was not in compliance with its own benchmarks.

In September 1992, Mr. Cardone met with the PPMC and presented a recovery program to them. This recovery program was the same program that he had presented to the superintendent of insurance in July and which had been rejected by the superintendent at that time. The PPMC found the plan unacceptable as well and told Mr. Cardone that they would conduct site visits and that Empire would lose the BCBS trademarks if it did not meet reserve requirements.

In November 1992, the Association met with Empire's board and told them they needed a financial recovery program and restated the 1993 and 1994 reserve requirements. The board said they were committed to Empire's social mission and questioned whether the National standards were appropriate, notwithstanding the fact that the capital benchmark requirement of the Association is less than the statutory reserve required by New York Insurance Code.

When we questioned the Blue Cross/Blue Shield Association officials, we noted several areas that were not investigated by the Association in its overview of Empire's performance. A thorough review of these and other areas, combined with strong action by the Association in conjunction with the New York State Insurance Commissioner, might have prevented a too-little, too-late problem involving Empire.

The Association has not investigated the following: outside audits done by companies contracted with Empire. As discussed in other sections of our report, a review of these audits could have provided vital insight into the problems of poor service by Empire.

The Association also did not look at the National accounts that had terminated their contracts to ascertain the reason for ending their Empire accounts.

The Association similarly did not look into the issue of Medicare as a secondary payor, which has been outlined in a separate section of this report.

The Association representatives whom we interviewed said they had no knowledge of the ongoing audit of the Medicare secondary payment issue and the potential impact it could have on the financial condition of Empire.

Association representatives said that issues of this nature are not reviewed by the Association unless it has a material effect on the overall financial condition of the plan.

In summary, the Association has for several years had serious concerns which it expressed to Empire management regarding Empire's financial well-being. Moreover, the staff believes that the Association had enough information contained in its files to indicate that it knew or should have known that Empire has been experiencing major management problems for several years. By contrast to its role in previous cases reviewed by the Subcommittee, the Association did bring its concerns to the attention of the plan's board of directors and the State Insurance Department. However, it is the staff's understanding that the Association did not do so until August of 1992.

I would also note in conjunction with that that it was in early January of 1992 that the Association was informed by this Subcommittee of its intention to begin looking into the problems of the various Blue Cross/Blue Shield plans throughout the country.

By the time the Association did bring its concerns to the plan and the Insurance Department, it may have been too late to effectively reverse the financial drain on Empire.

One of the key issues which the Subcommittee has been concerned with in its investigation of Blue Cross and Blue Shield plans has been that of accountability. As has been noted in previous hearings, individual Blue Cross plans, because of their status as non-profit organizations, do not have shareholders to whom they must answer. Therefore, the role of the board of directors takes on an even greater importance for these plans in terms of providing a system of checks and balances over the actions of management.

In the three troubled plans which the Subcommittee has examined to date, one constant has been the abdication by the board of directors of their role as an independent oversight body. Unfortunately, it appears that the board of directors at Empire fits this same pattern. The staff's investigation of Empire found a board which was self-perpetuating, yet at the same time lacking in expertise, ill-informed, and both dominated and co-opted by management.

Empire's current by-laws provide for a board of directors consisting of 18 to 20 directors. The by-laws further provide that these directors shall be elected by a separate body comprised of 78 individuals known as voting members. While this would appear to place the selection of the board in the hands of an independent body, in fact this is far from true. Thirteen of the 78 members, voting members, serve by virtue of their positions on various county medical societies. Another 10 are selected by the United Hospital Fund. Yet the vast majority of the voting members, 55 of the 78, are selected by the board of directors themselves. What thus has been created is, in essence, a self-perpetuating process by which the board selects those very individuals whose job it is to select the board.

Another area of concern is the fact that Empire's chief executive officer also held the position of chairman of the board of directors. This is an issue which the Subcommittee has found problematic in looking at the boards of several Blue Cross plans.

We would note that the Insurance Department has expressed concerns with this issue throughout the years, although it has not seen fit until just recently, within the last few weeks, to truly make an issue of it. And we also further note that upon the resig-

nation of Mr. Cardone as CEO and chairman of the board of Empire, the plan did take the action of separating those two positions by naming a separate acting CEO and a separate chairman of the board.

It seems clear that the problem of management domination of the board has existed for some time. What seems equally clear, unfortunately, is that the board itself has had little, if any, realization of this fact. In numerous interviews, past and current board members told the staff how they thought they were an active, involved, and informed board which was not afraid to ask questions of management. After being informed of various corporate problems by the staff, however, many of these board members did state that the board may have had certain shortcomings.

On June 2, 1993, the staff interviewed Harold E. Vogt, the newly named chairman of the board of Empire. Mr. Vogt has been a member of Empire's board of directors since 1983. At the outset of the staff's interview, Mr. Vogt told the staff that he considered the Empire board to be very active. He further stated that he had never felt wanting for information as a board member, nor had he felt that Mr. Cardone was keeping information from the board.

Despite these comments, there appeared to be a number of areas of Empire's business about which Mr. Vogt was either ill-informed or uninformed. Mr. Vogt told the staff that the first time he learned of an April 27, 1993, letter to Empire from the Health Care Financing Administration was when he read about it in the *New York Times*. Mr. Vogt further stated that he had no idea that Empire had ranked 45th out of the 47 intermediaries in its handling of Medicare claims for doctor bills or 46th out of 51 in its handling of Medicare claims for hospital bills. Mr. Vogt did say that the board had been told several years ago that Empire had been doing very well in its ranking by HCFA.

Mr. Vogt similarly could not recall being informed of an ongoing audit by the Department of Health and Human Services concerning possible violations by Empire of the Medicare secondary provisions of the Social Security Act. Mr. Vogt had no idea what NMIS scores were in general or what Empire's NMIS scores were in particular. He said that he knew that the Blue Cross and Blue Shield Association ranked customer service performance and that he knew that Empire needed help in this area, but he stated that he was "not too concerned with where we stood with everybody else."

With respect to two major lawsuits in which Empire is involved, Mr. Vogt had limited information and had received that information only recently. Concerning a lawsuit filed against Empire in March 1993 by AT&T, claiming that Empire was involved in improperly withholding hospital differentials from AT&T, Mr. Vogt only learned of this matter during a meeting with the superintendent of insurance a month-and-a-half earlier.

With respect to a lawsuit filed by Empire claiming that a number of individuals and groups had established phony businesses for the purposes of obtaining insurance, thereby causing Empire over $22 million in losses, Mr. Vogt stated that he had learned of

this matter sometime in late 1992 or early 1993. The original complaint in this matter had been filed by Empire in December 1991. [1]

Mr. Vogt had received no reports on Empire's subsequent efforts to re-credential its small-group business and was unaware of the fact that initial surveys performed in connection with this re-credentialing had shown over half of the groups surveyed to be unqualified. It appears that despite his initial impression there was a great deal about Empire's business as to which Mr. Vogt knew little. As he concluded his interview with the staff, Mr. Vogt stated, and I quote, "I'm learning a lot here talking with you."

Some of the sharpest criticism of Empire's board comes from former officers and employees of Empire. The staff spoke with several former senior vice presidents, directors, and employees who were highly critical of the board's lack of oversight. One 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 Mr. Cardone. A number said that the board was merely a rubber stamp for senior management and for Mr. Cardone in particular.

One former employee, however, was perhaps the most humorous and the most damning at the same time when he opined that characterizing the board as a rubber stamp was probably too kind because, in his words, "at least a rubber stamp leaves an impression."

In addition to the plan's board of directors and the Blue Cross/Blue Shield Association, the State Department of Insurance is the crucial third leg of the oversight triad which can impose some measure of accountability on a Blue Cross plan. In the case of Empire, the role of regulator is played by the New York State Department of Insurance, a department which has been cited by its peers as one of the most effective insurance regulators in the Nation. The Department ranks second in expenditures and fourth in staffing among all State Insurance Departments. Moreover, New York State has been recognized as having some of the toughest insurance laws in the country.

In spite of this, the staff finds that the level of oversight provided by the department with respect to the regulation of Empire has been woefully inadequate. The staff found a pattern of actions evidencing regulatory forbearance which appeared to border on favoritism. This pattern included a propensity by the department to reverse itself when such action would be to Empire's benefit, and failure by the department to enforce its authority over Empire in certain instances as well as a willingness on the department's part to allow Empire to ignore department recommendations and regulations with impunity.

With respect to Healthnet, Empire's HMO operation, the department has reversed itself to the benefit of Empire, allowing Empire to ignore State regulations governing HMO's and failing to follow through on its authority over Empire's HMO operations. [2] As a

[1] Exhibit No. 5 is retained in the files of the Subcommittee.
[2] Exhibit No. 65 is retained in the files of the Subcommittee.

result, Empire has been allowed to maintain an HMO operation which has drained over $115 million from the plan's surplus and which, in 7 years of operations, has had just one year of modest profitability.

Chairman NUNN. What are you saying the department should have done about that?

Mr. EDELMAN. Well, in regard to this particular operation, I would just cite a memorandum, an internal memorandum from the department, of September 1988 which was just 2 years after Empire had established Healthnet. This was a memorandum from the department's chief of the Property Companies Bureau in which he wrote to the deputy superintendent discussing how Mr. Cardone had boasted that he had been able to "overcome the sentiment of his board" with respect to Healthnet. In this same memorandum, the chief of the Property Companies Bureau said that there was a need to keep a rein on what he referred to as over-ambitious or headstrong presidents.

Chairman NUNN. Well, would the department have had the authority to say to Empire we want you to get out of this HMO business? Would they have had that ability? Would they have had the legal authority to do that?

Mr. EDELMAN. The department has the authority in terms of setting the rates for the HMO product. The HMO's are community-rated business, so they have the authority to set rates, and to set them in a manner which would assure more profitability than Empire had been showing over its years with its HMO operations. In fact, in one year the department did do this by granting a greater increase on the rate request for the HMO operations than Empire itself had even requested. This, in fact, was the only instance that the staff recalls over the last few years in which Empire has objected to the State's decision on a rate increase filing. So the only time they objected was the time in which the department gave them greater rates than they had requested.

Beyond that, though, the department, we believe, does have the ability to attempt to influence the plan through its board of directors and through its other authorities in terms of general oversight by requiring explanations from the plan, by doing investigations and requiring other reporting from the plan itself.

The department has also allowed Empire to disregard various State regulations by failing to take any action to enforce these regulations. As has been discussed in detail in previous sections of this statement, the department continued to allow Empire to invade its reserves on a number of occasions, even though Empire had failed to comply with regulatory requirements regarding the establishment and execution of a 3-year plan to restore invaded reserves.

Despite the requirement of the 3-year plan, counsel for the department has said that it could not order Empire to do anything, but could only make recommendations. Nevertheless, the department admitted that when it did make such recommendations with regard to a 3-year plan, "The plan did not listen to the recommendation."

Another State regulation requires that Empire make a contribution from its experience-rated business to subsidize its community-rated business. According to the department, Empire failed to

make this contribution in 1990 and 1991 and made less than a 1 percent contribution from the profits of its experience-rated business in 1992. Despite these failures, the department did nothing to enforce its regulation.

When the staff questioned Superintendent Curiale as to this, he responded by saying, "If they don't make any money, what should I do?" When the staff asked, "You're the superintendent of insurance. You tell us what you should do," Mr. Curiale responded by shrugging his shoulders and saying, "If you tell them to charge higher premiums, they'll lose customers. The department just doesn't have the expertise or the authority to price the product."

Staff notes that time and again the superintendent has made the argument that his department has neither the expertise nor the authority to tell Empire how to run its business. The staff questions, however, whether what is missing is not the authority to regulate but, rather, the will to regulate.

It appears to the staff that rather than taking an aggressive approach with respect to its authority in order to force Empire to confront the harsh realities of its problems, this department and the superintendent have done all they could to help Empire avoid these realities.

This was done in May 1992 when Superintendent Curiale met with top officials from Empire and Empire's outside auditors, Deloitte and Touche. Confronted with the possibility that Deloitte and Touche might issue a qualified opinion on Empire's finances because of fear of potential regulatory action, Superintendent Curiale assured the auditors that despite his power to order the liquidation or supervision of Empire, he had no intention of taking any such regulatory steps against the plan. [1]

Chairman NUNN. OK. Here is an area I think you have to explore a little bit. You have got Empire that basically insures about roughly 45 percent of the people of New York State. Is that right?

Mr. EDELMAN. Correct, sir.

Chairman NUNN. Huge effect. You have got an insurance commissioner who is meeting with an auditor. You have got an auditor who is trying to decide whether to issue a qualified or unqualified type opinion. Qualified, by definition, would mean there is a serious problem here. Is that the definition of qualified?

Mr. EDELMAN. Yes, sir.

Chairman NUNN. And you have got the insurance commissioner who has the choice of saying this company has a serious problem and thereby have a qualified report go out on account, or an insurance commissioner who has got the authority to close them down or to take them over, I assume, under certain circumstances, but who chooses to tell the auditor, "I'm not planning on doing that."

We see the consequences of the insurance commissioner basically saying we are not going to slam down on this. What would be the consequences if the insurance commissioner said we are going to slam down on it, we are going to shut this plan down? I mean, I think we have to begin to ask that question because I can see how an insurance commissioner could be in a situation where either

[1] See Exhibit No. 33 on page 318.

way they go, it is bad. What are the consequences? I know you are not the expert on this, but you know enough about it. What are the consequences if the insurance commissioner had gone the other way and said, OK, by golly, to the auditor, we are going to slam this plan down? Then the word goes out. What happens in New York State? What happens to the policyholders?

Mr. EDELMAN. You are absolutely correct——

Chairman NUNN. We have absolute panic out there. I mean, is the insurance commissioner capable of taking over Empire and running it? If so, what do they do? Do they have the option of kicking out the whole board, kicking out the executive group, kicking out all the officers, and basically keeping the employees and going in? What are the options here?

Mr. EDELMAN. Well, you are absolutely right, Mr. Chairman, that the consequences of an Insurance Department taking such action are very grave, indeed, and when you are talking about a plan the size of Empire, which insures 45 percent of the citizens of New York could have the potential for creating a panic within the industry and other similarly unintended consequences.

Before an Insurance Department takes such a step, it had better have a very clear plan as to what it will do with an insurance company of that size. You have to find other insurers to take over the various blocks of business. You have to decide how you are going to manage the losses of the plan and how the department will run this plan until it can find somebody perhaps to come in and take it over or find another company with which Empire could merge.

Chairman NUNN. So an insurance commissioner would have to think long and hard before they would take the alternate route of really saying to the auditor, or even just, in effect, taking over the plan. They would have to have an alternative way of running that business and protecting the policyholders, would they not, either through other insurance companies or through some other alternative?

Mr. EDELMAN. They should, yes. I mean, it is certainly not a step that an Insurance Department should or would take lightly.

Chairman NUNN. So there is a very hard critique here in this report of the Insurance Department, but I think the way I see it, at least, having gone through this and been through four or five plans now, you have to also say, What are their options? This gets to the question, Do we have non-profits out here that are so big that the regulators really are damned if they do and damned if they don't? And I think we will have to ask the insurance commissioners about that, and others, at a later point.

Mr. SOPKO. Mr. Chairman, could I just——

Chairman NUNN. But let me ask one other question. Would they have the option, would the insurance commissioner have the option of saying, look, this management is really fouling up here. We have got waste all over the place. We have got computers that aren't working right. We have got no detection system for fraud. We have got excesses in every direction. We are just going to say to the board of directors, You get rid of the management, get new management in. Is that something the insurance commissioner has the authority to do under the law?

Mr. EDELMAN. Prior to this year, that is a question that perhaps we are not clear on, and that might be an appropriate question to address to the superintendent when he is here next week. As a result of the community-rating bill which was passed, there were other pieces of legislation that were appended to that which expanded upon the authorities of the superintendent which gave him more of a say in the selection of the board of directors of the plan and, therefore, gives him more of an influence over the board, which thus has the authority over the management of the plan.

Chairman NUNN. It seems to me that the regulators are going to have to be given the authority in State laws to do something short of taking over a whole plan or basically being caught between either trying to justify everything and being somewhat of a cheerleader for the plan or, on the other hand, basically taking it over or shutting it down. I mean, those are terrible choices. We sort of see the result of one choice, but you have to walk through the other side of it to see.

I think we are going to have to explore this area because this has huge policy implications for health care reform. I don't know what kind of purchasing alliances are being envisioned by the White House now, and I don't know what will come out of the congressional process. But, obviously, there are going to be some very large organizations out there, and any kind of health care reform, whether they are run by the State government or whether they are nonprofits, and I think we have got to get over this situation in this country where if you have got the word "non-profit" in front of you, all of a sudden you are presumed to be sitting by the side of the road and serving your fellow man. It is not the way it works.

Do you have any other thoughts about the remedies that would be applicable here or would have been applicable at the right time?

Mr. EDELMAN. I think the one thing that is important that a regulator needs to do—and it may be in instances like this that an insurance regulator has no more than the power of persuasion, so to speak, which many political scientists have really said, in essence, is about the only power that the President of the United States has. But it seems that particularly in an instance like Empire where this is not something that has just happened overnight, it is something that has been building up over the years to crisis proportions. And a regulator needs to use whatever authority he has and to interpret perhaps in some instances as broadly as he can, to be aggressive when he first spots those early warning signs of a plan that may be headed down the road to trouble.

I think this is a criticism that not only we have of this insurance department, but it is a criticism that New York State's own comptroller general has had about this Insurance Department. They issued an audit report in 1991 about the Insurance Department in which they criticized, in their terms, the will to regulate of this department and cited its reluctance with respect to insolvent insurers to take action at an early point in time and cited a willingness of the department to try to help a plan along and see how far it could go before it ultimately took that big step of taking it down. In their opinion, that process of delaying action sometimes led to worse consequences than you would have had if you stepped in at an early point and took action.

Obviously, you need to have a plan as to what you are going to do with an insurer before you come in and take it over. But perhaps that suggests that the department needs to develop these plans from the outset and not wait until an insurer reaches crisis stages before it first starts thinking about what it would do if it had to take it over.

The Subcommittee's efforts to examine the operation of the Blue Cross and Blue Shield system began last year with a hearing on Blue Cross and Blue Shield of West Virginia. That plan was the first and so far the only Blue Cross plan to fail. Our purpose in investigating the West Virginia plan was not only to understand why it had failed, but to determine whether there had been any of these early warning signs which should have alerted the appropriate authorities to the possibility of failure.

Subsequent hearings on the Blue Cross plans of Maryland and the District of Columbia were similarly aimed at identifying indicators of potential trouble. Unfortunately, the Subcommittee found many, including mismanagement, excesses on the part of plan officials, inadequate oversight by the board of directors, and ineffective regulation by the State insurance authorities.

As a consequence of those hearings, however, both the Maryland plan and the D.C. plan have taken steps to address their problems and to turn their plans around before it becomes too late. In all of our efforts to date, the Subcommittee's overriding concern has been the protection of the millions of men, women, and children who rely on these plans in order to meet the costs of health care. These people have a right to know how their Blue Cross plan is being operated and how it is being regulated, because it is only with this information in hand that they can make an individual judgment as to whether their reliance is well placed or misplaced.

It was with these concerns in mind that the Subcommittee approached its examination of Empire Blue Cross and Blue Shield, the Nation's largest Blue Cross plan. Once again, it has been the staff's sad duty to report that the warning signs are posted. We hope that Empire will heed these signs. If Empire is to survive and to prosper, it must do more than rely on the external and artificial means of support to which it has turned in the past. It must look inside itself and find the will to change from within.

At this point, Mr. Chairman, we have a number of very detailed conclusions flowing from our investigation. I would be happy to just have these submitted as part of the record if you would rather that we not go through all of it at this point.

Chairman NUNN. Approximately how long will that take?

Mr. EDELMAN. We have about 12 conclusions.

Chairman NUNN. See if you can highlight them, and go through them, but not in terrific detail.

Mr. EDELMAN. We have obviously gone through the plan's detailed financial history, and I think it is clear to everyone at this point that the plan is in a very serious financial state at this point.

We have also discussed the cherrypicking argument which the plan has put forth with great vigor for the last few years. However, our conclusion is that on the basis of our investigation we could not find nor has the plan been able to provide credible evidence to support this argument in full. Likewise, neither the Insurance Depart-

ment nor Arthur Andersen could provide such credible evidence to the staff.

Although the competitive practices by commercial insurers may have aggravated the poor financial condition of Empire, the staff believes that gross mismanagement, poor business planning and operations, as well as fraud, were the principal factors generating the serious losses encountered by the plan.

Plan management has shown great difficulty in effectively carrying out the most basic functions of any successful insurance company, including the ability to properly price its product, accurately collect its premiums, and pay the proper claims in a timely manner. This has resulted in exceedingly poor service and the loss of much business.

The staff has uncovered evidence that Empire has inadequate internal controls and as a result has repeatedly been the victim of massive fraud resulting in substantial losses to the company.

Both the plan and the Insurance Department have been aware of shortcomings with internal controls and fraud-detection capabilities, but have not adequately addressed these problems.

At a time during which it has been losing subscribers, increasing its premiums, and incurring staggering underwriting losses, the plan has made excessive expenditures for the benefit of its senior officers and board of directors.

The former CEO and chairman of the board, Mr. Cardone, has exercised excessive domination and control over the operations of the plan, leading to a board of directors which has exercised little, if any, control over the operations or the excesses of its management.

Finally, the New York Department of Insurance appears to the staff to have been ineffective in carrying out its responsibility to effectively regulate and monitor the operations of this plan. Whether intentionally or unintentionally, it appears the department's response to the worsening management and financial situation at Empire has been regulatory forbearance.

Those are the highlights of our conclusions. Obviously we have a very detailed statement, and we would ask that our entire statement be printed as part of the record.[1]

Chairman NUNN. Without objection, it will be a part of the record.

Mr. EDELMAN. In addition, Mr. Chairman, we have a bulky exhibit of some 100 or more documents which we also ask be made an exhibit to the record.[2]

Chairman NUNN. Without objection, they will be made part of the record, labeled as exhibits numbered accordingly.

I want to thank you, Alan and John and Eleni. And, Mr. Maloney, we appreciate very much all you have done. You didn't testify this morning, but you have done a great deal, and we appreciate your help.

Also, I want to thank all the staff who are sitting right behind you who worked diligently and many hours on this. They didn't testify, but their work was invaluable: John Forbes, Mark Webster,

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[1] The prepared Staff Statement and Appendices appears on page 141.
[2] The exhibits appears in the Appendix on pages 271 to 408.

Gene Richardson, Mariea Wilt, Mary Robertson, and Cindy Comstock. We thank all of you.

I will now call our next panel of witnesses. Our second panel of witnesses this morning will be two former employees of Empire Blue Cross and Blue Shield: Joan Boyle and William Fuessler, if I am pronouncing that correctly. Mr. Fuessler, is that reasonably close?

Mr. FUESSLER. Yes.

Chairman NUNN. Ms. Boyle had a vice president position at Empire for several months in 1991, during which time she served as executive assistant to the chairman. Mr. Fuessler was hired by Empire in 1990 to serve as special assistant to the chairman in charge of special projects. We will hear today from these two witnesses of their role in promoting the community-rating legislation and of events leading to their departure from Empire.

We thank you for being here. We don't have other Senators here this morning, not because of lack of interest but because we were in session last night until approximately 3:45 a.m. So that is the reason we don't have a full group here today. We are going to take approximately a 4-minute break, and then we will come back and I will swear in the witnesses, and you can introduce—Mr. Fuessler, do you have an attorney here with you?

Mr. FUESSLER. Yes.

Chairman NUNN. We will have you introduce him when we come back.

[Recess.]

Chairman NUNN. I have already introduced the panel, but I am going to ask each member of the panel here who is going to testify to please stand and raise their right hand. We swear in all the witnesses before the Subcommittee. Do you swear the testimony you give before the Subcommittee will be the truth, the whole truth, and nothing but the truth, so help you God?

Ms. BOYLE. I do.

Mr. FUESSLER. I do.

Chairman NUNN. Ms. Boyle and Mr. Fuessler, we appreciate your being here. I note that you have a person accompanying you, each of you, I assume. If they are your lawyers, we would be pleased for the lawyers to give their names and addresses and be introduced now.

Mr. WORK. Mr. Chairman, I am Charles Work. I am at McDermott, Will, and Emery, and I represent Joan Boyle.

Chairman NUNN. Ms. Boyle, you will have the right, if you would like at any point, to consult with your attorney before answering any question. We welcome the attorneys here, and we respect their role.

Mr. Fuessler.

Mr. DERMAN. Herbert B. Derman from New York, City, representing Mr. William Fuessler.

Chairman NUNN. Mr. Fuessler, likewise, if you would like to consult with your attorney before answering any question, we certainly would accord you that privilege.

We are grateful to both of you for being here, and we are grateful to you for coming forward and cooperating with our staff. You have, I think, some important comments to make about the subject

and scope of our hearing today, in particular relating to certain records and so forth. So, Ms. Boyle, we will be delighted to have your statement first, and then Mr. Fuessler, and then we will ask questions.

TESTIMONY OF JOAN BOYLE,[1] FORMER EMPLOYEE, EMPIRE BLUE CROSS AND BLUE SHIELD; ACCOMPANIED BY CHARLES R. WORK, COUNSEL

Ms. BOYLE. Thank you. Good morning, Mr. Chairman and members of the Subcommittee. My name is Joan Boyle——

Chairman NUNN. Maybe you could start off by telling us where you are from and what you are doing right now.

Ms. BOYLE. Right now I am executive vice president, chief operating officer, for an insurance company in Illinois called Pioneer Life.

Chairman NUNN. Thank you.

Ms. BOYLE. And I have been there since September.

I am here to testify regarding my employment at Empire Blue Cross and Blue Shield.

Prior to joining Empire, I was employed for 22 years with Blue Cross and Blue Shield of New Jersey, serving as executive vice president and chief financial officer. In 1991, the New Jersey plan replaced the chief executive officer, and I chose to leave as well. In August of 1991, I contacted Al Cardone, CEO of Empire, who I had come to know through various Blue Cross and Blue Shield activities, and told him that I was interested in discussing with him future employment opportunities, including consulting, because at that point I didn't know what I wanted to do and I knew that Al had many contacts in the health insurance field.

Al invited me to join Empire, and in October of 1991 I decided to do so. Due to a contractual obligation with the New Jersey plan, I worked for Empire as a consultant from October of 1991 until January 1, 1992, at which time I became a vice president and executive assistant to the CEO. Throughout my consulting work and my employment as executive assistant, my compensation and responsibilities remained the same.

According to notes I maintained, Al outlined my job responsibilities to me on November 12, 1991. They included: planning Empire's operational strategy; managing strategic issues, including New York State and the National Association; compiling the 1992 budget; overseeing a sales improvement plan; overseeing an ongoing consulting project which was being performed by Booz Allen Hamilton; and overseeing several major corporate projects, like those in the information systems area.

In this role I had three Empire employees who reported to me on areas of concern to the office of the chairman. Mary Ann Nagy was responsible for goals setting and planning; Peter Chin reported on major information systems projects; and Bill Fuessler monitored financial issues for the plan. I believe each of these employees was a director-level employee at the time.

One of my assignments as executive assistant was to prepare Al Cardone's presentation to officers and directors on a new 1992

[1] The prepared statement of Ms. Boyle appears on page 228.

management incentive compensation program. Corporate profitability was one of the goals used to assess the incentive awards, and I asked Bill Fuessler to assist me in preparing slides in this regard.

On February 3, 1992, Bill came to me and expressed concern over two sets of figures he had discovered on Empire's gains and losses on its community-rated and non-community-rated business. He said that one set of numbers came from the Actuarial Department and another set came from Empire's "Black Book." The Black Book was the term applied to the document which I believe listed the most up-to-date figures on Empire's gains and losses. I believe the Black Book was updated monthly or quarterly by the chief financial officer, Jerry Weissman, and his staff. The Black Book was not widely distributed, as far as I know. Bill and I had access to it because we were part of the CEO's staff, but I believe only the CEO and the CFO received a copy of the Black Book.

As Bill pointed out to me, the figures in the Black Book were different from the figures reported by the Actuarial Department. I asked Bill what investigation he had done, and he told me that he had shown the two sets of figures to Sharon Smerzler and Dave Sanders in the Actuarial Department, seeking an explanation of the difference.

When he asked for an explanation, Bill said that Dave Sanders turned and walked out, and Sharon told him that the Black Book numbers were for internal purposes and the others were for external purposes. Bill told me that when he pressed Sharon for a better explanation, she told him to talk to Jerry Weissman. Instead of going directly to Jerry, Bill came to see me.

I decided that I should confront Jerry, and my notes say that Bill went with me, but I don't recall if he was there or not.

Chairman NUNN. Bill worked for you; is that right?

Ms. BOYLE. He worked for me.

Chairman NUNN. You were his supervisor?

Ms. BOYLE. Correct.

We waited until later in the day when most of the staff had gone home. When I showed Jerry the numbers, he appeared nervous and he repeated what Sharon Smerzler had said to Bill. The Black Book numbers were for internal purposes, and the actuarial numbers were for external purposes. I asked Jerry which ones were accurate. He said that the Black Book figures were right and the other figures were "more politically acceptable."

I was very disturbed by this, and I told Jerry that I felt he had a professional obligation to consistently report accurate figures. At that point, Jerry folded his arms and told me that I should talk to Al Cardone about this issue. When I asked Jerry if Al was aware of the two sets of figures, he didn't respond except to tell me that I should talk to Al.

Realizing that Bill's discovery may lead to a difficult situation, I told Bill that I would talk to Al alone the following morning. I was relatively new to the company, and I didn't want Bill to jeopardize his position. On February 4, 1992, I met with Al and told him what I had found. Al appeared to be surprised and told me that he did not know anything about it. When I explained to Al how the dis-

covery was made, he wanted to see Bill, and I called Bill into the room.

Bill then joined us, and Al asked us which set of the two numbers was accurate. I told Al that we have always relied on the Black Book figures as being accurate, and he responded that nobody knows which set of figures is right. He added, "I can't rely on any numbers coming out of actuarial. They're jelly. Neither you nor I know which set of figures is accurate."

Al suggested that perhaps the discrepancy in figures was a result of investment income allocations. I told him that this was not possible since investment income allocation would not affect underwriting gains or losses. Al then asked that Bill and I audit the figures to determine which ones were, in fact, accurate. I told him that we, the two of us, could not possibly perform such a monumental task and advised that we would need to bring in outside auditors to do an accurate job. I suggested that the best source to determine the accuracy of the numbers was Jerry and the people in the Actuarial Department who prepared them. At that point Al telephoned Jerry, but Jerry was out sick that day.

The following morning, on February 5th, Jerry Weissman came to see me, and he asked if I had had the opportunity to talk to Al about the books. I told him that I had and that Al said he didn't know anything about two sets of numbers. Jerry smirked, and I believe he said, "Al said that?" And I said, "Yes," and I said, "Jerry, I believe Al will be talking to you about this issue."

That evening, February 5th, I did prepare a handwritten memo for my own files, for my own records, of the experience. When I was contacted by the Subcommittee staff, I located the document, and I am submitting it to the Subcommittee with this statement. This memo has helped to refresh my recollection as to the details of these events.[1]

Chairman NUNN. You made this memo yourself? This is your handwriting; is that correct?

Ms. BOYLE. That is correct.

Chairman NUNN. And you did that at home at night or at the office?

Ms. BOYLE. At home at night.

Chairman NUNN. Did you normally do that at night at home, make memos, or did you think that was of special significance, this series of events?

Ms. BOYLE. I thought that this was of special significance.

Chairman NUNN. And you——

Ms. BOYLE. It was not my common practice to make notes of business issues for home files.

Ms. BOYLE. Specifically I made a notation of the two sets of figures as follows—and they are listed in my statement. Do you believe I should read those numbers?

Chairman NUNN. I think it would be helpful if you read the statement because you could perhaps give us an explanation as you go along.

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[1] The memo referred to above appears on page 230.

Ms. BOYLE. I will read some of the numbers as an example. These are dollars in millions of dollars, and they represent net underwriting gains.

For the year 1989, the Black Book showed community-rated had a gain of $20 million, but the Actuarial numbers, which tied with Schedule 5 of the financial statements, showed a loss of $23.7 million.

Chairman NUNN. And CR on your notes stands for——

Ms. BOYLE. Community-rated.

Chairman NUNN. It stands for community-rated.

Ms. BOYLE. Right. On the non-community-rated business, marked ER, there was a loss of $21 million in the Black Book, but a gain of $22.6 million in the Schedule 5 numbers.

I have also listed Healthnet, which was the HMO, and those numbers were virtually consistent in both documents, and the totals were exactly the same.

For 1990, the numbers varied also. Community-rated per the Black Book was a loss of $19.8 million, but the Actuarial document, which tied to Schedule 5, was a loss of $27.8 million. For experience-rated, the Black Book showed a gain of $38.1 million, but the Actuarial numbers showed a gain of $46 million. Again, Healthnet numbers are virtually the same and the bottom line is the same.

Chairman NUNN. So someone had obviously reconciled these totals because the totals were exactly the same. It was the component parts, the difference between what you have labeled CR and ER that were really the variables; right?

Ms. BOYLE. That is correct.

Prior to these events, Mr. Cardone and I had maintained a very good working relationship. Subsequently, my perception was that he treated me more coolly, and within weeks, he asked me if I would take the job of vice president of sales. While I had no sales experience, I felt that it would be a good opportunity for me in a field I hadn't done to round out my resume. I also felt that I didn't truly have a choice in the matter. When I moved off the executive floor to another building to assume the sales responsibility, Bill Fuessler was moved along with me. Al felt that Bill needed additional line experience, and I was happy to have him accompany me to the Sales Department.

Shortly thereafter, in March 1992, a recruiting firm contacted me regarding another position, the one I am currently in, and in September of 1992, I joined Pioneer Life Insurance Company of Illinois, where I currently serve as executive VP and chief operating officer.

I will be happy to answer any questions you may have.

Chairman NUNN. Let me ask just a couple, and then we may come back after Mr. Fuessler testifies.

Down at the bottom of this memo dated February 5, 1992, if I am reading your handwriting correctly—and I commend you on the legibility of it. It is much better than I would have had. You say down at the bottom, "When shown the facts, he clearly said the Black Book numbers are right but the other numbers are more politically acceptable." Who was "he" in this case?

Ms. BOYLE. Jerry Weissman. This is the meeting with Jerry.

Chairman NUNN. And he was the chief financial officer?

Ms. BOYLE. Correct.

Chairman NUNN. Then you go on. Why don't you read that next sentence over to the top of the page.

Ms. BOYLE. "He also said the 'manipulated' numbers are filed in the annual blank as Schedule 5. I asked if A.A.C."—Al Cardone—"knew what was happening and Jerry Weissman said yes."

Chairman NUNN. And when you said "filed in the annual blank on Schedule 5," could you tell us what the annual blank on Schedule 5 is, where that goes, the significance of it?

Ms. BOYLE. It is the NAIC statutory filing. It is called the blank because it is a standard filing. It is done by every insurance company once a year and submitted to the Insurance Department around March 1st of the following year.

Chairman NUNN. And did Mr. Weissman use the term "manipulated"? You have that in quote marks.

Ms. BOYLE. That was his word.

Chairman NUNN. So the word "manipulated" was his?

Ms. BOYLE. Correct.

Chairman NUNN. You obviously believed this was a significant event. You wrote it down, and you kept the memo and so forth. You confronted everybody all the way up the line with this, and you felt you needed to protect Mr. Fuessler to the extent possible. So it was a very significant event in your mind; correct?

Ms. BOYLE. That is correct.

Chairman NUNN. Tell us why. You know this business, and many of us are learning it. Could you tell us why this was significant in your mind?

Ms. BOYLE. The reason it was significant is that in one document versus the other, community-rated losses were overstated—that was the document that was external, if you will; that was the explanation I was given—versus the other document which was internal. Community-rated lines of business are regulated, and to show those losses higher in one document than another I thought was significant.

Quite frankly, it would not have been significant if when I approached Jerry or Al I had gotten an adequate explanation of the differences. But there was no explanation given or offered.

Chairman NUNN. Did you have in your mind at that time any kind of motive or reason for these "manipulated" numbers and showing a different number for community rating on the filing with the insurance commissioner as opposed to the Black Book? Did you in your own mind say, wait, why are they doing this? What is the reason they are doing it?

Ms. BOYLE. I was actually very new to the company. I was there a total of 10 months, and it is difficult for me to read motivation into why they were doing certain things. All I knew is for the presentation I was doing, it was an important element, this distinction between community-rated gains and losses and experience-rated. And I couldn't get answers to the discrepancy.

Chairman NUNN. So at that time, you didn't fully in your own mind have a thought as to what the reason for this was?

Ms. BOYLE. No, and I have no idea how these numbers were used. It was only for my individual presentation that I was concerned at that point.

Chairman NUNN. Looking back on it now, do you have any judgment, looking back, as to why these numbers were different based on what you know now?

Ms. BOYLE. That would require significant speculation on my part, and I have read what is in the newspapers, and all I can say is that to overstate community-rated losses could be valuable if you were trying to get rate increases.

Chairman NUNN. OK. Thank you, Ms. Boyle.

Mr. Fuessler.

TESTIMONY OF WILLIAM FUESSLER,[1] FORMER EMPLOYEE, EMPIRE BLUE CROSS AND BLUE SHIELD; ACCOMPANIED BY HERBERT B. DERMAN, COUNSEL

Mr. FUESSLER. Good afternoon, Mr. Chairman, members of the Subcommittee. My name is Bill Fuessler, and I have been subpoenaed to testify today concerning my involvement with Empire Blue Cross and Blue Shield.

I am a 1979 graduate of Adelphi University, with a bachelor's degree in accounting. Upon graduating, I was employed by Peat Marwick in its auditing department. While I was employed there, I became a certified public accountant. For the last year-and-a-half at that firm, I was working as a consultant in the consulting division.

In December 1985, I joined Metropolitan Life as a manager in the corporate comptroller's department. I spent approximately 2 years there, and in February of 1988, I joined Ernst & Young's insurance consulting practice. A year later I was promoted to senior manager and worked primarily on insurance industry-related issues.

In May 1990, I joined Empire. My position was director, Office of the Chairman. I reported directly to Mr. Cardone and was responsible for various non-systems-related corporate initiatives and special projects.

In October 1991, Joan Boyle was hired, first as a consultant and later as an Empire employee, and I began to report to her. At that time some of the special projects that I was working on related to budgeting issues, Healthnet, and detailed sales reporting.

Some time in late January or early February 1992, I was putting together a presentation to be made to the Empire board of directors. In the course of doing this, I reviewed a number of financial schedules and noticed a discrepancy between a schedule summarizing results sent to the Department of Insurance and an internal schedule maintained by the plan. Attached as Appendix A is a document I was provided by this Subcommittee's staff entitled "Empire Blue Cross and Blue Shield, Underwriting Results, 1978–1991 ($Thousands)." This document was prepared by the Actuarial Department and summarizes certain financial data that is provided to the New York State Insurance Department. The internal schedule I had reviewed was part of the monthly internal financial reports commonly referred to in the plan as the "Black Book."

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[1] The prepared statement of Mr. Fuessler appears on page 232.

The discrepancies I noted dealt with losses reported in the experience-rated and community-rated lines of business. At that point in time, I prepared a handwritten table showing these discrepancies. Shortly thereafter, my table was typewritten. I was given a table by the staff, which appears to be a copy of this table. It is attached to the statement as Appendix B.

I recall that when I was preparing the presentation for the board, the financial data for 1991 had not been finalized. I was looking at the finalized 1989 and 1990 data when I noticed the discrepancies.

I felt these discrepancies were important enough to ask the Actuarial Department to give an explanation. I spoke with Sharon Schmerzler and her immediate supervisor, David Sanders, who worked in the Actuarial Department. I asked them about this discrepancy, and they told me that they would get back to me as soon as possible. Approximately a day or two later, I received a call to see them, and when I went to see them, they told me that they agreed that there was a discrepancy, but that I would have to see Jerry Weissman for an explanation.

I immediately went back to my office and spoke to Joan Boyle and told her about the discrepancy and my conversation with the Actuarial Department. Joan indicated that we needed to get an explanation.

Shortly thereafter, she arranged a meeting with Jerry Weissman, at which time we presented the two schedules and noted the discrepancies and asked him to explain the difference. Mr. Weissman agreed that there were different numbers and said that it was politically more beneficial to show the numbers that way.

When pressed for an explanation on why there were two different numbers, Mr. Weissman said, "You need to talk to Al." Upon leaving this meeting, Joan immediately set up a meeting with Al Cardone.

Before the meeting with Al, Joan told me that she would rather go and see Mr. Cardone by herself. She explained that "It may get messy" and she was worried that it would jeopardize my career at Empire.

Within 5 minutes of the beginning of the meeting, I was summoned by Mr. Cardone's secretary to join them. At the meeting was Mr. Cardone, Joan Boyle, and myself. Mr. Cardone asked me what I had found. I explained the schedules to him, noted the different numbers. My best recollection is that Mr. Cardone stated that "you can't trust any numbers around here" and that "I don't know which numbers are right and neither do the two of you." We concluded the meeting with Mr. Cardone recommending that Joan and I do a profit-and-loss analysis on the National account business. I do recall that Mr. Cardone appeared to be upset during this meeting.

Approximately one month later, on March 17, 1992, I was called into Mr. Cardone's conference room. At that time I was told that effective immediately I had a new assignment as director in the Incentive-Rated Sales Division. In particular, I would be in charge of underwriting and financial issues. I had not requested a transfer. I also had no background in underwriting. I was not surprised by the

transfer since Joan Boyle had informed me shortly before this date that Mr. Cardone was going to transfer both of us to sales.

Upon being transferred, I moved with Joan to another building outside of the headquarters building. At that time Joan Boyle and I were the only Incentive-Rated Sales Division employees on that floor in that building. Subsequently, others joined us.

Since I was transferred in March 1992 to my new position, I did not complete the presentation material for the board nor the profit-and-loss analysis. I do know the presentation was completed. I do not know what, if any, numbers were utilized in that presentation. I do know the profit-and-loss analysis was done, but I do not recall the results.

About mid-October 1992, I voluntarily left Empire. I am presently employed in a consulting capacity to the insurance industry. Before leaving, I recall two other instances in which the discrepancies in the numbers came up. I recall one meeting at which time Jerry Weissman asked me if I had talked to Al Cardone about the discrepancies. He wanted to know what Al said. I told Mr. Weissman that Mr. Cardone did not have a satisfactory explanation for the discrepancies and had asked for a profit-and-loss statement for the National account business. I do not recall what, if any, response Mr. Weissman had to that.

On another occasion, after an officers and directors meeting, I attended the reception. Joan Boyle was also in attendance at this reception. I recall a number of employees joking about the fact that the plan had two sets of numbers.

I will be happy to answer any questions you may have for me at this time.

Chairman NUNN. When you say they were joking about the fact there were two sets of numbers, could you characterize that further?

Mr. FUESSLER. It was taken on the light side, the fact that there were two sets of numbers, and there was some joking about it.

Chairman NUNN. Mr. Fuessler, what did you think about this? Did you, yourself, at that time believe that there was some particular motive for these discrepancies in the numbers and having two sets of books?

Mr. FUESSLER. I don't want to speculate, but the only thing I will say is that it appeared that in order to enhance their belief on the community-rated losses, it might be a possible explanation.

Chairman NUNN. Because community-rated losses are used to demonstrate the need for rate increases?

Mr. FUESSLER. Yes, sir.

Chairman NUNN. Whereas, experience-rated losses are not; is that right?

Mr. FUESSLER. That is correct.

Chairman NUNN. Now, looking at this, Ms. Boyle, looking again at this memo you wrote, in 1989 you have got community-rated in the Black Book, community-rated loss or profit, as I read this figure that is a $20 million profit.

Ms. BOYLE. Correct.

Chairman NUNN. And that was what was demonstrated in the Black Book.

Ms. BOYLE. Correct.

Chairman NUNN. And if you look at the next column, the actuarial schedule, the blank that was actually filed with the Insurance Department on community-rated showed a $23.7 million loss.

Ms. BOYLE. Correct.

Chairman NUNN. So basically that is a swing of $43.7 million.

Ms. BOYLE. That is correct. That is why I thought it was significant.

Chairman NUNN. Very significant.

The next year, as I read it, the difference is not as significant.

Ms. BOYLE. No. It is about $8 million.

Chairman NUNN. The difference is about $8 million.

Had you seen, Mr. Fuessler, this memo? Did you ever see this memo that was written by Ms. Boyle?

Mr. FUESSLER. No, I did not, until today.

Chairman NUNN. Today. So your testimony wasn't based on this memo. It was based on your own recollection?

Mr. FUESSLER. Yes, it is, sir.

Chairman NUNN. In other words, you didn't use this memo to prepare your own testimony?

Mr. FUESSLER. No, I did not.

Chairman NUNN. Ms. Boyle, Mr. Fuessler testified that there were other employees in the department that were actually laughing about two sets of numbers. Is that something you recall? Did you ever see that?

Ms. BOYLE. I was not in the—we were at a reception, and we were in different locations. I was not with Bill during that meeting, when he encountered that.

Chairman NUNN. Do you know whether any other Empire employees were aware that two sets of books were maintained other than the two of you who looked at it and then the people you confronted with it, Mr. Weissman and Mr. Cardone? Do you know whether there were other people who had an awareness, who knew that there were two sets of books being kept?

Ms. BOYLE. We knew that at least two people in the Actuarial Department who Bill had spoken to were aware of this, and it is my presumption that staff had to put these numbers together. So there were probably others, but I am not aware of them.

This issue had never been brought to my attention until Bill found it.

Chairman NUNN. Mr. Fuessler, had you ever suspected there were two sets of books being kept? Did you have a suspicion that led up to your discovery, or was it something that just came out of the blue when you were looking at all these numbers?

Mr. FUESSLER. I basically tripped upon it by accident.

Chairman NUNN. By accident. Was it logical that you would have tripped up on it, or was it sort of an unusual thing that was happenstance? In other words, in the normal course of your duties, would you have discovered that, or was this just something that was sort of a coincidence that you discovered it?

Mr. FUESSLER. It was a coincidence. I just happened to see a number that didn't look right, and I looked at another number that I have probably previously looked at, saw there was a discrepancy, and then it stuck in my mind.

Chairman NUNN. In other words, given the nature of your job, this discovery by you was not inevitable?

Mr. FUESSLER. No, it was not.

Chairman NUNN. Would you call it something that was likely to have happened given the nature, or was it more unlikely that you would have discovered it?

Mr. FUESSLER. Unlikely.

Chairman NUNN. How about you, Ms. Boyle? Of course, you were notified by Mr. Fuessler.

Ms. BOYLE. It would be very unlikely that I would have compared the Schedule 5 results with the Black Book. Very unlikely.

Chairman NUNN. So if he had not brought it to your attention, you may have never known it?

Ms. BOYLE. I never would have found it, the likelihood is.

Chairman NUNN. Do you believe you and Mr. Fuessler were transferred to the Sales Department because of this discovery that you made and because of the fact you revealed it and confronted Mr. Weissman and Mr. Cardone? Do you believe that your transfer was a coincidence, or do you think it was related to this?

Ms. BOYLE. I really—I don't know for sure. I did sense—and it could have been my own perception, but I did sense a change in attitude, and I was being invited to fewer meetings, and then I was offered this other position in the sales area.

Chairman NUNN. Do you know on your own whether the Insurance Department was ever notified of the Black Book and the discrepancy? Do you know yourself whether they knew about the Black Book and two sets of books?

Ms. BOYLE. No, I do not.

Chairman NUNN. You would have no way of knowing that.

Ms. BOYLE. No, I do not.

Chairman NUNN. Do you, Mr. Fuessler, know whether the Insurance Department of the State of New York was aware of this Black Book, two separate books.

Mr. FUESSLER. I do not know.

Chairman NUNN. What was your reaction, Ms. Boyle, when you were told by the chief executive officer of the Nation's largest nonprofit health insurer that you couldn't really trust the numbers coming out of the Actuarial Department?

Ms. BOYLE. I thought it was a strange statement from the CEO, but the fact of the matter was, in trying to do our job, Bill and I had a very difficult time getting consistent financial information.

I understood what Al meant, but coming from the CEO, I thought that was a strange statement.

Chairman NUNN. Did you hear that, Mr. Fuessler? Were you in that meeting?

Mr. FUESSLER. I am sorry—yes, I was at that meeting. Yes.

Chairman NUNN. What was your reaction to being told by the chief executive officer that basically, I believe the term was used, these numbers were like jelly and that nobody knew which ones were accurate and so forth? What was your general reaction to that?

Mr. FUESSLER. Well, I was a little surprised, but I wasn't shocked because, as Joan mentioned, there are many times when numbers

were inconsistent and we would have to reconcile them. So it didn't shock me.

Chairman NUNN. Do either of you have any further testimony you think is relevant to our inquiry that you would like to tell us about this morning?

Ms. BOYLE. I do not.

Mr. FUESSLER. I do not.

Chairman NUNN. We appreciate very much your being here, and we appreciate your coming forward. I know it is never easy to come forward, and yet that is the duty, I believe, of people who really want to see the health insurance system work better, and I know both of you do. So we are very grateful to you, and you have added to the testimony.

Do either one of the attorneys have any further comment?

Mr. WORK. No. Thank you very much, Senator.

Mr. DERMAN. I have nothing.

Chairman NUNN. Thank you.

Ms. BOYLE. Thank you.

Chairman NUNN. All right. We appreciate very much your being here. Good luck to both of you.

Ms. BOYLE. Thank you.

Chairman NUNN. I would just like to announce that we will be having a hearing next Wednesday, which is June 30th, 9:30 a.m., in this room. We will have at that time a panel: Mr. Albert Cardone, the former CEO and chairman of the board of Empire; Mr. Donald Morchower, acting CEO, Empire; Mr. Jerry Weissman, chief financial officer, Empire; Ms. Maroa Velez, vice president of auditing, Empire; and Mr. Harold Vogt, chairman of the board of Empire; as well as the second panel will be Mr. Salvatore Curiale who is the superintendent of insurance for the State of New York.

At this point the Subcommittee will adjourn until next Wednesday.

[Whereupon, at 12:27 p.m., the Subcommittee was adjourned.]

OVERSIGHT OF THE INSURANCE INDUSTRY: BLUE CROSS/BLUE SHIELD—EMPIRE PLAN (NEW YORK)

WEDNESDAY, JUNE 30, 1993

U.S. SENATE,
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS,
OF THE COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 9:35 a.m., in room SD-342, Dirksen Senate Office Building, Hon. Sam Nunn, Chairman of the Subcommittee, presiding.

Present: Senators Nunn, Roth, and McCain.

Staff Present: Eleanore J. Hill, Chief Counsel; John F. Sopko, Deputy Chief Counsel; Mary D. Robertson, Chief Clerk; Alan I. Edelman, Counsel; Eleni P. Kalisch, Counsel; Harold B. Lippman, Investigator; R. Mark Webster, Investigator; Scott E. Newton, Investigator; Cynthia Comstock, Executive Assistant to Chief Counsel; Mariea Wilt, Staff Assistant; Daniel F. Rinzel, Minority Chief Counsel; Stephen H. Levin, Minority Counsel; Carla J. Martin, Minority Assistant Chief Clerk; Mike Maloney, GAO Detail; John Forbes, Customs Service Detail; Gene Richardson, AID Detail; Grant Fox (Senator Cochran); Paul Feeney (Senator McCain); Dave McIntyre (Senator McCain); Diana Craig (Senator Stevens); Jennifer Walker (Senator McCain); Giona Bonmartini (Senator Roth); Jee Hun Nam, Intern; Jeff DiSantis, Intern; and Alison Bracewell, Intern.

OPENING STATEMENT OF SENATOR NUNN

Chairman NUNN. The Subcommittee will come to order. Today, the Permanent Subcommittee on Investigations continues our examination of Empire Blue Cross and Blue Shield. Last Friday, the Subcommittee heard testimony from our staff based upon their 6-month investigation of the management of Empire, the Nation's largest non-profit health insurer.

The staff detailed the severe financial problems which Empire has experienced in recent years. In the past 2 years, Empire has suffered over $444 million in underwriting losses and has seen its reserves dwindle from $295 million at the end of 1990 to just $40 million at the end of 1992, although it has improved during 1993. We will get into that during the course of the hearing.

In its report, the staff presented the basis for its findings that Empire's problems were, for the most part, of its own making. The staff found that Empire exhibited significant internal problems

which led to an inability to properly execute the most basic functions of an insurance company. The staff also reported on what appeared to be a pattern of excessive expenditures for the benefit of senior Empire officers and members of the board of directors and on the failure of Empire's board of directors to provide adequate oversight of management activities.

In addition, the Subcommittee heard the revealing and startling testimony of two former Empire employees, Joan Boyle and William Fuessler, who told the Subcommittee how Empire apparently kept two sets of financial books, one for internal purposes and one for public consumption. According to Ms. Boyle and Mr. Fuessler, Empire's chief financial officer admitted to them that the financial figures presented publicly to State insurance officials were "manipulated," in order to make them more "politically acceptable." This revelation, if proved true, could obviously have serious implications for Empire.

Today, we will continue to explore this matter, as well as others raised by the staff, as we hear from a panel of past and current Empire officials. Appearing today will be Albert Cardone, who, until May of this year, was Empire's chief executive officer and chairman of the board. We will also hear from Jerry Weissman, Empire's chief financial officer, who is currently on leave of absence without pay, as I understand the status; Donald Morchower, Empire's chief operating officer and current acting CEO; and Harold Vogt, Empire's current chairman of the board. We look forward to the testimony of these individuals and to their responses to the many serious issues which were aired during last Friday's hearing.

We will also hear today from Superintendent of Insurance for the State of New York, Salvatore Curiale. In its report, the staff detailed its findings with respect to what it termed the "inefficient regulation," by the Department of Insurance of New York.

Clearly, I believe there are some valid questions as to the range of alternatives an insurance department has in dealing with entities the size of Empire and whether such entities are indeed too big to regulate in one sense of the overall situation. Nevertheless, the staff has found a number of shortcomings in the approach that the New York Insurance Department took with respect to the regulation of Empire. This morning, we look forward to hearing the superintendent's views on these matters.

As I stated on Friday, the questions raised by the Subcommittee's examination of Empire are important not only for the future of the Blue Cross/Blue Shield system, but for the future of the Nation's health care reform effort in general. These questions of authority, of accountability, and of trust go to the very heart of any reform effort. They are questions which we would ignore at our peril.

Again, I thank Senator Roth for his cooperation and support throughout our investigation of the Blue Cross system. I know he shares my interest in the testimony presented this morning, and I am sure he will be here a little later this morning.

Senator McCain, did you have any opening remarks?

OPENING STATEMENT OF SENATOR MCCAIN

Senator MCCAIN. Thank you, Mr. Chairman. I want to thank you and Senator Roth and the investigative staff of this Subcommittee for the vast amount of work that you have done on this issue. I am grateful to you for calling this series of hearings on difficulties in the Blue Cross and Blue Shield network because I think our findings will have profound ramifications for all Americans as we move toward a revamping of our Nation's health care system.

The body of information and evidence you have garnered on the serious problems pertaining to Empire Blue Cross and Blue Shield of New York is indeed impressive and compelling. The conclusions reached by Subcommittee investigators on the disturbing legacy of mismanagement by Empire officials and the compliance timidity of the New York State Department of Insurance is deeply troubling. A review of the Subcommittee report on Empire, along with other independent audits and media investigation, leads one to the unavoidable conclusion that Empire is a health care giant perched on the edge of financial collapse.

I want to emphasize we look forward to the testimony of the witnesses and their rebuttals to the information that the Subcommittee has or media reports, and that is the reason why we are having this hearing. How Empire got to this point is a complicated and frustrating journey filled with management errors and excesses, arrogant and wasteful leadership at the top, accounting practices that may turn out to be fraudulent, and regulatory oversight that was totally ineffective, if not invisible.

It appears that every fundamental aspect of Empire Blue Cross and Blue Shield business practices, from computer systems to pricing to customer service, were either inadequate or self-destructive, and often both. I think the record shows that in the last 2 years Empire has lost $250 million, had thousands of their customers flee, been threatened with the loss of vital Medicare contracts and their Blue Cross and Blue Shield trademark due to poor service, and come under investigation by Federal, State and local law enforcement authorities.

Mr. Chairman, one of the most troubling aspects of this dilemma has been the lack of willingness on behalf of the New York State Department of Insurance to take strong action with regard to Empire Blue Cross and Blue Shield. The findings of Subcommittee investigators portray a department and a superintendent that are virtually paralyzed at the thought of implementing any measures to stop the hemorrhaging of subscriber funds at Empire.

Senator investigators describe the department's performance as "woefully inadequate," and charges that the department's regulatory forbearance with regard to Empire, "bordered on favoritism." I hope the regulatory coma that the superintendent and his department have been in for several years regarding the oversight of Empire Blue Cross and Blue Shield is finally over, though I fear it may be a little late.

I look forward to this morning's testimony, Mr. Chairman, and thank you for your leadership on this issue.

Chairman NUNN. Thank you, Senator McCain.

Our first panel of witnesses this morning will be current and former officers of Empire Blue Cross and Blue Shield. Acting Chief Executive Officer Donald Morchower will testify, as will Maroa Velez, Vice President of Auditing; Harold Vogt, current chairman of the board at Empire. Have I got that right, Mr. Vogt?

Mr. VOGT. Yes, sir.

Chairman NUNN. We also have with us Empire's former chief executive officer and chairman of the board, Albert Cardone; and Jerry Weissman, Empire's chief financial officer. Mr. Weissman, I believe, has taken a leave of absence without pay as of last week.

The Subcommittee thanks all of you for being here and looks forward to your testimony. I note that several of you have attorneys with you, and because of spacing problems they are seated behind you, but we will accord each of you the right to consult with your attorney as we proceed. If you would like to consult with your attorney before answering a question, that will be accorded you as a matter of privilege. So I wanted to let you know that.

If the attorneys would perhaps introduce themselves and state who you are representing, it would be helpful for the record.

Mr. CRACO. Mr. Chairman, my name is Louis Craco from the firm of Willkie, Farr and Gallagher. With my partner, Elizabeth Stong, and the general counsel of Empire Blue Cross and Blue Shield, Mr. Drewsen, we represent the company and Mr. Morchower, Mr. Vogt, and Maroa Velez.

Chairman NUNN. Thank you.

Mr. ZORNOW. Mr. Chairman, my name is David Zornow. I am with the firm of Skadden, Arps, Slate, Meagher and Flom in New York, and I represent Ms. Velez.

Chairman NUNN. Thank you.

Mr. KENNEY. Mr. Chairman, if I may, my name is John Kenney. I am with the firm of Simpson, Thacher and Bartlett, and I represent Jerry Weissman.

Chairman NUNN. Thank you.

Mr. THAL. Mr. Chairman, my name is Steven Thal, and together with my partner, Christopher Jones, of the law firm of Oppenheimer, Wolff and Donnelly in New York, we represent Mr. Cardone.

Chairman NUNN. Thank you, and all the witnesses understand that if you would like to consult with your attorney at any point in time, you will be certainly accorded that privilege.

I am going to ask all those who are going to be testifying this morning, with the exception of Mr. Weissman—I am going to give you, Mr. Weissman, a separate oath in respect of your religious beliefs. So I will ask all those, except Mr. Weissman, to please stand and take the oath.

Do you swear the testimony you give before this Subcommittee will be the truth, the whole truth, and nothing but the truth, so help you God?

Mr. CARDONE. I do.

Mr. MORCHOWER. I do.

Mr. VOGT. I do.

Ms. VELEZ. I do.

Chairman NUNN. Thank you.

Mr. Weissman, do you affirm the testimony you will give before this Subcommittee will be the truth, the whole truth, and nothing but the truth?

Mr. WEISSMAN. I do.

Chairman NUNN. Thank you.

Mr. Cardone, we will ask you if you would like to go forward with your statement first, and then we will hear from Mr. Weissman and then we will proceed with the present company officials.

TESTIMONY OF ALBERT A. CARDONE,[1] FORMER CHIEF EXECUTIVE OFFICER AND CHAIRMAN OF THE BOARD, EMPIRE BLUE CROSS AND BLUE SHIELD

Mr. CARDONE. Thank you, Senator Nunn, and good morning, Senators, Committee members, and staff. I appreciate the opportunity to appear before the United States Committee on Governmental Affairs, Permanent Subcommittee on Investigations.

I served as chairman of the board and chief executive officer of Empire Blue Cross/Blue Shield from April 16, 1987, to May 19, 1993. Prior to joining Empire as deputy chairman in July of 1985, I was a partner at the international public accounting firm of Deloitte, Haskins and Sells, now Deloitte and Touche, where I held the position of national industry director for that firm's national health care practice.

I left my partnership at Deloitte to join Empire at their invitation. Before joining Empire, those Empire directors and members of the board involved in my recruitment informed me of the importance of Empire's mission which, simply stated, is to provide quality health insurance to as many people as possible.

Those directors realized the importance of Empire as the insurer of last resort to hundreds of thousands of New Yorkers, and wanted to be assured that if I was selected I would do all that I could to preserve the corporation's noble mission. During my tenure at Empire, I always placed the highest priority on fidelity to Empire's mission of providing health insurance to as many people as possible, regardless of their health status, the industry they worked in, or any other discriminating factors.

Now, as I reflect upon 1985, Empire was being attacked on several fronts. First, there was the movement of large groups toward self-insurance. In New York, it was especially advantageous for large groups to assume the insurance risk themselves so that they could avoid the cost of providing State-mandated health benefits to their employees.

Next, New York State was encouraging the growth of HMOs by extending to them, regardless of their profit or not-for-profit status, Empire's statutory advantage of paying hospitals a cost-based payment rate that was less than that paid to other payers. Of course, those HMOs immediately set out to attract the company's good-risk business.

In addition, Empire's customers were demanding more products and services from the company than ever before. Empire's non-group, or individual customers—and that is the population that has

[1] The prepared statement of Mr. Cardone, with attachments, appears on page 240.

the most difficult time obtaining health insurance in most States other than New York—were then dissatisfied with the products made available to them. Those products were hospital-only or hospital and basic medical coverage, and they wanted the broader major medical insurance products that were offered to group customers.

The board of Empire, the management of Empire, agreed that their requests should be satisfied and they started offering major medical policies to individual customers in late 1986. Now, from a societal point of view, that decision was a good one. From an economic point of view, it strained the company's financial resources, as individuals stricken with catastrophic illnesses like AIDS, cancer, heart disease, and chronic illnesses like diabetes and multiple sclerosis, or organ transplants—those are the people that purchased Empire's major medical products.

Notwithstanding those challenges and financial burdens that no other competing insurer would undertake, Empire added in excess of $100 million to its capital for the 3 years ended December 31, 1990, by more than offsetting underwriting losses on its community-rated business with investment income and gains on its experience-rated business.

In early 1991, Empire started to experience unprecedented losses on its community-related lines of business due to a practice that is commonly referred to as cherrypicking. In addition, we noticed that our competitors were selectively avoiding customers who are high consumers of health care, or poor risks, and were suggesting that they purchase an individual major medical policy from Empire as an individual customer. We came to refer to that practice as dumping.

It was the combination of both the cherrypicking and the dumping practices that occurred in 1991 and 1992 that caused Empire's widely publicized $250 million in losses. In fact, Empire was able to partly offset even greater amounts of community-rated losses by investment income and profits on its other highly competitive experience-rated medium- and large-group business.

At the end of 1992, Empire's capital stood at $40 million. However, while it lost, as has been reported, approximately $250 million of its financial capital, it won a major legislative victory that should ensure its financial survival and ability to be faithful to its mission for the future. It is also important to note that Empire's reserves have climbed to $206 million at the time I left Empire, and that amount is 12 percent higher than its capital position when I became chief executive officer and chairman in 1987.

Now, during this same 2-year period, 1991 to 1992, while Empire was being unfairly competed against as its competitors skimmed off its community-rated, small-group, good risk, profitable business and used Empire's open enrollment community-rated pools as a dumping ground for their poor risks, a very important and historic battle was being waged in the New York State Legislature. The battle was over whether all insurers who sell health insurance to small groups—that means groups up to 50—and to individuals should be required to do so on a community-rated basis and no longer have the ability to discriminate and deny coverage to

anyone on the basis of health status, age, employment, or other factors. Now, we refer to that as open enrollment.

By community-rated basis, I mean that the price charged for a specific policy cannot vary because of a person's age, medical status, or any other discriminating factor; that is, the price is determined on the basis of the overall community pool's experience and not the experience of any particular individual or group within the community pool. Therefore, a uniform price is charged to all customers, regardless of their age, health history, present health status, where they work, if they work, and where they live.

Last July, New York State passed the law that mandates community rating and open enrollment to small-group and individual health insurance. That legislation was enacted with the support of numerous groups representing a wide array of citizens confronting the devastating costs of dealing with serious illnesses, and was opposed almost exclusively by commercial insurance interests. A listing of those who wrote to the governor regarding the bill, together with some of the supportive letters, is attached to my testimony.

During that battle, Empire did all that it could to obtain the necessary reform to New York State's insurance law. Those opposed to this reform accused Empire of mismanagement and said that the reforms were not needed. To satisfy those voices, the law that was finally enacted in July of 1992, with an effective date of April 1, 1993, contained a requirement that Empire be subjected to an independent financial and management audit, and that the causes of its losses be ascertained.

In October 1992, the firm of Arthur Andersen was selected by the New York State Department of Insurance to perform an independent financial and management audit. I believe a copy of that report has been furnished to the Subcommittee.

Arthur Andersen reported that indeed Empire's losses were in its community-rated lines of business and were caused by the very conditions, cherrypicking and dumping, that the community-rating law sought to correct. Specifically, Arthur Andersen concluded that, and I am quoting from their report, (1) "Empire's annual administrative expenses over the past three years have been fairly stable and reasonable given the overall environment in which it operates"; (2) that "the number of Empire's officers and their compensation is reasonable"; (3) that "Empire's travel and entertainment practices are stringent and the level of expenses are reasonable." That report also concluded that "administrative costs are not the cause for rising insurance premiums," but rather, "the main causes for premium rate increases have been the dramatic rise in the cost of health care and the increased utilization of health care benefits by subscribers remaining in the community-rated pool."

Andersen also confirmed what the company had known for some time. They said, "Empire's community-rated pool has deteriorated in recent years as a result of natural flight and cherrypicking, a practical business technique of the company's competitors. The fact that Empire's subscribers use more health care services than other insurers' subscribers puts strong upward pressure on premiums. This can be clearly seen when comparing the loss ratio of those groups that have left Empire in recent years versus those that have stayed in the pool."

I was not surprised by Arthur Andersen's conclusions and that Empire's administrative expenses were reasonable and not the cause of Empire's losses. Empire had previously engaged the independent consulting firm of Booz, Allen, Hamilton and Company to study Empire's administrative costs, and that firm also concluded Empire's administrative costs were reasonable. Empire's administrative costs are about 7 percent, and that means that only 7 cents of every premium dollar is spent on administrative activities like claims processing, customer services, marketing, sales, product development, legal, accounting, etc.

That 7 cents compares very favorably to Empire's competitors, who spend 20 to 25 cents on administrative activities, and it also is at the low end of the other Blue Cross and Blue Shield plans around the country. Senator, I believe your staff has essentially confirmed the fact that the Blues run an average of 8 percent or higher.

Considering that the Arthur Andersen study cost New York State $2.1 million to perform, I hope we can spend our time today on the very important issues of health insurance regulation and reform. In that regard, I was very pleased to read in Arthur Andersen's report that they also feel that additional reform is necessary in order to achieve a level, competitive playing field in New York.

Specifically, there is a need to require that any health insurer who desires to sell health insurance in New York be required to sell to all market segments. We refer to this proposal as the all-markets reform issue. This would result in greater spreading among insurance carriers of the individual—and that is generally the poorer-risk population—that is presently avoided by most commercial insurers. To help keep the prices of individual policies affordable, all health insurers should be required to share in the extraordinary losses incurred by those insurers who presently must serve a disproportionate amount of the individual population. Governor Mario Cuomo has proposed such reform in his 1993 health care proposal which is being debated in the legislature at this present time.

Now, I had hoped that by this time the Clinton administration would have presented its national health plan that would have contained those very important principles of fairness, like community rating, open enrollment, and the requirement that insurers sell to all and not strategically sell only to the profitable market segments. I, on behalf of Empire, fought hard to eliminate risk selection as a basis for competition among health insurers, and thanks to the enactment of the community rating, open enrollment law, it is now illegal to compete on the basis of risk selection in New York State.

Senator Nunn, time does not permit to describe the evil employment practices that result from risk selection, as employers avoid hiring people who are poor health risks because of their age, their medical condition, their history, or other factors that hint at high consumption of health care resources. It is obvious to me that the present legally allowable, in most States, practice of insurance competition based on the ability to select risk must be outlawed nationally if we are to start any meaningful regulation and reform of the health care industry.

While it is unfortunate that we have to wait a few months for the administration's plan, your Committee has an opportunity to recommend to the administration the kinds of reform to the health insurance industry like community rating, open enrollment, and the all-markets concepts that go a long way toward making health insurance both accessible and affordable to all Americans.

Empire has been faithful to its mission of providing health insurance to all for 58 years, and were it not for Empire's legislative initiative, New York State would have many more uninsured citizens than it presently does. In addition, had Empire ceased to be faithful to its mission of providing insurance to individuals and small-group customers on an open enrollment, community-rated basis, New York State would have been burdened by additional costs of approximately $900 million a year. This $900 million estimate was calculated by independent consultants on behalf of the New York State Conference of Blue Cross and Blue Shields Plans.

As aptly described by an official in New York responsible for the Medicaid program, Empire, a private, not-for-profit corporation, serves as a safety net for thousands of New Yorkers, and if the Empire net breaks, the only remaining safety net would be the Medicaid net, and that net is already badly strained.

Empire offers a prime example of how community rating with open enrollment can work for the benefit of all Americans. Presently, New Yorkers, regardless of their age or medical condition, are able to purchase health insurance at prices that compare favorably with those in other metropolitan areas, except for one very important fact, and that is New Yorkers need not fear being unable to obtain insurance because they have a serious illness, have recovered from a serious illness, or are at grave risk of getting a serious illness.

Now, having fought for community rating and open enrollment in New York State on Empire's behalf, and contributed to a significant legislative victory, I hope that that law in New York remains alive. In that regard, there are those who already are suggesting repeal of the community rating, open enrollment law that just became effective on April 1 of this year.

Senator you and your Committee could help if you use your investigative capability to tell the real Empire story of a company that has carried out its mission of providing health insurance to all, despite the lack of a level playing field, and how critical insurance regulation and reform is to achieving the goal of making broad-coverage, affordable health insurance available to all.

Now, I know you are keenly interested in the subject of whether regulation required to reform the health insurance industry should be nationally or State-determined and administered. Based on my experience, Senator, it is clear that national guidelines are needed that apply to all States. Frankly, State regulators and legislators are not a fair match for the powerful special interest groups that presently have a vested financial interest in preserving the profitable status quo in the health insurance industry.

Their weapons like threats to move jobs out of a State, combined with their ability to mobilize the segments of the population who would have to pay more for health insurance under community rating because they presently are good risks, make it extraordinari-

ly difficult for a State to do the job that has to be done. New York State, with Empire's help, took a giant step last year, and already opposing forces are gathering to repeal the reforms that were enacted. For these reasons, I urge you to do all that you can to bring about national guidelines for health insurance that I have discussed.

As chairman of the board and CEO for Empire for the last 6 years, I had the privilege of fighting for fairness in health insurance and I am proud of what we did. In this context, I also think it appropriate for me to firmly advise this Committee that all of the recent highly publicized critical comments about me and my tenure at Empire are absolutely and unequivocally untrue, and are but another effort by special interests to discredit me and a fine institution that has been true to its noble mission and has been a safety net for thousands of New Yorkers who would have been otherwise uninsured were it not for Empire.

Now, I would like to add some supplemental remarks as a result of certain allegations that have surfaced over the past few weeks, where I have read stories in the press referring to internal books which have been anonymously dropped at the door steps of newspapers, and statements of former employees regarding black books and two sets of figures.

These reports and statements appear designed to depict a story of financial conspiracy and dark dealings. I am here to tell you today that all this is indeed pure fantasy and fiction. All news reports reporting such allegations are purely and simply wrong. The implications in the Senate staff report, in my opinion, are unfounded.

During most of my tenure at Empire, financial and statutory reporting was handled by Jerry Weissman, the gentleman on my left. To the best of my knowledge, Mr. Weissman performed his duties capably and professionally.

Now, without attempting to describe the very complex accounting and actuarial processes that Empire undertakes to prepare its financial statements, which are similar to those employed by other health insurance companies, I would like to assure you of the following key facts as the former CEO of Empire, to the best of my knowledge.

One, Empire had one set of books and it prepares one set of financial statements that at any given moment of time presented Empire's financial position and results of its operations.

Two, Empire, similar to all companies, prepared for internal management purposes monthly financial statements and schedules.

Three, Empire's internal financial statements, which are customarily prepared within 30 to 35 days after a month-end, were used for management planning and control purposes.

Four, Empire prepares its statutory filings for a given accounting period using these internal financial statements as a basis. As a part of this process, adjustments are frequently made to the internal financial reports to reflect more current data and analysis.

The reason that such adjustments are made for statutory filings or for the annual audited financial statements is simply due to timing; that is, the company has additional time between the preparation of the internal financial statements and its statutory or

annual audited financial statements to obtain additional IBNR information and to include such in accordance with the applicable statutory accounting requirements.

One of the most difficult aspects of Empire's reporting involves this IBNR, which is an acronym to describe incidents of care that have been incurred but not yet reported. Empire, as other insurance companies, is required to accrue for these unreported claims. In our experience, most claims are reported to Empire within 18 months after services are rendered. Thus, the IBNR calculation is an actuarial estimate at a particular point in time of the value of unreported claims that have been incurred but not reported and which Empire can expect to incur. It is an estimate. It is based on experience, but it is subject to adjustment over time based on subsequent events and information.

Thus, one's estimate for IBNR for the first quarter of 1993 would be much more reliable in December of 1993 than it would have been in May of 1993. The passage of time and the receipt of new information allows one's estimating basis to improve.

Now, the IBNR was calculated on a top-down, global basis for Empire's financial statements. Since both the internal financial statements and the statutory filings with the insurance department require certain segment reporting, this global IBNR must be allocated to Empire's market segments. This allocation was performed by the company's actuaries and accountants, in consultation with the underwriting department, and it was approved by Mr. Weissman.

Empire's internal management financial reports were prepared monthly and as quickly as possible, and were not intended to serve as statutory reporting documents. However, they contained the best information available at that time that they were prepared. Since the IBNR is essentially a moving target, its estimation as a whole and its allocation among market segments will, of course, improve over time.

The later the date of a financial report, the more precise the IBNR number. Therefore, a filing with the New York State Insurance Department is, by definition, far more precise than an internal monthly statement prepared some 30 or 45 days earlier. To the best of my knowledge, all statutory filings during my tenure have been fair presentations in accordance with the applicable statutory accounting requirements.

I have never requested, required, or suggested that anyone at Empire falsify or misrepresent any financial information in any of the company's filings. There is no mystery or slight of hand here, Senator. The internal financial statements, or the so-called black books, are one part of a continuum, a single process of developing financial data over a period of time.

Senators and staff, thank you for your attention. That concludes my testimony. I shall be pleased to help the Subcommittee in any way I can to bring about reform to the health insurance industry in this country.

Chairman NUNN. Thank you, Mr. Cardone.

Mr. Weissman.

TESTIMONY OF JERRY WEISSMAN,[1] CHIEF FINANCIAL OFFICER, EMPIRE BLUE CROSS AND BLUE SHIELD

Mr. WEISSMAN. Thank you, Mr. Chairman, Senators. Good morning. My name is Jerry Weissman. In the days preceding the commencement of this hearing, the accuracy of statements of Empire Blue Cross/Blue Shield which were provided to the New York State Department of Insurance has been called into question. I was the chief financial officer of Empire at the time these statements were submitted to the State of New York and will limit my brief remarks to this issue.

The information to which I refer is provided to the State of New York on a quarterly basis. The statement submitted to the State is referred to as the Blank. The Blank, copies of which have been provided to the Committee staff, contains a substantial amount of information, including insurance claims against the company which fall primarily into two categories—paid claims and projections.

The amount of paid claims are taken from the records of Empire. The amount of projections reflect the calculation of the contingent liabilities of the company which arise from claims against the company which have been incurred but not reported. This is commonly referred to as the IBNR.

In every case, the figures submitted to the State of New York, both in the aggregate and as allocated among areas of Empire's business, were, to the best of my knowledge, either accurate and correct or a reasonable estimation of the IBNR in light of the information available to me and the company at the time the Blank was submitted.

I am the person responsible for the submission of this information to the State of New York. I have responded to all requests by this Committee's staff for information and I welcome the opportunity to respond to any questions the Committee may have on this subject or, of course, on any other matter of interest to the Committee.

Mr. Chairman, that concludes my remarks for this morning.

Chairman NUNN. Thank you, Mr. Weissman. Just one question and then I will come back to this. I notice your statement is very carefully worded. You say that in every case, "the figures submitted to the State of New York, both in the aggregate and as allocated among areas of Empire's business, were, to the best of my knowledge, either accurate and correct or a reasonable estimation of the IBNR in light of the information available to me and the company at the time the Blank was submitted." It seems to me there is clearly an alternative to being accurate and correct.

Mr. WEISSMAN. Again, these are projections that were done initially by the actuarial people and reviewed by myself. They are rather substantial estimations and there were times where, after the fact, we found that the estimations may have either been overstated or understated.

Chairman NUNN. Mr. Weissman, do you believe the State Insurance Department knew how you were arriving at these "reasonable estimations?"

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[1] The prepared statement of Mr. Weissman appears on page 254.

Mr. WEISSMAN. Yes. I believe that the insurance department had audited these figures.

Chairman NUNN. OK.

Mr. Morchower. Or is Mr. Vogt going to go first?

TESTIMONY OF HAROLD E. VOGT,[1] CHAIRMAN OF THE BOARD OF DIRECTORS, EMPIRE BLUE CROSS AND BLUE SHIELD

Mr. VOGT. Mr. Chairman, members of the Subcommittee, I am Harold Vogt, the current chairman of the board of Empire Blue Cross and Blue Shield. With me today are Donald L. Morchower, executive vice president and chief operating officer of Empire Blue Cross and Blue Shield, who is currently serving as acting chief executive officer until a permanent CEO is selected by the board of directors; and Maroa Velez, vice president for internal auditing.

I would like to thank the Subcommittee for affording Empire this opportunity to testify about the functioning of its board of directors, its financial condition, operating practices, and the situation in which it finds itself today. My brief opening statement will address matters concerning Empire generally and the functioning of the board of directors. Mr. Morchower will address the financial condition and operating practices at Empire.

I would like to preface my statement with the following observations. Empire is a company that successfully serves the health care needs of the people of New York and beyond. For half a century, Empire Blue Cross and Blue Shield has been the principal health insurer, often the insurer of last resort for millions of people in New York State. Let us not lose sight of this.

Yes, Empire had its problems, as the board and management have recognized, and as we have heard in the Subcommittee staff report and testimony given on Friday, June 25th. For some 6 months, Empire and many of its 9,000 hard-working and committed employees have worked closely with the Subcommittee staff as we explored some of these problems, and let me make clear that prior to the staff report the board already endorsed actions to address allegations of fraud committed against Empire; possibly inaccurate financial statements filed with the New York State Insurance Department; allegations of "lavish" compensation and "perks" for my predecessor as chairman, who was also CEO; deficiencies in handling Medicare claims under contract with the Federal Government; and charges of having an inattentive and "rubber stamp" board.

All these matters are important and Empire has taken them very seriously. But it is also important to remember that these matters arose during a period when Empire provided approximately $53 billion in health insurance coverage and paid approximately $50 billion in claims. In dollar terms, whatever the combined impact of all of our problems might have been, it just constitutes a small percentage of the good Empire has done.

Mr. Chairman, I do not mean to minimize Empire's problems to this Subcommittee. We know we need to work harder and smarter to reduce our problems, zero them out, turn the company around,

[1] The prepared statement of Mr. Vogt, with attachments, appears on page 254.

and restore Empire's financial health. With the full support of a proactive board, we have already begun that process to become more efficient, to restore internal morale and public confidence, and to do a lot of things to repair the damage Empire and its constituencies have suffered.

While we cannot say that we enjoy either these hearings today or the steady drum beat of negative press Empire has been receiving in recent months, we hope that we can look back at all this and say it focused our minds and contributed to the improvement of ourselves, our great company, and the health insurance industry of which we are a part.

I have read the testimony to be given by Don Morchower on behalf of Empire and I certainly concur with what he will tell the Committee. Nonetheless, given my 10 years on the board and my current position as chairman, I think it is important, in light of the inquiries from this Committee, the New York State Insurance Department and others, that I outline the board's active role in the governance of Empire and, in particular, its involvement in the events of the last few months and the steps we have taken to return Empire to financial and operational stability.

First, I would like to point out that I personally subscribe to the principle that the board of directors is the key to the governance process. It is the fulcrum of accountability in the system which, at Empire, includes management, State regulators, policyholders, health care providers, the community, and the public at large.

In the case of Empire, that responsibility is discharged by a board of directors, all of whom are unpaid volunteers performing this duty solely as a public service. The board's responsibility is to ensure that the corporation has in place the best management available and to be willing to change failing managements in a timely fashion when necessary.

The board's challenge is to stay sufficiently informed of current performance, to be concerned with and address the future, and to know when it is time to change and to be sufficiently independent to make the change. I believe this is a challenge that Empire's board of directors has met even though hindsight now shows that we may not have been in the position to either fully appreciate or recognize some of the problems now uncovered.

As you know, as part of New York's landmark community rating, open enrollment legislation, the State Insurance Department retained Arthur Andersen and Company to conduct a financial and management audit of Empire. On April 15, 1993, Empire received a draft of Andersen's audit report which contained 120 recommendations for changes at Empire, including separation of the offices of chairman of the board and chief executive officer, which was then held by Albert Cardone.

At the board of directors meeting on April 21, 1993, the board formed a special ad hoc committee that was charged with reviewing the Arthur Andersen recommendations and reporting to the full board on the issues of corporate governance, organizational structure, managed care systems, customer service, corporate culture, and the company's external relations. I was elected to be chairman of that ad hoc committee.

The ad hoc committee was also asked to consider comments from the Superintendent of Insurance, Salvatore Curiale, in a personal letter he sent to each board member dated April 14, 1993, in which he criticized the board for inattention to our duties as board members, the first personally addressed letter I have ever received from the superintendent of insurance in all my 10 years on the board. While we questioned the superintendent's criticism, we felt it necessary to have the ad hoc committee review all issues, including the superintendent's letter, and a copy is appended and submitted with my text.

The ad hoc committee immediately met with the superintendent and began its work. In the course of its investigation, it interviewed Deloitte Touche, the independent outside auditors of Empire; Arthur Andersen and Company; senior officers and other employees of Empire, as well as persons outside Empire.

As a result of these interviews and considerable discussion at committee meetings, it became clear to the members of the board ad hoc committee that Empire needed new leadership to improve its external relationships and take a fresh look at both external and internal problems.

At the board meeting of May 9, 1993, I made the report of the ad hoc committee to the full board in an executive session. That session was held following a report to the board by Mr. Cardone in which he stated that he would resign if the board determined that that was in the best interests of Empire. After a lengthy discussion, the board informed Mr. Cardone that it would accept his resignation, which he tendered.

The board then passed a resolution splitting the positions of chairman of the board and chief executive officer, which had been one of the recommendations of Arthur Andersen and the superintendent of insurance, and elected me as the new chairman of the board. At the same time, the board named Donald L. Morchower, Empire's executive vice president and chief operating officer, to serve as chief executive officer.

Since that date, Don Morchower and I have been actively involved in running the affairs of the company, developing and implementing transition organization plans and strategies and reaching out to all our constituencies—customers, employees, government officials, and the public—to begin to reestablish Empire's reputation and position in the marketplace.

In a little more than a month, the board of directors has set a new course for the company. In addition to accepting the resignation of Empire's former chairman and chief executive officer, and separating those offices, the board has strengthened its ability to act independently and expeditiously in fulfilling its responsibilities to determine the company's direction and policies, as well as assuring its position in management oversight. While Empire's board has always been proactive with management, the current actions serve to preclude management influence on that role.

To further ensure the flow of accurate and timely information to the board, it has also moved the company's internal audit function and the corporate secretary function from being direct reports to management to being direct reports to the board through its chairman and board committees. The effectiveness of those important

actions has already been demonstrated by the fact that I as board chairman was in the position to direct an accelerated inquiry into an apparent discrepancy between internal reports and our filings with the State Insurance Department.

Questions had been raised about the fact that certain internal documents could not be reconciled with the annual statement for 1991 that had been filed with the insurance department. I asked Empire's internal auditor to conduct an immediate review of this issue. When she reported to me that she could not obtain adequate explanatory documents from the affected areas and that her inquiries seemed to show that the numbers submitted on the annual statement were incorrect, Empire immediately launched an internal investigation. I informed the superintendent of insurance of this development and our general counsel alerted this Committee.

The company retained the firm of Willkie, Farr and Gallagher to conduct interviews of employees and to review the documents, and the board of directors designated the audit committee of the board to oversee the investigation. The board has retained Otto Obermaier, formerly the United States Attorney for the Southern District of New York and presently a partner in the firm of Weil, Gotshal and Manges, to oversee the investigation and to advise the audit committee and the full board. That investigation has not been completed and it would be premature to comment further. Of course, when the investigation is completed, a report will be made public.

About a week-and-a-half ago on June 18, 1993, I received a call at approximately 10 a.m. in the morning from the superintendent of insurance requesting that I call a special meeting of Empire's board of directors for later that day so that he could meet with the board to discuss what he characterized as a matter of "impacting Empire's future."

I acquiesced to his request. All board members were contacted and the meeting commenced at 2 p.m. At that meeting, the superintendent presented his views on the impact and unfavorable public reaction and perceptions to the series of newspaper articles concerning Empire that have appeared over the last 3 months, and conveyed his view that "dramatic changes" in Empire were required immediately in order to change the perceptions of Empire resulting from the media coverage.

He proceeded to outline to the board a series of requests he felt would constitute appropriate changes in governance of the company, and specifically who the company should consider as candidates for the positions of chairman of the board, chief executive officer, and additional directors for an expanded board.

The board discussed the superintendent's suggestions with him and then independently in executive session. Following deliberations on the superintendent's requests, the board unanimously passed a resolution, which was already scheduled for consideration at the next regularly scheduled meeting on June 23rd, and appointed a seven-person search committee to accelerate the process of recruiting a new chairman of the board and a new chief executive officer.

On June 18th, the board also decided to move forward with its plan to increase the size of the board, and to do so in keeping with

the superintendent's request, by expanding the board from its present authorized number of 20 to a new total of 25. Finally, the board decided to move as swiftly as possible to identify candidates for those new positions and to existing vacancies.

Mr. Chairman, with over 8 million subscribers, from individuals whom no one else will ensure to major corporations with tens of thousands of employees, Empire has been for many years among the most well respected health insurers in the country. Despite this successful corporate history, Empire must now work hard to recapture the trust of the public and the support of the marketplace.

Our efforts to reestablish our financial base have borne fruit. I appear before you today able to report that our capital reserve for the protection of our customers today stands at $236 million, up from $40 million at year-end 1992. That amount already exceeds, and is projected at year-end to exceed the capital target established earlier by the Blue Cross and Blue Shield Association for year-end 1993.

The board, if allowed the opportunity, will continue to lead the effort to accomplish those objectives cited, and I will continue to participate actively first as chairman until a new chairman is selected in due course by the board, and then as a member of our board. We plan to work closely with the State Insurance Department, and I have already pledged my personal and the company's full cooperation to the chairman of the nine-person oversight committee that was formed by the governor and State Legislature to review affairs of Empire and report annually to the superintendent, the legislature, and the governor.

We have long been known as an insurer of last resort in New York State and our social mission has long been to accept all applicants without regard to their age, sex, or prior illness, and to rate all individuals and small groups on a community-rated basis. The board of directors is committed to maintaining this social mission, to make necessary changes in response to a changing health care environment, and to leading Empire out of this, its most troubling time.

I thank you for allowing me to deliver this opening statement. I would be pleased to answer any questions you may have now or following Mr. Morchower's testimony.

Chairman NUNN. Thank you, Mr. Vogt.

Mr. Morchower.

TESTIMONY OF DONALD L. MORCHOWER,[1] ACTING CHIEF EXECUTIVE OFFICER, EMPIRE BLUE CROSS AND BLUE SHIELD; ACCOMPANIED BY MAROA VELEZ, VICE PRESIDENT, AUDITING, EMPIRE BLUE CROSS AND BLUE SHIELD

Mr. MORCHOWER. Thank you, Mr. Chairman and members of the Subcommittee. My name is Donald Morchower. I am the executive vice president and chief operating officer of Empire Blue Cross and Blue Shield, and I am serving as acting chief executive officer until a permanent CEO is selected by the board of directors.

[1] The prepared statement of Mr. Morchower, with an attachment, appears on page 260.

Last Friday, I provided to the Subcommittee a statement that included a historical perspective on Empire, its social mission, its commitment to the principles of open enrollment and community rating, the statutory and regulatory burdens and oversight under which we operate, to which no commercial insurer is subjected, and the fact that health insurance is our only business. I also discussed the recent allegations of financial mis-reporting which we brought to your attention as soon as it was discovered.

Today, I want to discuss some of the issues raised at last Friday's hearing. Your staff testified then at length on their views and conclusions about Empire's management and operations, and I hope I can provide some additional insight and facts for both this Subcommittee and the general public.

Empire is facing the most serious challenges, both strategic and financial, that it has confronted in its almost 60 years of existence as a health insurer. Many of these challenges are the result of internal problems, but that is not the whole story and it is vital to understand Empire's challenges to tell the whole story.

The staff statement recited a litany of management problems at Empire. The statement——

Chairman NUNN. Mr. Morchower, can I just ask you one question now?

Mr. MORCHOWER. Yes, sir.

Chairman NUNN. Mr. Cardone said in his statement that all critical comments about his tenure and about Empire are untrue, and you just said many of these challenges are the result of internal problems.

Mr. MORCHOWER. Yes, sir.

Chairman NUNN. So, obviously, you disagree with Mr. Cardone's conclusions?

Mr. MORCHOWER. And as I go through, there are points that I will be making in terms of things that have to be done with respect to the corporation to improve it.

Chairman NUNN. So you don't agree with Mr. Cardone's statement that all critical comments are untrue?

Mr. MORCHOWER. I do not believe that all critical comments are untrue.

Chairman NUNN. Thank you.

Mr. MORCHOWER. The statement relied heavily on criticisms by former officers or employees, some of them responsible at the time they were at Empire for the very functions they now criticize. It attempted to discredit every outside organization that audits us, regulates us, consults with us, such as Arthur Andersen, the New York State Insurance Department, Deloitte and Touche, Milliman and Robertson. While criticizing the work of these organizations, it relied itself on many of the same sources of information and on unsubstantiated allegations and anecdotes.

Not heard on Friday were Empire subscribers, like a Mr. R.C. of Manhattan who told us on May 18th, "I had Blue Cross for years and never needed them. Then I had an accident and developed a bone disease. All of a sudden, I had 6 different surgeries and huge medical bills. Thank God, knock on wood, Blue Cross was there for me. When I needed them, they came through like a champ." And I

have many other examples, but I will spare you that today, and they are noted in my prepared statement.

Chairman NUNN. We will be glad to have those added in the record.

Mr. MORCHOWER. They are part of the testimony which you have, sir.

Chairman NUNN. Yes, without objection.

Mr. MORCHOWER. It is worth contemplating how, and even whether, hundreds of thousands of our subscribers, particularly the elderly and the seriously ill, would receive health care and benefits and what they would have to pay if Empire did not exist as a non-profit provider. Even today with New York's new open enrollment and community rating law in effect, Empire remains the only significant insurer of non-group individuals like the customer I just quoted.

We regret that our problems may have caused concern and anxiety for many of our customers. Some may be fearful and others may be angry. We are working to correct the situation. Certainly, there have been internal problems at Empire, but I pledge to you and to the public that Empire is acting, and will continue to act to correct this internal situation and any external problems it created. This will be a difficult process which involves restoring the trust between ourselves, our regulators, our legislators, but we are committed to do it.

Empire's losses stem from market forces much broader than the management problems identified by the staff. The discriminatory practices of commercial insurers, referred to as cherrypicking, are and have been an issue and will be an issue in the National debate on health care. Empire's internal problems should not be used to obscure the impact of these practices on Empire and others, or to undermine the enormous accomplishment represented by the new law in New York.

With your indulgence today, Mr. Chairman, I would like to focus primarily on the issues of financial condition, information systems problems, fraud, and customer service that were addressed by staff. On behalf of Empire's more than 9,000 dedicated, hard-working, caring employees and its 8 million customers, I will try to complete the record on some very important issues and will follow up with a document subsequent to this meeting that goes into greater detail on inaccuracies and misinterpretations contained in the staff statement.

Chairman NUNN. We certainly want to know where there are inaccuracies because that is how we will make sure we have the right information before those of us on the Subcommittee make any kind of final report.

Mr. MORCHOWER. Sir, I will provide you with a detailed response.

There is no question that in 1991 and 1992 the company experienced a significant drop in its capital or surplus, which is called the reserves for the protection of our customers. That reserve is, of course, over and above the resources required to pay actuarily anticipated claims and meet expected expenses.

As you heard, our capital position stood at $40 million, down from $145 million a year earlier. However, 1993 is shaping up to be a good year financially. At the end of May, capital surplus stood at

about $236 million. By year end, after we complete the pass-through to customers of almost $100 million in rate credits, capital is forecast to be about $160 million. That compares with the $92 million target and represents, in my judgment, a strong turnaround.

As to the "surprising" ruling in the staff report by the New York State Insurance Department concerning the reduction in supplemental reserves, this ruling was hardly surprising. No other plan in New York, except Empire, carried that reserve on its statutory books. This ruling made our accounting consistent with all other New York plans.

In addition, much attention has been focused on Empire's settlement of a lawsuit involving New York's excess malpractice fund. It has been characterized as a bail-out and a State cash infusion. Again, we need to set the record straight.

This was a lawsuit that Empire and other plans in New York State initiated to collect surplus payments into the fund. We reached a settlement that returned $93 million to Empire, as well as amounts to other plans and HMOs. And importantly for our customers, the full amount is applied under the settlement as a rate credit for our community-rated subscribers.

Chairman NUNN. Is the recovery of that $93 million, Mr. Morchower, the main reason your condition has improved from $40 million up so far this year?

Mr. MORCHOWER. No, sir. By the end of the year, that entire $93 million will have been given out in the form of rate credits or reductions to our direct pay community subscribers. None of that will remain as part of the $160 million.

Chairman NUNN. Is it part of the $145 million that is your surplus as you now——

Mr. MORCHOWER. It is part of the current $236 million, yes, sir, and that is why between now and the end of the year that 236 will be reduced down to the estimated $160 million.

Chairman NUNN. OK, it is part of the 236.

Mr. MORCHOWER. The Subcommittee statement disputes the fact that Empire's losses were primarily driven by our community-rated business. Rather, the staff concluded that gross mismanagement caused our losses. It is interesting to note that every professional accounting or actuarial firm that has reviewed Empire's losses has concluded that they were caused principally by Empire's community-rated line of business. These losses are real and reflect the unfortunate fact that our community-rated subscribers utilize health care more heavily than other market segments, and this should not be surprising.

Up until April 1, 1993, only non-profit insurers like Empire offered community-rated coverage without medical underwriting. Further, even today with the new law, Empire is the only carrier in the State offering an individual direct-pay major medical policy. In summary, as the insurer of last resort, we believe our losses are largely related to the faithfulness to our unique mission.

Chairman NUNN. Mr. Morchower, it would be a big help if we had an analytical product that showed that. I think the staff concluded that there was no analysis that basically demonstrated the point that you all have been making over and over and over again,

and they also concluded that the accountants who came to that conclusion simply relied on the same basic oral presentations, each one of them did, that you have been making over and over and over again.

What is missing here as far as we know—and maybe you have this and we haven't seen it—is any kind of analysis that really shows the heart of your problems comes from so called cherrypicking and community rates, and so forth.

Mr. MORCHOWER. If I may, Mr. Chairman, I will provide that to you as part of the follow-up to this testimony, the document that I mentioned before I would submit to you.

Chairman NUNN. We have been asking for it for 6 months, and that is the reason I am puzzled that we keep getting assertions about this, but we don't get an analytical product that shows it, nor do we get that from any of the accounting firms. Do you have a document? Do you have a study? What is it that you rely on other than your intuitive feelings? Your intuitive feelings may be right, but there is no empirical evidence at all of this.

Mr. MORCHOWER. We have a number of different analyses. We do have information and I will provide them to you.

Chairman NUNN. Is it in the form of some study somebody has done, internal study or——

Mr. MORCHOWER. Studies that our people have done, analyses that outside actuaries have performed, and we have a series of data that we should make available to you.

Chairman NUNN. Well, it would be a big help and it might clarify some of this, but I don't know why we haven't gotten it already because we have been into this for a long time. Nor is it part of any kind of accountant, Arthur Andersen or any of these other firms—they don't have any analysis that backs up those assertions.

Mr. MORCHOWER. I will provide you that, sir.

Chairman NUNN. I don't think there is any doubt that some of your problems are attributable to those items. The question is how much.

Mr. MORCHOWER. I think the substantial portion; I know the substantial portion, and I will give that data.

Chairman NUNN. OK, thank you.

Mr. MORCHOWER. We are not alone, also, in that view. For example, as recently as December 1992, the Wall Street firm of Donaldson, Lufkin and Jenrette stated, "Empire Blue Cross/Blue Shield of New York, while troubled, is not on its death bed. While Empire lacks the required statutory reserves, it still has $1 billion in long- and short-term capital and a cash flow more than adequate for its claims payment."

It also said, "Empire Blue Cross and Blue Shield plans are unfairly maligned for inefficiency, when, in fact, a significant cause of their financial woes is a very sick membership base. It receives many groups and individuals who are deemed uninsurable by the indemnity insurance companies and HMOs, and it is virtually impossible to have underwriting gains under such circumstances."

I will talk a few minutes on information systems. Mr. Chairman, I have to admit that I found the staff statement and discussion on information systems to be particularly inaccurate, damaging and misleading.

Chairman NUNN. Mr. Morchower, let me back up just one moment. You make reference to a December 1992 Wall Street firm, Donaldson, Lufkin and Jenrette, study. Our staff hasn't had access to that study. We have never seen the study.

Mr. MORCHOWER. I cannot explain why you haven't. But, again, I will make sure that you get it.

Chairman NUNN. Was that an internal study done?

Mr. MORCHOWER. No. It was a study performed by themselves.

Chairman NUNN. All right, but I mean was it for internal purposes or was it public?

Mr. MORCHOWER. Public.

Chairman NUNN. It became a public document?

Mr. MORCHOWER. Yes.

Chairman NUNN. Filed with the insurance department?

Mr. MORCHOWER. No. It was just a research study that they performed and made available to all of their customers, clients, etc.

Chairman NUNN. I see, so this was an analytical product, not done at your request?

Mr. MORCHOWER. That is correct, sir.

Chairman NUNN. OK. It would be helpful if we had that.

Mr. MORCHOWER. In terms of information systems, first, Empire was budgeted to spend $100 million per year on data processing when I joined the company in 1987, not the $525 million noted in the staff statement. Then, fully 80 to 85 percent was spent on systems maintenance. Now, we are spending most of our resources on the development of new, state-of-the-art systems. Many old and redundant systems have already been eliminated. Our aim is to eliminate all duplicative systems, and our technologies have been recognized and acknowledged by clients to be superior.

The staff report cites certain negative statements from the work of Arthur Andersen and Towers Perrin, but those quotes, respectfully, leave a misleading impression. Let me complete the picture with additional information from the same studies and same work that was quoted in the staff report from Towers Perrin and Arthur Andersen.

Towers Perrin stated, "The current systems strategy has high reward potential" and "Empire has taken steps toward successful implementation and to manage the risks" involved in development of a complex strategy. Arthur Andersen also said, "The size of the maintenance group has dramatically been reduced since 1990, with most of the resources shifting to new development work." "Image, work stations and relational databases form the technological building blocks of the system of the future. Empire has brought all the pieces together int he development of CS/90 and EXCEL."

Further, "Empire has done a good job in keeping the use of consultants to a minimum while not placing its projects at risk or becoming too dependent on the consultants." "Although this (the EDP projects) is a significant corporate investment, the aggregate benefits resulting from each of these initiatives will be significant." "To Empire's credit, the company has used the new technologies . . . to significantly streamline and automate specific work flows within the context of their existing processes."

The staff alleges also that, according to one former vice president, CS/90 was scheduled for completion in 1990, but the contract

for this project was not even signed until June of 1990. Only preliminary work began as early as 1988 and that included movement of all of the Albany systems into the New York systems. This was not the first phase of CS/90. In addition, this did not result in a supposed loss of thousands of claims. Indeed, to confirm that all hospital claims were processed, the claims thought to be lost were resubmitted and matched to our paid claims file to ensure that they were paid and paid correctly.

The staff statement properly pointed out problems with the first accounts converted to CS/90. Such problems typically occur whenever a major new system is installed. The statement, however, did not mention that the second major implementation went smoothly and is providing ever greater improvements in productivity than originally estimated.

I will talk for a minute about generic codes and physician provider files. The staff stated the Empire routinely paid claims to doctors, dentists, pharmacies, hospitals and durable medical goods providers without verifying whether any of these providers even exist. The staff stated that these payments exceed $500 million every year and result from weaknesses within the plan's computer systems. The staff has overlooked many important controls. This is a very complex issue. I will try to be brief in explaining the situation.

At the outset, it is important to note that 21 percent of all claims are rejected because they fail to meet our control criteria. Also, generic codes are utilized by most, if not all, health insurance carriers. There is no national database for physicians, DOs, private duty nurses, registered nurses, hospitals, durable medical equipment providers, etc. Even when generic codes are used, many controls exist which will determine whether or not a claimant is paid.

Empire is required by State regulation to accept all claims forms. These forms must have specific information, such as the patient and customer information, the exact services rendered, the diagnosis, a charge for each service, the provider's name and address, and an itemized attached bill, before they can be processed. Claims without this information are not processed. Approximately 2,500 claims each day are rejected because this critical information is missing.

All claims above certain dollar thresholds, regardless of whether they are generically coded or not, are suspended for special review prior to payment. All payments to providers and subscribers are looked at in total, in the aggregate, to see whether there is anything abnormal about the totals or if they exceed certain specified limits, and they are flagged for investigation.

Examiners are trained to recognize invalid bills, and we are also working to reduce the use of generic codes. The Blue Cross and Blue Shield Association is developing a new inter-plan processing system called ITS, which will price and code claims and verify the provider at the local plan, and it is scheduled to be implemented April of 1994.

Generic codes are also used for the processing of prescription drug claims. However, claims processors examine drug claims and verify that the drug dispensed requires a prescription and is classified in the Physician Desk Reference manual. We also require an

original receipt from the pharmacy which must include the name and address of the pharmacy, the name of the drug, the prescribing physician's name, the prescription number, and the quantity.

We performed a cost-benefit analysis to determine whether we should look up the drug code, key it into the system, and enter the specific drug codes instead of a generic code, and determined that it would cost subscribers $6 million more per year than would be saved in preventing a few mis-paid claims. In the near future, however, generic prescription drug coding will be eliminated, as these claims will be out-sourced to a third-party vendor for all community-rated products after approval is received from the insurance department. This step will enable on-line, real-time validation of the dispensing pharmacy. Since March 1993, durable medical equipment claims are processed using definitive coding and pricing.

With respect to the New York portion of the physician provider file, Empire began in 1992 to revalidate the file using the New York State license data. As a result of this, 56,000 MDs and DOs on the file were compared with the State file. Approximately 3,000 providers were unmatched and have not responded to letters or phone calls. For those 3,000 physicians, 228 claims valued at approximately $125,000 are currently suspended. We are not paying those claims if we can't find the physician.

This time period is approximately two-and-a-half months, from April 2 through June 15, and if you extrapolate that on an annual basis, it comes to a potential payment of $600,000 for unmatched, unverified providers. Even if we assume that all of these providers are not bona fide, which I do not believe to be the case, the extent of possible mis-payment in any one year is $600,000, a tiny fraction of the amount cited by staff.

Finally, I have appended to my statement for your review a description of all of the checks that we go through to prevent duplicate processing of so-called generic-coded claims, and I will spare you the technical detail today, but it is attached and I will be happy to review all of our logic in this area with staff.

Mr. Chairman, we pay a lot of attention to these issues. The accusation that we would pay a claim submitted on a napkin is just wrong and unfairly maligns a lot of hard-working, conscientious and dedicated people. No control system is perfect, but we feel that ours is good and is being made better constantly.

Chairman NUNN. Mr. Morchower, that statement was made by one of your internal auditors to our staff. That wasn't a staff conclusion. That was a quote from one of your own internal auditors.

Mr. MORCHOWER. A claim submitted on a napkin would be paid is from one of our people?

Chairman NUNN. Yes, sir.

Mr. MORCHOWER. Well, regardless of where it came, it is absolutely not true.

Chairman NUNN. This statement was made by Mr. Tom Ward, who is head of your Empire anti-fraud unit.

Mr. MORCHOWER. Mr. Ward is incorrect in his statement.

Chairman NUNN. Well, he is the man in charge of that.

Mr. MORCHOWER. I am the man in charge of processing the claims, sir.

Chairman NUNN. On this point about your internal fraud, let me show you examination request number 131 dated March 5, 1993. Let me just read it to you and then I will show it to you. This is from the New York Insurance Department by Mr. Martin Schwartzman.

He says, "As you are aware, I have commenced a review of Empire's program security fraud investigative unit. In discussions with Ms. Velez, Mr. Dobbs and Mr. Ward, it was acknowledged that one of the most significant problems hampering any effort the company makes to combat fraud and abuse is the use of dummy codes to process claims. In fact, dummy codes were implicated in many of the fraud cases uncovered by program security, and in some cases they appear to have facilitated the fraud. It is my understanding that problems associated with the use of dummy codes were brought to the attention of Mr. Donald Morchower, chief operating officer, on or about 1990 as part of 20 recommendations to close the window of opportunity for fraud. Although a copy of these recommendations were requested as part of the examination request 131, dated February 23, 1993, they have not been provided. The examiners have been provided fraud detection recommendation updates, dated August 25, 1992, and January 31, 1993, which appear to address some of the recommendations for the CS/90 system only. However, it is noted that dummy codes are still in use."

So, I mean this is not simply a staff conclusion. This is a conclusion by your own people, and also by the New York Insurance Department.

Mr. MORCHOWER. I am familiar with the letter, sir. Dummy codes—generic codes are still in use. The risk is much less, in my judgment, than indicated in the report. We are closing the magnitude of the risk even further, and I think we have—and we have a task force working on implementing many of the recommendations that came out of Ms. Velez' unit and that came out of the recommendations from the State Insurance Department.

Senator MCCAIN. Why can't you just stop using them?

Mr. MORCHOWER. The problem is if we get a claim in, for example—if one of our subscribers is traveling out of State and our provider file contains New York providers only. There is no national provider file. We cannot determine that the physician is, in fact, a valid physician. We do not have the license number on file and things like that.

Absent a national file, the other alternative is to phone the local plan or try to get additional information. The local plan, given our volumes, is not going to be receptive to constantly following up on a situation like this. The Blue Cross Association is dealing with it, and that is the new system that is coming up in April of 1994. So it is recognized nationally that something has to be done about it and it is being worked on so that out-of-area will be solved.

The drug problem, the pharmacy problem that I mentioned a second ago—we are going to a vendor that will do all of our pharmacy prescription fulfillment, tied into the local pharmacy, on-line, real-time, with a card. It will be validated immediately. So we are taking steps, but there is no single file that contains nurses, RNs, durable medical equipment vendors, physicians, hospitals, etc.

Even given that, we have a program to try to develop our own and we have already found 7,000 physician records from out of State and we have already added them to our file. So we are trying to piece it together and we have a detailed work plan to do it, but it is not as easy as saying let us do it and let us get all—even the 50 States don't have all of their records in single places, and not all of them have them mechanized, sir.

Let me talk for a minute about, if I may, Empire's alleged blue chip mentality. For a company such as Empire, it is a vexing problem to meet marketplace standards of performance expected from a Fortune 500 company while meeting the standards of frugality expected of a not-for-profit status company. The necessary balance is elusive.

Clearly, the staff report concluded that we had missed the balance by a wide margin. I don't believe the answer is that simple and I would like to address just two examples of the unfair, in my judgment, exaggeration in the staff statement—automobiles and employee awards.

The staff statement identifies Empire's fleet of 82 corporate vehicles purchased for its officers as perhaps the most costly of all corporate perks at Empire. Again, we need to set the record straight. First, we only have 61 officers. Second, only 20 of them have automobiles. The remainder are for salespeople and for moving mail and other information among our many locations. Cars for officers or any other employee are based upon job requirements. We did a cost-benefit analysis to see whether we should run our own fleet or out-source it to a rental company, and it is cheaper for us to run our own fleet.

I also think that the staff statement did a grave injustice to all of Empire's employees when it described the company as "bestowing" gifts on its employees. Most corporations, whether for-profit or not-for-profit, honor their employees for years of service and outstanding achievement. To say that Empire, because it is not for profit, can't do the same is absurd.

I think it unfair for the Committee staff to criticize Empire for the following practices that are standard in all industries, private, for-profit, not-for-profit, and government. The staff statement implied that employee awards are high-end items such as jewelry or clocks. This is not true. While service milestone awards—5 years, 10 years, etc.—may include such items, Empire's service awards are well within industry norms.

For example, an employee with 25 years of service receives a gift with an average value of $316, an average of $12 per year of service. Moreover, the average cost of the Circle of Stars awards, the most frequently given award for jobs well done, is about $13.

Chairman NUNN. Mr. Vogt, do you agree with the gift policy as Mr. Morchower defends it?

Mr. VOGT. Chairman, I do. I believe it is necessary to keep a workforce motivated and to recognize their success and contributions to the organization. I don't find it unusual at all. It has been done in most of the not-for-profit corporations I have been with for the last 40 years.

Chairman NUNN. I thought you testified that the board directed Empire to eliminate gifts nearly 2 years ago in recognition of the

fiscal constraints impacting the organization. That is what you said.

Mr. VOGT. For directors, sir.

Chairman NUNN. For directors only?

Mr. VOGT. Members of the board of directors.

Senator MCCAIN. Mr. Vogt, is it appropriate that if someone's limousine breaks down that he should rent another one for $11,000 for a 2-month period?

Mr. VOGT. I don't know how appropriate it is. I have no idea what instance you might be talking about, sir.

Senator MCCAIN. According to media reports, the company limousine broke down, Mr. Cardone rented one for 2 months at a cost of $11,000.

Mr. VOGT. I don't know the accuracy of that report, sir.

Senator MCCAIN. If it is accurate, is it appropriate?

Mr. VOGT. I would have some difficulty with it, sir.

Senator MCCAIN. Thank you.

Chairman NUNN. Mr. Vogt, do you make a distinction when the company is losing money and when it is making money, or do you make the distinction as to the appropriateness of gifts even for employees during a period of time where you are having to raise the rates by in some cases 200 or 300 percent in a 2- or 3-year period, and go to the New York State Legislature to basically seek relief?

I mean, it seems to me there is a distinction between a company in distress as to its gift policy and its catering policy and all of that and one that is making money. Wouldn't you think there would be a distinction there, or do you just operate as usual no matter how much money you are losing?

Mr. VOGT. We are a not-for-profit, Senator, and not-for-profits aren't supposed to make money. We do have reserves. We return those reserves to no one except our ratepayers—no shareholders. I don't think it is inappropriate to award employees some recognition of their service, and I think the total amount of those awards is such an insignificant blip in the total expense costs of this corporation——

Chairman NUNN. You don't think it has any psychological effect with broader implications that go throughout the country in terms of setting the tone? You gave a directive to eliminate gifts nearly 2 years ago. Our records indicate that the board spent $50,000 in gifts and party expenses for the board just in 1991, and an additional $18,000 in catering expenses in 1991; last year, $11,000 in catering expenses, $5,000 in gifts to the board. Last year, Empire spent over $300,000 in gifts and awards to employees for things like perfect attendance, donating blood, and participating in the United Way.

I can see those things happening in a company that is really returning some real benefit to its stockholders in a profit sense or, in the case of a non-profit, returning a managed kind of company that doesn't have to increase premiums every year and really ask the policyholders to pay more and more. It seems to me there is a fundamental distinction here as to the climate and the atmosphere when you are losing huge numbers of dollars. Not-for-profit does not mean you wanted to lose $300 or $400 million in a 2-year period, does it?

Mr. VOGT. No, sir, it does not.

Chairman NUNN. Do you see a distinction as to when you are making money, or do you basically in the board believe that you keep policy as usual even if you are having extreme difficulty and having to go back to the policyholders for more and more premiums?

Mr. VOGT. For the employees, sir, we do believe that they should be recognized, yes.

Chairman NUNN. No matter what the condition of the company?

Mr. VOGT. Well, we have a need to maintain a workforce in order to serve our subscribers, and that workforce—we count on it to do a great deal of work. They process a lot of claims every day, they receive a lot of phone calls every day. How they react and how they handle all of that is very important to us, and when it is done well they should be recognized for doing it. And I think doing it well is important at any point in the company's fiscal plight.

Chairman NUNN. So $1.1 million in 5 years in terms of gifts for employees and the board in a period of time where you are having to raise the premiums to the average person insured out there and go to the State of New York for extraordinary legislative relief—you believe that is an appropriate policy?

Mr. VOGT. One point how many million, sir, in 5 years?

Chairman NUNN. I think it is 1.1.

Mr. VOGT. In 5 years?

Chairman NUNN. Service gifts.

Mr. VOGT. I think it is appropriate. I have no reason to think it is not.

Chairman NUNN. Why did you cut out gifts to the board, then?

Mr. VOGT. It was the board's decision. It was the board's decision not to accept any gifts. We don't serve with any compensation whatsoever. There are 48 plans, about 89 percent of them in this country, that do provide monetary compensation to their boards at the rate of about $9,600 a director. We don't—in any event, sir, we don't have any compensation coming back to our board.

Chairman NUNN. OK.

Mr. VOGT. And if we looked at those costs on a per-director basis, maybe we are talking about $800 a year per director.

Mr. MORCHOWER. Mr. Chairman, may I add something to that, please?

Chairman NUNN. Sure.

Mr. MORCHOWER. We have taken a lot of action with respect to these things, such as we eliminated the employee annual picnic, we eliminated retirement dinners, we eliminated a lot of high-cost items. What remains is the one small gift of a vase or an inexpensive watch, but most of the expensive things have been eliminated.

Chairman NUNN. I have here, Mr. Morchower and Mr. Vogt, just the top officers here. Just several weeks ago, in spite of all the problems, my figures indicate the staff received from Empire the incentive payments. Mr. Morchower, you had a $45,000 payment, a 12-percent increase, during this whole period; Mr. Weissman, $21,000, a 10-percent increase in incentive payment; Drewsen, $22,000, an 11-percent increase; Furey, $16,000, and that is a 9-percent increase; and Schlesinger, $18,969, an 11-percent increase. Now, these are incentive payments, correct?

Mr. VOGT. No, sir, that isn't correct. If I may, this is a portion of salaries that these employees place at risk based upon the attainment of goals that are set by the board of directors. In other words, they have the potential to earn the full amount of their salary, but a portion of that is placed at risk based upon performance of the company, as set—the goals set by the board. It isn't a bonus. It is part of their compensation package.

Chairman NUNN. But this was during a period of time where the company was taking staggering losses and going to the people of New York for more premiums and to the State legislature for legislative relief. What would they have gotten if you had been making a profit and keeping your premiums level?

Mr. VOGT. Well, if they had met their goals, they would have gotten 100 percent of the pool that was set up for this as part of the payroll.

Chairman NUNN. Did they not get 100 percent of the pool?

Mr. VOGT. No, sir. They got 50 percent of the pool, or less. I don't know what——

Mr. MORCHOWER. Less than 50 percent.

Chairman NUNN. Fifty percent of the pool, and yet it was still a pool that was big enough to accommodate these kinds of incentive increases in a period of time where the company was clearly going downhill and at risk by almost anybody's definition.

Mr. MORCHOWER. Sir, this was money taken from employee raises, officer raises, which had been frozen and set aside for incentive compensation. It was part of what would have been their base pay. It was a portion of the base pay taken out and put in a pool to be given only if certain performance goals were met at the corporate, divisional and individual level.

Chairman NUNN. OK, go ahead.

Mr. MORCHOWER. I would like to talk for a few minutes about our relationship with Sigma Corporation, which was addressed—if I may, sir, if I have the time—that was addressed in the staff report and has received a lot of publicity.

The Committee has raised questions about the relationship between Empire and Sigma. Before I joined Empire in July 1987, Empire engaged International Systems Services Corp. on a time and materials basis, fee-for-service basis, to explore the practicality of imaging certain Empire processes. More than 6 months after Empire asked ISS to cease work, Empire entered into a formal arrangement with Sigma for professional services related to the imaging system known as OmniDesk.

We looked at product offerings from IBM, FileNet and other vendors, and it became apparent that the systems were essentially microfilm replacements, lacking the work flow component so critical to Empire's core business of processing claims. In addition, these systems used expensive proprietary software and none had the capability or capacity to handle our huge daily volumes.

Against this backdrop, let me address the genesis of the Empire–Sigma relationship and the circumstances under which it continues. Dr. William Stratigos, a principal of Sigma, a voting member of Empire, not a member of Empire's board of directors, as was so often stated in the Committee statement, had a business relationship with ISS. However, in late 1987, I became aware of an issue

raised by Mr. Cardone over Dr. Stratigos' role as a voting member of Empire. Voting members meet annually to elect the board of directors and have no other governance function.

Dr. Stratigos had disclosed his ISS activities to Empire's project officer. Nevertheless, Dr. Stratigos voluntarily resigned from the voting board on November 1, 1987. So how did Empire into a business relationship with Sigma?

Late in 1987, Empire was considering alternatives to ISS. In early 1988, Dr. Stratigos informed me that Mordechai Beizer, ISS' chief technical resource, had resigned from ISS in late 1987. Dr. Stratigos added that as of January 1988, Mr. Beizer had joined Sigma. Mr. Beizer, a magna cum laude graduate in computer science from Yale University, with an MBA from Harvard Business School, had impeccable credentials and several years' experience in developing commercial software.

Sigma also possessed a great deal of what Empire needed; namely, clear title to the intellectual property for which Empire had paid ISS, and now a highly skilled technical resource who was intimately familiar with the software and with what would be required to attract, secure and manage additional specialized resources familiar with imaging. Contrary to published reports, Sigma was considered because of the technical skills of Mr. Beizer, not Dr. Stratigos.

Without regard to a particular vendor, Empire formulated a corporate strategy to modernize many aspects of its information systems. By early 1988, we believed that Sigma had the potential to help with these initiatives. At my direction, Empire negotiated the following agreement. Empire would own all of the intellectual property developed by Sigma. Empire would set the priorities of what was to be developed and in what sequence. Empire would set an annual budget based on prior year's performance, and Empire would receive 95 percent of all revenues from Sigma from the sale of its software and derivative products to third parties. In return, Sigma would receive 100 percent, not 60 percent, of their actual costs, no mark-up, for Empire-dedicated resources; office space, although Stratigos provided free office space during 1988; and 5 percent of the royalties for sales to third parties.

In April of 1988, Empire and Sigma entered into a business relationship that is clearly defined and we believe fair to Sigma and favorable to Empire. The staff questions whether there have been delays in Sigma's work. The only two major causes of delay were beyond Sigma's or Empire's control. In the first case, Sigma was dependent on IBM's new OS/2 software operating system. The delays associated with the delivery and subsequent stabilization of OS/2 were well publicized by both the trade journals and the press. As a result, Sigma, Empire and the rest of the world all incurred delays in their OS/2-based development projects.

In the second case, we became aware of more reliable and more cost-effective hardware, specifically high-speed scanners and high-capacity archives manufactured by Eastman Kodak, and we switched to that equipment.

The staff statement also suggests that Empire overpaid for Omni-Desk by comparing it to a system developed by another vendor. But without specific details, it is impossible to assess the value or fair-

ness of such a comparison. For example, how large is that system? What are the daily volume requirements of the customer? What are the ongoing costs of maintaining the system, etc.?

Indeed, from a cost perspective, I believe that the Arthur Andersen report says it best, "The fees for this custom systems development effort appear reasonable given the technical environment, the scheduled number of work stations to be installed, and the capabilities of the system scheduled for delivery at the end of 1993." Further, from 1988 through 1992, Empire's share of Sigma's revenues from sales to third parties amounted to over $5 million, which translates into savings for our subscribers.

Sigma's technical competence is illustrated by its resellers, which include Unisys Corporation, Wang Laboratories, Ameritech, Marubeni, TSI International, to name a few. Sigma's direct sales customers, won through competitive bidding, include such companies as Chase Manhattan Bank, Consolidated Edison of New York, Sears, Roebuck and Company. Customers of Sigma's resellers include nearly 100 major companies worldwide and Sigma software has won major industry awards in the past 2 years. Empire, I might add, won a BIS imaging excellence award in 1991 for installation of OmniDesk at our Yorktown Heights processing facility.

The staff questions Empire's ability to price its business, pay claims and collect premiums effectively. With the assistance of leading-edge technologies, these basic abilities are clearly present today and are improving daily.

On the pricing situation, Empire's experience-rated business is priced on a highly analytical basis. All major proposals consider over 50 variables in aggregating the cost to process claims, handle inquiries, and perform membership transactions. These variables include reasonable expectancies of claim processing productivity, claims and service volume projections, supervising requirements, involvement of other plans, location, and start-up costs. Contrary to staff's view, costing information might appear to lack consistency, but this is because the information necessary to price all accounts varies considerably from one customer to another.

"Cost allocation is a problem with the experience-rated groups losing money," said one vice president. Not true. Empire's allocations have been reviewed and approved by the Office of Inspector General of the Department of Health and Human Services, the Federal employees health benefits program, the New York State account, and Arthur Andersen and Company.

"Profitability is not controlled by sales since price is dictated by underwriting." This is a true statement and it is consistent with most insurance companies. Sales personnel do not determine price, for the obvious conflict of interest reason.

Claims paying: The assertion that Empire is unable to process claims also is untrue. Staff states a number of remarks from hospital personnel. Example: Empire does not begin to review claim status until 30 days have passed after submission. That is simply erroneous. Our production standards and quality controls are monitored daily. Hospitals may check claim status on-line electronically at any time, and that is available at 97 percent of the hospitals in New York State, accounting for a vast majority of private sector claims in the State.

In addition, the staff states that receivables from Empire alone average 60 to 65 days of delinquent claims pay-out, which for one hospital totaled $12 million. This would be troubling if true, but Empire pays clean claims from New York hospitals in about 6 days. By contrast, in 1992, hospitals took an average of more than 77 days to submit outpatient claims to us. They take 77 days; we pay it in 6. If they submitted it in 6 days, they would get paid in 12 days.

It took 67 days, on average, for hospitals to submit inpatient claims to us. At the same time, Empire provides the hospitals some $250 million in cash advances to compensate for expenses incurred by hospitals on claims which have not been submitted or paid; in other words, work in process. If hospitals, again, sent us their claims sooner, they would be paid sooner.

Premium collection: Overall, our accounts receivable balance is approximately $320 million, of which 78 percent has been outstanding 60 days or less. Vigorous collection efforts, coupled with automatic policy cancelation and claims payment holds for non-payment of premium, have resulted in a steady decline in premium from 1991 to present. As staff notes, accounts receivable over 91 days, December 1991, were $99 million. This number is now $67 million, a $32 million improvement. It clearly demonstrates our ability to manage premium collection effectively.

Customer service: The staff statement stated that Empire received over 5 million complaints or telephone inquiries directly from our subscribers last year. That statement is both accurate and misleading. Only 1.7 percent of these contacts, of these 5 million calls, were due to processing errors and resulted in corrections. Ninety-three point eight percent were for information, blank claims forms, referrals, updates, resolution of administrative issues, which are an integral part of the service we render.

Mr. Chairman, I hope my testimony has helped you better understand Empire Blue Cross and Blue Shield, the problems it faces, and the initiatives we have taken to solve them. I hope that we have demonstrated that we know how to price our product, collect premiums in a timely and accurate manner, and accurately and efficiently pay the more than 25 million claims that we process each year, and I might add with a greater than 97-percent financial accuracy rate, which is within industry norms.

I also realize, though, that we have a way to go to prove to you and to your Committee and our other constituencies that we deserve our historic and ongoing role as a vital part of the health care delivery and financing system in New York and the Nation. I hope you recognize the important steps we have already taken down that road.

I thank you very much.

Chairman NUNN. Thank you, Mr. Morchower.

Ms. Velez, do you have a prepared statement you would like to make or would you just like to respond to questions?

Ms. VELEZ. I do not, Senator, but I would be happy to answer any questions you may have.

Chairman NUNN. OK, good.

Mr. Morchower, I have here a statement that is—really, these are the internal notes of the Towers Perrin report where they are

interviewing you. This is dated 1-26-93, and I will send this out to the desk and let you look at it, but there is a category here that says "performance indicators," and these are the notes they took from you and this is allegedly what you said, "No sense of efficiency compared to other carriers, other Blue plans."

Now, your statement today paints a totally different story of that.

Mr. MORCHOWER. No sense of efficiency compared with—I do not recall ever making that statement.

Chairman NUNN. Why don't you take a look at it? These are not your notes. These are notes that were taken from an interview Towers Perrin had with you.

Mr. MORCHOWER. The context in which that was made was that I didn't have a basis for going through a plan-by-plan comparison because different plans measure and process—they asked me how do we stack up against plan A, plan B and plan C, and I said I didn't have a basis for doing that comparison.

Chairman NUNN. That is not what the note said. I mean, that may be what you think you said. That is not what the note——

Mr. MORCHOWER. It says, no sense of efficiency compared to other carriers, other Blues plans, because it is so difficult to compare apples to apples, although Empire's administrative expense is 7 percent.

Chairman NUNN. OK. You talked about all the things Empire is doing right, and that is in spite of having to go back over and over again to the legislature and basically getting some very favorable treatment there. You said there were internal problems. What is wrong with Empire? If you listed five things that are wrong with Empire, what would they be now, or three things?

Mr. MORCHOWER. First, we do not have a long-term vision of where we should be going as a corporation with respect to managed care, and that is one of the highest priorities that Mr. Vogt and I set out to do when we assumed command, albeit temporarily. So we need a long-term vision.

Second, regardless of how well we are doing in customer service, customer service has to be improved even further. Our new technologies will enable us to do that. Third, employee morale is terrible. One of our biggest jobs is to make the people feel proud of this corporation and to give them a sense of worth.

Fourth, one of the reports—I think it was the Andersen report—said Empire has no friends out there. We have to establish relations, build relationships or rebuild relationships with all of the external constituencies—the regulators, the legislators, the media, the providers, the customers, etc.

We have to take a look at our product line. We have too many products to attempt to administer, which makes it very difficult, and we have to reduce the number of different products we have and that is a major short-term initiative.

We have to make sure we adhere to our schedules for delivering the new software. We say that by 1995, all accounts will be converted and we must ensure that that happens.

I think those are the major things, Senator, Mr. Chairman.

Chairman NUNN. Mr. Weissman, do you know Joan Boyle?

Mr. WEISSMAN. Yes, I do, Senator.

Chairman NUNN. Did she work for Empire?

Mr. WEISSMAN. For a short period of time, she was both a consultant and an employee of Empire.

Chairman NUNN. Do you know William Fuessler?

Mr. WEISSMAN. Yes, I do, Mr. Chairman.

Chairman NUNN. And did he work for Empire?

Mr. WEISSMAN. My recollection is that he worked for Empire for a period of about 2 years.

Chairman NUNN. Do you recall, Mr. Weissman, some time in late January or early February 1992 meeting with Bill Fuessler and Joan Boyle concerning a discrepancy that Mr. Fuessler had found between the black book numbers and the actuarial numbers filed with the insurance department as Schedule 5?

Mr. WEISSMAN. Yes, Senator, I recall meeting with both of them.

Chairman NUNN. Do you want to tell us about what you recall?

Mr. WEISSMAN. My recollection is that Ms. Boyle and Mr. Fuessler were preparing a presentation for an officers and directors meeting that related to the officers incentive compensation program for 1992. They had reviewed figures at the time for 1989 and 1990 and observed the discrepancy. Since they wanted to include 1991 figures in their presentation, they asked me if the internal accounting records for 1991 were the accurate records to be used for the purposes of that presentation.

I indicated to them that since the presentation would be made in the next couple of days that we would not have completed the statutory filings with the State until the end of the month, and therefore I felt it was appropriate for them to use what we refer to as the black book or the internal accounting statements, since the State filing wouldn't be ready for an additional 2 to 3 weeks. That was the extent of my recollection of that meeting.

Chairman NUNN. Ms. Boyle testified last week about that meeting and she said the following, quoting from her testimony, "When I showed Jerry the numbers, he appeared nervous and repeated what Sharon Schmerzler had said. The black book numbers were for internal purposes and the actuarial numbers were for external purposes. When I asked Jerry which ones were accurate, he said the black book figures were right and the other figures were more politically acceptable." She went on to say, "I was very disturbed by this and told Jerry that he had a professional obligation to present accurate figures. At that point, Jerry folded his arms and told me to talk to Al about it. When I asked Jerry if Al was aware of the two sets of figures, he didn't respond except to tell me to talk to Al."

What do you say about that testimony?

Mr. WEISSMAN. I don't believe that that characterization is accurate with respect to the meeting that we had. Again, I told her to use the internal accounting records because at that time we had not completed the State filings and I didn't think we would have those figures available in time for the presentation.

Chairman NUNN. Do you remember using the term "politically acceptable?"

Mr. WEISSMAN. Absolutely not.

Chairman NUNN. You remember not using it? You are clear on that?

Mr. WEISSMAN. I am clear that I did not use that term.

Chairman NUNN. If she says you used that term, then she is either mistaken or is not telling the truth. Is that right?

Mr. WEISSMAN. I believe that is true, yes, Senator.

Chairman NUNN. And you realize you are under oath?

Mr. WEISSMAN. Yes, I do.

Chairman NUNN. We also have testimony from Mr. Fuessler where he says, "Shortly thereafter, she arranged a meeting with Jerry Weissman, at which time we presented the two schedules and noted the discrepancies and asked him to explain the difference. Mr. Weissman agreed there were different numbers and said it was politically more beneficial to show the numbers that way."

Do you agree with Mr. Fuessler's testimony?

Mr. WEISSMAN. No, I do not.

Chairman NUNN. So he is wrong or he is telling an untruth, is that right?

Mr. WEISSMAN. That is my opinion, sir.

Chairman NUNN. In the notes Ms. Boyle prepared contemporaneously with that meeting she wrote, "On 2–3 late in the day, 5:30 p.m., I went with my staff person to see Jerry Weissman. When shown the facts, he clearly said the black book numbers are right, but the other numbers are more politically acceptable."

Did you say that?

Mr. WEISSMAN. No, I did not, Senator.

Chairman NUNN. You never used the words "politically acceptable?"

Mr. WEISSMAN. No, I did not.

Chairman NUNN. Do you recall what you did say?

Mr. WEISSMAN. Again, I indicated that at that point in time we did not have the statutory blanks available for 1991 which was going to be the basis of the presentation, and I said that since there were no other numbers at that point that I felt the black books were correct and that that is what they should use for the purposes of that presentation.

Chairman NUNN. Ms. Boyle goes on to write in her handwritten notes concerning her meeting with you on February 3rd and she states as follows, "He," meaning Jerry Weissman, "also said the manipulated numbers are filed in the annual blank as Schedule 5." Do you recall having said that?

Mr. WEISSMAN. I don't think I would have used the term "manipulated." I think reallocated on the basis of additional information was the term that I used.

Chairman NUNN. Are you swearing you didn't use the term "manipulated?"

Mr. WEISSMAN. I do not recall——

Chairman NUNN. I will strike the word "swear." Are you testifying that you are not using the term "manipulated?"

Mr. WEISSMAN. I do not recall using the term "manipulated."

Chairman NUNN. You could have used it, but you don't recall? What is your precise testimony?

Mr. WEISSMAN. My precise testimony is that I believe that I said that there were reallocations that were made on the basis of updated information.

Chairman NUNN. Mr. Weissman, did you use these figures to try to convince the State Insurance Department to grant new rate increases and the State Legislature to change the law dealing with community rating at that time? Is that the reason these numbers were used?

Mr. WEISSMAN. At the time we had several meetings with the Department of Insurance. Over the 2-year period 1991 and 1992, Empire Blue Cross actually lost about $400 million on its community-rated or regulated lines of business. Quite frankly, I can't understand how a $20 million difference could have made a difference to the legislature as to whether they would have passed a bill or not.

Chairman NUNN. Ms. Boyle goes on to say in her contemporaneously prepared notes the following, "I asked AAC"—and I assume that that is Mr. Cardone—"I asked if AAC knew what was happening, and JW"—I assume that is Jerry Weissman—"said yes." Is that what you said?

Mr. WEISSMAN. Yes. I said that Mr. Cardone was familiar with the fact that we had the internal set of accounting records and that we used updated information in developing the statutory filings.

Chairman NUNN. Tell us how you knew that Mr. Cardone was aware of this.

Mr. WEISSMAN. My recollection is that I had a discussion with Mr. Cardone, one discussion in 1989 when we first started preparing the internal accounting records, and I informed him of the fact at that point, since that was a rather new process, that I was uncomfortable with some of the allocations in the internal accounting records and that there would be differences between those figures and the figures used in the State filing. And, again, this came up in 1991 when we were preparing one of the quarterly filings where I had indicated that I thought that, on the basis of the work that the actuarial department had done, some reallocations would be appropriate.

Chairman NUNN. Do you remember telling the staff that in early 1991 you informed Empire's chairman, Albert Cardone, of anticipated large losses in Empire's experience-rated business?

Mr. WEISSMAN. Yes, I do.

Chairman NUNN. Do you remember explaining that this conversation took place at the time Empire was preparing to file its quarterly report with the insurance department?

Mr. WEISSMAN. Yes, I do.

Chairman NUNN. You stated that the projections you provided to Mr. Cardone during that conversation were based on figures you had derived after making your customary reallocations. Is that correct?

Mr. WEISSMAN. That is correct, sir.

Chairman NUNN. You also stated in your deposition that Mr. Cardone told you that, quoting from that deposition, "This is not a time for me to be super-conservative and show losses that were greater than we expected the actual results to be, and that I had better make sure that if you were showing losses that, in fact, these losses did occur." That is from page 218 of your deposition. Do you remember testifying to that?

Mr. WEISSMAN. Yes, sir, I do.

Chairman NUNN. Is that accurate, and you still stand by that?

Mr. WEISSMAN. Yes, sir.

Chairman NUNN. What did you mean by this?

Mr. WEISSMAN. What I meant by that, sir, was that we had just gotten approval for a rather significant rate increase on our community-rated line of business that was effective March 1st of 1991. I believe the rate increase was about 17 percent. I went in to Mr. Cardone and I said that while the plan for the year called for the corporation to approximately break even that it was then my projection that we were going to lose about $150 million.

The primary reason for that was losses on the community-rated lines of business. However, I also felt that at the end of 1990 when we had put together our projections that we were overly optimistic about the results on the experience-rated lines of business, that there were losses that I was then aware of, some union situations, some association groups. And basically I told him that the reserves that we had built up over the prior 3 years—and I think you have heard earlier this morning that we increased reserves about $135 million between 1988 and 1990—that we were going to wipe out those 3 years of increases in 1991.

Chairman NUNN. In your staff deposition, page 221, 222, again quoting you, you stated, "I think I was upset that he 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 I took a look at the reserves, and my recollection is that whatever adjustments that I had recommended initially between the internal accounting report and the statutory report, that I increased the adjustment between the experience and the community-rated business."

Is that correct?

Mr. WEISSMAN. Yes, sir.

Chairman NUNN. Do you stand by that statement?

Mr. WEISSMAN. Yes, sir, I do.

Chairman NUNN. Do you believe that Mr. Cardone wanted you to change the numbers so the losses for the experience-rated business were lower and the losses for the community-rated business were higher?

Mr. WEISSMAN. I believe that what Mr. Cardone wanted was to make damn sure that the numbers that I was reporting were accurate and that we were not overstating losses.

Chairman NUNN. In which category?

Mr. WEISSMAN. Probably both, but more so on the experience-rated side.

Chairman NUNN. But you were basically shifting. It wasn't a matter, as I read the numbers, of exaggerating losses. It was a matter of which category the losses were occurring in, and how much.

Mr. WEISSMAN. If at that time I had felt that there was a material overstatement or understatement of losses, I believe that we could have changed the internal accounting records at that point on the basis of additional information, and may have changed the overall loss or gain result as well.

Chairman NUNN. Did you, in fact, change the numbers?

Mr. WEISSMAN. To the best of my recollection, I did make an additional adjustment at that point.

Chairman NUNN. What was the effect of that change?

Mr. WEISSMAN. My recollection is that the result was to moderately increase the loss on community-rated and decrease the loss on the experience-rated lines of business.

Chairman NUNN. And the result of that was really intended to reduce the experience-rated claims?

Mr. WEISSMAN. I don't think that was the intent. The intent was to listen to the instructions that I had gotten from Mr. Cardone, to review the numbers, and to make sure that I felt comfortable with the numbers that were being presented.

Chairman NUNN. OK. Let me read you this deposition. You tell us if there is anything in it that is wrong. These are the questions by the staff and the answers you gave. "Do you recall whether the impact of these new adjustments were to raise the community-rated claims and lower the experience-rated claims?" Your answer: "My recollection is that the additional adjustments were intended to reduce the experience-rated claims." Do you recall that answer?

Mr. WEISSMAN. Yes, sir, I do.

Chairman NUNN. The next question: "Why was that the intention?" Your answer: "Because my feeling of the conversation with Mr. Cardone was that what he was telling me was that it was all right to show experience-rated losses if that is what I believe the situation to be. However, if I showed losses on the experience-rated that turned out to be greater than they ultimately were, then I was in trouble." Do you recall that statement?

Mr. WEISSMAN. Yes, sir, I do.

Senator MCCAIN. What kind of trouble?

Mr. WEISSMAN. I felt, walking out of the meeting, that if the losses were overstated that it meant my job.

Chairman NUNN. Then you went on: "Now, previously you said that your recollection was that he didn't really differentiate what kind of losses he was talking about. So why did you come away with the impression that he was most concerned with the experience-rated losses?" Your answer to that is, "I mean, because, you know, the community-rated losses again—you know, those could easily be blamed on cherrypicking, on increased enrollment in the non-group, losses in Medigap, on the fact that the superintendent had cut back on the rate increase request." Do you remember saying that?

Mr. WEISSMAN. Yes, sir, I do.

Chairman NUNN. Is that accurate?

Mr. WEISSMAN. Yes, I believe it is.

Chairman NUNN. And then you went on to say in your answer, "I didn't think that he took that as really his problem. However, if we were going to show losses on the unregulated business or the experience-rated business, that would show the company in an unfavorable light." Is that correct?

Mr. WEISSMAN. Yes, sir.

Chairman NUNN. So, basically, you knew your job was going to be gone if you didn't basically make the community-based losses as high as possible and the experience-rated losses as low as possible?

Mr. WEISSMAN. I wouldn't characterize it that way, Senator. I would say that if I had overstated the losses, then I thought my job was on the line.

Chairman NUNN. Ms. Velez, did you have occasion to discuss this matter we have just been into with Mr. Weissman, I believe on June 16th of this year?

Ms. VELEZ. Yes, I did, Senator.

Chairman NUNN. Could you tell us the context of that meeting and then tell us your recollection of what was said there?

Ms. VELEZ. Sure.

Chairman NUNN. Give us your position first for the record.

Ms. VELEZ. I am vice—my name is Maroa Velez. I am vice president of the Internal Audit Division of Empire Blue Cross and Blue Shield, and that includes responsibilities for the internal audit function, as well as the program security area which is charged with the responsibility of investigating fraud, and, lastly, the group integrity area which is charged with the responsibility of investigating membership fraud.

Chairman NUNN. OK, and I believe you filed an affidavit with the insurance department about this, did you not?

Ms. VELEZ. Yes, I did.

Chairman NUNN. Would you just tell us the content of that affidavit, if you would like to refer to it, however you would like to testify?

Ms. VELEZ. I don't have it in front of me.

Chairman NUNN. Perhaps you would just like to refresh your recollection or just read—the most material part on this question, I believe, is paragraph 3, but whatever parts you think are material.

Ms. VELEZ. Senator, I would like to make clear that the insurance department did not ask me to give the whole story relating to this matter. They just asked me to relay the portion relating to the conversation that took place on June 16th. So if you would like, I will read the portion from the affidavit that relates to that conversation and answer any questions you may have subsequent to that.

Chairman NUNN. That would be fine.

Ms. VELEZ. Paragraph 3, quoting from my affidavit, "The conversation in question took place during the morning of June 16th in my office at Empire. Mr. Weissman and I were the only ones present. The subject of the conversation was the discrepancy between the community-rated and experience-rated losses as reported in the market segment reports included in Empire's internal financial statements, as compared to those figures reported in the annual statements. Mr. Weissman stated that there was no supportable reason for these differences in 1991, 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.

"Immediately after the conclusion of my conversation with Mr. Weissman, I went to meet with Harold Vogt, chairman of Empire, and recounted the entire conversation, as well as certain other events leading up to the conversation. Mr. Vogt then directed me to provide this information immediately to Alan Drewsen, the general counsel of Empire, and I did so. I also promptly contacted by

telephone Donald Morchower, the acting chief executive officer of Empire, and gave him the information as well."

Chairman NUNN. Thank you.

Mr. Weissman, do you agree with Ms. Velez' summary here?

Mr. WEISSMAN. No, I do not, Senator.

Chairman NUNN. Tell us where you differ.

Mr. WEISSMAN. I think there are two important places where I differ. I believe Ms. Velez' question to me with respect to Mr. Cardone's instruction was, did Al speak to you, and my answer to that was yes, and I think I have testified earlier this morning as to what exactly the conversation was that took place between Mr. Cardone and myself.

The other area where I disagree with Ms. Velez' testimony is I believe the question was if I thought there was supporting documentation to support the reallocation, and I said I didn't know if there was any.

Chairman NUNN. You said you didn't know if there was any documentation to support the reallocation?

Mr. WEISSMAN. That is correct.

Chairman NUNN. Now, why do you reallocate if you don't have anything in back of it?

Mr. WEISSMAN. Well, again, at the time I was going through the underwriter's records. I was reviewing individual reserves for some of our larger accounts, and that was the basis upon which I made the adjustments. I don't know if detailed documentation was maintained at the time either by myself or within the actuarial department that would support the reallocations that were made.

Chairman NUNN. Mr. Weissman, isn't it true that you really reallocated because that is what Mr. Cardone wanted and you knew your job was at stake?

Mr. WEISSMAN. No, sir, that is not the case.

Chairman NUNN. It is not the case?

Mr. WEISSMAN. It is——

Senator MCCAIN. Can you provide the Committee with the documentation that motivated you to change those numbers?

Mr. WEISSMAN. I am sorry. I didn't hear the question.

Senator MCCAIN. Can you provide the Committee with information that motivated you to change those numbers if it was not your conversation with Mr. Cardone?

Mr. WEISSMAN. Again, my conversation with Mr. Cardone was much earlier in the year. At the time that we were doing the statutory blanks that we are referring to, that was probably 8 or 9 months later. I am not going to say that I didn't have Mr. Cardone's conversation in the back of my mind when I was preparing the figures. However, I believe that I prepared the most accurate figures possible for 1991, and on the basis of a subsequent review of the IBNR or the reserve, I believe that the figures that I reallocated were significantly more accurate than the original allocations done by the actuaries.

Chairman NUNN. Mr. Weissman, I am quoting from the affidavit Ms. Velez just read—and, Ms. Velez, you are saying this affidavit is accurate today, are you not?

Ms. VELEZ. Yes, I am.

Chairman NUNN. You stand by this affidavit?

Ms. VELEZ. I stand by it.

Chairman NUNN. And you say Mr. Weissman told you, and I am quoting from this affidavit again—"Mr. Weissman stated there were not 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."

Ms. VELEZ. That is correct, Senator.

Chairman NUNN. Mr. Weissman, you are saying that is wrong?

Mr. WEISSMAN. I believe that that is mischaracterized in, again, two areas that I have identified. The question was if I had a conversation with Mr. Cardone, to which I answered yes, and if I thought that there was supportable documentation, which I think differs from the testimony that Ms. Velez gave.

Chairman NUNN. Well, are you saying there was supportable documentation or not?

Mr. WEISSMAN. Again, I don't know if there is written documentation.

Chairman NUNN. Well, if you don't, who does?

Mr. WEISSMAN. I would have to check my files. For the last few weeks, I have not been allowed into the building, so I don't know if there is supportable documentation or not.

Chairman NUNN. Mr. Weissman, in your deposition to staff you were asked the question on this same subject, do you think your original numbers were more accurate than your new numbers, and your answer then was, "Obviously, I thought they were more accurate. That was the basis on which I went in to Cardone in the first place."

Mr. WEISSMAN. Again, that conversation took place early in 1991. The conversation that—the issue that we are discussing about now had to do with numbers that were prepared in early 1992. They are two different conversations.

Senator MCCAIN. And you are telling the Committee that you are not sure whether there is documentation or not to support your change in the numbers. Is that a correct assessment?

Mr. WEISSMAN. Again, I don't know if there is written documentation. If I had access to my files, I may be able to find them.

Chairman NUNN. We have here Ms. Boyle's notes that were contemporaneous notes that she wrote down and presented to us and are in this hearing record, and basically they show the 1989 and 1990 figures and they basically show that the black book numbers, Mr. Weissman, on community rating showed a $20 million profit and the Schedule 5 numbers filed with the insurance commission showed a $23.7 million loss, so from a $20 million profit to a $23.7 million loss. Do you remember whether these are correct or not?

Mr. WEISSMAN. To the best of my knowledge, those are correct.

Chairman NUNN. Do you think that is a significant shift?

Mr. WEISSMAN. Again, it has to be put into the overall context of the corporation. The corporation is about a $6 billion corporation. A shift of $40 million may sound like a lot, but it is under 1 percent in the context of the overall corporation.

Chairman NUNN. But that is not the question. The question on the bottom line is on a non-profit corporation, you are not going to show a whole lot one way or the other. It is a very, very large

amount of money when you are looking at the bottom line and if you are looking at setting rates, is it not?

Mr. WEISSMAN. Well, those numbers had nothing to do with setting rates. There were separate rate applications that were filed with the insurance department at different points in time. They used the latest information available and at no time did they include either the numbers in the black books or the numbers in the State filings.

Chairman NUNN. Now, you show on the 1989—the experience rating black book showed $21 million in losses and your Schedule 5 showed $22.6 million in profit. Is it your view, also, as the chief financial officer, or former chief financial officer, that this also is insignificant?

Mr. WEISSMAN. Again, put in the context of the overall corporation, it was less than a 1-percent shift.

Chairman NUNN. Well, it was just about 80 percent—well, 70 percent, as I figure it—60 to 70 percent of the total reserves. Your reserves at the end of 1992 were $40 million.

Mr. WEISSMAN. I believe——

Chairman NUNN. And you are talking about a swing here of $40 million in community rating. If you look at the whole swing from a $23 million profit to a $20 million loss, and vice versa, you are talking in terms of almost 100 percent of the total reserves of the company.

Mr. WEISSMAN. I believe that the figures that the Senator is reading from relate to 1989. In 1989, the reserves of the company were about $160 million.

Chairman NUNN. OK. That is 25 percent of the reserves, then. Is that still insignificant?

Mr. WEISSMAN. Again, these are not being viewed in terms of the bottom-line reserves of the company. These are being viewed in terms of reallocation of the IBNR and the IBNR—if the premium base was about $6 billion, the IBNR was about $2 billion, and therefore the shift in the IBNR that we are talking about is about 2 percent.

Chairman NUNN. Well, Mr. Weissman, if these were so insignificant, why did you think your job was on the line if you were wrong?

Mr. WEISSMAN. I did not think that that was the case in 1989 or 1990. The year that I thought, and I had the conversation with Mr. Cardone, related to the year 1991, and at the time Ms. Boyle put together this document we did not know what the shift would be between the internal accounting work papers and the State statutory filings.

Chairman NUNN. Well, it would seem to me you would be really pretty offended to think that your job was going to be on the line and you might be fired for such an insignificant, trivial matter.

Mr. WEISSMAN. I wasn't offended. Again, you know, I took it——

Chairman NUNN. Did you think Mr. Cardone was just trivial and petty, or did you think he was really capable of taking this kind of action against you? You just said you thought your job was on the line. Did you think he would take that kind of action against you over such small matters, as you have described them?

Mr. WEISSMAN. I think that if the company had shown losses on its experience-rated business that were greater than what they actually ultimately proved to be that, yes, my job was on the line.

Chairman NUNN. So you are saying that Ms. Boyle's testimony is wrong?

Mr. WEISSMAN. In the aspects that I identified earlier, yes, sir.

Chairman NUNN. And you are saying Mr. Fuessler's testimony is wrong in those aspects that you have identified?

Mr. WEISSMAN. That, and one other aspect. If I may, Senator, I believe that Ms. Boyle in her testimony identifies that on February 4th, the day after our conversation, that I was out ill. I have checked my calendar. I had internal meetings in the corporation and I think that is another area where her testimony is incorrect.

Chairman NUNN. How about Mr. Fuessler's testimony? You are saying it was wrong, too, in those respects?

Mr. WEISSMAN. Yes, sir.

Chairman NUNN. How about Ms. Velez? You are saying she is wrong in what she has testified here to today that occurred on June 16th?

Mr. WEISSMAN. Again, in the two areas that I identified, yes, I believe she is wrong.

Chairman NUNN. Mr. Weissman, do you think you have a problem as the chief financial officer when your own conversations are so misunderstood by the people working directly under you?

Mr. WEISSMAN. None of these people worked for me, sir.

Chairman NUNN. Well, they obviously were involved in financial matters or they wouldn't have been questioning these areas. Do you think you have got a problem in communicating?

Mr. WEISSMAN. I don't think as a general rule I have a problem communicating.

Chairman NUNN. How do you explain this? Do you think these people are after you or something?

Mr. WEISSMAN. I don't know what the motivations may be.

Chairman NUNN. Mr. Cardone, you have heard all of this. Did you tell Mr. Weissman to move losses from the experience-rated accounts to the community-rated accounts?

Mr. CARDONE. No, Senator.

Chairman NUNN. Never?

Mr. CARDONE. I did not. Never.

Chairman NUNN. Did you put pressure on him and indicate to him where you thought these matters should come out?

Mr. CARDONE. No, Senator, I did not.

Chairman NUNN. Why do you think he believed his job was on the line?

Mr. CARDONE. It is important to go back to the first quarter, early 1991, and understand what was happening. We had come off of 3 years, 3 profitable years, and almost out of nowhere we started to see increases in the amount of claims that were being paid for our community-rated customers at an unprecedented level in the corporation's history, and this was brought to Mr. Weissman's attention and he brought it to my attention.

It was the subject of many meetings with the senior officers of the corporation who were involved and responsible for both experience- and community-rated lines of business. And when Mr. Weiss-

man came to me and said, Al, we have got a problem because while one month—I remember the expression that actuaries use a lot, one month doesn't make a trend—it now looks that this pattern is persistent, and the financial plan that we had that called for break-even was going to have to be changed.

And I pressed my chief financial officer hard—that is my style—and made it quite clear that, yes, we are in a—Empire is in a fish bowl, and with the magnitude of the losses that we could be talking about here, there was the need for the best actuarial estimates and the best accounting possible. That was the tone of that conversation. I did not threaten Jerry, saying that I would fire him, but I was clear that because of the dynamics in the marketplace, because of the exposure of Empire to financial losses, I needed the best actuarial estimates and the best accounting I could get, and I would hope that any chief executive officer would behave the same way. That was the tone of that meeting. That is precisely the way it went, and I think what is very telling here is Mr. Weissman's response to Senator McCain's question. In the final analysis, the numbers that were filed proved to be the better numbers, and I think that is the bottom line.

Chairman NUNN. Mr. Cardone, do you remember meeting with Ms. Boyle about this discrepancy in numbers?

Mr. CARDONE. Yes, sir.

Chairman NUNN. Her notes indicate, quoting her notes that she testified to, part of the record, "Al claimed no knowledge of the situation; said he didn't believe any of the numbers—they are all jelly—and was very dissatisfied." Do you agree with that?

Mr. CARDONE. No, sir, I do not agree.

Chairman NUNN. She is wrong?

Mr. CARDONE. I do not agree with the context, the characterization. I might have said we are in an area where numbers move, and they do, and I have so testified under oath, and they should. I was a little surprised that Ms. Boyle, considering her years of experience with an insurance company, wasn't more knowledgeable about the fact that you are going to have these timing differences and we are dealing with a moving target, which is why I dispatched her to the CFO of the corporation.

Chairman NUNN. You don't ever remember saying "they are all jelly" in terms of the numbers?

Mr. CARDONE. Frankly, Senator, I might have said that because we are dealing with subjective estimates, and any insurance expert who is qualified will tell the Committee so.

Chairman NUNN. Mr. Vogt——

Mr. CARDONE. This is an art, not a science.

Chairman NUNN. Mr. Vogt, who made the decision that Jerry Weissman was to be relieved from his job without pay?

Mr. VOGT. The board of directors did, sir.

Chairman NUNN. Could you tell us why?

Mr. VOGT. It was upon recommendation of counsel, Mr. Obermaier, who is conducting the investigation, sir.

Chairman NUNN. Well, what was the nature of the offense? Isn't it unusual to have someone laid off without pay?

Mr. CRACO. One moment, Mr. Chairman.

Chairman NUNN. Yes, sir.

[Mr. Vogt consulted with counsel.]

Mr. VOGT. Mr. Chairman, as I indicated, I think, earlier, we were advised based upon the results of Mr. Obermaier's investigation up to that point that it would be desirable to have Mr. Weissman placed on leave without pay. The investigation is still in progress and I don't have any specifics at this point in time, but it was the recommendation of our audit committee of the board and the board itself.

Senator MCCAIN. You relieved Mr. Weissman without pay without any specifics?

Mr. VOGT. Pardon?

Senator MCCAIN. You relieved Mr. Weissman of his duties without pay without being briefed on any of the specifics?

Mr. VOGT. I think we did have specifics. In fact, this whole investigation was triggered by the fact that Mr. Weissman left the building immediately upon being advised that Ms. Velez was going to be coming into my office and reporting this incident.

Senator MCCAIN. Mr. Vogt, if I understand your answer to Senator Nunn's question, it was that Mr. Weissman was relieved without pay because of recommendation of counsel.

Mr. VOGT. That is correct.

Senator MCCAIN. And my follow-up question is were you given any additional information as to why the counsel made this recommendation, and if so can you share it with this Committee?

Mr. VOGT. I was not—the audit committee may have additional information, sir.

Senator MCCAIN. You had no additional information, except the recommendation of the counsel?

Mr. VOGT. Recommendation of counsel and the report that I received from Ms. Velez.

Chairman NUNN. What was the report you received from Ms. Velez?

Mr. VOGT. The report was that she was unable to get a satisfactory answer on the difference of the two figures, on the two reports, and that she had been stonewalled by most of the people who worked for Mr. Weissman in terms of giving any information.

Chairman NUNN. Is that correct, Ms. Velez?

Ms. VELEZ. Yes, Senator, it is.

Chairman NUNN. Why don't you tell us what you think about this two sets of books and two sets of numbers? Do you think we are talking about something we shouldn't be worried about as trivial and doesn't matter, insignificant, or do you think this is significant?

Ms. VELEZ. Senator, the only thing I can say is that we have to wait until the end of the investigation. I started—I began the investigation, as you heard before, at the request of Harold Vogt, some time around June 3rd and I have spoken to Jerry on numerous occasions as to why these differences occurred, as well as some of his staff, and I was never able to get the right answers to the questions.

Chairman NUNN. Had you known there were two sets of books?

Ms. VELEZ. No. Up until right around this time, Jerry even showed me that there were—there really aren't two sets of books,

Mr. Chairman. I just want to clarify that. There are the internal financial statements and then there are the statutory blanks.

Chairman NUNN. OK.

Ms. VELEZ. For the record, it is not two sets of books.

Chairman NUNN. Well, the discrepancy between the internal and——

Ms. VELEZ. Discrepancies between the—I tried speaking to Mr. Weissman's comptroller. I asked him for the reasons why there would be discrepancies in these numbers and he was not able to articulate why, and he was also not even able to tell me why they hadn't been reconciled.

I had discussions subsequently to that with Mr. Weissman's actuaries and they were not able to articulate the matter. In fact, all that they asked me to do was to speak to Jerry, speak to Jerry as to why there would be discrepancies. When I demanded—and that is a harsh word, but that is exactly what occurred—when I demanded the documentation supporting the information on Schedule 5, they refused to give it to me. They asked me to see Jerry, and that brings us up through June 16th where Jerry and I had the conversation about this matter and Jerry told me that there was no documentation and that, in fact, the reason why there was a discrepancy in 1991 was because he had been instructed by Mr. Cardone to make the differences.

With respect to 1990, it was an immaterial amount. He didn't remember very much about it; it was only $8 million. And with respect to 1989, what he said was that we had had problems with the claims data. There had been a migration of the system from Albany down to New York. It had screwed up our claim payments patterns because we had had to stop claim payments for a while, but that what he felt had been filed with the insurance department was, in fact, the best estimates of the company at the time.

Chairman NUNN. What turned out to be accurate on those 1989 numbers?

Ms. VELEZ. Well, that is what we are trying to determine right now, Mr. Chairman.

Chairman NUNN. You still don't know?

Ms. VELEZ. We still don't know. We have to look at all the ultimate claim payments and find out what the true numbers, in fact, turned out to be, recognizing that at the time that the filings were made, as Mr. Weissman did say, they were estimates.

Senator MCCAIN. Has it been your experience that this kind of internal discrepancy exists anywhere else in your experience?

Ms. VELEZ. Well, in my—I am an accountant. I am not an actuary, but there are differences sometimes between the final books and statutory filings. And if, in fact, those adjustments are because we have found information—an error, that we made an error in the prior period and were correcting the error, then I wouldn't find that to be unusual, but there would be supporting documentation for that difference.

Senator MCCAIN. And you have seen no supporting documentation?

Ms. VELEZ. No, I have not.

Senator MCCAIN. Are you getting cooperation now?

Ms. VELEZ. At this time, I am not the one conducting the investigation. The investigation is being conducted by the outside counsel.

Senator MCCAIN. May I ask what Mr. Morchower's response was when you informed him of this problem?

Ms. VELEZ. On June 16th?

Senator MCCAIN. Yes.

Ms. VELEZ. Mr. Morchower at that point was very distressed by the matter. He wanted to make sure that the appropriate parties had been informed, and that included both this Committee as well as the insurance department, and he wanted the investigation to start as quickly as possible, and it did that afternoon.

Chairman NUNN. So, basically, you were asked to take on the task of determining how you could reconcile these numbers and you went to Mr. Weissman and his people and you were, in effect, stonewalled, is that right?

Ms. VELEZ. Given explanations that didn't make sense to me, Mr. Chairman, and when I asked for supporting documentation, it was not given to me. So for a couple-of-week period there, I was stonewalled.

Chairman NUNN. Mr. Cardone just said the information filed with the insurance department turned out to be more accurate than the internal information. You are saying that you don't know that yet, is that right?

Ms. VELEZ. I don't know that yet, but that may turn out to be true.

Chairman NUNN. How does he know that? Is there any documentation that would permit him to know that? Have you seen anything that would permit him to make the statement he just made that that——

Ms. VELEZ. I have not, Mr. Chairman, but maybe he has.

Chairman NUNN. OK.

Senator MCCAIN. Do you want to respond to that?

Chairman NUNN. Mr. Weissman or Mr.——

Mr. WEISSMAN. I would like to. In 1991, at the time that—shortly after I reported to Mr. Cardone the fact that we were seeing losses that were greater than had been projected in 1991, we brought in the independent consulting actuarial firm of Milliman and Robertson, and I believe that at the end of 1991—I believe it was in December of 1991—they issued a report which indicated that for the year 1989 that the IBNR had been overstated by approximately $100 million, and that in 1990 it was their impression at that point that the IBNR had been overstated by about $45 million. So there is an actuarial report done by an independent consulting actuary that at least for the years 1989 and 1990 it indicates that the reserves were more than adequate.

Senator MCCAIN. Is that what you were referring to, Mr. Cardone?

Mr. CARDONE. Yes, Senator.

Senator MCCAIN. What about 1991?

Mr. CARDONE. Senator, my recollection is that in terms of our statutory filings, I got comfort, great comfort, from attending meetings of the audit committee where independent actuarial experts of the firm of Milliman and Robertson, and also the firm of Deloitte and Touche, were called upon to do a mid-year review of the esti-

mation of the benefits paid that took them deep into all of these actuarial estimates. And I always took great comfort from those outside professionals in their reporting to the board committee, the audit committee, that they were satisfied with the estimation process, with the methods that were being used, and the like.

Senator MCCAIN. Mr. Weissman, do you believe that you stonewalled Ms. Velez or refused to give her the information she sought?

Mr. WEISSMAN. Again, Ms. Velez was looking for specific documentation. I had not looked at that time to check my files to see if we had the kind of audit trail and documentation that I thought would satisfy Ms. Velez. I had given her a letter that we had sent to Arthur Andersen a couple of weeks earlier which was a partial explanation of what had been done.

My recollection is that in a hallway conversation she indicated that this is "BS," that your letter to Andersen is not correct. I said I would be pleased to sit down and discuss it with her, take her through it in greater detail. I do not believe that I was afforded that opportunity at that time.

One of the criticisms, I may add, in the Milliman and Robertson report of late 1991 was the fact that there was inadequate documentation to support some of the reallocations and some of the reserves that we had done, and in 1992 we fixed that problem by having a memorandum that was included in the actuarial department's reserve file on a monthly basis that clearly elaborated what the changes—the subjective changes that were being made either by the actuaries, the underwriters, or myself.

Chairman NUNN. Ms. Velez, do you want to respond to that?

Ms. VELEZ. Yes, Senator. Over the course of the last 2 weeks, I have had numerous—sorry—over the course of the period between June 3rd and June 16th, I had numerous conversations with Jerry Weissman. I have never, ever told him that he can't—that I would not give him an opportunity to discuss the issue.

When he refers to the fact that I said that the memo was "BS," what I said was that I didn't understand how he could attribute the differences to an explanation that he had written in the memo to Paul Gauthier, and that was a letter dated May 17th, which was—the differences were the differences between the top-down versus bottom-up approach of allocating the reserves. And I articulated to him why I did not understand that theory as being a plausible theory with respect to explaining the differences in 1991.

I also further—and we are going to have to get into a story, and I am sorry, but I spoke to him on that at great length. We tried to tie in the numbers. I brought in my directors to try and tie in the numbers because we couldn't even tie in the numbers initially. That was cleared up.

On Tuesday, June 6th, I believe, I brought in his deputy chief financial officer and I asked him to explain to me the differences between the two numbers and if, in fact, it could be attributed to the top-down versus bottom-up approach. That didn't make sense to me, and the reason it didn't make sense to me, Mr. Chairman, is the fact that both of the numbers for claims, both on the internal financial statements as well as on the statutory blank—the source of both of those numbers come from the actuarial area.

The bottom-up numbers, which is the underwriter's calculation of reserve, is only taken—it only impacts premium; it does not impact claims. So after discussing that at length with his deputy chief financial officer, he too accepted the fact that this isn't a plausible explanation, but what he said is maybe it is sloppiness that we have had throughout the numbers, but we have never reconciled them.

I went back to Jerry. We tried to have this conversation one more time, and I also told him that I was going to proceed by looking at the information in the actuarial area. On June 15th, I asked to speak to Sharon Schmerzler, who is one of the actuaries in Jerry's area, because her boss, Dave Sanders, was in Chicago. I asked Sharon to come down and speak to me. Sharon at that point was—I told her what I wanted to talk to her about. She was very nervous and she—every time I asked her to explain the differences to me, she asked me to take it up with Jerry Weissman.

Jerry interrupted the meeting twice to speak to Sharon. Sharon came back in the room finally at the end of the day, and at this point she was very distraught. She was crying. She told me that she wanted to leave the room and that she didn't want to talk anymore; would that be possible. And I said, obviously. She left. I went to see Jerry. Jerry wasn't there that night.

The next morning, early in the morning, I called my directors and asked them to get the supporting documentation directly from the actuarial area, to meet them in the actuarial department. My directors did so, and Sharon would not turn over the documentation. She was very upset. She said, go see Jerry.

The next morning, I got in around 10 o'clock because that is how long it took me—since I stayed home to talk to my directors—to get into work. I spoke to Jerry. I saw Jerry. I asked him to step into my office. I told him what is going—I asked him, Jerry, what is going on, and he repeated the conversation that I gave to you a few minutes ago. He said, there is no documentation; we should just leave this issue alone.

Chairman NUNN. So you are basically saying what Mr. Weissman testified here to today is wrong?

Ms. VELEZ. Yes.

Chairman NUNN. OK. At this stage, I have one other area I would like to get into, Ms. Velez, but I will do it very briefly and then come back to it and then I want to turn it over to Senator Roth.

I have here a report from Harry Pantos dated March 22, 1993, subject: Year-End Status Report, Group Integrity Department, and it is addressed to you. If I could send you that, there is a bracket down at the bottom of that report. If you could just look at the report and give us a brief statement on the context and then tell us what that last sentence means to you on the bracket? Could you just give us the context of that and tell us what that—maybe read that last sentence and tell us what that meant in terms of the context of that report?

Ms. VELEZ. As a brief background, I am sure that your staff is well aware of the efforts of this department, Mr. Chairman, but for your information let me tell you that the Group Integrity Unit is charged with the responsibility of conducting audits of groups that

have had losses to ensure that its membership adheres to the underwriting guidelines of Empire Blue Cross and Blue Shield, and they have results that will have—for example, we will cancel a group if they don't have minimum penetration or we find that there are people in the group that are not legitimate employees of that group, and we will cancel them from the group membership as well.

What this statement here, which I will read for the purposes of the record—"Little or no evidence of cherrypicking was found on the part of those groups audited." What my people were saying was that they didn't find in the audits that they have conducted—and at the time in 1992, I believe it was 2,004 group audits—they had not found evidence of dumping of bad risk onto a group, meaning that they had not found evidence where they had gone into a plant that employs 100 people—they had not found that we have 10 people who are very sick and 90 people are insured by Aetna, which is one of our concerns. We want to make sure that in the groups there would not be dumping.

However, I should mention for your purposes, Mr. Chairman, that I would think that from a common-sense standpoint, if there was dumping to be had that it would probably be in our direct-pay pool, as opposed to in the groups. It would be a lot harder to dump in the groups than it would be to dump in our direct-pay.

Chairman NUNN. So you did not find cherrypicking or dumping in this audit on these groups, but you are saying that doesn't answer the question overall?

Ms. VELEZ. That is correct. I think that if we were to find dumping, it would probably be in our direct-pay pools.

Chairman NUNN. Has anybody done an analysis in the direct-pay pools to determine if there really is cherrypicking and dumping there?

Ms. VELEZ. My division has not done that analysis, Senator, but I think that there are other areas in the company that have, in fact, been looking at this issue.

Chairman NUNN. Have you seen any report that documents in an analytical form at all that there is cherrypicking and dumping going on in any group? Have you seen a documented written report?

Ms. VELEZ. I have not seen a report, but that doesn't necessarily—I don't see every report in Empire.

Chairman NUNN. You don't see every report, right.

Ms. VELEZ. So it may very well be that such a report exists.

Chairman NUNN. Well, that is something we haven't seen either. As we discussed with Mr. Morchower, this is the very heart of a whole lot of the argument about Blue Cross and Blue Shield and the legislative battles and the rate-setting and all of that, and yet we don't seem to be able to find any analytical report that documents that and is subject to being examined in terms of accuracy.

At this stage, let me turn to Senator Roth. He has been very patient.

Senator MCCAIN. Could I just ask—Mr. Morchower, did you testify earlier that that information will be made available to the Committee?

Mr. MORCHOWER. Yes, sir.

Senator McCAIN. And you had no response as to why, in the last 6 months that the Committee has been asking, we haven't received it?

Mr. MORCHOWER. I was not asked for it, as I remember. Whether they asked somebody else in the corporation who didn't know it existed or what, I don't know. It does exist. I will provide it to this Subcommittee.

Senator McCAIN. Thank you.

Excuse me, Senator.

OPENING STATEMENT OF SENATOR ROTH

Senator ROTH. I do have an opening statement which I won't read at this time in its entirety, but I do want to make a couple of points because it seems to me that these hearings focusing on the problems experienced by the Empire plan, the largest Blue Cross/Blue Shield plan in the country, show that size alone is no guarantee that a plan is well-run, and it most certainly is no guarantee that it will be well-regulated.

The New York Insurance Department has the second largest budget of any State insurance department, more than $62 million. New York also has the fourth largest staff of any State insurance department, with 788 full-time employees. Now, despite these resources, PSI staff investigators have found that the regulation of Empire has been woefully inadequate. They have detected a pattern of action which appears to border on favoritism. The staff report went on to assert that, in essence, Empire has become too big to be allowed to fail. So the question arises, has Empire really turned the tables. Do we have a case of the regulated ruling the regulators?

I believe that the issues that are being raised in these hearings have very important implications for the ongoing debate on how to best reform our health care system. If, as some have suggested, entities far larger than Empire are created to administer health care in this country, how will they be effectively managed and supervised?

My own view is that the Empire case demonstrates that over-reliance on government regulation to control health care and health costs produces only a false sense of security for which the public inevitably winds up paying a steep price. I do not believe we can have meaningful reform of health care by relying solely on government regulation or government-created entities.

Relying too heavily on the government to regulate health care without the discipline of market forces is like giving a transfusion to a patient without first stopping the bleeding. Market competition is the most effective tourniquet that we have available to stem the flow of rising health care costs. We need meaningful competition, not just government-managed competition.

So, Mr. Chairman, I would ask that my full statement be included as if read.

Chairman NUNN. Without objection, it will be.

Senator ROTH. Now, Mr. Cardone, I would like to ask you some questions in another area. I would like to ask you some questions

regarding Empire's Medicare secondary payer policy, sometimes known as MSP. I am sure you are familiar with the program.

Mr. CARDONE. Yes, Senator.

Senator ROTH. So that everybody understands what we are talking about, the MSP program involves primarily the working elderly, people who are over 65 years of age but are still employed, and through their employment they have private health insurance.

Now, legislation has been enacted into law that requires that the primary insurance by which the working elderly are covered pays the primary cost of medical bills, while Medicare pays secondarily. In other words, if you have a senior citizen over 65 who is eligible for Medicare but is working and has insurance, under the law it is required that the insurance be the primary payer of any health costs and Medicare is secondary. You are familiar with that, Mr.——

Mr. CARDONE. I understand that, Senator.

Senator ROTH. This is a matter of considerable interest to both the Subcommittee and the Government because some time ago we held extensive investigations on this matter and we found that because some insurance companies were knowingly sending bills which they should have paid to Medicare, the Federal Government was losing something like $1 billion a year. In other words, Medicare was paying where the insurance company should be paying.

Now, I understand, Mr. Cardone, that Empire has a contract with the Federal Health Care Financing Administration. Is that correct?

Mr. CARDONE. Yes, sir.

Senator ROTH. And how large a contract is that?

Mr. CARDONE. It is probably close to $100 million.

Senator ROTH. $100 million a year?

Mr. CARDONE. $100 million. We serve as the intermediary for the Federal Government in the Medicare program.

Senator ROTH. So it is a very sizable contract, $100 million a year?

Mr. CARDONE. Yes, sir.

Senator ROTH. You mentioned the word "intermediary." Can you explain what Empire's responsibility under its contract would be as a Medicare intermediary?

Mr. CARDONE. It is to process claims submitted by Medicare beneficiaries for the Federal Government; for, to be more specific, the Health Care Financing Administration, HCFA.

Senator ROTH. When you say "process," what do you mean by "process?"

Mr. CARDONE. The claims processing, as well as customer service, which means receiving telephone inquiries and correspondence, and the payment of the claims to the providers—the administration associated with the Medicare program.

Senator ROTH. So to better understand the word "process," when you process, what the Federal Government is doing, as I understand it, is to pay Empire to make sure that the bills are sent to the proper payer. Isn't that the purpose of it?

Mr. CARDONE. The purpose of it is—and the Medicare program is quite specific in terms of what they reimburse an intermediary to do. It is a cost-based arrangement and they are very detailed in

terms of the specific procedures that they want you to carry out, and they satisfy themselves that the costs associated with carrying out those procedures are reasonable.

Senator ROTH. In other words, the purpose of the contract is to ensure that the proper medical costs are paid, that they are reasonable, and that they are paid by the proper party?

Mr. CARDONE. The reason I hesitate to say yes, Senator, is because we have made many recommendations to HCFA as to ways where we could pay less on behalf of the Federal Government, but the nature of the program is so structured and it is so specific that we are paid to carry out the procedures that are specified by the Federal Government through the Health Care Financing Administration.

Senator ROTH. The law does require that the insurance carrier be the primary payer, isn't that correct?

Mr. CARDONE. In the case of—could you be a little more specific with me on that when you say the law does require——

Senator ROTH. The law requires that the insurance carrier is the primary payer in the case of a senior citizen who is working and is covered by insurance?

Mr. CARDONE. That is my understanding of the law. If you have a person aged 65 or over who is working and there is supplemental insurance, the carrier responsible for the supplemental insurance should pay the claim and the Government would become secondary. That is my understanding of the requirement.

Senator ROTH. Now, Mr. Cardone, I would like to show you two Empire internal memoranda dated September 21, 1988, and October 24, 1988, that were provided to the Subcommittee by Empire.[1] You may want to take a minute to look at those.

[Pause.]

Senator ROTH. Now, Mr. Cardone, the September 21, 1988, memo——

Mr. CARDONE. Could I have a couple more minutes to read this, please?

Senator ROTH. Yes, sure.

Mr. CARDONE. Thank you. [Perusing documents.]

Senator ROTH. In the September 21, 1988, memo it appears to state that in 1986 Empire adopted a policy that, when Medicare had incorrectly paid an MSP claim as primary, Empire would only pay as a secondary insurer, even though Empire was, by law, the primary insurer. Was that, in fact, Empire's MSP policy?

Mr. CARDONE. Without studying this, I can't frankly respond to the question of whether this says that was the policy, but I can tell you this. My remembrance of this issue was that we complied with the law to the extent that we knew if a senior citizen was working and the responsibility for informing us as to whether or not that person was working, a retired person was working, was with the employer, and I believe that definitional dispute was the subject of a lawsuit and—I think this is where the corporation's counsel might be useful—a lawsuit that is still going on.

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[1] See Exhibit No. 78 on page 336.

Senator ROTH. Do you know the names Pat Blaise and Frank Herbert?

Mr. CARDONE. I do not. They are not familiar to me.

Senator ROTH. Well, let me quote from the September 21, 1988, memo. In the second paragraph it states that, "If we are only paying a balance after Medicare when Medicare paid in error, we are then collecting a premium for full coverage, however, only paying partial benefits." Isn't that exactly what Empire was doing, and isn't that policy a violation of Federal law?

Mr. CARDONE. I can't tell from this memorandum if that is what Empire was doing, Senator.

Senator ROTH. Well, let me quote from the September 21, 1988, memo. In the second paragraph the memo suggests that Empire adjust its payment rationale for MSP claims. Now, judging from that October 24, 1988, memo, that suggestion was rejected by Les Strasburg. Who is Les Strasburg and what position did he hold at Empire?

Mr. CARDONE. Les Strasburg was an actuary and his responsibilities changed, and I cannot really be specific as to exactly when they changed. I came to the company in 1985 and he was——

Senator ROTH. Wasn't he a vice president?

Mr. CARDONE. He was an officer of the corporation.

Senator ROTH. He was an officer of the corporation?

Mr. CARDONE. He was an assistant vice president, I believe.

Senator ROTH. Was he a vice president?

Mr. CARDONE. Well, when I came he was a director. I believe he was advanced to assistant vice president. He was in the actuarial division, and at some point he moved into one of our market segments as an—was responsible for underwriting, but I remember the name and the person. He has since left the company, I believe.

Senator ROTH. All right. Mr. Cardone, I would like to address your attention to the handwritten comments on the September 21, 1988, memo which apparently were written by Mr. Strasburg, the vice president. In the left margin next to where the memo suggests that Empire change its policy to comply with Federal law, Strasburg writes, "no way."

Mr. Cardone, were you aware that Mr. Strasburg rejected this attempt by Empire staff to correct the company's policy?

Mr. CARDONE. No, sir, I was not aware of that.

Senator ROTH. You were aware of the contract?

Mr. CARDONE. Yes, I am aware, was aware, of the Medicare contract.

Senator ROTH. Well, finally, I would like to direct your attention to the second paragraph of the October 24, 1988, memo which states, "In essence, he is stating that we should continue to only pay balances if Medicare has made a payment incorrectly as a primary. We will therefore continue making payment on these claims as we have been."

Now, Mr. Cardone, was this Empire's MSP policy at the time you left Empire earlier this year?

Mr. CARDONE. My understanding of Empire's policy as of the date that I left the company, which was June 1st, was that we were in compliance with the Medicare program. I believe there is still a definitional dispute that is the subject of litigation.

Senator ROTH. Well, certainly, in these letters it was recognized by Empire employees that the practice of the company was not in accordance with the law, nor does it seem to me was it in accordance with the contract.

Mr. Cardone, isn't it true that it was Empire, acting as a Medicare intermediary, which had incorrectly paid the MSP claim as the primary insurer?

Mr. CARDONE. Senator, I can't tell that from reading this correspondence.

Senator ROTH. You were the contractor, weren't you?

Mr. CARDONE. We were—we have had the Medicare contract almost since the inception of the program.

Senator ROTH. And the purpose of the contract was to ensure that the appropriate costs were paid in accordance with the law, isn't that correct?

Mr. CARDONE. I think that is a little too broad a responsibility to impose upon the intermediary.

Senator ROTH. Mr. Cardone, you earlier testified that the purpose of the law was that the primary payer of health costs of a senior citizen who was employed and covered by insurance was the insurance carrier and Medicare was secondary. You specifically agreed that that was the requirement of the law.

Now, are you arguing that the contract had some other purpose? Wasn't the purpose of the contract in hiring Empire as an intermediary to ensure that the law was complied with?

Mr. CARDONE. I am not arguing that, Senator. All I am saying is——

Senator ROTH. So you agree with that, is that correct?

Mr. CARDONE. I do within the context of what Empire was contractually obligated to do.

Senator ROTH. And isn't it true that Empire's left hand, acting as Medicare intermediary, was incorrectly overpaying MSP claims, while Empire's right hand knew this was going on but refused to correct it because it was to Empire's financial advantage not to do so?

Mr. CARDONE. I am not aware of that, Senator, and I cannot conclude from reading these memorandums that that was the fact.

Senator ROTH. Well, it was, of course, to the taxpayers' disadvantage, would you not agree with that?

Mr. CARDONE. If the assumptions that you made are correct, then it would be to the disadvantage of the taxpayer.

Senator ROTH. Mr. Cardone, the Office of the Inspector General of the Department of Health and Human Services is currently auditing Empire's compliance with the MSP program. Interim reports indicate Empire may owe Medicare as much as $150 million for failing to correctly pay MSP claims. Has Empire provided these memoranda to the inspector general?

Mr. CARDONE. I don't know.

Senator ROTH. Well, you have read the memoranda. Do you agree that they are a smoking gun that shows Empire was deliberately violating the law?

Mr. CARDONE. I think we have some people in middle management expressing some views, and I am not certain whether or not those are correct views. I have never seen these memorandums

until you presented them to me and I am not certain as to their factual accuracy.

Senator ROTH. Wasn't Mr. Strasburg a vice president, so he was an officer of the company?

Mr. CARDONE. At this moment of time, I am uncertain whether he was a director or an assistant vice president of the corporation. There is also something else on this memorandum that confuses me, and that is, just as you pointed out, on the left-hand side there are some handwritten comments, there is a dispute here because the same person who wrote "no way" also says "incorrect." So, apparently, we have a dispute in terms of the factual—or the presentation on these two sheets of paper.

Senator ROTH. The term "incorrect" is answered in the next memorandum and has nothing to do with the practice.

Let me ask, Mr. Morchower, are you familiar with this contract?

Mr. MORCHOWER. Yes, I am.

Senator ROTH. Are you familiar with this correspondence?

Mr. MORCHOWER. No. I had never seen the letters, and in 1988 my responsibilities were completely different than what they are today.

Senator ROTH. I am sorry. I couldn't hear you.

Mr. MORCHOWER. My responsibilities in 1988 were completely different than what they are today.

Senator ROTH. But you do have a current contract with HCFA?

Mr. MORCHOWER. Yes, sir.

Senator ROTH. Do you know what the policy is, whether this policy has been revoked or changed?

Mr. MORCHOWER. I don't understand the memorandum, but let me explain to you what we do do, which maybe would be more helpful. We have at the present time, and have had for several years, in the private sector an MSP unit. This unit receives both from our Medicare processing, the people within Empire whom the contract is awarded to, as well as any other Medicare carrier or intermediary, those claims where the Medicare carrier believes that they are not primary.

They come directly to this unit and this unit reviews it, reviews the claim, claim by claim, to determine whether or not the private carrier, Empire, or Medicare is, in fact, primary. In the several years since we have had this unit in operation, we have received roughly 33,000 claims where the intermediary or the Medicare carrier thought or claimed that these were—where they were secondary rather than the private carrier being secondary.

The claims amounted, in total, to about $180 million, of which we have processed so far $96 million worth of those claims, so we have a little backlog. We are adding people; we are doubling the size of the unit to work down the backlog.

Of the $96 million that has been processed so far, we have found $6 million where, in fact, we are primary and Medicare is secondary and, in fact, we have reimbursed or paid accordingly. That percentage is about 6.25 percent, but we do—insofar as my understanding of what the law is and what the procedure is, we are complying with that, sir.

Senator ROTH. Ms. Velez, are you familiar with this problem?

Ms. VELEZ. No, Senator. I have never been involved with the Medicare secondary payer area at all.

Senator ROTH. Mr. Vogt, has this problem ever been brought to the attention of the board of directors?

Mr. VOGT. Yes, sir, it has recently.

Senator ROTH. And what was the nature of this recent discussion?

Mr. VOGT. It was just reported to the board by counsel, and I believe Mr. Cardone at the time, that there was a problem.

Senator ROTH. What was the nature of the problem?

Mr. VOGT. The problem concerned who was primarily responsible for payment of claims, whether it be either Medicare or the insurer who may have carried insurance on the employed individual.

Senator ROTH. There was no problem with the policy, was there? That was pretty clearly stated in the law and the contract, is that correct?

Mr. VOGT. I don't know of the specific policy that you are referring to, sir. I don't think I have ever seen a policy.

Senator ROTH. But you said the problem came up to the board. What I would like to understand exactly is what was the nature of the problem?

Mr. VOGT. Well, I think the problem was that there was a suit and there was a dispute over who was responsible for payment of these claims in full, and we understood at the time it was in litigation, or was going into litigation or would be resolved through litigation. I haven't had a report recently on the status of it, so I don't currently know.

Senator ROTH. So there was a position within the company that they were not the primary payer if they covered a senior citizen?

Mr. VOGT. No, I don't know that for a fact, sir.

Mr. MORCHOWER. May I interject?

Senator ROTH. Yes.

Mr. MORCHOWER. The reference that Mr. Vogt is referring to was a briefing given to him in terms of the status.

Senator ROTH. And what was the nature of the briefing?

Mr. MORCHOWER. The briefing in terms of the allegation of the amount of money that you stated a few minutes ago in terms of its being out there, the fact that it is being litigated, and the fact that we do have, as I mentioned before, a unit that is complying with the law as we understand it.

Senator ROTH. But there was an allegation, then, or a position within the company that Empire was not primarily liable?

Mr. MORCHOWER. No, sir. It is dealt with on a case-by-case basis and where, in fact, Empire is primary——

Senator ROTH. What was the basic policy, then, of the company?

Mr. MORCHOWER. Since I have been involved, the policy is to comply with the law, and where we are primary and, in fact, there is—we provide a supplemental policy; we pay primary. And if, in fact, Medicare has paid incorrectly because the beneficiary has submitted it incorrectly to Medicare, we reimburse Medicare accordingly.

Senator ROTH. So what you did represents a change of policy?

Mr. MORCHOWER. I don't know what occurred in 1988. I am stating that since I have been responsible, that is how it works and, to

the best of my knowledge and on advice of our attorneys and their interpretation of the law, we are doing—we are in compliance with the law.

Senator ROTH. Well, I just want to point out that in the October 24, 1988, memo in which it is stated that the past policy would be continued, and that was that it would be permitted for Medicare to continue to pay as primary, it says, "Debbie, please be sure that we will continue to train in the same fashion." In other words, they are going to continue to hold Medicare as primary; they were not going to correct that.

So when you went into office, you changed that policy?

Mr. MORCHOWER. I made sure—I didn't deal with it as a policy issue. I made sure that this unit was processing in compliance with the law. We also did one other thing, and that is we brought in all of the salespeople to train them on the issue, to have them go out to all of the accounts to brief the accounts, the clients, to make sure they understood the policy and to make sure that it was their obligation to advise us of change in status or when somebody retired so we would have the information in order to be able to pay correctly. So there had been an education process for all of our clients, as well as our salespeople.

Senator ROTH. I have no further questions, Mr. Chairman.

Chairman NUNN. Thank you, Senator Roth.

I know the panel has been here quite a while now and I would like to plow on through. I think in about 15, 20 minutes we will be through, but if you need a break, I would respect that.

[No response.]

Chairman NUNN. OK. I would like to address this to Mr. Cardone and Mr. Morchower. The staff testified that Empire has lost 78 national accounts, totaling 350,000 subscribers, since 1988, and that Empire now has approximately 50 national accounts remaining.

Why do you believe, Mr. Morchower, that Empire has had a problem retaining the National accounts?

Mr. MORCHOWER. Let me—I will answer you specifically, Senator. I will try not to be defensive by saying that a lot of this occurred before I was responsible and not all of them are recent, so let me put that in context. We did lose some national accounts because of service, as properly stated in the staff's report.

We have implemented major changes with respect to service. We have moved national account processing to a brand new facility in Middletown, New York. We have made it state-of-the-art. We have upgraded our training. We have made a major investment in terms of improving what had been in many respects poor service to some of our accounts.

What the report does not state is that national account enrollment has, in fact, been steady or has slightly risen over the period of the years. In other words, we have added business to our national accounts business. We have added some very reputable clients—American Home Products, Merrill Lynch. NYNEX has moved all of their business to us from New England telephone; the International Ladies Garment Workers Union; the Amalgamated Clothing and Textile Workers Union, etc.

So, yes, we have lost business over the past 5 years. The losses have really been reduced in the past year or two to almost being de minimis, and because of our new facility and our new technologies we have added back at least what we lost, and possibly a little bit more.

Chairman NUNN. Our staff interviewed 42 companies, the largest companies who terminated their national accounts with Empire, and 18 of them told us that they left because of poor service. Ten left because they consolidated all their health programs. Six left because of company mergers, and four left involuntarily upon being advised of termination by Empire. We found only 6 out of the 42 who left because of rates. In other words, the at least plurality of those companies left because of what they described as very poor service.

Mr. MORCHOWER. I think you said 18 left because of service.

Chairman NUNN. Right.

Mr. MORCHOWER. And service for many of those accounts was not acceptable, was not according to our current levels, and we have made a major investment to improve it. So, yes, many of them left because of poor service at that time.

Chairman NUNN. Mr. Cardone, do you agree with Mr. Morchower that there were a number of them that left because of poor service?

Mr. CARDONE. Yes, Senator, I do. If I could just expand on it a bit——

Chairman NUNN. Sure.

Mr. CARDONE [continuing]. It is important to understand that serving a national account requires the efforts of plans other than Empire Blue Cross and Blue Shield. By definition, a national account means that the account's employees are distributed in different States in the Nation, and therefore serving a national account requires a level of plan coordination and control that, quite candidly, the Blues have not been able to deliver until very recently.

This has been a subject that was a top priority to not only Empire Blue Cross and Blue Shield, but other plans who are situated in areas where there are large national account customers, so that I do agree that service has been a problem in the National accounts area and what we did was all we could. In fact, I was chairman of the Blue Cross/Blue Shield Association committee that addressed this problem, and enormous progress has been made and we are just about there in terms of the identification of the plans who will commit themselves to satisfying the requirements of a national account customer.

But the good news is that notwithstanding all of those losses, we were successful in picking out large customers where we could attract more business so that actually the total contract count was, I believe, level and even increased a bit over a period of about 3 years.

Chairman NUNN. But you would say the criticism for poor service—in your experience, a good bit of that was justified?

Mr. CARDONE. I would say it is fair.

Chairman NUNN. That contradicts your opening statement, doesn't it?

Mr. CARDONE. No, I don't believe so.

Chairman NUNN. You said all the criticism was invalid.

Mr. CARDONE. Sir, what I was referring to was the criticism that has appeared in the press that essentially concludes I mismanaged the company.

Chairman NUNN. OK. Well, it was a much broader statement than that.

Mr. Vogt, you have been quoted in the press several times as having said that you and other board members, "were very active," and that, "the board was kept informed." Looking at these various revelations that have been made public in recent days, do you still feel that the board was adequately informed by management?

Mr. VOGT. I have come to believe there was information available that didn't find itself to the board on a timely basis which may have enabled it to make, or participate more in decisionmaking.

Chairman NUNN. Whose fault was that, the board's fault or the management's fault?

Mr. VOGT. I believe the board has the right to expect that management is going to provide it with full information, and we have found instances where that didn't quite occur.

Chairman NUNN. I won't ask you for the details, but what are the main areas where you believe management did not properly inform the board?

Mr. VOGT. I think some of the characterizations of the company by many of our constituencies were pretty well known to management earlier in the year through some work that was done for the company by Towers Perrin. To my way of thinking, that recognition, which I understand management didn't agree fully with, should have been brought to the board for its own evaluation. Customer service has been a concern of many of the directors for some time, and it has been a topic of discussion at many of our board meetings.

Chairman NUNN. Do any other areas come to mind where you don't believe the board was properly informed?

Mr. VOGT. There was two others, sir, but I don't recall the specifics concerning them now.

Chairman NUNN. Let me go through a few of these with you. It may be helpful. Do you believe you were adequately informed about the Health Care Financing Administration's criticism of Empire's handling of the Medicare contract, some of which was touched on by Senator Roth?

Mr. VOGT. No, sir.

Chairman NUNN. When did you first learn of that?

Mr. VOGT. I don't know the exact date, but it was very recently, this year perhaps.

Chairman NUNN. How did you find out?

Mr. VOGT. I think many of us read about it in the *New York Times.*

Chairman NUNN. When did you and the board first learn about the ongoing audit of Empire by the HHS inspector for improper secondary payer problems with Medicare? How did you learn about that? Let me put it that way without putting a direct date on it.

Mr. VOGT. I believe many of the directors learned about that, also, in the papers. However, I think you must recognize we were a

committee-driven board and it is very possible that one of the Committees could have had reports on this and it never did get to the full board.

Chairman NUNN. When did you first learn about it yourself?

Mr. VOGT. I don't recall, sir.

Chairman NUNN. You don't recall?

Mr. VOGT. I don't recall the date.

Chairman NUNN. When did you and the board first learn about the Office of Personnel Management audit that found Empire had overcharged the Federal Government by $6 million?

Mr. VOGT. I don't recall when that was, sir.

Chairman NUNN. Was that timely? Did you know about that in a timely fashion?

Mr. VOGT. I really don't remember when that was brought to the Board.

Chairman NUNN. Staff tells me that they informed you of that. Is that accurate?

Mr. VOGT. Oh, they are talking recently.

Chairman NUNN. Yes.

Mr. VOGT. They are talking within the last 3 or 4 weeks, perhaps.

Chairman NUNN. Right, but had you known about it before they told you?

Mr. VOGT. Not in that kind of detail, no.

Chairman NUNN. When did you first learn about the low marks given to the plan by the Blue Cross/Blue Shield National Association because of poor customer service?

Mr. VOGT. I think we have known about that for some time because the board set as one of the criteria or goals to be achieved by management improved customer service and we were using the National standards.

Chairman NUNN. So you did know about that?

Mr. VOGT. We did know about that.

Chairman NUNN. When did you learn about the AT&T lawsuit?

Mr. VOGT. When we were—when the board visited with the superintendent of insurance.

Chairman NUNN. You were told by the insurance commissioner of that?

Mr. VOGT. That is correct.

Chairman NUNN. Approximately what time frame?

Mr. VOGT. It was following his June 14th letter to the board—no—I believe that I am mixing dates here. It may have been earlier. It may have been when he wrote to the board.

Chairman NUNN. I was informed it was May of 1993. Is that——

Mr. VOGT. Yes, that may be it.

Chairman NUNN. When did you first learn about Empire's—or how did you learn—let me put it that way instead of "when." How did you first learn about Empire's lawsuit against Mr. Finkelstein concerning fraudulent membership that might have cost the plan $25 to $30 million?

Mr. VOGT. I think we knew or were informed in the normal course of things about the lawsuit. I don't think the board was given complete details or understood the impact of the losses.

Chairman NUNN. How did you first learn that Empire was losing a lot of national accounts because of poor service, as described in the staff report and as acknowledged by Mr. Cardone and Mr. Morchower?

Mr. VOGT. I think the board knew right along, as we received pretty regular reports on what our business segments were doing, and we knew that we were losing business in that area. There were several staff changes, also, in the National account responsibility which signaled problems.

Chairman NUNN. Mr. Vogt, going beyond these specific instances, you have been on the board how long?

Mr. VOGT. Ten years, sir.

Chairman NUNN. Ten years, and you don't get paid, is that right?

Mr. VOGT. That is correct.

Chairman NUNN. You spend a lot of time on it?

Mr. VOGT. A great deal of time, especially recently.

Chairman NUNN. How do you make a living?

Mr. VOGT. I manage a chamber of commerce, a 3,000-member organization, in Westchester County, New York.

Chairman NUNN. Do you believe that we can afford to have board of directors members who are non-paid and simply do this in their spare time when you are running one of the largest businesses in the country?

Mr. VOGT. I think you are focusing on one of the big problems, Senator. You make the comment that Empire should be run like a business, and I agree with you totally, it probably should. Unfortunately, Empire gets embroiled in a lot of political questions and political decisions in New York State, and into conflicts between the legislature and the governor, and very often reacts, in my judgment, not in a business-like way, but in a way which is acceptable to the political community, and I don't know whether that always results in the best decisions.

Chairman NUNN. In other words, when decisions are made many times they are basically political decisions rather than what just a pure business decision would be?

Mr. VOGT. Very many times, yes, sir, at least while I have been here as chairman.

Chairman NUNN. If you had the power to make changes in this yourself, how would you go about this? Should we have a board of directors that is basically unpaid and doing other things full-time and busy with their own businesses, or should we have a more attentive board that is adequately compensated and then basically does what a board of directors is supposed to do?

Mr. VOGT. I would opt for the latter, sir, a compensated board that would be required and accountable to run this corporation the way it should.

Chairman NUNN. As chairman of the board, do you have the ability to really get the board to spend hours and hours, let us say, in small committees, doing this on strictly a charitable basis?

Mr. VOGT. They are doing it, yes, sir.

Chairman NUNN. It takes some pretty motivated people to do that, though.

Mr. VOGT. It takes people who believe in the social mission of this corporation, and they have to believe in it very strongly in it. That was my reason for becoming part of the board initially, and the reason for my interest in what this company was doing for the community, and for health care financing in New York State. It is a very crucial position.

Chairman NUNN. Isn't it too big a business, though, to be run on a social obligation type basis now?

Mr. VOGT. I think that's true and I think some of the kinds of business we do has to be rethought, and I think we have to reexamine our way of doing business in some areas.

Chairman NUNN. And you yourself believe the whole nature of the board needs to change, is that right?

Mr. VOGT. I think it certainly needs to be expanded. We had considered doing that. We need to have more outreach into the community that we serve, 28 counties in the State of New York, and I think we need a broader representation of business minds in there to help make decisions.

Chairman NUNN. It is pretty hard for a board to follow the details of this kind of huge business empire, isn't it? In presentations by management, isn't it hard for board members who are all engaged in other professions or other businesses or other endeavors to really understand what the board is given by management?

Mr. VOGT. It is difficult, sir.

Chairman NUNN. Mr. Cardone—and I would also ask Mr. Morchower to comment on this—on page 10 of your testimony, you refer to the "thorough management audit carried out by Arthur Andersen." That was while you were there, right?

Mr. CARDONE. Yes, sir.

Chairman NUNN. And when did you actually leave Empire? What was the date?

Mr. CARDONE. June 1st.

Chairman NUNN. Of this year, 1993?

Mr. CARDONE. Of this year.

Chairman NUNN. That was Mr. Morchower's statement on page 10, I assume. I referred to the "thorough management audit carried out by Arthur Andersen," and I believe I said Mr. Cardone's statement, but it was Mr. Morchower's statement.

Mr. Cardone, do you agree with that characterization? Do you think the Andersen study was thorough?

Mr. CARDONE. I think in certain respects it was very thorough. In others, I have a different view of some of the commentary that was contained in that report.

Chairman NUNN. I will ask both of you this series of questions. Mr. Cardone, were you aware that Arthur Andersen did not interview national accounts that had left? Were you aware of that before this staff report came out?

Mr. CARDONE. No, sir.

Chairman NUNN. Mr. Morchower, were you aware of that?

Mr. MORCHOWER. I was told that Andersen reviewed national accounts. Now, I don't know whether they were current or former, but I was told they interviewed national accounts.

Chairman NUNN. That they did interview national accounts?

Mr. MORCHOWER. Yes.

Chairman NUNN. So you thought that they had interviewed national accounts?

Mr. MORCHOWER. Yes.

Chairman NUNN. Our staff was told they did not.

Mr. MORCHOWER. I understand that.

Chairman NUNN. Mr. Morchower, were you aware that they did not interview subscribers, that Arthur Andersen did not interview subscribers?

Mr. MORCHOWER. No, sir. Mr. Chairman, I was told by them specifically that they did interview subscribers.

Chairman NUNN. Mr. Cardone, did you have any understanding on that? If you didn't have any understanding one way or the other, just say so.

Mr. CARDONE. I was led to believe that they were going to conduct interviews with customers and subscribers.

Chairman NUNN. You believed they were?

Mr. CARDONE. Yes, sir.

Chairman NUNN. Mr. Morchower, did you realize that Arthur Andersen had not interviewed former board members?

Mr. MORCHOWER. No, I never discussed that with them.

Chairman NUNN. Mr. Cardone?

Mr. CARDONE. Could I have that question again?

Chairman NUNN. Former board members—were you aware that Arthur Andersen did not interview former board members?

Mr. CARDONE. No, sir, I was not aware of that.

Chairman NUNN. Mr. Morchower, were you aware Arthur Andersen did not verify on their own analysis the so-called cherrypicking argument?

Mr. MORCHOWER. I don't know that they did or they didn't. I know what the staff report says. I have never asked them the question as to whether, nor have they volunteered, as to whether or not they did.

Chairman NUNN. Mr. Cardone, did you think they were going to use their audit as an independent analysis of the cherrypicking argument, the loss-leader argument, and the community market analysis? Were you expecting them to do their own independent analysis of those arguments?

Mr. CARDONE. I expected them to, and I thought they did a lot of analysis in that area because they knew at the inception of their audit that that was a key question. I believe it might have been even written into the request for proposal from all the bidders that they ascertain the reason for Empire's losses. So I was led to believe that they did satisfy themselves. I had just a few meetings with them, and you appreciate the circumstances. We were not—we had no control over them. We had nothing to do with the selection or the scope of their work.

Chairman NUNN. Right.

Mr. CARDONE. But they did meet with me on several occasions.

Chairman NUNN. It was really supposed to be an independent outside audit as a check on management and a check on the whole operation, right?

Mr. CARDONE. That is correct, and I can assure you while we—I issued instructions that we cooperate fully, but we—it was independently done and there was no—it was very similar—well, I

shouldn't say similar to because it was much more penetrating, but we had no say in the scope of the examination, the type of procedures that they were going to employ. I just had some briefings with them towards the end.

Chairman NUNN. Would you be surprised to learn that the Andersen team admitted to our staff they did no independent studies or reports on their own on the whole subject of cherrypicking, that they basically relied solely upon the plan's representations, and that was how they arrived at their conclusion that it is a real phenomenon?

Mr. CARDONE. Senator, if I were confronted with that and I were in your position, I would really question the word "independent." You may have an issue here with outside professionals who are being very technical. I mean, there is a lot of information at Empire about the proof of cherrypicking, loss/benefit ratios, the fact that the company only losses—what a coincidence—good-risk business that is highly profitable, and you look at the preponderance of the new customers coming in and they seem to be poor risks.

We had independent consultants, outsiders—I believe it was Milliman and Robertson—look at this issue. They confirmed that the cherrypicking was severe and gave us some recommendations to actually change and split the pools in two between good risk and poor risk. So I think what you may have there is a definitional issue where Arthur Andersen is saying they are placing a lot of importance on the word "independent," as contrasted with an outside consultant heavily analyzing data that is supplied by the corporation and coming to a conclusion that, all right, this is what happened, and I think they did that.

Chairman NUNN. Would it surprise you to know that Arthur Andersen told our staff that they did not know that HHS was contemplating suing Empire, they did not know about the AT&T lawsuit until it was in the newspapers, they did know about deferred compensation, they did not independently study the plan's compensation plan, they did not report officers' salaries and compensation, they did not test management assertions regarding paying high compensation to retain officers? As I understand it, they did not review the Deloitte and Touche work papers, so they did not review what had previously been done. That is what staff found in their interview with Arthur Andersen.

Mr. CARDONE. Again, Senator, I think——

Chairman NUNN. Would you call that an independent audit if this is true? I am not asking you whether it is true. I am asking whether——

Mr. CARDONE. I think there is a definitional issue here because, to my knowledge, they spent a lot of time in the areas that you just recited, a lot of time reviewing material that was supplied to them by our company—the compensation issue and the like.

Chairman NUNN. Of course, the problem is if you do an independent audit, you are supposed to go outside and check some of the information, at least samplings of it, to determine if it is accurate. An audit that is done strictly with the papers provided by the company itself is not what I would call an independent audit. Maybe somebody else has a different definition of it.

Mr. Vogt, how do you view that? Did you expect an independent audit to really take only the basic assertions and papers furnished by the company?

Mr. VOGT. Well, if, in fact, what you have outlined there is true, I would have to ask what the State paid for. I mean, all that other information has gone to the State right along and they had access to it, and if they didn't do the independent studies, as you are saying, I don't know what the purpose was. We were under the impression that they did.

Chairman NUNN. Well, we haven't heard completely Arthur Andersen's side of this story, so we will certainly not make final, conclusive judgments until we have heard from them. I don't know whether we will have hearings, but we will at least invite them to testify, or at least to submit testimony. But I don't see how an audit is really independent if nothing is checked beyond what the company furnishes because all of that information could have been compiled by an internal audit.

Mr. Cardone.

Mr. CARDONE. Senator, I am aware in discussions with them—like in the compensation area, what they said was they looked at all of our material, but then used some material that they obtained from objective sources. They questioned the surveys that we obtained that were independent of our company from independent consultants. So I am a little surprised at the recitation and I think you may have a definitional—but by all means, I think you should ask Arthur Andersen.

Chairman NUNN. OK. We will. Do any of you have any other points you think need making this morning?

Mr. ZORNOW. Senator, on behalf of Ms. Velez, we would respectfully request that we have the opportunity to submit a statement for the record with respect to certain matters that I have discussed with Ms. Hill of the Subcommittee staff.

Chairman NUNN. Without objection, we will certainly accord you that privilege.

Mr. ZORNOW. Thank you.

Mr. VOGT. Senator, I believe Mr. Morchower has agreed to furnish the Committee with other information and we will make sure we do that.

Mr. MORCHOWER. Yes, sir.

Chairman NUNN. We will be glad for you to submit supplemental information for the record.

Mr. VOGT. Thank you.

Chairman NUNN. We had planned to be through with this part of the hearing about 12:30, and obviously it has gone on much longer. Mr. Curiale, I know you would like to have a chance to testify. If we have you testify, I am going to have to reserve the right to have you come back for maybe questions at a later time, but I will accord you the right to testify today, at least get your testimony on the record. I am not going to be able to have time to ask the questions because I have got another hearing I have to preside on in the Armed Services Committee in about 45 minutes.

So we will dismiss this panel and thank all of you for appearing, and we will ask the insurance commissioner, Mr. Salvatore Curiale, if I am pronouncing that correctly, to please come up.

Mr. Curiale, we swear in all the witnesses that appear before our Subcommittee. Do you swear the testimony you give before the Subcommittee will be the truth, the whole truth, and nothing but the truth, so help you God?

Mr. CURIALE. I do, Senator.

Chairman NUNN. Thank you. Mr. Curiale, I may interrupt you a couple of times with questions, but I am not going to be able to ask all the questions that I would like to. I know you want to go ahead and give your testimony today, and I would like to supplement this session today with some other questions for you.

TESTIMONY OF SALVATORE R. CURIALE,[1] SUPERINTENDENT OF INSURANCE, STATE OF NEW YORK

Mr. CURIALE. Yes, Senator. Mr. Chairman and members of the Subcommittee, thank you for the opportunity to testify here this afternoon in connection with your inquiry into Empire Blue Cross/Blue Shield, the New York State Insurance Department's regulation of Empire, and health insurance availability——

Chairman NUNN. Mr. Curiale, could you talk right into that mike? These mikes are real sensitive and you have to be pointing right at them.

Mr. CURIALE. How is that, Senator?

Chairman NUNN. That is good.

Mr. CURIALE. OK. Again, thanks for the opportunity. Throughout the course of your year-long inquiry, you have asked several very important questions and drawn some important conclusions. You have asked whether certain of the Blues plans, now specifically Empire, are too big to fail. Under the laws that existed in New York prior to April 1, 1993, the effective date of health insurance reform legislation, I would agree, Empire was too big to fail. It provided health insurance to hundreds of thousands of people who could obtain meaningful health insurance coverage only from this insurer.

To the question you have asked, I would add one other. Is Empire too big to succeed? My answer to that, again, under the prior law, and perhaps even now under the present conditions of delivery of health care and the current health insurance marketplace, may be yes, unless Empire changes and unless we as a Nation make the changes we need to control health care costs, reform the way we deliver and pay for health care, and the way we distribute the cost of health care expenses.

I agree with the Subcommittee staff that there have been mismanagement problems at Empire, some of which the department has discovered in the course of its examination of the company, some of which have just recently come to light. The New York Insurance Department disagrees, however, with the Subcommittee staff's contention that mismanagement at Empire was the root cause of the financial deterioration. Rather, we believe its deterioration was pre-ordained by a health insurance system in need of reform and a health care marketplace that changed drastically over the course of the last 10 years and doomed Empire, a corpora-

[1] The prepared statement of Mr. Curiale appears on page 268.

tion writing only health insurance and functioning as an insurer of last resort, writing some of the most expensive risks in the country.

Senator in your opening statement you asked the question, can we build a health care system relying extensively on huge nonprofit 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.

Contrary to the charge that we were paralyzed by fear of regulating Empire, we proceeded on a course that was designed to reduce and even eliminate New York State's dependence on Empire, and to give all our citizens, including the oldest and sickest, the opportunity to purchase health insurance on a community-rated, open enrollment basis from any health insurer in the individual and small-group market writing such business in the State.

In this way, if any individual policyholder insured with Empire were unhappy with the level of its premiums, with its service, or with the CEO's salary, that individual would have the option of going to another carrier without the fear of rejection because of age, health status, or occupation.

This course put me and the department squarely against the powerful commercial health insurance lobby, which was determined to protect its prerogative to select its policyholders and to insure only those people whom it didn't consider to be risky or costly, particularly in the small-group and individual marketplace.

How did the department form its view? Well, Empire insures over 8 million people, which means nearly half of all insured New Yorkers look to Empire for some kind of health insurance. Empire had a premium volume of $6.6 billion in 1992. For many years, Empire has participated in an unwritten social contract with the people of New York. For its part, Empire has assumed the responsibility for insuring all who apply, regardless of age, sex, health status, or occupation.

On its own, Empire has chosen to serve as the insurer of last resort in some of the most difficult and high-cost counties of New York, offering basic medical and hospital, and in recent years major medical insurance, on a community-rated, open enrollment basis.

Commercial health insurers have for years sought to insure lower-risk groups and individuals whose rates remained low as long as they remained healthy. Empire has also performed other community services, including providing coverage to all who apply for Medicare supplement insurance generally at a subsidized rate, paying hospitals in advance for patient services, and participating in State pilot projects relating to health insurance. In recognition of its social mission, Empire and other not-for-profit insurers have paid a hospital rate that was less than that paid by commercial insurers, and have received certain tax exemptions not available to for-profit insurers.

Empire's legislated advantages over the commercial insurers were intended to level the playing field and to recognize and encourage the continuation of the community services it provides.

However, the trend away from in-hospital services has diminished the beneficial impact of the hospital rate differential.

It has been said generally, with a negative connotation, that the New York Insurance Department has a special relationship with the Blues. New York is supportive of the Blues because of the social contract they have with our citizens. Empire and the other not-for-profits provide necessary coverage and services to our citizens that are not provided by commercial insurers.

Mr. Chairman, if it said in your report that I am a cheerleader for the Blues, I dispute that, definitely. I am a cheerleader for the people who are insured by the Blues and who have no other place to go, at least until April 1, 1993.

Chairman NUNN. Mr. Curiale, you don't mention poor service anywhere in your statement this morning. That doesn't mean you aren't concerned about it, but what is your authority to deal with the charges of poor service by the policyholders? We have run into that over and over and over again. Are you authorized to really take some action because of poor service, and did you run into an inordinate amount of poor service from Empire?

Mr. CURIALE. Absolutely, Chairman, there is poor service by Empire. That is part of our examination report. It is part of our complaints that we have had back and forth with Empire. But, Mr. Chairman, the point that I have been trying to make—and I haven't finished with my initial statement.

Chairman NUNN. Right.

Mr. CURIALE. The point is, Mr. Chairman, that we have felt that the problems that have led to the deterioration of the financial condition of Empire relate more to the systemic problems that plague not only New York State, but the entire country, and that plague any not-for-profit, one-line health insurer like Empire that has to take care of a residual market, on the one hand, and try and support that residual market with profits from the experienced-rated groups on the other. And that is not to condone all their problems, and there are many of them. And believe me, Mr. Chairman, we will get into those.

But, anyway, what went wrong? There are many contributing causes—the cost of health care which, in New York, as elsewhere in the country, has continued to increase well beyond the CPI. You know the statistics. The Commerce Department has come down with them, I guess, as long ago as January—1 out of 7 dollars spent on health care in this country, going from $800 billion-plus last year to $900 billion-plus this year to $1,000,600,000,000 by the year 2000 unless something is done.

Intensification of competition for large-group business by commercial carriers which were not limited to writing health insurance and could therefore afford to lose money on their health insurance business while making a profit on other insurance sold to the same policyholders—before, Mr. Chairman, I was listening to comments and questions about national accounts that are not leaving Empire because of price. I would submit to you they are not leaving because of price because those contracts are already underpriced. They are leaving because of service because they have already got a price that is too low for Empire to be charging in the

misguided attempt to continue its market share with the hope that things will turn around.

It is my personal opinion, it is the opinion of the department, that they just cannot do it. They can't compete with life insurers/health insurers that can come in and can price a product and can give efficiency because they know they will make it up on the life insurance, on the pension plan management, on the other services, on their subsidiaries in property and casualty. They can afford to take that market share.

Apparent underpricing by Empire to keep this large-group business and protect its market share at all costs—that is what I am talking about. Bigger is better. Management difficulties? Yes, there are management difficulties. In my mind, that was probably the biggest management difficulty, the thought perhaps, like General Motors, that if we keep trying to sell those Cadillacs—and I don't want to disparage General Motors, in spite of the fact that Lexus and other luxury cars are perhaps kicking the tar out of us—maybe some day it will turn around.

Selective underwriting at favorable rates by commercial insurers of the healthiest and youngest people, whether individuals or small groups, leaving the worst risks to Empire, which absorbed substantial losses from this business—again, the cherrypicking argument. Did we see evidence of it? Mr. Chairman, all you have to do is sit at an Empire Blue Cross/Blue Shield rate hearing and listen to the hundreds of people that testify. They come in, individuals who buy their insurance directly, but lots of small groups, small groups that are small employers who come in and complain bitterly about the high rates that Empire is charging, but on the other hand say, I have got nowhere else to go. Why? No one else will take me. Why will no one else take you? Because I am a small business, because they collect forms that say is anybody sick, does anybody have a bad record, how old are you, what is the average age, what occupation are you in, are you a risky occupation?

And then what? They don't take you. Where do they go? They go to Empire or other not-for-profit corporations. Are their losses going up? Yes. Is their volume going down, in spite of losses going up? Yes. Why? Because the only people that are left are the people that are sicker, that are riskier, that are exhausting the premium in terms of health care costs.

The reluctance of the department to grant an entire rate increase request on specified policies as the department attempted to balance the concerns of subscribers faced with substantial increases against the level of reserves necessary to maintain financial viability—that is the constant dilemma that the regulator has. The regulator has the responsibility to balance.

You have got to, as a regulator, provide or preside over a market where valuable products, necessary products, are provided at reasonable rates in relationship to the risks, and that the companies remain solvent. This system was rapidly running out of kilter, again because we have a residual carrier with a burden that is not shared by the commercial carriers of this country at the same time trying to make do with the old mechanism that worked. It worked for a long time before health care costs got up to here, before people and companies said we have got to self-insure because we

can't stand these premiums, before companies dropped out, before compartmentalization. Anybody that was healthy enough or young enough dropped out, the law of large numbers falling apart, risk-spreading falling apart.

Empire's procedure of paying first and pursuing later, adopted because of its enormous volume of claims, some 100,000 payments per day, and its recognition, at least lip service-wise and attempts-wise, for prompt claims settlement—damned if you do and damned if you don't, Mr. Chairman. You are vulnerable to fraud because you don't have the right internal controls. At the same time, you have edits; you might have dummy codes, generic codes, and that is a problem and our examination report treats it.

And you mentioned in your questions before to Empire brass, what about Mr. Schwartzman's letter to Mr. Cardone asking him questions about it. And, yes, that is a problem, and they rely on it too much. But, again, Senator, damned if you do and damned if you don't. If you don't pay the bills, in spite of a missing edit, you get killed because people are complaining; subscribers are complaining, providers are complaining. If you pay them, you are vulnerable to fraud.

Many of these problems at Empire were exacerbated by the company's continued commitment to community rating and open enrollment of individuals and small groups. We put it to them in 1986 and 1987; we said we want you to do major medical insurance coverage for individuals. They said OK. They began writing very meaningful products for individuals.

People that come to an insurance company as an individual tend to be sicker, riskier, more vulnerable people. Why? They are either out of work, they are not in a group. Maybe they have gotten sick and have been bounced out of a group because they were causing that group's premiums to rise with a commercial carrier. That is where the dumping is and that is where the bleeding is in terms of any residual market insurer.

By late 1991, we at the New York State Insurance Department were convinced that the insurance system in New York had to be changed. We were aware that many commercial insurers were leaving or had left the individual market and those that remained selected only the very best risks. That left Blue Cross as the insurer of last resort for individuals with health problems.

Mr. Chairman, you have asked, what independent studies have you done; what have you got to prove this other than Empire's statistics. Well, we have the hearings, we have the testimony, we have the losses, we have our common sense. We have underwriting guidelines of insurers that say, no florists. Why no florists? Let me guess. I even would hazard to guess. Maybe you should guess. No construction contractors, no firemen, no barbers. These are real. This is what the commercial carriers were doing. These are the people, for some reason or not, who seem risky. Of course, they can't ask certain other questions on their applications, but they can have those underwriting guidelines.

We reviewed the underwriting rules of some of them. That is what we found. We found those lists, and some of those companies that I have mentioned include restaurants, motels, police and fire departments, taxicab companies. I have mentioned some of the

other ones. The members of the smallest groups that applied to commercial carriers for coverage were subject to strict underwriting rules that could disqualify the entire group from coverage. The medical condition of one member of a small group could result in denial of the whole group. In addition, the offering of a health insurance policy was something made contingent upon the purchase of life insurance.

Now, Senator, we will have very shortly a lot more information on this because since we went to community rating and open enrollment for all commercial carriers that are writing small-group business in New York State they had to come in and file for community rates, and when they came in it was very interesting. They filed for increased rates on the basis of, well, now they were going to have to take older people; well, now they were going to have to take sicker people, or now they weren't going to be able to get rid of people. They weren't going to be able to raise their rates on the basis of their individual experience.

So what did they do? They said, well, this is what we have to do; we have to raise our rates. To do what? To do what Empire and the other Blues were doing, that is what, and we will have evidence developed of that. I told your investigators during the course of my 5-hour investigation—and by the way, if none of you have ever been interviewed by John Sopko, and especially you, Chairman Nunn, I would greatly suggest that you do it. It is an experience. [Laughter.]

Chairman NUNN. I have an advantage over him. I sign his paycheck. [Laughter.]

Mr. CURIALE. But we will have data on all of that and we will have data coming up from our pool, our internal pool, which is set up to balance off the risks based upon demographics and expensive health care costs as between all of these commercial carriers, which we think have plain vanilla pools as opposed to Empire's down-and-dirty, community-rated, savaged pools that have old people, sick people, risky people. That is what they have. We will have the data very, very shortly.

Chairman NUNN. Mr. Curiale, I don't doubt that there is a big factor here in this whole area. I don't think the staff is saying that. They are basically saying, though, in spite of all the arguments that have been going on for years and years and years, in spite of the testimony to the legislature, in spite of an independent report by Arthur Andersen that was paid for by, I assume, the taxpayers of New York, there is not an analytical product.

If it is such common sense and such an evident situation, it looks like somebody could have pretty well documented it in some independent study somewhere along the line, since it goes to the very heart of the argument.

Mr. CURIALE. It is very hard to do an independent study that divorces itself of the Empire data. I mean, it is the Empire data that represents what is happening in New York State in terms of not only cherrypicking, but in terms of what is happening with regard to the New York——

Chairman NUNN. It doesn't mean you don't have to use the data. It means you check it.

Mr. CURIALE. Well, we have checked the data. We have checked it.

Chairman NUNN. Where is the product that shows that? We haven't seen it. Have you furnished it to us?

Mr. CURIALE. Well, Senator, we don't have written reports. What we have is our experts look at this data and make their conclusions about what is happening, and make their conclusions——

Chairman NUNN. You don't make any notes when you go out and check independently and verify things?

Mr. CURIALE. Senator, we will have reports very, very soon. We have changed the law. We have seen commercial companies come in and ask for rate increases on the basis of what their pools were like before.

Chairman NUNN. But you have already made your conclusions without an analytical product. I mean, I don't have any doubt about what your studies are going to show now that you are so firmly on record as to the result.

Mr. CURIALE. Senator, I invite your very good investigators in once again when we have this information to look at it. If we have a mea culpa to give you, it is that perhaps we didn't have a nice little neat report with a ribbon bound on it. What we have was our——

Chairman NUNN. But I think a lot of people would have felt that that is what the Arthur Andersen study was designed to do, but apparently it didn't.

Mr. CURIALE. Well, I think the Arthur Andersen study did one very good thing that helped me out a great deal. If you read between the lines in the Arthur Andersen study, it said that management must go, things have to be turned around, and that is exactly what has happened.

Chairman NUNN. Do you have the authority to basically require the board of directors to fire people? Do you have that authority?

Mr. CURIALE. No, I don't have that authority, Senator, but what I do have in terms of the timing and in terms of my picking my spots as far as when the right time to act was I got the community-rating, open enrollment law. That was most important to me because I felt that that cured the systemic problem that not only Empire—and, really, what we needed that law for was not for Empire. Again, I am not a cheerleader for Empire. I don't make $600,000. I don't have a golden parachute. I don't even have a silk handkerchief. Maybe this one here qualifies, but I think it is synthetic, Senator.

What we do and what we are cheerleaders for are for the policyholders, and it is the policyholders who have for years been stuck with Empire and stuck with not-for-profit, one-line health insurers like Empire with nowhere else to go. Senator, if Empire is the Titanic, I am—and I hope they are not the Titanic, or at least not historically—I and the insurance department are a tugboat trying to tug and pull this way and that way.

We are not concerned about the crew. We are not concerned about the captain partying perhaps, doing too much at the captain's quarters. We are concerned about the men, women and children who are on that boat with no life boats, with no ocean liners

to come by to take them off. Now, after April 1, 1993, there are ocean liners to take them off, there are life boats.

If what we have done, and nothing more than what we have done, is to partly cut the umbilical cord with Empire Blue Cross/Blue Shield, whether Empire is a cherub or Rosemary's Baby, that was worthwhile. And, frankly, Senator, we are now in a position to change management around.

Chairman NUNN. Do you want to tell us which one you think Empire is? [Laughter.]

Mr. CURIALE. In a way, Senator, I think it is more like Dr. Jekyll and Mr. Hyde. In some respects they are Dr. Jekyll, and in some respects they are Mr. Hyde. But what we have been trying to do all along—and I think, Senator, I have been wrongly criticized, and my department, for not having courage here.

The New York State Department of Insurance, I think, has the most courage of any regulatory agency in this country. We have demonstrated that in many, many instances with Mutual Benefit Life, with Executive Life, with Equitable, with various—and that is all in my reign, and before that in others with our junk bond regulation that we put in in 1986 and 1987 when everybody else was saying junk bonds are the best thing, you needn't limit these investments.

I don't want to go through our record. I think the Empire situation will bear us out, also. We did what we were supposed to do to cure the long-range problem, and we are picking our spots. We are moving at a time when we can move in terms of the vulnerability of a recalcitrant and complacent board of directors.

You know, Senator, I waited, and I waited, and I waited. That is the complaint of your Committee. Well, you know what I waited for? I waited for the opportunity to go to a board that had rejected the department time and time again, that had not cooperated with us time and time again, in spite of the fact that we certainly wanted them to do that, OK? But they didn't cooperate with us, and I had the kind of power that is throw the baby out with the bath water, OK? I can say, you are not cooperating with us, we are going to have a hearing, I am going to take away all your board members as being untrustworthy, in spite of the fact that I can't get into their heads, Senator. I can't get into their heads and determine what they are deciding, on what basis they are deciding, whether they are going along because they think it is a good idea, whether they are going along because Al Cardone is some sort of Svengali; you know, whether they are going along because they like the gifts that they get.

It is very difficult, and it is also difficult at a time before this company is still the insurer of last resort to go in there and say, Al Cardone stinks, the board stinks, and this thing has got to be going under, especially when, Senator, the commercial insurance industry is telling me and telling the world, you don't have to change this system, this is fine, we can underwrite and they can take everyone—all they have got to do is do better business, they have got to manage business better. We didn't believe that and we didn't want to play into those hands. And, Senator, yes——

Chairman NUNN. You are saying you were very frustrated and you made demand after demand on the board and they really didn't pay any attention to you for years. Is that right?

Mr. CURIALE. They didn't pay any attention to us for years, Senator.

Chairman NUNN. OK. That is what I want to get at. Then does that mean that it was too big a company, it performed too crucial a service to New York policyholders as the last-resort company for people who couldn't get insurance, for you to be able to take the tough regulatory steps that are necessary? Isn't that the conclusion we are drawing here?

Mr. CURIALE. No, Senator. I took the tough regulatory steps, but I gave them plenty of rope and I did what I thought would cure the system best first, with the most long-lasting results, and now we are in a position—and, in fact, due to the efforts of——

Chairman NUNN. But you would agree that it was just too big to take strong action, right, and too important to take strong action?

Mr. CURIALE. Senator, I would agree that a regulator like——

Chairman NUNN. I mean, that is what I am hearing you say, I thought.

Mr. CURIALE. Absolutely, and I have said that in my testimony. I have said perhaps it is too big to regulate under these circumstances, under these conditions, and perhaps it is even too big to succeed, Senator, under those circumstances and under other conditions.

You have asked in your opening statement, can we rely on these kinds of organizations to carry forward in the future.

Chairman NUNN. Right.

Mr. CURIALE. And I have said, no, we can't. You can't rely on a not-for-profit, one-line company that furnishes the residual market with coverage. You can't rely on them. They are not managed well and the burden is too heavy for them, and I think all the facts and circumstances that we have seen have shown that the burden is too heavy for them. It is not going to work. What worked 10 years ago can't work now.

The only thing that will work is if you have everyone, commercial carriers—if you have not-for-profits, if you have the vehicles that we will be seeing shortly over the next few months or years, if it takes that long, because I think a lot of parties are circling the wagons, Mr. Chairman, on all of these issues because there is so much at stake—it will take everyone to solve this problem.

There are two problems in health insurance, Mr. Chairman. There are the problems of the costs which are running away, and we know they are running away, and the other problem is how do you spread those costs and how do you finance them. Up to now, we have been in a situation where we have a financing system which is devoid of discipline. It is a fee-for-service system; it encourages fraud. Supply and demand is in the hands of the provider. The person that is the user of the health care has no incentive, no incentive whatsoever, to control costs, to question the provider, do I need this MRI, do I need this CAT scan, is it the right price.

We have got to make some difficult, difficult decisions. One of the decisions we have to make, and it is the one that I have been concerned with in New York and am concerned with always, is

how to spread that risk effectively, how to avoid compartmentalization of the risks that are out there, how to avoid people going to self-insurance when they think that it will benefit them and then coming back into the system when they think that they are going to be risky—lots and lots of tough questions.

What do we pay—what price do we pay for hope? How do you criticize a company, a not-for-profit company, one day for having premiums that are too high in its residual market and then the next day for turning down bone marrow transplants for twin sisters on the basis of statistics that show that perhaps there is a 1 in 20 chance that life will be extended for 2 years and at a cost of $200,000 apiece?

These are the gut-wrenching questions that we have to deal with. These are the gut-wrenching questions that nobody wants to decide, certainly not on a personal level. These are the gut-wrenching questions that residual markets like Empire Blue Cross/Blue Shield have had to cope with, and they shouldn't be strictly the burden of a residual market. They should be the burden of everyone—the law of large numbers, maximum spread of risk.

Chairman NUNN. Do you think you have leveled the playing field in New York now under the new law?

Mr. CURIALE. Not completely, Mr. Chairman. There is one little part that is left to be done, and that is right now under the law of New York there is insurance equity for small groups. There is insurance equity for those people that want to go to HMOs because there is open enrollment and community-rating, but right now under the law of New York people who are buying insurance directly from insurance companies, people who are not in groups, need to be insured desperately. Again, they are mostly sicker, riskier people. These people have only one place to go, and that right now is Empire and the other not-for-profit corporations.

Empire's problem is worse than the others because they service New York City and the down-State counties. There is an AIDS problem, there is a tuberculosis problem, there is a cancer problem. Like everything else, New York City has it in spades. We have the worst problems, we have the best advantages, we have it all. Because of that, Empire has it all.

Chairman NUNN. Mr. Superintendent, you passed a law saying insurance companies had to have 12.5 percent of new premium income as statutory reserve, and that was for the protection of the customer, right?

Mr. CURIALE. I didn't pass that law.

Chairman NUNN. The State legislature.

Mr. CURIALE. The State passed that law.

Chairman NUNN. And in the 6 years or so since that requirement has been on the books, Empire has never met that mandated level?

Mr. CURIALE. Absolutely not.

Chairman NUNN. All right. Does that mean the law is wrong or does it mean that Empire is just not able to meet it, or does it mean there wasn't enough regulation? What is the answer to that?

Mr. CURIALE. Well, Mr. Senator, what it means is that that is a figure devoutly to be wished in the mind of perhaps insurers that are concerned solely with solvency. But in a situation like this

where you have people depending on a company for coverage that can't go anywhere else, you have got to balance the availability of a product with the desired impact in terms of what you need as a particular surplus.

Chairman NUNN. Have you gone in to tell the State legislature the law is wrong and they should have lower requirements for reserves?

Mr. CURIALE. No, I haven't told that to the State legislature, but I have ignored the law, and so have they. They have ignored it and, in fact, they just extended the time within which that law needs to be complied with. When I went to——

Chairman NUNN. How does the State legislature ignore the law? They don't enforce the law.

Mr. CURIALE. Well, they haven't—I will tell you how they ignore it, Senator. They come to rate hearings, OK, where I am sitting up there in front of about 200 or 300 people saying please don't let them raise my rate, please give me somewhere else to go, please help me. And do you know what the State senators and the assemblymen come in and say? What they say, and what they said in 1990, in 1991, in 1992 was, Mr. Superintendent, don't raise this rate, we need a legislative solution, OK?

What they said was not, we have got to make sure that this surplus is way up here. What they said is what any elected official would say, is that let us find a way to do this, let us find a way to cover these people, to take care of our sick people, to take care of our risky people, and let us not price them out of coverage because we have got to get to some point that we put up in the law and, by the way, has been changing from year to year to year; let us not do that before we have a chance to change the system and make it work.

Chairman NUNN. OK. I am not going to interrupt you anymore. Why don't you see if you can wrap it up, if you would, because I have got to go preside over another hearing.

Mr. CURIALE. Senator, I would like to just wrap it up to say I think your Committee has done a great service to this country. It has done a great service to the New York State Insurance Department. The pressure that you have put on, the pressure that the press has put on, has put me in a situation where I could do what I have wanted to do all along, and that is accomplish a change in the law, which we did, and be in a position to change the management philosophy of Empire Blue Cross/Blue Shield and, Senator, to do what you would be recommending us to do, and that is not rely on one carrier to do it all because if you are going to rely on one carrier to do it all, you are going to go down. You are going to go down unless you make the State manage that company and, in fact, the State doesn't have the capability of managing that company.

Chairman NUNN. Well, you make a number of good points, and I see the dilemma of a regulator, particularly when a company gets this big and this crucial in terms of the number of people they insure in New York State and the number of people who rely on them as an insurer of last resort. You have got a real dilemma. I mean, if you crack down too hard and they basically go under, then all of a sudden it is your responsibility, and what are you going to

do with all the people out there? If you take over the management of it, who is going to run it?

I think we have got to look at some of the lessons of this whole Blue Cross/Blue Shield area and get it out of our mind that a "non-profit" is automatically going to be well-managed because they don't have that ugly profit motive that we attribute to people who are trying to make a profit, because we have got no accountability. I mean, the only way the policyholders of New York can really hold Blue Cross/Blue Shield accountable is through your office, and that puts a terrible burden on you.

You are really substituting yourself as a regulator for what normally a marketplace does, what a profit does, what a paid board of directors does that really has some accountability, instead of people doing it part-time for no fee. You are in the middle of all this. You are really trying to make a regulatory kind of apparatus work. It is tough. I have sympathy with your position.

Mr. CURIALE. Thank you, Mr. Chairman. I would like to say one other thing, too. There are a lot of problems at Empire Blue Cross/Blue Shield, and we have been lied to consistently. We have been lied to by some of the people in this room here today, some of the people in this room today that even haven't been accused of lying by this Committee. We intend to do something about that. We have got law enforcement agencies in New York City, in New York State. The Federal authorities are looking into this, and we ourselves are cooperating in those efforts.

Management has to be changed, the leadership of the board of directors has to be changed. Mr. Vogt talked about perceptions. The very first meeting I had with the board of directors of Empire after I sent them that letter, that wake-up call letter on April 14th—I told them we need a new chairman, and I suggested again that they ought to, as reasonable people, think about whether Al Cardone could serve in any capacity with Empire Blue Cross/Blue Shield.

There will be heads that will be rolling. I have, and the department has put into place a new team, not yet, but the potentiality of a new team at Empire Blue Cross/Blue Shield. We feel that once that new team is in there, we will be able to publish our examination report which we have held back because, frankly, we thought that the present organization, directorship and management of Empire would use the process—and there is plenty of process to hold up a report, as your staff knows—use the process to hold it up.

Once that new management goes in, we will have a report which will have plenty of recommendations to improve Empire Blue Cross/Blue Shield, some that are not even in your exhaustive report.

Thank you, Mr. Chairman.

Chairman NUNN. I would just like to ask one question. You have heard all the back-and-forth on these two sets of books, two sets of numbers. You are the insurance superintendent. You rely on the forms and the accuracy of the information supplied by these companies. Have you been surprised at this that there were really two sets of numbers, or is this just an internal mechanism? Is it a serious matter? How significant is it?

Mr. CURIALE. Mr. Chairman, it is a very serious matter, not in terms of the impact on the rates because these were estimated numbers. What is serious, Mr. Chairman, is to have people in positions such as the positions that we are talking about—CEO, CFO—lying to anyone, to the regulator, to the legislature. That is what is serious. They have destroyed the credibility of Empire Blue Cross/Blue Shield.

As the internal auditor said, and some of my statements have said that I thought that perhaps there was an overreaction. The overreaction that I was talking about was to a contention that there were two sets of books, OK? And the internal auditor indeed said it is not that there are two sets of books, but there is data that was kept from the insurance department. We had been trying to get that data for quite some time, not to see whether there was two sets of books, but to analyze the performance of the National accounts that Empire Blue Cross/Blue Shield was writing. We have felt for a while that those national accounts were grossly underpriced, again, like General Motors and the Cadillac.

We have been lied to. We have been lied to not on a question of what was used in terms of those numbers as far as the preparation of the annual statement. We have been lied to as to the very existence of a set of figures that represented market segmented experience, and that indeed is very serious.

Chairman NUNN. Thank you, Mr. Superintendent, and I am glad we got through your testimony because I know you wanted to be heard, and we will probably have some follow-up questions.[1] I had a lot of things I was going to go over with you, particularly philosophy about how we move in the reform area. I think there are certainly some lessons to be learned from the Blue Cross/Blue Shield system and in the investigations that we have had that pour over into the reform area in national health insurance. I am not sure what all those lessons are yet, but I would certainly want to explore that with you, and we will perhaps do it for the record with a few questions.

Mr. CURIALE. I am at your disposal, Mr. Chairman.

Chairman NUNN. Thank you very much.

[Whereupon, at 1:57 p.m., the Subcommittee was adjourned.]

[1] See Exhibit No. 83 on page 360.

APPENDIX

STAFF STATEMENT

U.S. SENATE PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

HEARINGS ON OVERSIGHT OF THE INSURANCE INDUSTRY: BLUE CROSS & BLUE SHIELD—EMPIRE PLAN (NEW YORK)

JUNE 25 and 30, 1993

TABLE OF CONTENTS

I. INTRODUCTION

Mr. Chairman and Members of the Subcommittee, today the Subcommittee continues its inquiry into the ability of State regulators to oversee the operations of the 71 Blue Cross and Blue Shield insurance plans that provide health care coverage to almost 100 million Americans. This morning, the Staff is prepared to report for the fourth time the results of its investigation of a specific Blue Cross and Blue Shield Plan, Empire Blue Cross and Blue Shield of New York.

At the outset, the Staff notes that in the case of Empire, as with the three Blue Cross Plans previously examined by staff, we again confronted what appears to be some serious weaknesses in our health care system. As the nation continues to wrestle with the task of health care reform, we believe the problems at Empire reiterate the need to address these basic issues:

—What is the proper role of non-profit insurers in the health care system?
—Can non-profits compete effectively with commercial insurers and still deliver affordable, quality service to their policyholders? If not, is their role so essential that taxpayers and policyholders alike should be asked to subsidize their continued existence?
—In the case of non-profits, how do you assure some basic level of accountability to policyholders?
—Can State regulators ever be adequately equipped to oversee insurers which, as in Empire's case, dominate huge portions of the market?

Mr. Chairman, we believe that our case study of Empire needs to be examined in the context of those types of questions. In our view, what we have learned in this case goes far beyond Empire and touches on problems and concerns that need to be addressed in the system as a whole. With that in mind, we will now discuss the re-

sults of our 6-month analysis of the largest of the Plans that make up the Blue Cross and Blue Shield system.

Empire is a Plan which insures nearly 8.2 million subscribers, almost 45 percent of the citizens of New York, and collects annual premiums of nearly $7 billion. It is a Plan that has been fraught with controversy for some time as its financial picture deteriorated over the last few years while at the same time it sought significant rate increases.

Indicative of the financial problems with Empire is a letter we received from a subscriber of the Empire Plan, Finley Gottlieb, of Manhasset, New York, dated July 21, 1992. In his letter which was sent to us before we had even started to look at Empire, he described a startling example of the Plan's poor finances. He states that:

> On March 25, 1992, I received a check from Empire Blue Cross in the sum of $41. Since their bank and mine at the time were the same (Chase Manhattan) I asked the teller if it were possible to cash the check. Upon pulling the data on the Blue Cross account, she told me that the usable liquid funds in their account did not have a sufficient amount at that time to permit that. Forty-one dollars! I deposited the check and it did clear.
>
> Perhaps your inquiry should include Empire Blue Cross. It is my understanding that their president receives $600,000 per year. A public company's board of directors would demand his resignation.

Eventually, approximately a year later on May 19, 1993, the Board of Empire Blue Cross did indeed force out their Chief Executive Officer, Albert Cardone.

Today, the Subcommittee is faced with a patient that, from all accounts, has been in the intensive care unit for several years. Gross mismanagement, wasteful expenditures, fraud and a history of inattentiveness and non-action by its Board of Directors and the State Insurance Department have left it critically ill.

The Staff's review of the Plan's financial results shows that its underwriting losses for the past 6 years have totaled $617 million. The majority of these underwriting losses, approximately $444 million, have occurred in the last 2 years, 1991 and 1992.

Since 1987, the Plan's deteriorating financial condition has resulted in a serious decline in its reserves needed to protect its policyholders. This important protection for its subscribers has fallen from $222 million to $40 million in 1992. Had it not been for a surprising ruling by the New York Insurance Department in August of 1992 to release $80 million in supplemental reserves held by the Plan for hospital reimbursements, Empire's actual reserves would have fallen below zero to a negative $40 million.

In some respects, the Staff found Empire to be very similar to the three other Plans we previously examined. In all of our investigations, including Empire, the Staff has identified wasteful practices, extravagant expenditures and extremely poor management decisions. Likewise, in every Plan investigated so far, these problems were compounded by a compliant Board of Directors and ineffective State oversight.

Yet, in other respects, Empire is quite different from some of the other Plans the Staff has investigated. For example, the Staff found no significant subsidiary activity resulting in large losses to the Plan. Unlike the other three Plans we have investigated, Empire operates its HMO, Healthnet, as a line of business, rather than as a subsidiary. Also, the Staff did not find expenditures in the nature of country club memberships, stadium skyboxes, or international travel upon the Concorde. Empire management, on the other hand, spent subscriber funds on lavish gifts for themselves and the Board of Directors; a fleet of company cars; and, given their financial difficulties, excessive catering bills for meetings, seminars, and parties.

As was true in the case of Maryland, Empire's senior officers and Board of Directors appear to be in a state of self-delusion and denial. They refuse to accept ultimate responsibility for the current financial and management crisis within the Plan. Even after the forced termination of their long-standing CEO and Chairman of the Board, Albert Cardone, on May 19, 1993, the new Chairman of the Board, Harold E. Vogt, told the Staff that there were no serious problems with the way the Plan was operated. He opined that any problems it had were the result of outside sources such as the health care market and commercial competitors.

The New York Insurance Department is apparently in agreement with the Plan and Mr. Vogt. In a May 27th interview with the Subcommittee Staff, Superintendent Salvatore Curiale placed nearly all the blame for the Plan's financial predicament on external sources such as the "economy," "inflation," and unfair competition from the "commercials."

On the basis of its investigation, the Staff disagrees with both the company and the State Insurance Department. The Plan's current illness is, for the most part, the

result of its own making and can not be easily shifted to others, such as the economy, inflation, or commercial competitors. To understand what went wrong with Empire, one must look within its operations. Although external forces to some extent exacerbated its internal problems, the Staff concludes that the "sine qua non" of this Plan's financial crisis was and continues to be gross mismanagement.

As evidence of this mismanagement, the Staff notes that this Plan has been incapable of effectively carrying out the three most basic functions of insurance underwriting—correctly pricing its product, collecting premiums in a timely and accurate manner, and accurately and efficiently paying its claims.

One additional factor has recently come to light which needs to be addressed and which underscores the timeliness of these hearings. From the outset of this investigation, the Staff has sought to understand the reasons behind Empire's dramatic losses in 1991, and, in particular, the tremendous losses incurred by Empire in its community-rated lines of business in that year. In light of what appeared to the Staff to be a huge aberration in underwriting results, the Staff has continuously pressed Empire's chief financial officer and other top Empire officials for an explanation of these losses.

In particular, the Staff has had concerns that several of Empire's community-rated lines of business showed a strange anomaly in 1991—a steady decline in enrollment combined with a precipitous rise in both number of claims filed and amount of claims incurred.

It now appears from recent events that the Staff's concerns over this issue may have been justified. In a deposition of Jerry Weissman, Empire's Chief Financial Officer, taken by the Staff on June 11, 1993, the Staff questioned Mr. Weissman about the accuracy of information filed by Empire with the Department of Insurance. The following questions and answers are taken from Mr. Weissman's deposition:

> Q. At any time, did you have any reason to believe that the information presented to the Department of Insurance in any of the formal filings or presentations made by Empire did not reflect the true financial position of the company?
>
> A. To the best of my knowledge, the financials that have been the statutory filings are the best representation of our financial statements and have been signed off on by our external auditors.
>
> Q. Are you aware of any discussions within Empire pertaining to falsifying information on filings of the department or presenting them in a light that would not be truly reflective of the actual financial condition of the company?
>
> A. Yes. Recently there has been an inquiry from the press and from, I think, one of the assemblymen that information was given to them that showed an internal document that had different numbers within what we call the market segments for the internal reports versus the external reports, what we file with the Insurance Department. Basically what that is is that in 1988—actually in 1989, shortly after I became CFO, as I indicated, the Underwriting Department did not report to me, and I felt that we needed an internal mechanism that would allow us to show information on an account-by-account basis to have P&L information on each of our groups so that we can hold the salespeople and the underwriters accountable for that information.
>
> The actuaries, when they do the statutory blanks or the statutory annual statements, they do what we call a top-down. So they do an overall reserve for the corporation, and then they allocate that reserve into the different buckets as required in the Insurance Department filings.
>
> The actuaries' data does not include information on an individual account basis, so we could not use that information to develop what we call in-house the brick-by-brick analysis that holds the salespeople accountable.
>
> Now, the underwriters are the ones who do the reserves for the brick-by-brick. I mean, they set the brick-by-brick information. You have two different methodologies. You have the top-down that's done by the actuaries, and then you have the brick-by-brick that's done by the underwriters. You're not going to get the same results when you use two different methodologies. And my feeling always was that it was more important to have the information than to try to reconcile to the nearest dollar the differences in the two methodologies.
>
> Basically, by having the brick-by-brick information I mean, that was the basis on which we got out of the association business in 1991. I think you're aware of that. And the numbers don't lie. I mean, my recollection is that in 1991, for example, there was about a $30 million difference between the in-

ternal report and the external report that we sent to the Insurance Department. Again, $30 million may sound like a lot of money, but you've got to put that in the context of the overall business. We're a $6 billion corporation, and if the two methodologies developed a result that was a half a percent difference, I wasn't going to kill myself. It was more important to have the information by which to track the salespeople and the underwriters. And, you know, we made a lot of decisions on accounts. We have adjusted our prices.

So, yes, I'm aware of it. We have explained it to the press. We explained it to the press; and we explained it to the assemblyman's office.

On June 16, 1993, the Staff received a telephone call from counsel for Empire. Counsel informed the Staff that Empire had discovered that there may in fact have been some discrepancies in certain information filed by Empire with the Department of Insurance. Counsel stated that the effect of these discrepancies may have been to understate the losses incurred by Empire in its experience-rated lines of business. The Staff was informed that Empire had requested that its outside counsel, Willkie, Farr and Gallagher, conduct a thorough investigation of the matter.

The following day, June 17, 1993, *The New York Times*, in a front page article reported annual reports filed by Empire in 1989, 1990, and 1991 had not only understated Empire losses on its experience-rated business but had overstated its losses on its community-rated business. According to this article,

> . . internal books, which were sent to *The Times* anonymously, showed that Empire lost $150.6 million on its policies with individuals and small groups in 1991. But on its State filing for the same year, Empire reported a loss of $181.6 million on those policies.
>
> And the internal books showed a loss of $66 million on policies sold to large companies. The figures filed with New York State showed a loss of $35.1 million.

According to *The Times* article, Empire officials acknowledged that reports filed with the Insurance Department were "erroneous." Empire officials, in fact, confirmed this in an interview with the Staff.

On June 22, 1993, the Staff re-deposed Mr. Weissman. During the course of this deposition, Mr. Weissman explained the reasoning for keeping the internal set of financial records, which he referred to as the "black books." He also explained the process by which Empire generated the set of financial figures reported to the Insurance Department on the Annual Statement, and the reasons why these figures were not always identical to those reflected in the internal records. According to Mr. Weissman, the internal records formed the initial basis for generating the figures for the Annual Statement. Adjustments, known as reallocations, were then made among the claims figures contained in the internal records. In particular, the adjustments were made to that portion of the claims figures which represented claims incurred but not reported ("IBNR").

Mr. Weissman testified that the reallocations were made on the basis of additional information which was received between the time the internal records were finalized and the Annual Statement was due, a period of approximately 3 to 4 weeks. These reallocations had the effect of lowering the claims figures for some lines of business and raising them for others. As a consequence, the gain or loss on those lines would also be effected.

Under questioning by the Staff, however, Mr. Weissman admitted that these reallocations were subjective, and in fact somewhat discretionary, decisions.

> Q. Are these, in essence, just subjective decisions?
>
> A. There is a certain amount of subjectivity in all estimations and I would certainly tell you that there is a certain amount of subjectivity in the calculation of the IBNR.
>
> Q. Is there room for discretion in terms of how you would choose to allocate or reallocate these things?
>
> A. There certainly is room for discretion. However, you would hope that the person who was doing the allocation or the reallocation is doing what they think is appropriate as far as presenting the allocations of the IBNR and the claim numbers.

Mr. Weissman subsequently related to the Staff one instance in which one might question whether the reallocations made were in fact appropriate. According to Mr. Weissman, in early 1991 he informed Empire's CEO, Albert Cardone, of anticipated large losses in Empire's experience rated business. Mr. Weissman testified that this conversation took place at the time Empire was preparing to file its Quarterly

Report with the Insurance Department. Mr. Weissman stated that the projections he provided to Mr. Cardone during that conversation were based on figures he had derived after making his customary reallocations.

Mr. Weissman related that Mr. Cardone was concerned with these projections, and told Mr. Weissman that "this is not a time for me to be super-conservative and show losses that were greater than we expected the actual results to be, and that I had better make sure that if we were showing losses that, in fact, those losses did occur." This conversation apparently left a bad taste in Mr. Weissman's mouth. His testimony on this point was as follows:

> . . . I think I was upset that he had questioned my numbers. That really had not happened in the 2½ years since I had become CFO. I felt extreme pressure that I'd better make sure that our numbers are right. I don't know how you could do that when you're dealing with some fairly sizable projections. But you know, he was a tough guy, and this is the way he dealt with us.
>
> I went back and I took a look at the reserves, and my recollections is that whatever adjustments that I had recommended initially between the internal accounting report and the statutory report, that I increased the adjustment between the experience and the community-rated business.

The Staff then questioned Mr. Weissman as to the effect of the adjustments.

> Q. Do you recall whether the impact of these new adjustments were to raise the community-rated claims and lower the experience-rated claims?
>
> A. My recollection is that the additional adjustments were intended to reduce the experience-rated claims.
>
> Q. Why was that the intention?
>
> A. Because my feeling off of the conversation with Mr. Cardone was that what he was telling me was that it was all right to show experience-rated losses, if that is what I believed the situation to be; however, if I showed losses on the experience-rated that turned out to be greater than they ultimately were, that I was in trouble.
>
> Q. Now previously you said that your recollection was that he didn't—when he made his statement, he didn't really differentiate what kind of losses he was talking about. So why did you come away with the impression that he was most concerned with the experience-rated losses?
>
> A. I mean, because, you know, the community-rated losses, again, you know—those could easily be blamed on cherrypicking, on increased enrollment in the non-group, losses in the Medigap, on the fact that the Superintendent had cut back on the rate increase request.
>
> I didn't think that he took that as really his problem. However, if we were going to show losses on the unregulated business or the experience-rated business, that that would show the company in an unfavorable light.

Mr. Weissman testified that he did not think the new numbers were his best judgment, because, in his 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." The Staff then asked Mr. Weissman whether, based on the subjectivity involved in these adjustments, one could justify almost anything.

> Q. So if your marching orders are, then, to make the experience-rated losses lesser, then you can go in and come up with reallocations to justify that, in essence?
>
> A. I mean, basically, yeah. What I did was, I wasn't you know, very happy with what I was doing, but I also felt that on an overall basis these were a reasonable reflection of what the ultimate results would be.
>
> Q. Why weren't you very happy with what you were doing?
>
> A. Because I would have preferred to stay with the original numbers.
>
> Q. Did you think your original numbers were more accurate than the new numbers?
>
> A. Obviously I thought they were more accurate. That was the basis on which I went in to Cardone in the first place.

It thus appears from Mr. Weissman's testimony that in 1991, the year in which Empire suffered massive losses which it blamed on cherrypicking and other outside factors, the Plan shifted claims from its experienced rated accounts to its community-rated accounts in order to avoid casting the Plan in an unfavorable light. This would appear to place Empire's reliance on the cherrypicking argument in doubt,

and tends to support the Staff's contention that the major causes of Empire's losses were mismanagement and fraud.

In sum, the Staff found the following serious problems with the management, operations, and regulation of the Empire Plan:

—an inability to properly execute the most basic functions of an insurance company, resulting in abysmally poor service to subscribers and providers;
—a severe lack of internal controls leading to a high degree of vulnerability to fraud;
—excessive expenditures for the benefit of senior officers and members of the Board of Directors. These expenditures are not large enough to be a principle cause of Empire's financial problems but they do create a climate within the organization that makes strong financial discipline very unlikely;
—a propensity on the part of Plan management to blame external factors for the Plan's failings and to rely on external sources of relief to keep it afloat;
—inadequate oversight of management activities by the Board of Directors and;
—ineffective regulation of the Plan by the State Department of Insurance.

II. BACKGROUND

A. *The Plan*

Today, Empire Blue Cross and Blue Shield is the nation's largest private not-for-profit health insurer. It is also the largest of the 71 plans that make up the national Blue Cross and Blue Shield Association. Founded in 1935, Empire serves over 8.2 million subscribers in the 28 counties of eastern New York State.

In 1992, Empire collected approximately $6.6 billion in premium and paid out approximately $6.3 billion in claims. It employs over 10,000 people and has an annual payroll of almost $308 million.

Empire is the direct successor to Associated Hospital Service (AHS), which was formed in 1935 as the result of legislation passed the year before by the State of New York creating "prepaid not-for-profit health care organizations." At that time the Plan offered individual, and then later, family and group hospital insurance.

In 1940, the Medical Expense Fund (MEF) was formed as a non-profit medical insurer for the New York City area. In 1944, the Medical Expense Fund merged with Community Medical Care, a subsidiary of AHS, to form United Medical Services, Inc. (UMS), as a single Blue Shield Plan for New York City and its surrounding suburbs.

On June 1, 1974, AHS and UMS merged to form Blue Cross and Blue Shield of Greater New York (BCBSGNY). This entity functioned until 1985 when BCBSGNY merged with Blue Cross of Northeastern New York which operated in the Albany area. This merger was, in part, the result of financial difficulties then facing the Albany Plan. The result of this merger which was approved by both Boards and the New York Department of Insurance was Empire Blue Cross and Blue Shield.

Both AHS and MEF were created with a social purpose that has been passed down to today's Empire Plan. As noted by the then-newly appointed Chairman, Albert Cardone, in the Plan's 1987 annual report, Empire's corporate mission for the last 50 years has been:

> our social commitment to provide affordable health insurance to as large a segment of the population as possible.

To sustain this corporate mission, Empire has historically relied upon two practices—open enrollment and community rating, for a certain percentage of their business. During 1992, this amounted to less than 26 percent of total premiums earned by the company but approximately 80 percent of their underwriting losses.

"Open enrollment" means that coverage is available to all individuals or groups who apply for health insurance. Under this approach, Empire will offer health insurance coverage to virtually every applicant, all year long, regardless of health condition or type of employment, etc.

Empire does establish certain guidelines on group size, legitimate employee status and minimum employee participation in order for a group of individuals to qualify for group rates. However, if the group does not qualify, then individual members could get insurance through individual coverage though usually for more expensive premiums.

Empire also limits coverage under open enrollment to non-pre-existing conditions. This clause is standard to almost any insurance contract and limits or denies coverage for 11 months for any pre-existing condition of new subscribers. The Staff has learned that there is a waiver to this pre-existing condition clause, if requested, for small groups. As will be described in more detail later in the Staff Statement, this

waiver has become a central issue in a number of frauds committed upon the Plan and is just now coming to light.

Customers who obtain health care insurance through the "open enrollment" policy of Empire are placed in "pools" of risk which are charged the same premium regardless of individual health. Three of these pools have been the focus of a great deal of attention in recent years. They are the "small group" pool which consists of groups of fewer than 50 individuals. The second pool consists of all individuals who are purchasing insurance from Empire and is commonly referred to as the "Direct Pay Pool." The third pool consists of those individuals purchasing health insurance to supplement Medicare coverage, i.e. the "Med Supp" pool.

The cost of health care coverage for all the subscribers of each particular pool is aggregated and all members of the pool are charged the same average premium. This is known as the "community rate." The community rate for the specific pool is based upon the average costs of the pool and not the individual health or sickness of a member of the pool.

The actual product offered to these pools and the premium charged are regulated by the Insurance Department. Any changes to either are subject to prior approval of the Department after a written submission with supporting evidence. Usually, rate increases and product changes have resulted in public hearings during which any interested party can express their views either in favor or in opposition to the request.

The community rated lines of business have been a dramatic drain on the company in the last few years. Starting in 1989, this line of business has constantly lost money culminating in approximately $240 million in losses in 1992.

There was another pool that had historically been subject to open enrollment and community rating until 1988. This pool consisted of groups from 50 to 249 members. In that year, the Department of Insurance, at the request of Empire, carved this pool out of the community rated line of business and established an "incentive rate" for it. "Incentive rated" business is a cross between traditional "experience rated" and the unique "community rated" formats. The premiums are calculated using a combination of community and experience rates and are not subject to prior approval of the Insurance Department for rate increases.

The Staff has learned that the incentive rated line of business has been one of Empire's most profitable products. Although it composes a very small portion of the Plan's overall business, less than 5 percent, it showed an underwriting gain of approximately $25 million in 1992. This segment has shown a profit in all of the last 4 years.

As noted above, community rated business amounts to approximately 26 percent of Empire's premium income. Despite its historical mission, the bulk of Empire's business is not "community rated" business but rather "experience rated" just like commercial insurance companies. "Experience rating' means that Empire and other insurers set premiums that reflect a particular group's actual health care usage. The rates charged are tailored to the group in question. By using this rating mechanism, Empire competes directly with other commercial insurers for larger accounts both within New York as well as beyond the State.

There are two main segments of Empire's experience rated business. The first, called "Local Experience Rated" consists of insurance sold to groups with 250 or more employees, all of whom work within the geographic territory of Empire. Premiums and products for this line of business do not require prior approval of the State Insurance Department although the "retention" formula does. Retention is the amount of profit earned for Empire from selling this line of business.

Empire's Local Experience Rated business is their largest line of business. It has shown spotty results over the last 4 years including a dramatic decline in enrollment since 1989 and an underwriting loss in 1991. It showed a $13 million underwriting gain in 1992.

The second segment of the experience rated market includes insurance sold to companies who have employees in both New York and elsewhere within the United States. It is called "National Experience Rated" or "National Account" business. As with the Local Experience Rated business, there is no prior approval of rates and forms but rather the "retention" rate must be approved by the Insurance Department.

The National Accounts have been poor performers for the Plan. They showed a slight underwriting gain in 1989, followed by 3 years of losses including approximately $50 million in 1991 and $35 million in 1992. They are also projected to lose millions in 1993.

Empire views the experience rated business as a means to offset any losses incurred in the community-rated lines of business. In essence, the Plan has historical-

ly justified this business as a way to subsidize the social objective of being the insurer of last resort. In their 1988 Annual Report, it is noted that:

This subsidy has been formally required by the Insurance Department although the actual amount is not stated in the insurance code. The Department has told the Staff that by law the Plan is required to use its experience rated markets to subsidize the community rated business. The amount of that subsidy is determined by the Plan, however. As a result, the Department only expects the Plan to return 1 percent of any profits from the experience rated business to cover the costs of the community-rated line of business. Historically, the Plan has had problems even complying with this self-imposed 1 percent requirement.

Because of its use of open enrollment and community rating, Empire has historically called itself the "insurer of last resort." This, combined with the fact that Empire is licensed and registered in New York as a Section 501(C)(3) Not-For-Profit Corporation, has, to some extent, caused some confusion about health care coverage in New York. Empire has never operated as a charity and provided insurance to the needy who could not afford insurance. Empire may take all New Yorkers who want to buy insurance, but they still have to be able to pay for it. Even with Empire's stated social goal of being the insurer of last resort, New York still has a serious problem of the "uninsured" who can not afford the community rated premiums of Empire or since April 1993, the other insurers who are now selling community rated products.

However, historically because of their willingness to sell insurance per community rating and open enrollment, Empire and the other Blues have been granted certain monetary incentives not enjoyed by other insurance companies in New York. These advantages arose at a time when only Empire and the other Blue Cross/Blue Shield Plans in the State offered community rated products. Although this changed on April 1, 1993, the special benefits granted to the Blues continue to date and are not enjoyed by the commercial carriers selling community rated products even with the passage of the new Community Rating Bill of 1992. This and other aspects of the bill will be discussed below.

These benefits are rather substantial and include:

—no State or local income tax,

—a reduced tax on premiums (per capita tax) of only .3 percent instead of the 2 percent charged commercial insurers,

—reduced property taxes,

—a 13 percent "hospital differential" on their reimbursements to hospitals

The hospital differential has been one of the most significant advantages that the State of New York has historically used to compensate Empire for marketing community rated open enrollment business. The hospital differential indicates the difference in reimbursements paid by the Plan to hospitals for their services in comparison with their commercial competitors. Empire reimburses the hospitals in New York on the basis of their actual costs, whereas commercial insurers must pay more—equal to the differential. The 13 percent differential currently given to Empire means that the hospitals will charge the commercial insurers 13 percent more than charged to Empire for the same procedure.

B.Recent Legislative Initiatives

Faced with dramatic losses in its community rated lines of business, the Plan in 1991 set in motion a series of events that eventually culminated in the passage of a major overhaul of the community rated insurance market. A number of individuals interviewed by the Plan, including the Superintendent of Insurance, indicated that the 1991 rate request of the Plan and its additional request to divide the community rated pool into high risk and low risk segments, intentionally brought to a head the problem of the Plan's losses.

In the 1991 rate request and subsequent public hearings, Empire attributed its dire financial condition to the practice of risk selection and cherrypicking by its commercial competitors. Empire argued that such actions left it with a predominance of the sick and elderly in the community rated market for which Empire was the only insurer.

As indicated by State Senator Michael Tully, Jr., Chairman of the New York Senate Committee on Health, during public hearings on February 25, 1993, Empire's arguments resulted in the passage in July 1992 of Chapter 501 of the Laws of 1992, the Community Rating Bill. Senator Tully described that bill as:

> This piece of legislation was an attempt to "level the playing field" between Empire and its commercial competitors. In essence, it mandated that

as of April 1, 1993, all insurers and health maintenance organizations (HMO's) that sell small group and individual policies must "community rate" and "open enroll" like Empire has been doing for years.

As Superintendent Curiale said before a joint hearing of the State insurance and health committees on February 25, 1993:

> As of April 1, less than 6 weeks from now, insurers of small groups and individuals will no longer be able to reject applicants based on their age, sex, health or occupation. Moreover, under the new rules, most policyholders who change employers will not be required to serve more than one waiting period for pre-existing conditions.

In addition, the 1992 legislation required the establishment of two types of "risk pools" to further assist Empire. One is a "demographic pool" and the other a "large medical claim pool." Insurers with low risks based upon demographics or medical usage will be required to make contributions to these pools which, in turn, will be disbursed to insurers such as Empire who because of their long history of being the insurer of last resort are anticipated to have older and sicker subscribers even after the statute takes effect. As a result of this provision, Empire has estimated they will receive anywhere from $90—$130 million.

Further provisions of the 1992 bill enhanced the authority of the State Insurance Department. Under Section 11 of the law, the Superintendent of Insurance can reject, defer or reduce rate requests if, in his judgment, the salary increases for senior level management are excessive or unwarranted given the financial condition or overall performance of the Plan.

In addition, under Section 12 of the new law, the Superintendent was required to order an independent management and financial audit of Empire. To carry out this audit, the sum of $3.5 million was appropriated. Once the audit was completed, the Superintendent was empowered to order the Plan to implement any recommendations resulting from the report.

Faced with rate increases of over 60 percent for Empire's individual direct pay subscribers in December of 1992, the State Legislature passed another measure in an attempt to address Empire's problems. In January of 1993, they enacted Chapter 1 of 1993, which reduced part of the rate increase, created an independent advisory review and oversight panel for Empire and gave additional enforcement tools to the Superintendent of Insurance.

It is within this historical and legal context that the Staff now reports on its review of the operations and regulation of the Empire Plan.

III. FINANCIAL PICTURE

A. *History of Losses*

To assess the Plan's financial condition, the Staff reviewed internal and external audits, audit workpapers and memoranda, and other financial and operating performance data prepared by the Plan, its consultants, the New York Insurance Department and the Blue Cross Blue Shield Association.

The Staff's review of the Plan's financial results shows that for the 4 years beginning in 1987, Empire lost $57 million in 1987, and made profits of $52 million, $38 million, and $38 million in the years 1988 through 1990.

The deterioration of the Plan's financial condition has been great since 1990 as it incurred losses of $255 million during 1991 and 1992, with reserves going into free-fall—decreasing from $295 million at December 31, 1990 to $40 million at December 31, 1992. Had it not been for a 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. Empire's gains and losses during the past 6 years are shown in the following chart. (See attached chart.)

To put this in context, we refer to our last hearing dealing with the D.C. Plan. If you recall, the reserves required for that Plan by the State of Virginia were $54.6 million. Thus, in 1992 Empire's 8.2 million subscribers were protected by less reserves than that required for the D.C. Plan which only has 1.1 million subscribers. The Staff notes that the amount of reserves in the D.C. Plan was $49.64 per policyholder, but Empire's reserves amounted to only $4.84 per policy holder. Furthermore, of the 71 Blues Plans, Empire's reserves at December 31, 1992 were higher than only 14 other Plans. Generally speaking, these are not the larger plans. In fact, Empire, with $6.6 billion in premiums is the largest Plan.

During the 6-year period from 1987 through 1992, Empire had $35.1 billion in premiums earned. Its $33.1 billion in claims paid and $2.7 billion in administrative expenses resulted in underwriting losses of $617 million for the period. Its investment

income of $421 million and miscellaneous items, reduced the operating loss to $210 million. The aforementioned release of $80 million and changes in non-admitted assets of approximately $52 million results in Empire's reserves of $40 million at December 31, 1992. The following Empire's premiums and claims. (See attached chart.)

1. *Underwriting Losses*

Empire's underwriting losses have totaled $617 million during the past 6 years, with the majority of those losses ($444 million) occurring in 1991 & 1992. The following chart shows underwriting losses since 1987.

Empire's underwriting losses are broken out further for the past 2 years as follows:

Incentive Rated	$25.0	$21.2
Local Experience	7.4	(8.9)
New York State	5.8	4.2
National Accounts	(35.4)	(51.5)
Community Rated	(237.7)	(162.2)
Healthnet	7.8	(19.4)
Total	(227.1)	(216.6)

Some of the experience rated accounts with recent underwriting losses were unions. For example, United Welfare Fund lost $10.6 million, Local 1-J lost $10.7 million, and Amalgamated Lithographers lost $958,000 in 1991.

2. *Healthnet*

Empire's HMO, Healthnet, began business in 1986 and has lost approximately $116 million through 1992. Its losses have greatly contributed to Empire's dire financial condition over the past few years. Healthnet's administrative expense ratio has greatly exceeded Empire's every year, ranging from 10.7 percent to 24.2 percent. While the profitability of many HMOs has increased in the recent past, with 50 percent of HMOs making a profit in 1989 and 79 percent in 1991, Healthnet did not make a profit until 1992. Of 19 HMOs in the New York Area it ranked fifth in size, but last in profitability in 1991.

3. *Empire's Reserves*

Empire is required by New York State Insurance Law to maintain a reserve for the protection of customers. The reserve consists of admitted assets less liabilities. (Admitted assets include receivables aged less than 90 days, cash, investments, and real estate). In 1986, New York increased its statutory reserve requirement from 5 percent to 12.5 percent of 12 months net premium income as set forth in the State insurance law. The reserve fund is to grow by one percent a year, starting in 1986, until it gets to 12.5 percent. The statutory reserve requirement is frozen during years in which Empire invades its reserves. Therefore, it will take at least five more years for Empire to get to 12.5 percent, since Empire was at 8 percent in December 1992. New York allows for invasions of reserves if funds are needed to cover expenses. The law also provides that the reserve should not be below one half of the statutory minimum. The Insurance Superintendent told the Staff that invasions up to 50 percent of reserves do not cause him concern.

Empire first invaded its reserves in January 1987 when its reserves at month's end were $204 million or $12.9 million below the statutory requirement. Formal notice was conveyed to the Superintendent of Insurance. Permission was requested from the Insurance Department to reduce the amount required by not more than 50 percent. Permission was granted subject to submitting and obtaining approval for a plan of restoration over 3 years. The law provides that when an insurer invades its statutory reserves, it must submit a plan to the Superintendent for restoring the reserves within 3 years. This law was recently amended to state that restoration must be within 6 years. It also provides that the statutory requirement will not increase during the year in which a reduction is authorized. If a company does not invade reserves, its statutory reserve requirement will increase if it collects additional premiums. Once a company invades reserves its requirement will be frozen. Accordingly, the statutory requirement remained at 5.5 percent throughout 1987. Reserves at December 31, 1987 represented 3.70 percent of the year's premium income compared to the statutory requirement of 5.5 percent.

Insurance Department personnel told the Staff that it was "fairly evident that Empire would not be able to pay back the invasion of reserves through the 1987 to

1990 period." When asked what options were available to the Department to force Empire to meet its legal reserve requirements, a Department attorney said they "attempted to formulate a plan to get Empire back to the level they were supposed to be at." He said the Department cannot "order" Empire to take certain actions but it could make "recommendations," which it did, but "the Plan did not listen to the recommendations."

The Staff asked why a 3-year plan wasn't filed in 1990. The Department admitted that "technically" another plan should have been filed in 1990 but that it really wasn't crucial since there was "an ongoing plan to make money and cut costs and we were monitoring the plan so closely." When asked what the Department did beyond monitoring, there was silence—the Department never did anything else. The Superintendent said he did not have the authority to do anything else. Insurance Department staff stated that they could only impose a $500 fine for failing to submit a 3-year plan but even this wasn't done.

Chart shows the decline in Empire's reserves during the past 2 years as well as the growing reserve deficit (difference between actual and statutory reserves).

In May 1991 the Department granted Empire's request to reduce its reserve to $246 million or 50 percent of what was then the required amount. During 1991 Empire invaded beyond the 50 percent limit and legally, the Department could have taken them over, but did not. Department personnel told the Staff that taking over Empire would not have been prudent, given that nine million insureds were still getting their claims paid and cash flow was sufficient. They predicted that the action would have ended up in court, the good accounts would have left, and there would have been "negative publicity."

Instead, the Department requested monthly financial reports in October 1991 to better monitor the financial condition. At December 31, 1991 Empire's reserves were 2.14 percent of the year's net premiums, compared to the statutory requirement of 7.5 percent. Due to its significant losses, Empire filed with the Insurance Department to invade the statutory minimum in 1991. The Department froze the statutory minimum at $492 million through June 30, 1992.

Empire submitted a 3-year plan to restore reserves to the Department in July 1992 which described the savings obtainable through product restructuring, the fiscal impact of future rate increases, the recapture of past payments into the Excess Malpractice Pool, a Medicaid waiver of the 9 percent increase in payments to hospitals by HMOs and discontinuance of future payments into the Excess Malpractice Pool. The plan also included Empire's commitment to keep administrative costs below 8 percent.

Empire's reserves at December 31, 1992 were $40 million. It received a settlement of $93.5 million from the State Medical Malpractice fund in March 1993 because Empire and others sued New York for excess funds contributed. Empire's reserves, as reported in its unaudited quarterly statement as of March 31, 1993 were $206 million which includes the $93.5 million just discussed. However, the reserve is still below 50 percent of the statutory reserve of $543 million.

4. *Audit Opinions*

The accounting firm of Deloitte & Touche (previously Deloitte, Haskins & Sells) has issued unqualified opinions[1] on Empire's financial statements for the years 1987 through 1992. Deloitte also considered Empire's internal control structure in order to determine its auditing procedures and did not report any material internal control weaknesses. As discussed later, the Staff has found that Empire has lost millions due in part to internal control problems.

The Staff reviewed minutes of Empire's Audit Committee meetings. During Empire's November 1991 Audit Committee meeting, partner Ruben Nava of Deloitte & Touche, noted that according to American Institute of Certified Public Accountants Statement on Auditing Standards No. 59, "the auditor has a responsibility to evaluate whether there is substantial doubt about the entity's ability to continue as a going concern for a reasonable period of time, not to exceed one year beyond the date of the financial statements being audited."

Deloitte & Touche planned further discussions with management before any such going concern qualification was set forth in the audit opinion or noted in the finan-

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[1] An "unqualified opinion" is a term of art of the accounting profession and means that the independent auditor has no "qualifications" to his opinion that the financial statements he has reviewed fairly present, in all material respects, the corporation's financial position, results of operations and cash flows in conformity with generally accepted accounting principles. A "qualified" opinion states that, except for the effects of the matter(s) to which the qualification relates, financial statements fairly present, in all material respects, the corporation's financial position, results of operations and cash flows in conformity with generally accepted accounting principles.

cial statements. The minutes also said Nava stated that Deloitte & Touche had "received inquiries from some of Empire's major customers expressing concern about Empire's financial condition."

In May 1992, Nava met with Empire's CEO, CFO, and General Counsel, an attorney from Hinman & Straub, the Insurance Superintendent, Deputy Superintendent and another high level Insurance Department official to discuss Empire's financial position and rate increase applications. According to a memo the Staff found in the Deloitte & Touche workpapers which summarized this meeting, Nava wrote:

> "I then discussed with Mr. Curiale the fact that Empire's surplus position at December 31, 1991 and projected surplus position at December 31, 1992 are below the statutory minimum surplus and therefore, may affect our opinion on Empire's 1991 financial statements since the Insurance Department is empowered to take regulatory action such as department supervision of the company, liquidation of the company, etc.
>
> Mr. Curiale promised me that he has no intentions of taking regulatory action against Empire. In view of such assurances, I do not believe that there is substantial doubt about Empire's ability to continue as a going concern due to any regulatory actions."

Deloitte & Touche's unqualified opinion on Empire's financial statements is dated May 8, 1992, 4 days after this meeting. The Staff noted that the audit opinion dates in the 5 years previous to 1992 ranged from February 2nd to February 13th.

According to the minutes of the November 1992 Audit Committee meeting, Nava said "Deloitte & Touche will also determine if there is substantial doubt as to whether Empire can continue as a going concern for the coming year. Deloitte & Touche will review management's 3-year recovery plan along with the impact of any rate increases granted as a result of the pending application." Rich Gander, a Deloitte partner, said "another going concern issue is whether the Blue Cross and Blue Shield Association will need to begin the process of revoking the license to use the names and trademarks." Nava emphasized the "need for a long term recovery plan."

According to a Deloitte & Touche internal memo, in March 1993, Deloitte & Touche met with the Insurance Department because Empire's reserve was below one half of the statutory reserve minimum. The Department again assured the auditors that they had "no intention to take control of the company or put it into rehabilitation" and "that it has been the practice of the Insurance Department to grant Empire substantially all of the rate increases they had requested."

In February 1989 the Insurance Department issued a report titled *Report of the Special Investigation of Empire Blue Cross and Blue Shield by the New York State Insurance Department* which included a recommendation that Empire change its external auditors because of an appearance of a lack of independence. The Insurance Department was concerned about the presence of ten former Deloitte personnel holding high level positions at Empire. In a workpaper prepared by Deloitte, the accounting firm said the State Insurance Department expected Empire to abide by the recommendation.

> "As a result, we were put in a situation where we were threatened with losing Empire as an audit client. We first met with the State Insurance Department, but they were unwilling to withdraw their recommendation. We then realized that our only chance was to convince the Audit Committee and the Board of Directors to ignore the State's recommendation."

Deloitte's efforts apparently were successful and they once again were awarded the audit for 1989 by a Board vote of 28 to 3.

5. *Receivables*

As discussed in a later section, Empire has difficulty collecting its receivables, which primarily include premiums owed to Empire from subscribers, in a timely manner. Its CFO estimated that it has written off approximately $10 million to $20 million annually for the past 5 years. Empire also has significant amounts of receivables over 90 days old.

The ability of an organization to collect its receivables in a timely manner improves the organization's cash flow and allows more funds to be available for investing—thereby improving its financial condition. In the case of a company like Empire, if it does not collect a receivable within 90 days, that receivable becomes a "non-admitted" asset and according to the statutory reserve requirement, cannot be used as a part of Empire's reserve for the protection of customers. The "older" a receivable gets the less likely it is to be collected due to lack of documentation,

bankruptcies and debtors moving. Eventually, uncollectible receivables are written off resulting in a loss.

Empire's non-admitted assets have increased from $83.2 million in 1987 to $124.2 million in 1992. (See attached chart.) The primary reasons for this increase has been an increase of $16.1 million in uncollected premiums and an increase of $20.9 million in miscellaneous accounts receivable.

The current Insurance Department examiner, Martin Schwartzman, told the Staff that reconciliations were not performed on interplan receivables in a timely manner and Empire has difficulty collecting without proper documentation. In fact the inter-plan unreconciled file was $28.7 million. He expects they will write off $13 million. As discussed in a later section of the Staff Statement, the Insurance Department examination covers the 4 years ended December 31, 1991 and is not expected to be completed until later this summer, with the resulting report filed later. The Staff questions the usefulness of this old information.

An Internal Audit report of the Inter-Plan Bank—Home Bank program in June 1992 found that approximately $12.3 million of receivables over one year old were included as admitted assets for Empire.

Empire's accounts receivable over 91 days at December 31, 1991 were $99,240,307 of which $37,645,816 was non-admitted. Some receivables aged more than 90 days which are admitted are $14.2 million with New York City, $3.3 million with New York State, and $1.1 million with the Federal government (these 3 government receivables are exempt from non-admit status). Further, due to Empire's relationship with hospitals, hospital receivables of $34.8 million were exempt from non-admit status. Also, based on the client's longstanding relationship with the group, an $11.7 million receivable with SPA Local 1199 was not non-admitted.

The CFO told the Staff that Empire's overdue receivables and writeoffs are not material to a $7 billion company.

Empire's problems with collecting amounts it is owed is historical. An Internal Audit report from July 1988 reported interplan receivables of $11.1 million which were over 120 days old.

Empire also wrote off $50 million in uncollected and unbilled sums over the period 1984 to 1986 due to a computer dropping off amounts greater than $100,000. This issue is discussed in more detail in a later section.

6. *Financial Forecasts*

Empire's forecasting of its financial results has been unimpressive. While Staff acknowledges that forecasting is an inexact science, Empire's forecasting has been particularly bad. Accurate forecasts are necessary for management to make prudent business decisions. However, Empire's forecasts have been overly optimistic. Following are examples of Empire's forecasts and actual results:

—At a Finance Committee meeting on February 5, 1992, Cardone said he expected a breakeven year for 1992. However, Empire's loss that year was $104 million.

—Empire's 1991 Corporate Plan and Budget projected an underwriting loss of $29 million for 1991. The actual results were a loss of $217 million, or $188 million worse than projected.

—Empire's 1989 Corporate Plan and Budget forecast an underwriting gain of $54 million in 1989. In June 1989 Empire revised its projected underwriting loss to $11.5 million for the year. Actual underwriting losses were $38 million, or $92 million worse than forecasted.

—Regarding Empire's 60 percent owned subsidiary Beacon, an Empire Director said at a January 1987 Board meeting that financial projections called for profits to be attained after the third year with a recoupment to break even for the project expected by the end of the fourth year. Actual results are that Beacon has lost money in each of its 6 years of existence with Empire's share of the loss $6.8 million through 1991.

—Empire projected that another subsidiary, ENASCO, would earn a profit of $293,000 for 1991. Actual results were a loss of $2.4 million that year, more than nine times worse than projected.

—Empire projected that its subsidiary Northeastern New York Health Care Consortium, Inc. would earn $76,000 in 1990. Instead, it lost $808,000 that year, more than 11 times worse than projected.

—Empire projected its investment income to remain flat at $80 million for 1989. Actual investment income was $71 million.

—Empire projected an underwriting loss of $51 million for 1987 and ended up with a loss of $118 million, a difference of $67 million, or 131 percent off the mark.

Others who have recently analyzed Empire have concluded that Empire's forecasting is weak. Eric Edelstein of Arthur Andersen met with the Staff in May 1993 and said "Empire's forecasting is not good, based on their past record, and it will be very difficult for Empire to meet its 1993 forecast of $67 million profit." The BCBSA told the Staff that Empire's projected Capital Benchmark was optimistic and that Empire's CFO admitted to BCBSA that Empire's forecast that it will receive $130 million from the demographic pool was too high, but did not revise that forecast until several months later.

Had Empire's forecasts been better the Board of Directors may have been able to take swift and decisive action to turn the company's finances around.

7. *"Window Dressing"*

The Plan may be making its financial condition appear to be better than it really is by holding on to funds for as long as possible before paying claims. As evidence of this, the Staff reviewed Empire's Provision for Outstanding Checks, which is a provision for checks issued by Empire, but not yet presented to Empire's banks for payment. This is a standard accounting provision used by companies to reconcile its bank accounts for checks issued but not yet presented for payment. The Staff found it unusual that this amount of "outstanding checks" increased dramatically this year, thereby improving the company's financial picture.

Our review showed that the average balance for the 12 months of 1991 in the Provision for Outstanding Checks was $68 million, so the ending balance on December 31, 1992 of $148.3 million was extremely high. These amounts were around $35 million in the mid 1980s. When asked by the Staff about the large balance at year end 1992, the CFO said it was a timing difference.

The Greater New York Hospital Association discovered a claims payment slowdown during the past 2 years. The Association has found that its receivables over 60 days outstanding from Empire have increased from 47 percent to 58 percent between January 1991 and December 1992. The percentage at mid year 1992 was 52 percent, which indicates a pronounced trend in the last 6 months that year. This indicates that Empire is holding on to cash longer.

Empire may also be inflating its financial condition through its use of a Pursue and Pay Questionnaire which went into effect in April 1993. The questionnaire must be completed by all Empire subscribers discharged from hospitals and returned to Empire before the claim will be considered. Previously, Empire had a Pay and Pursue policy which meant it paid claims and then followed up to determine whether the patient had other coverage. Conversely, with Pursue and Pay, Empire is now determining other coverage and then paying. The effect of this policy allows Empire to pay claims later, thereby improving cash flow.

One hospital administrator told the Staff that he "estimated a 15–40 percent decrease in cash flow to hospitals" as a result of this new procedure, and that "Empire's quarterly statement for June will look great since they're sitting on the hospital's money." Empire's CFO told the Staff that he is aware of this situation and said that "other insurers have been doing this all along."

8. *Administrative Expenses*

Empire's administrative expenses increased from $372 million in 1987 to $512 million in 1991. This represents an average increase of 9.4 percent a year. Administrative expenses leveled off in 1992. This changes in these expenses.

Empire claims that its administrative expense ratio (administrative expenses divided by premiums earned) of around 7–8 percent compares very favorably with commercials whose ratio is around 15–35 percent. The Staff has learned that this is not a valid comparison because commercial insurers would inherently have higher expenses. Commercials pay commissions to brokers, which are included in administrative expenses, while Empire does not. Furthermore, Empire receives tax breaks from New York, while commercials do not. Even Empire's CFO, Jerry Weissman, admitted to Arthur Andersen that comparisons of the administrative ratio are not important because companies calculate it differently.

In addition, Empire's administrative expenses should be lower than most insurers because it has a disproportionate amount of hospital-only business which traditionally has lower administrative costs. Blue Cross Association staff confirmed that Empire should have lower administration ratio than most commercials and other BC/BS Plans because of their mix of business. When asked, a National Association representative said that among all the Blues Plans, those that come closest to Empire's mix of business are the Pennsylvania Blue Cross Plans. A review of those

Plans for the years 1988 through 1992 showed the following ranges in administrative expenses:4

Blue Cross of North East Pennsylvania	3.68 to 4.35 percent
Blue Cross of Western Pennsylvania	1.47 to 2.25 percent
Capital Blue Cross	4.74 to 5.15 percent
Independence Blue Cross	5.65 to 7.19 percent

Empire's ratios during the same time ranged from 7.21 percent to 7.78 percent, which actually put Empire at the higher end of the spectrum. Thus, it appears that Empire's administrative costs may actually be out of line with what they should be.

B. *Various Bailouts by State/Insurance Department*

In August 1992 the New York Insurance Department advised Empire that a hospital supplemental payment reserve for possible retrospective hospital rate adjustments for claims incurred after December 31, 1987 and to be paid by prospective rate adjustment, should not be maintained. This action by the Department resulted in Empire reducing its supplemental reserve by $266,754,000 which had the effect of increasing surplus by $79,859,000 and kept the Plan from dropping below zero at year-end.

In January 1993 an agreement was reached to settle a medical malpractice lawsuit that Empire and others held against New York. Empire was awarded and received $93.5 million from the State medical malpractice fund in March. This lawsuit was brought for the return of excess funds contributed to the fund.

C. *Conclusions*

Empire's financial condition is precarious at best. The Plan has had underwriting losses of $444 million the past 2 years and its reserves decreased from $295 million at December 31, 1990 to $40 million at December 31, 1992, or $485 million below the statutory limit. New York allows for invasions of reserves of up to 50 percent provided a 3-year plan of restoration is approved by the Insurance Department. Empire first invaded reserves in January 1987 and then went below the 50 percent statutory minimum during 1991. Therefore, since 1991 and through April 1993 Empire has been below 50 percent of the statutory reserve requirement, although the Insurance Department has decided not to take it over or put it into receivership. It has had to rely on large rate increases, which drive away subscribers, and various cash infusions—such as the release of $80 million in reserves in 1992 and $93.5 million from settlement of a lawsuit in 1993 to stay in business.

Empire's forecasting of its financial results have historically been poor. Actual results almost always end up far short of the forecasts. Empire's Board has lost opportunities to take action to improve finances since its Finance Committee hears upbeat forecasts but the corporation's condition continues to worsen.

Arthur Andersen and the National Association agree that Empire's forecasts are optimistic.

Empire's external auditor, Deloitte & Touche has issued unqualified opinions on Empire's financial statements and has not noted any material internal control weaknesses. However, as discussed later in the Staff Statement, Empire has numerous problems resulting from internal control weaknesses. The auditors issued unqualified opinions only after express assurances from the Department of Insurance that, despite its failure to meet reserve requirements, Empire would not be taken over by State regulatory authorities.

Empire has had to rely on extraordinary measures to keep them in business—20 percent rate increases, receipt of $93 million in settling a lawsuit, release of a reserve which contributed $80 million to surplus and favorable legislation. The company is also relying on an expected payment of around $90 million in 1993 to maintain a positive reserve. The Staff believes that Empire needs to focus on managing its business better and becoming profitable rather than relying on such extraordinary means to stay above water.

IV. EMPIRE'S EXPLANATION—IT'S SOMEONE ELSE'S FAULT

In addressing the issue of its financial decline, Empire has consistently sought to place the blame for its predicament on outside parties and outside factors. Among the favorite targets are commercial insurers, the State Insurance Department, the economy, and the health care system. There seems to be little, if any, recognition on the part of Empire's management that Empire's problems may have been of its own making. Indeed, in an interview with reporters from *The New York Times* earlier

this year, Empire's President, Albert Cardone, was asked what Empire had done wrong which had contributed to its problems. Mr. Cardone's response was, "Empire did nothing wrong."

In briefings and interviews with the Staff, Empire officials have taken a similar position, and have pointed to a number of specific factors to explain their recent losses, including: (1) the insurance underwriting cycle; (2) "cherrypicking" and "dumping" by commercial insurers; and (3) rate suppression by the Department of Insurance. While each of these factors may have contributed in some way to Empire's problems, Empire's almost complete reliance on them to explain away over $440 million in underwriting losses and over $250 million in operating losses over the past 2 years is too facile, ignores other contributing factors, and, moreover, ignores Empire's own contributory blame for the cited factors themselves.

At first blush then, Empire's reliance on the cyclicality of the insurance industry would appear to be reasonable. A closer examination of the underwriting cycle, however, reveals that the years 1991 and 1992 were good years for Blue Cross and Blue Shield Plans in aggregate—that is, they were part of the up-cycle. The year 1991 was the third year of the traditional 3-year period of underwriting gains, and 1992 turned out to be an extra fourth year of underwriting profits. During this same time period, though, Empire was suffering some of its largest underwriting losses ever. Indeed, Empire suffered varying degrees of underwriting losses throughout the entire period of this most recent up-cycle.

Empire's response to this fact is to say that it has always been on its own cycle, a cycle which it claims has consistently run 18 to 24 months ahead of or behind the rest of the industry. However, a study by Weiss Research Inc. of West Palm Beach, Florida, has shown that, in fact, Empire's cycle of gains and losses has for the most part paralleled that of other Blues Plans since the mid-70s. Indeed, Weiss sees Empire's underwriting losses in 1991 and 1992, at a time when other Blues Plans were still enjoying underwriting gains, as an ominous sign:

> "For the last 4 years, the health insurance industry has been in a recovery phase. Most Blue Cross and Blue Shield and commercial carriers have been making money and building reserves. Even the other Blues in New York State have been gradually coming out of the red. . . . But throughout this recovery phase, Empire has continued to deteriorate. . . ."

In light of what Weiss refers to as Empire's "countercyclical losses," he poses a very serious question:

> "If Empire is doing so poorly during a period which has been relatively favorable for the rest of the industry, what will be the results for Empire if the rest of the industry turns down?"

Empire's reliance on the insurance cycle thus is not only simplistic, it is misplaced.

Probably Empire's biggest source of blame for its financial woes is what it sees as the behavior of its competitors in the commercial insurance industry. In presentations to the New York State Insurance Department, to its subscribers, to its Board of Directors, to the media, and to the Staff, Empire's management has continuously excoriated commercial insurers for what it refers to as "cherrypicking" and "dumping." These activities, according to Empire, are at the root of Empire's tremendous losses in its community rated business, and it is these losses that have forced Empire to seek often double-digit rate increases in the past few years.

As Empire defines it, "cherrypicking" involves selective underwriting practices by commercial insurers through which they seek to attract the better risks from Empire's community pool (i.e., the "cherries") by offering them lower prices, while avoiding the poorer risks by refusing to underwrite them at any price. "Dumping," according to Empire, is a practice by which a carrier will agree to underwrite a particular small group, but refuse to include one or more selected individuals within the group because of those individuals' particular medical history or condition. Empire claims that these people end up being "dumped" into Empire's individual direct pay market segment. Empire claims that the effect of these practices is to leave Empire with a constantly deteriorating risk pool which consumes an ever-higher amount of health care services, thereby creating ever-increasing underwriting losses for this pool.

Although Empire has consistently blamed the commercial carriers for stealing all of its best risks, Empire's own small group cancellation study, dated January 1992, and using data provided by Gallup, shows that less than half (45.8 percent) of those groups that canceled their Empire coverage in 1991 went to commercial carriers. Indeed, in Gallup's separate report, dated February 1992, it found that 36 percent of

those that canceled their Empire coverage no longer maintained health insurance coverage at all. Of those that did cancel Empire coverage for that provided by a commercial carrier, over 20 percent canceled for reasons other than cheaper costs (i.e., for reasons other than being cherrypicked)—8 percent left because their business moved, was merged, or was sold; 7 percent left because of poor service by Empire, and 6 percent left because Empire canceled them.

The Staff also has concerns about Empire's reliance on a second study conducted by Milliman and Robertson. Although the Milliman study concludes that "Empire's competition is using risk selection techniques that unravel Empire's community rated pool." Milliman reached its conclusions on the basis of information and data provided by Empire itself, without doing any independent verification of that data. In particular, with respect to its comparison of loss ratios, Milliman made no effort to ascertain the reasons behind the higher loss ratios for those groups which were not cherrypicked away by other insurers. The Staff's own investigation has uncovered internal Empire audits which now show that a large percentage of Empire's losses in some of its small groups were the result of groups and individuals who were never eligible for this insurance coverage in the first place. Indeed, in a number of these cases, the high loss ratio was the result of outright fraud as exemplified in the recent revelations concerning the Finkelstein case which will be explained later in this statement.

It would thus appear from Empire's own data that, at best, only about half of its lost business in the small group market was the result of cherrypicking, and that the deterioration of the small group line of business is not necessarily a result of cherrypicking. In the Staff's opinion, this data does not, and cannot, sufficiently explain the vast losses incurred in Empire's community rated pool during 1991 and 1992.

One must also remember that the "cherrypicking" argument is only applicable to the small group line of business. Indeed, Empire's evidence of cherrypicking consists of studies done on cancellations in only Empire's small group business. This line of business, which in Empire's Annual Statement filed with the Insurance Department is referred to as "Group Remittance," covers groups of between 3 and 49 members. Empire's community rated pool, however, is made up of other lines of business as well, including group conversion subscribers, direct pay subscribers, Medicare supplementary subscribers, and HMO subscribers. These other lines of business accounted for over 65 percent of Empire's losses in its community rated pool in 1991, and 78 percent of its losses in its community rated pool in 1992. This data seems to suggest that, even giving Empire the full benefit of the doubt on it cherrypicking logic, this argument can only account for a small percentage of Empire's overall losses in its community rated pool.

Empire has argued that dumping by commercial carriers, which is in essence a by-product of cherrypicking, affects its direct pay line of business, a line which has incurred large losses over the past few years. Empire, however, has never provided statistical evidence of dumping, never provided figures as to the number of its direct pay subscribers who were dumped by other carriers, and never quantified the monetary impact of dumping on Empire's direct pay line of business.

In fact, a 1992 audit of over 2000 high loss small groups performed by Empire's Internal Audit Department found "little to no evidence" of cherrypicking or dumping. Moreover, in an interview with *The New York Times* conducted earlier this year, Mr. Cardone was asked for evidence to back up Empire's claims of dumping. Mr. Cardone produced for *The Times* applications for direct pay coverage submitted by individuals who had been denied coverage from their employer's commercial insurer based on various medical underwriting criteria. Noting with an air of surprise how honest these people were for admitting on their Empire application that they had been dumped, Mr. Cardone nevertheless told *The Times* that Empire "won't cover them." In Mr. Cardone's words, Empire "is the insurer of last resort; we are not the reinsurer of [commercial insurers'] good risks gone bad." It would therefore seem that the only proof of dumping which Empire has is in connection with people Empire itself has refused to cover, and therefore not adversely affecting its direct pay line of business is.

A corollary to the cherrypicking/dumping argument has been Empire's claim that commercial carriers deliberately underprice their experience rated national accounts to serve as a loss leader for other insurance products they hope to market to these accounts. Empire has claimed that this practice has forced it to price its own national accounts very close to the edge profit-wise, and has thereby restricted its ability to generate underwriting gains on this segment of its business.

While Empire continues to make this argument, it has to date offered little, if any credible evidence to support its claim. Conversely, the Staff has interviewed a

number of representatives from the commercial insurance industry, all of whom deny that their companies use health insurance as a loss leader. Indeed, one representative of a major commercial insurer told the Staff that if the head of health underwriting operated his division on a loss leader basis, that individual would not be employed with the company very long. And in fact, the commercial carriers provided the Staff with figures showing that they had generated profits on their health underwriting in recent years.

Another tactic which Empire has used to excuse its large losses has been to blame the State Insurance Department. In particular, Empire has blamed the Insurance Department for what it has termed rate suppression for the community-rated lines of business where the Plan prices the product and the Insurance Department must approve it. Empire's claim in this regard is that denials of rate increase requests led to inadequate rates, which in turn led to losses in the community rated lines of business. While it is true that Empire has not succeeded in obtaining the full measure of its rate increase requests throughout the years, this argument is once again, too facile to be relied upon in great measure.

For its part, the Department of Insurance has denied that there has been any wholesale rate suppression, and argues that even more consumers would have been priced out of the market had Empire been granted its full rate requests. In fact, a review of Empire's rate applications and the Department's opinions and decisions on these applications shows that with the exception of the rate increase requested for 1992, Empire has fared rather well in obtaining its requested increases. For the year 1989, Empire received 82 percent of its requested increase, and for the years 1990 and 1991, it received over 93 percent of its request.

Information obtained from the Blue Cross and Blue Shield Association further shows that rate denials are only a partial answer. In a document dated August 18, 1992, the Association states that rate denials and reductions by the Department of Insurance accounted for only 47 percent of Empire's underwriting losses on its community rated lines of business during the years 1988 through 1992. The document goes on to state however, that even if Empire had been granted its rate requests in full during this period, it still would have lost over $365 million for these years.

A subsequent Association document, dated February 1993, makes a similar point, stating that for the period 1986 through 1992, less tnan half (49 percent) of Empire's losses on community rated lines of business were due to rate denials. This document, however, specifically states that the balance of the losses during this period were due to inadequate rate requests by Empire. Recently, the Staff interviewed officials of the Association and asked them about the issue of rate denials leading to losses. In a June 9, 1993 interview with the Staff, Susan Barrish, the Association's Executive Director, Business Performance Review, confirmed the statement in the 1992 document when she told the Staff that even if Empire had been granted its rate increase requests in full over the years, it still would have suffered large losses.

Despite its complaints about rate suppression what is perhaps most telling is the fact that prior to 1992, Empire never bothered to appeal any of the Department's rate decisions, despite its legal right to do so. In fact the only time Empire objected to a rate decision was in 1990 when the Department granted Empire's HMO more of an increase than Empire had requested.

V. ARTHUR ANDERSEN STUDY: A FLAWED REPORT

A. *Background and Context Raises Questions*

From the inception of the Subcommittee's investigation of Empire, the Staff was told that a legislatively mandated management report being conducted by Arthur Andersen would address a number of outstanding issues relating to the Plan. Repeatedly, when interviewees at either the Plan or the Insurance Department could not answer a particular question, they told the Staff that "the Arthur Andersen study" would address our question or concerns.

It is in this context that the Subcommittee Staff reviewed the results of the $1.9 million, 7-month long management and financial audit of the Empire Plan performed by Arthur Andersen. In doing so, the Staff interviewed the managers of the Arthur Andersen team on three separate occasions, subpoenaed their work papers, including all of their interview notes and reviewed the pertinent records of the Insurance Department dealing with the granting of the contract.

The Staff's review raises concerns about the ultimate validity of a number of the findings of this report. The Staff believes the report may be fatally flawed and questions:

—the overall objectivity of the Arthur Andersen report;

—the thoroughness of the Insurance Department's contracting process for the Arthur Andersen contract;

—the accuracy, completeness and independence of the report; and

—the undue reliance upon representations of the Plan without any independent verification.

B. *Legislative Requirements: An Independent Review*

In July of 1992, the New York State Legislature passed the Community Rating Bill (Chapter 501 of the Laws of 1992). Under section 12 of that bill, the Superintendent of insurance was authorized to order an "independent management and financial audit" of Empire in order to:

> develop a detailed understanding of such corporation's financial status and to determine the viability of such corporation's products.

This audit was required to be completed by May 1, 1993 at which time it was to be provided to the Departments of Insurance and Health, the Senate and Assembly committees on health and insurance as well as the Plan and each member of its Board of Directors. Three and a half million was appropriated to cover the cost of this audit.

The New York legislature only placed one condition on the Insurance Department's authority to grant a contract under this provision. The legislation specifically barred any organization from performing the audit if they were found to have done work for Empire within the last 5 years, unless there was an affirmative showing of independence and objectivity.

C. *Arthur Andersen: Questions of Objectivity*

On July 27, 1992, the Superintendent of Insurance issued a Request for Proposal (RFP) for the independent management audit. On August 31, 1992, Arthur Andersen responded with a proposal. Seven other auditing consulting firms also submitted proposals.

On or about September 15, 1992, the Superintendent picked Arthur Andersen, the lowest bidder at $1,921,100. In justifying this decision, a letter subsequently prepared in December, 1992, states that Arthur Andersen had a better understanding of the issues, a demonstrated level of expertise equal to or greater than all other proposals submitted, a demonstrated ability and competence, an ability to meet the time schedule required and they were the lowest bidder.

The Staff has learned that at the time Arthur Andersen was awarded the contract they had a significant business relationship with Empire. A review of the Plan's annual statements filed with the Insurance Department revealed that Andersen Consulting, a business unit of Arthur Andersen, was paid $371,000 in 1992 by Empire. In 1991, the Plan paid them $447,000. The size of these contracts made Andersen Consulting one of the highest paid "consultants" listed on the documents submitted by the Plan to the Insurance Department for both years.

The Subcommittee Staff interviewed Eric Edelstein, the Project Director of the Arthur Andersen study and Paul Anello of Andersen Consulting. They told the Staff that while $3.5 million was appropriated for this audit, Arthur Andersen bid about $1.945 million. When asked, they did not know if they made a profit on this contract, although they thought they had. They admitted that in order to get the contract, the price:

> "was discounted from our normal rates because we wanted to be helpful, improve our credentials, get more work from other Blues, and build staff skills."

When asked, they said that they were not specifically hoping to get more business from Empire as a result of this contract but that, certainly, they hoped to get "more Blues business" because of it.

Edelstein acknowledged that in order to get the contract, bidders had to indicate that they provided no services for Empire during the past 5 years; or, if they had, that there was no conflict. When asked what, if anything, Arthur Andersen did to adequately demonstrate that such services would not compromise their performance or objectivity, as required by the statute, they responded that "we told the Department we were independent and there was no conflict."

Edelstein said that "Basically, the Insurance Department relied upon our assurances to meet this requirement." Mr. Anello later stated that:

> "someone from the Insurance Department, maybe Miriam Boggio or a Mr. Klein, telephoned us sometime after we submitted the proposal and asked us if we were independent and did we feel we had a conflict."

On May 27, 1993 the Subcommittee Staff interviewed the New York State Superintendent of Insurance, Salvatore Curiale, along with a number of members of his senior staff on a number of topics including Arthur Andersen's study. It was his recollection that Stan Dorf, Director of Policy and Planning for the Department, informed him that Arthur Andersen was the consensus choice and that he went along with their decision. Superintendent Curiale was not certain of all of the criteria used by his staff but did recall that Andersen was the low bidder.

The Staff was told that this decision was orally presented to Curiale and that there was no written document recommending Arthur Andersen prepared contemporaneously to his making the decision to award this important $1.9 million contract.

When asked about Andersen's independence and objectivity, Curiale recalled that the bid addressed the issue and that the committee would have taken it into account. However, at the time of the bidding process, Curiale was not aware that Andersen or any of its subsidiaries had done or was doing work for Empire. When directly asked, he admitted that he did not know that Andersen Consultants was one of the highest paid consultants for the Plan in 1991 and 1992. He also did not know what steps the committee took to verify Arthur Andersen's independence.

When told that the Andersen consultants had informed the Subcommittee Staff that the extent of the Department's efforts to determine Andersen's objectivity apparently consisted of asking them if they were independent, including a telephone call from Deputy Superintendent Boggio, he indicated he did not know what his Department had done. Ms. Boggio was present in the room during this interview and did not deny she had called Andersen.

A review of the files provided to the Subcommittee by the Insurance Department does not evidence any independent verification of Andersen's independence. There is no evidence that the reviewers even knew the full extent of Andersen's contractual relationship with the Plan. None of the material provided would indicate that any overt steps were taken to determine the existence of a conflict other than asking Arthur Andersen if there was one. For instance, the Department staff should have taken any of the following options:

—reviewed the extent and nature of the contracts Arthur Andersen had with the Plan;

—interviewed Andersen's staff to determine whether they had performed work for Empire;

—reviewed Schedule G of Empire's Annual Statements filed with the Department to determine amounts previously paid to Andersen;

—asked Empire what work Andersen had done for them; and

—reviewed Andersen's work products on Empire.

D. *The Report: Findings Agree With Plan*

The Arthur Andersen report includes almost fifty pages of recommendations and conclusions. Many are quite detailed and deal with the minutia of insurance company operations. They will not be the subject of this section although the entire report will be made a part of the Staff Statement's appendices and be part of the official files of the Subcommittee.

Rather, the Staff's review focused upon a number of the most important conclusions of the report that relate to the causes of the Plan's current financial dilemma. As previously mentioned, the Plan has for some time argued that its losses were the result of "cherrypicking" and other competitive activities by commercial insurers. Likewise, the Plan has argued that "rate suppression" by the Insurance Department has also led to its dramatic losses in 1991 and 1992. As a corollary to their argument, the Plan also has insisted that neither mismanagement nor internal fraud have significantly affected their financial picture.

The Arthur Andersen report addressed most of these issues and tended to agree with the Plan's arguments. Among other things, they concluded that:

—"Cherrypicking is a real phenomenon and has directly contributed to the deterioration of Empire's small group pool."

—"Empire's experience rated business is not draining resources from the Company as a whole."

—"Empire should continue its initiatives in National Accounts."

—"The number of Empire's officers and their compensation is reasonable."

—"Administrative costs are not the cause for rising insurance premiums."

—"Many observers have blamed rising insurance premiums on Empire mismanagement, citing excessive administrative expenses as an example. In fact, the main causes for premium rate increases have been the dramatic rise in the cost of healthcare and the increased utilization of healthcare benefits by subscribers remaining in the community rated pool."

E. *Critical Flaws In The Report*

In concluding the interview of May 27th, the Superintendent refused to express an overall opinion on the quality of the Arthur Andersen report. After repeated attempts to discern his overall impression, Superintendent Curiale would only state that he felt the report was "professional."

Others have not been so reticent. As an example, the Staff was provided correspondence from a recently retired senior official of the Plan which was highly critical of the report. He noted the following shortcomings:

—"I was amazed that there was no discussion, evaluation, audit, etc. of the Underwriting process at Empire. . . . Given that this process is an integral insurance activity and at the heart of much of the cherrypicking and managed care controversy, I would have thought that there would have been some review as to how Empire prices and underwrites its products.

—"Much of the comments in the body of the report were accurate and 'on target' but the conclusions drawn in the executive summary belie the actual report findings. For example, it is summarily recommended that Empire remain in the National Accounts business while the comments in the body of the report would all suggest discontinuing participation."

The Staff's analysis of the report raises additional concerns about the following findings from the Andersen report:

1. *Cherrypicking*

Although this is one of the most critical issues in the current debate over the Plan's financial predicament, Arthur Andersen devotes little attention to it. In a 284 page section on Empire's operating environment, they spend only three pages discussing this issue. Moreover, Andersen's analysis of this important issue consists merely of repeating the Plan's argument that cherrypicking has been a primary factor contributing to the deterioration of its community rated pool.

Andersen refers to a number of unnamed reports that it claims supports the Plan's contentions but when the Staff asked for further details, the Andersen team could not provide any further information about these reports. They couldn't provide the Staff with either the actual reports or even their names since they had been returned to the Plan pursuant to a signed confidentiality agreement between the Insurance Department, Arthur Andersen, and the Plan that required the return of all of the Plan's documents upon completion of the study. The Staff notes that this confidentiality agreement was finalized on March 12, 1993, months after Andersen began work on the project but only one day after the Subcommittee Staff's second meeting with Arthur Andersen. A copy of that agreement will be made an exhibit to this statement.

The Andersen team admitted to the Staff that they did "no independent studies or reports" of their own in support of this conclusion. They relied solely upon the Plan's representations and nothing else when they concluded that cherrypicking "is a real phenomena." As such, the Staff feels the Arthur Andersen report does nothing in clearing up the important question about the impact of "cherrypicking" on the Plan's community-rated lines of business.

2. *National Accounts and Experience Rated Business*

The Staff found similar problems with Andersen's conclusions dealing with the National Account and experience Rated Business. The Staff concludes that the Andersen team appeared to have relied upon the Plan's assertions even in the face of contradictory facts and observations included in the body of their report.

When asked for any documentary or financial analysis in support of this conclusion, once again the Andersen team was unable to provide any to the Staff. When pressed to explain this anomalous situation, they defended their conclusion as being their professional judgment although admittedly based in large measure on representations from the Plan.

When asked, Edelstein also admitted that the Andersen team never attempted to contact the numerous companies that have dropped Empire in the last few years to determine their reasons for leaving Empire. He felt it was unnecessary to do so since they had interviewed a number of brokers who represented some of Empire's current clients.

If Andersen had interviewed former clients, the Staff believes they would have found, as the Subcommittee Staff did, that the reason they left was essentially because of poor service and not because the commercials offered a less expensive product. Andersen would have also discovered, as the Subcommittee did, that the decision to change health care providers is one that most companies will postpone doing even in the face of very poor service because of the inherent disruption and cost of such a changeover. If Andersen had interviewed former customers as the Staff did, they would have realized that the service provided by Empire was so bad that these former customers of Empire nevertheless decided to change health providers.

In addition, if Andersen had even closely reviewed its own interview notes from the four brokers who handle Empire accounts, they would have noted that there is no substance to the Plan's argument of "loss-leading."

3. *Executive Compensation*

Arthur Andersen's study of Empire's executive compensation program was limited in scope and relied on existing studies without determining their relevance to a non-profit like Empire. Andersen was unaware of some key aspects of the compensation program and placed too much reliance on Empire's assertions. Andersen's Eric Edelstein's conclusion that executives are underpaid was not based on empirical evidence, but rather on Empire's representations.

4. *Other Explanations for Losses: Mismanagement and Fraud*

Even though the Andersen study's most critical sections dealt with the management style and organization of the Plan, there is no discussion of its implications on the losses of the Plan. Edelstein refused to accept the proposition that any of the internal problems Andersen identified significantly influenced the losses of the Plan. Nor did he feel that there was any evidence of mismanagement at the Plan. It appears from a review of the Andersen study as well as the interviews with Edelstein that such a possibility was not even considered.

For example, Edelstein told the Staff that Andersen was unaware of AT&T's civil RICO lawsuit against Empire until it appeared in a recent newspaper article. Even though it raises serious management questions as well as the possibility that another major national account was dissatisfied with Empire's operations, neither Empire nor the Insurance Department told Arthur Andersen about the suit and the years of problems AT&T has had with Empire that led up to it.

Edelstein also admitted that the Andersen group was unaware of the $20 million lawsuit Empire brought in 1991 against a broker and various rabbis. Nor was he aware of its implications on the ability of the Plan to prevent and detect fraud within the Plan.

The Andersen group was also unaware of internal problems with the Plan's payment of millions of dollars to unlicensed/uncredentialed providers. Edelstein admitted that they did not focus on this issue even though it may have potential financial implications to the Plan.

The Andersen group was aware of a potential lawsuit by the Department of Health and Human Services for approximately $140 million due to incorrect charges as a secondary payor. Eric Edelstein agreed that this would be a significant issue if Empire had to pay anything near that sum. However, he felt that this concern was unwarranted since the Andersen team was assured by Empire that it would never happen. Edelstein admitted that the Andersen team did no independent verification of this assurance and never spoke with any federal officials in HHS or the HHS Inspector General's office which currently has Empire under investigation for this issue.

Edelstein also admitted that the Andersen team relied upon assurances from the Plan that service problems under Medicare Part A and Part B had been addressed. If they had contacted the relevant federal authorities, which Edelstein admitted they had not, they would have learned that contrary to the Plan's representations, service levels had not improved and had actually deteriorated to such a state that on April 26, 1993, shortly after the release of the Andersen draft report, HHS sent the Plan a letter threatening the non-renewal of the contract.

F. *The Absence of Professional Skepticism*

In conclusion, the Staff noted the following areas where the Andersen report evidenced an undue reliance upon the Plan's representations and other poor accounting practices. It appears that Arthur Andersen did not:

—interview national accounts that left;

—interview subscribers;

—interview former Board members;

—review National Blue Cross/Blue Shield documents;
—verify cherrypicking argument;
—verify "loss-leader" argument on national accounts;
—analyze segments of community-rated market;
—review minutes of Board meetings that took place before 1991;
—know about medical bills paid to uncredentialed physicians;
—know that HHS is contemplating suing Empire;
—interview federal officials about Medicare and other federal issues, but instead they relied on management assuranceness;
—talk to OPM or HHS IG's;
—know about AT&T's lawsuit until it was in the newspapers;
—know about deferred compensation;
—independently study the Plan's compensation program;
—retain or report officers' salaries and compensation;
—test management assertions regarding paying high compensation to retain officers;
—analyze potential contingencies, nor
—look at Deloitte & Touche's workpapers.

It is also possible that they did not even review Deloitte's annual financial statements, since the Project Manager could not recall looking at the annual financial audits. "I guess we did," was Eric Edelstein's response to the Staff's question.

VI. MANAGEMENT OF THE PLAN: CONTRIBUTING TO LOSSES

In the course of this investigation, the Staff reviewed the management practices at Empire. What the Staff found was a Plan which appeared incapable of effectively carrying out the most basic functions of an insurer. It seemed incapable of:

—pricing its product correctly,
—collecting the right premiums, and
—paying its claims in a timely and accurate manner.

A. *Towers Perrin Study*

What the Staff found in this regard closely approximates the preliminary findings of a internal management review currently being conducted by Towers Perrin. Apparently, the existence of the study has been kept a secret until recently and little is known about it even inside the Empire Plan. The Insurance Department was totally unaware of it until the Staff informed the Superintendent on May 27, 1993.

The Towers Perrin internal management review was requested by Mr. Cardone on December 24, 1992. It cost the Plan approximately $1.25 million and, as Mr. Cardone admitted during a recent deposition, it was done without prior discussions with or approval of his Board of Directors. As mentioned in a letter from Towers Perrin to Mr. Cardone confirming the contract, the study was intended "to develop a strategic direction that will enable the Plan to rebuild its capital position." Or, as one of the consultants later told the Staff, it was basically intended to "stop the bleeding."

Part of this internal management review consisted of a "voluntary self-examination" by Empire conducted by joint teams of Plan executives and Towers Perrin staff.

In doing this work, the teams were permitted to interview whomever they wanted within the Plan and then to report back a "consensus" document on their findings. Since the study was understood by all who were interviewed to be internally-generated and officially sponsored by Cardone himself, the working groups were able to garner very candid responses.

Accordingly, the Towers Perrin fact finding process produced a unique and far more unflattering picture of the internal workings of Empire than did the Arthur Andersen review. The Towers Perrin study uncovered a very troubled Plan and described serious management problems which the Andersen report failed to document. As one of the Towers Perrin officials commented, "it was hard to find something that wasn't broke."

The Subcommittee subpoenaed all of the reports connected to this internal management review including the consultant's work papers and notes of each of their interviews. In addition, the Staff interviewed the Towers Perrin consulting team that oversaw this exercise on three separate occasions. The following is a summary of the highlights of the Staff's review of the Towers Perrin material:

1. *Empire's Financial Position is Weak and Significant Near Term Improvement is Unlikely*

Numerous interviews of senior officials in the Plan indicated the severity of the financial problems facing the Plan as well as the absence of a credible strategy to address this problem. For example, one official told the working group that he doubted that they would meet the "risk-based capital requirements of the National" in the foreseeable future. If this occurred, he noted the Plan ran the risk of losing its trademark. Similarly, one vice president said that in his view "the plan was currently insolvent."

An officer of the Plan noted that "our managers don't really appreciate the trouble we're in." He noted that many people did not have the right attitude on "how to save money." One vice president noted that he found he was surrounded with people who had "no basic understanding as to the needs for expenses to be controlled."

One official said that the Plan suffered from "a social service mentality" and the belief that there was a "lifetime employment" guarantee. Another noted that it was nearly impossible to get rid of dead wood. There is, as one director noted, "a not my job syndrome" pervading the Plan.

2. *Empire Doesn't Know How to Price Its Products*

It was clear from the interviews reviewed by the Staff that the Plan did not know the true administrative and operational costs of many of the products being sold. Costing information was not consistently used in the sales/marketing decision-making process. In part because no one knew the actual cost and in other cases because this information was never communicated to the right individuals.

As a result, costs were allocated by methods that did not accurately reflect the true expense of a product. These practices constrained Empire's ability to tailor and price service not only to make a profit but also to meet the different service requirements of customers.

The notes from an interview with one vice president indicated that he said he "was unaware of specific costs relative to account profitability." Another interview noted that the "pricing here stinks." A third said that "cost allocation is a problem [with the] experience rated groups losing money" because of bad cost allocations. As indicated by another, "current cost allocation methods are not rational." As one vice president noted disparagingly, "sales had no control over price—budget does." His interview went on to note that "profitability is not controlled by sales since price is dictated by underwriting."

The result of this process as noted by many of the employees interviewed was that the Plan got into unprofitable lines of business or contracts—especially in the National Accounts market. A number of senior managers cited the national accounts as "losing money," "a drain on our resources" because of "bad deals" and the "lack of information." A few made special note of the AT&T and Merrill Lynch contracts as being "money losers" for the Plan.

3. *Service is Still a Major Problem*

Although there has been much argument over whether customer service has improved at Empire, a review of the interview notes of the various working groups shows that this is still a major problem in the eyes of many officers and key employees of the Plan. A significant number of the employees interviewed indicated that customer service and provider services was bad. As one employee noted, "we are numbers driven, not service driven and not customer driven at all." One vice president cited a recent survey that indicated 60 percent of the people interviewed said customer service was bad. Another vice president noted that "service problems are historic." A different vice president stated in his interview that "servicing national accounts has been horrendous."

A good measure of the service problems was tied to the lack of communications between those who market the products and those that have to actually service the contracts. As one director stated, "more is promised than can be delivered." He went on to say that sometimes the sales staff agrees to delivering a certain product or service when they know that it is not possible to be delivered—"they know it is untrue, whereas Travelers and Prudential would say no." Another employee succinctly said "we should not sell what we cannot service or what we don't have."

There were also very strong and universal criticisms of the manner in which Empire measures the quality of its "service levels." Empire utilizes the National Management Information Service, or NMIS system which "quantitatively measures service levels on a quarterly basis." This apparently means that Empire determines if its service is improving by "numerical improvements," i.e. number of claims processed, phone calls answered, correspondence answered, etc.Those employed by

Empire universally thought such a measurement was an inaccurate measurement of "service." As one Vice President stated, "NMIS does not always correlate with customer satisfaction."

4. *The Existing Systems Environment is Complex, Costly and Inefficient*

Complaints about Empire's various computer systems were rampant throughout the interview notes reviewed by the Staff and included such comments as:

—"everything is a No. 1 priority and the No. 1 priority changes frequently,"

—"technologies being used, especially imaging, have had a difficult history and may not meet all requirements,"

—"too many systems, too complex"

—"CS 90 is not stable,"

—"mess ups in claims are getting worse,"

—"low first pass rate in NASCO—the lower the first pass rate the higher the cost in staffing—as low as 30 percent."

5. *Empire Lacks a Managed Care Strategy and Product to Adequately Respond to The Changing Health Care Marketplace*

The Towers Perrin internal management review found a Plan lacking the tools to address the future of health care in New York—managed care. It found Empire's business is heavily concentrated in the "increasingly obsolete Hospital-only and Wrap business" which are traditional indemnity lines of business. Although the company has devoted considerable funds in developing its own HMO, called Healthnet, and a point of service provider network (POS) through a product called BlueChoice, the Towers Perrin review was very critical of their management and operations.

In the fastest growing market, network-based managed care, "Empire lags the competition" and "is not competitive." In part this was determined to be because Empire's price "was not competitive" and its product "does not meet the service need of its customers." But the internal management review also found that the company was unable to develop or implement a realistic strategy to move into the managed care arena. As one officer stated in his interview, the company "gives lip service to managed care."

Some of the other conclusions of the Towers Perrin study on this topic included:

—The Healthnet provider network has not been rationalized to reflect an overall network strategy or to further reduce costs;

—The need to redesign/redevelop the Healthnet network is widely recognized, but has yet to be addressed;

—The current network is difficult to manage;

—Healthnet has no cost advantage;

—In a growing HMO market, Healthnet membership has declined steeply;

—To date, BlueChoice has captured only a small share of the fast growing POS market;

—The BlueChoice network is not being managed because of a lack of data and reports.

6. *Empire's Organizational Structure is Too Complex and Hampers Effectiveness*

Like the Arthur Andersen report, the Towers Perrin internal management review identified serious problems with Empire's organizational structure. Towers Perrin found that:

—the organization has many layers of authority,

—certain functions are fragmented,

—there's insufficient documentation and communication of organization structure, roles and responsibilities,

—accountability and responsibility are misaligned, and

—Empire suffers from several weaknesses frequently found in functional systems.

As a consequence of this, "decisions are frequently untimely, suboptimal, and unnecessarily burdensome." One official interviewed said that Empire was "managed by process as opposed to managing the process." A vice president said that the company has "too many committees and is too bureaucratic."

The end result was that the organizational structure makes it difficult for the company to respond to customer needs and changes in the marketplace. A number of individuals interviewed noted that competitors responded faster than Empire

could. Others noted that their response time was "hindered by bureaucracy" which "handcuffed management."

B. *Empire's Management Style: The Culture of Cardone*

Both Arthur Andersen and Towers Perrin point to a corporate culture at Empire that fostered these types of management problems.

The Andersen study, in one of the few sections that was critical to the Plan, made a number of negative observations about the corporate culture. They noted that:

> "The autocratic nature of senior management has contributed to a corporate culture which fosters little or no empowerment of middle and lower level employees."
>
> "The senior management of Empire tends to be 'autocratic' in nature and is generally reluctant to delegate decision making responsibility to the lower levels of management of the Company."

The Towers Perrin internal management review also identified serious problems with Empire's corporate culture. In a slide used to brief higher management about the problems they identified, they provided the following summary of terms which based upon their interviews and observations, best described Empire's culture:

—suspicious/defensive/secretive; lack of trust

—reluctance to ask for help/admit weakness

—unable to be wrong; can't say "I don't know"

—risk-averse individuals; self-interest/entitlement; not success-oriented

—turf-conscious

—whistle-blowing/blaming/checking/abusive

Others interviewed by the Staff placed much of the blame for the current state of the Empire culture on Albert Cardone, the recently terminated CEO and Chairman of the Board. Numerous current and former Empire executives were critical of him for having created what one called the "culture of Cardone."

Chester Burrell was the former president of Blue Cross and Blue Shield of Northeastern New York until its merger with Empire. He termed that merger "a disaster" with everything being run out of New York City. There were 25 different people in Albany reporting to 25 different people in New York and the twain never met. It was "the most confusing organization you can imagine."

Burrell referred to Cardone's management style as "a reign of terror." Cardone was out to "annihilate people" and ruled the Plan "by edicts from his office." Referring to Empire's management under Cardone, Burrell claimed:

> "The market could never do to them what they did to themselves."

Sue Ann Lamantia was an Assistant Vice President of Group Claims in Albany until she left in 1987. She had been with the Blues organization for over 13 years and described her dismay at the new management style of Cardone, a style that eventually caused her to leave. She noted that in Albany:

> "We were used to the president driving himself in his own car to work. Then Mr. Cardone came and started to come to work in a limousine with the chauffeur handing him his briefcase. . . . The company was top heavy and could have used more Indians and fewer chiefs."

John Lovett was also at Empire when Cardone took over. When Lovett left in 1988 he was Vice President of the New York markets division. Lovett noted that once Cardone took over he "promptly cleaned house" and replaced "each and every one of them with a colleague of his from Deloitte."

Lovett questioned the competency of these new executives since none of them seemed to have experience in the areas to which Cardone assigned them. Lovett noted in his interview that Cardone's style is so abrasive that since he came on board, "the executive management roster has turned over 2½ times."

Lovett told the Staff that the National accounts are big losers for the Plan. He had advised Cardone of that fact and strongly urged him to get out of this losing line of business and let the local accounts make up the slack. Cardone refused and ultimately fired Lovett over similar management disagreements.

Overall, Lovett felt the problems at Empire are directly related to "high expenses, a woefully inadequate sales force and disastrous systems processing." Lovett warned that the problems at Empire may be masked by financial statements, since "there's poetic license in those numbers." And as an example, he noted that in 1992 he knows from the hospital he was then working at, that Empire was very slow toward

the end of the year in making payments to them despite large accounts receivables. In January, however, his hospital received an $8 to $9 million check from Empire. He opined that if Empire did that for all of its hospitals, it would make Empire's year end financials look a lot better.

Rodney Hook was Empire's Chief Financial Officer until 1988. According to Hook, Cardone had a confrontational management style and management was in a continual state of flux. Cardone never stuck with anything long enough to give it a chance to work. He operated the same way with personnel. Hook said Cardone often let people go without having adequate replacements lined up. Hook referred to Cardone as "an obstacle not a leader."

What struck Hook was the "not-for-profit" attitude within the Blues system. The attitude was that it was okay to lose money, and making profits was looked down on. Cost cutting, consequently, did not seem to be a priority for Empire.

Dr. William Roy, the former Director of National Accounts from 1986 to 1988, cited the same attitude as one of the reasons the Plan was not well-managed. He stated that:

> "Overall, Empire was not a well-managed company primarily because it was a management that did not have to be responsible to the stockholder base. The rank and file's attitude, supported by management was, "I don't care what it costs—we'll just pass it on."

Another senior Vice President who recently left the Plan made a similar observation. He noted that in the face of huge losses, management's attitude was "no problem since in the end the community will cover it with increased premiums." This same former executive complained that Cardone's management style was such that "people were afraid to make decisions."

C. *Poor Service/Consumer Complaints*

The New York State Department of Insurance conducts a market conduct review of its insurers, as do most insurance departments throughout the country. The market conduct review examines insurers' compliance with insurance statutes, rules and regulations, and also determines if insurers' operations are consistent with the public interest.

The New York State Insurance Department last conducted a market conduct review of Empire at year-end 1987. This review, which was part of the financial examination filed in January 1991, consisted of a one-page finding that Empire was utilizing low reimbursement rates to some of its providers.

The one-page market conduct report stated that a review was directed at sales and advertising, yet made no mention of any findings or recommendations in this area. The one-page report also referred to underwriting and rating reviews, yet outlined no findings in either of these areas. Finally, the one-page report noted that a review of claims was conducted, yet again, no details of the examination of claims was included.

During numerous meetings with the New York Insurance Department, the Staff expressed its concern over the cursory nature of the market conduct review. Several weeks ago, the Staff was pleased to learn that the Department has decided to issue a detailed market conduct report separate from the financial review which is presently being conducted.

In interviewing the Chief of the Consumer Service Bureau of the New York Insurance Department, the Staff learned that the Department closed 4,200 complaints against Empire in 1992. Given the fact that Empire insures over 8 million people, the Staff was impressed by this seemingly low number of complaints. A closer look, however, revealed this number to be misleading.

A large number of the 4,200 complaints was reviewed by the Staff and found to be almost exclusively from subscribers with individual, direct-pay policies. This figure does not account for the thousands of complaints registered by employees of Empire's large national accounts, which will be discussed later in this statement, nor does it account for complaints of hospitals and complaints lodged with Empire directly.

The primary complaint the Staff heard from the hospital administrators was that Empire often loses claims or denies ever receiving them. This is true even when the claims are sent return receipt requested or transmitted electronically. Empire also has a practice of demanding medical records on routine claims before processing will begin. One of the hospitals told the Staff that they automatically forward medical records to Empire in an attempt to expedite claims processing. Empire, however, will not respond to the hospital's inquiry about the claim until 30 days have passed since the claim was submitted. The hospital, therefore, waits the required 30 days with no response from Empire, makes an inquiry as to the status of the claim only

to have Empire respond that they did not receive the medical records. Then the cycle repeats itself.

Another large problem associated with the hospital business is Empire's use of Dedicated Service Centers for its large accounts. The DSCs are formed to service specific accounts, including processing the claims, of Empire's large national accounts, such as IBM and the State of New York. The hospitals cannot send the claims directly to the DSCs but must route them through Empire. Again, a problem arises regarding lost claims; the DSCs deny receiving them from Empire and Empire denies receiving them from the hospitals.

Additionally, the DSCs operate independently of Empire and do not utilize electronic remittances. Thus, the hospitals must maintain not only a receivable from Empire, but a separate receivable for each of the DSCs. The receivable from Empire alone averages 60–65 days of delinquent claims payments which, for one hospital, totals over $12 million.

One hospital administrator told the Staff that his sister submitted a claim to Empire for $2,600 and received four checks, each for $2,600. She called Empire customer service to explain the mistake and was told that it "was her lucky day" and to just keep the checks. Uncomfortable with this, the woman actually took the checks to Empire's offices and attempted to return them to the customer service representatives. She was told that the system couldn't handle returned checks and that she should just keep them.

Representatives of the Greater New York Hospital Association told the Staff that "there is an appearance of cordiality with Empire but nothing gets resolved."

The Staff inquired as to Empire's argument that they insure the sickest population in New York City because of the "cherrypicking" of their healthy customers and the "dumping" of the unhealthy group members by the commercials. The hospital administrators denied that cherrypicking is Empire's problem. They maintain that subscribers are leaving Empire because of service. "The Guardian provides better service at a higher price," one said, "and people are willing to pay for it. That's not cherrypicking."

Another hospital administrator explained that if the cherrypicking argument were true, then the "Case Mix Index" for Empire patients at the hospital should be increasing. The Case Mix Index represents the length of stay and intensity of treatment on in-patient subscribers. The administrator checked his figures and noted that for the first 3 months of 1993, prior to the enactment of the Community Rating law, Empire's Case Mix Index figure had decreased, indicating a healthier population of subscribers.

When asked to compare Empire service to that of the commercial insurers, the hospital administrators agreed that the commercials are much more efficient. They cited very few instances of lost claims and much less frequent requests for medical records. They also felt that electronic claims submissions had streamlined operations for both Empire and the commercial insurers, but felt that Empire simply "had no desire to pay what they owe." As one administrator summed up: "There is no across-the-board craziness with the commercials as there is with Empire."

In March of this year, one of Empire's largest national accounts, AT&T, filed a civil RICO action against Empire alleging that Empire defrauded AT&T by sending the company inflated hospital bills. Pursuant to its agreement with Empire, AT&T was expecting to receive the hospital discount on its claims which varied in amount from State to State. Based on information from outside consultants, AT&T alleges that the Blue Cross/Blue Shield Plans in various states across the country forwarded the hospital bills, less the negotiated discount, to Empire to be paid on behalf of AT&T and that Empire then sought reimbursement from AT&T of the full amount of the hospital bill, pocketing the discounted portion for themselves.

When AT&T requested an audit of Empire's books on this matter, Empire stalled in agreeing to confidentiality terms of the audit. After several years of unsuccessful negotiation with Empire on this point, AT&T filed suit. Almost immediately, Empire, and several other plans named as defendants, agreed to the audit in exchange for the lawsuit being stayed. The inflated hospital bills to AT&T allegedly date back to 1984 but AT&T has told the Staff that they will have no estimate on the amount which has accrued over the past 9 years until the audits are completed.

Empire's response to the AT&T allegations is that no wrongdoing has occurred and that AT&T's goal in filing the lawsuit was to gain access to Empire's books.

By including the employees of National Accounts and the participating hospitals, the Staff finds that the pool of complaints regarding Empire service is much greater than the 4,200 letters received by the Insurance Department in 1992. In addition, Empire itself received over 5 million complaints or telephone inquiries directly from subscribers last year and over 13,000 complaints which had been forwarded to the

Plan from outside agencies such as the Office of Consumer Affairs and U.S. Senate offices.

As for the individual complaints against Empire, the subscribers represented by the 4,200 cases closed by the Insurance Department first attempted to resolve their problems by contacting Empire directly. After repeated efforts to convince customer service representatives that a claim was incorrectly processed, the subscriber often turned to the Insurance Department for help in securing payment from Empire.

For example, an Empire subscriber collapsed in her home and was found unconscious by her sister. She was rushed by ambulance to a hospital emergency room where various tests were conducted. Empire refused to pay for these tests because the woman failed to receive pre-certification for what Empire considered non-emergency medical care. After numerous irate letters from the subscriber and intervention by the Insurance Department, Empire finally determined that the treatment was, in fact, an emergency and paid the $1,500 claim almost a year after it was incurred.

In March, 1989, a subscriber gave birth to a baby boy who was hospitalized for treatment of jaundice. Empire refused to pay the $852 claim on the grounds that "routine nursery care" was not covered. Repeated phone calls and letters to Empire customer service representatives resulted in the new mother being assured that an error had been made and that the jaundice treatment was indeed covered. After a year and a half, however, no payment had been forthcoming so the woman contacted the State Insurance Department. In January, 1992, almost 3 years later, she received payment from Empire.

In 1990, an Empire subscriber gave birth to triplets, each of whom required intensive care hospitalization. Empire made partial payment on one of the claims but refused to acknowledge the claims of two of the babies. The subscriber found that Empire's computer system could not process the three claims separately because each of the babies had the same date of birth and were, therefore, processed as only one birth. The subscriber told the Staff that the babies are almost 3 years old now yet the claim with Empire is still not resolved.

In 1991, one subscriber actually had to sell her home to pay $20,000 in medical bills for her father-in-law, which should have been paid by Empire. After the father-in-law died in 1987, Empire made several payments to the hospital but failed to pay an outstanding hospital bill of $20,000 until February, 1991. By that time, the hospital had received a judgment against the woman and her husband who sold their home to pay the bill. When Empire eventually reimbursed the couple, they included a letter apologizing for taking "so long to resolve this issue, particularly since it was Empire's error in the first place."

Additional examples of subscriber complaints against Empire will be included as an exhibit to the official hearing record. In short, the Staff found that Empire usually found its way clear to pay the subscriber's claim once the Insurance Department became involved in the matter.

The position of Empire officials regarding its reputation for poor customer service is that it is merely a "perception" problem. They argue that internal surveys show that timeliness and accuracy in handling written and telephone complaints is exemplary. The Staff's interviews have clearly indicated that Empire's poor treatment of customers is much more than a perception problem. Empire officials need to acknowledge that this is an earned reputation and that serious steps must be taken to improve relations with extremely unhappy subscribers.

VII. CAN'T COMPETE

A. *Termination of National Accounts*

Staff investigators have accumulated substantial evidence that Empire also cannot meet the competition when it comes to servicing its large accounts. They continue to lose major accounts, not because of what the Plan says is "cherrypicking," but because they are providing poor service to the dwindling number of accounts that they still have under contract.

Empire serves as the control Plan for numerous "National Accounts," primarily large companies headquartered in New York City. In these accounts, the employee health benefit claims for the company, on a nationwide basis, are controlled and serviced by Empire. Currently, the number of national accounts totals 51. However, since 1988, 78 organizations involving nearly 350,000 employees and retirees, have terminated their contracts with Empire. The majority of the companies cited poor service as a major reason for cancellation of their national account. Corporate mergers and the consolidation of all employee health benefits with insurance companies, other than Empire, were the other considerations. Sadly for Empire, their reputa-

tion for poor service has spread to entire segments of the business community (banking and public relations in particular).

Staff investigators contacted the 42 largest companies, those having from 1,100 to 57,000 individuals in the Plan, to determine the reasons for the terminations.[2] Each was asked to explain the primary reason for termination, as well as to comment on any secondary reasons. The following is a summary of the Staff's review of their reasons for leaving Empire:

**Eighteen companies complained that poor service was their primary reason for moving to a new contractor. Slow payment and a failure to follow up on complaints were the main sources of concern. Numerous companies tried, without success, to change the pattern of poor service by confronting Empire management, including Mr. Cardone, with their complaints. Empire would usually propose a performance improvement plan and assign specific employees to service the complaining company. This renewed effort by Empire was geared toward keeping the company from defecting to another carrier. When problems continued, these companies eventually did move to other insurance companies, in many cases at a greater cost but always finding better service with the new insurers. A sampling of the comments made by representatives of 13 former national accounts includes:

Empire may do fine on local accounts, but they are just not a national company, they know nothing about the rates in Arkansas.

Let me put it this way . . . I have a full crop of grey hair and every damned one of them came as a result of my dealings with Empire Blue Cross.

Dealing with Empire was like dealing with a black hole. You never could get anyone to deal with your problems—no one had the authority or responsibility to do anything.

They are a nightmare to work with.

Difficult to get through to customer service and poor follow-up on complaints to supervisors.

The account management was not centralized, leading to different answers coming from different regional service representatives.

Claims processing was slow and sloppy.

The billings were often wrong, the employees hated it and we got fed up with it.

They just couldn't do the claims processing; money wasn't the issue, we just wanted service on our claims.

Some of the identification cards they issued even had the wrong information on them.

Abysmal service.

Empire could not cut the mustard on utilization management.

I have been involved with the Blues twice in my professional life and both were the worst experiences of my life. I should have learned from my experience in Chicago. . . . They kept giving an image that they have marvelous data, but they don't . . . in both cases they were disastrous experiences. . . . I went to the facility myself and not on a guided tour as before. I found that there was no dedicated computer and no dedicated staff . . . it was terrible, . . . it took weeks just to get the claims out of the mail room. . . . Empire suckered me. We were set to go with another company when Empire promised us utilization reports. . . . The single reason we took them on was the utilization reports they promised. We never even got one.

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[2] National Empire Control Accounts Cancellations 1988 to Present, List of Companies Contacted by Staff: ADT Security Services Inc., American Bureau of Shipping, Chase Manhattan Bank, ChemicalBank, Citibank N.A., Coopers & Lybrand, Culbro Corp./Moll Tool & Plastic Corp., Cushman and Wakefield, Dictaphone Corp., District 65 Security Plan, Drexel Burnham Lambert, E.F. Hutton and Co., Inc., Ebasco Services, Inc., Eden Park Nursing Home, Fischbach Corporation, Fleet/Norstar Bank, Inc., GHI-Federal, Goldman Sachs & Co., Golub Corporation, Irving Bank Corp, J.P. Morgan & Co., Inc., J. Walter Thompson & Co., Macy's (except for retirees and Rx), Manufacturers Hanover Trust, March of Dimes Foundation, National Westminster Bank Retirees, Neighborhood Cleaners Association, New York Farm Bureau, Ogilvy & Mather, Inc., Pall Corporation, S.E. Nichols, Inc., Simmonds Precision, Sony Music Entertainment, Inc., The Associated Press, The Bank of New York Co., Inc., The Chubb Corporation (2), The Dunn & Bradstreet Corp., The Hearst Corp., The New York Times, United Welfare Fund Amal. Union, Veeco Instruments, Inc., and Ziff Communications Company.

**Ten companies consolidated all their health benefit programs under one insurance carrier other than Empire and listed this as their primary reason for termination of their contract. Most (55 of 78) of the canceled national contracts were for hospitalization only. These companies consolidated their hospitalization with their major medical, dental, and other employee benefit programs. In some cases when the invitation for bids was published, Empire would submit a bid; however, it was not considered the most responsive or cost effective. In many cases the Empire bid was not encouraged or accepted, even if it was the lowest, because the past experiences of the company were unacceptable. The secondary reason given most often by this group was poor service, as with the companies in the first category.

**Six companies merged their operations with other companies which already had satisfactory health insurance, or re-bid their contracts as part of the merger, leaving Empire out for reasons similar to those listed above.

**Six companies determined that the rates at Empire were excessive and re-bid their contracts. In the case of the contract involving the Federal Employees Program, the U.S. Office of Personnel Management (OPM) encouraged the contractor to cease the claims processing contract with Empire and do the work by themselves at less cost.

**Three trade associations left involuntarily when they were informed by Empire that they no longer would do business with associations. One of these reported poor service as a factor while the contract was in effect. According to records from Empire, between 1989 and 1990, 95 association group contracts incurred claims of over $135 million dollars on revenues of just over $128 million. Empire ceased doing business with most associations when they determined the risks were too great after losing over $7 million during those 2 years.

"So much for being the 'insurer of last resort,' " complained an association member.

**One company was discovered to be a fraudulent operation and was removed after Empire found it was paying claims for unqualified recipients.

In general, most of the current large national accounts that have "dedicated units," established by Empire, to deal exclusively with the individual company, are more satisfied with the service. Many are administrative service only (ASO) contracts with an increasing number of companies becoming self-insured.

Some large companies that are currently under contract, fear that they may have an "AT&T-type problem" and are actively reviewing their relationship with Empire on the issue of hospital discounts.

Four of the national accounts in effect as of January, 1993, were "performance guarantee" contracts; i.e., if Empire fails to meet certain standards agreed to in the contract, during a specific time frame, Empire must pay a monetary penalty.

One company routinely collects several million dollars every year from Empire for its failure to meet established standards involving timeliness in paying claims and responding to inquiries. This company is one of the three largest of all the national accounts. Another of these companies recently terminated its contract when Empire failed to meet specific standards.

In response to the issue of service problems, Mr. Cardone and other senior officials at the Plan argue that the service cannot be that bad, since the Plan's total number of national account subscribers has remained relatively stable over the years. They note that though they may have lost some contracts, they have retained their large contracts and recently picked up Merrill Lynch and American Home Products, to name a few.

The Staff questions whether this evidence supports the Plan's argument that service levels are good. In fact, it appears that the only reason the Plan has been able to maintain these large contracts or pick up new contracts is that they intentionally sell their insurance to them at a loss.

Donald Morchower, the COO of the Plan and now acting CEO, noted in his interview with Arthur Andersen that the Plan made the decision to "buy Merrill Lynch business" with low retention rates for the first 3 years—essentially losing money on it for 3 years with the hope of keeping the contract in the fourth year, raising the premiums, and recouping their losses. The CFO of the Plan, Jerry Weissman, also admitted to Arthur Andersen that no one can deny that the Plan made "bad deals" like this on their experience rated accounts.

B. *Local Experience Rated Accounts*

Although we did not systematically contact accounts that were not designated as "national" in scope, we did receive comments from several major local accounts. One company, that had been associated with Empire since the 1950's, in frustration, terminated its contract after experiencing what we found has become the typical scenario with many companies and their relationship with Empire, just as with the national accounts.

The company's problems began when it added major medical coverage to its hospitalization contract. Their problems started gradually and grew until it became impossible to deal with Empire. This company reported delays in payment, improper payments, inconsistent claims payment for the same event, poor communication, etc. It gave Empire ample time to correct the problem and turn things around. It brought Empire employees to its office to help set up a "dedicated service center." The dedicated system turned out to be one or two Empire employees trying to answer hundreds of complaints, and the problems only worsened.

In a last-ditch effort to salvage the contract, the company orchestrated a meeting between Al Cardone and its own CEO in an effort to try once again to obtain improved service. "All Cardone could talk about was his own problems, and no one in Empire ever did any follow-up to the meeting." Empire's cavalier attitude in this matter finally drove them to end the relationship and prompted a company official to remark:

> . . . One thing you can say about Empire is that they did not show favoritism in their screw-ups—they were non-discriminatory, they screwed up everyone's claims.

C. *Outside Audits*

During the course of our investigation, we noted that the warning signs were everywhere relating to system problems, failed management oversight, and poor communication. Numerous private companies, well-known hospitals, universities, and governmental organizations performed their own audits of Empire's performance and came to the same conclusions independent of one another. A sampling of the negative audit findings for reports issued during the past few years is listed below.

1. *Blue Cross and Blue Shield Association*

The most notable outside audit came from the Blue Cross and Blue Shield Association (BCBSA) in Chicago in its National Account Performance Review (NAPR) completed in December of 1991. The dramatic statements by the BCBSA leaves no doubt in the reader's mind that Empire had major problems that had not been addressed in a meaningful way. The following quotes from the comprehensive report highlight the areas of concern:

> Significant operational deficiencies were identified Plan-wide for national accounts and the Federal Employee Program (FEP). Performance levels for most functions deteriorated during 1990 and 1991 . . . were below the National Account Performance Standards in two thirds of the categories . . . index score of 73.9 points, ranking the Plan 20 of 26 monitored Plans . . . for FEP, only one performance goal was met. . . . The major deficiencies contributing to these performance problems include the following:

—Lack of processing controls regarding work flow and capacity analysis, work distribution control and planning and forecasting.

—Inadequate and inaccurate management information.

—Inadequately trained staff, with no general understanding of national accounts, as well as specific knowledge of account systems or processes.

The NAPR process has been used for several years as a standard for evaluation of all Plans by BCBSA, enhancing the significance of the report.

2. *New York State Department of Civil Service*

This audit tested the $404,515,310 hospital claims paid in 1989 and concluded in summary:

> The electronic system, internal controls and administrative procedures used by Empire in 1989 did not adequately protect the assets of the New York State Health Insurance Plan. Overpayment of $3,105,524 should be returned.
>
> In another audit by the State Comptroller, it was determined after reviewing claims for the 2-year period ending in 1991 that Empire should pay the State an additional $945,991 for improper payments.

3. *New York Marriott Marquis—Performance Audit Dated 2/3/1990*

Our evaluation of Empire vis-a-vis commercial carriers is that Empire enjoys a cost advantage of 6–7 percent in institutional claim cost, but that fee reductions on professional claims is largely or entirely negated by permissive claim processing practices and/or inadequate medical policy.

4. *The New York Hospital Employee Benefit Plan—Claims Administration Audit (1/1/1991 to 11/1/1991)*

Each of these levels (for accuracy) are below Empire's own standard and industry standard. . . . The claims turnaround time does not appear to meet the performance guarantee standards agreed to by Empire and the Hospital.

5. *The Mount Sinai Medical Center—Audit of Health Claims Processed Dated 4/18/1991*

The audit results, in terms of processing error rates, indicate that Empire's performance is below industry standards.

6. *Columbia University—March 1992*

This review of Empire's overall effectiveness in claims processing for the university resulted in:

—A financial error rate of 1.06 percent

—A payment error rate of 14.14 percent

—An overall error rate of 22.22 percent

—Timeliness of processing was 80.72 percent of all claims processed in 14 calendar days

The results of the audit demonstrate that in every category Empire fell below the standard of performance as developed by (the auditors) through their interaction with the insurance industry.

7. *The View of Insurance Brokers*

As previously mentioned, the Arthur Andersen (AA) study commissioned by the New York State Insurance Commissioner concluded that Empire should maintain its national accounts business. The Arthur Andersen team leaders noted that much of Empire business was lost to other companies because of the "loss leader" issue. Our review of AA's formal notes, obtained by subpoena, simply does not support this contention. Companies were not leaving because they could get life insurance or other types of insurance with their major medical and hospitalization. A sample of statements from the AA interviews with four different brokers is revealing, considering their vantage point, in dealing with Empire, as well as its competitors.

The President of Morrell Insurance told AA that:

"The management as a whole needs to be looked at internally . . . clients have told him that they were leaving due to poor customer service, 'hassles,' and 'claims reputation'. . . . When he calls Empire the phone 'rings forever,' and he gets poor service when the phone is answered. . . . When he goes to the customer service counter he feels that he is in 'a combination of a zoo and a deli counter' . . . he would only place business with Empire if 'there were no other choice.' "

A principal of TPF & C told AA that:

"Multi-State accounts have poor coordination . . . service perceived as inferior to the commercials . . . Blues almost always high-priced vendor. . . . They do very well with hospitals because of the price advantage combined with the fact that the hospitals do most of the interacting with the insurer (less service issues). . . . Empire does not compete well here (medical) because of weak service (claims, membership and billing support). . . . Commercials market their products better. Healthnet is high priced, poorly managed, and poorly promoted."

Two partners at Kwasha Lipton told AA that:

"The Blues are inflexible and offer 'lousy service.' . . . The only reason someone would consider the Blues is to take advantage of the hospital differential. . . . 'A lot of headaches come from the Blues.' . . . 'Team care has a bad reputation.' Account representatives are 'not good.' Their turnover rate is too high to build any reliable relationships. It is impossible to get a good, quick answer to a technical question. . . . People are not concerned

with the financial future of Empire because they can replace health insurance if Empire goes under."

A managing consultant at Foster Higgins said:

"Generally inferior service . . . can't count on the service reps to be professional . . . high administrative fees . . . reporting system is inadequate. . . . She is 'continually surprised at how vehemently (her) clients are against Empire. . . . This is a very strong feeling.' 'They don't know how to treat a Corporate client. . . . ' BEING BIG DIDN'T SAVE THE DINOSAUR."

VIII. FEDERAL PROGRAMS: MORE MANAGEMENT PROBLEMS

A. *The Federal Employees Health Benefit Program (FEHBP)*

The FEHBP was created to provide health benefits to Federal employees, annuitants, and dependents by way of a contract with the BCBSA, which delegates authority to local BCBS Plans to administer the program in designated geographic areas. Empire serves over 82,000 Federal employees in greater New York. As another indication of widespread management problems at Empire, the Staff noted the findings in the most recent audit of the FEHBP.

This audit was performed by the Inspector General of the U.S. Office of Personnel Management in a report, covering 1985–1987, which was issued in March of 1993.

> The report contains questioned health benefits charges totaling $5,219,482 for benefit payment recoveries not returned to the FEHBP; $379,445 for lost investment income; $324,373 for incorrectly adjudicated claims; $266,767 for unsupported health benefits payments; and $9,732 for miscellaneous income not credited to the FEHBP. Questioned administrative expenses, totaling $106,730, are comprised of unallowable advertising expenses.

B. *Medicare Secondary Payor Program May Cost Empire Over $143 Million*

The Staff has learned of a mammoth problem that, when adjudicated, could cause irreparable damage to the already-fragile financial condition of Empire. The Medicare program may have been erroneously billed in excess of $143 million by Empire.

The Health Care Financing Administration (HCFA), within the U.S. Department of Health and Human Services (HHS), pays contractors to process the bills and claims and otherwise administer the program. Empire BCBS is under contract with HCFA and is the largest Medicare contractor in the U.S.

Medicare is divided into part A (Hospital Insurance) which covers services furnished by hospitals, home health agencies, hospices, and nursing facilities. Medicare part B (Supplemental Medical Insurance) covers physicians' services and a range of other noninstitutional services, such as diagnostic laboratory tests and dialysis for those with end-stage renal disease.

When instituted in 1965, the Congress made Medicare the secondary payor for beneficiaries covered by both Medicare and workers' compensation. During the 1980's Congress made several statutory changes that also made Medicare the secondary payor to certain employer-sponsored group health insurance plans and to automobile and other liability insurance plans. These changes are commonly referred to by HCFA and the health care insurance industry as the MSP provisions of Medicare.

With the increase in the number of people actively working past the age of 65 and covered by employer-sponsored Empire BCBS insurance or covered by employed spouse BCBS private pay plans, the Medicare program should experience less of a burden as the primary payor of health benefits on persons still employed. This is not necessarily the case with Empire, as the Inspector General's office of HHS has discovered in an ongoing audit of the MSP program.

In 1988, at the request of HCFA, the IG started an audit specifically to identify the extent to which Empire mistakenly paid claims as primary payor for individuals subject to the working aged criteria of the MSP legislation, when Empire's private lines of business should have been the primary payor for these medical services. The working aged provisions are covered by the Social Security Act as 42 U.S.C. 1395y(b).

Thus far in the audit, the computerized private side employer group health plan (EGHP) enrollment files, as well as applicable health plan contracts, were obtained from Empire and the reliability of the data validated. These data were matched against both the Medicare payment history files maintained by Empire as a Medicare contractor and the HCFA central office Medicare Automated Data Retrieval System payment history files for all other Medicare contractors.

The audit to date has shown that the monies involved are substantial. The validated sampling frame includes 13 million claims totaling about $2.8 billion for 350,000 beneficiaries who met only the age criteria of the MSP legislation and who were part of the Empire EGHP during the period January 1, 1983, through November 20, 1989.

Based on statistical sampling, the IG estimates that a 3-percent error rate has occurred, and improper payments may total as much as $143 million. While these are considered estimates at this time, HHS auditors are confident that the final figures will be very significant.

The impact of this audit cannot be determined until after its completion, which is scheduled for the fall of this year. However, given Empire's current fragile financial condition, a significant bill of collection from HHS could have a very detrimental impact on its operations.

C. *Medicare Contract Put on Probation*

The Medicare contract at Empire is in trouble, and was put on probation for 1993 by the U.S. Department of Health and Human Services, Health Care Financing Administration, for not meeting Government-wide standards for the past 2 years.

Part A of the Medicare contract covers hospitalization, skilled nursing facilities and comprehensive outpatient rehabilitation services for approximately 2.5 million recipients with total billings of over $6 billion for over six million claims. After a rather stable 2 years of performance in 1990 and 1991, a sharp decline was noted by HCFA for 1992, resulting in Empire's dropping to 46th out of 51 intermediaries on a nationwide performance rating scale. The major problems noted were:

—Interim hospital rates established during the past year did not meet Medicare requirements, resulting in significant over- and under-benefit payments.

—Processing of fraud and abuse cases did not include providing timely status to complainants' allegations.

—Electronic media claims goals for comprehensive rehabilitation facilities bills were not met.

Part B of the Medicare contract covers outpatient services from individual physicians and other providers to over 1.6 million beneficiaries, with total billings through Empire in FY 1991 of $1.7 billion for 24 million claims. In the HCFA performance ratings Empire dropped to 45th among 47 carriers on a nationwide basis in 1992. The major performance deficiencies noted were:

—Claims processing timeliness standards for processing clean participating physicians claims within 17 days and for nonparticipating physicians within 24 days were not met.

—The accuracy of reviews was abysmal. Eleven errors were identified from a 60-case sample.

—Processing of fraud and abuse complaints was not timely.

—Telephone service to beneficiaries and providers was seriously deficient.

—Empire's inability to send Medicare Participating Physician and Supplier Directories to appropriate Social Security Administration offices and failure to mail all enrollment letters led to the failure and negatively impacted on both the providers and beneficiaries in the service area.

—Empire was identified as a high-cost contractor, according to the Complexity Index developed for FY 1992 Budget and Performance Requirements. This problem is persisting into 1993.

In a letter from the Director of the Bureau of Operations at HCFA, dated April 26, 1993, to Mr. Albert A. Cardone, Empire was notified that the Regional Office of HCFA would be closely monitoring its performance and that, if progress is not made, the contract will not be renewed.

Should the contract not be renewed, Empire stands to lose nearly $100,000,000 in administrative cost it receives annually from HCFA and approximately 1,500 full-time equivalent positions designated to serve the Medicare population.

Ironically, the current Chairman of the Board, Harold Vogt, told the Staff that he did not know about the pending problems with the Medicare contract until he read about it in *The New York Times* in May of this year.

IX. INFORMATION SYSTEMS PROBLEMS: PRELUDE TO FRAUD

The Staff found that the Plan has had a long history of systems and computer problems. These have resulted in not only inefficient operations and higher adminis-

tration costs but may have unintentionally made the Plan especially vulnerable to both internal and external fraud. The result has been higher overall premiums for its subscribers as well as a possible explanation for the dramatic losses incurred by the Plan in the last few years.

The following sections document the systems problems at the Plan and how they laid the predicate for the payment of thousands of erroneous and fraudulent claims.

A. *Information Systems Mismanagement*

Information systems are at the core of any corporation's operations. These systems, when effectively developed, hold the promise for increased productivity, better accountability, accurate and timely financial data, interoperability within and outside the corporate structure, and reduction of costly paper processes.

When the systems don't work well, as with Empire, expenses go up, productivity declines, customer service deteriorates, and losses occur.

The Staff found that Empire's current problems with its computer and information systems predates its own existence. Many of the current problems are directly related to the numerous mergers of Blues Plans that eventually created a single legal entity, Empire, but never a single unified computer information system.

In 1974, Associated Hospital Service (the Blue Cross—Hospital Plan) and United Medical Service (the Blue Shield—provider plan) merged to create Blue Cross and Blue Shield of Greater New York (BCBSGNY), Empire's corporate predecessor. Their computer systems were incompatible. As reported in the Arthur Andersen study, the result of this merger were at least 4 separate claims and reporting systems that were not interoperable. In addition, a large amount of their claims processing was being done "out of house" by Electronic Data Systems (EDS).

Following the merger Mr. Werner, then the CEO of BCBSGNY decided to reduce the Plan's dependence on EDS and bring that portion of the processing in-house as well. His motivation to do this was in part because of EDS' poor service record and its expense which was reported to be accountable for 40 percent of the 1973 rate increase.

The difficulty encountered by the Plan in its attempt to set up this in-house program is indicative of the Plan's problems with effectively managing information systems. After deciding to cancel the EDS contract in 1976 it was not until 1981 that they succeeded in doing so and this was only after reaching out to Booz Allen to advise them, at the cost of $5 million, on how to proceed with this development. In the process, the Staff was told the Plan paid as much as $100 million to develop their own in-house system for medical claims, the Medical Claims System (MCS), to replace EDS.

Although MCS provided Empire with its own in-house system for processing medical claims, it still was not fully compatible with a totally separate claims system that Empire had to use to process institutional claims and hospital claims (ICS). There was still no one system to process both. It has taken Empire almost 10 years to even purchase a system that will merge both of those functions.

When Blue Cross and Blue Shield of Greater New York (BCBSGNY) and Blue Cross of Northeastern New York (Albany) merged in 1985 to form Empire, management again found that none of the systems were compatible. In addition, the merger resulted in the redundancy of hundreds of systems that management had to try to coordinate. As time progressed, the Staff was told, Empire tried to eliminate many of these redundant systems. In the process, thousands of claims were reportedly lost, claims processing was significantly backlogged and accounts receivables rose dramatically.

In mid-1987, Al Cardone, the new CEO of Empire, hired Donald Morchower from Deloitte, Haskins and Sells to become the Chief Information Officer for the Plan. Mr. Morchower has publicly described himself as having a strong information systems background which brought him to Mr. Cardone's attention. Mr. Morchower told the Staff that he was hired with the purpose of bringing some order to Empire's myriad systems. The focus was on eliminating duplicate systems merging the systems that were left into one or more inter-operable systems.

The state of Empire's systems during that time have been described to the Staff by the then-Chief Financial Officer, Rodney Hook, as a nightmare. He explained that they were badly designed, unreliable and very costly, costing at least $60 to $80 million in lost receivables. At the time Mr. Morchower took over, Mr. Morchower told the Staff that the Plan was paying $525 million per year on data processing and that fully 80–85 percent of that on "systems maintenance."

The Staff has been told by many current and former officers of the Plan as well as by various providers and subscribers that things have not improved much since Mr. Morchower was brought in to fix these systems problems. Arthur Andersen's recent management audit confirmed this and stated that the current systems envi-

ronment at Empire still consists of a number of disparate systems, many of which have older technologies and were built 15 to 20 years ago. Likewise, the 1993 Towers Perrin internal management review identified similar problems.

Appendix A describes a number of those problems that the Staff still found to exist with current computer information systems. In addition, the Staff identified one specific system that exemplifies a number of serious problems with the Plan's management of its computer systems—the SIGMA imaging system which it will describe below.

B. *Sigma Imaging Systems*

In 1986, in response to higher than normal claims processing costs, Empire entered into a contract with David Sarna, then the President of the International Systems Services Company ("ISS") to examine their claims expense to determine if a new data processing system could be designed to reduce these costs.

Sarna explained that part of the problem was that Empire had developed and was utilizing a "front end processing system" whereby the claim information was physically keyed into the MCS system. The "keyed in claim" would be processed without any associated paperwork or physical claim. In the case of a rejected claim, someone had to physically find the associated paperwork, fix the claim, and manually reenter it back into the MCS system. Since most of the processing costs relate to personnel costs, such a manually intensive system was very time-consuming and expensive.

Sarna and his company were looking into developing an "imaging system" to cut down Empire's reliance on paper claims. An imaging system would digitize paper documents as electronic images that can be easily retrieved from computer storage and used by anyone on the computer network. No longer would claims have to be microfilmed for storage and retrieved manually in case of a rejection of the claim.

Sarna told the Staff that at around the same time that he had started to work on the imaging issue, the then-Empire CEO, Edwin Werner, approached him and explained that his dentist, Dr. William Stratigos, had developed an Optical Character Reading ("OCR") system for use in his dental practice. He asked Sarna to evaluate it for potential use by Empire.

Stratigos, at the time, was a Voting member of Empire's Board. The associated duties of a Voting Member are to select and evaluate potential actual Board members. Stratigos was also a practicing dentist whose clients included Mr. Werner and Jerry Weissman's the Chief Financial Officer for the Plan.

According to Sarna, he, at that time, also engaged Dr. Stratigos to be his dentist. During this relationship, Stratigos told Sarna of his OCR idea. Sarna told the Staff that because of Stratigos' relationship to the Board and especially Mr. Werner, he felt that if he worked with Stratigos he would have an "in" with the Plan. As a result, in November, 1986, Sarna, on behalf of his company, ISS, signed a formal agreement with Stratigos and his shell company, Sigma Computer Research Associates, Inc.

This led to two subsequent engagements with Empire to develop the imaging concept and to create a prototype. Sarna assumed the risk of initial development. He agreed that ISS would, using their own funding and resources, develop an imaging prototype using one small block of subscribers, a steamfitters union. If the prototype worked, then Empire would agree to reimburse ISS for development costs and, in return, receive unrestricted license to the system.

In early 1987, Sarna had the prototype completed and tested. Other than one minor discrepancy, the imaging system proved to process claims at a 98 percent pass (accuracy) rate.Sarna told the Staff that Empire's Internal Audit Department evaluated this prototype. According to Sarna, it was clear that the auditors understood the system and reported that it worked according to specifications. Sarna claimed that when the new CEO, Mr. Cardone, showed him the audit report, it appeared to him that Cardone tried to "doctor" the report to make it appear that the Audit Department found the prototype didn't meet expectations. Sarna felt there were probably two audit reports, one showing the true results and one showing the results Cardone wanted to show.

Although the Staff requested copies of any and all audits of this project, none to date have been provided. Therefore, the Staff cannot determine the veracity of this claim. However, the Staff was able to confirm that Mr. Sarna's relationship with the Plan abruptly ended after providing the Plan with the prototype. The Plan and Dr. Stratigos claim that it ended because of delays in delivering the prototype and cost over-runs. In February 1988, Empire paid Sarna and ISS $500,000 and terminated their relationship. In April 1988, just 2 months later, Empire awarded a cost contract to Sigma.

While the Staff does not question the value of imaging technology or the ability of Sigma's programmers, the circumstances surrounding Empire's contract with Sigma does raise concerns.

The first involves the potential for a conflict of interest between Dr. Stratigos and Empire. Prior to signing the contract with Empire, Stratigos was CEO Werner's personal dentist. He was also the Chief Financial Officer, Jerry Weissman's dentist. He was also a Voting Member of the Board of Directors. This relationship raises an obvious appearance of a conflict in his receipt of such a lucrative contract that appears to have been given without any semblance of competitive bidding. The fact that he is given a contract shortly after Mr. Sarna and his company, ISS, is suddenly terminated raises additional questions about possible favoritism being shown to Dr. Stratigos. His resignation as a Voting Board Member shortly before negotiating the contract on behalf of Sigma for work that, if not the same, was obviously related to his prior contractual involvement with ISS, heightens the appearance of a conflict.

The Staff is not alone in this concern. Superintendent Curiale has also publicly questioned the propriety of this arrangement. He told the Staff that he first learned of the Sigma contract in early 1992 at which time he had a meeting with Cardone and told him that Cardone could "stand on his head and spit nickels before he could convince me that the Stratigos contract doesn't stink."

Curiale said the Sigma contract is being looked at as part of the current exam. However, he told the Staff that he did not know why the contract, which was awarded in 1988, was not looked at by the previous examiner who completed his work in 1990.

A second question that the Sigma transaction raises concerns the additional expense and delivery time of this contract. When Dr. Stratigos and Sigma signed their contract with Empire, they had only two employees and no real facility to work out of. Empire essentially subsidized their start up costs, paid nearly all of Sigma's overhead costs and provided them, free of charge, office space on one of the floors in Empire's own office building.

The total cost of the Sigma project to Empire is hard to determine. Empire officials told the Staff that it only cost the Plan $14 million. Dr. Stratigos claimed he didn't know for sure but thought it was roughly $20 million. However, the Insurance Department claims that its real costs are over $40 million. This higher figure is confirmed by an internal audit report of the Plan prepared in 1992 which cited $40.3 million.

New York State Insurance regulators told the Staff that Empire has a total investment in Sigma in excess of $40 million. This includes paying at least 60 percent of all Sigma salaries, to include Stratigos and his partner, and free use of an entire floor in Empire's mid-town Manhattan offices. Additionally, Empire pays for all equipment purchases and owns all Sigma's office furnishings. This is in addition to the $27 million Empire spent on computer consultants and vendors in the years 1988 through 1991.

There is also a question of the schedule of deliverables to Empire. In an October 6, 1992 Internal Audit report, Empire recommends that Sigma implement a formal system of development methodology for the balance of the Imaging system project. The Audit noted that failure to implement and enforce a structured system development practice with proper controls increased the risk that systems will not be properly controlled, developed on time, or within budget, and therefore will not meet management's expectations.

The audit further noted that Sigma's Omnidesk software was to be delivered 3 months previous and implemented into production. Because of various development errors, the audit reports that an error-free version hadn't been tested or delivered and no date to do so was given.

Sigma signed its contract with Empire in 1988 and promised a completion date in 1996. However, they have incurred numerous unforeseen setbacks and thus some doubts have been expressed to the Staff on whether Sigma will meet that prediction.

It is difficult to estimate what the actual cost and delivery date would have been if the Plan had stayed with Mr. Sarna and ISS. At the time ISS' contract with Empire was terminated, ISS was already established and not being subsidized by Empire. In fact, Mr. Sarna went on to design and implement a similar imaging system for a comparable health care provider. The Staff interviewed the company for which Mr. Sarna is now developing an imaging system that nearly mirrors the work Sigma is still attempting to develop for Empire. They are very pleased with him and his work and expressed their belief that his system will be fully operational by the middle of this summer. Their costs are significantly lower than Empire's. The company has paid only $12 million "from start to full ramp-up" and Mr. Sarna

has only had to invest $6 million for capital start-up, by comparison to the estimates of somewhere between $20 million to $40 million for Empire's costs for the Sigma contract.

The events surrounding the SIGMA contract exemplifies a number of problems with the management of the Plan. Not only did the Plan apparently pay more for the SIGMA contract than it would have had if it remained with Mr. Sarna and ISS, but it also raises serious questions about the Plan's contracting procedures. Dr. Stratigos and SIGMA were awarded a very important and extremely lucrative contract without any competitive bidding and apparently only because of Dr. Stratigos' special relationship to Mr. Werner, the former CEO, as his personal dentist and being a Voting Member of the Board. It appears these were the sole qualifications for Dr. Stratigos' deposition conducted by the Staff wherein Mr. Cardone could not enumerate any special training or experience that would qualify Stratigos to develop the "imaging system" which is an extremely complicated, "cutting edge" technology.

X. FRAUD, WASTE AND ABUSE

In a company as large as Empire, truly no one will ever know the exact extent of fraud. However, there are several rules of thumb that experts use to try to evaluate the extent of a company's total exposure to fraud and, in turn, the need for strong anti-fraud measures within a company. For example, both the General Accounting Office (GAO) and the Health Insurance Association of America (HIAA) estimate that approximately 10 percent of all medical claims are fraudulent. If so, then based upon its volume of claims processed, Empire's probable exposure to fraud would be nearly $640 million in 1992 alone.

Senior Empire officials themselves, in an interview with the Staff admitted that one of the causes for their losses in 1991 was fraudulent activity related to some of their union accounts and association business. However, these officials have downplayed its significance in relationship to the overall losses of the Plan in 1991 and 1992. The Plan's losses, they have consistently argued, are primarily due to cherrypicking and other unfair competition by commercial insurers in the community rated market as well as rate suppression by the Insurance Department.

As previously noted, the Staff believes that cherrypicking may not be as significant a factor as senior management of the Plan has claimed. In addition, as we will describe below, the Staff also believes that fraud, waste and abuse may also have played a much larger role in the financial demise of the Plan. The Plan has insisted that losses in their community rated lines of business are at the heart of their total corporate losses since 1991. In view of that, recent revelations of fraudulent activity by just one broker in this market, potentially costing the Plan up to $25 million, raises serious questions as to whether cherrypicking is a valid explanation for their community rated losses.

Based upon its review of not only this case but the entire fraud prevention environment at Empire, the Staff concludes that:

—Empire is extremely vulnerable to fraud, waste and abuse because of a long history of shortcomings in its computer systems and fraud detection capabilities;

—As a result, Empire has suffered major losses due to fraud, waste and abuse, which the Company itself in internal documents has admitted totals over $64.5 million in 1991 and 1992 alone, which is approximately 25 percent of the Plan's net losses for those 2 years;

—Neither the Insurance Department nor the Plan have attempted to verify the total potential losses that the Plan has suffered due to fraud; but based upon the Plan's own internal reports that are discussed later in the Staff Statement, the Subcommittee Staff believes that the Plan's potential fraud losses could be extremely high;

—The Community-rated, small groups market is particularly susceptible to potential fraud and, up to mid-1991, Empire never attempted to determine the extent to which possible fraud contributed to the Plan's losses in that market;

—Empire has historically done very little to protect itself from potential fraud and continues to have an inadequate fraud detection capability.

—Although no one has attempted to quantify what percentage of the over $400 million the Plan claims it lost in the community rated market was due to fraud, the Staff believes again that a significant amount of these losses may be directly related to false or improper claims paid by the Plan.

A. *System Weaknesses*

1. *Dummy Codes and Physician Provider Files*

The Staff discovered that Empire has routinely been paying claims to doctors, dentists, pharmacies, hospitals and durable medical goods providers without verifying whether any of these providers even exist. This problem, the Staff learned, is significant and amounts to over $500 million every year in claims paid by the Plan. The Staff found that it is the result of weaknesses within the Plan's computer systems and practices that the Plan has been aware of for years but never attempted to correct until recently. It is directly related to the fact that the Plan's computers were rejecting claims because of inadequate data concerning the provider codes, which are similar to social security numbers, which uniquely identify valid Empire providers, i.e. doctors, dentists, etc. The answer to this computer problem was to create "dummy codes" to essentially "fool" the computer to allow these claims to be processed.

The problem that the Staff discovered with the use of dummy codes is that it has opened the Empire claims system to potentially significant amounts of fraud. As the head of internal audit at Empire explained in a February 25, 1993 memorandum to Al Cardone, on the status of the Plan's efforts to stop the use of dummy codes:

> "Abusive use of dummy coding to facilitate employee fraud or to improve performance statistics is highly possible due to the well known lack of back-end/detective review of the dummy code utilization data."

To better understand the "dummy code" problem, one needs to review how Empire processes claims. The Staff has been told that when a claim is submitted to Empire by a subscriber, the information is eventually entered into Empire's claims payment computer, the MCS. Here the claim goes through a number of edit checks. These checks are supposed to be utilized, among other things, to see if the person submitting the claim is a valid Empire subscriber, if the procedure is proper, and if the provider is listed as an approved, licensed physician, dentist, durable medical goods supplier, etc.

If any one of these are not quite right, the computer is programmed to "suspend," or stop processing the claim. When this occurs, an Empire claims processor must physically take over the processing of the claim. For example, if a provider is listed in Empire's database, the system will automatically enter that provider's identification number on the claim and continue on. If the claim "suspends" because the provider is not found in the Plan's data base for all approved physicians, the processor must either physically find the provider number or utilize a dummy identification number, which is a generic number not coded to a specific individual, which the computer program will "recognize" to allow the claims process to proceed. This procedure, as one Empire employee told the Staff, "happens all the time."

The Staff learned that the inherent problem with the use of "dummy codes" is that their usage prevents subsequent verification that the service was provided by a licensed, credentialed physician or even if the service was performed at all. Equally significant, their usage opens the door for fraud. As it was described to the Staff, the system currently permits someone in the claims processing area of the Plan to submit a completely fictitious claim, utilizing a dummy code to fraudulently pay a claim to himself or herself or a confederate.

Although totally ignored by the Arthur Andersen study, consultants from the firm of Towers Perrin, who were conducting the internal management assessment, commented to the Staff that Empire's internal controls over the MCS system were so bad that Empire couldn't even tell if a physician getting payments was dead or alive. This latter point the Staff confirmed in its review of internal documents of the Plan, including the payments to non-existent and possibly deceased providers. As one former employee of the Plan jokingly commented, "in Chicago the dead vote, here they treat people and get paid."

The Staff deposed Thomas J. Ward, who until shortly before his deposition with the Subcommittee, was the Director of Program Security at the Empire Plan. He verified that he has been concerned about the potential fraud from the use of dummy codes and other corporate shortcomings since he joined the Plan in 1987. He testified that as a fraud investigator he would "want to eradicate them from the face of the earth."

He explained to the Staff one particular case that his office handled that dealt with the use of dummy codes to defraud the company. It involved an employee who dummy coded not only a fictitious provider but also a fictitious patient. With this information she fraudulently mailed Empire checks for bogus treatment to herself until she was caught because she later admitted she got sloppy and resubmitted the same exact phony claim repeatedly. Ward explained that the Plan is rarely this lucky and catches few of the employees who may be defrauding the company.

When asked if anything was ever done in the Plan to effectively deal with the dummy code issue, Ward said there have been some incremental improvements and that committees were formed to look into the issue. But, overall, "dummy codes" remain "a window of vulnerability that needs to be shut very quickly," in Ward's view.

The Staff has reviewed an internal audit report of Empire dated September 26, 1991, addressed to Mr. Morchower from Empire's Corporate Vice President of Auditing, Maroa Velez. In that report, it describes the extent of the problem with the usage of these codes. In part, it states:

> In our opinion, the system of internal controls was inadequate to ensure an accurate, complete, and valid physician database. Our appraisal was based on the following concerns:
>
> Minimum credentialing criteria to establish a physician as an authentic and current practitioner were not established.
>
> Physicians' credentials have not been validated against independent, external sources such as the American Medical Association or New York State Department of Education—Division of Professional Licensing Services.
>
> The last general purge of the Provider File occurred in 1984, and records that do not meet the established purge criteria may be contained on the Provider File, e.g., deceased doctors with no claims activity within 18 months.
>
> Effective input control procedures, including reviews for validity, accuracy and completeness of additions and changes to the Provider File, have not been established.
>
> 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.
>
> In 1990, *the Corporation paid $219 million* through the Medical Claims System (MCS) in benefits as a result of claims submitted *for services performed by non-credentialed physicians.* (emphasis added)

Ms. Velez recommended that management validate and re-credential all existing physician records and, in order to maintain a database of current physician records, the Provider file should be purged at reasonably scheduled intervals. The report also indicates her support for further efforts to limit the use of dummy codes in the future.

In an interview with the Staff on April 9, 1993, Mr. Morchower expressed his concerns about the massive amount of claims paid by the Plan utilizing "dummy codes." He indicated that $219 million apparently was paid in 1990 via "dummy codes" to non-credentialed physicians. He said that not all of this was fraudulent and that the Plan was compiling a list to confirm the license of the physicians in their database. As of this year, they found 8,000 physicians for which services were paid that they couldn't verify.

He indicated that they would have an approximate value of the improper payments in a few weeks. Since then, the Staff repeatedly requested these figures but never received them.

When the Staff interviewed Ms. Velez, the author of the previously cited internal audit report, a few weeks after talking to Mr. Morchower, she disagreed with the concerns of both Mr. Ward and Mr. Morchower. She downplayed the importance of the issue and even criticized her own memorandum for inaccuracies.

The Audit Division's Director of Program Security, Mr. Thomas Ward, did not agree with Velez's position that the 1991 report was erroneous or sloppy. He told the Staff that the report meant just what it said, that there was $219 million of physician care that was billed to Empire that Empire could not verify because they processed the claims with "dummy" codes.

He also noted that although no one knows for sure how many millions of dollars in claims are actually being paid using "dummy codes," he believes there may be more dummy code activity beyond the $219 million dealing with physicians. He said that the practice of paying claims when the provider could not be identified more accurately totalled approximately $504 million in 1991.

In the course of the deposition of Mr. Ward, he was shown the above-mentioned September 26, 1991 memorandum of Ms. Velez. In identifying it, Mr. Ward noted

that he had seen a subsequent document dealing with this same subject that showed greater potential losses:

> "There was a report called an audit report, I understand it has never been released, that was dated January 13th of 1993. The signatory of the copy I have is unsigned. It is from Maroa Velez to Donald Morchower and to Harvey Friedman. I got this copy from Patricia Lancellotti and also from the secretary to Jack Furka, the temporary secretary to Jack Furka, named Carol Lee. I went over and wanted to get a copy of this report, because I wanted to prepare my annual report on internal control deficiencies, which was one of my corporate objectives and a goal that I would be measured on. I used that report in writing my final report.
>
> Q. Was that report critical to the Plan?
>
> A. It is the report that says that $504 million were coded with generic codes, and it did say that the use of these dummy codes was conducive to fraud. I am not sure it said facilitated certain frauds, but it certainly indicated that action needed to be taken to remedy this situation.

Mr. Ward testified in his deposition that Ms. Velez attempted to hide the details of this report from the New York Regulators and Arthur Andersen auditors because she didn't want the adverse information getting out.[3]

At the time of preparing the Staff Statement, the Subcommittee had not been provided with a copy of this draft report even though it asked for it subsequent to Mr. Ward's deposition. However, the Staff was recently provided, just 5 days ago, with a copy of a February 25, 1993 memorandum from Ms. Velez which confirms Mr. Ward's claim that the dummy code problem is serious, exceeds $500 million per year, and involves potential fraud. A copy of that memorandum will be made part of the hearing record and an exhibit of the Subcommittee.

Although the Staff has no evidence that the total amount of claims processed with dummy codes is fraudulent, it is quite apparent that a certain percentage of all the dummy codes could be fraudulent. As Mr. Ward testified in his deposition:

> "And certainly I think if anyone wanted to come up and just look at our inventory of cases, they would see that it is a significant problem and one that needs to be corrected immediately."

No one knows what percentage of the total amount of dummy coding, apparently estimated by the Plan to total $723 million in 1991 and 1992 alone is fraudulent. Neither the Insurance Department nor the Plan even bothered to inquire into the question of potential fraud until after the Subcommittee started its investigation. Yet, based upon the Staff's investigation as well as the concerns expressed by both the Plan's internal auditors and the Insurance Department, it appears that dummy coding may have opened the Plan to significant fraud losses. This is confirmed in a March 5, 1993 memorandum from Martin Schwartzman of the Insurance Department to Albert Cardone, then-CEO of the Plan in which Schwartzman notes:

> It appears that without immediate corrective actions to eliminate or drastically reduce the usage of "dummy codes" to process claims, Empire could continue to make itself vulnerable to paying fraudulent and abusive claims. Further, any efforts to combat fraud and abuse could be hampered by the Company's continued usage of "dummy codes."

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[3] Deposition of Thomas Ward, June 11, 1993 at pp. 107-110:

"In my meeting with Susan Tobin of Arthur Andersen in January of this year, I mentioned that she has probably read the dummy code audit report and that she knows the significance of this problem with respect to fraud. . .

"I think the next day or the day after . . . I met with Maroa Velez and she asked me what we discussed. I told her the topics we discussed. She was very upset that I had mentioned dummy codes to Arthur Andersen. I had told her, well, there is a dummy code audit report and I think it clearly paints this as a problem that needs to be corrected and one that hopefully the audit division is moving to make these corrections.

"She told me at that time that report had not been released and it had not been released, she said, because she did not want Arthur Andersen or any outside auditors to see it.

". . . and I believe on the 14th then we had a meeting with Maroz Velez in the Liberty Room. . . . The meeting opened up with her saying how can anyone discuss dummy codes, how can anyone talk about dummy codes. I then said that it is absolutely impossible to discuss fraud without discussing dummy codes. . . .

"She was quite distressed that people had discussed the issue of dummy codes. I believe that is the meeting where she said we are not to give Arthur Andersen the meat to sink Empire, we are here to protect Empire. We left after that."

2. *Recredentialing of Small Community Rated Groups*

The Staff uncovered a second, and equally troubling systems and internal control problem that may have resulted in significant losses to the Plan due to the improper and sometimes fraudulent payment of claims. It concerns the Plan's ability to monitor the membership of many of its small groups to ensure that only valid subscribers are permitted to submit claims to the Plan. The Staff's review points to grossly inadequate controls and the potential for millions of dollars of improper claims having been paid by the Plan.

The Staff discovered that, until recently, Empire did not perform any audits of its small, community rated groups. The reason for this, as explained by Jerry Weissman, the Plan's Chief Financial Officer, was in part due to the nature of community rated business. Since the Plan had to take individuals and groups regardless of their health risk, the Plan never bothered to concern itself with the particular group's profit or loss, rather the focus was always on the community pool as a whole.

Until 1991, Empire knew little about its small group market. For specific groups, Empire did not know the claims ratio (the difference between premium and actual claims paid), they did not know if they met underwriting standards, or even, as it later came out, that a particular group really existed.

What caused this to change in 1991 was the discovery that the Plan was the victim of an expensive fraud involving small groups. In response to questioning about what led to Empire's decision to look at profits and losses of small groups at that time, Mr. Weissman stated:

> An internal review of a situation that has become known as the Finkelstein case, where people were being brought in and got coverage with waivers of pre-existing conditions, was the basis upon which the corporation made a decision to pursue all of our small groups and satisfy ourselves that, in fact, all of the groups in the community rated pool met the underwriting regulations."

That review is still ongoing. Its results so far indicate that Empire was defrauded in more than just the Finkelstein case, the details of which will be discussed shortly.

Mr. Ward told the Staff that in the summer of 1991, the Plan set up a task force to look at the groups "in the community area to see if they were real groups." When asked the reason for this, Mr. Ward responded:

> "My recollection is because of the massive losses taking place in the community rated area. I also think they were looking to see what evidence of cherrypicking was taking place, too, if I remember correctly."

The Staff has reviewed the 1992 Year-End Status report of that task force, which is called the "Group Integrity Department." It shows significant problems with the integrity of the Plan's small groups and lays the basis for the Staff's concern about significant fraud having been perpetrated upon the Plan through the small group market.

Based on the latest report, from April 1992 to December 1992, the special task force conducted audits on 2,004 groups. Each of the groups experience losses ranging from $35,000 to $1 million. This resulted in an overall loss to the Plan from these groups of $149,500,000. The audits resulted in the cancellation of 377 groups that did not meet Empire's underwriting requirements, refused access to the auditors, or were unable to be found. This report indicates that from the 377 groups that were canceled, Empire lost $25,000,000 for the 1990–1991 period.

Other findings from that 1992 year end report indicate:

—Empire canceled 17 bogus groups and estimates a $1.75 million yearly loss avoidance for the 17;

—Empire's Law Department is preparing legal cases against six of the bogus groups;

—Empire canceled 30 groups because they could not contact them or were refused access. Empire estimates a $1 million yearly loss avoidance from these 30 cancellations;

—Empire canceled 87 groups because they were below minimum enrollment requirements. Empire estimates a $4.6 million yearly loss avoidance from these cancellations; and

—Empire canceled the remaining 243 groups for various reasons, including termination of the business and estimates a $6 million yearly loss avoidance from these cancellations.

In 1993 the Group Integrity Department plans to audit 1,603 groups which lost a total of $115.2 million in 1992. Each group lost a minimum of $35,000 and the average loss per group was $71,917.

The Staff has determined that the Group Integrity Department has audited 876 groups of its planned 1603 groups and that it is 55 percent (876/1603) of the way through its 1993 workload. So far in 1993 it canceled 201 of the 876 groups (23 percent). Assuming it continues at this rate for the rest of 1993, it will cancel 167 of the remaining 727 groups left to audit this year. Based on the average losses of the groups the Plan has already audited, losses on the remaining 167 will be estimated at $12 million (167 x $71,917).

The Staff has been conservative and further assumes that the Group Integrity Department has audited the worst groups first. Our basis for that assumption is that the groups audited represented only 5 percent of Empire's 60,000 groups, yet accounted for 64 percent of the community-rated losses.

Empire's cancellation rate on these groups was 18 percent in 1992 and 23 percent in the first 4½ months of 1993. Of the approximately 56,000 groups remaining to be audited after 1993, these groups lost $114.6 million in 1992. (Community rated losses of $229.9 million during 1992 less the $115.3 million reported by the Group Integrity Department linked to the 1,603 groups). Based on the foregoing, the Staff assumes a very conservative cancellation rate of 1 percent of the remaining groups yet to be audited. Consequently, we estimate Empire will cancel 560 groups with a loss of $71,917 per group, resulting in losses of $40.3 million after 1993.

According to the Group Integrity Department, between April 1992 and May 1993 it audited 2,880 groups and found only 1,173 or 41 percent to be qualified. It canceled 578 groups (20 percent), had 299 groups pending (open issues) and had 830 groups (29 percent) pending cancellation.

The Group Integrity Department estimated $13.35 million in yearly loss avoidance due to canceling 377 groups in 1992. The Staff estimates loss avoidance associated with the Group's 1993 audits at $26.5 million and at $40.3 million for post 1993 audits.

Significantly, this report also made a finding concerning the Plan's cherrypicking argument. It noted that:

> Little to no evidence of "cherrypicking" was found on the part of those groups audited.

The Staff interviewed Ms. Velez about the recredentialing project. She indicated that there were actually two projects. The first started in July 1991 and lasted 3 months. During that audit, they attempted to visit approximately 814 "high dollar loss community groups." They were only able to visit 471 groups, or approximately 58 percent of the initial groups. Of those, 171 were found to have actionable problems. As a result of this review, they found that 64 percent of the groups they contacted had some sort of problem, either the group had a non-existent member, they failed to meet underwriting standards, or the group didn't actually exist.

Ms. Velez said that based upon their initial audit, it was decided that a larger and more intense review was called for. But, before embarking upon this second audit, they gave any plan that had membership problems a month-long "amnesty" to admit their problems in return for which the Plan would attempt to help the group convert their coverage. The amnesty resulted in the cancellation of 1,229 groups and approximately 19,000 subscribers.

These results were the basis for setting up the Group Integrity Division and the second audit of the largest losing groups. Overall, she said that their audit found that 60 percent of the groups reviewed did not meet Empire's underwriting standards for some reason.

3. *The Finkelstein case*

The Staff's review of the Finkelstein case raises a number of questions not only about the ease by which the Plan was apparently defrauded but also the adequacy of both the Plan and the Insurance Department's anti-fraud capabilities. Tom Ward told the Staff that the amount of the suspected fraud in this case was approaching $29 million and was, by far, the biggest fraud in Empire's history.

The Staff learned that in the fall of 1991, Empire decided to pursue this case civilly and sued Mr. Finkelstein and others alleging damages of approximately $22.5 million. Just recently, the Staff learned that the Plan entered into an agreement to settle the matter for $250,000.

The Staff has learned that only recently have law enforcement officials initiated a criminal investigation of this matter, even though both the Plan and the Insurance Department were alerted to the fraud in 1986. The Staff has also learned that U.S. Postal authorities were briefed by the Plan in 1991 and expressed an interest in in-

vestigating the matter criminally, but that the Plan never officially referred the matter to them due to their decision to proceed against the alleged perpetrators in a civil court action.

In particular, the Staff's review of this conspiracy to successfully defraud the Plan by placing invalid subscribers on several bogus corporation's health care groups raises the following questions:

—why wasn't this fraud uncovered earlier since both the Plan and the Department had essential details of the conspiracy and the names of the key co-conspirators in November, 1986;

—why didn't the Plan or the Department ever follow up on statements given by a Plan employee in 1991 that higher officials of the Plan were aware of this scheme;

—what if any influence did this statement have on the Plan's decision to proceed civilly against the conspirators instead of turning the matter over to the U.S. Postal Service which was willing to investigate it for criminal violations;

—what is the total amount of losses incurred by the Plan as a result of this conspiracy and other similar fraudulent activities.

The following is a brief synopsis of the facts surrounding the largest fraud ever committed against Empire.

In November, 1986, Eliezer Dvir, a private citizen residing in Brooklyn, complained to the Insurance Department that he had been asked to participate in a fraud against Empire. In that complaint, he gives a very detailed description of the fraudulent scheme as well as the names of a number of the participants, including Reuven Finkelstein. He stated:

> I was informed by Rabbi Pinchus Horowitz to purchase insurance through this individual (this is a very common situation that people purchase Major Medical insurance through this man) for urgent necessary surgery for a pre-existent condition *without* informing Blue Cross/Blue Shield of the already existing condition.
>
> I came here from Israel October 15, 1986 for this express purpose in an attempt to defraud Blue Cross Blue Shield. Mr. Horowitz's father, Rabbi Levi Horowitz was the individual that initiated the whole process from Brookline, Massachusetts even before I came here with my family, without bothering to mention the fraud aspect. This point was not mentioned until I was ready to actually pay for this insurance by avoiding the 11-month clause limiting treatment on pre-existent conditions.
>
> This has been done by the same company (KCG) under the auspices of both Pinchus and Levi Horowitz on numerous occasions in the past with people having pre-existent conditions according to their own admission. They already defrauded the Blue Cross/Blue Shield corporation of hundreds of thousands, if not millions of dollars, which people without exception came here from foreign lands, primarily Israel, with pre-existing medical/surgical problems. All of which avoid the 11-month limitation clause and most of whom stayed here only for treatment after which they returned to their native countries.
>
> Since I refused to participate in this fraud, I can not give you a policy or claim number. This is primarily to alert you that this situation that has been going on for many years and that I hope you can cause this situation to stop.

The Insurance Department apparently did nothing with this initial complaint except to send it to the Plan to investigate. Thomas Ward said that when they received the allegation, they looked at it and tried to contact Dvir. Dvir had subsequently moved to Canada to receive the medical attention he needed and, therefore, they could not interview him. Ward told the Staff that although they continued working on the Dvir allegations for some time, they encountered a lot of difficulties identifying the policies, groups and actual individuals involved because of the poor state of records at Empire.

Between 1988 and 1991, Ward told the Staff that an Internal Auditor, George Jamesley, examined the profit/loss data on a number of small groups through a self-designed computer program. He discovered a link between a number of these groups and an individual employee at Empire.

Based upon the connections that Jamesley and others made to various groups, Ward told the Staff that he felt they had sufficient information to proceed criminally with these allegations. Due to the Plan's limited resources, a meeting was set up

with John Feiter of the U.S. Postal Service in August of 1991. At that time Mr. Ward and others presented the evidence that they had uncovered to date. Mr. Feiter expressed interest in the case and said that his office would be interested in handling the matter criminally.

Ward indicated that at almost the end of the meeting, Ms. Velez, his superior, expressed her desire to proceed both criminally and civilly with this matter. She asked for Feiter's reaction to such a proposal. Feiter explained that the U.S. Attorney's office has a policy against such tandem actions because they do not want to be viewed as the "bill collectors" for corporations. Feiter recommended that they proceed criminally and then the Plan could go civilly. The meeting ended with Velez indicating that the Plan would get back to him about their decision.[4]

In the interim between this meeting and the final decision to proceed civilly with the matter, Ward's investigators had identified an Empire employee who appeared to be connected to many of these groups. He was Robert Garafallou, an Empire salesman. On September 6, 1991, Robert Garafallou, provided the Internal Audit investigators an affidavit, wherein he explained that he had started working in the Queens office of Empire in 1984. He recalled first selling Finkelstein a small group policy in 1984. Later, Finkelstein introduced him to other groups to which he subsequently sold Empire insurance.

He told the investigators that his instructions concerning his sales practices included:

> Be careful with the Jewish organizations because they know everybody, including senior staff members at BC/BS.
>
> I wasn't quite sure what Ron meant at the time but this advice was confirmed by the other Reps and subsequently by the Yeshivas and Jewish organizations who immediately began to "name drop." I generally found the Rabbis difficult to deal with and the Hasidic community very aloof. Many of the Rabbis appeared to know more about our products than I perceived myself to.

A few months after he started working in that office, Garafallou told the investigators that his manager, Ron Dennis, asked him and the other salesmen to prepare a list of accounts in their binders of groups that they felt might be phony, which he did.

> We were told to prepare a list of accounts in our binder of groups we felt might be "phony groups" or associations, etc. I prepared a list of 30–40 groups that were suspect based upon the criteria we were given. Such criteria included but was not limited to:
>
> —Lack of activity around the premises.
>
> —Multiple groups in one location or administered out of one location.
>
> —Inability to get into account.
>
> Of course, all the Reps in the Brooklyn Queens office produced some hefty lists. Included in my list were the groups I have discussed thus far. Although I did not have a strong feeling that anything was wrong, they met the criteria set forth. I would probably be criticized at a later date if I

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[4] Deposition of Thomas Ward, June 11, 1993 at pp. 15–16:

I had invited John (Feiter) in. I was quite convinced that this was a criminal case. It was the largest fraud in the history of Empire. At that point, it was $22.5 million. It has now grown to be $29 million. I didn't see any problem in pursuing this criminally. John, again, thought it was an excellent case, and frankly I felt that that day John would leave with that case and we would be working with them.

Q. So were you surprised that Ms. Velez raised the civil perspective? Had she discussed that before with any of you?

A. I don't recall any discussions on that. There had been discussions, as I alluded to before, on pursuing restitution in a number of cases, and my position of that, for the most part, is that the best way to deal with these frauds is to prosecute them. . . .

But the best way to do that, the best way to get the biggest bang for the buck is to prosecute, convict, and then try to get restitution in Criminal Court, get a criminal Court Judge or a Federal Court Judge to order restitution, or then get that, get a confession of judgment and go into Civil court also, and if it's a provider, also go after the provider's license and then fourthly to publicize these cases, so that it acts as a deterrent to the community.

I passionately had argued that this is a criminal case, and there were a lot of implications that needed to be pursued, and there are many things that were unknown. I took the case, my unit took the case, as far as we could. We really needed the arm of public law enforcement to pursue this case further.

did not include them. In any event, the list was given to Ron Dennis who told us it was going to be investigated by program security and the legal area. Mr. Ronald Zammit was the acting director at the time and remembers this project today in 1991.

We were told to lay off of these accounts until they were checked out and either canceled or cleared. This meant avoid contact, business transactions, etc.

A few months went by and someone asked at one of our office meetings what had become of the lists that we all prepared. Ron Dennis said that they had all been checked out and everything was okay.

In his affidavit, Garafallou indicated that throughout the next year or so he continued servicing these groups, including the ones that he had previously indicated were suspicious. In 1986, he was transferred out of the Queens sales office to a Long Island office where he met Finkelstein again and sold policies to a number of new groups that Finkelstein wanted covered, including several groups whose addresses were post office boxes. Eventually, Garafallou added his sister to an association for health coverage, for which he was fired by the Plan shortly after giving the affidavit.

In Garafallou's affidavit he also discussed the general attitude towards these groups, which he claimed everyone knew were suspicious. He stated that:

> The general tone in the Queens Village office was to treat the Jewish organizations with kid gloves because they were all connected to senior people in our company. This meant to me: backdate an app. when needed, jump on service issues, give as much information as possible, just generally don't piss them off. These groups often asked for some outrageous things and we were to offer little resistance if the request was in the realm of "doability."

Tom Ward, in his subcommittee deposition, indicated that Garafallou never specifically identified who, if any, senior officials were connected to these organizations. Ward said that he would have followed up on these allegations but shortly after he obtained the affidavit, he was told by Maroa Velez that the case was going to be handled as a civil suit. Ward told the Staff that the matter was taken out of his hands at that time, and he and the other Plan investigators never did anything else of substance in regards to it.

The Staff is aware that both the Insurance Department and federal law enforcement officials reopened an investigation of this matter in early 1993 and are now actively pursuing many of the same leads that the Plan's own investigators had first uncovered in 1991.

B. *Empire Internal Audit Division*

The Staff's review of the Finkelstein case raises a number of questions concerning the Plan's ability to prevent as well as uncover fraudulent activities.

Tom Ward, the former Director of Program Security told the Staff in his deposition that based upon his experience, there were serious problems with security at the Plan, starting with its emphasis on numbers, not quality. He explained that the basic problem with internal controls and fraud prevention at the Plan is that it is not a top priority of management. A detailed analysis of Empire's internal control systems and the limited number of criminal investigations conducted by it are included in Appendix B.

XI. PAY ISSUES AND EXPENDITURES

In addition to customer service complaints, the Staff also found Empire's large executive salaries to be of utmost concern to subscribers.

This chart depicts the corporate organization of Empire Blue Cross and Blue Shield as of September, 1992. According to this chart, which was provided to the Subcommittee by Empire officials the corporate structure includes 20 Assistant Vice Presidents, 39 Vice Presidents, three Corporate Vice Presidents, one Executive Vice President, one Corporate Secretary and one Chief Executive Officer, for a total of 65 executives.

The next chart lists the total cash compensation of Empire's top seven executives for the past 6 years. As you can see, Chief Executive Officer Al Cardone received compensation of $600,000 last year as well as in 1991. While the Staff commends Mr. Cardone for forgoing a salary increase after the Plan's large losses in 1991, we find the amount of $600,000 extremely generous for the CEO of a company which is in dire financial straits. The same can be said of Donald Morchower, the recently

appointed acting CEO, earning over $427,000 while the information systems of the company flounder under his supervision. A generous $227,000 is also paid to Jerry Weissman, Empire's Chief Financial Officer, who is responsible for the Plan's finances.

Additionally, as the next , the top ten executives have been very good to themselves in awarding pay increases when compared to the rest of the work force at Empire. The compensation to the top ten executives has increased 56 percent since 1987 while the remaining 8,000 plus employees have received pay increases of only 27 percent since 1987.

In 1991, the Blue Cross and Blue Shield National Association conducted a study of all 72 plans in order to compare and contrast executive compensation schedules. According to the study, Al Cardone's compensation of $600,000 placed him within approximately the 85th percentile of CEOs within the 60 plans responding to the survey. Given that Empire is the largest Blue Cross/Blue Shield Plan, the Staff finds this reasonable. We contend, however, that the CEOs earning these impressive amounts should at least be operating financially sound plans.

Additional compensation surveys have been conducted by Sibson and Company, a consulting firm which has an ongoing oral contract with Empire. Sibson has received over $500,000 from Empire since it conducted its first compensation study for the Plan in 1987. Sibson's initial study for Empire was a competitive assessment of salaries with other insurers and financial institutions. Mike Conover, the Sibson consultant assigned to Empire's account, told the Staff that he relied upon published surveys of both Sibson and other consultants and could not provide a list of companies against which Empire salaries were compared. He did believe that the companies used in the surveys he referenced were insurance companies and financial institutions.

The initial 1987 study by Sibson found that Empire's salary structure was "competitive" but that its incentives compared less favorably with other companies. As a result, Sibson recommended that an incentive program be adopted. In 1989, Empire did, in fact, implement an incentive program for officers based on Sibson's determination that Empire's lack of incentive pay was a "competitive deficiency." When questioned by the Staff as to whether Empire actually had a problem competing for qualified executives, Mr. Conover admitted that he had no specific information that this was true and that he accepted Cardone's representation that such was the case.

While Empire has announced that it has frozen officers' salaries at the 1991 level, it has not frozen the incentive program and will continue to award substantial incentives to its officers to supplement their salaries.

According to Empire's corporate policy, each year's incentive payment is based on performance of the Plan in the previous year. Thus, the incentives based on 1991's business performance, the year in which Empire experience $150 million in losses, were awarded in 1992. As the chart reveals, these figures were significantly greater than in the previous year (with the exception of the General Counsel position), despite Empire's poor performance. Empire officials explained that this was possible because incentive payments also incorporate divisional and personal goals of each officer. Thus, they maintain, the Plan may do poorly while individual divisions and individual officers do well. The Staff is uncertain how the Plan could perform so poorly in 1991 if all but one officer was performing so well.

The Staff found that divisional and officer goals included such basic requirements as "complete the year within the approved expense budget" and "support and meet the corporate affirmative action goals." Even the Arthur Anderson audit report stated that officer incentive goals "should 'stretch' beyond normal job requirements." When asked about this statement, Arthur Andersen auditors stated that Empire officers receive incentive payments for simply "showing up and doing their jobs."

Given the fact that financial institutions were included in the pool of companies with which Sibson compared Empire's salaries and incentives, the Staff interviewed a corporate benefits expert at a major New York bank. He told the Staff that the use of incentive programs tied to personal and corporate performance is common within major financial institutions in New York, but added that these averaged only 4 to 4.5 percent over the last 4 years.

When informed of Empire's average incentive payment of 11 to 13 percent each year, the benefits expert told the Staff that:

> "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."

The Staff asked about the compensation studies provided by Sibson. The benefits expert commented that the only reason to increase benefits is if employees are leaving because of a lack of benefits or if morale is low. His sense of the awarding of benefits at Empire is that "they decide what they want, then bring in data to support it." He added that such behavior would never be tolerated at a for-profit company but that it is typical of non-profit attitudes.

As is evident from the chart, Mr. Cardone did not participate in the Plan's incentive program. Given that he administered the program by determining whether goals had been met and the amount of incentive an officer should receive, Mr. Cardone did not feel it would be appropriate to participate in the program himself. The Budget and Compensation Committee of the Board of Directors, however, commissioned Sibson and Company to create the framework for an incentive program exclusively for Mr. Cardone.

Mike Conover at Sibson told the Staff that there was no evidence that Cardone was dissatisfied with his salary nor that Cardone was contemplating leaving. Rather, Board minutes reflect that the Compensation Committee voted "unanimously and with some strength of feeling . . . that the Chairman's performance in 1990 had been truly outstanding, and must be rewarded." The Board then voted to increase Mr. Cardone's salary by $60,000, from $540,000 to $600,000, effective January 1, 1991. The Board also agreed to continue working with Sibson and Company to formulate a total compensation package for Mr. Cardone which would include some type of bonus arrangement. Sibson provided the information for such a program but the Board decided against it. Conover stated that he did not know why the program was not adopted.

As for the $60,000 pay increase for Mr. Cardone, it did not become effective January 1, 1991 as planned. The raise was delayed until after Empire received its 19 percent rate increase in March, 1991. Superintendent Curiale told the Staff that he expressed his outrage to Cardone that the Board would wait until the rate increase had been approved then impose a retroactive pay raise for their Chairman. Cardone maintains that retroactive pay raises are routine at Empire.

In addition to salary and incentive payments, Empire officers, and employees making over $60,535, are eligible to participate in the Plan's deferred compensation program. Because the money an officer elects to defer is not included as part of the pension benefit calculations, Empire has adopted a Supplemental Employee Retirement Plan, or SERP. SERP basically provides that an officer will receive a lump-sum payment upon retirement calculated as if the amounts deferred were included in the base compensation.

Al Cardone initially joined Empire with an employment contract but was working pursuant to three Board resolutions for the past several years. The most recent resolution, passed in April, 1992, provided that Mr. Cardone's severance would be payable

> in a lump sum before the earlier of 30 days after his termination of employment or July 28, 1995, in the amount equal to (i) the lump sum equivalent at his severance date of the annuity benefit to which he would be entitled at age 65 under [EBCBS] Pension Plan C . . . plus (ii) the lump sum benefit to which he would be entitled under the [EBCBS] Supplemental Pension Plan . . . provided that . . . Mr. Cardone shall be treated as though he had continued in the employ of the Corporation, with no change in his compensation, and retired at age 65.

The Board minutes also reflect that this resolution, and the preceding two resolutions concerning Mr. Cardone's severance, were approved by the Board without any question as to how much it would actually cost. Estimates place Mr. Cardone's severance payment at $1.4 to $2 million. When questioned by the Staff, Cardone denied that he expected to receive a "golden parachute" as a result of his resignation. In any case, it does appear that Mr. Cardone, who is 58 years old, will receive 7 years credit towards his retirement despite the fact that his termination was initiated by the Board of Directors.

In 1987, when Edwin Werner stepped aside as CEO of Empire, he was retained by the company on a consulting basis. The Staff found that, in the year following his retirement, Werner received $105,000 in consulting fees for his assistance in the transition of administrations.

Several other Empire officers also left Empire's payroll only to be immediately rehired on a consulting basis. For example, John Lovett, a former Empire Vice President of New York Markets, was earning over $160,000 when Cardone "cleaned house" in 1987. Yet, in 1987, he also received over $145,000 as a consultant to Empire. David Willis, Lovett's replacement, was earning over $200,000 upon his

1990 termination, and earned an additional $169,000 as a consultant to Empire in 1991. Rodney Hook, Empire's former Chief Financial Officer, was earning over $160,000 when he was terminated by Cardone in 1987; he immediately became a consultant to the Plan and received $71,000 in consulting fees. A fourth officer, William Roy, Vice President of National Accounts, was also terminated from a $180,000 position in 1987, only to earn $96,000 as a consultant to Empire.

Mr. Cardone maintains that the consulting work performed by these officers involved assisting in the transition period for their successors. The Staff has some question, however, as to whether these officers actually served as consultants to the Plan or whether the consulting fees were actually a form of severance.

A. *Perquisites*

In addition to complaints about excessive salaries and incentive payments to Empire executives, the Staff has also received complaints concerning the perquisites Empire officials enjoy.

The figures presented on the compensation chart do not include the value of fringe benefits provided to these and other officers. The next chart depicts the total amount of money Empire spent on certain officer perquisites for the past 5 years. The Plan paid for health club memberships, luncheon club memberships, physical examinations and parking costs for many of its executive officers.

Perhaps the most costly of all corporate perks at Empire is the fleet of corporate automobiles. Empire has purchased 82 automobiles for its officers, ranging in model years from 1988 through 1992, with a current fair market value of over one million dollars.

Corporate policy for employees to whom these cars are assigned provides that the cars may be used for both business and personal purposes. Officers and employees with assigned vehicles are required to submit a yearly statement of the number of business miles versus the number of personal miles the car has been driven and to compensate the Plan for personal use. Interestingly, the Staff found that some officers actually reported using the vehicle for more personal use than business.

In addition to the fleet of 82 assigned vehicles, Empire also owns a fleet of 41 "pool cars," or cars which are available for employees for specific Empire-related purposes. This fleet of cars also ranges in model years from 1988 to 1992 and has a fair market value of one-half million dollars.

The Staff found it remarkable that despite 82 officers having vehicles assigned to them for personal and business use, and despite employees having 41 pool cars available to them for Empire business outside the office, the company still engages the services of several limousine companies.

Last year, Empire spent over $50,000 on limousine services while in 1991, the company spent over $91,000 for chauffeured rides. The Staff found that during the past 6 years—despite its own extensive fleet of cars—Empire spent a staggering $226,000 on limousine services for officers, employees and guests.

This figure includes over $11,000 for just 2 months of limo services for Al Cardone to ride to and from his home in New Canaan, Connecticut to Empire headquarters in New York City, at an average of $300 per roundtrip. It also includes $1,100 in cellular phone usage while Mr. Cardone was riding in the limousines. When questioned about these costs, Mr. Cardone told the Staff that he believes his corporate car was having repairs done during this time period. When asked if he considered using one of Empire's "pool cars," Mr. Cardone responded indignantly: "I was recruited by this company and I was promised a car."

The Staff finds that such expenditures of subscriber's hard-earned money typifies the blue-chip mentality of Empire executives. Throughout this investigation, the Staff has been told that we would be hard-pressed to find extravagant overseas travel upon the Concorde or $300,000 skyboxes for stadium events or lavish country club memberships, as we have found in our investigations of other Blue Cross and Blue Shield Plans. Mr. Chairman, that much is true. What we did find, however, is that Empire operates as if it is a profitable Fortune 500 company rather than a nonprofit health insurer.

In addition to the corporate perks described above, Empire also lavishes its staff with numerous gifts and rewards at subscriber expense. Last year Empire created a company-wide "Employee Recognition Program" to reward employees for specific achievements.

The Staff has found that during the 8 months since the program was begun last year, these awards were very generously bestowed. For example, over 5,000 employees received the Circle of Stars awards, 1,200 employees received Service Awards, and 995 employees received Attendance awards.

These employees receive substantial gifts, as shown in this enlargement of Empire's gift catalogue. These awards include diamond and sapphire jewelry, Water-

ford crystal, pearl necklaces, gold wristwatches engraved with the Empire logo, binoculars, 45-piece flatware in chests, desk sets, wall clocks, carriage clocks, grandfather clocks, and cash gifts up to $2,500. Last year, these gifts to employees cost Empire subscribers over $255,000.

Additionally, the Staff has reviewed the expenditures for the 5-year period, 1988 through 1992, and found that Empire spent in excess of $1.1 million in similar gifts for its employees prior to the initiation of the Employee Recognition Program. The Staff's concerns in this area are threefold.

First, Empire is a non-profit corporation. As such, it enjoys certain benefits unavailable to the commercial insurers, such as exemption from State taxes and a substantial discount on the amount it must pay to hospitals. The purpose of these legislatively mandated savings to Empire are intended to benefit the subscribers, not Empire's workers. Yet, corporate officials at Empire seem to have lost sight of this fact and are spending subscriber premiums in ways and in amounts which the Staff finds inappropriate for a non-profit company.

Second, the purchase of these gifts does not appear to be influenced in any way by the financial performance of the company. The dollar amount spent on jewelry and clocks for employees increased steadily from $109,000 in 1988 to over a quarter of a million dollars in 1992. This despite the fact that 1991 saw Empire experiencing a loss of $150 million.

Finally, the premium rates charged to subscribers have been skyrocketing throughout this period in which Empire has been bestowing over a million dollars in gifts to its employees. This a history of rate increases granted to Empire for its community rated contracts with small business and direct paying subscribers.

The Staff has also learned that Empire bestows even more gifts upon its employees for participating in such worthy causes as the United Way Campaign, March of Dimes fundraisers and Red Cross Blood Drives.

During the 4-year period 1989 through 1992, Empire spent an additional $264,000 in "rewards" for employees who participated in these events. Again, the Staff is concerned about the propriety of a non-profit health insurer spending subscribers' premium monies in order to reward employees for such acts as contributing to charity or donating blood.

In 1987, the Board of Directors established the Edwin R. Werner Scholarship Fund in honor of the Plan's former CEO. The Werner scholarship consists of two undergraduate college scholarships awarded to the children of full-time Empire employees. Since the scholarships were established in 1987, the Plan has awarded over $400,000 in scholarships to 12 students. These scholarships are not funded by Edwin R. Werner, nor by the executive officers, nor by the Board of Directors. The money for these scholarships comes from Empire subscribers.

Another example of Empire's Fortune 500 attitude can be found in its catering and meal expenses. Empire contracts with several catering companies to provide food and beverage services to the Plan. In reviewing the company's catering bills, the Staff found routine, almost daily staff meetings at which hundreds of dollars of food and beverage is served. The meetings are almost always scheduled during the lunch hour in order to justify the catering bill or, in some cases, morning staff meetings are held with expensive breakfast bills being incurred.

Empire also subsidizes the costs of its cafeteria expenses in an effort to offer convenience and affordable food to its employees. The amount of this subsidy totalled $1.3 million in 1989; $1.6 million in 1990; over $$2 million in 1991 and again over $$2 million last year. According to its food service contracts, Empire is responsible for determining the prices of the food the cafeteria serves and given the large amount of its subsidies, the Staff recommends that Empire reevaluate its pricing mechanism.

Empire also subscribes to a rather lenient overtime policy for its employees. The Corporate Employee Travel, Expense, and Conference Planning Manual for Empire provides:

> On regular work days, breakfast and lunch are not reimbursable. Dinner, however, is reimbursable if the employee works at least three hours after the normal departure time for the department. On holidays and weekends, all meals are reimbursable if the employee is working during those hours. . . . The usual limit for overtime meals, including tax and tip, is $18.

In reviewing employee expense reports, however, the Staff found that this policy is grossly abused. Numerous employees routinely claim overtime meals with no indication that the 3-hour minimum overtime requirement has been met. Furthermore, many of the overtime meals which were claimed and fully reimbursed substantially exceeded the $18 limit. The majority of Empire employees who claim to be working

late are not ordering in sandwiches from the corner deli, but are rewarding themselves with expensive meals at New York City restaurants.

In addition to meals, employees working overtime are reimbursed for the cost of driving to work (gasoline and tolls) or the cost of transportation by taxicab.

The Staff reviewed the file of one officer, chosen at random, and found that he received reimbursement of almost $4,000 for his overtime meals and transportation in 1991 alone. From our review of corporate officer's expense files, the Staff finds that this officer is not alone in taking advantage of Empire's overtime policy. The practice of treating one's self to dinner and charging it to the Plan on the basis of working overtime appears to be widespread.

In January, 1991, an internal audit of Empire's overtime policies was conducted and found lacking. Maroa Velez, Vice President of Auditing at Empire conducted the review of overtime procedures and found that "overtime control procedures need improvement to ensure compliance with overtime authorization policy." Ms. Velez's review even revealed instances where employees received overtime pay for days when they were out sick or on vacation.

The Staff also found that Empire's corporate employee manual prohibits reimbursement for meals where only Empire employees are present. Like the reimbursement for overtime meals, this policy is also abused.

Another area of expenditure which the Staff found to be excessive in other Blue Cross/Blue Shield Plans was travel. We did not find extravagant trips to Europe nor did we find travel upon the Concorde, as we did in previous investigations of Blue Cross/Blue Shield Plans. What we did find was much less extravagant travel, yet quite expensive nonetheless.

For example, the Staff found a large expenditure for 12 Empire officers to attend a seminar at Disney World in Orlando, Florida in July and October, 1990. The seminar, which was entitled "The Disney Approach to Quality Service," was available at a registration fee of $1,713 per person, or over $20,000 for Empire's twelve officers.

This $20,000 covered the cost of hotel rooms and seminar registration for Empire's twelve officers, but did not cover the cost of transportation to and from Orlando, nor the cost of meals. The Staff found that ten of the twelve Empire officers who attended the Disney seminar flew to Orlando at a reasonable coach airfare. Two of the officers, CEO Al Cardone and Vice President of Corporate Quality Control, Beverly Palmer, flew first class at a cost to the Plan of $1,720. When questioned by the Staff, both Cardone and Palmer maintain that they were working and therefore had to sit together in First Class.

CEO Al Cardone accompanied the first group of six officers who attended the Disney seminar in July, 1990. Mr. Cardone, however, made a special request for a two-room villa at a cost of $725 per night rather than stay in the room which is included in the $1,713 seminar fee. Mr. Cardone incurred room service charges the first day in the amount of $395 and the second day in the amount of $492. The total bill for Al Cardone's attendance at the 3-day Disney seminar was over $5,000, paid for by the subscribers of Empire.

Mr. Cardone told the Staff in a sworn deposition that he attended the Disney Seminar on two occasions at Empire expense. Subpoenaed documents, however, only included the costs of one of Cardone's trips to the Seminar.

The Staff found numerous other instances of the Fortune 500 mentality of Empire officers and employees, including the following:

> Empire paid $300,000 to be one of eight major sponsors of the coffee table book entitled The Power to Heal, Ancient Arts & Modern Medicine. The Staff notes that none of the other sponsors—Eastman Kodak, Parke-Davis, United States Surgical Company, Pan Am World Airways, Apple Computer, Nikon, and the San Francisco Marriott—are non-profit organizations.
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> Last year, Empire spent over one-half million dollars to lobby lawmakers in the State Capitol. This was more than any other organization in the State, except one, the New York State United Teachers, which only outspent Empire by less than $3,000. The Staff questions such excessive spending on lobbying fees by a non-profit company which is raising its premium rates and receiving an infusion of funds from the State.
>
> Empire officers appear to be unwilling to incur the slightest personal expense associated with their jobs. For example, Maroa Velez, Vice President of Auditing, making over $166,000 a year, charged an 11 cent telephone call to the Plan; Bernard Schoen, Vice President of Experience Rated Sales, making over $268,000 charged $2.50 to the Plan for tolls he had to pay to attend the funeral of a co-worker's mother; Michael Blumenfeld, Vice President of Public and Governmental Affairs, making over $161,000, received reimbursement from the Plan for a 40 cent newspaper and $1.50 for batter-

ies for his calculator; and Alan Drewsen, Empire's General Counsel making over $227,000 charged the Plan for lead for his mechanical pencil.

A $2,000 outdoor party was given for a single employee, including food, open bar and security, to acknowledge her induction into the American Society of Actuaries.

In 1991, Empire hosted a $2,400 reception in the atrium of its Albany office for those attending the Albany Symphony Orchestra's Grand Viennese Ball.

In 1990, Empire spent $7,600 to install a hidden camera in the office of an employee suspected of drug use and to hire an undercover agent to pose as an employee and monitor the suspect's activity for a 3-week period. When questioned about this surveillance, Alan Drewsen, General Counsel to the Plan, stated that he acted on a tip from an employee who Mr. Drewsen could not identify for the Staff. The suspected employee had been with Empire for over 10 years at the time surveillance was commenced. The surveillance revealed no drug activity. In addition to Mr. Drewsen, only four other employees were aware of the surveillance: two security officials a former Human Resources employee, and Donald Morchower, the now-acting CEO. Mr. Drewsen told the Staff that he did not feel it necessary to inform Mr. Cardone.

Again, the Staff is concerned not only about the appearance of such expenses but the impact such spending has on corporate attitudes. Empire officials clearly operate as if there is an endless supply of money and indulge themselves at subscriber expense. The Staff was disturbed to find that this unwieldy practice of spending extended beyond the officers and employees, to Empire's Board of Directors, the very group responsible for holding the Plan accountable.

B. *Albert Cardone*

As the Staff's investigation progressed, we learned more and more about the manner in which Al Cardone ran Empire Blue Cross and Blue Shield. It was, indeed, his "empire" and he reigned supreme. As one disgruntled Empire subscriber wrote: "The tone of any organization is set by its leader, and Mr. Cardone seems still to be living the corporate high life of the early 1980's."

Indeed, the Staff found that Mr. Cardone, until his recent resignation, was enjoying all the accouterments of a Chief Executive of a profitable Fortune 500 company, while failing to show the restraint in spending which one would expect of a nonprofit CEO.

Travel documents reviewed by the Staff revealed that Mr. Cardone virtually always travelled first-class and, if accompanied by another officer or employee of Empire, he or she also was allowed to travel first-class.

As CEO, Mr. Cardone was entitled to one of the 82 assigned vehicles. The Staff was told that, in 1990, Mr. Cardone failed to follow procedure in requesting bids for a vehicle through Empire's fleet administration office but instead visited a car dealership, chose a Lincoln Town Car off the lot, and had the Plan pay for the $30,000 car. In addition, Mr. Cardone hired a chauffeur to drive him around in the Lincoln Town Car and to serve as an armed bodyguard. The Staff interviewed the chauffeur/bodyguard, Jim Byrne, a retired Connecticut police officer. Mr. Byrne stated that death threats had been made against Mr. Cardone and his family and that Cardone was therefore in need of protection when he left the building. Mr. Byrne acknowledged, however, that Mr. Cardone had not received a death threat in the 2½ years that Byrne had been assigned to him and that no protection was afforded members of Cardone's family.

In 1990, in response to alleged death threats, Mr. Cardone had a security system installed at his home at a cost to subscribers of $17,000, plus $2,000 annual maintenance. Again, Mr. Cardone did not follow proper bidding procedure but instead awarded the job to PMD Alarms Company which Empire's Director of Security had recommended.

In 1991, Mr. Cardone decided that he also needed a telecommunications system installed at his home which would provide a direct link from his home to Empire headquarters; the cost to subscribers: $27,000. Again, Mr. Cardone bypassed the formal bid process and had Rolm, Inc. install the system at his home since Rolm had been used for Empire's telecommunications system.

In another effort to maintain his direct link with the office, Mr. Cardone had a cellular phone installed on what he called his "larger boat." The installation cost of $1,000 to $2,000 was paid by Empire.

In addition to the costs of commuting—whether by limousine or by chauffeured company car—Mr. Cardone also spent several nights at the Helmsley Hotel on the eve of early morning business.

In earlier years, from 1985 through 1989, Empire maintained a corporate apartment at the Dumont Plaza in New York City at a cost of $48,000 annually. According to Empire documents, the purpose of this apartment was to "provide accommodations for the Chairman." When the lease expired in 1989, Empire decided not to renew primarily because "Mr. Cardone prefers accommodations offering 24-hour food service."

The food services group at Empire provides a monthly accounting for what it terms "Cardone Services." The Staff was told that these figures represent meals Mr. Cardone has had the Empire food service Staff deliver to his office. Many of the items listed under "Cardone Services" simply state "Meal for One" or "Meal for Two." Last year alone these "Cardone Services" cost Empire subscribers over $26,000. Mr. Cardone maintains that each of these meals was business related.

Despite corporate policy to the contrary, Mr. Cardone believed in holding Staff meetings at New York restaurants. Expense records revealed Mr. Cardone treating six Staff members to Giordano's at a cost to the Plan of $448; another Staff meeting for five at Giordano's with a tab of $324; another Staff meeting for four at a restaurant called Time and Again, costing the Plan $277; and lunch for three at the River Cafe for $214. Mr. Cardone told the Staff that he worked his people hard and "they deserve a sandwich here and there."

In 1989, Mr. Cardone initiated a sweeping design and construction overhaul of the executive offices and boardroom on the 26th floor of Empire headquarters. The Staff interviewed the employee assigned to oversee this project, Rochelle Vella. Ms. Vella, manager of Design and Construction, worked closely with Mr. Cardone in developing the concept he wanted for the renovation. Ms. Vella and Mr. Cardone visited furniture warehouses where he would indicate his preferences in style and color schemes, from which Ms. Vella would create sketches.

An outside consulting firm, Gagne and Associates, was then hired to create presentation boards at a cost of approximately $50,000. Several different schemes were presented to Mr. Cardone and he gave preliminary approval of the colors and furniture he liked. Ms. Vella also requested engineer drawings from Syska & Hennessy at a cost to the Plan of approximately $65,000. An additional $3,000 was paid to a company called R.J. Martin for an analysis of audio visual equipment needed for the boardroom renovation.

After spending $118,000 on this project, and countless hours choosing fabric samples, furniture styles, and color schemes for presentation to Mr. Cardone, Ms. Vella was suddenly informed that the project was "on hold." This occurred sometime in 1991 and Ms. Vella said that she now considers the project canceled. She said that she was never given an explanation and that she never asked for one.

The Staff has reviewed the proposals for which Al Cardone had given his preliminary approval and found such items as a $50,000 breakfront, a $22,000 conference table, and a $14,000 oriental rug.

Of particular note is a $20,000 Mahogany Chippendale desk which Mr. Cardone had requested for his office. According to Ms. Vella, Mr. Cardone selected this desk on one of their outings to a furniture warehouse and Empire did, in fact, purchase the desk for him. When the Staff visited Empire headquarters and asked to see Mr. Cardone's office, we were struck by the absence of the Chippendale desk. Ms. Vella confirmed that even though the $20,000 desk had been paid for, the desk was being stored off-site in a warehouse. When asked why the desk would be kept in storage even after it had been paid for, Mr. Cardone told the Staff that it would have "stuck out like a sore thumb" in his office without the other items he had envisioned as part of the redecorating project.

Another purchase instigated by Mr. Cardone was a set of china and glassware from Tiffany's. Shortly after Mr. Cardone became CEO at Empire, he hosted a meeting with IBM at which drinks were apparently served. Embarrassed by the quality of glassware available for the meeting, Cardone placed a $1,400 order for Tiffany china and glassware bearing the Empire logo.

In fact, the Staff has discovered that Empire established a corporate account with Tiffany's in 1986 which it has used to purchase over $45,000 in giftware. Empire also maintains a corporate account with Cartier's and has purchased similar gift items during the past 5 years at a cost to Empire subscribers of over $13,000.

Mr. Cardone received a luncheon membership at The Sky Club in New York City courtesy of Empire subscribers. In addition to the $1,800 annual dues, Cardone incurred over $17,000 in meal expenses at The Sky Club in 1992, and over $50,000 in the past 5 years.

Mr. Cardone also has a luncheon membership at the Windows on the World restaurant atop the World Trade Center. According to Empire documents, however, Mr. Cardone has only dined at Windows on the World three times, in March of 1990 for $204; in May of 1991 for $342; and in April of 1992 for $552. Each of these expensive lunches were with representatives of the Health Care Financing Administration, the agency responsible for oversight of the Medicare programs.

XII. BLUE CROSS AND BLUE SHIELD ASSOCIATION

Our review of the files subpoenaed from the Blue Cross/Blue Shield Association in Chicago (BCBSA, or the Association) reveal its steady concern about Empire's performance and the Association's efforts to bring those concerns to the attention of Empire management and the Superintendent of Insurance. However, it also shows a lack of action strong enough to thus far reverse the downward trends detected by the Association's oversight.

The National Association has recognized that Empire's reserves have been low since 1988, and has put Empire on conditional status in 1988, 1989, 1991 and 1992. The Plan has had a low liquidity position since 1988 and, in early 1993, that position reached "Early Warning" levels.

In May 1992, the Association's Plan Performance and Membership Committee (PPMC) renewed Empire for one year and put them on the "concern level," which is the next to highest level of monitoring, and told Empire it needed a recovery program. They requested that Al Cardone present the program personally in September, so they could ask him questions.

In August 1992 the Association put Empire on "contingency protocol" which is the highest level of monitoring. Association officials met with the Insurance Superintendent Curiale that month and told him that Empire needed to have positive reserves in order to keep the Blue Cross Blue Shield trademarks and that the Plan was not in compliance with the benchmarks. The Superintendent told the Association that it was his impression that Empire had to have positive reserves at year end, but the Association advised him he was wrong and it was a monthly requirement. Curiale assured the National Association representatives that he was considering some accounting changes that may help the Plan. Shortly thereafter, the Insurance Department told Empire to release $80 million in reserves from a hospital supplemental payment reserve which no longer needed to be maintained. The Association told the Staff that the Insurance Department was content with Empire's low reserves and excused the Plan from compliance with the statutory requirement.

In September 1992, Al Cardone met with the PPMC and presented the same recovery Plan which the Superintendent had already rejected in July. The PPMC found the Plan unacceptable as well and told Cardone they will conduct site visits and that Empire would lose the BCBS trademarks if it did not meet reserve requirements.

The Association again met with the Superintendent in September 1992 and restated the reserve requirements of 10 percent or $9$2 million in 1993, and 25 percent in 1994.

BCBSA Staff conducted an on-site review of Empire in November 1992 and found that Empire projected a 1993 net gain of $64.7 million which would be derived from the estimated $130 million in equalization payments the Plan expects to receive from the demographic pooling mechanism in 1993.

In November 1992 BCBSA Staff asked Empire for selected internal audit reports to confirm treatment on the Plan's books relative to accounts receivable, HMO operations, and systems implementation, but this request was denied by Plan Staff. The National Association told the Staff that the request was denied because Al Cardone said "the National Association had no need for that information."

The National Association made several phone calls to Empire requesting these audit reports between November and mid February, but the refusals continued. The Association told Cardone that if access was not granted to these audit reports, the matter would be raised at the National Association's Board meeting on February 18th and with the Empire Board via a letter. Cardone relented and the National Association received access during its next site visit in March 1993.

In November 1992 the Association met with Empire's Board and told them they needed a financial recovery program and restated the 1993 and 1994 reserve requirements. The Board said they were committed to Empire's social mission and questioned whether the National's standards were appropriate, notwithstanding the fact that the Capital Benchmark requirement is less than the statutory reserve required by the New York Insurance Code.

The President of the BCBSA met with Al Cardone in February 1993 and expressed his concern about Empire's condition. In April 1993 the Association told Empire's Board that it would have trouble meeting the reserves and that it needed a detailed rehabilitation program.

BCBSA Staff identified significant risk that the Plan will likely be unable to achieve compliance with the 10 percent of Capital Benchmark requirement at December 31, 1993. They noted that Empire estimates getting $95 million in 1993 from the demographic pool, but that some New York HMOs and commercial insurers are challenging the legality of this. Furthermore, the HMOs are depositing the payments into an escrow account, not into the pool. The Insurance Department cannot estimate how much Empire will get from the pool, but the Association told the Staff it could be zero.

Association Staff noted that Empire's 1993 forecast of a net gain of $79 million and a reserve of $118.7 million depends on $130 million demographic pooling payments, no adverse effect of reform legislation, increased retention on national accounts, but no major account losses and a major turnaround in enrollment losses in all lines of business. Without the demographic pooling money Empire will not meet BCBSA minimum financial requirements.

BCBSA's forecast is less optimistic—a reserve of $90.5 million, which would be 10 percent of Capital benchmark. Empire's first quarter results for 1993 were better than expected because of the $93 million received from the Malpractice Fund and a release of unpaid claims liability of $55 million. However, Empire experience its greatest first quarter enrollment loss in 5 years. As mentioned earlier, one of Empire's assumptions in developing its forecast of a net gain of $79 million for 1993 was that enrollment losses would not occur.

Summary reports from the Association in 1993 show that Empire enrollment losses exceed 1.5 million in hospitalization and over 400,000 medical and surgical enrollees from 1988 through 1992.

These same National Association reports also indicate service performance has been consistently low for the past 5 years, primarily due to poor timeliness in the claims processing and inquiry response. BCBSA notes that first quarter 1993 enrollment losses are higher than in previous years and that preliminary April data indicate no turn-around in community enrollment. The following shows this deterioration:

Changes in Hospital Contract Enrollment

First Quarter 1993—Percent Change

	Percent
Community	-7.0
Local Group	-1.4
National	-5.0
HMO	-4.2
Total	-3.5

When we questioned BCBSA officials we noted several areas that were not investigated by the Association in its overview of Empire's performance. A thorough review of these and other areas, combined with strong action by the BCBSA, in conjunction with the New York State Insurance Superintendent, might have prevented a "too little, too late" problem involving Empire. The Association has not investigated the following:

**Outside audits done by companies contracted with Empire. As discussed in other sections of this report, a review of these audits could have provided vital insight into the problems of poor service by Empire.

**"National" accounts that had terminated their contracts to ascertain the reason for ending the Empire contract. The Staff believe that the information about poor performance, which would have been provided by contacting some of these major accounts, would have given the Association enough early warning signals to enable the BCBSA in helping Empire to avoid further losses.

**The issue of Medicare as a secondary payor, as outlined in a separate section of this report. The BCBSA representatives whom we interviewed said they had "no knowledge" of the ongoing audit of the Medicare second-

ary payment issue and the potential impact it could have on the financial condition of Empire. Staff suggested that the Association should also review this issue, because of its potential impact on Empire's already-fragile financial condition.

BCBSA representatives said that issues of this nature are not reviewed by the Association, unless it has a material effect on the overall financial condition of the Plan. It is our contention that poor service by a Plan does play a major role in its overall financial condition.

In summary, the BCBSA has, for several years, had serious concerns, which it expressed to Empire management, regarding Empire's financial well-being. Moreover, the Staff believe that the BCBSA had enough information contained in its files to indicate that it knew, or should have known, that Empire has been experiencing major management problems for several years. By contrast to its role in previous cases reviewed by the Subcommittee, the BCBSA did bring its concerns to the attention of the Plan's Board and the New York State Insurance Department. However, it is the Staff's understanding that the National Association did not do so until August of 1992. By then, it may have been too late to effectively reverse the financial drain on the Plan.

XIII. THE ROLE OF THE BOARD OF DIRECTORS

One of the key issues with which the Subcommittee has been concerned with in its investigation of the Blue Cross and Blue Shield system is that of accountability. As has been noted in previous hearings, individual Blue Cross Plans, because of their status as non-profit organizations, do not have shareholders to whom they must answer. Therefore, the role of the Board of Directors takes on even greater importance for these Plans in terms of providing a system of checks and balances over the actions of management.

In the three troubled Plans which the Subcommittee has examined to date, one constant has been the abdication by the Board of Directors of their role as an independent oversight body. Unfortunately, it appears that the Board of Directors at Empire fits the same pattern. The Staff's investigation of Empire found a Board which was self-perpetuating, yet at the same time lacking in expertise, ill-informed, and both dominated and coopted by management.

Empire's current by-laws provide for a Board of Directors consisting of 18 to 20 directors. The by-laws further provide that these directors shall be elected by a separate body comprised of 78 individuals known as "voting members." While this would appear to place the selection of the Board in the hands of a independent body, in fact this is far from true. Thirteen of the 78 voting members serve by virtue of their position on various county medical societies. Another 10 are selected by the United Hospital Fund. The vast majority (55 of 78) of the voting members, however, are selected by the Board of Directors themselves. What thus has been created is, in essence, a self-perpetuating process by which the Board selects those very individuals whose job it is to select the Board.

Further reinforcing the nature of this process, is the fact that the directors for whom the voting members vote are those which are nominated by the Nominating Committee of the Board of Directors. 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.

Concern as to the process for selecting Empire's Board, as well as the implications of that process, is not unique to this Subcommittee. In 1989, the New York Insurance Department raised similar concerns, noting in an internal memorandum that the procedure, "[did] not provide for participatory democracy by subscribers in the governance of EBCBS. . . ." Indeed, included in the recommendations of the Department's "Report of the Special Investigation of Empire Blue Cross and Blue Shield," dated February 23, 1989, is the following:

> Relative to EBCBS' by-laws prescribed method of electing members to the board of directors, it is recommended that the board of EBCBS undertake a study of the election process and propose a method to the Department which would evidence greater accountability of the board to the subscribers.

Unfortunately, Empire's response to this recommendation was mere lip service, noting in the first instance that its by-laws complied with both New York's insurance and non-profit corporation laws, but agreeing to refer the issue to a previously established Ad Hoc Committee on Corporate Governance. This ad hoc committee ultimately found nothing in the election process in need of change, and the Insurance

Department apparently chose not to force the issue through changes in the insurance laws. The same process, therefore, is still in effect today.

Another area of concern raised by the Insurance Department in 1989 dealt with the fact that Empire's Chief Executive Officer also held the position of Chairman of the Board of Directors. This is an issue which the Subcommittee has likewise found problematic in looking at the boards of several Blue Cross Plans. The approach to this issue which the Insurance Department took in 1989 is rather baffling to the Staff.

In its "Report of the Special Investigation" the Department noted that the position of Chairman of the Board, which had previously been a non-paid trusteeship, had been combined with that of the Chief Executive Officer. The Report went on to state that, "[t]he elimination of the chairman position as a non-paid trustee brings forth concerns as to the accountability of the chief executive officer to an independent person." The Department's recommendation to Empire, however, was only that, "the board of directors of EBCBS furnish a formal description of the process by which the change was made and its justification therefore."

In response, Empire stated that this change was made as a result of a 1981 recommendation by the Nominating Committee that the then-vacant position of Chairman of the Board be filled by the election of the then-Chief Executive Officer. The recommendation was adopted by the full Board, and the positions were combined. Empire's justification, as stated in a March 1989 letter to the Insurance Department, was that the company had "grown to be a multi-billion dollar enterprise with complex and important functions and operations; [and] that the Chairman of this enterprise should be a full-time participant in its direction. . . ."

In light of this response, the Department shifted its focus toward determining how to justify the presence of an officer on the Board of Directors. Because of its status as a non-profit insurer, the composition of Empire's Board is set by statute. This statute, in 1989, required that Empire's Board of Directors be composed of three distinct categories: (1) representatives of the provider community; (2) representatives of the subscriber community; and (3) representatives of the public interest. Empire had listed its Chairman/CEO as falling under the subscriber category.

Internal memoranda from the Insurance Department show that the Department's legal counsel had reached the determination that Empire's chief executive officer could not properly fall under either the subscriber category or the public interest category; however, the Department's Property Companies Bureau, which oversees health insurers, recommended that officers be allowed to serve as directors. The Bureau further recommended that such officer/directors not be subjected to the statutory requirement limiting a director's length of service. The Department ultimately adopted this position, and in a November 1, 1989 letter to Empire, stated:

> While the Superintendent must fulfill the statutory obligation . . . to assure the qualification of directors; the Department does not wish to unduly disrupt the operations of EBCBS. . . . Accordingly, the Department would support an industry sponsored initiative to seek an amendment to Section 4301 of the Insurance Law in the next legislative session to add a permissive fourth category of director (director/officer), which shall be limited to not more than three officers of the corporation, and to exempt such individuals from the requirement that they relinquish their status as a director after 10 years.

Such an amendment apparently was passed, and, at least until May of this year, Empire's Chief Executive Officer continued to hold the position of Chairman of the Board under the category "officer-employee."

The Staff is mystified by the fact that in the Insurance Department's handling of this issue, the concern over the accountability of the chief executive officer somehow seems to have been dropped along the wayside by the Department. The issue of accountability was specifically raised by the examiner who authored the Department's 1989 Special Report. Yet, based on documents provided to the Subcommittee by the Department, the matter apparently was never raised again in subsequent communications with Empire. Indeed, the Department ultimately suggested to Empire that State law be amended to allow Empire to perpetuate the combination of chairman and CEO positions.

In fact, it was only this year, apparently after this Subcommittee had commenced its inquiry into Empire, that Superintendent Curiale decided that perhaps the combination of these positions was not such a good thing after all. In an interview with *The New York Times* in early May of this year, Mr. Curiale stated that he reached his decision "in hindsight, with 3 years of experience." In an interview with the Staff in late May of this year, he stated that his concern was that it appeared to

him that "[Chief Executive Officer Albert] Cardone may have been dominating the Board."

In its management and financial audit of Empire issued on April 30, 1993, Arthur Andersen also came to the conclusion that the positions of Chief Executive Officer and Chairman of the Board should be separated. Ultimately, Empire's Board of Directors came to the same conclusion as well, and on May 19, 1993, after calling for the resignation of Mr. Cardone from both positions, the Board named separate individuals as Acting Chief Executive Officer and Chairman of the Board.

It seems clear that the problem of management domination of the Board has existed for some time. What seems equally clear, unfortunately, is that the Board itself has had little, if any, realization of this fact. In numerous interviews, past and current Board members told the Staff how they thought they were an active, involved, and informed Board which was not afraid to ask questions of management. After being informed of various corporate problems by the Staff, however, many of these Board members did state that the Board may have had certain shortcomings.

The most frequently admitted shortcoming was a lack of technical expertise on the part of Board members. One Board member told the Staff that presentations at Board meetings were often very technical and not easily comprehended unless one had the appropriate background. As a result, the Board was at a loss to ask specific questions in certain areas and had to rely more heavily of management. One current Board member stated that the Board didn't delve deeply enough into issues, but rather was willing to accept surface answers. A former Board member put it succinctly when he said, "there was no shortage of information, but rather a shortage of questions." A former Empire Vice President interviewed by the Staff was also critical of the Board in this regard, stating that, "the Board didn't know what to ask even if they wanted to find out what was going on."

The flow of information to the Board also appears to have been a major problem. That flow was controlled by management. A number of Board members now admit that the adequacy and completeness of the information provided to the Board left something to be desired. While others still maintain that they were adequately informed, their responses to questions by the Staff reveal that there were numerous matters of grave importance to the company of which they were not aware.

On June 2, 1993, the Staff interviewed Harold E. Vogt, the newly-named Chairman of the Board of Empire. Mr. Vogt has been a member of Empire's Board of Directors since 1983. At the outset of the Staff's interview, Mr. Vogt told the Staff that he considered the Empire Board to be very active. He further stated that he had never felt wanting for information as a Board member, nor had he felt that Mr. Cardone was keeping information from the Board. Despite these comments, there appeared to be a number of areas of Empire's business about which Mr. Vogt was either ill-informed or uninformed.

Mr. Vogt told the Staff that the first time he learned of an April 27, 1993 letter to Empire from the Health Care Financing Administration criticizing Empire for the Insurance Department's handling of its Medicare contract and threatening cancellation of part of that contract was when he read about it in *The New York Times*. Mr. Vogt further stated that he had had no idea that Empire had been ranked 45th out of 47 intermediaries in the Insurance Department's handling of Medicare claims for doctor bills, or 46th out of 51 in the Insurance Department's handling of Medicare claims for hospital bills. Mr. Vogt did say that the Board had been told several years ago that Empire had been doing very well in its rankings by HCFA.

Mr. Vogt similarly could not recall being informed of an ongoing audit by the Department of Health and Human Services Office of Inspector General concerning possible violations by Empire of the Medicare Secondary Payor provisions of the Social Security Act. He was unaware of any specifics as to whether Empire may owe the federal government any money as a result of this audit. Mr. Vogt also professed ignorance with respect to a completed audit by the Office of Personnel Management which had determined that Empire had overcharged the federal government by $6 million in the Insurance Department's handling of the federal employee health benefit program.

Mr. Vogt had no idea what NMIS scores were in general, or what Empire's NMIS scores were in particular. He said that he knew that the Blue Cross and Blue Shield Association ranked customer service performance, and that he knew that Empire needed help in this area, but he stated that he was "not too concerned with where we stood with everybody else."

With respect to two major lawsuits in which Empire is involved, Mr. Vogt had limited information, and had received that information only recently. Concerning a lawsuit filed against Empire in March 1993 by AT&T claiming Empire was involved in improperly withholding hospital differentials from AT&T obtained for its ac-

count, Mr. Vogt only learned of this matter during a meeting with the Superintendent of Insurance a month and a half later. With respect to a lawsuit filed by Empire claiming that a number of individuals and groups had established phony businesses for the purpose of obtaining insurance and thereby caused Empire over $2$2 million in losses, Mr. Vogt stated that he had learned of this matter sometime in late 1992 or early 1993. The original complaint in this matter was filed by Empire in December 1991.

Mr. Vogt had received no reports on Empire's subsequent efforts to recredential all of its small group business. He was unaware of the fact that initial surveys performed in connection with this recredentialling had shown over half of the groups surveyed to be unqualified.

With respect to the controversy surrounding Empire's contract with Sigma, Mr. Vogt stated that he "probably was aware" of the contract prior to its being awarded, but that he knew nothing of the principals behind Sigma. Mr. Vogt was unaware that Empire paid a large portion of the salaries of Sigma's officers, and similarly was unaware that Sigma offices were located in Empire's own building.

It appears that, despite his initial impression, there was a great deal about Empire's business as to which Mr. Vogt knew little. As he concluded his interview with the Staff Mr. Vogt stated, "I'm learning a lot here talking to you." A few days later, in an interview with *The New York Times*, Mr. Vogt seemed more willing to admit to the limitations under which the Board had been working.

In that interview Mr. Vogt stated that "[w]e react to the information we receive," and admitted that the Board now realizes that it can no longer rely solely on information provided by the chief executive. Indeed, *The Times* reported Mr. Vogt as saying that the Board's agenda "was controlled by Mr. Cardone," and that the Board "had not been furnished with some audit material, status reports and information about unusual and questionable occurrences within the company."

Another current Board member with whom the Staff spoke was amazed at the realization that the Board was not better informed, although he was more willing to place some of the blame for this on the Board itself. In describing the role of the Board in overseeing management, this member stated that the Board was "not as close as we should have been." He said, "we got a lot of information from management, just not what we needed." He saw the problem as the fact that the Board was not getting information from the "foot soldiers," but just from upper management. In his opinion, the Board was not inquisitive enough and was not asking the right questions at all times. When questions were asked, the answers seemed to address the questions, but this member said that he now knew that "we didn't get all the information that was available."

This member, who has been on the Board since 1989, had no idea that the Blue Cross and Blue Shield Association evaluates Plans as to their customer service capabilities and provides the Plans with their scores. Nor did he know that the Association reviews Plans generally and communicates problems it finds to the Plans. Similarly, he had never known of any problems which HCFA had had over the years with Empire performance as a Medicare intermediary. He stated that he thought that HCFA was just "jumping on the bandwagon" in its recent criticism of Empire.

Some of the sharpest criticism of the Board, however, comes from former officers and employees of Empire. The Staff spoke with several former senior vice presidents, directors, and employees who were highly critical of the Board's lack of oversight. One 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. A number said that the Board was merely a rubber stamp for senior management, and Cardone in particular. One former employee, however, was perhaps the most humorous and most damning at the same time, when he opined that characterizing the Board as a "rubber stamp" was probably too kind because "at least a rubber stamp leaves an impression."

Why the Board did not impose a tighter rein on management is a matter of speculation. It does seem, however, that management worked hard to cultivate and to coopt the Board through lavish parties, annual Board retreats, and semiannual gifts to Board members. In addition, management held out a large carrot to Board members in the form of free lifetime health insurance for a member and spouse when the member retired after 10 years of service.

When Al Cardone became Chief Executive Officer of Empire in 1985, the Board of Directors was comprised of 44 directors, including Cardone himself as Chairman of the Board. Over the next 6 years, Cardone drastically downsized the Board of Directors, primarily through attrition, to 19 members. A former Empire officer told the Staff that Al Cardone removed every board member who might question some of his

actions as CEO and kept only those members who were "rubber stamps" for Cardone's actions.

Although both the 44-member Board and the 19-member Board did not receive financial compensation from Empire, they were extravagant in spending subscriber funds for Board meetings, receptions, seminars and gifts.

In addition to its regularly scheduled meetings, the Board also treats its members and their spouses to annual seminars held at conference centers outside of New York City. Anywhere from 20 to 30 Empire officers and spouses also attend. In 1987, the seminar was held at the Garden City Hotel on Long Island; from 1988 through 1990, the seminars were held at the Tarrytown Conference Center in Tarrytown, New York; and in 1991, at the Sagamore Hotel on Lake George in Bolton Landing, New York. According to Mr. Vogt, the Board chose not to hold a seminar in 1992 because "we had plenty to do right here." He explained that the purpose of the offsite seminars was to a hold a board meeting away from "the distractions and ringing phones" at Empire.

In reviewing documents subpoenaed from Empire, the Staff found that each of the Board seminars incorporated a theme into its extravagant decorations and floral arrangements. For example, in 1990, the theme of the Board seminar was "Amadeus," as depicted by a masquerade motif. Empire purchased 147 masks on sticks (such as this) at a cost to subscribers of almost $3,000. Several of the masks were used in floral centerpieces which cost subscribers an additional $1,500, plus another $1,000 for the delivery and set up of these "Amadeus" decorations.

The decor for the 1989 Board seminar portrayed an "Art Deco" theme and cost subscribers over $9,000 in decorations and floral centerpieces. In 1988, a "Broadway" theme was used and included a display of theatrical posters (such as this one) at a total cost to subscribers of $9,700.

In addition to the decorative themes at the Board seminars, Empire management also took this opportunity to bestow gifts upon its Board members for their service to Empire. In 1991, the Board received lavish food baskets, expensive cameras and fancy photo albums at a cost to subscribers of over $16,000. The Staff learned that Empire employees assisting with the preparations for the Board seminars also received these gifts.

In 1990, the year of the Amadeus seminar, the Board received exclusive Ghurka luggage, more gift baskets and golf umbrellas; cost to subscribers, over $25,000.

In 1989, more Ghurka luggage and more gift baskets to the Board cost subscribers an additional $12,000 and in 1988 Tiffany decanters and more gift baskets again totalled over $12,000.

While hosting grand dinner parties and receiving valuable gifts is an expensive part of the Board seminars, food and drink at these 3-day seminars is also significant. Subscribers paid almost $23,000 to feed the 87 seminar attendees in 1989 and almost $22,000 for 62 attendees the following year. In 1991, the seminar attendance dropped to 56, with Empire officers and spouses outnumbering the Board members and spouses. Their total food and beverage bill cost subscribers over $15,000. Accommodations at the seminar are, of course, another large expense, ranging from $28,000 to $32,000 per seminar.

The program for the Board itself was comprised typically of the following: a Thursday evening arrival accompanied by a reception and followed by dinner; a Friday morning breakfast followed by opening remarks by Al Cardone, a 3-hour Board meeting, then lunch; after lunch no activities are Planned until the 7 p.m. reception and 8 p.m. dinner. Saturday morning also begins with breakfast and is followed by two to three hours of lectures on topics such as "Cost Containment." The Directors then adjourn for lunch and for the day.

The Staff found that each seminar costs subscribers an average of $142,000 in food, drink, accommodations, and gifts. Surprisingly, when questioned by the Staff about these seminars, Mr. Vogt, the new Board Chairman, stated that he may have received "cheese and crackers" but nothing of significance. He did not recall having received Ghurka luggage or a Tiffany decanter but admitted that he doesn't "pay much attention to things like that" but that his wife would probably remember. He also said that there were no fancy parties at the seminars, "only dinner." Although Mr. Vogt refused to comment on whether the $142,000 expenditure on the seminars was appropriate, he did acknowledge that he would not recommend such an expense and would not approve of it in the future.

The Board seminars, held in September or October of each year, are followed a few months later by the annual Board of Directors Christmas Party. According to Mr. Vogt, last year's Christmas party was canceled because Empire's "fiscal position was unsound."

A review of subpoenaed documents from Empire revealed that the company spent over $5,000 a year to decorate the Board room for the Christmas reception and an additional $2,000 a year for Christmas decorations for the executive suite at Empire headquarters. The catering expenses for the Christmas receptions cost subscribers approximately $20,000 each year.

The Christmas holidays also present another opportunity for Board members to receive gifts. Both current and retired board members receive Christmas gifts at subscribers' expense. In 1991, subscribers paid $3,700 for Ginger Jars to be given to the retired directors and over $14,000 for silver punch bowls and ladles for the 19 active Board members. These $700 punch bowls were purchased through the Smithsonian Institution's Mail Order Division operating out of Springfield, Virginia. Empire ordered these bowls in May, 1991, charging $14,133 to its corporate American Express account. Although the bowls have been paid for in full, the Smithsonian representatives informed the Staff that Empire has refused to accept delivery of the gifts. The 19 bowls (and this is one of them) have been held in storage by the Smithsonian for over 2 years.

In 1990, retired board members received $2,000 worth of Tiffany mugs, while sitting board members received $17,000 worth of cashmere blankets. These blankets were ordered from a San Francisco, California company which individually gift wrapped the $650 blankets for delivery to each of the Board members.

In 1989, retired directors again received Tiffany glassware valued at $2,000. The active Board members, meanwhile, received picnic baskets at a cost to subscribers of over $12,000. Similarly, in 1988, the active board received $12,000 in glassware from Baccarat and retired board members were given $1,600 in unspecified gifts from a company called Astro Minerals.

All told, the annual Board of Directors Christmas parties cost subscribers over $40,000 in food, beverage, decorations and gifts. As with the seminars, Mr. Vogt did not recall receiving any of these Christmas gifts nor did he recall anything extravagant about the parties. He estimated the attendance at the Christmas receptions at approximately 75 to 80 people including 10–12 Empire officers and their spouses. As for the cost of the reception, Mr. Vogt again stated that he "had no idea" and had "never asked."

In addition to the annual Board of Directors seminar and the annual Board Christmas party, gifts are also bestowed upon Board members when they retire. The typical retirement gift package includes a framed copy of the Board resolution acknowledging the Director's retirement. These framed resolutions, which are ornately designed with blue, gold and black lettering, brush capital letters, a gold seal and blue ribbon, cost subscribers $450 each and have totalled $10,000 in the past 5 years. Board retirees also receive framed portraits and framed caricatures of themselves, costing subscribers over $8,500 in the past 5 years. $600 Tiffany clocks are also given to retiring Board members. Finally, retired board members receive free health care coverage for themselves and their spouses for life.

Edwin Werner, Empire's former CEO, received numerous retirement gifts as well as a party in his honor upon his retirement. A $2,500 glass Excalibur paperweight from Steuben Glass (pictured here) was presented to Mr. Werner along with a $500 Steuben Glass eagle. A $6,000 silver tray with an inscription to Mr. Werner was also given to him in honor of his retirement. The Board of Directors held a reception for Werner's retirement at a cost of $3,800. The Staff asked Mr. Vogt about any retirement gifts or receptions for Mr. Cardone, and he responded that, to his knowledge, there are no Plans for honoring Mr. Cardone's retirement.

XIV. ROLE OF THE DEPARTMENT OF INSURANCE

In addition to a Plan's own directors and the Blue Cross and Blue Shield Association, the State department of insurance is the crucial third leg of the oversight triad which can impose some measure of accountability on a Blue Cross Plan. In the case of Empire, the role of regulator is played by the New York State Department of Insurance, a department which has been cited by its peers as one of the most effective insurance regulators in the nation. The Department ranks second in expenditures and fourth in Staffing among all State Insurance Departments. Moreover, New York State has been recognized as having some of the toughest insurance laws in the country.

In spite of this, the Staff finds that the level of oversight provided by the Department with respect to the regulation of Empire has been woefully inadequate. The Staff found a pattern of actions evidencing regulatory forbearance which appeared to border on favoritism. This pattern included a propensity by the Department to reverse itself when such action would be to Empire's benefit, the failure by the De-

partment to enforce its authority over Empire in certain instances, a willingness on the Department's part to allow Empire to ignore Department recommendations and regulations with impunity, and the transformation of the Department into an advocate on behalf of Empire.

While the Staff is critical of the actions, or more appropriately, inactions of the New York Insurance Department, this criticism must be put into context. Empire is a very large insurance company whose importance to the health care delivery system in New York overshadows even its financial size. Empire insures nearly 45 percent of the citizens of the State of New York. With such a concentration of market share in one company, the Staff recognizes that Empire presents inordinate difficulties to any regulator, even an aggressive, well-run one.

The Insurance Superintendent acknowledged his dilemma in an interview with the Staff. He repeatedly kept asking, rhetorically, "what am I supposed to do; I don't have the manpower or expertise" to tell Empire how to make money. Superintendent Curiale's quandary is, in itself, enlightening to the overall review of the Blue Cross/Blue Shield system that the Subcommittee started over a year ago. At that time, Mr. Chairman, you indicated that one of the questions the Subcommittee would attempt to answer was whether the "Blues are too big to regulate" by State insurance departments. To some extent, Superintendent Curiale's question to the Staff is the answer to that question posed by you.

Yet, although Empire now may be too big to regulate out of its current financial mess, the Staff believes that if the Insurance Department had acted aggressively in the past to specific, incremental problems and issues, the current situation may not have come about. The following is a summary of some of the more important areas where the Department failed to regulate Empire.

With respect to Healthnet, Empire's HMO operation, the Department has reversed itself to the benefit of Empire, allowed Empire to ignore State regulations governing HMOs, and failed to follow through on its authority over Empire's HMO operations. As a result, Empire has been allowed to maintain an HMO operation which has drained over $115 million from the Plan's surplus, and which in 7 years of operation has had just one year of modest profitability.

Empire first made application to the Department for permission to operate an HMO in 1986. This application stated that Empire would use subscriber funds to cover the start-up of this venture, which would be operated as a line of business within Empire. Empire asserted that it would have to contribute $11.5 million in start-up costs from subscriber funds before Healthnet would obtain a sufficient number of subscribers to permit it to break even in its operations.

In fact, Empire's subsidization of Healthnet continued for 6 years and reached over $115 million before Healthnet showed its first profit. In all that time, the Department did nothing to stem the tide of Healthnet's losses and constant subsidization, even though it had evidence in 1988 (just 2 years after Healthnet's creation) that Empire's Board of Directors wanted to discontinue Healthnet in order to end its continuing drain on surplus.

In a memorandum dated September 21, 1988, James McDonald, Chief of the Property Companies Bureau informed Deputy Superintendent Miriam Boggio how Empire's President Albert Cardone had boasted that he was able to "overcome the sentiment of [the] board" on this matter. In this same memorandum, Mr. McDonald made reference to the need to keep a rein on "an overambitious or headstrong president." As a result of the Department's failure to stop Empire's contributions to Healthnet, Empire's subscribers continue to subsidize a money losing operation.

The Plan to set up its HMO operations as a line of business and to use subscriber funds to cover start-up costs was at first objected to by the Department. Frederic Bodner, the Department's Chief of Health and Life Policy Bureau, determined in 1984, in connection with an HMO application by Rochester Blue Cross, that a Blue Cross Plan could not "donate" its subscriber funds. After a lobbying effort on behalf of the Blues by the law firm of Hinman, Straub, Piggors & Manning ("Hinman Straub"), the Department reversed this position and decided to allow the use of subscriber funds for such operations.

By establishing its HMO operations as a line of business, Empire and the other Blue Cross Plans determined that they would not be required to file annual balance sheets with the Department. This determination was reached despite a clear requirement in State law that required audited financial statements.

At first, the Department took the position that a balance sheet was required. In fact, this position was supported at that time by Mr. Curiale, who was then a Deputy Superintendent. The importance of the balance sheet was that it would clearly set forth the subsidy given to an HMO as a liability of the HMO. It would

further permit the Plan's overall subscribers to have a better picture of where their premium money was going.

Although the Department maintained this position in several letters to Blue Cross Plans across the State, and in fact directed some to submit a balance sheet, in February 1988, following another lobbying campaign by Hinman Straub, the Department reversed its position.

The requirement of a separate balance sheet for HMO operations would have shown that Healthnet was unable throughout its first 6 years to meet the State requirement that an HMO maintain 5 percent reserves. The Department never enforced this requirement against Healthnet and has told the Staff that it is because Healthnet is operated as a line of business. It should be noted at this point that the only insurers in New York which operate HMOs as a line of business are the New York Blue Cross Plans.

In their original applications, Empire and the other Blue Cross Plans asserted that they would recoup the subsidies which they would provide to their HMOs. When such recoupment did not take place after several years of continued subsidization, the Department sought through a directive issued in 1988 to force the Plans to obtain this recoupment. The response of the State's Blue Cross Plans was to sue the Department, claiming that the Department lacked the authority to order recoupment.

In a decision rendered by the New York State Supreme Court in 1989, this suit was dismissed and the authority of the Department was upheld. In the ensuing 4 years, however, the Department has taken no steps to enforce this authority or to follow through on its recoupment directive. When the Staff asked of the status of this decision in May of this year, the Department's Mr. Henricks replied that it was "on [his] agenda."

It appears to the Staff that the Department has shown a special sensitivity to the concerns of Empire. One of the ways in which this sensitivity has been manifested has been in the Department's propensity to temper its language with respect to criticisms of, and recommendations to Empire contained in public documents. This is perhaps best evidenced by the Department's handling of its triennial examination of Empire for the period ending December 31, 1987. The report of that examination included both the normal financial report and a special report prepared in response to the allegations raised by Mr. Mattia. Language in both of these reports was changed in ways that raise a number of questions in Staff's mind.

The Staff has previously discussed in this statement the concerns expressed by the Department to Empire regarding Empire's decision to combine the positions of CEO and Chairman of the Board. Staff has detailed the Department's request to Empire in 1989 for an explanation as to how these positions came to be combined and the justification for this combination. Staff has also detailed the Department's willingness to accept Empire's justification, along with its willingness to assist Empire in maintaining this combination.

A review of an early draft of the 1987 Examination Report reveals, however, that the Department's Examiner was inclined to take a rather different position on this issue. The Examiner's early draft of this report read as follows:

> A review of the composition of the Corporation's Board of Directors indicates that one officer of the Corporation, Mr. Albert Cardone, also serves as a representative of the general public on the board. Representatives of the general public are defined in Section 4301(k)(1)(B) of the New York Insurance Law as, ". . . persons whose background and experience indicate that they are qualified to act in the broad public interest. . . ." It is the examiner's conclusion that an officer of the Corporation cannot be expected to adequately represent the general public. The examiner also notes that the Department's General Counsel, in a memorandum dated May 12, 1989, reached a similar conclusion. Accordingly, it is recommended that Mr. Cardone be replaced on the board by an individual meeting the above described requirements for a board member representative of the general public.

In the final version of the Examination Report this section of the Report was totally deleted.

It should be noted that the same examiner who wrote the Department's Examination Report, Michael Scharff, also wrote the Department's report on the Mattia allegations. One of Mr. Mattia's allegations related to the composition and electoral procedures of Empire's Board of Directors. Indeed, the concerns over the combination of the CEO and Chairman of the Board positions, which the Staff discussed earlier, came from the Department's report on the Mattia allegations. A review of Mr.

Scharff's original draft of this report, however, reveals that he had once again taken a much stronger position than the Department appeared willing to accept.

Mr. Scharff's original draft of the report on the Mattia allegations included the recommendation that "[t]he Company should re-establish the Chairman's position as a non-paid trusteeship." This, in essence, would have meant that Mr. Cardone could no longer hold the position of Chairman of the Board. The final version of this report, however, contained a far different recommendation:

> Relative to the offices of chairman of the board and chief executive officer now being filled by the same paid employee, it is recommended that the board of directors of EBCBS furnish to the Department a formal description of the process by which the change was made and its justification therefore.

This was not the only change made to Mr. Scharff's original draft of the report on the Mattia allegations. At the beginning of his report, Mr. Scharff explained why he felt the Mattia allegations were, in essence, without merit. Before addressing the specifics of the allegations, however, his draft made the following statement:

> Nevertheless, he does raise some important issues and does make some valid points. We agree with three of his final recommendations and also believe one additional step needs to be taken to help insure that management uses subscriber premium dollars in a prudent fashion, that decisions made by management are in the best interests of subscribers, and that conflicts of interest are avoided.

The final version of the report deleted everything from this paragraph but the first sentence.

This deletion is particularly notable because Mr. Scharff's draft referred to steps which needed to be taken to insure that subscriber funds were used in a prudent fashion. Mr. Scharff's original draft included other language along these same lines which was also modified.

In responding to Mr. Mattia's allegation that Mr. Cardone had had Empire purchase a Lincoln for his company car rather than the Buicks used by other officers, Mr. Scharff's draft used the following language:

> This can be viewed as either a waste of subscriber dollars or as perquisites befitting the head of a multi-billion dollar corporation. Even considering that no benefit at all was derived by the subscribers for such expenditures, the total amount involved is approximately only $65,000 [sic].

The final version of the report tempered this language substantially to read as follows:

> While these items might not seem inappropriate for the chairman of the board and chief executive officer of a multi-billion dollar corporation, recognition should be given to the fact that EBCBS is a not-for-profit corporation. Although EBCBS' expense ratio is within limitation on expenses set forth in Section 4309 of the Insurance Law, every effort should be made to keep expenses at a reasonable level. While some savings would have been realized had Mr. Cardone exercised various economies in incurring expenses, a review of his expenses leads to the conclusion that they have not been unreasonable.

It appears to the Staff that this language in Mr. Scharff's original draft may have come too dangerously close to the legal term "waste of assets" which is contained in New York Corporation law, and which is punishable as a misdemeanor. Although both Mr. Scharff and his then supervisor, Mr. Martin Carus, deny that this is the case, the modification of this language, combined with the deletion of Mr. Scharff's reference to using subscriber dollars in a prudent fashion, leads the Staff to have its doubts.

Not only was the Department sensitive to tempering language in its reports before the final versions were issued, but it also went so far as to temper a report after the final version was issued and publicly filed. On January 31, 1990, Mr. Scharff signed a notarized attestation page stating that the Report of Examination (including the report on the Mattia allegations) was true to the best of his knowledge and belief. The report, as attested to by Mr. Scharff, was ultimately filed by the Department on May 22, 1990.

As part of the normal filing process, the Department, by certified letter dated April 16, 1990, provided Empire with a copy of the report prior to filing. Empire was given 10 days in which to take exception to the report. Empire responded by a letter dated May 3, 1990, agreeing with some of the report's recommendations and dis-

agreeing with others. In particular, Empire disagreed with a recommendation concerning its cooperation with the conduct of the examination.

After reviewing Empire's response, Mr. Carus, the Department's Assistant Chief Examiner, in a memorandum dated May 14, 1990, determined that "no report revisions are necessary." Accordingly, the report was filed on May 22, 1990, and Empire was informed of this fact.

Upon being notified of the filing of the report, Mr. Cardone immediately telephoned then-Acting Superintendent Wendy Cooper to complain. That very same day the Department called the Corporate Affairs Bureau and instructed that the previously filed report be withdrawn. After the report was withdrawn, Empire was allowed to present its objections to the Department. The Department thereupon agreed to make several modifications to the report as requested by Empire, including a modification of the recommendation concerning Empire's cooperation. The modification included the insertion of additional language as follows:

> Empire's upper level management indicated that it was unaware of the problems the examiners encountered. Management indicated that had it known of these problems, it would have taken action to alleviate the conditions and that such problems will be avoided on ensuing examinations.

Following these modifications, the report was refiled by the Department.

When questioned by the Staff about this incident, Mr. Curiale admitted that he had known nothing about it prior to the Staff's investigation. He stated that it was highly unusual and that he could think of no other time when a report had been officially withdrawn. Deputy Superintendent Miriam Boggio insisted that the initial filing had been simply "a mistake" because the examiners who reviewed Empire's original response had not realized that the response was actually objecting to parts of the report. The confusion, according to Ms. Boggio, was that Empire had failed to "use the magic words" which would automatically trigger a Departmental hearing prior to filing.

What is particularly interesting to the Staff is the modification made to the recommendation concerning Empire's cooperation with the examination. A similar criticism had been made of Empire in the previous exam report for the period ending December 31, 1984. In a sworn deposition taken by the Staff, Mr. Carus testified that a finding repeated in a report over two or more examinations could:

> escalate the amount of penalties or legal action that could be taken. Having formally informed the company and had them agree by virtue of the filing of the report that, indeed, a lack of cooperation had taken place and . . . that if it happened again, and if we could prove that he was aware of it and it continued to happen, we would be in a much stronger position.

It therefore seems that it was very important to Empire to have that particular recommendation modified. The Department, for its part, apparently was willing to accept at face value Empire's assertions that management was unaware of any problems.

After the changes were made, the Department did not get the examiner who wrote the report, Mr. Scharff, to sign a new attestation page. The original page had been signed in January 1990. Instead of having Mr. Scharff sign a new attestation that this changed report was true to the best of his knowledge and belief, the Department merely appended the page signed a year earlier to this report. Mr. Curiale said he had never heard of anything like this happening before. Although this seemed to suggest to the Staff that perhaps the changes were made without his knowledge, Mr. Scharff testified to the Staff that either he made the changes or someone else did with his knowledge.

Mr. Scharff could not recall whether he made the changes or someone else did. Mr. Scharff testified regarding this matter at one point in his deposition. Mr. Scharff stated in testimony that 3 days prior to his deposition he had attended a Staff meeting with Superintendent Curiale and other top Department Staff. According to Mr. Scharff, the subject of the change in the report came up at the meeting. Mr. Scharff's testimony at this point was as follows:

> Q. So it sounds like there was some discussion other than the brief fact that you were testifying, at that Tuesday meeting. Did they go over questions that you were going to be asked and what your response was going to be?
>
> A. Nothing specific. Just the general thrust was that I would be asked about the change in the report after the original signature in January of 1990.

Q. How did this come up? Did somebody go around the room and say, well, Mr. Carus, you are going to be asked this or, Mr. Scharff, you should be aware of this? How did it come up at the Tuesday meeting?

A. Well, it came up, when the Superintendent was outlining how the Department could be made to look bad, and one of the ways was the change in the dates, which could be inferred that the higher-ups overruled the examiner or changed the examiner's report without my knowledge. It was agreed that that's not what happened, that I had full knowledge of any changes that were made—either I made the changes myself or saw the changes before the final report was issued to the company.

Q. So the Superintendent made this statement, and then what; somebody asked you a question about that, as to what you were going to be asked and how you would respond?

A. Right. And I was asked "Well, that is the case, Mike, isn't it, that you did have full knowledge?" And I said, "Yes, I did."

Even when the Department has been willing to criticize Empire, it has allowed Empire to ignore its criticisms with virtual impunity. Each triennial examination report contains a section detailing the Plan's compliance with the comments and recommendations of the previous report. In the examination report for the period dating December 31, 1983, the report noted that three of its four previous recommendations had not been complied with. Similarly, the report for the period ending December 31, 1987 listed five recommendations from the 1983 report which had not been complied with. The Staff is unaware of any penalties being assessed in any of those cases.

The Staff has previously reported in this statement how the Department's 1989 recommendations concerning the election process for the Board of Directors was, in essence, ignored by Empire. Included along with that recommendation was another recommendation concerning Empire's use of the accounting firm Deloitte Haskins and Sells ("Deloitte") as it auditors. The Department felt that in light of the fact that a number of Empire's officers were formerly associated with Deloitte, the use of the Deloitte firm as independent auditor could create at least the appearance of a conflict of interest. The Department therefore recommended that Empire change its auditors to avoid this appearance problem.

Empire's response to this recommendation was to state that it had concluded that there was no reason to question the independence of Deloitte and that the possible perception of lack of independence had to be balanced against the cost involved in switching auditors. Noting that a number of "Fortune 500" corporations also have directors and officers who are former partners of their outside auditors, Empire's Board voted overwhelmingly to maintain Deloitte in spite of the Department's recommendation.

For 4 years the Department seemed content to allow Empire to disregard this recommendation. Interestingly enough, however, Superintendent Curiale has found new merit in this old recommendation. In his April 30, 1993 meeting with the Empire's Board, Superintendent Curiale again raised this issue, suggesting to the Board that it rotate its external auditors.

The Department has also allowed Empire to disregard various State regulations by failing to take any action to enforce these regulations. As has been discussed in detail in previous sections of the statement, the Department continued to allow Empire to invade reserves on a number of occasions even though Empire failed to comply with regulatory requirements regarding the establishment and execution of a 3-year Plan to restore, and add to, invaded reserves. Despite the requirement of the 3-year Plan, counsel for the Department has said that it could not order Empire to do anything, but could only make recommendations. Nevertheless, the Department admitted that when it did make such recommendations with regard to a 3-year Plan, "the Plan did not listen to the recommendation."

Another State regulation requires that Empire make a contribution from its experience rated business to subsidize its community-rated business. According to the Department, Empire failed to make a contribution in 1990 and 1991 and made less than a 1 percent contribution from the profits of its experience rated business in 1992. Despite these failures, the Department did nothing to enforce this regulation. When asked what their response was to the Plan's failure to make this contribution, Mr. Henricks said that the Department had asked for an explanation and that the response given (i.e., large losses from various groups and unions which had been dropped) "was satisfactory" to him.

The Department did nothing else to enforce this requirement because, as Mr. Curiale stated, "if they don't make any money, what should I do?" When the Staff asked, "you're the Superintendent of Insurance, you tell us what you should do,"

Mr. Curiale responded by shrugging his shoulders and saying "if you tell them to charge higher premiums they'll lose customers—the Department just doesn't have the expertise or authority to price the product."

Apparently, the Superintendent is admitting he lacks both the expertise and authority to determine the correct price for Empire's insurance product. If the Insurance Department cannot do this, then, within the current regulatory scheme for health care coverage, who is equipped to do so? Apparently, no one, since only the Insurance Department is authorized to do so. The Superintendent's rhetorical question may actually belie a more serious policy issue concerning rate setting for not-for-profit health care providers such as Empire. Namely, that since ultimate corporate profits are not relevant to a not-for-profit like Empire since it has no shareholders or owners, per se, its premiums are determined not so much on "profitability" or "return to investments" but for more social policy related reasons. Thus, when the Superintendent argues he doesn't know how to set premiums at a level to be profitable, he may be in actuality admitting he may not be able to set "profitable premiums" while still ensuring low-cost health care coverage for the many New Yorkers in the community-rated pools.The Staff notes that time and again, Superintendent Curiale has made the argument that his Department has neither the expertise nor the authority to tell Empire how to run its business. Yet, when asked if his Department had sufficient authority to properly regulate Empire, Mr. Curiale has stated that he has more than enough. In fact, as was pointed out in a New York State Senate hearing earlier this year, the Superintendent has very broad powers over insurers, including the power to: (1) issue, suspend and revoke license; (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.

The Staff questions whether what is missing is not the authority to regulate, but rather the will to regulate. It appears to the Staff that rather than taking an aggressive approach with respect to its authority in order to force Empire to confront the harsh realities of its problems, this Department and this Superintendent have done all they could to help Empire avoid these realities.

This was done in May 1992, when Superintendent Curiale met with top officials from Empire and Empire's outside auditors, Deloitte and Touche. Confronted with the possibility that Deloitte and Touche might issue a qualified opinion on Empire's finances because of fear of potential regulatory action, Superintendent Curiale assured the auditors that despite his power to order the liquidation or supervision of Empire, he had no intention of taking any such regulatory steps against Empire. Four days after this meeting Deloitte and Touche issued an unqualified opinion on Empire.

A similar assurance was given to Empire's auditors this year as well. In a March 1993 meeting, the Department once again assured Deloitte and Touche that it had no intention of taking control, or seeking the rehabilitation, of Empire. On the basis of this new assurance, Deloitte and Touche once again issued an unqualified opinion for Empire's finances.

In August 1992, in a meeting held with officials of the Blue Cross and Blue Shield Association Mr. Curiale was told that Empire was in danger of losing the Blue Cross and Blue Shield trademarks if it slipped into negative reserve numbers. In response, Mr. Curiale assured the Association officials that he was contemplating some accounting procedures which would help Empire's reserve position. Within a short time after that meeting, the Department came up with an interpretation which declared certain special reserve funds held by Empire to pay hospital claims to be "redundant." The result of this interpretation was to release close to $80 million into Empire's general reserves. Without this interpretation, Empire's 1992 reserves for the protection of its customers would have been -$40 million.

Indeed, it appears to the Staff that rather than taking on the role of aggressive regulator, the Superintendent and his Department have often taken on the role of cheerleader for Empire's cause. At times, Mr. Curiale has seemed almost indistinguishable from Empire officials in the vigor with which he has propounded Empire's cherrypicking argument as an explanation for Empire's recent financial woes. The Department also appeared to work side-by-side with Empire to push its Community Rating bill through a somewhat skeptical State Senate, going so far as to threaten the approval of large rate increases for Empire if the bill was not passed.

During the course of its investigation, the Staff learned that its requests to the Department for information and documentation on Empire were being communicated by the Department to Empire. In a May 1993 interview with Superintendent Curiale and his top deputies, the Staff told the Department that it had been informed

that document requests were being passed on to Empire. Mr. Curiale, Mr. Henricks, and Assistant General Counsel Paul Altruda all denied that this was true.

Deputy Superintendent Boggio, however, admitted that she may have "mentioned in passing" that the Staff had requested copies of financial statements or "something like that." When asked if she had provided Empire with a list of the Staff requests, Ms. Boggio responded, "it depends on what you call a list; I didn't give them a formal list." When pressed by the Staff, Ms. Boggio insisted that she only mentioned financials or "maybe quarterlies or Opinions and Decisions." She then stated, however, that "there is so much going on, I don't know specifically what I've mentioned." When asked with whom she was speaking at Empire, Ms. Boggio named Alan Drewsen, Empire's General Counsel. When asked if this practice had stopped, Ms. Boggio refused to elaborate.

In light of the vagueness of Ms. Boggio's response, and her refusal to elaborate on whether the Department's communication with Empire had stopped, the Staff cannot be sure just what the Department has passed on to Empire about this investigation or for how long it has engaged in this practice.

The Staff found that the Superintendent and his Department were unaware of several important issues affecting Empire's business. As the Staff has mentioned, Mr. Curiale has been a vigorous proponent of the cherrypicking argument. Department personnel, however, have told the Staff that the Department has never done its own study to verify this argument or ascertain the extent to which it may be applicable. It has simply relied on Empire's own studies.

When asked about the large number of National Accounts which Empire had lost, the Department was unaware of these losses. Nor had the Department ever bothered to attempt to contact former national accounts to determine why they were leaving Empire.

In his interview with the Staff, Mr. Curiale said he had never met with the Blue Cross and Blue Shield Association concerning its evaluations of Empire prior to 1992. He said that he was unfamiliar with the Association's NMIS score system and had no knowledge of Empire's poor rating in this system.

Mr. Curiale had never received a copy of the letter to Empire from the Health Care Financing Administration concerning Empire's poor Medicare service—Curiale said he only learned of it from the newspaper. He was also unaware of the current audit of Empire by the Department of Health and Human Services concerning Medicare Secondary Payor issues.

While he was aware of an issue involving the use of dummy codes, he had no idea that it involved over $200 million in payments. Similarly, while he had some knowledge of a recredentialling process being undertaken by Empire with respect to small groups, he had no knowledge that Empire had already established over $25 million in payments to ineligible groups in 1990–91.

In fact, when the Staff recited for the Superintendent the losses incurred by Empire on bogus unions, ineligible and bogus small groups, and unnecessary payments on workers compensation claims, Superintendent Curiale admitted that mismanagement at Empire "may be significant."

Once again, the Staff wishes to emphasize that it does not ascribe any improper motivation to the Superintendent or his Staff. We believe they are honest individuals who are attempting to do what they believe is in the best interests of the citizens of New York. The Staff does believe, however, that the dominance of Empire within the health insurance market of New York has led to a situation where the viability of Empire has become synonymous with the viability of the market itself. This has led the Insurance Department to seek to preserve Empire through whatever means are necessary. In essence, Empire has become too big to fail, or more appropriately, too big to be allowed to fail.

Although Mr. Curiale has, in testimony before the New York State Senate, labelled this idea as "simplistic," the Staff believes it is an important issue, particularly insofar as it reflects upon a regulator's will to regulate. In this regard, the Staff notes that this issue of the will to regulate has been raised before with respect to this Department.

A 1992 audit report, by the New York State Office of State Comptroller, entitled "State Insurance Department, Monitoring Insurer Solvency," made the following points:

—Our audit found instances in which Department management did not always demonstrate a strong will to regulate.

—In many cases, we found that management knew of insurer financial impairments years before rehabilitation or liquidation action was initiated.

—Delaying inevitable liquidations (an insolvent insurer with an inadequate Plan for corrective action and no new capital infusions) often results in insolvencies of greater magnitude and increases costs to all parties to insurance transactions

—While Department managers claim to have achieved some success delaying rehabilitation and liquidation, we believe that such delays are not always appropriate given the historical experience with such actions. Troubled insurers often continue to operate for years without improving their poor financial condition. We agree that Department management should work with troubled insurers to minimize insolvencies. However, if specified improvements cannot be made within reasonably established timeframes, Department management should take more forceful actions such as limiting new business, requiring expanded financial reporting or liquidating the insurers. Because records show that the costs of insolvencies can dramatically increase as time passes, Department management should not wait years for insurers to improve.

The Staff feels these audit findings are significant. In our opinion, they support the Staff's own belief that a Department's lack of aggressive oversight can lead to a situation where an insurer spins out of control, thereby creating the potential for even greater harm in the event of a crash than if the Department had taken control of the wheel at the early signs of danger. We hope the New York State Insurance Department will take these audit findings, and the Staff's own findings, to heart as it carries out its regulatory responsibilities with respect to Empire.

XV. CONCLUSIONS

The Subcommittee's efforts to examine the operation of the Blue Cross and Blue Shield system began last year with a hearing on Blue Cross and Blue Shield of West Virginia. That Plan was the first, and so far the only, Blue Cross Plan to fail. Our purpose in investigating the West Virginia Plan was not only to understand why it had failed, but to determine whether there had been any early warning signs which should have alerted the appropriate authorities to the possibility of failure.

Subsequent hearings on the Blue Cross Plans of Maryland and the District of Columbia were similarly aimed at identifying indicators of potential trouble. Unfortunately, the Subcommittee found many, including mismanagement, excesses on the part of Plan officials inadequate oversight by the Board of Directors, and ineffective regulation by the State insurance authorities. As a consequence of those hearings, however, both the Maryland Plan and the D.C. Plan have taken steps to address their problems and to turn their Plans around before it becomes too late.

In all of our efforts to date, the Subcommittee's overriding concern has been the protection of the million of men, women, and children who rely on these Plans in order to meet the costs of health care. These people have a right to know how their Blue Cross Plan is being operated and how it is being regulated, because it is only with this information in hand that they can make an individual judgment as to whether their reliance is well-placed or misplaced.

It was with these concerns in mind that the Subcommittee approached its examination of Empire Blue Cross and Blue Shield, the nation's largest Blue Cross Plan. Once again, it has been the Staff's sad duty to report that the warnings signs are posted. We hope that Empire will heed these signs. If Empire is to survive and to prosper, it must do more than rely on the external and artificial means of support to which it has turned in the past. It must look inside itself and find the will to change from within.

In furtherance of this end, the Staff makes the following conclusions:

(1) Empire's financial condition is precarious at best. For the past six consecutive years, Empire's reserves have failed to meet statutory reserve requirements. In the past 2 years, the Plan has had underwriting losses of $444 million and its reserves have decreased from $295 million at the end of 1990 to $40 million as of December 31, 1992. This is $485 million below the reserve level required by New York insurance law. In fact, since 1991, Empire has continuously been below 50 percent of its statutorily required reserve. As of year-end 1992, Empire's reserves stood at 7.6 percent of the statutory requirement.

(2) Despite repeated claims that unfair competitive practices including "cherrypicking" by their commercial competitors (i.e. the pricing of insurance to lure away healthy groups and individuals from Empire in the community rated market) caused Empire's recent losses, the Staff was unable to find nor could the Plan provide credible evidence to support this assertion. Likewise, neither the Insurance Department nor Arthur Andersen,

the outside consultant recently hired by the Department to conduct a special management audit of the Empire Plan, could provide credible evidence to support this claim. Both admitted to the Staff that they have essentially relied upon the assertions of the Plan that they were unfairly victimized by their commercial competitors, and have not independently verified this assertion.

(3) Although competitive practices by commercial insurers may have aggravated the poor financial condition of the Plan, the Staff believes that gross mismanagement, poor business Planning and operations as well as fraud were the principal factors generating the serious losses encountered by the Plan.

(4) Plan management has shown great difficulty in effectively carrying out the most basic functions of any successful insurance company, including the ability to properly price its product, accurately collect its premiums and pay the proper claims in a timely manner. This has resulted in exceedingly poor service and the loss of much business.

(5) The Staff has uncovered evidence that Empire has inadequate internal controls and as a result has repeatedly been the victim of massive fraud resulting in substantial losses to the company.

(6) Both the Plan and the Insurance Department have been aware of shortcomings with internal controls and fraud detection capabilities at the Plan but have not adequately addressed these problems.

(7) At a time during which it has been losing subscribers, increasing its premiums and incurring staggering underwriting losses, the Plan made excessive expenditures for the benefit of its senior officers and Board of Directors. Plan management authorized officer compensation, perks and fringe benefits as if the Plan were a profitable Fortune 500 company without regard for its not-for-profit status and whether such expenditures ultimately benefited the Plan's subscribers.

(8) Former Chief Executive Officer and Chairman of the Board, Albert Cardone, exercised excessive domination and control over the operations of this Plan.

(9) The Board of Directors of the Plan have exercised little if any control over the operations of this Plan or the excesses of its senior management.

(10) The New York Department of Insurance has been ineffective in carrying out its responsibility to effectively regulate and monitor the operations of this Plan. Whether intentionally or unintentionally, the Department's response to the worsening management and financial situation at the Plan has been regulatory forbearance.

(11) The Arthur Andersen special Management and Financial Audit commissioned by the State of New York and costing over $1.9 million in taxpayers funds did not adequately address the requirements of the statute by not verifying crucial assertions made by the Plan and others.

(12) There is the appearance of a conflict of interest with the external auditors for the Plan, Deloitte & Touche. Many of the senior officers of the Plan, including the former Chairman of the Board and Chief Executive Officer as well as the acting CEO, were former partners or employees with Deloitte & Touche.

(13) The National Blue Cross and Blue Shield Association for years has had serious concerns about the operations of this Plan but has been unable to effectively control and prevent the inadequacies and excesses of the Plan. In contrast to previous cases examined by the Subcommittee, the Association did bring these concerns to the attention of both the Plan's Board of Directors and the State regulators. This did not occur, however until 1992. By then, it may have been too late to effectively reverse the financial drain on the Plan.

APPENDIX A

SYSTEMS PROBLEMS

1. *InterPlan Data Reporting System*

In 1984 the InterPlan Data Reporting System ("IPDR") was developed to be used throughout the Blue Cross/Blue Shield system. This system was designed to process

"national" claims to permit one Plan to be reimbursed when that Plan paid the claims of another Plan's subscribers.

The Staff found that in 1985, internal auditors for Empire were reporting potential computer inter-operability problems involving Empire's use of IPDR to collect Empire's reimbursements for claims paid for the subscribers of other Plans. Apparently, IPDR was not compatible with the system used by Empire. Thus, Empire's systems would pay the claims of other Plans' subscribers but when Empire then submitted those claims for reimbursement from the other Plans, the IPDR system would not be able to process the claims. This resulted in a growing amount of unpaid reimbursements from other Plans to Empire.

As the backlog of claims built up, so did Empire's receivables on the IPDR system. In 1987, according to a former Empire Vice President who had been with Empire since 1974, approximately $50 million worth of claims were aged to the point that they were deemed "uncollectible" and subsequently taken off Empire's books. He told the Staff that the corporate culture at the time at Empire was such that higher management wasn't concerned about these amounts and did nothing to fix Empire's systems to stop these losses. He complained to the Staff that no one cared about $50 million then because of their large amount of reserves at that time and that, in the end, the community rated subscribers would pay for it (through rate increases).

A January 9, 1989 Internal Audit Report to Mr. Morchower was reviewed by the Staff and appears to indicate that the claims processing system was changed to effectuate Internal Audits' 1988 recommendations. Unfortunately, the Audit report also indicated that proper management approvals were not obtained prior to putting the modifications to the claim system software into production, and that proper application system tests were not documented by the Information Systems Staff. By not following these company procedures, the report noted that there was no means of ensuring that the modifications actually performed as intended.

Apparently, the auditor's concerns of 1989 were well founded. A July 31, 1992 Internal Audit report discovered by the Staff indicates that the balance in the "General Ledger Account for Accounts Receivable—InterPlan Bank," as of March 31, 1992, was approximately $58.3 million, an amount which the Staff determined was verified by Deloitte & Touche during their 1992 year end audit.

The internal audit report noted that this was considered high in comparison to the normal claims inventory balance of approximately $20 million. The report also noted that the claims inventory balance had been increasing since the third quarter of 1991, and was the focus of management attention.

Of this, the report stated that $14.3 million of unreconciled bank paid claims were over 12 months old, exceeding the BCBSA statute of limitations for a home Plan being required to research its records or make adjustments, which may result in this amount being unrecoverable.

2. *CS/90*

As previously mentioned, sometime in the late 1980's, Empire again sought to integrate its claims systems so that it would merge a number of its redundant systems including the MCS and ICS claims processing systems. CS/90 is supposed to be the answer to the Plan's problems of redundant and non-integrated systems inherited from the various mergers. It is one of Empire's largest systems development projects and the Plan predicts that its implementation will be completed sometime in 1995.

As of October, 1992, according to an interview with Mr. Morchower, Empire spent over $20 million on CS/90. He also indicated that they project spending an additional $10 million in 1993 on its implementation. Total costs, according to Mr. Morchower, may reach as high as $50 million when it is completed by the end of 1995.

The Staff received a number of allegations that the systems implementation has fallen dramatically behind schedule which one former Vice President told the Staff was supposed to project completion for 1990. Mr. Morchower disagreed with this interpretation and claimed that the project didn't actually start until 1990 and that everything is proceeding close to schedule. However, the Staff found references to CS/90 in the 1989 Corporate Plan and Budget dated December, 1988.

The Staff found that the first component of CS/90 has already been installed to cover the hospital business of the Mercer Hospital accounts. This component is for claims processing only. The Staff has found that there have been serious problems with this first component.

In a May 27, 1992 Internal Audit report to Mr. Morchower, auditors reported that CS/90 started processing claims at Mercer in January 1992. The old central claims processing system, MCS, had been shut down since the beginning of December 1991 which caused a build up of outstanding claims.

The claim inventory upon CS/90's start-up was over 17,000 claims. As CS/90 ran, backlogs continued to rise, increasing to a high of over 28,000 less than a month

later. The Staff learned from the report that Mr. Morchower decided at that point to relax certain CS/90 edits to increase the flow of claims and reduce the growing backlog. This action had a positive effect on the inventory. By April, the inventory was reduced but was still over 10,000 claims—a figure that the internal audit report noted was higher than the level management hoped to achieve.

The Staff learned that by suspending these edits, Empire became re-exposed to the potential for fraud. Built into CS/90, were edit checks that would suspend any claim using a "dummy code" for a period of 28 days. This editing function in CS/90 was intended to protect the Plan from potential abuse of "dummy codes" which are generic codes used to process claims that would otherwise be rejected by the computer program because the provider receiving the check does not have a legitimate code that identifies him or her.

This edit was temporarily suspended, along with others, to expedite the processing of the claims backlog. The claims having the "dummy" code were then processed manually. Because of this, according to the audit report, no detailed analysis of the suspended claims could be performed to determine if the suspensions for missing provider numbers were caused by incompleteness or potentially fraudulent activities.

The Staff was told by an Internal Auditor that, up until recently, "Empire would process any claim even if it were written on a napkin."

APPENDIX B

Empire Internal Audit Division

The Staff's review of the Finkelstein case raises a number of questions concerning the Plan's ability to prevent as well as uncover fraudulent activities. The Staff's review of this matter raises serious concerns about both the ability as well as the willingness of the Plan to effectively combat fraud.

Tom Ward, the former Director of Program Security told the Staff in his deposition that based upon his experience, there were serious problems with security at the Plan, starting with its emphasis on numbers not quality:

> Q. Why did you view it as intolerable there?
>
> A. I think there were differences between myself and Maroa Velez in terms of the philosophy as to how a fraud unit should work. I thought that we needed to be more directed toward . . . qualitative measures and I found that there was too much emphasis being placed on quantitative aspects of the investigations. . . . I don't think numbers should drive decisions with respect to investigations.

The Staff found in reviewing the records of the New York State Insurance Frauds Bureau's Suspicious Transactions Reports (STR's) that in 1992, Empire referred 32 instances of alleged fraud, totalling $654,562. This figure is approximately 0.1 percent of the suspected losses.

The Staff questions why more attention is not being given to pursuing waste and fraud, in particular as it relates to automated systems. In a firm of over 10,000 employees, there were only 76 assigned to ensure internal integrity, 24 of those paid for by the United States Government through the Medicare program. Relative to fraud investigations, at the current time, there is only one individual in the Internal Audit Division, the unit which conducts these investigations, who has fraud investigative experience.

The Internal Audit Division (IAD) is the locus for Empire's fraud, waste, and abuse prevention and detection effort. According to Ms. Velez, the Vice President for the IAD, the budget was $5.6 million in 1992 and $4.8 million in 1993.

1. *Detecting Fraud*

Suspect activities, once identified by the IAD, are assigned for investigation, although not all are cases involving fraud. An internal filtering process sorts the cases. All suspect cases are forwarded to the Program Security Department. A preliminary review of the allegation is conducted, and internal records are reviewed by investigations to establish the basis for fraud. The Staff was told by members of the Internal Audit Division that because of the lack of systems uniformity and computer access, these evaluations are exceedingly time consuming. In some cases, data cannot be found to substantiate that a transaction ever occurred in the first place.

The Staff was told that the responsibility for actual proactive fraud detection, beyond a typical audit, for a company with annual premiums of over $6.5 billion

and nearly 10,000 employees rested on the shoulders of one man, George Jamesley, who sat in a small room and "played" with scenarios on his computer. Unfortunately, Mr. Jamesley recently retired from Empire.

If billing or other errors are detected, the cases are closed with appropriate corrections. Cases warranting further examination are forwarded to senior investigations. If fraud is substantiated, the investigation is then referred to the New York State Insurance Department Insurance Frauds Bureau via a Suspicious Transaction Report and the Case Review Committee (CRC).

2. *Fraud Referrals*

The Case Review Committee is an in-house group which determines what action should be taken on the cases that appear to be fraud. Generally, if an employee is involved and the dollar loss is not significant, they are usually dismissed. If fraud is involved and the threshold amounts meet the Federal or State guidelines, then Empire refers these cases for criminal prosecution in the appropriate venue. In all cases of employee fraud, criminal prosecution is sought, according to Tom Ward, the Director of Program Security. Recoupment of losses is also pursued civilly.

The Suspicious Transaction Reports (STR's) serve as a referral medium and are sent to the New York State Insurance Frauds Bureau. These reports cite the nature of the alleged fraud and fraud attempts; the violators; the dollar value, if known; whether the matter had been referred to a law enforcement agency; and the contact person at Empire.

The dollar figures, which are provided by Empire, are usually very conservative. In some cases, no figures are given; in more complex frauds, only further investigation by law enforcement authorities can determine the parameters of the loss.

The Insurance Frauds Bureau uses these forms to record violators and determine if criminal action should be taken. If Empire makes a criminal referral itself, a notation is made on the form. If no referral is made by Empire, the Insurance Department will attempt to pursue it.

The Staff performed an analysis of the 367 referrals on file with the Insurance Department, submitted by Empire from 1986 to 1992. The Staff found that fraud detection referrals were for de minimis amounts compared to the $6 billion in claims processed. Vulnerabilities to fraud in the provider and pharmacy claims area were not aggressively pursued, even though patterns of fraud existed. Very little effort seemed to be placed on international and out-of-State claims fraud, internal fraud, although only one STR referral was made, it appears to be significant. As an example in the late 1980's, Empire's CFO, Jerry Weissman received two claims checks, which were not his, in the mail at his residence. One check bore his address but a different name. According to Tom Ward, they were never able to determine how the checks were sent out or who sent them. Incredibly Empire's computer system could not identify where these checks originated. This means that checks can be sent from the Plan without any means to track them.

The Staff believes that Empire, pursuing its current posture of lax procedures and computer vulnerability, makes itself a lucrative target for internal and external fraud.

3. *Internal Fraud*

The Staff was told that there were 22 arrests made in recent years at Empire for various crimes. A large number had to do with internal claims fraud. The Staff found only one referral on record with the Frauds Bureau for internal fraud for $150,000. The Staff discovered another case involving a $90,000 internal claims fraud which was investigated by the U.S. Postal authorities. In these two cases alone, Empire lost $240,000, by far greater than many other groups, which makes internal fraud one of the largest loss areas in Empire's operations.

4. *External Fraud*

a. *Provider Fraud*

While these frauds were detected by Empire, they were few in numbers and point to a greater problem. In most instances, practitioners and staff were billing for services not rendered. There were 53 allegations of fraud from 1987 to 1992, which amounted to $906,690, of which $65,992 was detected in 1992. There were 23 cases referred to law enforcement or a professional ethics committee, two of which were made in 1992. There was only one referral over $100,000 and one as minor as $67. An example of the types of frauds are identified below:

> A physician billed for a hysterectomy when a lesser procedure was in fact performed. In fact, the hysterectomy was performed the previous year by another physician. Fraud detected before payment.

A physician billed $2,000 for in-house medical services when the patient's family and hospital concluded it was not rendered.

A physician was accused of submitting over $13,000 in overstated and false claims for his office Staff.

A physician bill of $4,500 for acupuncture treatments which were never delivered.

A physician billed for $3,230 for in-patient service medical psychotherapy after the patient was discharged from a psychiatric facility.

A physician billed $46,000 for psychotherapy visits which were in fact telephone calls to patient's homes.

A dentist billed $799 for multiple root canals when only one was performed.

A dentist misrepresented services of $943 for bridge inserted by another dentist.

A physician whose license was revoked 8 years prior had submitted $14,000 in claims in a prior 3-year period.

Physicians' Staffs having access to the claims systems, generally without the doctors' knowledge, were responsible for $62,196 in fraud. Some examples are:

A dentist, former employee, and four accomplices filed nearly $31,000 in fraudulent dental and medical claims.

A subscriber and former office manager filed $4,000 in claims.

Former employees of a major hospital filed $7,000 in false claims under the names of two unknowing physicians.

b. *California Laboratory Cases*

The California rolling lab cases accounted for 22 criminal referrals and totaled $412,117 in false claims submitted to Empire. One referral was made in 1992, but no loss figure was given. Michael Smushkevich, a Russian citizen, lured people into taking medical testing at clinics throughout Southern California. He billed $1 billion in false claims and received $50 million of it. According to the U.S. Postal Service, it was the largest fraud case ever worked by that agency. The Staff notes that no local lab was detected by Empire for submitting false claims. The fraud was instead discovered by California law enforcement authorities.

c. *Pharmacies*

Frauds committed by pharmacies accounted for several criminal referrals and totalled $290,084, from 1987 to 1992. Examples of some of these false claims are:

A subscriber, who was a physician, submitted $11,000 in false claims for medication which he used to stock his pharmacy.

A pharmacist submitted $12,000 in false claims.

A pharmacy submitted $142,000 in false claims.

d. *International Claims*

There were 14 instances of international claims fraud, which accounted for $109,345 from 1987 to 1992. The majority of these false claims came from the Dominican Republic and Nigeria for services never performed. A number of these frauds were perpetrated by organized rings. The major problem with international claims fraud is the difficulty in identifying providers and medical facilities.

e. *Subscriber Claims Fraud*

There were 57 subscriber claims frauds totalling $1,417,831, which were referred by Empire to law enforcement authorities since 1987. In 1992, only seven STR's totalling $389,453 were made to law enforcement authorities.

Pharmacy claims accounted for $711,513, and out-of-State claims accounted for $180,097. These are the two most identifiable types of claims fraud referred to law enforcement. The Staff noted that there were several fraud conspiracies identified by Empire. In 1992, Empire made five criminal referrals totaling $349,097.

There were approximately 207 referrals for subscriber claims frauds, amounting to $730,807, which were not directly referred to law enforcement by Empire. Of that number, there were six over $10,000; 85 claims totalling $31,343 which were under $500; 13 under $100; and one as low as $9.95. In 1992, there were 25 cases generated, valued at $193,965.

The majority of the submissions were outright false claims, the utilization of a subscriber's card to cover an uninsured individual, the continued use of a deceased subscriber's card by a family member, and, in some cases, the ordering of prosthetic equipment where the subscriber spent the funds and never picked up the equipment. One type of fraud which appeared was the billing of multiple insurers.

5. *Corporate Culture*

The Staff reviewed approximately 100 Internal Audit Reports dating from 1987 up to December 1992. One glaring issue was that nearly 50 percent of these Internal Audits had the same findings, often in the same area of responsibility. These findings dealt with system security. The following are excerpts from these audits:

Unauthorized and excessive access to Purchasing system data files.

Computer IDs assigned for a terminated employee and one assigned to someone nobody ever heard of.

Unauthorized modifications can be made in Purchasing because individuals can initiate and close a purchase order as well as process receiving transactions.

Shared logon IDs.

No formal system development methodology for the Imaging project.

PCs not password protected.

Unauthorized claims submissions or changes can be made by Empire employees.

No security implemented over all Corporate IDMS/R (relational database)

Access controls need strengthening.

System files not protected by security software.

Inappropriate Staff given authorization to modify files.

No off-site backup.

Computer room can be accessed by unauthorized people.

Lack of policies and procedures.

When we reviewed the Audit Reports, it was common to see remarks indicating that management didn't take action with respect to the Audit Division's findings and recommendations. For example:

Of the eight issues originally reported to senior management, none have been fully addressed.

Management's response is not adequate.

It appears that certain recommendations in our previous report have not been addressed.

Corrective measures to address our concerns were only partially implemented and several issues remain unaddressed.

Our comment that management did not periodically assess the timeliness and accuracy of processing the advances specifically addresses the failure of management to establish standards for accurate and timely processing of advances and to measure performance against these standards.

Corrective measures to address audit concerns were only partially implemented.

We noted that management did not reduce the inventory of blank checks on hand.

These problems were identified 2 years ago and discussed with management. Corrective action was not taken to resolve the issues.

It appears that many of the audits are ineffective in generating improvements in the efficiency of the audited departments and in reducing exposure to fraud.

APPENDIX C

Compensation Paid to Empire Executives 1990 - 1992

		Salary	Incentive (% of salary)	Total Compensation
A. Cardone	90	$ 540,000	N/A	$ 540,000
CEO	91	600,000	N/A	600,000
	92	600,000	N/A	600,000
D. Morchower	90	$ 335,531	$ 27,996 (8%)	$ 363,527
COO	91	370,000	49,722 (13%)	419,722
	92	370,000	57,141 (15%)	427,141
J. Weissman	90	$ 195,000	$ 13,728 (7%)	$ 208,728
CFO	91	205,000	21,973 (11%)	226,973
	92	205,000	22,622 (11%)	227,662
A. Drewsen	90	$ 195,000	$ 15,482 (8%)	$ 210,482
Gen. Counsel	91	205,000	27,422 (13%)	232,422
	92	205,000	22,019 (11%)	227,020
T. Furey	90	$ 165,000	$ 10,656 (6%)	$ 175,656
VP Admin.	91	185,000	19,576 (11%)	204,576
Serv.	92	185,000	21,096 (11%)	206,096
B. Schoen	90	N/A	N/A	N/A
VP Exp.	91	$ 213,750	N/A	$ 213,750
Rated Sales	92	261,952	$ 6,298 (2%)	268,250

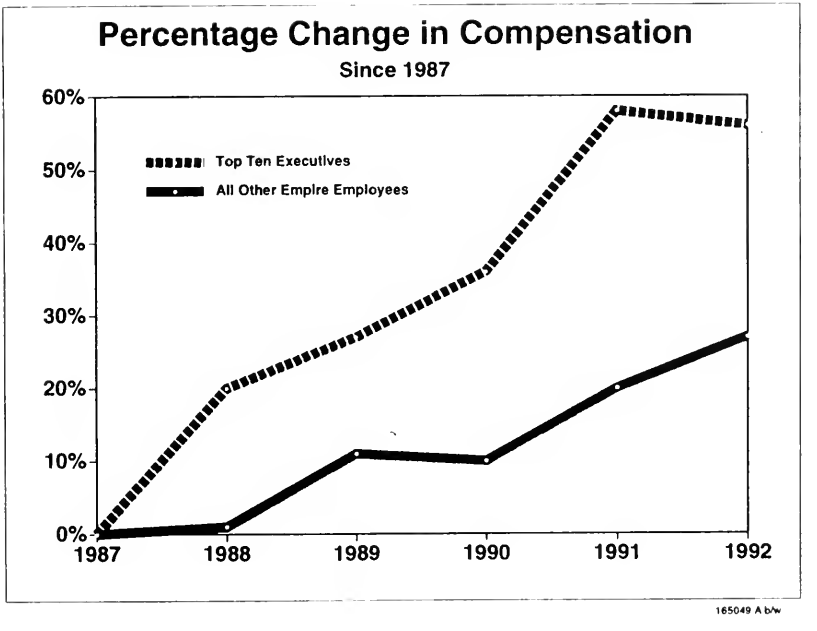
Examples of Rate Increases for Empire's Community - Rated Groups

Basic Medical Coverage: 350% increase
(Matrix II)

	Individual/Month	Family/Month
1989	$ 29.55	$ 73.90
1993	138.90	318.55

Major Medical Coverage: 230% increase
(Wraparound Plus)

	Individual/Month	Family/Month
1989	$ 97.90	$ 226.80
1993	$ 323.95	$ 752.35



Empire Officer Perquisites in dollar amounts

	1992	1991	1990	1989	1988
Health Club Memberships	14,851	12,160	18,800	21,120	20,420
Parking	48,000	30,871	36,960	27,000	19,495
Lunch Club Memberships	4,000	4,151	1,640	696	85
Physical Examinations	3,000	1,689	2,411	843	3,425
	69,851	48,871	59,811	49,659	43,425

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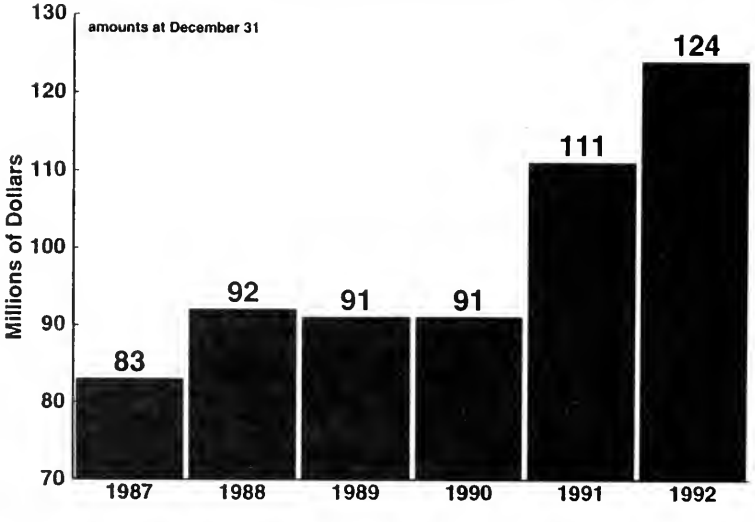
Empire's Non Admitted Assets



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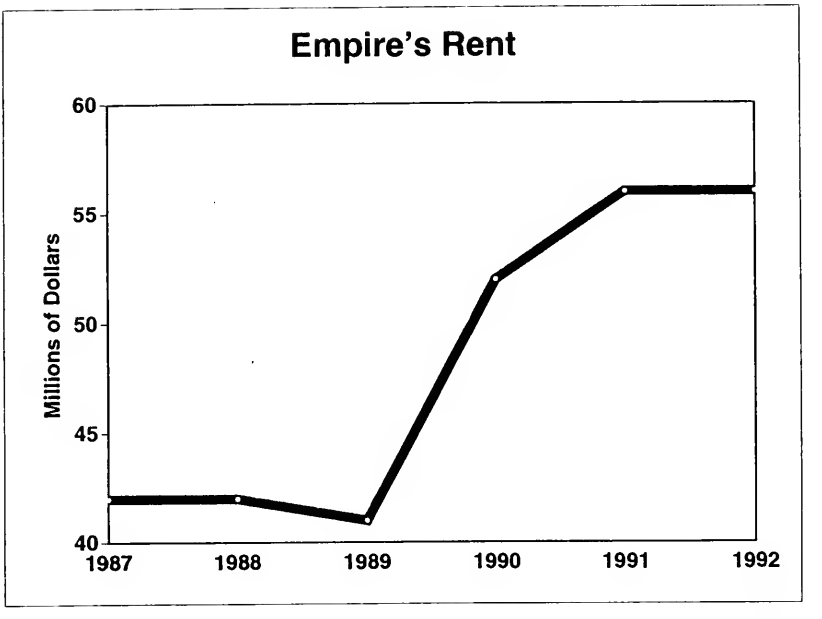

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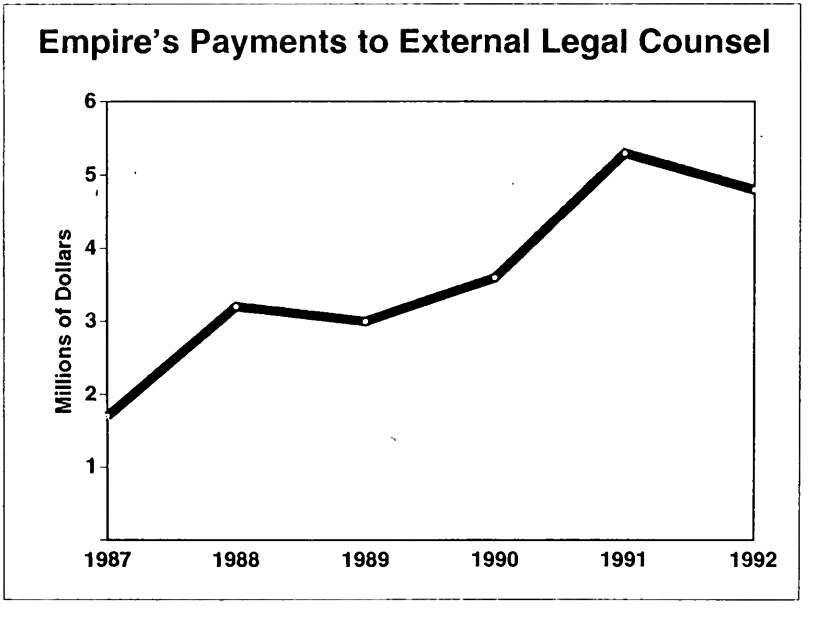

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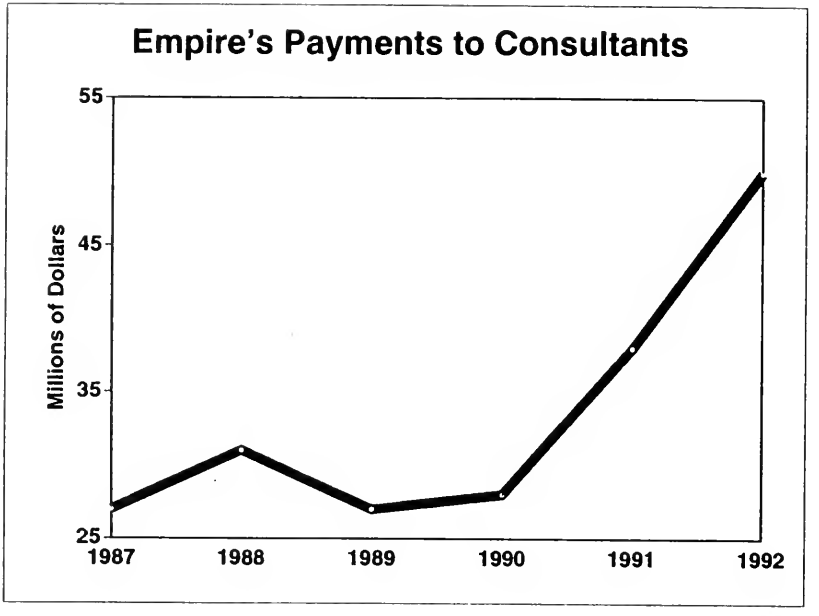

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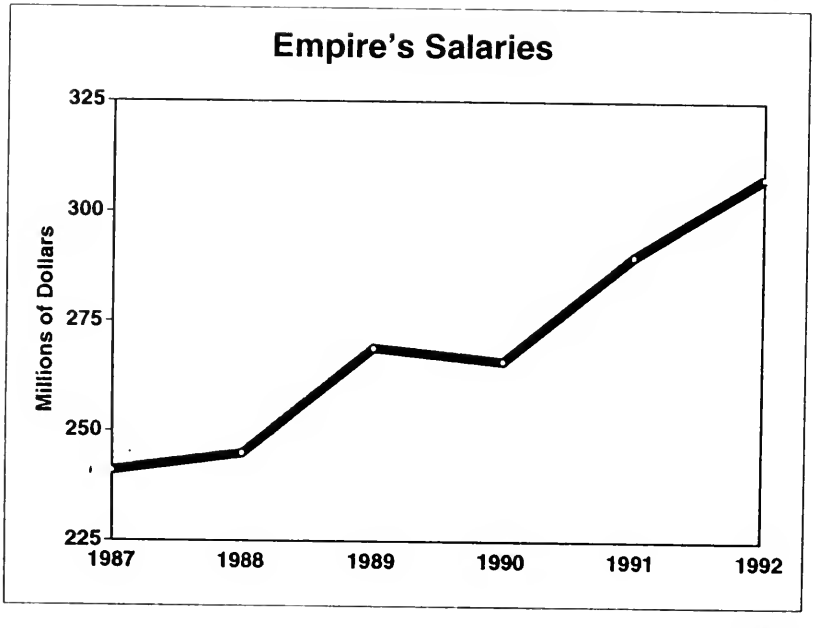

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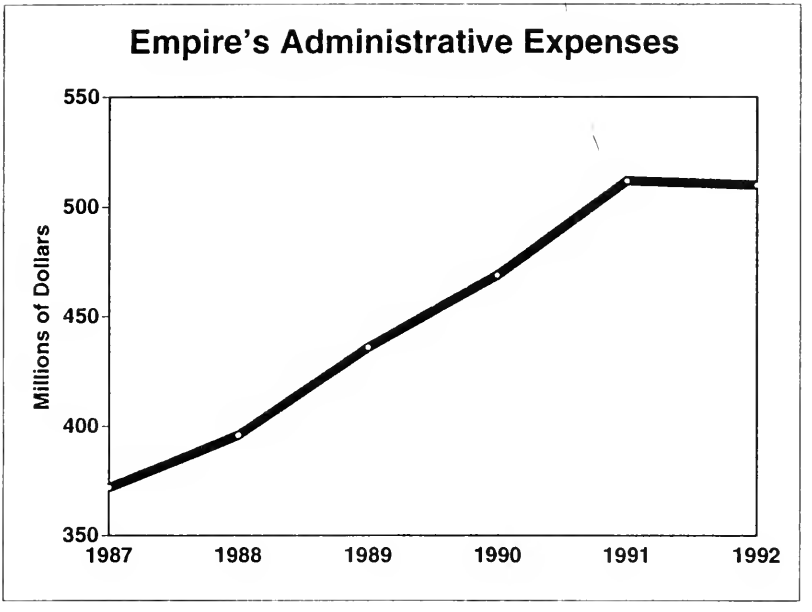

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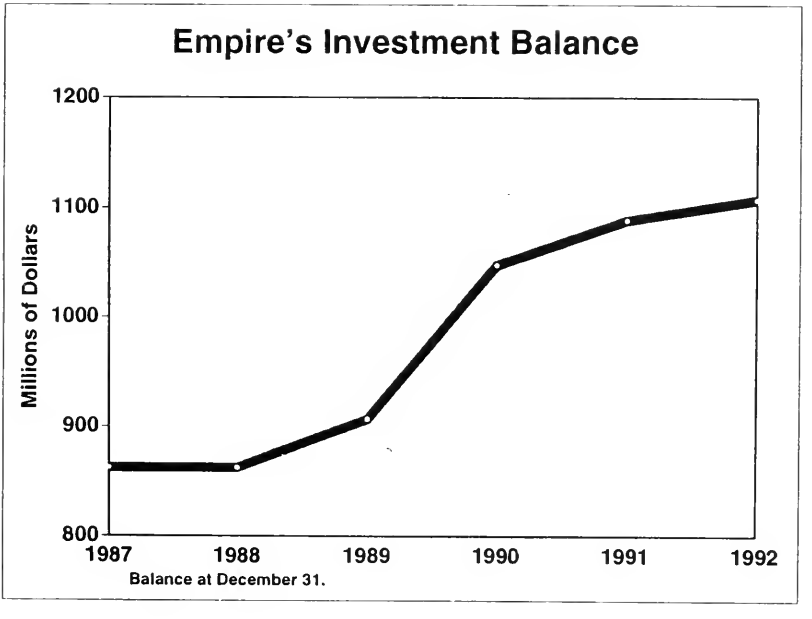

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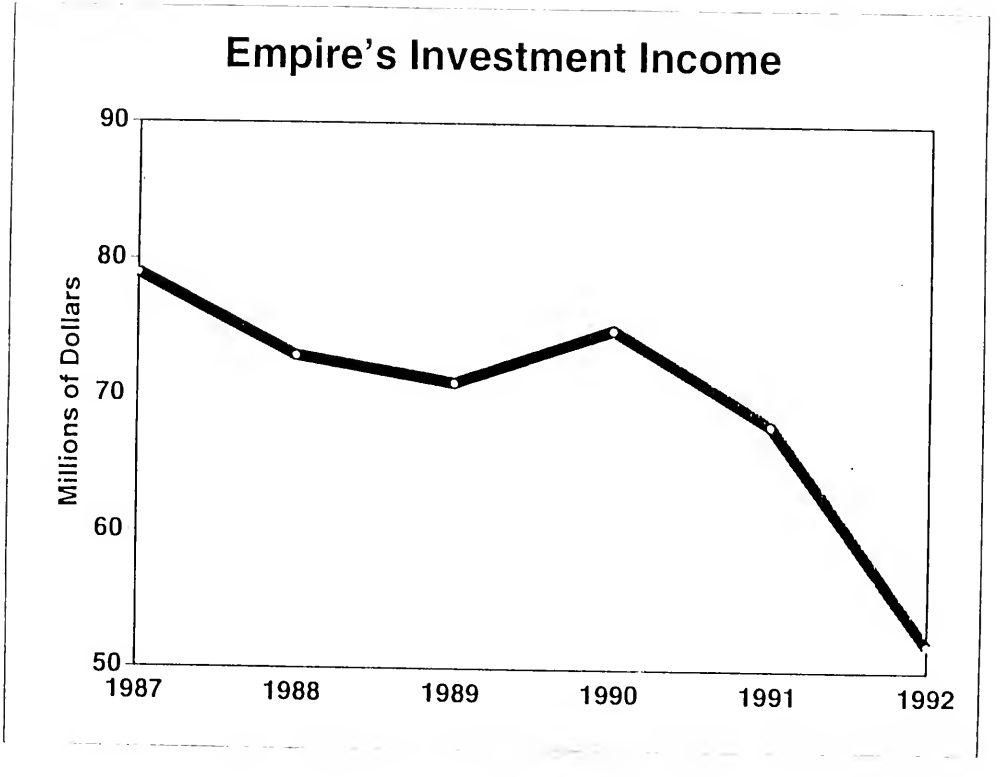
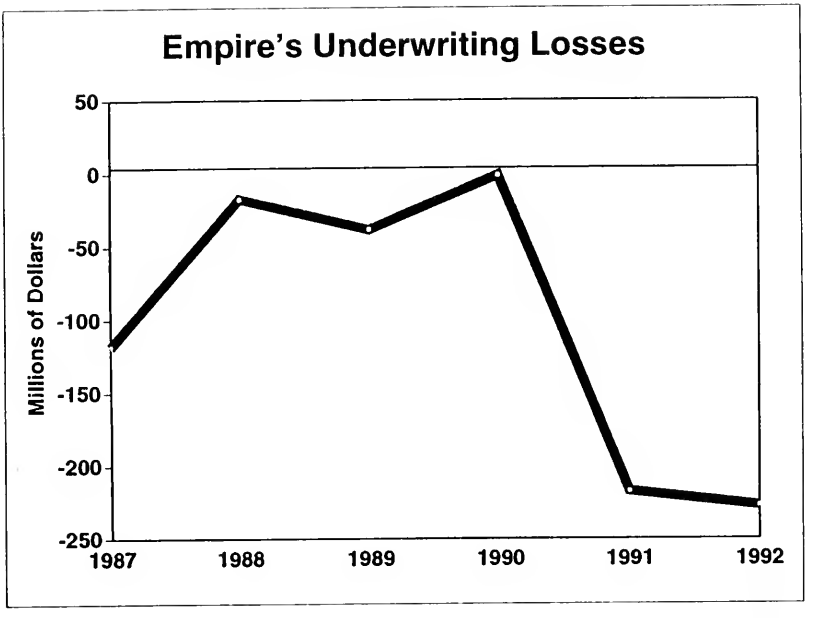

Empire's Investment Income
Millions of Dollars
90
80
70
60
50
1987
1988
1989
1990
1991
1992

165005 F



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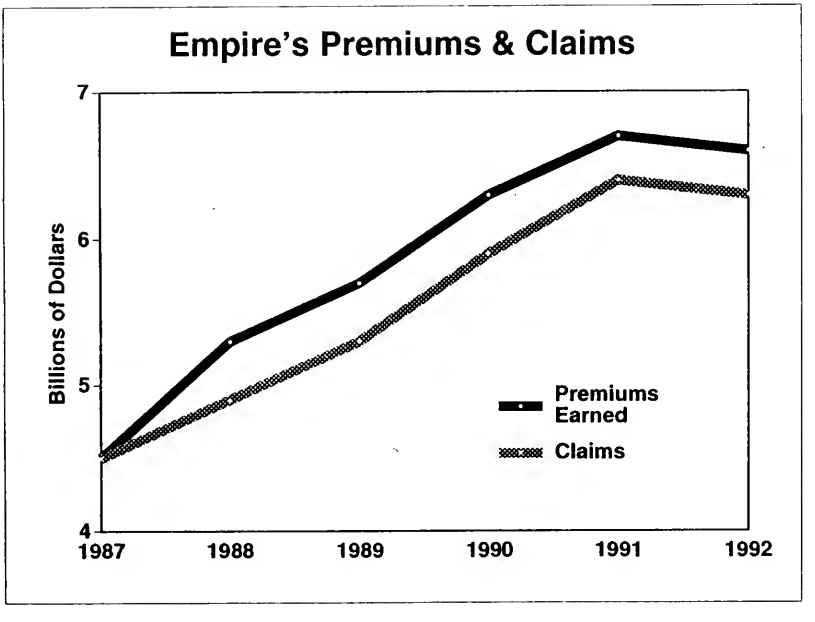

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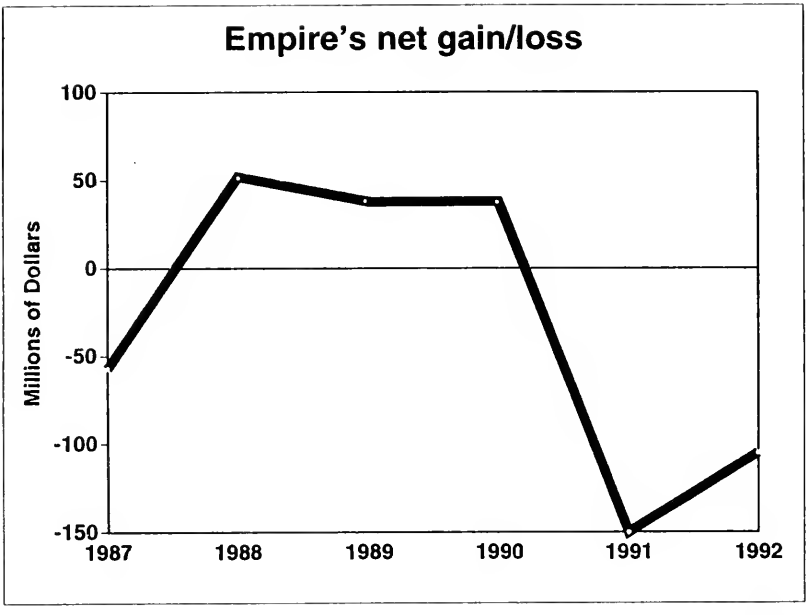

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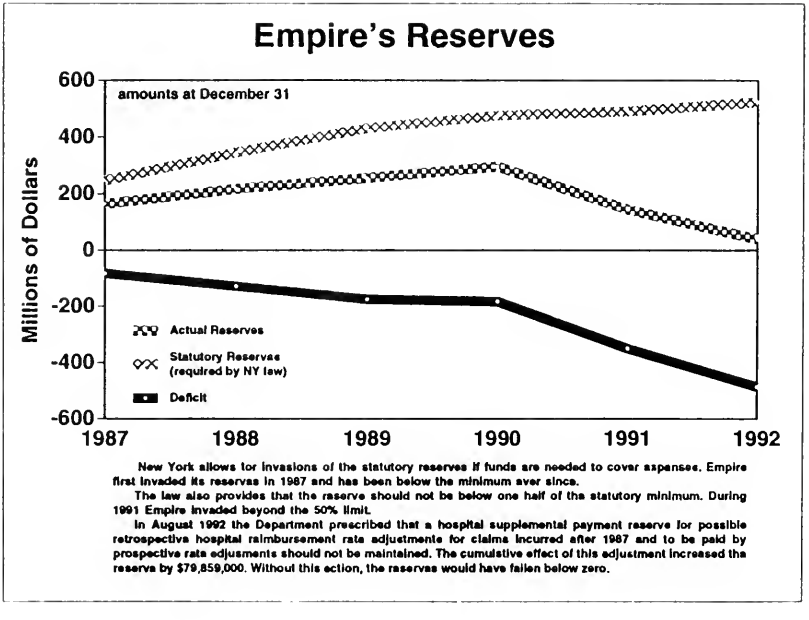

New York allows for invasions of the statutory reserves if funds are needed to cover expenses. Empire first invaded its reserves in 1987 and has been below the minimum ever since.

The law also provides that the reserve should not be below one half of the statutory minimum. During 1991 Empire invaded beyond the 50% limit.

In August 1992 the Department prescribed that a hospital supplemental payment reserve for possible retrospective hospital reimbursement rate adjustments for claims incurred after 1987 and to be paid by prospective rate adjusments should not be maintained. The cumulative effect of this adjustment increased the reserve by $79,859,000. Without this action, the reserves would have fallen below zero.

165005 A

Hospital Enrollment Losses

	1988	1989	1990	1991	1992	Five Year Total
Hospital Contracts (000s)	4,922	4,619	4,427	3,993	3,733	1,189,000
Annual % Change	-5.9%	-6.2%	-4.1%	-9.8%	-6.5%	32.5%

Medical/Surgical Enrollment Losses

	1988	1989	1990	1991	1992	Five Year Total
Med/Surg Contracts (000s)	2,000	1,707	1,602	1,667	1,584	416,000
Annual % Change	-3.7%	-14.6%	-6.2%	+4.1%	-5.0%	25.4%

Source: Blue Cross/Blue Shield Association

PREPARED STATEMENT OF MS. BOYLE

Good morning, Mr. Chairman and Members of the Subcommittee. My name is Joan Boyle and I am here to testify regarding my employment with Empire Blue Cross and Blue Shield.

Prior to joining Empire, I was employed for 22 years with Blue Cross and Blue Shield of New Jersey, serving as Executive Vice President and Chief Financial Officer. In 1991, the New Jersey plan replaced the Chief Executive Officer and I chose to leave as well. In August, 1991, I contacted Al Cardone, CEO of Empire, whom I had come to know through various Blue Cross/Blue Shield activities. I was interested in future employment opportunities, including consulting, and knew that Al had many contacts in the health insurance field.

Al invited me to join Empire and, in October, 1991, I decided to do so. Due to contractual obligations with the New Jersey plan, I worked for Empire on a consulting basis from October 1991 until January 1, 1992, at which time I became a Vice President and Executive Assistant to the CEO. Throughout both my consulting work and my employment as executive Assistant, my compensation and responsibilities remained the same.

According to notes I maintained, Al outlined my job responsibilities to me on November 12, 1991. They included: planning Empire's operational strategy; managing strategic issues regarding New York State and the National Association; compiling the 1992 budget; overseeing a sales improvement plan; and overseeing ongoing consulting project being performed by Booz Allen Hamilton; and overseeing major corporate projects, like those in the information systems area.

I had three Empire employees who reported to me on areas of concern to the Chairman. Nary Ann Nagy was responsible for goals setting; Peter Chin reported on major information system projects; and Bill Fuessler monitored financial issues for the Plan. I believe each of these employees was a Director level employee.

One of my assignments as Executive Assistant was to prepare Al's presentation to officers and Directors on the new 1992 management incentive compensation program. Corporate profitability was one of the goals used to assess the incentive awards and I asked Bill Fuessler to assist me in preparing slides in this regard.

On February 3, 1992, Bill came to me and expressed concern over two sets of figures he had discovered on Empire's gains and losses on its community-rated and non-community-rated business. He said that one set of numbers came from the actuarial department and another came from Empire's "Black Book." The Black Book was the term applied to the document which I believe listed the most up-to-date figures on Empire's gains and losses. I believe the Black Book was updated monthly or quarterly by the Chief Financial Officer, Jerry Weissman, and his staff. The Black Book was not widely distributed, as far as I know. I had access to it because I was part of the CEO's staff but I believe only the CEO and CFO received a copy of the Black Book.

As Bill pointed out to me, the figures in the Black Book were different from the figures provided by Actuarial. I asked Bill what investigation he had done and he told me that he had shown the two sets of figures to Sharon Smerzler and Dave Sanders in Actuarial. When he asked for an explanation, Bill said that Dave Sanders turned and walked out and Sharon told him that the Black Book numbers were for internal purposes and the others are for external purposes. Bill told me that when he pressed Sharon for a better explanation, she toad him to ask Jerry Weissman. Instead of going to Jerry, Bill came to me.

I decided that I should confront Jerry and my notes say that Bill went with me, but I don't recall if he was there or not. I waited until later in the day when most of the staff had gone home. When I showed Jerry the numbers he appeared nervous and repeated what Sharon Smerzler had said: the Black Book numbers were for internal purposes and the actuarial numbers were for external purposes. When I asked Jerry which ones were accurate he said that the Black Book figures were right and that the other figures were "more politically acceptable."

I was very disturbed by this and told Jerry that he had a professional obligation to present accurate figures. At that point, Jerry folded his arms and told me to talk to Al about it. When I asked Jerry if Al was aware of the two sets of figures, he didn't respond except to tell me to talk to Al.

Realizing that Bill's discovery may lead to a difficult situation, I told Bill that I would talk to Al alone the following morning. I was relatively new to the company and I didn't want Bill to jeopardize his position. On February 4, I met with Al and told him what I found. Al appeared to be surprised and told me that he did not know anything about it. When I explained to Al how the discovery was made, he wanted to see Bill. Bill then joined us and Al asked which of the two sets of figures

were accurate. I told Al that we have always relied on the Black Book figures as being accurate and he responded that "nobody knows what figures are right." He added, "I can't rely on any numbers coming out of actuarial. They're jelly. Neither you nor I know which figures are accurate."

Al suggested that perhaps the discrepancy in figures were a result of investment income. I told him that this was not possible since allocation of investment income would not affect underwriting gains or losses. Al then asked that Bill and I audit the figures to determine which ones were, in fact, accurate. I told him that we couldn't possibly perform such a monumental task and advised that we would need to bring in outside auditors to do the job. I suggested the best source to determine the accuracy of the numbers was Jerry and the people in the actuarial department. At that point, Al telephoned Jerry but he was out sick that day.

The following morning, February 5, 1992, Jerry Weissman asked me if I had talked to Al about the books. I told him that I had and that Al said he didn't know anything about it. Jerry smirked and I believe he said "Al said that?" I then told Jerry that Al was going to talk to him about it.

That evening, February 5, 1992, I prepared a handwritten memo of this experience. When contacted by the Subcommittee staff, I located the document and am submitting it to the Subcommittee with this statement. This memo has helped to refresh my recollection as to the details of these events.

Specifically, I made a notation of the two sets of figures as follows:

($ millions)

	1989		1990	
	"Black Book"	Acturarial (Sched 5)	"Black Book"	Acturial (Sched 5)
CR	$20.0	($23.7)	($19.8)	($27.8)
ER	(21.0)	22.6	38.1	46.0
Healthnet	(36.7)	(36.6)	(19.5)	(19.4)
Total	(37.7)	(37.7)	(1.2)	(1.2)

Prior to these events, Al and I maintained a good working relationship. Subsequently, he treated me coldly and within weeks, asked me if I wanted to be Vice President of Sales. I had no sales experience and felt that it would be a good opportunity to round out my resume. However, I also felt that I did not have a choice in the matter. When I moved off of the executive floor to another building to assume the Sales responsibilities Bill Fuessler was moved along with me. Al belt that Bill needed additional experience and I was happy to have him accompany me to the Sales Department.

Shortly thereafter, in March, 1992, a recruiting firm contacted me regarding another position and in September, 1992 I joined Pioneer Life Insurance Company of Illinois where I serve as Executive Vice president and Chief Operating Officer.

I will be happy to answer any questions that you may have.

EXHIBIT SUBMITTED TO PERMANENT
SUBCOMMITTEE ON INVESTIGATIONS
BY JOAN BOYLE

Memo to File 2/5/92

On 2/3/92, in the process of preparing a multi year slide presentation to Officers & Directors to communicate the 1992 Executive Plan, a staff member uncovered the fact that data on underwriting results, when segmented between CR and non-CR has been inconsistently reported. In the "Black Book" - considered the financial "bible" & used as the basis for the rate filings results differ significantly from results given by the Actuarial area (& I have been told, are reported in Schedule S of the Annual Blank).

	1989 ($ millions)		1990	
	"Black Book"	Actuarial (Sched S)	"Black Book"	Actuarial (Sched S)
CR	$20.0	($23.7)	$(19.8)	$(27.8)
GR	(21.0)	22.6	38.1	46.0
Healthnet	(36.7)	(36.6)	(19.5)	(19.4)
TOTAL	(37.7)	(37.7)	(1.2)	(1.2)

The differences were so significant they required clarification. My staff member went to V.P. - Director of Actuarial area. When shown the data, V.P. within awe - Director explained the "Black Book" was for internal use & the other numbers were for external publication - Boyle pressed for a better explanation. Director said to see the Corporate V.P. + CFO. On 2/3 late in the day (5:30 p.m.) I went with my staff person to see J. Bergsman. When shown the facts, he clearly said the Black Book numbers are right but the other numbers are more politically acceptable. He also said the "manipulated" numbers are filed in the annual blank as

Schedule 5. I asked if A.A.C. knew what was happening & J.W. said yes.

Oct 9:00 AM 2/4/92 I confronted A.A.C. with this issue. He indicated lack of knowledge of this situation. Said he needs to find out which numbers are right. Indicated we should look at the allocation of investment income (not an issue here since these are unbenefitting losses/gains only, no allocation of I.I. has been done). Asked me to go in & audit the numbers top to bottom. I said I could not do that — need significant staff & time to accurately trace all data. He then asked for client specific loss ratios, etc. He also tried to call J. Wilson, to discuss this issue w him. But, J.W. was not in. Sal claimed no knowledge of the situation; said he didn't believe any of the numbers (term he used "jelly"); and was very dissatisfied.

Subsequent to that meeting to my knowledge no action has been taken to correct the problems.

I specifically asked A.A.C. about the impact this situation will have on the 1992 recommended goals which are also split between CE & non-CE & mentioned the concern with misreporting which could lead to unjust enrichment of the Officers & Directors. He said that would not be allowed.

PREPARED STATEMENT OF MR. FUESSLER

Good morning, Mr. Chairman and other Members of the Subcommittee. My name is Bill Fuessler and I have been subpoenaed to testify today concerning my employment with Empire Blue Cross and Blue Shield.

I am a 1979 graduate of Adelphi University, with a bachelors degree in Accounting. Upon graduating, I was employed by Peat Marwick in its auditing department. While I was employed there, I became a Certified Public Accountant. For the last year and a half at that firm I was working as a consultant in their consulting division.

In December, 1985, I joined Metropolitan Life as a manager in their Corporate Control Department. I spent approximately 2 years there and in February of 1988 I joined Ernst and Young's insurance consulting practice. A year later was promoted to become a Senior Manager and worked on insurance industry related issues.

In May 1990, I joined Empire. My position was Director, Office of the Chairman. I reported directly to Mr. Cardone and was responsible for various non-systems related corporate initiatives and special projects.

In October 1991, Joan Boyle was hired, first as a consultant and later as an Empire employee and I began to report to her. At that time, some of the special projects that I was working on related to budgeting issues, HealthNet and detailed sales reporting.

Some time in late January or early February 1992, I was putting together a presentation to be made to the Empire Board of Directors. In the course of doing this, I reviewed a number of financial schedules and noticed a discrepancy between a schedule summarizing results sent to the Department of Insurance and an internal schedule maintained by the Plan. Attached as Appendix A is a document I was provided by this Subcommittee's staff entitled "Empire Blue Cross Blue Shield—Underwriters Results—1978-1991 ($Thousands)". This document was prepared by the Actuarial Department and summarizes certain financial data that is provided to the New York Insurance Department. The internal schedule I had reviewed was part of the monthly internal financial reports commonly referred to in the Plan as the "black book".

The discrepancies I noted dealt with losses reported in the experienced rated and community rated lines of business. At that point in time, I prepared a handwritten table showing these discrepancies. Shortly thereafter, my table was typewritten. I was given a table by the staff, which appears to be a copy of this table. It is attached to this statement as Appendix B.

I recall that when I was preparing the presentation for the Board, the financial data for 1991 had not been finalized. I was looking at the finalized 1989 and 1990 data when I noticed the discrepancies.

I felt these discrepancies were important enough to ask the Actuarial Department to give an explanation. I spoke with Sharon Schmerzler and her immediate supervisor David Sanders who worked in the Actuarial Department. I asked them about this discrepancy and they told me that they would get back to me as soon as possible. Approximately a day or two later, I received a call to see them and when I went to see them they told me that they agreed that there was a discrepancy but that I would have to see Jerry Weissman for an explanation.

I immediately went back to my office and spoke to Joan Boyle and told her about this discrepancy and my conversation with the Actuarial Department. Ms. Boyle indicated that we needed to get an explanation.

Shortly thereafter she arranged a meeting with Jerry Weissman at which time we presented the two schedules and noted the discrepancies and asked him to explain the difference. Mr. Weissman agreed that there were different numbers and said that it was politically more beneficial to show the numbers that way.

When pressed for an explanation on why there were two different numbers, Mr. Weissman said "you need to talk to Al". Upon leaving this meeting, Ms. Boyle immediately set up a meeting with Al Cardone.

Before the meeting, Ms. Boyle told me that she would rather go and see Mr. Cardone by herself. She explained that "it may get messy" and she was worried that it would jeopardize my career at Empire.

Within five minutes of the beginning of the meeting, I was summoned by Mr. Cardone's secretary to join them. At the meeting was Mr. Cardone, Joan Boyle and myself. Mr. Cardone asked me what I had found. I explained the schedules to him, noted the different numbers. My best recollection is that Mr. Cardone stated that "you can't trust any numbers around here" and that "I don't know which numbers are right and neither do the two of you". We concluded the meeting with Mr. Cardone recommending that Ms. Boyle and I do a profit/loss analysis on the National

Account business. I do recall that Mr. Cardone appeared to be upset during this meeting.

Approximately one month later, on March 17, 1992, I was called into Mr. Cardone's conference room. At that time, I was told that effective immediately, I had a new assignment as Director in the Incentive Rated Sales Division. In particular, I would be in charge of underwriting and finance issues. I had not requested a transfer. I also had no background in underwriting. I was not surprised by the transfer since Joan Boyle had informed me shortly before this date that Mr. Cardone was going to transfer both of us to sales.

Upon being transferred, I moved with Ms. Boyle to another building outside of the headquarters building. At that time, Joan Boyle and I were the only Incentive Rated Sales Division employees in that building. Subsequently others joined us.

Since I was transferred in March 1992 to my new position, I did not complete the presentation material for the Board nor the profit and loss analysis. I do know the presentation was completed. I do not know what, if any, numbers were utilized in that presentation. I do know the profit/loss analysis was done, but I do not recall the results.

About mid-October 1992, I voluntarily left Empire. I am presently employed in a consulting capacity to the insurance industry. Before leaving, I recall two other instances in which the discrepancies in the numbers came up. I recall one meeting at which time Jerry Weissman asked me if I had talked to Al Cardone about the discrepancy. He wanted to know what Al said. I told Mr. Weissman that Mr. Cardone did not have a satisfactory explanation for the discrepancies and had asked for a profit/loss statement. I do not recall what, if any, response Mr. Weissman had to that.

On another occasion, after an Officers and Directors Meeting, I attended the reception. Joan Boyle was also in attendance at this reception. I recall a number of employees joking about the fact that the Plan had two sets of numbers.

I will be happy to answer any questions you may have for me at this time.

APPENDIX A

13-Jan
01:58 PM

EMPIRE BLUE CROSS BLUE SHIELD
----UNDERWRITING RESULTS-----
1978 – 1991 ($THOUSANDS)

YEAR	DIRECT PAY			COMMUNITY GROUP			EXPERIENCE RATED	GRAND TOTAL
	REGULAR	SENIOR CARE	TOTAL	REGULAR	HEALTHNET	TOTAL	TOTAL	
1978	($1,857)	$7,177	$5,320	$28,764	$0	$28,764	$3,267	$37,351
1979	(5,112)	(287)	(5,399)	(6,679)	0	(6,679)	7,416	(4,662)
1980	1,256	(5,051)	(3,795)	(66,833)	0	(66,833)	12,205	(58,423)
1981	(25,613)	(12,834)	(38,447)	(14)	0	(14)	10,638	(27,823)
1982	(16,044)	(16,528)	(32,572)	19,161	0	19,161	2,401	(11,010)
1983	(22,962)	(11,443)	(34,405)	37,852	0	37,852	16,468	19,915
1984	(30,218)	(16,574)	(46,792)	59,994	0	59,994	18,554	31,756
1985	(37,589)	845	(36,744)	(10,008)	0	(10,008)	(492)	(47,244)
1986	(42,714)	(14,719)	(57,433)	(57,685)	(20,268)	(77,953)	(18,186)	(153,572)
1987	(33,252)	(26,322)	(59,574)	(64,506)	(17,157)	(81,663)	23,208	(118,029)
1988	(13,967)	(33,939)	(47,906)	24,067	(22,380)	1,687	29,547	(16,672)
1989	(38,819)	6,735	(32,084)	8,418	(36,649)	(28,231)	22,629	(37,686)
1990	(7,540)	(3,114)	(10,654)	(17,150)	(19,427)	(36,577)	45,992	(1,239)
TOTAL	($274,431)	($126,054)	($400,485)	($44,619)	($115,881)	($160,500)	$173,647	($387,338)
1991 (P)	(79,900)	(77,000)	(156,900)	(15,400)	(7,600)	(23,000)	(33,000)	(212,900)

* Prior to 1985 the results reflect Blue Cross Blue Shield of Greater New York only

APPENDIX B

	1989		1990	
	Y/E Financials	Actuarial	Y/E Financials	Actuarial
Community Rated	$20.0	($23.7)	($19.8)	($27.8)
Experience Rated	($21.0)	$22.6	$38.1	$46.0
HealthNet	($36.7)	($36.6)	($19.5)	($19.4)
Total	($37.7)	($37.7)	($1.2)	($1.2)

PREPARED STATEMENT OF MR. MORCHOWER SUBMITTED JUNE 25, 1993

Mr. Chairman and Members of the Subcommittee: My name is Donald Morchower. I am the Executive Vice President and Chief Operating Officer of Empire Blue Cross and Blue Shield, and I am serving as Acting Chief Executive Officer until a permanent CEO is selected by the Board of Directors. With me today to testify on behalf of Empire are Harold E. Vogt, Chairman of the Board of Directors, and Maroa Velez, Vice President for Internal Auditing. I would like to thank the Subcommittee for affording Empire this opportunity to testify about its financial condition operating practices and the situation in which it finds itself today.

Empire is the largest not-for-profit health insurer in the nation, with eight million customers and some 9,000 employees. It offers a variety of individual and group hospital and medical products as well as a health maintenance organization and a point-of-service product to the residents of its operating area, the 28 counties of eastern New York State. In addition, Empire is the fiscal intermediary for Medicare Part A in New York State and the carrier for Medicare Part B in 16 counties of lower New York State.

Both its size and the unique role it plays in New York State and the nation as a whole make Empire of crucial importance to the health care financing system. Significant changes in that financing system during the last decade, as well as the uncertain prospects of national and local reform efforts, have combined to produce the most serious strategic challenge that Empire has faced during the course of its almost 60 years of existence as a health insurer. In order to understand the important issues facing Empire and, indeed, the entire health care financing system, I will focus for a few minutes on the company's mission, its operating practices, and the recent events that have brought it into the public eye.

From its origins in the early 1930s, Empire has never departed from its early vision of health insurance as an essential service to which all Americans should have access. As its Statement of Corporate Purpose puts it, Empire's major aim is

> to establish, maintain and improve efficient programs for non-profit health care financing by providing through the private, voluntary system the best possible coverage for the largest possible portion of the self-sustaining population on the most cost-efficient basis.

In practice, this has meant a long-standing commitment to the principles of open enrollment and community rating. Under open enrollment, all who desire insurance are afforded access to it regardless of their age, their sex, where they work or live and their actual health status; under community rating, premiums are set at the same level for every purchaser of a particular policy. Over the years, these principles have enabled Empire to spread the costs of health care widely among a large population and thus insure a far broader proportion of the residents of its operating area than would otherwise have been the case. The creation of broad risk pools is at the very heart of an equitable and effective health care financing system, and Empire has played a major role in establishing that concept and helping to keep it alive amid a host of commercial insurers dedicated to a vision of health insurance as a vehicle for profit.

Naturally, in a highly competitive marketplace in which its competitors have always operated on very different principles, Empire has, over the years, been forced to modify its methods of operation in order to carry out its social mission effectively. In the 1950s, for example, intense commercial competition forced Empire to utilize experience rating for its larger group customers, setting their premiums solely on the basis of the health care utilization of their employees rather than on that of the entire community of covered persons. By successfully retaining the business of large employers in this manner, Empire was able to use the surplus generated by their accounts to subsidize the premiums of its smaller group and individual customers in order to preserve the principle of broad risk sharing and the wide dissemination of access to health insurance among the general population.

It has, nonetheless, always been the case that Empire's competitors have been able to attract the best, that is, the lowest-risk, customers in the company's community pools by offering them coverage at lower premiums than those possible under a community rating methodology, which bases its prices on the average utilization of both higher- and lower-risk groups. Naturally, Empire has attracted the highest risk groups and individuals, for whom insurance was largely unavailable elsewhere. In such a situation, more than goodwill and adherence to socially useful principles has been required to make Empire's approach effective. What has been required is an offset to the substantial advantage enjoyed by commercial insurers as a result of medical underwriting i.e., the selection of customers on the basis of risk.

The requisite competitive advantage was provided through New York State's hospital reimbursement law, which controls payments for inpatient services to hospitals located in the State. This statute, known as the New York Prospective Hospital Reimbursement Methodology (NYPHRM), provides that Empire and other not-for-profit issuers pay cost-based rates and that their for-profit competitors pay the cost-based rates plus a "differential" (an add on) that reflects the State's public policy decision to encourage those insurers that provide coverage to the worst risks and undertake other important initiatives.

By providing this differential, which translates into lower premiums for their customers, the State gives Empire and other not-for-profit companies a means of retaining the business of larger and more profitable employer groups. The gain on those accounts has been used to subsidize the premiums of higher-risk and more expensive small group and individual customers. This has had the effect of making insurance more widely available than it would otherwise be and has allowed Empire to continue its policies of open enrollment and community rating for more than a million customers.

It is important to stress that Empire also must bear significantly enhanced statutory and regulatory burdens as a result of its status in New York's health financing system. Premium increases in Empire's community-rated pools must, for example, be approved by the Superintendent of Insurance after thorough public hearings, a degree of scrutiny to which no commercial insurer is subjected. Empire is, in addition, severely restricted as to the type of business it can engage in; for example, it is not authorized to offer life insurance or pay broker commissions, restrictions that place it at a significant competitive disadvantage. Finally, the company is subject to a considerably augmented degree of State financial supervision and oversight, including tight controls on investment and reserve policies and stringent periodic audits. I do not mention these burdens in order to complain about them, but rather to point out the degree to which Empire is, inevitably, in the public eye and the extent to which all of our operations are scrutinized by responsible and, on the whole, effective public bodies operating in the public interest.

Traditionally, Empire's ability to keep its community pools functioning and thus to offer insurance to all small groups and individuals who desire it was, to a large degree, dependent on the inpatient hospital differential. But the value of the differential and its usefulness in offsetting the risk selection practices of commercial insurers declined substantially during the 1980s and early 1990s.

The differential was as high as 30 percent in the late 1970s, but was reduced by law to its current level of 13 percent in the years following 1983. In addition, commercial insurers are offered a 2 percent discount for fast payment of hospital bills, a discount which they often appear to take even in circumstances that do not justify it. HMOs, many of which now operate on a for-profit basis, also have become entitled to the full differential, even though few of them over the years were willing to employ the non-discriminatory underwriting practices that have distinguished Empire from its competitors.

Further contributing to the decline of the value of the differential was the shift of medical services from the inpatient setting to outpatient facilities. Since, in Empire's operating region, inpatient hospital services account for no more than 35 percent of the total costs of a group's health care bills—and this percentage continues to decline—the 13 percent differential is, in reality, worth no more than 4 to 5 percent on an employer group's combined hospital and medical coverage.

The 1980s also saw an intensification of commercial competition for the best health risks under conditions of stagnating insurance markets and continually rising costs of health care. In order to maintain profits, commercial insurers found it necessary to "raid" the pools of other insurers and gradually to tighten insurance underwriting restrictions to ensure that they would attract healthy customers only. For most insurers, competition was based on the ability to avoid, rather than spread risk and efficiently manage it.

Empire's community pools, whose premiums are determined, as I noted earlier, by averaging the experience of high and low utilizers, were, unfortunately, an ideal target for commercial insurers who were able to offer lower prices to healthier groups while avoiding less healthy groups. Those insurers utilized the full array of socially undesirable practices with which we have become all-too-familiar: strict medical underwriting, industry blacklisting, and geographical redlining, which resulted in what has become known for excellent reasons as the "cherrypicking" of good risks.

At first, commercial insurers targeted the medium-size groups in Empire's community pools, those with between 50 and 250 employees. In order to counteract their efforts, the company was reluctantly forced in 1986 to emulate, at least partially,

the methodology it had used in the 1950s to preserve its largest groups. It created a new pooling process, known as "incentive rating," under which the premiums of groups with between 50 and 250 lives were determined by blending the actual experience of the individual group and the average experience of the wider community of groups in its size band. Incentive rating was intended to allow Empire to offer more competitive premiums to its lowest-risk medium-sized groups without raising the rates of groups with worse experience to unaffordable levels. At the same time, operating surplus from these groups, who no longer formed part of the general community pools, would be used to subsidize the rates of individual customers and the smallest groups—those with fewer than 50 members—who did remain in the pools. Thus, an appropriate manner of continuing community rating for those most in need of it was once again found.

As the 1980s proceeded, however, ever-more sophisticated techniques for risk-avoidance allowed commercial insurers to set their sights on the smallest groups, those with 50 or fewer members. By the late 1980s, the coincidence of the intensification of ordinary commercial profit-oriented practices and the decline of the value of the differential—the major tool enabling the not-for-profit sector to offset such practices—created a major crisis for Empire. The best groups in its remaining community pools were skimmed away, leading to a spiral of increased community pool premiums over and beyond those that would have been required in any case by the medical cost explosion of those same years.

Even with increased premiums, the company's underwriting losses in its community lines of business grew substantially as well, since an increasingly sick customer base naturally required larger and larger amounts of health care. Nor, finally, could surplus gained from coverage of the larger employer groups entirely make up for these trends. It was precisely during this period that more intense competition for that business and the growing tendency of groups to self-fund their coverage—and thus entirely remove themselves from the wider risk pools—substantially reduced the company's ability to realize operating surpluses in those markets in order to subsidize smaller groups and individuals.

Empire's adherence to its mission was costly indeed. The loss of a considerable proportion of the best customers in its community markets, the resultant large underwriting losses in its community pools, and the deferral or denial of needed rate increases, produced a continuous drain on the surplus funds of the company, its so-called statutory reserve. By the end of 1992, the statutory reserve fund had reached dangerously low levels. The causes of its decline—as confirmed by an independent management audit commissioned by the State—lay in Empire's adherence to its social mission, while competitors attracted low-risk customers and shunned the high-risk, for whom Empire was the only source of insurance.

The company was, therefore, faced with a critical situation by the early 1990s, to which only two solutions were possible: either Empire could abandon its long-standing traditions of community rating and open enrollment, or it could attempt to change the rules by which other insurers competed for business. True to its social mission, Empire chose the latter course. To this end, it was instrumental in creating a state-wide coalition of not-for-profit insurers, groups representing people with chronic illness, state agencies and progressive legislators, and concerned members of the insurance-purchasing public. This coalition was responsible for the passage in mid-1992 of a wide-ranging community-rating and open enrollment bill that has completely altered the conditions under which health insurance is sold to individuals and small groups in New York State. Recent allegations that debate over this landmark legislation was seriously affected by discrepancies in Empire's financial reporting should not be used to undermine a significant bi-partisan legislative effort, which today is being considered as a potential model for national health care financing reform.

Under the new law, which went into effect April 1, 1993, and is the most thorough-going of its kind in the nation, all insurers selling to individuals or groups with fewer than 50 members must offer coverage to anyone who applies for it and pays the premiums. Premiums must be set on the basis of strict community rating, with adjustments allowed only for differences among reasonable geographical regions and for family coverage versus single person coverage. In addition, minimum standards for loss ratios are imposed, the use of preexisting condition clauses is restricted, and the cancellation of policies due to the experience of a particular group is prohibited.

Finally, and of particular importance, demographic and large claims pools are created to which carriers with lower-than-average age composition and relatively small numbers of very expensive cases contribute, and from which those with larger numbers of large claims and higher-than-average age composition draw out funds. The

pools are, initially, meant to ensure that carriers, such as Empire, that have traditionally used open enrollment and community rating, and therefore have older and sicker customers in their pools, do not remain at a serious competitive disadvantage. For the future, it will help to ensure that no carrier suffers unduly from the random effects of adverse selection or from potentially anti-competitive practices on the part of other insurers. Taken together, these provisions of the new law should have a salutary effect on Empire's community pools and the company's financial position, as well as on the market for health insurance in New York State in general.

I have stressed Empire's adherence to a beneficial social mission and the events that have led to its recent fiscal crisis precisely because it is important to understand that crisis in its proper context. It is especially necessary to do so at the present time, when a combination of circumstances has led to the recent barrage of allegations leveled against Empire.

Although the most significant charges of fiscal misconduct, extensive waste, and lavish corporate spending have little to do with the real cause of Empire's financial problems, they have fed on the reality of the large losses incurred in the community lines a of business and the company's need to raise premiums significantly over the last few years. Many find it easier to believe that Empire has squandered its customer's resources than to understand the structural problems created by Empire's fidelity to its mission in a marketplace that had become inhospitable to that mission. In addition, commercial insurers and others opposed to the State's landmark community rating and open enrollment law continue to accuse Empire of mismanagement despite the facts.

These factors have led to the intense and unprecedented public scrutiny under which Empire had been operating for more than two years. In 1993 alone, Empire has actively cooperated in audits and investigations conducted by: (1) Empire's independent outside public accounting firm; (2) the New York State Insurance Department, carrying out its triennial financial audit; (3) Arthur Andersen & Company, conducting a management audit, mandated by the State Legislature, under the supervision of the Insurance Department; and (4) this Subcommittee, which has been looking at the finances and business practices of several Blue Cross and Blue Shield Plans.

These inquiries, the internal reviews they triggered, and the media scrutiny that run parallel to them, have brought many issues to light, not all to the credit of the corporation. Some decisions, in hindsight, should not have been made; others seemed correct at the time but did not turn out as hoped, a problem of all human endeavor. Others represent policy issues and decisions about which reasonable people will always disagree to some extent. And a few clearly suggest that Empire has failed to live up to its own high standards of efficiency and sound business practices.

About these we are deeply concerned, but I believe the record must reflect that such failures do not explain the financial crisis from which the company has already begun to recover. In fact, the thorough management audit carried out by Arthur Andersen found no evidence to substantiate the charges of excessive spending, salaries and perquisites or mismanagement leveled against the company.

This is not to say that Arthur Andersen had no criticisms to make of Empire management: in fact, that audit report made 120 separate recommendations for change. As a result of that audit, and issues raised by this Subcommittee and others, Empire's Board of Directors, in conjunction with management, have recognized that new directions are necessary in areas of corporate governance and operations and that a variety of problems, especially in the area of customer service, must be resolved. We have already delivered to the Superintendent of Insurance our response to the audit report and we have begun implementing almost all the Arthur Andersen recommendations.

Apart from the business issues addressed by Arthur Andersen, there have been more sensational allegations highlighted in media coverage of Empire, and I am sure we will be dealing with some of them as your questioning proceeds today. However, I would like briefly to make just a few points at this time.

Empire has, above all, been accused of administrative waste. Yet the truth is that Empire's administrative costs—its expense ratio—at less than 8 percent of premium, is already among the lowest of any health insurer, including other Blue Cross and Blue Shield plans. In terms of absolute dollars, Empire spent less in 1992 than in 1991. With respect to salaries and travel and entertainment expenses the issues most easily understood and most easily misconstrued by the public, Arthur Andersen determined that compensation was reasonable and "T&E" policies so tight that the company might even be harming its own capacity to win new business in a highly competitive marketplace.

Let me also touch on the issue of corporate leadership, which Mr. Vogt will also address on behalf of the Board. The main focus of public criticism of Empire was aimed at Albert A. Cardone, until recently Empire's Chairman of the Board and Chief Executive Officer. Those of us who worked with Mr. Cardone are aware of his tireless effort on behalf of Empire and his many accomplishments, but it is also clear that his leadership produced mixed results. For example, his successful but bruising campaign to pass the state's new community rating and open enrollment law undermined his relationships with many outside of Empire.

For these reasons, on May 19 of this year, Empire's Board of Directors felt it necessary to accept Mr. Cardone's resignation. Since then, the Board has strengthened corporate governance, further enhanced its already active role in the company's policy, financial and operational decision-making, streamlined management, and begun the process that will soon lead to permanent replacements for the two positions of Chairman of the Board and Chief Executive Officer.

Just as these positive steps were being taken, a major new problem emerged. Empire announced that an internal inquiry ordered by Mr. Vogt and me revealed that filings made with the New York State Department of Insurance misstated information. While these filings did not change the presentation of the financial condition of the corporation, the erroneous filing did misstate the operating results of particular market segments. The day this was discovered, we advised both this Subcommittee and the New York State Superintendent of Insurance.

We do not believe, despite reports to the contrary, that the inaccurate reporting led to inflated rates for any customer, and the Superintendent of Insurance has concurred in this. Nor do we believe that it affected our audited financial statements, but it obviously raised serious problems of credibility for Empire. The Board of Directors has retained Otto Obermaier, formerly the United States Attorney for the Southern District of New York, to oversee an investigation of this issue, and the results will be made public as soon as possible. The issues are too new for us to make conclusive statements at this time.

Despite this distressing development, I strongly believe that we are in process of taking the steps necessary to restore our reputation with the public and move beyond the present period of crisis to reinstate our leadership in a rapidly changing health insurance marketplace.

As to our finances, our capital (that is, surplus) has risen to over $200 million, up from $40 million at year end 1992. The salutary effects of the reform of the small group and individual markets are beginning to make themselves felt, as Empire's product offerings for small groups are now highly competitive on price. Clearly Empire has a long road ahead of it before it can fully regain financial stability and declare its crisis ended, but Empire's Board of Directors and management know what must be done and are firmly committed to doing it as rapidly as possible.

Mr. Chairman, we at Empire very much respect the intent of these hearings to ensure that the nation's largest not-for-profit health insurer is operated in a responsible and efficient manner. We believe that your Subcommittee deserves credit for focusing attention on the problems facing Empire and the not-for-profit health insurance sector.

To that end, we have attempted to cooperate with your investigation as fully as possible by making all documents requested of us available to you on a timely basis and by making Empire employees available for interviews prior to these hearings. We hope that we can continue to work with you and with all other concerned parties to restore Empire's public credibility and trust, and enable it to play the major role that its history and its resources make it so well-suited for in the coming era of health care reform.

I would be pleased to answer whatever questions you have.

PREPARED STATEMENT OF MR. CARDONE

Senator Nunn, other Committee Members and Staff, good morning. I appreciate the opportunity to appear before the United States Committee on Governmental Affairs Permanent Subcommittee on Investigations.

I served as Chairman of the Board and Chief Executive Officer of Empire Blue Cross and Blue Shield ("Empire") from April 16, 1987 to May 19, 1993. Prior to joining Empire as Deputy Chairman in July 1985, I was a partner at the International Public Accounting Firm of Deloitte Haskins and Sells, now Deloitte and Touche, where I had the position of National Industry Director for that firms national health care practice.

I left my partnership at Deloitte to join Empire at their invitation. Before joining Empire, those Empire Directors involved in my recruitment informed me of the importance of Empire's mission which, simply stated, is to provide quality health insurance to as many people as possible. Those Directors realized the importance of Empire as the insurer of last resort to hundreds of thousands of New Yorkers and wanted to be assured that if I was selected—I would do all that I could to preserve the Corporation's noble mission. During my tenure at Empire, I always placed the highest priority on fidelity to Empire's mission of providing health insurance to as many people as possible regardless of their health status, the industry they worked in, or any other discriminatory factors.

As I reflect upon 1985, Empire was being attacked on many fronts. First, there was the movement of large groups toward self-insurance. In New York, it was especially advantageous for large groups to assume the insurance risk themselves, as they could avoid the cost of providing State mandated health benefits to their employees. Next, New York State was encouraging growth of HMO's by extending to them (regardless of their profit or not for profit status) Empire's statutory advantage of paying hospitals a cost based payment rate that was less than that paid by other payers. Of course these HMO's immediately set out to attract Empire's good risk business. In addition, Empire's customers were demanding more products and services from the Company than ever before. Empire's non-group, or individual, customers (that is the customer population that has the most difficult time obtaining health insurance in most states other than New York), were dissatisfied with the products made available to them—hospital only, or hospital and basic medical coverage—and wanted the broader major medical insurance products that were offered to group customers. Empire satisfied their requests and started offering major medical policies to individual customers in late 1986. From a societal point of view, that decision was a good one. From an economic point of view, it strained the Company's financial resources as individuals stricken with catastrophic illnesses such as AIDS, Cancer, Heart Disease or chronic illnesses (like diabetes and multiple sclerosis), or organ transplants, purchased Empire's major medical products. Notwithstanding those challenges and financial burdens that no other competing insurer would undertake, Empire added in excess of $100 million to its capital for the three years ended December 31, 1990 by more than offsetting underwriting losses on its community rated business with investment income and gains on its experience rated business.

In early 1991, Empire started to experience unprecedented losses on its community rated lines of businesses—due to a practice that is commonly referred to as "cherry picking." In addition, Empire noticed that its competitors were selectively avoiding customers who were high consumers of health care, or poor risks, and were suggesting that they purchase an individual major medical policy from Empire as an individual customer. We came to refer to that practice as "dumping."

It was the combination of both the cherry picking and dumping practices that occurred during 1991 and 1992 that caused Empire's widely publicized $250 million in losses. In fact, Empire was able to partly offset even greater community rated losses by investment income and profits on its other, highly competitive—experienced rated medium and large group businesses. At the end of 1992, Empire's capital stood at $40 million. However, while it lost approximately $250 million of its financial capital, it WON a major legislative victory that should ensure its financial survival and ability to be faithful to its mission for the future. It is also important to note that Empire's reserves had climbed to $206 million at the time I left Empire, an amount over 12% higher than its capital position when I became CEO and Chairman in 1987.

During this same two year period (1991 and 1992), while Empire was being unfairly competed against as its competitors skinned off its community rated, small group, good-risk, profitable business and used Empire's open-enrollment community rated pools as a dumping ground for their poor risks, a very important—and historic

battle was heavily waged in the New York State Legislature. The battle was over whether all insurers who sell health insurance to small groups (up to 50) and individuals should be required to do so on a community rated basis and no longer have the ability to discriminate against and deny coverage to anyone on the basis of health status, age, employment and other factors. (We refer to this as open enrollment.) By community-rated basis, I mean that the price charged for a specific policy cannot vary because of a person's age, medical status or any other discriminatory factor, that is the price is determined on the basis of the overall community pool's experience and not the experience of any particular individual or group within the community pool. Therefore, a uniform price is charged to all customers regardless of their age, health history, present health status, where they work, if they work and where they live. Last July, New York State passed the law that mandates community rating and open enrollment for small group and individual health insurance. This legislation was enacted with the support of numerous groups representing a wide array of citizens confronting the devastating costs of dealing with serious illness and was opposed almost exclusively by commercial insurance interests. A listing of those who wrote to the Governor regarding the bill, together with some of the supportive letters, is attached.

During that legislative battle, Empire did all it could to obtain the necessary reform to New York State's Insurance law. Those opposed to this reform, accused Empire of mismanagement and said that the reforms were not needed. To satisfy those voices, the law that was finally enacted in July of 1992, with an effective date of April 1, 1993, contained a requirement that Empire be subjected to an independent financial and management audit and that the causes of its losses be ascertained. In October of 1992, the firm of Arthur Andersen & Co. was selected by the New York State Department of Insurance to perform an independent financial and management audit. I believe a copy of that report has been furnished to the Subcommittee. Arthur Andersen & Co. have reported that indeed Empire's losses were in its community rated lines of business and were caused by the very, conditions (cherry picking, dumping) that the Community Rating law sought to correct. specifically, Arthur Andersen concluded that: "Empire's annual administrative expenses over the past three years have been fairly stable and reasonable given the overall environment in which it operates"; (ii) that "the number of Empire's officers and their compensation is reasonable"; and (iii) that "Empire's travel and entertainment policies are stringent and the level of expenses are reasonable." That report also concluded that "administrative costs are not the cause for rising insurance premiums" but rather, "the main causes for premium rate increases have been the dramatic rise in the cost of healthcare and the increased utilization of healthcare benefits by subscribers remaining in the community rated pool." Andersen also confirmed what Empire had known for some time:

> Empire's Community Rated pool has deteriorated in recent years as a result of natural flight and cherry picking, a practical business technique of the Company's competitors. The fact that Empire's subscribers use more healthcare services than other insurers' subscribers, puts strong upward pressure on premiums. This can be clearly seen when comparing the loss ratio of those groups that have left Empire in recent years versus those that have stayed in the pool.

I was not surprised by Arthur Andersen's conclusions and that Empire's administrative expenses were reasonable and not the cause of Empire's losses. Empire had previously engaged the independent consulting firm of Booz, Allen, Hamilton & Co. to study Empire's administrative costs and that firm also concluded Empire's Administrative costs were reasonable. Empire's administration costs are about 7%, which means that only 7 cents of every premium dollar is spent on administrative activities like claims processing, customer services, marketing, sales, product development, legal, accounting, etc.; that 7 cents compares very favorably to Empire's competitors—who spend 20–25 cents on administrative activities—and also is at the low-end of the other Blue Cross and Blue Shield Plans across the nation.

Considering that the Arthur Andersen study cost New York State $2.1 million to perform, I hope we can spend our time today on the very important issues of health insurance regulation and reform. In that regard I was very pleased to read in Arthur Andersen & Co.'s report that they also feel, as I do, that additional reform is necessary in order to achieve a level, competitive playing field in New York. Specifically, there is a need to require that any health insurer who desires to sell health insurance in New York be required to sell to all market segments. This proposal is referred to as the "all markets" reform issue. This would result in greater spreading among insurance carriers of the individual (generally poorer risk) population that is

avoided by most commercial insurers. To help keep the prices of individual polices affordable, all health insurers should be required to share in the extraordinary losses incurred by those insurers who presently must serve a disproportionate amount of the individual population. Governor Cuomo has proposed such reform in his 1993 health care proposal which is being debated in the Legislature at this time.

I had hoped that by this time, the Clinton Administration would have presented its National Health Plan that would have contained those very important principles of fairness like community rating, open enrollment and the requirement that insurers sell to all—and not strategically sell only to the profitable market segments.

I, on behalf of Empire, fought hard to eliminate "risk selection" as a basis for competition among health insurers and thanks to the enactment of the Community Rating/Open Enrollment law it is now illegal to compete on the basis of risk selection in New York State. Senator Nunn, time does not permit me to describe the evil employment practices that result from "risk selection," as employers avoid hiring people who are poor health risks because of their age, medical condition or history or other factors that hint at high consumption of health care resources. It is obvious to me that the present, legally allowable, in most states, practice of insurance competition based on the ability to select risk must be outlawed nationally if we are to start any meaningful regulation and reform of the healthcare industry. While it is unfortunate that we must wait a few months for the Administration's plan, your Committee has an opportunity to recommend to the Administration the kinds of reform to the health insurance industry, like Community Rating, Open Enrollment and the All Markets concepts, that go a long way toward making health insurance both accessible and affordable to all Americans.

Empire Blue Cross has been faithful to its mission of providing health insurance to all, for 58 years and were it not for Empire's legislative initiative, New York State would have many more uninsured citizens than it presently does. In addition, had Empire ceased to be faithful to its mission of providing insurance to individuals and small group customers on an open enrollment community rated basis, New York State would have been burdened by additional costs, of approximately $900 million a year. This $900 million estimate was calculated by independent consultants on behalf of the New York State Conference of Blue Cross and Blue Shield Plans. As aptly described by an official in New York responsible for the Medicaid Program, Empire, a private not-for profit corporation, serves as a safety net for thousands of New Yorkers; if the Empire net breaks, the only remaining safety net would be the Medicaid net—that is already badly strained.

Empire offers a prime example of how community rating with open enrollment can work for the benefit of all Americans. Presently, New Yorkers—regardless of their age or medical condition are able to purchase health insurance at prices that compare favorably with those in other metropolitan areas, *except that New Yorkers need not fear being unable to obtain* insurance because they have a serious illness, have recovered from a serious illness, or at grave risk of a serious illness.

Having fought for Community Rating/Open Enrollment in New York State on Empire's behalf, and contributed to a significant legislature victory, I hope that New York law remains alive. In that regard, there are those who already are suggesting repeal of the community rating, open enrollment law that just became effective April 1, 1993. Senator—you and your Committee could help if you used your investigative capability to tell the real Empire story of a company that has carried out its mission of providing health insurance to all—despite lack of a level playing field—and how critical insurance regulation and reform is to achieving the goal of making broad coverage, affordable, health insurance available to all.

I realize that you are keenly interested in the subject of whether the regulation required to reform the health insurance industry should be nationally or State determined and administered. Based upon my experience, it is clear that national guidelines are needed that apply to all states. Frankly, state regulators, and legislators are not a fair match for the powerful special interest groups that presently have a vested financial interest in preserving the profitable status quo in the health insurance industry. Their weapons—like threats to move jobs out of state combined with their ability to mobilize the segments of the population who would have to pay more for health insurance under community rating because they are presently good risks—make it extraordinarily difficult for a state to do the job that has to be done. New York State—with Empire's help—took a giant step last year and already opposing forces are gathering to repeal the reforms that were enacted. For these reasons, I urge you to do all you can to bring about national guidelines for health insurance that I have discussed.

As Chairman of the Board and CEO of Empire, for the last six years, I had the privilege of fighting for fairness in health insurance and am proud of what has been

accomplished. In this context, I also think it appropriate for me to firmly advise this Committee that all of the recent, highly publicized critical comments about me and my tenure at Empire are absolutely and unequivocally untrue, and are but another effort by special interests to discredit me and a fine institution which has been true to its noble mission and has been a safety net for thousands of New Yorkers, who would have been otherwise uninsured were it not for Empire.

I would be pleased to assist you and your Committee in any way I can to help bring about similar health insurance reforms on a National basis.

THOSE WHO WROTE IN SUPPORT OF THE COMMUNITY RATING LAW

1. Ann Aust
2. American Lung Association
3. State of New York Division for Women
4. Greater Rochester Metro Chamber of Commerce
5. Capital Area Community Health Plan, Inc.
6. Health Insurance Plan of Greater New York
7. The New York State Health Maintenance Organization Conference
8. New York State Conference of Blue Cross and Blue Shield Plans
9. United Cerebral Palsy Association of New York State
10. New York Public Interest Research Group (NYPIRG)
11. Gay Men's Health Crisis (G.M.H.C.)
12. Statewide Senior Action Council
13. Cancer Care Inc.
14. American Cancer Society
15. Hemophilia Association
16. National Multiple Sclerosis Society
17. New Yorkers for Accessible Health Coverage
18. New York State Nurses Association
19. Medical Society of the State of New York
20. State of New York Council on Children and Families
21. State of New York Office of Mental Health
22. State of New York Office of Mental Retardation and Developmental Disabilities
23. Consumer Protection Board
24. New York State Office for the Aging
25. State of New York Department of Law
26. State of New York Insurance Department
27. Division of the Budget
28. New York State Association of Counties (NYSAC)

THOSE WHO WROTE AGAINST THE COMMUNITY RATING LAW

1. Frank C. Perry
2. National Casualty Company
3. Nationwide Insurance
4. Maxine Caselbore
5. State Farm Insurance Company
6. New York Chamber of Commerce
7. Life Insurance Council of New York, Incorporated
8. American Council of Life Insurance
9. Health Insurance Association of America
10. Metropolitan Package Store Association Inc.

THOSE WHO COULD NOT GIVE RECOMMENDATIONS FOR OR AGAINST THE COMMUNITY RATING LAW

1. New York Department of State

American Lung Association of New York State

[illegible] Mountain View Avenue, Albany New York 12205-

Tel: 518/459-4197 Fax: 518/459-5604

"The Christmas Seal People"

July 8, 1992

The Honorable Elizabeth D. Moore
Counsel to the Governor
Executive Chamber
New York State Capitol
Albany, New York 12224

Dear Ms. Moore:

This letter is in response to your communication of July 7, 1992 concerning bill A. 12350A/Grannis.

The mission of the American Lung Association of New York State (ALA NYS) is the prevention, control, and cure of lung disease, and to that end, this organization advocates for effective public policy which furthers our mission.

ALA NYS is in support of A. 12350A as a means of increasing access to medical care for individuals with lung disease. I am including our memo in support of this legislation which further details ALA NYS position.

Please do not hesitate to contact me if you would like any further information regarding our position on A. 12350A.

Sincerely,

Martha McNeil
Director of Governmental Affairs

American Lung Association of New York State

5 Mountain View Avenue, Albany, New York 12205 Tel 518/459-4197 Fax 518/459-8601

"The Christmas Seal People"

MEMORANDUM IN SUPPORT/ A. 12350A - Grannis
COMMUNITY RATING/OPEN ENROLLMENT

AN ACT to amend the insurance law and the public health law, in relation to requiring that individual and small group health insurance be made available on an open enrollment basis; community rating of individual and small group health insurance policies; portability of health insurance coverage and continuation of hospital, surgical or medical expense insurance and making an appropriation therefor

The American Lung Association of New York State (ALA NYS) is a voluntary health organization whose mission is the prevention, control, and cure of lung disease. To that end, ALA NYS advocates for effective public policy which furthers the above stated mission. The American Lung Association of New York S... ...s the above mentioned bill.

As a health organization, ALA NYS is in favor of measures that will increase the number of individuals who have access to affordable medical care. Currently, millions of New York state residents have inadequate health insurance, and over 2 million have no health insurance at all. While some of this 2 million choose to be without health insurance, the majority simply find it too expensive. Two provisions of the above captioned bill would allow many New Yorkers better access to affordable health care: community rating and open enrollment.

Community Rating would replace the practice of experience rating which currently permits commercial insurers to select only the "good risks" and deny coverage to "bad risks." These "bad risks" include individuals with lung disease: emphysema, asthma, chronic bronchitis, and lung cancer. A 12350-A would require that commercial insurers doing business in the individual and small group markets base their premiums on the community rate. The community rate requires that every insurer charge the same rate for a policy in a wide geographic area without regard to subscriber's age, sex, occupation, or health status. Furthermore, commercial insurers would have to accept all individuals and small groups who apply for coverage.

The American Lung Association of New York State applauds the above two measures as major steps in solving New York state's health insurance crisis. Community Rating and Open Enrollment would increase access to care for many individuals by leveling the playing field among commercial insurers and Blue Cross/Blue Shield.

It is also pertinent to note that the American Lung Association of New York State is a non profit organization that offers Blue Cross/Blue Shield health insurance to its 19 employees. From an operational stand point, it would be quite difficult for ALA NYS to absorb a large rate increase by Blue Cross/Blue Shield.

The American Lung Association of New York State strongly supports A. 12350A and urges its swift passage by the New York State Senate.

SS C.501 A.12350

UNITED CEREBRAL PALSY ASSOCIATIONS OF NEW YORK STATE, INC.

President
T. KEVIN MENEILLY, ESQ
Executive Director
MICHAEL PARKER, PH.D.

155 Washington Avenue Albany, NY 12210 (518) 436-0178 FACSIMILE (518) 436-8619

July 17, 1992

Governor Mario M. Cuomo
Executive Chamber
State Capitol
Albany, New York 12224

RE: MEMORANDUM OF SUPPORT FOR ASSEMBLY BILL 12350, GRANNIS

Dear Governor Cuomo;

United Cerebral Palsy Associations of New York State support Assembly bill 12350 and request your approval of this important legislation.

This legislation is one of the first steps in a series of important health care reforms needed to make adequate health care coverage accessible and affordable for all New York residents.

UCP supports the provisions that require community rating for groups of 50 or less and hopes that community rating provisions are expanded to all groups as quickly as possible.

Other provisions of this legislation, including open enrollment and portability of coverage requirements, will begin to ease problems experienced by some individuals with disabilities and their families. Many other issues will need to be addressed in future legislation.

We laud the efforts of all who worked to reach the agreements necessary to allow this first and very important step in health care reform. We look forward to the opportunity to work with others on future proposals to assure appropriate health care services for individuals with chronic health care needs.

Sincerely,

Michael Parker /bat

Michael Parker, Ph.D.
Executive Director

JJ

C.501

July 10, 1992

The Honorable Mario M. Cuomo
Governor
State of New York
State Capitol
Albany, New York 12224

RE: A.12350-A/S.8978

Dear Governor Cuomo:

After months of deliberation, the New York State Legislature has passed A.12350-A/S.8978. I am writing to urge you to sign this bill into law.

Gay Men's Health Crisis (GMHC), in cooperation with a number of organizations representing those living with chronic illnesses and senior citizens, has advocated on behalf of this landmark legislation. The measure, by requiring open enrollment and community rating of individual and small group policies, will allow individuals living with HIV, or other illnesses, to obtain health insurance at affordable rates.

This bill, which originated as a Governor's Program Bill, will put an end to the insidious discriminatory practices of commercial health insurers. No longer will individuals be denied coverage because they, or a family member, are living with cancer, multiple sclerosis, or AIDS. No longer will insurance companies drop coverage of small businesses that employ individuals who face high medical costs. No longer will companies face blacklisting by insurers who do not want to write policies for occupations which are seen as "risky." This ugly form of discrimination, which should never have been tolerated, will cease upon enactment of A.12350-A/S.8978.

GMHC looks forward to your signing this critical piece of legislation which will fundamentally alter the way that insurance companies do business in New York.

Sincerely,

Tim Sweeney

Tim Sweeney
Executive Director

cc: Elizabeth Moore, Esq.
Joanne Jenkins, Esq.

C-501

1180 Avenue of the Americas
New York, NY 10036
(212) 221-3300
FAX (212) 719-0263

Long Island Office
20 Crossways Park North
Suite 304
Woodbury, NY 11797
(516) 364-8130
FAX (516) 364-8699

New Jersey Offices
Central Office
241 Millburn Avenue
Suite 241-C
Millburn, NJ 07041
(201) 379-7500
FAX (201) 379-1082

Bergen County Office
141 Dayton Street
Suite 205
Ridgewood, NJ 07450
(201) 444-6630
FAX (201) 444-0978

Connecticut Office
120 East Avenue
Norwalk, CT 06851
(203) 854-9911
FAX (203) 854-0809

CancerCare, Inc.®
AND THE NATIONAL CANCER CARE FOUNDATION, INC

July 7, 1992

The Honorable Mario M. Cuomo
Governor of New York
Executive Chamber
Albany, NY 12224

Dear Governor Cuomo:

On behalf of the Public Affairs Committee of Cancer Care, I am writing to encourage you to sign into law the Goodman/Grannis community rating bill (A. 12350/ S. 8978).

Cancer Care is a nonprofit social work agency established in 1944 to provide direct services to help patients and families cope with the consequences of cancer. Health insurance has become one of the most complex and burdensome problems facing our clients, although there is often very little Cancer Care can do to help. Consequently, Cancer Care staff, volunteers and clients have worked tirelessly in support of this legislation for the past year as active members of New Yorkers for Accessible Health Coverage. The succesful outcome of our efforts will end of discrimination in the health insurance marketplace, representing a major victory for people with cancer and other diseases.

We applaud the leadership and collaboration demonstrated by your staff in support of this legislation. Upon signing the bill, you will finalize a process which promises to increase access and reasonable rate-setting principles in New York.

Sincerely,

Kimberly Calder

Kimberly Calder, MPS
Public Affairs Coordinator

cc: Elizabeth Moore
Joanne Jenkins

C-501 A.12350-A

AMERICAN CANCER SOCIETY NEW YORK STATE PUBLIC AFFAIRS OFFICE

July 15, 1992

Elizabeth D. Moore
Counsel to the Governor
Executive Chamber
State Capitol
Albany, NY 12224

Re: A.12350-A/Grannis
S.8978/Velella

Dear Ms. Moore:

I am writing to urge the Governor's approval of the above-referenced bill, which would require all insurance companies in New York State to community rate their health insurance policies and to provide coverage on an open enrollment basis.

Due to advances in medical care and aggressive public education, nearly half of those diagnosed with cancer will survive the disease. Unfortunately, a frightening number of New Yorkers are not reaping the benefits of such advances because of a lack of insurance, inadequate insurance or limited financial resources to afford proper health care.

The health insurance crisis is compounded by several discriminatory, yet legal, health insurance underwriting practices in New York State. Under the current system of "experience rating," insurance coverage is regularly denied, canceled or made unaffordable by no fault of the potential or current policy-holder. In effect, many insurance companies are in the business of insuring, to the greatest extent possible, only the young, healthy and low-risk groups, the result being that insurance becomes inaccessible and unaffordable to higher risk groups such as those with cancer, cancer survivors and those at greatest risk of getting cancer.

A.12350-A/S.8978 would be a major step forward in reforming the system of writing health insurance in New York State and sealing some of the cracks in the health care system that leave countless cancer patients without insurance coverage and without access to adequate, life-saving treatments. The bill provides a more rational and humane basis for determining premium rates and increases accessibility and affordability of health insurance for those who need it most.

Under community rating, all insurance companies would be required to calculate their premiums by combining the claims experiences of good risks and bad risks and arriving at an average, uniform premium rate for all policy-holders. Open enrollment would ensure that people seeking insurance would not be denied coverage. While these reforms may result in slightly higher premiums for younger, healthier groups, it provides the needed security that affordable insurance will be available when many of these policy-holders become old and sick. This security is particularly necessary for the cancer patient given the extremely high costs associated with many cancer treatments.

While this bill provides necessary reforms that address immediate problems, the state needs to make a long-term commitment to disease prevention if we are to alleviate the enormous burden on our health care system. Without such a commitment, legislative reform measures will not keep pace with spiraling health care costs. However, passage of A.12350-A/S.8978 would be a significant first step toward expanding health care to all New Yorkers, regardless of age, sex, health condition and socio-economic status.

The American Cancer Society therefore urges the Governor to sign A.12350-A/S.8978 into law.

Sincerely,

Maryann Carrigan
Chair, Legislative Affairs Committee
American Cancer Society

JJ.

A 12350

STOP THE BLEEDING©

HEMOPHILIA ASSOCIATION OF NEW YORK, INC. • 104 East 40th Street, Suite 506, New York, NY 10016
Tel: 212-682-5510
Fax: 212-983-1114

July 7, 1992

The Honorable Mario M. Cuomo
Governor of New York
Executive Chamber
State Capitol
Albany, NY 12224

Dear Governor Cuomo:

Obviously, after working toward health insurance reform for the past twelve months, the Trustees, members, and clients of the Hemophilia Association, are in support of A.12350/S.8978. We urge your enactment of this legislation into law.

Those who we represent (persons with hemophilia, related bleeding disorders, and the complications of these conditions) are but a small number of the hundreds of thousands, if not millions, of New Yorkers who will benefit from this landmark action. Yet, the treatment of hemophilia has time and again demonstrated that with proper medical care, persons with chronic illnesses and disabilities can be productive citizens. This ability to function in society is most often tied to the accessibility and affordability of health insurance. Without that coverage these people are forced to collapse into the system of public assistance. Whole families can be lost from the economy.

Your leadership toward the reforms passed by the Legislature are recognized and appreciated. It has been a long, wearing campaign. We look forward to your signing of A.12350/S.8978.

Very sincerely yours,

Edward G. Rogoff
President

cc: Elizabeth Moore
Joanne Jenkins
HANY Trustees & members

A copy of the latest annual report can be obtained from HANY or from the

A. 12350-A

National Multiple Sclerosis Society / New York City Chapter / 30 West 26th Street, New York, N.Y. 10010-2094
(212) 463-7787
Fax: (212) 989-4362

July 7, 1992

Governor Mario Cuomo
Executive Chamber
State Capitol
Albany, NY 12224

Dear Governor Cuomo:

This letter comes to thank you for your support in the creation of legislative bill number: A12350A/S8978. This landmark health insurance reform bill, which recently passed both houses of the State Legislature, makes great strides in ending insurance industry discriminatory practices against the chronically ill and disabled.

The National Multiple Sclerosis Societys-New York City Chapter strongly urges you to sign this important act into law. Your continued support and advocacy for the disabled community will be reaffirmed when A12350A/S8978 becomes law.

Thank you again.

Respectfully,

Margaret D. Domanski, A.C.S.W.
Director of Chapter Services

MDD:ct

cc: JoAnn Jenkins
Carol Kurzig
Susan Parker

NYSNA
NEW YORK STATE NURSES ASSOCIATION • 2113 WESTERN AVENUE • GUILDERLAND, NY 12084 • 518/456-5371

MEMORANDUM OF SUPPORT

A12350-A
by Assemblyman Grannis
Rules Report Cal. 1345

AN ACT to amend the insurance law and the public health law, in relation to requiring that health maintenance organizations accept individuals and small groups on an open enrollment basis; rating and underwriting of individual and small group health insurance policies; and portability of group health insurance coverage

The New York State Nurses Association, representing more than 33,000 registered professional nurses, supports this bill because it will assure that health insurance is accessible and affordable for the residents of New York state.

Millions are uninsured or underinsured. Others are forced to pay ruinous premiums or find their coverage cancelled just when they need it most. The Medicaid system is overwhelmed. Proposed rate increases will force many small businesses, families, and individuals to drop their coverage, adding to the numbers of uninsured in New York. The ramifications of this action will be felt by all taxpayers when Medicaid assumes the costs of treatment for those who previously had private insurance.

The health insurance reforms included in this bill will make a big difference in a relatively short period of time. The requirement for spreading the risks among large groups of people will guarantee that health insurers, operating under the same set of rules, will be able to compete in a fair market environment. Insurers will no longer be allowed to discriminate by denying coverage or making costs unbearable for those who need care the most. It will end the insurance industry practice of setting premiums based on medical history, age, sex, or occupation.

The Legislature must require community rating, open enrollment, portability, and guaranteed renewability of all insurers. Although these improvements cannot solve all the problems plaguing the health care system, NYSNA strongly urges prompt passage of A12350-A. These health insurance reforms constitute an important, intermediate step toward providing accessible, affordable, quality health care for all New Yorkers.

6/29/92

PREPARED STATEMENT OF MR. WEISSMAN

Good morning, my name is Jerry Weissman. In the days preceding the commencement of this hearing, the accuracy of statements of Empire Blue Cross Blue Shield ("Empire") which were provided to the New York State Department of Insurance has been called into question.

I was the Chief Financial Officer of Empire at the time these statements were submitted to the State of New York and will limit my brief remarks to this issue. The information to which I refer is provided to the State of New York on a quarterly basis. The statement submitted to the State is referred to as the "Blank." The Blank, copies of which have been provided to the Committee's staff, contains a substantial amount of information including Insurance Claims against the company which fall primarily into two categories, paid claims and projections.

The amount of paid claims are taken from the records of Empire. The amount of projections reflect the calculation of the contingent liabilities of the company which arise from claims against the company which have been incurred but not yet reported. This is commonly referred to as "IBNR."

In every case, the figures submitted to the State of New York, both in the aggregate and as allocated among areas of Empire's business, were, to the best of my knowledge, either accurate and correct or a reasonable estimation of the IBNR in light of the information available to me and the company at the time the Blank was submitted.

I am the person responsible for the submission of this information to the State of New York. I have responded to all requests by this Committee's staff for information and I welcome the opportunity to respond to any questions the Committee may have on this subject, or of course, on any other matter of interest to the Committee.

PREPARED STATEMENT OF MR. VOGT

Mr. Chairman and Members of the Subcommittee: I am Harold E. Vogt, the current Chairman of the Board of Empire Blue Cross and Blue Shield. With me today are Donald L. Morchower, Executive Vice President and Chief Operating Officer of Empire Blue Cross and Blue Shield who is currently serving as Acting Chief Executive Officer until a permanent CEO is selected by the Board of Directors, and Maroa Velez, Vice President for Internal Auditing. I would like to thank the Subcommittee for affording Empire this opportunity to testify about the functioning of its Board of Directors, its financial condition, operating practices and the situation in which it finds itself today.

My brief opening statement will address matters concerning Empire generally, and the functioning of its Board of Directors. Mr. Morchower's will address the financial condition and operating practices at Empire.

I would like to preface my statement with the following observations. Empire is a successful company that successfully served the health care needs of the people of New York and beyond.

For half a century, Empire Blue Cross and Blue Shield has been the principal health insurer, often the insurer of last resort, for millions of people in New York State. Let's not lose sight of this.

Yes, Empire has had its problems, as the Board and management have recognized and as we have heard in the subcommittee staff report and testimony given on Friday, June 25. For some six months, Empire and its employees have worked closely with the Subcommittee's Staff as we explored some of these problems. Let me make clear that prior to the staff report, the Board already endorsed actions to address:

- allegations of fraud committed against Empire;
- possibly inaccurate financial statements filed with the New York State Insurance Department;
- allegations of "lavish" compensation and "perks" for my predecessor as Chairman (who was also CEO);
- deficiencies in handling Medicare claims under contract with the federal government;
- charges of having an inattentive and "rubber stamp" Board.

All of these matters are important, and Empire has taken them very seriously. But it is also important to remember that these matters arose during a period when Empire provided approximately $53 billion in health insurance coverage and paid approximately $50 billion in claims, dollar terms, whatever the combined impact of

all our problems might have been, it constitutes just a small percentage of the good Empire has done.

Mr. Chairman, I do not mean to minimize Empire's problems to this Subcommittee. We know we need to work harder and smarter to reduce our problems—zero them out, turn the Company around and restore Empire's financial health. With the full support of a pro-active Board, we have already begun that process to become more efficient, to restore internal morale and public confidence, and to do a lot of things to repair the damage Empire and its constituencies have suffered.

And while we cannot say that we enjoy either these hearings today or the steady drum-beat of negative press Empire has been receiving in recent months, we hope that we can look back at all this and say it focused our minds and contributed to the improvement of ourselves, our great company, and the health insurance industry of which we are a part.

I have read the testimony to be given by Don Morchower on behalf of Empire, and I certainly concur with what he will tell the Committee. Nonetheless, given my ten years on the Board and my current position as Chairman, I think it is important, in light of the inquiries from this Committee, the New York State Insurance Department and others, that I outline the Board's active role in the governance of Empire and in particular its involvement in the events of the last few months and the steps we have taken to return Empire to financial and operational stability.

First, I would like to point out that I personally subscribe to the principle that a Board of Directors is the key to the governance process. It is the fulcrum of accountability in the system which at Empire includes management, state regulators, policy holders, the health care provider community and the public at large. The Board's responsibility is to ensure that the corporation has in place the best management available and to be willing to change failing managements in a timely fashion when necessary. The Board's challenge is to stay sufficiently informed of current performance, to be concerned with and address the future, to know when it's time to change, and to be sufficiently independent to make the change. I believe this is a challenge that Empire's Board of Directors has met. Even though hind sight now shows that we may not have been in the position to either fully appreciate or recognize some of the problems now uncovered.

As you know, as part of New York's landmark community rating/open enrollment legislation, the State Insurance Department retained Arthur Andersen & Co. to conduct a financial and management audit of Empire. On April 15, 1993, Empire received the draft of Andersen's audit report, which contained 120 recommendations for changes at Empire, including separation of the offices of Chairman of the Board and Chief Executive Officer, which were then held by Albert A. Cardone. At the Board of Directors meeting on April 21, 1993 the Board formed a special Ad Hoc Committee that was charged with reviewing the Arthur Andersen recommendations and reporting to the full Board on the issues of corporate governance, organizational structure, managed care, systems, customer service, corporate culture and the company's external relations. I was elected to be the Chairman of that Ad Hoc Committee.

The Ad Hoc Committee was also asked to consider comments from the Superintendent of Insurance, Salvatore Curiale, in a personal letter he sent to each Board member dated April 14, 1993, in which he criticized the Board for inattention to our duties as Board members—the first personally addressed letter I had ever received from a Superintendent of Insurance in all my ten years on the Board. While we questioned the Superintendent's criticisms, we but felt it necessary to have the Ad Hoc Committee review all current issues, including the Superintendent's letter. (Copy appended to submitted text).

The Ad Hoc Committee immediately met with the Superintendent and began its work. In the course of its investigation, it interviewed Deloitte & Touche, the independent outside auditors of Empire, Arthur Andersen & Co., senior officers and other employees of Empire, as well as persons outside Empire.

As a result of these interviews and considerable discussion at Committee meetings, it became clear to the members of the Board's Ad Hoc Committee that Empire needed new leadership to improve its external relationships and take a fresh look at both external and internal problems.

At the Board meeting of May 19, 1993, I made the report of the Ad Hoc Committee to the full Board in an Executive Session. That session was held following a report to the Board by Mr. Cardone in which he stated that he would resign if the Board determined that was in the best interests of Empire. After a lengthy discussion, the Board informed Mr. Cardone that it would accept his resignation, which he tendered. The Board then passed a resolution splitting the positions of Chairman of the Board and Chief Executive Officer, which had been one of the recommendations

of Arthur Andersen and the Superintendent of Insurance, and elected me as the new Chairman of the Board. At the same time, the Board named Donald L. Morchower, Empire's Executive Vice President and Chief Operating Officer, to serve as acting Chief Executive Officer.

Since that date, Don Morchower and I have been actively involved in running the affairs of the company, developing and implementing transition organization plans and strategies and reaching out to all our constituencies—customers, employees, governmental officials and the public to begin to re-establish Empire's reputation and position in the marketplace. In a little more than a month, the Board of Directors has set a new course for the Company. In addition to accepting the resignation of Empire's former Chairman and Chief Executive Officer and separating those offices, the Board has strengthened its ability to act independently and expeditiously in fulfilling its responsibilities to determine the Company's direction and policies as well as assuring its position in management oversight. While Empire's Board has always been pro-active with management, the current actions serve to preclude management influence on that role. To further insure the flow of accurate and timely information to the Board, it has also moved the Company's Internal Audit function and the Corporate Secretary function from being direct reports to management to being direct reports to the Board through its Chairman and Board Committees. The effectiveness of those important actions has already been demonstrated by the fact that I as Board Chairman was in the position to direct an accelerated inquiry into an apparent discrepancy between internal reports and our filings with the State Insurance Department.

Questions had been raised about the fact that certain internal documents could not be reconciled with the Annual Statement for 1991 that had been filed with the Insurance Department. I asked Empire's internal auditor to conduct an immediate review of this issue. When she reported to me that she could not obtain adequate explanatory documents from the affected areas and that her inquiries seemed to show that the numbers submitted on the Annual Statement were incorrect, Empire immediately launched an internal investigation. I informed the Superintendent of Insurance of this development, and our General Counsel alerted this Committee. The company detained the firm of Willkie Farr & Gallagher to conduct interviews of employees and to review the documents, and the Board of Directors designated the Audit Committee of the Board to oversee the investigation. The Board has retained Otto Obermaier, formerly the United States Attorney for the Southern District of New York and presently a partner in the firm of Weil, Gotshal & Manges, to oversee the investigation and advise the Audit Committee and the full Board. That investigation has not been completed and it would be premature to comment further. Of course, when the investigation is completed, a report will be made public.

About a week and one half ago on June 18, 1993, I received a call at approximately 10:00 a.m. from the Superintendent of Insurance requesting that I call a special meeting of Empire's Board of Directors for later that day so that he could meet with the Board to discuss what he characterized as a matter "impacting Empire's future". I acquiesced to his request, all Board members were contacted, and the meeting commenced at 2:00 p.m. At the meeting the Superintendent presented his views on the impact and unfavorable public reaction and perceptions to the series of newspaper articles concerning Empire that have appeared over the last three months and conveyed his view that "dramatic changes" in Empire were required immediately in order to change the perceptions of Empire resulting from the media coverage. He proceeded to outline to the Board a series of requests he felt would constitute appropriate changes in governance of the company and specifically who the company should consider as candidates for the positions of Chairman of the Board, Chief Executive Officer and additional directors for an expanded Board.

The Board discussed the Superintendent's suggestions with him and then independently in Executive Session. Following deliberations on the Superintendent's requests. On June 18th the Board unanimously passed a resolution, which was already scheduled for consideration at the next regularly scheduled meeting on June 23rd, and appointed a seven-person Search Committee to accelerate the process of recruiting a new Chairman of the Board and a new Chief Executive Officer. On June 18, the Board also decided to move forward with its plan to increase the size of the Board, and to do so in keeping with the Superintendent's request, by expanding the Board from the present authorized number of 20 to a new total of 25. Finally, the board decided to move as swiftly as possible to identify candidates for those new positions and two existing vacancies.

Before closing, I would like to address another matter that has been raised in the Subcommittee staff report. That matter is the "lavish gifts and parties" cited in the report. First, let me point out that the members of Empire's Board of Directors

serve without compensation and played no role in requesting or soliciting such gifts. I know of no director who volunteered and spent countless hours in service to the organization who was motivated by the opportunity to receive gifts that were a token expression of appreciation for the time spent devoted to Empire and its subscribers. In fact, it was the Board that directed management to eliminate gifts nearly two years ago in recognition of the fiscal constraints impacting the organization.

As to the Board seminars, they were working sessions that required directors to give up workdays and part of their weekends to have Board and Committee meetings and learn more about Empire, its facilities and operations and health care issues. I can assure you that I and other directors could have put the time we willingly gave to Empire for these programs to other good use had we not felt it our responsibility to participate in these meetings and seminar programs. All the investigations Empire has had to respond to these past few years have had far greater fiscal impact on rate payers than all the programs held for the Board of Directors, including any gifts they may have received.

With over eight million subscribers—from individuals whom no one else will insure to major corporations with tens of thousands of employees—Empire has been for many years among the most well respected health insurers in the country. Despite this successful corporate history, Empire must now work hard to recapture the trust of the public and the support of the marketplace. Our efforts to re-establish our financial base have borne fruit. I appear before you today, able to report that our capital (reserves for the protection of our customers) today stands at $236 million up from $40 million at year end 1992. That amount already exceeds the capital target established earlier by the Blue Cross and Blue Shield Association, for year end 1993.

The Board, if allowed the opportunity, will continue to lead the effort to accomplish those objectives cited, and I will continue to participate actively, first as Chairman until a new Chairman is selected in due course by the Board, and then as a member of this committed Board. We plan to work closely with the State Insurance Department, and I have already pledged my personal and the company's full cooperation to the Chairman of the nine-person oversight committee that was formed by the Governor and State Legislature to review affairs of Empire and report annually to the Superintendent, the Legislature and the Governor.

We have long been known as the insurer of last resort in New York State and our social mission has long been to accept all applicants without regard for their age, sex, or prior illness and to rate all individuals and small groups on a community rated basis. The Board of Directors is committed to maintaining this social mission, to make necessary changes in response to a changing health care environment and to leading Empire out of this, its most troubling time.

I would be pleased to answer any questions you may have now or following Mr. Morchower's testimony.

APPENDIX
LETTER REFERRED
TO ON PAGE 7

APR 15 1993

STATE OF NEW YORK
INSURANCE DEPARTMENT
160 WEST BROADWAY
NEW YORK, NEW YORK 10013-3383

SALVATORE R. CURIALE
SUPERINTENDENT OF INSURANCE

April 14, 1993

Albert A. Cardone
Chairman of the Board and
Chief Executive Officer
Empire Blue Cross and Blue Shield
622 Third Avenue - 26th floor
New York, NY 10017

Dear Mr. Carbone:

The implementation of the State's new community rating/open enrollment law is a watershed moment in the life of Empire Blue Cross/Blue Shield. With other companies required to operate in a fair and competitive market for individual and small group business, Empire is no longer New York's insurer of last resort. This in and of itself is a profound and dramatic change in the health insurance marketplace.

More change is expected. On May 1 we will receive the results of the Arthur Andersen management audit. The study is likely to outline an array of problems and recommended remedies requiring the Board's immediate attention.

It is for these reasons I write to you now to sound an urgent call for the Empire Board of Directors to recognize both the necessity of charting a new course for the company and the equally vital need to establish a fresh tone of responsiveness and sensitivity to public concerns regarding Empire's management style and substance.

It is the clear responsibility of the Board of Directors to set policy for the company and to oversee the conduct and performance of management. The Board record in these matters to date has been most disappointing. Despite warnings and specific recommendations on a number of important issues from the Insurance Department, the Board has, for the most part, sat on it its hands, ignoring the fire storm surrounding Empire. In fact, to my knowledge no Board Member--outside of Mr. Cardone--has attended an Empire public rate hearing over the past three years.

The Insurance Department has been unjustly criticized for failing to regulate Empire's management performance even though legally and historically that has not been our mandate. Those who argue we have been silent or disinterested in management issues of course ignore the record. As a Board Member you know very well we have alerted the Board to conflicts of interest, questionable management practices, lack of cooperation and the dominance of management in Board business. Realizing we lacked statutory authority to impose our regulatory will, the Board has mostly ignored the Department's advice. This must stop.

The Governor and the Legislature have already made clear with new legislation, that I supported, their resolve to get better results on a variety of fronts from Empire's management. The newly created advisory panel will provide a forum for both longstanding complaints against Empire management and the promotion of creative concepts for change.

It is not at all evident to me that the current Board is up to the task at hand. The record of late would certainly suggest that some Board Members view their role as symbolic or inconsequential. The issue of management's hold on Board deliberations remains unaddressed, especially the dual role of Chairman and CEO that Mr. Cardone plays in the organization.

I believe it is time for some Board Members to resign their positions making room for more interested and active members at the table. It is my expectation that this issue as well as others I raise in this letter be on the agenda of the Board's next meeting.

Yours truly,

Salvatore R. Curiale
Superintendent of Insurance

PREPARED STATEMENT OF MR. MORCHOWER SUBMITTED JUNE 26, 1993

Mr. Chairman and members of the Subcommittee: my name is Donald Morchower. I am the Executive Vice President and Chief Operating Officer of Empire Blue Cross and Blue Shield, and I am serving as Acting Chief Executive Officer until a permanent CEO is selected by the Board of Directors. I would like to thank the Subcommittee for affording Empire this opportunity to testify about its financial condition, operating practices and the situation in which it finds itself today.

Last Friday, I provided to the Subcommittee a statement that provided a historical perspective on Empire; its social mission; its commitment to the principles of open enrollment and community rating; the statutory and regulatory burdens and oversight under which we operate, to which no commercial insurer is subjected; and the fact that health insurance is our only business. We also discussed the recent allegations of financial misreporting, which we brought to your attention as soon as it was uncovered. Today I want to address some of the issues raised at Friday's hearings.

Your staff testified then at length on their views and conclusions about Empire's management and operations and I hope I can provide some additional insight and facts for both this Subcommittee and the general public.

Empire is facing the most serious challenges, both strategic and financial; that it has confronted in its almost 60 years of existence as a health insurer. Many of those challenges are the result of internal problems. But that is not the whole story, and it is vital to understanding Empire's challenges to tell the whole story.

The Staff Statement recited a litany of management problems at Empire. The Statement relied heavily on criticisms by former officers or employees—some of them responsible at the time they were at Empire for the very functions they now criticize. It attempted to discredit every outside organization that audits us, regulates us, and consults with us, such as: Arthur Andersen, The New York State Insurance Department, Deloitte & Touche, and Milliman & Robertson. While criticizing the work of these organizations, it relied itself on unsubstantiated allegations and anecdotes.

Not heard from on Friday were Empire subscribers like Mrs. M.W., of Queens, New York who told us on May 10:

> "Confronting cancer was the most difficult thing I have ever had to do in my life, but all your Blue Cross representatives wished me well and attended to my claims promptly. I am most grateful to you, indeed, for running the finest health insurance company in New York. You are everything you represent yourselves to be, and more."

or, Mr. J.G., of Brooklyn, who volunteered this testimonial on May 18:

> "I've been a Blue Cross subscriber for more than 35 years. They've always done a very professional job, and when my wife got seriously ill two years ago, there were so many bills. They were enormous and Blue Cross still did the same professional job. They were there when I needed them."

or, Mr. R.C., of Manhattan, who said on that same day:

> "I had Blue Cross for years but never needed them. Then I had an accident, and developed a bone disease. All of a sudden, I had six different surgeries and huge medical bills. Thank God, knock on wood, Blue Cross was there for me. When I needed them, they came through like a champ."

It is worth contemplating how and even whether hundreds of thousands of our subscribers, particularly the elderly and the seriously ill, would receive health care, and benefits, and what they would have to pay, if Empire did not exist as a non-profit provider. Even today, with New York's new Open Enrollment and Community Rating Law in effect, Empire remains the only significant insurer of non-group individuals like the three customers I just quoted.

We regret that our problems may have caused concern and anxiety for many of our customers. Some may be fearful, and others may be angry. We are working to correct that situation.

Certainly, there have been internal problems at Empire. In its recent decisions about management changes at Empire, the Board determined that at the top there were problems of style and substance that created larger problems in our operation, including internal controls, recordkeeping, and our relationship with our regulators. I pledge to you and to the public that Empire is acting now and will continue to act to correct this internal situation and any external problems it created. This will be a difficult process, which involves restoring the trust between ourselves, our regula-

tors, and our legislators but we are committed to doing it. And let me be clear: we can price our business, collect our premiums, and pay our claims.

Empire's losses stem from market forces much broader than the management problems identified by the staff. The discriminatory practices of commercial insurers—shorthandedly but incompletely referred to as "cherry picking"—are and have been an issue and will be an issue in the national debate on health care. Empire's internal problems should not be used to obscure the impact of these practices on Empire and others, or to undermine the enormous accomplishment represented by the new law in New York. It is going to make a real difference in New York for health care subscribers, and a real difference nationally in the health care debate. It is worth understanding that this is a positive result.

With your indulgence, Mr. Chairman, I'd like to focus today primarily on the issues of financial condition, information systems problems, fraud, and customer service that were addressed by the Staff. On behalf of Empire's more than 9,000 dedicated, hard working and caring employees and its 8 million customers, I will try to complete the record on some major issues, and will follow up with a document that goes into greater detail on inaccuracies and misinterpretations contained in the Staff Statement.

FINANCIAL CONDITION OF EMPIRE

There is no question that in 1991 and 1992, the Company experienced a significant drop in its capital, or surplus, which is also called Reserves for the Protection of Our Customers. That reserve is, of course, over and above the reserves required to pay actuarially anticipated claims and meet expected expenses. At December 31, 1992, our capital position stood at $40 million, down from $145 million a year earlier. However, 1993 is shaping up to be a good year financially. At the end of May, capital (surplus) stood at $235 million. By year-end 1993, after we complete the pass-through to customers of $100 million in rate credits, capital is forecast to be $160 million. That compares with a $92 million target. This represents a strong turnaround.

As to the "surprising" ruling in 1992 by the New York State Insurance Department concerning the reduction in supplemental reserves, this ruling was hardly "surprising". No other Plan in New York—except Empire—carried that reserve on its statutory books. This ruling made our accounting consistent with other New York Plans.

In addition, much attention has been focused on Empire's settlement of a lawsuit involving New York's excess medical malpractice fund. It has been characterized as a "bailout" and a State "cash infusion". Again, we need to set that record straight.

This was a lawsuit that Empire, and other Plans in New York State, initiated to collect surplus payments into this fund. We reached a settlement that returned $93 million to Empire (as well as amounts to other Plans and HMOs). And importantly, for our customers, the full amount is applied under the settlement as a rate credit for our community rated subscribers. In short, Empire acted in the best interests of our subscribers, and they have benefited directly.

REASONS FOR THE LOSSES

The Subcommittee Statement disputes the fact that Empire's losses were primarily driven by our community rated business. Rather, the staff concludes that gross mismanagement caused our losses.

It is interesting to note that every professional accounting or actuarial firm that has reviewed Empire's losses has concluded they were caused principally by Empire's community rated line of business. These losses are real, and reflect the unfortunate fact that our community rated subscribers utilize health care more heavily than our other market segments. And this should not be surprising. Up until April 1, 1993, only non-profit insurers like Empire offered community rated coverage without medical underwriting. Further, even today with the new law, Empire is the only carrier in the State offering an individual, direct pay major medical policy. In summary, as the insurer of last resort, we believe our losses are largely related to our faithfulness to our unique mission.

We are not alone in this view. For example, as recently as December 1992, the Wall Street firm of Donaldson, Lufkin and Jenrette stated:

- "Empire Blue Cross/Blue Shield of New York, while troubled, is not on its deathbed. . . . While Empire lacks the required statutory reserves, it still has $1 billion in long- and short-term capital and a cash flow more than adequate for claims payment."

- "Blue Cross/Blue Shield plans are unfairly maligned for inefficiency, when in fact a significant cause of their financial woes is a very sick membership base . . . it receives many groups and individuals who are deemed uninsurable by the indemnity insurance companies and HMOS. . . . It is virtually impossible to have underwriting gains under such circumstances . . ."
- "Small group market reform should correct the structural problems which have unfairly weighted the Blues' membership base with the sickest members."

INFORMATION SYSTEMS

Mr. Chairman, I have to admit that I found the Staff's Statement's discussion of information systems to be particularly inaccurate, damaging and misleading.

First, Empire was budgeted to spend about $100 million per year on data processing when I joined the company in 1987, not $525 million as noted in the Statement. Then, fully 80 to 85 percent was spent on systems maintenance. Now, we are spending most of our resources on development of new, state-of-the-art systems. Many old and redundant systems have been eliminated. Our aim is to eliminate all duplicative systems, and our new technologies have been recognized and acknowledged by clients to be superior

The staff cites certain negative statements from the work of Arthur Andersen and from Towers Perrin. But those quotes, respectfully, leave a misleading impression. Let me complete the picture with additional information from the work of Towers Perrin and Arthur Andersen.

For example, Towers Perrin states: "The current systems strategy has high reward potential" and "Empire has taken steps toward successful implementation and to manage the risks" involved in developing a complex strategy. And Arthur Andersen states "The size of the [systems] maintenance group has been dramatically reduced since 1990, with most of those resources shifting to new development work"; "Image, workstations and relational databases form the technological building blocks of the system of the future. Empire has brought all the pieces together in the development of CS/90 and EXCEL"; "Empire has done a good job in keeping the use of consultants to a minimum while not placing its projects at risk or becoming too dependent on the consultants"; "Although this (the EDP projects) is a significant corporate investment, the aggregate benefits resulting from each of these initiatives will be significant"; and "To Empire's credit, the company has used the new technologies, such as image and on-line processing, to significantly streamline and automate specific work flows within the context of their existing processes."

The staff alleges that according to one former Vice President, CS/90 was scheduled for project completion in 1990. But the contract for this project was not even signed until June 1990. Only the preliminary work to plan for CS/90 began as early as 1988. Part of this work included the 1989 migration of Albany claims processing to New York systems, but this was not the first phase of CS/90. In addition, it did not result in the supposed loss of thousands of claims. Indeed, to confirm that all hospital claims were processed, the claims though to be lost were resubmitted and matched to our paid claims file to ensure that they were paid correctly.

The Staff Statement properly pointed out problems with the first accounts converted to CS/90. Such problems typically occur whenever a major system is installed. The Statement did not mention that the second major implementation went smoothly and is providing even greater improvements in productivity than originally estimated.

GENERIC CODES AND PHYSICIAN PROVIDER FILES

The Staff stated that Empire routinely paid claims to doctors, dentists, pharmacies, hospitals, and durable medical goods providers without verifying whether any of these providers even exist. The Staff stated that those payments exceed $500 million every year and result from weaknesses within the Plan's computer systems.

The Staff has overlooked many important controls. This is a very complex issue, but I will attempt to be brief in explaining the situation. At the outset, it is important to note that 21 percent of claims are rejected because they fail to meet our control criteria. Also, generic codes are utilized by most, if not all, health insurance carriers to process specific claims, i.e., foreign, out-of-area, etc. There is no national provider file for physicians, DOs, private duty nurses, registered nurses, hospitals, durable medical equipment providers, etc. Even when generic codes are used, many controls will affect whether a claim is paid.

Empire is required by State regulation to accept all claim forms. These forms must have specific information, the patient and customer information, the exact services rendered, the diagnosis, a charge for each service, and the provider's name

and address, and an itemized bill, before they can be processed. Claims received without this information are not processed. Approximately 2,500 paper claims per day are rejected because critical information is missing.

All claims above certain dollar thresholds, regardless of whether they are generically coded, are suspended for special review prior to payment. Also, payments to providers are totaled, and if individual providers (and subscribers) exceed certain limits, they are flagged for investigation.

Examiners are trained to recognize invalid bills. During claim coding, processors identify potential fraud by looking for the clues such as: different color pens, differing handwriting, and the use of white-out. Alterations are referred to Program Security for investigation.

Empire is working to reduce its use of generic codes. Generic codes are used for out-of-state physicians. Empire began to build a national provider file based on claims processed in 1991. Approximately 11,400 providers (outside of New York) were targeted for validation, and questionnaires were sent requesting required documentation. And the Blue Cross and Blue Shield Association is currently developing a new interplan processing capability (called ITS). This system will price and code claims, and verify the provider, at the local Plan. This capability is scheduled to be implemented in April 1994.

Generic codes are also used for the processing of prescription drug claims. However, claims processors examine drug claims and verify that the drug dispensed requires a prescription and is classified in the Physician Desk Reference. We also require an original receipt from the pharmacy (which must include the name and address of the pharmacy), the name of the drug, the prescribing physician's name, the prescription number, and the quantity of the drug. We did a cost benefit analysis to determine whether we should key and enter specific codes instead of generic codes and determined that it would cost subscribers $6 million per year more than would be saved in preventing mispaid claims.

In the near future, however, generic prescription drug coding will be eliminated, as these claims will be out-sourced to a third party vendor for all community rated products after approval is received from the Insurance Department. This step will enable on-line validation of the dispensing pharmacy.

Prior to March 1993, generic procedure codes were also utilized for the processing of durable medical equipment claims. However, like prescription drugs, the generic code was applied only after validating that the item purchased was durable medical equipment. Since March 1993, payable durable medical equipment claims are processed using definitive coding and pricing.

With respect to the New York portion of the physician provider file, Empire decided in 1992 to revalidate the file utilizing New York State license data. Empire obtained the New York State license file and then matched it to its Corporate Provider File, and this procedure will now be done annually. As a result of this process:

- 56,125 MDs and DOs on Empire's provider file were compared with the State file.
- 3,018 providers were unmatched and have not responded to letters or phone calls.
- 228 of these 3,018 providers submitted approximately 1,250 claims (valued at approximately $125,000), and these claims are currently suspended. This covers a time period of approximately two and one half months (from 4/2/93 through 6/15/93), and translates into an annualized potential of $600,000 in billings for unmatched providers. So, even if we assume that all of these providers are not bonafide, which I do not believe to be the case, the extent of possible mispayment in any one year is $600,000, a tiny fraction of the sum cited by the Staff.

Finally, I have appended to my statement a brief summary of the edits that are performed to identify duplicate claims with generic coding, which I will not read to spare you this technical detail. However, I would be happy to review all of our duplicate checking logic with your staff.

Mr. Chairman, we pay a lot of attention to these issues. The accusation that we would pay "a claim submitted on a napkin" is just wrong and unfairly maligns a lot of hard-working, conscientious, and dedicated people. No control system is perfect, but we feel that ours is good and is being made better constantly.

EMPIRE'S ALLEGED "BLUE CHIP MENTALITY"

For a company such as Empire, it is a vexing problem to meet marketplace standards of performance expected from a "Fortune 500" company while meeting standards of frugality expected because of not-for-profit status. The necessary balance is elusive. Clearly, the Staff Statement concluded we had missed the balance by a wide

margin. I don't believe the answer is that simple. I would like to address just two examples of the unfair exaggeration in the Staff Statement: automobiles and employee awards.

The Staff Statement identifies Empire's fleet of 82 corporate vehicles purchased for its officers as "perhaps the most costly of all corporate perks at Empire."

Again, we need to set the record straight. We only have 61 officers, and 20 of them have cars. The remainder are for sales people and for moving mail and other information among our many locations. Cars for officers, and any employee, are based upon job requirements. Cost benefit analysis demonstrates that it is less expensive for us to own a fleet of automobiles then it would be to lease or rent automobiles. We monitor utilization of our fleet, and adjust its size accordingly.

The Staff Statement did a grave injustice to all of Empire's employees when it described the Company as "bestowing" gifts on its employees. Most corporations, whether for profit or not for profit, honor their employees for years of service and outstanding achievement. To say that Empire, because it is a not for profit, can't do the same is absurd. I think it is unfair for the Subcommittee staff to criticize Empire for following practices that are standard in all industries, private, for profit, not for profit and government. And the Staff Statement implied that employee awards are high-end items, such as jewelry or clocks. This is not true. While service milestone awards (5 years, 10 years, etc.) may include such items, Empire's service awards are well within industry norms. For example, an employee with 25 years of service receives a gift with an average value of $316—an average of just over $12 per year of service. Moreover, the average cost of the "Circle of Stars" awards, the most frequently given awards for jobs well done, is about $13.

RELATIONSHIP WITH SIGMA IMAGING SYSTEMS, INC.

This Committee has raised questions about the relationship between Empire and Sigma. I would like to address those concerns. Before I joined Empire in July 1987, Empire engaged International Systems Services Corp. on a time-and-materials, fee-for-service basis to explore the practicality of image-enabling certain Empire processes. Over six months after Empire asked ISS to cease work, Empire entered into a formal relationship with Sigma for professional services related to the imaging system known throughout the world as OmniDesk.

When Empire looked at product offerings from IBM, FileNet, and other vendors, it became apparent that the systems available were essentially microfilm replacements which lacked the work flow component so critical to Empire's core business of processing claims. In addition, these systems used expensive, proprietary hardware and software. Finally, none of the available systems had the capacity to manage our huge daily volumes.

Against this backdrop, let me address the genesis of the Empire/Sigma relationship and the circumstances under which it continues. Dr. William Stratigos, a principal of Sigma, a Voting Member of Empire, not a member of Empire's Board of Directors as was often misstated in the Committee's Statement, had a business relationship with ISS. Through his role at ISS, Dr. Stratigos spent a small amount of consulting time at Empire reviewing our paper-based processes while advocating ways in which they could be streamlined using imaging technology. Within two months of my arrival, Empire terminated the services of ISS and, as a result, Dr. Stratigos.

From September through December of 1987, I became aware of an issue raised by Mr. Cardone over Dr. Stratigos's role as a Voting Member of Empire. The Voting Members hold their annual mating in March. At the time of the 1987 Voting Board meeting, the ISS project was just underway. The 78 Voting Members are, like Empire's Board of Directors, unpaid. The Voting Members meet annually to elect the Board of Directors, and have no other governance responsibility. Dr. Stratigos disclosed his ISS activities to Empire's project officer. Ultimately, Dr. Stratigos voluntarily resigned from the Voting Board on November 1, 1987.

So how did Empire enter into a business relationship with Sigma? Late in 1987, Empire was seeking business alternatives to ISS. In early 1988, Dr. Stratigos informed me that Mordechai Beizer, ISS's chief technical resource, had resigned from ISS in late 1987. Dr. Stratigos added that as of January 1988, Mr. Beizer had joined Sigma. Mr. Beizer, a magna cum laude graduate in computer science from Yale University with an MBA from Harvard Business School, had impeccable credentials and several years of experience in developing commercial software. After verifying this information, I believed that Sigma possessed a great deal of what Empire needed, namely clear title to the intellectual property for which Empire had paid ISS and a highly skilled technical resource who was intimately familiar with the software and with what would be required to attract, secure, and manage additional

specialized technical resources familiar with imaging. Contrary to published reports, Sigma was considered because of the technical skills of Mr. Beizer—not Dr. Stratigos.

Without regard to a particular vendor, Empire formulated a corporate strategy to modernize many aspects of its information systems. By early 1988, we believed that Sigma had the potential to help with some of these imaging initiatives. At my direction, Empire negotiated the following terms: (a) Empire would own all of the intellectual property developed by Sigma; (b) Empire would set the priorities of what was to be developed and in what order; (c) Empire would set an annual budget based upon the prior year's performance; and (d) Empire would receive 95 percent of all royalties received by Sigma from the sale of its software and derivative products to third parties. In return, Sigma would receive: (a) 100 percent, not 60 percent, of their costs for Empire-dedicated resources; (b) Office space (although Stratigos provided free office space during 1988); and (c) five percent of royalties from sales to third parties. In April of 1988, Empire and Sigma entered into a business relationship that is clearly defined and, we believe fair to Sigma and favorable to Empire.

The Staff Statement questions whether there have been delays in Sigma's work. To this day, Empire carefully monitors Sigma's progress. The only two major causes of delays were beyond Sigma or Empire's control. In the first case, Sigma was dependent upon IBM's new OS/2 operating system. The delays associated with the delivery and subsequent stabilization of OS/2 were well publicized by both the trade journals and the press. As a result, Sigma, Empire, and the rest of the world all incurred delays in their OS/2-based development projects. In the second case, Empire became aware of more reliable and more cost-effective hardware—specifically high-speed scanners and high-capacity archives manufactured by Eastman Kodak.

The Staff Statement also suggests that Empire overpaid for OmniDesk by comparing it to a system developed by another vendor. But, without specific details, it is impossible to assess the value or fairness of such a comparison. For example, how large is the system? What are the daily volume requirements of the customer? What are the ongoing costs of maintaining the system? What are the equipment costs associated with the software? OmniDesk, which uses PCs as decentralized image servers, was designed to take advantage of standard, off-the-shelf microcomputers. Indeed, from a cost perspective, I believe that Arthur Andersen report says it best, and I quote, "the fees for this custom systems development effort appear reasonable given the technical environment, the scheduled number of workstations to be installed, and the capabilities of the system scheduled for delivery at the end of 1993".

Further, from 1988 through 1992, Empire's share of Sigma's revenues from sales to third parties amounted to over $5 million, which translates into savings for our subscribers.

Sigma's technical competence is illustrated by its resellers, which include Unisys Corporation, Wang Laboratories, Ameritech, Marubeni, and TSI International, to name a few. Sigma's direct sales customers, won through competitive bidding, include such companies as Chase Manhattan Bank, Consolidated Edison of New York, and Sears, Roebuck & Co. Customers of Sigma's resellers include nearly 100 major companies worldwide. And Sigma software has won three major industry awards in the past two years, including Imaging World's Industry Leadership Award in 1992 for an OmniDesk installation at Consolidated Edison of New York, Imaging Magazine's coveted Product of the Year Award in 1992 for Sigma's electronic workflow management software known as RouteBuilder, and BIS Strategic Decisions Imaging Excellence Award in 1993 for an OmniDesk installation at Sears Roebuck. Empire, I might add, won a similar BIS Imaging Excellence Award in 1991 for its installation of OmniDesk at our Yorktown Heights processing facility.

In sum, Empire believes overall, and I believe personally, that our relationship with Sigma is a sound business relationship that is in the best interests of Empire and its eight million subscribers.

BASIC FUNCTIONS

The Staff Statement questions Empire's ability to price its business, pay claims and collect premiums effectively. With the assistance of leading edge technologies, these basic abilities are clearly present today, and are improving daily.

PRICING

Empire's experience-related business is priced on a highly analytical basis. All major proposals consider over fifty variables in aggregating the cost to process claims, handle inquiries, and perform membership transactions. These variables in-

clude reasonable expectancies of claims processing productivity, claims and service volume projections, supervisory requirements, involvement of other plans, location, and start-up costs.

Contrary to the Staff's views:

- Costing information might appear to "lack consistency". But this is because, the information necessary to price all accounts varies considerably from one customer to the next.
- "Cost allocation is a problem with the experience rated groups losing money," said one vice president. Not true. Empire's allocations have been reviewed and approved by the Office of Inspector General of the Department of Health and Human Services, the Federal Employee Health Benefits Program, the New York State account, and the Arthur Andersen & Co.
- "Profitability is not controlled by sales since price is dictated by underwriting." True; this is consistent with most insurance companies. Sales personnel do not determine price.

CLAIMS PAYING

The assertion that Empire is unable to process claims is also untrue. The Staff Statement cites a number of remarks from hospital personnel. One claims that Empire does not begin to review inquiries claim status "until 30 days have passed" after the submission. This is simply erroneous. Our production standards and quality controls are monitored daily. Hospitals may check claim status at any time, which is available on-line at 97 percent of the private sector hospitals in New York State, accounting for the vast majority of the hospital claims in the state.

Another example cited by the Staff was that hospitals cannot send claims directly to a Dedicated Service Center. Again, this is simply not true; all electronically submitted claims are electronically routed to the proper dedicated center.

Additionally, the Staff states "the receivable from Empire alone averages 60–65 days of delinquent claims payouts which for one hospital, totaled over $12 million." This would be troubling, if it were true. But Empire pays "clean claims" from New York hospitals in about six days. By contrast, in 1992, hospitals took an average of more than 77 days to submit outpatient claims, and 67.2 days to submit inpatient claims. At the same time, Empire provides to hospitals some $250 million in cash advances to compensate for expenses incurred by the hospitals on claims which have not been submitted or paid.

PREMIUM COLLECTION

Overall, our Accounts Receivable balance is approximately $320 million, of which 78 percent has been outstanding sixty days or less. Vigorous collection efforts coupled with automatic policy cancellation and claims payment holds for non-payment of premium, have resulted in a steady decline in delinquent premium from 1991 to present. As the Staff Statement notes, accounts receivable over 91 days at December 31, 1991 were $99 million. But this number was $67 million at December 31, 1992—a $32 million improvement. This improvement clearly demonstrates our ability to manage premium collection effectively.

CUSTOMER SERVICE

The Staff Statement stated that "Empire received over 5 million complaints or telephone inquires directly from subscribers last year." That statement, while accurate is also misleading. Only 1.7 percent of those contacts were due to processing errors. 93.8 percent were for information, referrals, updates or resolution of administrative issues which, of course, are an integral part of the service we render.

CONCLUSION

Mr. Chairman, I hope my testimony has helped you better understand Empire Blue Cross and Blue Shield, the problems it faces and the initiatives we have taken to solve them. I hope that we have demonstrated that we know how to price our products, collect premiums in a timely and accurate manner, and accurately and efficiently pay the 25 million claims that we process each year. I also realize, though, that we have a way to go to prove to you and to our many other constituencies that we deserve our historic and ongoing role as a vital part of the health care delivery and financing system in New York and the nation. I hope you recognize the important steps we already have taken down that road.

DUPLICATE CHECKING CRITERIA FOR GENERIC CODES

OVERVIEW

Duplicate checking within MCS is achieved by the comparison of several key data elements between two claims and the assignment of "points" for equal or partially equal results. Key fields are:

- Place of Service
- Type of Service
- Procedure Code
- From Date of Service
- To Date of Service
- Provider Number
- Provider Initials
- Providers' Fee

For a claim with a generic provider number versus one with a real provider number, the match criteria is identical with the exception of the provider number field. The logic for dealing with the generic provider code is illustrated below:

REAL PROVIDER NUMBER	GENERIC PROVIDER NUMBER
current claim provider number is real and history provider number is real is a **match**	current claim provider number is generic and history provider number is generic is a **match**
current claim provider number is real and history provider number is generic is a **match**	current claim provider number is generic and history provider number is real is a **match**

For a claim with a generic procedure code, the procedure codes are compared to see if they are the same type of procedure codes (prescription drug, durable medical equipment, etc.). If they are the same type, they are considered equal.

Generic procedure and provider number coding results in a higher number of claims suspending as suspect duplicates than unique codes.

PREPARED STATEMENT OF MR. CURIALE

Thank you for the opportunity to testify before this Subcommittee in connection with your inquiry into Empire Blue Cross/Blue Shield, the New York State Insurance Department's regulation of Empire and health insurance availability and affordability in the State of New York.

Throughout the course of your year-long inquiry, you have asked several very important questions and drawn some important conclusions.

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 effective date of health insurance reform legislation, would agree. Empire was too big to fail. It provided health insurance to hundreds of thousands of people who could obtain meaningful health insurance coverage only from this insurer.

To the question that you have asked, I would add one other:

Is Empire too big to succeed? My answer to that, again under the prior law, and perhaps even now under the present conditions of delivery of health care and the current health insurance marketplace, may be yes, unless Empire changes and unless we as a nation make the changes we need to control health care costs, reform the way we deliver and pay for health care and the way we distribute the cost of health care expenses.

I agree with the Subcommittee's staff that there have been mismanagement problems at Empire, some of which the Department has discovered in the course of its examination of the company, some of which have just recently come to light.

The New York Insurance Department disagrees with the Subcommittee staff's contention that mismanagement at Empire was the root cause of its financial deterioration. Rather, we believe its deterioration was preordained by a health insurance system in need of reform and a health care marketplace that changed drastically over the course of the last ten years and doomed Empire, a corporation writing only health insurance and functioning as an insurer of last resort writing some of the most expensive risks in the country.

Senator, in your opening statement you asked the question: "Can we build a health care system relying extensively on huge non-profit organizations?" 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 insurers, self-insured employers and organizations, and whatever other financing vehicles may be fashioned in the coming months and years.

Contrary to the charge that we were "paralyzed by fear" of regulating Empire, we proceeded on a course that was designed to reduce and even eliminate New York State's dependence on Empire, and to give all our citizens, including the oldest and sickest, the opportunity to purchase health insurance on a community rated/open enrollment basis from icy health insurer in the individual and small group market writing such business in the state.

In this way, if any individual policyholder insured with Empire were unhappy with the level of its premiums, its service or Use CEO's salary, that individual would have the option of going to another carrier without the fear of rejection because of age, health status or occupation.

This course put me and the Department squarely against the powerful commercial health insurance lobby, which was determined to protect its prerogative to select its policyholders and to insure only those people whom it didn't consider to be risky, particularly in the small group and individual marketplace.

HOW THE DEPARTMENT FORMED ITS VIEW

A. The Importance of Empire

- Empire insures over eight million people, which means nearly half of all insured New Yorkers look to Empire for some kind of health insurance coverage. Empire had a premium volume of $6.6 billion in 1992.
- For many years, Empire has participated in an unwritten "social contract" with the people of New York. For its part, Empire has assumed the responsibility for insuring all who apply, regardless of age, sex, health status or type of occupation. On its own, Empire has chosen to serve as the insurer of last resort in some of the most difficult and high-cost counties of New York, offering basic medical and hospital—and, in recent years, major medical—insurance on a community-rated/open enrollment basis. Commercial health insurers have for years sought to insure lower-risk groups and individuals, whose rates remained low as long as they remained healthy.
- Empire has also performed other community services, including: providing coverage to all who apply for Medicare supplement insurance, generally at a subsi-

dized rate, paying hospitals in advance for inpatient services, and participating in state pilot projects relating to health insurance.

- In recognition of its social mission, Empire and other not-for-profit insurers have paid a hospital rate that was less than that paid by commercial insurers and have received certain tax exemptions not available to for-profit insurers.
- Empire's legislated advantages over the commercial insurers were intended to "level the playing field" and to recognize and encourage the continuation of the community services it provides. However, the trend away from in-hospital services has diminished the beneficial impact of the hospital rate differential.
- It has been said, generally with a negative connotation, that the New York Insurance Department has a "special" relationship with the Blues. New York ii supportive of the Blues because of the social contract they have with our citizens. Empire and the other not-for-profits provide necessary coverage and services to our citizens that are not provided by commercial insurers.

B. The Breakdown of the Engine That Powered The Blues

- Until the mid-1980s, New York's competitive health insurance market worked reasonably well.
- That went wrong? There are many contributing causes:

the cost of health care, which in New York, as elsewhere in the country, has continued to increase well beyond the CPI;

intensification of competition for large group business by commercial carriers, which were not limited to writing only health insurance and could therefore afford to lose money on their health business while making a profit on other insurance sold to the same policyholders;
apparent underpricing by Empire to keep this large group business and protect its market share at all costs, based on the philosophy that somehow bigger is better;

selective underwriting at favorable rates by commercial insurers of the healthiest and youngest people, whether individuals or small groups, leaving the worst risks to Empire, which absorbed substantial losses from this business;

the movement to self-insurance by many of the most desirable larger employers;

the reluctance of the Department to grant an entire rate increase request on specified policies, as the Department attempted to balance the concerns of subscribers faced with substantial increases against the level of reserves necessary to maintain financial viability.

Empire's procedure of paying first and pursuing later, adopted because of its enormous volume of claims—some 100,000 payments per business day—and its recognition of the necessity for prompt claims settlement.

- Many of these problems at Empire were exacerbated by the company s continued commitment to community rating and open enrollment of individuals and small groups.

By late 1991, we at the New York State Insurance Department were convinced that the health insurance system in New York had to be changed. We were aware that many commercial insurers were leaving or had left the individual market and those that remained selected only the very best risks. That left Blue Cross as the insurer of last resort for individuals with any health problems.

We reviewed the underwriting rules of some of the larger small group writers in New York and found that insurers maintained lists of blacklisted industries and occupations which they would not even consider for health insurance coverage, including the construction industry, the entertainment industry, transportation companies, restaurants, motels, florists, police and fire departments, taxicab companies and numerous other service-type industries. The members of the smallest groups that applied to commercial carriers for coverage were subject to strict underwriting rules that could disqualify the entire group from coverage. The medical condition of one member of the small group could result in denial of the whole group. In addition, the offering of a health insurance policy was sometimes made contingent upon the purchase of life insurance.

In summary:

- As a matter of public policy, we believed that all individuals and small groups should have access to health insurance coverage from all HMOs and from all insurers writing such coverage.

- We believed that if commercial insurers were permitted to continue the selective underwriting of younger and healthier policyholders, then inevitably Empire, as the insurer of last resort, would be left with only an older and sicker group of policyholders, whose premiums would be increasingly unaffordable.
- We believed that the costs for older and sicker people should be equitably spread across the entire community of policyholders.
- We believed that the elimination of selective underwriting and rating practices would lead to competition based on an insurer's ability to manage care and keep administrative expenses low.

What The Department Did To Address The Problem

The Department was the driving force in securing the passage of community-rating/open enrollment legislation in 1992, which requires all carriers writing individuals and small groups—whether commercials or not-for-profits—to insure every applicant. The new law eliminates, to a large extent, New York's dependence on the Blues—and particularly Empire—to insure all its citizens, including its high-risk citizens for both basic and major medical coverages.

Community rating and open enrollment were not proposed to bail out Empire and its executives, but it was intended to free hundreds of thousands of people, especially the older and sicker persons in the state, from having only one option for health insurance coverage, namely Blue Cross. It was aimed at making all insurers, commercial as well as not-for-profit, compete, not on the basis of whom they could avoid and keep out of the system but rather on how well they managed care, how quickly they paid claims and how well they serviced their policyholders.

We concentrated on the changes in Use system to provide help to the most vulnerable, with the belief that community rating, spreading the risk among the largest group possible with an average premium rate, would provide greater stability to health insurance consumers.

Our ongoing financial examination of Empire has identified numerous management shortcomings that are now being addressed. As you know, I've called upon Empire to replace management and significantly expand its Board. These changes could not have been accomplished so swiftly without the work of this Subcommittee.

The lessons of Empire have also led us to reevaluate our Department's examination process. For the future, we intend to enhance the Department's oversight of health insurers in such key areas as:

- detecting and pursuing white-collar fraud;
- penalizing and, if necessary, removing company officials who frustrate our regulatory purpose;
- imposing significant fines and sanctions on officers who fail to adequately comply with the recommendations of our examination reports;
- making certain that proper procedures are in place to assure the validity of claims, with particular attention to the credentials of health care providers and to claims that are subject to coordination of benefits submitted by subscribers wino have other health insurance coverages;
- requiring certification by a CPA of the underlying data contained in rate filings; and
- monitoring more closely the participation of the Board of Directors in overseeing the operations and management of the company.

We are all aware that we are in a period of significant change in the delivery and financing of health care services in this country. We in New York have been working toward improving our states's system and we pledge our support in the vital national effort. We appreciate the opportunity to express our views to the Subcommittee today and assure you of our continued cooperation.

MEMO

To: Mr. Albert C. Cardone

Date: November 14, 1991

From: Maroa C. Velez

Subject: Recredentialing Project

I have attached a status report of our recredentialing activities for the approximately 800 high dollar loss Community Groups selected for review. This document has been shared with Messrs Drewsen, Greenberg, Morchower, and Weissman.

Our initial field effort resulted in visits to 471 groups. Of those, 171 were found to have actionable problems such as failing to meet minimum membership requirements. At this point, there is a need to provide additional resources to visit the remaining groups as well as to complete the dispositioning of the originally visited groups. To this end, we have outlined the tasks required and the number and level of staffing. It is my firm belief that these activities should be folded into the recently initiated corporate recredentialing project managed by our Membership & Billing (M&B) area. We recently provided M&B with a detailed procedures manual developed from our experiences which will assist in this transition.

We have also obtained agreement from senior management on how to resolve a number of issues that were raised as a result of our initial field work. This will help M&B to expedite their corporate recredentialing process when similar cases occur.

Finally, we identified a number of control issues within the Community Group processing and monitoring functions. Many of these control deficiencies have been or will be corrected as we move further along in converting these groups to Traditional Plus contracts.

RECREDENTIALING PROJECT

INDEX

RECREDENTIALING PROJECT
Status as of : 10/31/91

Field Review and Task Force Deliberations

Groups were selected by Membership and Billing based upon high dollar loss in terms of claims expense incurred.

A total of 814 groups were called for field audits. Actual visits were completed for 471 groups (58%). The remaining 343 groups (42%) could not be visited for various reasons. For example, 229 requested call backs at a later date, would not commit to an interview, or were closed for the summer. In addition, approximately 90 other groups either refused to be audited, could not be contacted because their telephone was disconnected, or were either cancelled or being cancelled.

A multi-divisional Task Force was organized to review the results of the field audits. Of the 471 groups visited, 171 were determined to have actionable problems (see Exhibit 1). Three hundred (300) were determined to be qualified groups.

Policy issues on how to proceed for those groups that had actionable problems or could not be visited have been addressed in an Issues Document (see section II).

Internal Claims Review

Desk reviews of claims experience were conducted for all groups selected for field audits. Sixty-one (61) groups were identified as having some potential concerns, e.g., membership information disclosed short term enrollment coupled with high utilization. Field reviews to verify eligibility of identified high utilizers were conducted only at 34 groups since the remaining 27 fell into the categories of call backs, refusals, or cancellations. The 34 on-site reviews were able to confirm only 15 instances where the high utilizers were current employees. The remaining 19 groups will require a follow-up visit to verify employment for past employees found questionable as a result of our review process.

Secondly, to address processing quality, claims for 10 or the 61 groups were forwarded to claims management to review potential concerns regarding such areas as pre-existing conditions and overage sponsored dependents. Claims management was able to resolve all our concerns on pre-existing conditions and overage sponsored dependents to our satisfaction.

EXHIBIT I

RECREDENTIALING PROJECT
SUMMARY OF TASK FORCE DELIBERATIONS
THRU 10/31/91

Decision Status Categories:

Cancel-Fails to Meet Underwriting Standards	Potential Cancellation Pending Review of More Documentation	Cancel "Bogus" Group
97	4	2
(57%)	(2%)	(1%)

Group to Remain Intact with Unqualified Subscribers Cancelled/ Offered Conversion to Direct Pay	Decision Pending - Further Analysis Required
60	8
(35%)	(5%)

Community Rated Groups
Recredentialing Issues and Questions
as of November 8, 1991

RESOLVED ISSUES

Issue #1	What action should be taken if recredentialing determines a group to be "bogus" (i.e., not a valid group)?
Decision:	Terminate/cancel group and do not offer conversion option; for subscribers that are qualified, allow new enrollment without continuity; pursue group or individual for reimbursement/settlement for losses on a case by case basis.

Issue #2	What action should be taken if recredentialing determines that a group does not meet underwriting standards?
Decision:	Send letter to group allowing 60 day grace period for group to meet required underwriting standards. If minimum is not reached, terminate group and offer conversion to direct pay unless the group has other coverage.

Issue #3	Should follow-up field visits be made to specific groups to verify employment for past employees found questionable as a result of the internal claims/membership review process?
Decision:	Suspect groups should be contacted/visited where necessary, to obtain employment support for past employees. If unable to verify, seek reimbursement for losses.

RESOLVED ISSUES

Issue #4

How do we proceed in those instances where groups have not responded to our requests for additional documentation to determine appropriate eligibility of the group and/or our subscribers?

Options:

A. Send a letter to the group indicating that a failure to provide us with required documentation within 30 days will result in termination; allow conversion to direct pay.

B. Send notice of termination to group and do not offer direct pay conversion.

C. Do not send termination notice to the groups pending approval of new contracts by NYS Insurance Department.

Decision: Option A

Issue #5

What action should be taken if unqualified subscribers (i.e., Aunt Tillies) are identified during the recredentialing process? If termination is decided, should reimbursement of our losses be pursued retroactively?

Decision:

If originally a legitimate subscriber, terminate unqualified subscriber with conversion option; if not, terminate unqualified subscriber from group and offer conversion to direct pay only if subscriber has been enrolled for more than a 2 year period. If less than 2 years, no conversion and pursue civil remedies against the group, group administrator and subscriber if cost justified.

RESOLVED ISSUES

Issue #6	How do we proceed in those instances where groups could not be visited/audited due to: their refusal or telephone disconnects?
Decision:	Send a letter to each group indicating that their contract will be terminated within 30 days, if they do not allow us access for audit purposes; allow conversion only if legitimacy of group can be established; otherwise, allow to buy insurance.

Issue #7	How do we proceed in those instances where groups could not be visited/audited due to their: unavailability during original scheduling period, cancellation of prior scheduled appointments, stalling?
Decision:	Make follow-up phone call - if receptive, make appointment - if not, send 30 day termination letter; allow conversion to direct pay only if legitimacy of group can be established; otherwise, allow to buy insurance.

Issue #7A	How do we proceed with those groups that requested to be cancelled at the time appointments were being scheduled?
Decision:	If cancellation has not occurred, make follow-up call to request visit. If group will not commit to visit, send a 30 day termination letter; allow conversion to direct pay only if legitimacy of group can be established; otherwise, allow to buy insurance.

Community Rated Groups
Recredentialing Issues and Questions
as of November 8, 1991

OPEN ISSUES

Issue #8 — What are the allowable exclusions for participation (i.e., meeting underwriting standards)?

Options:

A. Adhering to current written, and filed, underwriting guidelines which allow only EBCBS coverage as an exclusion.

B. Amending underwriting guidelines to conform to current practices allowing - HIP and HNET coverage as exclusions.

C. Amending existing underwriting guidelines to conform to current practices allowing any HMO enrollment as an exclusion.

D. Amending existing underwriting guidelines to allow employees, who elect coverage through their spouse's group plan, to be excluded.

Recommendation: The Task Force recommends B and D (in addition to A), and is divided on C.

Decision:

RECREDENTIALING PROJECT

I. Complete field recredentialing of remaining original groups

Task	Level of Resource Required	# Required
Make follow-up phone calls to groups to make appointments or record refusals.	Telemarketing Representatives	N/A
Coordinate resources to perform group visits for scheduled appointments.	Project Leader (ECP) Team Leaders (ECP)	1 3*
Perform field visits or physical observations of groups.	Field Auditors (ECP; High Graded)	6-10
Evaluate all documentation received during field visits, make appropriate decisions on each group, and, where determined, prepare and present group cases to the Tribunal.	Team Leaders (ECP)	3*
Review and make final decisions on status of groups.	Tribunal	N/A

* Project requires a total of 3 Team Leaders

NOTE: Desk reviews of claims experience for remaining groups was completed previously

RECREDENTIALING PROJECT

II. Complete disposition of originally visited groups

Task	Level of Resource Required	# Required
Prepare and send letters to groups based on Tribunal decisions	Support Staff Composed of: Manager (ECP) Supervisor (ECP) Clerical (High Graded) Clerical (Middle Graded)	 1 2 1 6
Receive and process responses to group letters and/or other correspondence.		
Handle and resolve phone calls generated by letters to groups.		
Perform desk reviews of appropriate documents to determine the legitimacy of groups that refused access or whose phone is disconnected.		
Negotiate financial settlements with those unqualified subscribers (Aunt Tillies) identified during recredentialing, with less than two years enrollment, where cost justified.	Field Representatives (ECP)	2

Community Rated Groups
Credentialing/Recredentialing
Control Issues

MAJOR CONTROL ISSUES	CURRENT PROCEDURES/STATUS	RECOMMENDATIONS
Group Membership Processing - Prior to Tradition Plus, new groups were not consistently credentialed to ensure that they were bonafide businesses and all individuals requesting coverage were eligible members (i.e., employees of the group) who met EBCBS Underwriting Standards - Additions to existing groups were not credentialed to ensure they were employees or eligible dependents (except in the case of adopted, handicapped, sponsored, or overaged dependents).	Membership & Billing staff is currently credentialing all new groups using NY State tax data and Dun and Bradstreet information. However, groups requesting reinstatements are currently not required to provide evidence of member eligibility. Tradition Plus contracts requiring this information have been approved by the Insurance Department and will be issued to groups, shortly. This situation will therefore continue until the new applications are completed and returned. Auditing performed a limited test of the credentialing procedure. Based upon the results, procedures appear adequate to ensure that new Community Groups comply with underwriting guidelines. Currently, additions to existing groups are not verified for employment status. However, subscriber applications, including the new Tradition Plus form, are currently being revised to require proof of employment (i.e., pay stub). Until these applications are released and returned from the groups, this situation will continue. In the meantime, inserts are being developed to remind groups/subscribers of the proof of employment requirement. Management has requested budget monies to support an independent credentialing unit. Its primary function and other responsibilities are being developed.	A formal credentialing operation should be established. This area would be responsible for both internal and field underwriting in accordance with current corporate underwriting guidelines. Activities should include the credentialing of all new/reinstated groups and the periodic recredentialing of existing groups, the latter on a high risk basis or in accordance with an established frequency schedule. Payroll data, details of allowable exclusions, and all pertinent documentation should be obtained and verified prior to enrolling groups and their members. Also, this area should be responsible for implementing the other recommendations set forth in this report. Verification and approval of all new members to existing groups should also be performed. In addition, all questions on election forms should be completed and in agreement with corporate standards for enrollment.

Community Rated Groups
Credentialing/Recredentialing
Control Issues

MAJOR CONTROL ISSUES	CURRENT PROCEDURES/STATUS	RECOMMENDATIONS
Group Membership Processing (con't)		
• Community Groups were allowed to backdate enrollments to a member's employment date, if an application had not been submitted when the member was first eligible for benefits ("strict adherence eligibility").	This process has been eliminated under the Tradition Plus Contract. However, this situation continues to apply for existing groups with the strict adherence option until a Tradition Plus group application form is completed.	With Legal approval, notify all existing groups that this arrangement will be discontinued
Waivers		
• Groups with less than ten members and 50% employer contribution were eligible for initial waivers of waiting period (full family) due to apparent revisions to corporate underwriting guidelines for Tradition Plus contracts by NY Markets in July 1989.	Management has recently made a decision not to allow waivers to Community Groups unless the group is being transferred from a competitive carrier. Documentation of coverage by the previous carrier is required and will apply only to those initial enrollees formerly covered by the other carrier. Any deviation to this policy must be approved by either the Chairman of the Board and Chief Executive Officer, Executive Vice President and Chief Operating Executive Officer, or the Corporate Vice President and Chief Financial Officer.	None Made - Condition Addressed
• Waivers of waiting periods for pre-existing conditions were being granted to groups based on previous coverage, group size and employer contribution. However, contributions were difficult to monitor.	Auditing performed a limited test for adherence to this policy and found that procedures appear adequate to ensure adherence to the waiver requirements.	

Community Rated Groups
Credentialing/Recredentialing
Control Issues

MAJOR CONTROL ISSUES	CURRENT PROCEDURES/STATUS	RECOMMENDATIONS
Monitoring of Community Group Activity There was no ongoing monitoring of group and/or member activity to detect unusual situations that could provide an early indication of problems The types of monitoring techniques that should have been performed include but are not limited to the following: i) Profit and loss analyses ii) Membership and claim aberrance reviews (i.e., short term enrollment with high utilization) iii) Identification of groups which appear to be associated with certain occupations or where the last names of members are the same, which may indicate a family rather than a business group.	As previously discussed, budget monies have been requested to support an independent credentialing unit	Enhancements to corporate systems should be made to regularly generate, for the credentialing/recredentialing process, the types of monitoring reports outlined herein.

Community Rated Groups
Credentialing/Recredentialing
Control Issues

MAJOR CONTROL ISSUES	CURRENT PROCEDURES/STATUS	RECOMMENDATIONS
rough Contracts tion Traditional Plus contracts did not contain right to audit lauses since they were with the members and not the group	This clause is now included in the Tradition Plus Contract	None Made - Condition Addressed

Community Rated Groups
Credentialing/Recredentialing
Control Issues

MAJOR CONTROL ISSUES	CURRENT PROCEDURES/STATUS	RECOMMENDATIONS
Monitoring of Fraudulent Activity There was no formal process in place to ensure subscribers and/or ("bogus") groups cancelled due to fraud or questionable activities were monitored to prevent them from obtaining coverage in another fashion (new group or direct payment)	Management has established a manual monitoring process whereby groups/subscribers cancelled because of fraud do not get other coverage. An automated monitoring approach is being developed. Auditing performed a limited review of the process. Current procedures require enhancement in order to ensure that cancelled 'bogus' group members are not subsequently enrolled as dependents. Although all community groups were automatically upgraded to Tradition Plus, they have not as yet been requested to complete the new group and subscriber application forms. Therefore, until the credentialing unit is functional, existing groups will continue to submit the old subscriber application forms - which do not require dependent SS#s. An 'Alpha' system search is performed by M&B to try to identify the SS# - if successful, the prescreening process is performed. However, if a SS# is not located, the application is processed without prescreening. Management informed us that groups are not called to identify the SS# due to volume constraints (300 applications daily)	All subscriber applications, including dependent data, should be prescreened for subscribers cancelled for fraudulent activity. An automated system using subscriber identification numbers to monitor subscribers cancelled because of fraudulent activity should be implemented.

MEMO

To: Ms. Maroa C. Velez

Date: March 22, 1993

From: Harry Pantos
Helen Hone-Futterknecht

Subject: 1992 Year-End
Status Report:
Group Integrity Department

Summary

The Group Integrity Department (GID) was established in April 1992 and reached full staffing by June 1. Administratively, we created a policies and procedures manual and an extensive system database to monitor the Department's activities and provide appropriate management reports. Further, we drafted (and obtained approval from Senior Management) policies on major corporate issues involving the auditing of small groups (e.g., when would groups be denied conversion).

For the abbreviated year of April - December, audits were conducted on 2004 groups. Each of these groups experienced losses ranging from $35,000 to $1 million and a combined loss of approximately $149,500,000 in 1991. These audits resulted in the cancellation of 377 groups that did not meet our underwriting requirements, or either refused us access to audit or we were unable to contact. These cancelled groups, as a whole, produced losses of approximately $25,000,000 over the 1990-91 period. In addition, we identified 403 groups with 914 ineligible subscribers, all of whom (members) have been cancelled.

An analysis of all pre-amnesty completed audits revealed that, on average, 44% of the groups were found to be qualified (i.e., had no actionable problems) while 56% were deemed unqualified. However, a review of post-amnesty audit data (audits completed after July 31, 1992) revealed some reversal. Fifty one percent (51%) of those groups audited were qualified, and 49% unqualified. Note: During the six week amnesty period beginning July 1, Membership and Billing processed cancellations for 1229 groups and approximately 19,000 subscribers.

Results of our overall work are detailed below.

I. General Observations

- From our discussion with audited groups, it became apparent that there was a general lack of knowledge and/or understanding of Empire's underwriting requirements resulting in many of the actionable problems we found.

- Little to no evidence of "cherry picking" was found on the part of those groups audited.

II. Group Cancellations

Some highlights to note:

* 17 (5%) were cancelled without conversion privileges, as they were determined to be "bogus" groups (i.e., groups that refused us access or whom we were unable to contact and could not verify the existence of a business). Our Law Department has selected six groups to prepare legal cases against.

  We estimate a $1.75 million yearly "loss avoidance" from the cancellation of these groups.

* 30 were cancelled, for the most part, because we were unable to contact them or they refused us access (even though we were able to confirm that businesses existed).

  We estimate a $1 million yearly "loss avoidance" from the cancellation of these groups.

* 87 were cancelled because they were below our minimum enrollment requirements.

  We estimate a $4.6 million yearly "loss avoidance" from the cancellation of these groups.

* The remaining groups were cancelled for various reasons (e.g., no longer a business; group request).

  We estimate a $6 million yearly "loss avoidance" from the cancellation of these groups.

* Of the 360 groups cancelled with conversion privileges, our monitoring sample of 60 groups revealed that 47% of the subscribers from these groups converted to direct payment, 47% did not convert, and 6% transferred to other groups. We are currently determining whether the transfer of cancelled group subscribers to other groups was appropriate.

III. Ineligible Subscribers

Of the 914 ineligible subscribers identified:

* 889 were cancelled with conversion privileges, since they were on their groups for two years or longer; and twenty five (25) were cancelled without conversion, again applying the two year rule.

* Only 5% of the 914 ineligible subscribers were actually the high utilizers on those groups.

* Analysis of ineligible subscribers cancelled with conversion privileges revealed that, to date, only 33% have converted to direct payment, 64% have not converted, and 3% have transferred to other groups. As noted previously, we are also in the process of determining whether the transfer of these ineligible subscribers was appropriate.

We estimate an approximate 20% reduction in premium resulting from the removal of ineligible subscribers from groups to Direct Payment. Since premiums closely reflect benefits, a reduction in premium implies that overall benefits expense liability is reduced by at least the same amount.

IV. Referrals

Throughout the year, we received 50 suspect small group referrals from various areas of the Corporation (Program Security, Sales, and Membership and Billing). Our audits of these groups found 84% unqualified. It would appear from these results, that corporate areas have improved their procedures for identifying problem groups. We have cancelled the unqualified groups or removed ineligible subscribers, as appropriate.

V. 1993 Plan

We have identified and commenced audits on approximately 1600 groups with losses of $35,000 or greater in 1992 (see attached). Of the 1600, 277 had also suffered losses of $35,000 or more in 1991.

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GROUP INTEGRITY DEPARTMENT
1993 AUDITS

Loss Amount	# of Groups	Loss Value
>= $1,000,000	1	$1,989,315
$500,000–$999,999	1	523,934
$250,000–$499,999	10	3,604,025
$200,000–$249,999	21	4,763,556
$175,000–$199,999	23	4,313,599
$150,000–$174,999	35	5,721,274
$125,000–$149,999	48	6,524,868
$100,000–$124,999	90	10,023,712
$75,000–$99,999	251	21,586,779
$50,000–$74,999	479	29,129,698
$35,000–$49,999	644	27,102,741
Totals	1,603	115,283,501

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GROUP INTEGRITY DEPARTMENT
STATUS REPORT
WEEK ENDED JANUARY 1, 1993

I. AUDITS CONDUCTED TO DATE			2004
II. RESULTS TO DATE			
QUALIFIED GROUPS			795
UNQUALIFIED GROUPS:			
GROUPS CANCELLED			377
GROUPS PENDING CANCEL(LETTERS ISSUED)			
BELOW MINIMUM	122		
INELIGIBLE SUBSCRIBERS	403		
NOT A GROUP	40		
REFUSE ACCESS	29		
UNABLE TO CONTACT	26		
TOTAL			620
PENDING (OPEN ISSUES)			212
III. CANCELLATIONS			
GROUPS CANCELLED TO DATE			
BELOW MINIMUM	87		
NOT A GROUP	256		
REFUSE ACCESS	14	-	
UNABLE TO CONTACT	20		
TOTAL			377
RECOMMENDED GROUP CANCELLATIONS			
BELOW MINIMUM	122		
NOT A GROUP	40		
REFUSE ACCESS	29	-	
UNABLE TO CONTACT	26		
TOTAL			217
CANCELLED SUBSCRIBERS			
CONVERSION	889		
NO CONVERSION	25		
			914

Note: Number of audits conducted affected by decision to not schedule new visits during July amnesty period.

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GROUP INTEGRITY DEPARTMENT
STATUS REPORT
WEEK ENDED MAY 14, 1993

I. AUDITS CONDUCTED TO DATE				876
II. RESULTS TO DATE				
QUALIFIED GROUPS				378
UNQUALIFIED GROUPS:				
GROUPS CANCELLED				89
GROUPS W/INELIGIBLE SUBSCRIBERS CANCELLED				112
GROUPS PENDING CANCEL(LETTERS ISSUED)				
BELOW MINIMUM			89	
INELIGIBLE SUBSCRIBERS			63	
NOT A GROUP			10	
REFUSE ACCESS			24	
UNABLE TO CONTACT			24	
TOTAL				210
PENDING (OPEN ISSUES)				87
III. CANCELLATIONS				
GROUPS CANCELLED TO DATE				
BELOW MINIMUM		17		
NOT A GROUP		51		
REFUSE ACCESS		9		
UNABLE TO CONTACT		12		
TOTAL			89	
RECOMMENDED GROUP CANCELLATIONS				
BELOW MINIMUM	89			
NOT A GROUP	10			
REFUSE ACCESS	24			
UNABLE TO CONTACT	24			
TOTAL		147		
RECM'D GROUP CANCELLATION W/INELIGIBLES		63		
			210	
CANCELLED SUBSCRIBERS				
CONVERSION		607		
NO CONVERSION		19		
			626	

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Empire
Blue Cross
Blue Shield

622 Third Avenue, New York, N Y 10017

September 26, 1991

Donald L. Morchower, Chief Operating Officer
Michael Bihari, M.D., Vice President

We have completed a review of the Physicians Provider File System (the Provider File) maintained by Professional Benefits Administration. Historically, this file has been called the Corporate Provider File. However, in addition to this, there are several other provider files in use throughout the Corporation for programs such as, Dental, Drug, Hospital, and HealthNet.

In our opinion, the system of internal controls was inadequate to ensure an accurate, complete, and valid physician database. Our appraisal was based on the following significant concerns:

- Minimum credentialing criteria to establish a physician as an authentic and current practicioner were not established. Consequently, essential information pertaining to physician education, training, and relevant experience was not obtained. Presently, except for standard identifying information, a physician is only expected to provide a tax identification number and copy of a valid registration as evidence of qualification. Furthermore, we performed verification procedures of the documentation, and in some cases, this documentation (application and registration) was non-existent.

- Physicians' credentials have not been validated against independent, external sources such as the American Medical Association or New York State Department of Education - Division of Professional Licensing Services.

- The last general purge of the Provider File occurred in 1984, and records that do not meet the established purge criteria may be contained on the Provider File, e.g., deceased doctors with no claims activity within eighteen months.

- Effective input control procedures, including reviews for validity, accuracy and completeness of additions and changes to the Provider File, have not been established. In Provider Registry, quality reviews were limited to a few transactions, with no evaluation of a sub-sample of the senior's work. Batch ticket totals and daily summary totals on the Confirmation Report were not compared, and variances were not identified and investigated.

- 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. In 1990, the Corporation paid $219 million through the Medical Claims System (MCS) in benefits as a result of claims submitted for services performed by non-credentialed physicians.

We recommend that management validate and re-credential, as soon as possible, all existing physician records. A possible source enabling us to ascertain the reliability of our database would be the New York State Department of Education - Division of Professional Licensing Services.

We support the plans to transfer to Health Benefits Management Operations (HBMO) the credentialing function for all providers of service. These plans should also address standardization and minimum credentialing requirements for all programs. All applications and supporting documentation should be verified against the records of the issuing agencies, hospitals and/or schools. In conjunction with the current clean up efforts, if a fictitious, deceased or disbarred physician is identified, claim payment history should be reviewed and appropriate action taken. Separation of the credentialing and data entry functions will require joint control procedures within HBMO and Provider Registry. These should include:

- reconciliation of the number of providers credentialed and the records added to the Provider File

- sign-off, by HBMO, to acknowledge appropriate credentialing of all providers

- one-for-one checking, by Provider Registry, of all transactions to ensure that HBMO authorized all inputs to the Provider File, and that all records were input completely and accurately.

In order to maintain a database of current and relevant physician records, the Provider File should be purged at reasonably scheduled intervals, allowing for an eventual time limitation for filing claims. In conjunction with the purging procedures, management should institute ongoing comprehensive supervisory review procedures to ensure completeness, accuracy and validity of records.

Finally, we support management's efforts to control usage of dummy provider codes. Initiatives are underway to ascertain the

validity of all providers of service, and include:

- o the assignment of unique provider numbers to non-credentialed providers of service.

- o flagging on the system all non-credentialed providers who failed to respond to requests for credentialing data.

- o plans to analyze utilization of services and patterns of practice of non-credentialed physicians.

In addition, management should research the legal ramifications of eliminating payment to subscribers who select physicians whose credentials have not been validated by the Corporation.

Attached are management's responses to our findings and recommendations. We found that the responses in general lacked completed corrective actions and/or specific corrective actions to be taken, and target dates for completion. We understand that the corrective actions are contingent upon certain decisions. We would appreciate being informed when all corrective procedures have been implemented. Copies of policies/procedures developed to address our concerns should be provided also to us.

Our examination revealed other concerns of lesser importance that do not impact our overall opinion on internal controls. These concerns were discussed with area management, who have responded to us.

Maroa C. Velez
Corporate Vice President
Auditing

cc: Fred J. Barba, Vice President
Catherine A. Janowski, Vice President

memo

CONFIDENTIAL

To Mr. John Furka

From Catherine Janowski

Date September 12, 1991

Subject Physician's Provider File System ACN-13-91

cc: F. Barba
J. Kenney

We have reviewed the draft of the Provider File Audit Report and have the following comments:

- According to current corporate policy (which was developed by Legal, Health Affairs and Medicare some time ago) assignment of a provider number is based on a completed and signed application, a valid registration, a tax identification number and specialty documentation as indicated on the current application. The suggestion to demand information pertaining to education, training and experience and validate credentials against independent external sources will be considered when credentialling requirements are defined prior to the recredentialling of the providers on the Provider File.

- The documentation requested during the audit that could not be found was probably misfiled due to the fact that the Provider Register was moved twice during the past six months due to the renovation of the entire PBA area. We will continue to look for this documentation and advise you if it is found.

  It should also be noted that system requirements are currently being developed to Image these documents for permanent storage. Currently these documents are periodically microfilmed for permanent storage.

CONFIDENTIAL

- Batch ticket totals and daily totals on the confirmation report are currently not compared because there is a system problem. Due to other corporate priorities, this correction is still outstanding under UDC Number 89165-8457.

- The Provider File has not been purged since 1984 due to limited system resources because of major projects: the implementation of the New Provider File and TLC, the Albany Migration and most recently work to support POS, the new Medicare System and LRSP. Since recredentialling of all providers on the file is expected to begin shortly, we recommend purging the file once this is completed.

- Quality reviews of all functions within the Provider Register Unit are performed on a monthly basis. Included in this review is the maintenance function (updates to the provider file). Based on in area reports, these audits represents an average 12% of all transactions made. This sample audit does not include the 100% audit performed on all POS and Matrix Validation maintenance recently performed.

- PBA is ready to support the recredentialling activities that will be initiated by HBMO on the Provider File. As work begins, workflows between HBMO and PBA will be put in place to ensure the necessary controls are in place.

- PBA has implemented procedures to eliminate the use of dummy provider codes for all in state providers of service with the following exceptions: private duty nurses, pharmacies and outpatient departments of hospitals. These procedures utilize data received from the physician, in house sources (Healthnet & Dental Provider Files), and the NYS Physicians Directory to assign unique provider numbers. UPIN Data will be used once it is received from HCFA.

CJ:ldb

CONFIDENTIAL

MEMORANDUM

DATE: June 8, 1992 JOHN M. FURKA JUN 10 1992

TO: Jack Furka
Director, Auditing

FROM: Michael Bihari, M.D.
Vice President, Managed Care Operations

SUBJECT: Physicians Provider File System

As we recently discussed, I cannot provide you with a specific corrective action plan including target dates for completion until a decision is made about future physician reimbursement. The company is planning to adopt a fee schedule reimbursement system based on the RVRBS/Medicare Fee Schedule methodology. We will then establish a participating network targeting about 70% of the physicians in the Empire service area. The recruitment process will require that we contact all physicians in our service area and thereby will automatically allow us to recredential and/or purge physicians on the provider file. As contacting all the physicians on the file is a very costly endeavor, it makes sense to do a "cleansing" of the file as part of the recontracting process.

I will let you know as soon as a timeframe is established for the recontracting process.

M. Bihari

MB:rp

CONFIDENTIAL

MEMORANDUM

TO: Mr. Donald L. Morchower
Executive VP, & COO

FROM: Fred J. Barba
VP Core Processing Services

DATE: June 15, 1992

RE: Elimination of Dummy Provider Codes

This memo is a summary of many discussions that we have had on the above and it reflects the current status of many initiatives. The reason for Exhibits I and IA is to document the evolution of policy/procedures associated with the elimination of dummy provider codes. Exhibit IA represents recent changes made in the LRSP processing environment to accommodate account requests. In effect, the policy change allows EBCBS to pay the subscriber rather than reject the claim as detailed in Exhibit I. This modified policy has been implemented in all processing environments to ensure a consistent corporate methodology in dealing with "un-credentialed" providers. This policy will revert to original form (Exhibit I) after the 1099 file is integrated with the corporate provider file.

The information provided on both the HCFA UPIN file and the State License file is not sufficient to complete the fields on the corporate provider file. The HCFA UPIN file includes the medicare provider number and only the provider's state and zip code. The State Licensing file includes the license number and only the provider name and home address. The missing information is the office address and tax ID number. Recently, HBMO has provided access to the AMA, AHA and JCHA organizations for provider data; this should facilitate the resolution of the validation process.

Systems has developed an implementation plan for the integration of the 1099 and the corporate provider file; approximately 12,000 1099 records will be integrated by 7/10/92. The second phase will include matching the ICS institutional file with the NASCO institutional file. The policy detailed in Exhibit I will be implemented after the first phase is completed. This will be implemented for all Local and National systems. I have assigned Cathy Janowski to be the project coordinator.

Actuary has completed the pricing for DME procedure codes; the pricing file has been recently approved by Health Affairs with some adjustments recommended. Actuary has agreed with the adjustments and will update the files by 6/19/92. The systems/benefit implementation date for local systems is 8/1/92. Systems/benefit file personnel for national systems will be contacted to develop implementation dates. Other specialty providers will be processed accordingly as the corporate provider file is validated with outside data.

cc: Harvey Friedman, CVP, Gov't. Programs
Cathy Janowski, VP, Prof. Ben. Admin.
Gloria McCarthy, VP, Nat'l. Acct. Oper.
Ed Skoldberg, VP, Comp. Del Sys.
Maroa Velez, VP, Auditing

FJB:js

TO: Mr. Fred Barba, Vice President
Core Processing Services

FROM: Donald L. Morchower
Executive Vice President
and Chief Operating Officer

DATE: May 26, 1992

SUBJECT: Elimination of Dummy Provider Codes

I have reviewed your May 19 memorandum on elimination of dummy provider codes, and by copy of this memo am forwarding a copy to Maroa Velez for her review. Also, I have the following questions or comments relating to the material:

1. Does Exhibit LA replace Exhibit I? If so, shouldn't page 16 of LA be added to I?

2. Even though the HCFA UPIN file and the State license file are not complete, they do indicate that the provider is valid. Why can't we add them to our in-house provider file with a special code indicating valid provider, missing information?

3. Please get commitments from Systems and any other unit needed for out-of-area providers and complete the out-of-area plan by assigning completion dates and giving it a high priority. Further, the 1099 match is only part of this process. What will be the operational procedure going forward for missing provider numbers after the 1099 exercise is finished - for all local and national systems? Finally, how will DMEs and other "specialty" providers be handled?

Please copy Maroa on your response to me with respect to these issues.

DLM pk
Att.

cc: Mr. Edward Skoldberg, Vice President
Comprehensive Delivery Systems (w/o attachments)

Ms. Maroa Velez, Vice President
Internal Auditing (w/attachments)

CONFIDENTIAL

ELIMINATION OF DUMMY PROVIDER CODES

MANUAL WORKFLOWS

MCS/EDS/TBS

To eliminate the use of Dummy Provider Codes in claims processing several initiatives have been undertaken. All manual procedures have already been implemented and are now part of our standard operating procedures. Others are in progress.

The procedures implemented to date include:

The elimination of dummy provider codes for in area providers.

The implementation of the unapproved provider workflow. (See Exhibit I)

Access to the NASCO provider file to assist in the assignment of provider numbers.

CS/90

Work is also in progress to eliminate the use of Dummy Provider Codes in CS/90.

A workflow has been created to review all claims finalized with Dummy provider codes in CS/90 on a weekly basis. The Provider System, NASCO, Healthnet and Dental Systems will be searched. If the provider is not present on any of these systems, the provider will be added with an unapproved flag and sent an application. (See Exhibit II)

EXTERNAL SOURCES

In addition to the above, a review of the HCFA UPIN File and the State license file was completed to determine whether or not they could be used to help eliminate dummy provider codes.

Our review identified the following:

The HCFA UPIN File utilizes the Medicare Provider number as its key and contains only the state and zipcode of the provider's practice, not the complete address.

The state license file uses the license number as its key and includes the provider's name and home address, not the office address.

Neither of these files can be used in conjunction with a claim to create an unapproved Provider Record.

The New Jersey Blue Cross Blue Shield P.O.S. Network initially obtained to support Bi State P.O.S. has been reviewed and compared to the Professional Provider System. All providers not on the system were added to the Provider File on 5/11/92.

INTERNAL DATA REQUIRING SYSTEM SUPPORT

Since our 1099 file contains providers that have been paid using a Dummy Number, we plan to use this file as a source for out of area providers, used by our customers, that need Empire Provider numbers.

The 1099 file will be compared to the Professional Provider System. All providers not on the Professional Provider System will be assigned an unapproved provider number. A letter and application will be sent requesting appropriate credentials.

The current status of this project is as follows:

- The 1099 File is being reviewed for data content.
- Datasets are being created to compare the 1099 File with the Professional Provider System.

Attached is a detailed project plan identifying the activities needed to complete this project. (See Exhibit III)

Completion dates have not been indicated since system resources have been working on other corporate priorities, i.e., P.O.S. Directories, P.O.S. Pharmacies, Bi State P.O.S., EMHC.

Date Prepared: May 19, 1992

CONFIDENTIAL

Procedural Workflow: Processing claims received without an EBCBS Provider number.

Revised: February 14, 1992

Procedures

The following are the steps to be taken when a claim is received from a provider who does not have an EBCBS Provider Number:

1.0 The Pre Computer Examining area (New York City) checks for a provider number in the Provider File. If no number is found, the claim is forwarded to Provider Register for review.

1.1 If the claims are processed in Albany/Middletown/DSC's, a Record Add form is completed and sent to Provider Register for review.

2.0 The Provider Register department checks the Healthnet, Dental, and NASCO Provider Files:

2.1 If the provider is found and participates in Healthnet, Dental or NASCO, an approved non participating medical provider number is assigned and the claim is processed. Payment is issued to the subscriber.

2.2 If the provider is found but does not participate in Healthnet or Dental, an unapproved non participating medical provider number is assigned, action reason code 060 and effective date is appended to the Provider System, and the claim is processed. The claim will then suspend to a designated location for review (i.e., in MCS it will be Location 514).

2.3 If the provider is not found on the Healthnet, Dental or NASCO Provider Systems, the provider is assigned a non participating unapproved provider number, action reason code 060 and effective date is appended to the Provider System, and the claim is processed. The claim will then suspend to a designated location for review (i.e., in MCS it will be Location 514).

Initial unapproved provider claim receipts:

3.0 Claims coded and processed with an unapproved provider number will suspend to a designated location and have applications sent to the unapproved provider:

CONFIDENTIAL EXHIBIT

3.1 If no response is received by the provider within 28 days, the claims are pulled by Provider Register and forwarded to Post Computer Data Correction for on-line rejection.

3.2 If response is received within 28 days, the Provider Register area terminates the 060 flag and the claim processes in the system.

Subsequent claim receipts from an unapproved provider:

4.0 Claims coded with an unapproved provider number by Pre Computer Examining will suspend to the designated location.

4.1 Provider Register reviews the claims and if the 060 is older than 28 days, will inform Post Computer Data Correction to reject the claim.

4.2 If the 060 is less than 28 days, hold claims in suspense with original until 28 days is reached by original claim submission. If no response is received from provider, reject all claims.

Claims received from Group Based Physicians:

5.0 If a claim is received with a group practice listed as the provider of service and they do not have a provider number, either a phone call should be made or a letter generated to obtain the individual provider name.

Procedural Workflow: Processing claims received without an EBCBS Provider number.

Revised: March 17, 1992

Procedures

The following are the steps to be taken when a claim is received from a provider who does not have an EBCBS Provider Number:

1.0 The Pre Computer Examining area (New York City) checks for a provider number in the Provider File. If no number is found, the claim is forwarded to Provider Register for review.

1.1 If the claims are processed in Albany/Middletown/DSC's, a Record Add form is completed and sent to Provider Register for review.

2.0 The Provider Register department checks the Healthnet, Dental, and NASCO Provider Files:

2.1 If the provider is found and participates in Healthnet, Dental or NASCO, an approved non participating medical provider number is assigned and the claim is processed. Payment is issued to the subscriber.

2.2 If the provider is found but does not participate in Healthnet or Dental, an unapproved non participating medical provider number is assigned, action reason code 060 and effective date is appended to the Provider System, and the claim is processed. Payment is issued to the subscriber.

2.3 If the provider is not found on the Healthnet, Dental or NASCO Provider Systems, the provider is assigned a non participating unapproved provider number, action reason code 060 and effective date is appended to the Provider System, and the claim is processed. Payment is issued to the subscriber.

3.0 The Provider Register Department generates an unapproved letter and application to the provider for credentialling purposes.

NOTE: Workflow changed to conform to policy in LRSP involving the use of dummy provider codes.

CONFIDENTIAL

TO: Mr. James Kenney

FROM: Sharon Slotnick

DATE: April 15, 1992

SUBJ: CS/90 Dummy Provide Codes

cc: D. Kane
D. Kirk

As per your request, attached is the workflow for the elimination of Dummy Provider Codes from the CS/90 System.

Feel free to contact me if you have any questions.

SS:ms

attachment

ELIMINATION OF CS/90 DUMMY PROVIDER CODES

AREA	ACTION
HOSPITAL GROUP SERVICE CENTER	1. CS/90 claim is entered - Provider not found on CS/90 provider database.
	2. If provider not found then enter onto CS/90 with provider code 999951.
CS/90 SYSTEMS	3. Scan of CS/90 system for all claims finalized with provider code 999951.
	4. Create report of all claim numbers from step 3.
	5. Create disk with images of all claims from step 4. - Give disk and report to Provider Register.
PROVIDER REGISTER	6. Review each claim image to determine if provider is on database. - If provider is on Corporate Database, no further action needs to be taken. - If provider is not on Corporate Database, check Healthnet, Nasco, and Dental Systems. If provider is par on one of these 3 systems, add to Corporate Database as an approved provider using information from Healthnet (flag 003), Dental (flag 004) or NASCO (flag 005) screen. - If provider is not on Corporate Database or par on another system, add to provider database using 060-unapproved provider flag. Send an application to the provider. Applications should be returned to Diane Kane.
	7. Return disk to CS/90 Systems to recycle.
	8. Applications returned completed will be added to Corporate Database.

ELIMINATION OF DUMMY PROVIDER CODE

NCS OUT OF AREA CLAIMS

DATE PREPARED: 12/01/91
DATE REVISED: 05/19/92
PAGE: / OF 2

Status: C = Completed, T = Target, L = Late & H = Hold

ACTIVITY/DELIVERABLE	ESTIMATED START DATE	ESTIMATED COMP. DATE	STATUS: NOT STARTED ON TIME	STATUS: NOT STARTED LATE	STATUS: IN PROGRESS ON TIME	STATUS: IN PROGRESS LATE	COMPLETE	RESPONSIBILITY	COMMENTS
1. Obtain 1991 NCS Pseudo Provider File (1099 File) approximately 90,000 records.					X			A. Mallozzi S. Losardo	
2. Compare 1099 File with Professional Provider System to determine if record already exists.			X					J. Morgan	Providers found on file with unique numbers to be excluded
3. Review Output			X					S. Slotnick	
4. Develop System Specifications and edit/validation criteria to load provider records from 1099 (Defaults for County Code, Specialty)					X			S. Slotnick O. Kane J. Kenney	
5. Create provider number ranges to systematically assign individual records.					X			O. Kane S. Slotnick	
6. Expand Database to support 1099 file load.								O. Sheaesh	Impact on response time, batch run time under investigation.
7. Obtain DASD needed to support database expansion.					X			J. Roth	Request submitted to Data Center.
8. Load provider records which did not match to IDMS Test Region.								J. Morgan	

ELIMINATION OF DUMMY PROVIDER CODE

RCS OUT OF AREA CLAIMS

DATE PREPARED: 12/01/91
DATE REVISED: 05/19/92
PAGE: 2 OF 2

Status: C = Completed, T = Target, L = Late & H = Hold

ACTIVITY/DELIVERABLE	ESTIMATED		STATUS				COMPLETE	RESPONSIBILITY	COMMENTS
	START DATE	COMP. DATE	NOT STARTED ON TIME	NOT STARTED LATE	IN PROGRESS ON TIME	IN PROGRESS LATE			
9. Load to IDMS production.								J. Morgan	Coordination with Claims Systems required.
10. Draft a letter to send to unapproved providers.					X			S. Slotnick	
11. Determine what system will generate letters.									
12. Generate letter.									Date should take into consideration, prep time for mailing.
13. Mail letter and application forms to providers.								R. Goglia	To be collated by Mail Operations. Two weeks lead time needed to meet mailing date.
10. Review returned applications and supporting documentation.								Prov. Register	
15. Update Provider System								Prov. Register	
16. Audit Updates								Prov. Register	
17. Update Provider File to reflect providers that did not respond.									Corporate Policy needed on what action should be taken if provider never responds.

DEPARTMENT OF HEALTH & HUMAN SERVICES
BUREAU OF PROGRAM OPERATIONS

Health Care Financing Administration

6325 Security Boulevard
Baltimore MD 21207
Refer to: BPO-QE32

APR 4 8 1993

Mr. Albert A. Cardone
Chairman of the Board and Chief Executive Officer
Empire Blue Cross and Blue Shield
622 Third Avenue
New York, New York 10017

Dear Mr. Cardone:

I am writing to you regarding the performance of Empire Blue Cross and Blue Shield during Fiscal Year (FY) 1992. My comments are based on the Contractor Performance Evaluation Program (CPEP) results that were communicated to you by the New York Regional Office (NY RO).

In FY 1990 and 1991 Empire BC's 1-year performance was stable. However, in FY 1992, Empire BC showed several performance deficiencies, ranking it 46th among 51 intermediaries. This decline in performance placed Empire BC in the bottom 20th percent of intermediaries for the one and two year rankings. The following CPEP deficiencies caused these results:

- Interim hospital rates established during this past year did not meet Medicare program requirements, resulting in significant over and under benefit payments.
- Processing of fraud and abuse cases did not include providing timely status to complainants' allegations.
- Electronic media claims (EMC) goals were met for the hospital and skilled nursing facility, but the goal for "other bills" category, such as Comprehensive Outpatient Rehabilitation Facility bills, was not met.

The NY RO staff will be scheduling a meeting with you. The meeting is to make certain that Empire BC clearly understands the performance expectations of the Health Care Financing Administration (HCFA).

For the last three years, Empire BS' performance also has been in serious decline. Your FY 1992 performance reflects numerous deficiencies and an overall performance rank of 45th among 47 carriers. Consequently, Empire BS placed in the bottom 20th percent of carriers for both the one and two year rankings. This performance is unacceptable. The following summarizes your performance deficiencies:

- Your Medicare Part B operation was deficient in meeting claims processing timeliness standards for processing clean participating physician claims within 17 days and clean nonparticipating physician claims within 24 days. This was despite the extension of performance relief for the conversion to the Metropolitan Medicare System.

- The accuracy of your reviews was abysmal. Eleven errors were identified, from a 60-case sample. The errors included: failure to issue a review letter, improperly paid amounts, lack of responsiveness to requests, and failure to dismiss reviews. It is clear that Empire BS has not demonstrated sufficient control of this vital area.

- Processing of fraud and abuse cases did not include providing timely status to complainants' allegations.

- Telephone service to beneficiaries and providers was seriously deficient. Your inability to meet HCFA's timeliness requirements led to Empire BS' failures in these important service areas.

- Empire BS' inability to send the Medicare Participating Physician and Supplier Directories to appropriate Social Security Administration offices and failure to mail all enrollment letters led to the failure of the participating physician program requirements. This negatively impacted on service to both providers and beneficiaries in your area.

- Empire BS failed to meet its EMC goal of 55 percent. I am also concerned that Empire BS may not achieve its EMC goal for FY 1993.

- Finally, Empire BS was also identified as a high cost contractor according to the Complexity Index developed for the FY 1992 Budget and Performance Requirements. This index took into consideration workload mix and medium of receipts. Empire BS' high cost condition persists in FY 1993. HCFA expects that you will take the necessary action to reduce your cost.

We are not restoring the automatic renewal clause in your contract because of Empire's unsatisfactory costs and performance.

We are committed to insuring that beneficiaries and providers obtain the highest level of quality service at the lowest possible cost. I expect that performance from Empire Blue Cross and Blue Shield. We have received your corrective action plans and note your agenda to correct your deficiencies in both your operations. Your performance in these areas will be closely monitored by the NY RO.

While I realize that a HCFA Central and Regional Office team met with Empire BS in February to discuss FY 92 problems and your efforts to improve in FY 93, I still believe its necessary to meet with you to ensure there is a clear understanding of our expectations regarding necessary improvements in Empire BS' performance. My office will be contacting you to arrange for such a meeting.

Hopefully, a year from now we can look back on significantly improved performance. If this proves not to be the case, then I want to put you on notice now that HCFA will non-renew your Part B Medicare contract. I believe that Empire Blue Cross and Blue Shield can do a better job of managing the Medicare workload in the State of New York. I challenge your company to immediately recommit itself to this goal and intensify its efforts to achieve excellent performance in FY 1993 and beyond.

Sincerely,

Carol J. Walton
Director

cc: Regional Administrator, New York
Associate Regional Administrator
for Medicare, New York

bcc: DAAO

Lisa's Disk
BPO-QE32 EMPIRE
PSAB File Code: PA-6-6

DEPARTMENT OF HEALTH & HUMAN SERVICES
BUREAU OF PROGRAM OPERATIONS

Health Care Financing Administration
6325 Security Boulevard
Baltimore MD 21207

JUN 17 1993

Refer to: BPO-QE32

Mr. Donald Morchower
Acting Chief Executive Officer
Empire Blue Cross and Blue Shield
622 Third Avenue
New York, New York 10017

Dear Mr. Morchower:

This letter serves as a follow-up to our June 7, 1993 meeting on your performance in the Medicare program. I was pleased to hear of the progress your Plan is making to correct performance deficiencies noted during fiscal year (FY) 1992 and that you are working toward meeting the items in your Corrective Action Plan. However, as we discussed, I am still concerned with a number of performance issues (e.g., Medicare Secondary Payer, limiting charge, management of change) which we discussed and are described in the enclosed meeting report. You have agreed to provide us with additional information regarding some of the practices in question.

In addition to the various performance issues, one of the major concerns we raised was your status as a high cost contractor and the fact that HCFA cannot continue to subsidize large volume, high cost contractors like Empire when other contractors are meeting HCFA's requirements at lower costs. In an effort to reduce your costs, I am pleased that you agreed at the meeting that your Plan could meet the FY 1994 national average cost per claim. Currently we estimate this cost at $1.56. If Empire is truly committed to sharing the goals and objectives of HCFA, you should strive for continued Bottom Line Unit Cost decreases, particularly due to your volume of Medicare business.

Finally, please be advised that the enclosed meeting report is being forwarded to the Senate's Government Investigations Committee at its request. I anticipate that I will be hearing from you regarding the issues we discussed over the next several weeks. Please feel free to call me if you have any questions.

Sincerely,

Carol J. Walton
Director

Enclosure

cc: Acting Regional Administrator, New York
Associate Regional Administrator
for Medicare, New York

bcc: David J. Butler

BPO-QE32:KMcCarthy:06/10/93
DISK:KRISTIE(CPR & RELATED DOCUMENTS)/FILE:MORCHOWR.WP

Meeting Report
Empire Blue Shield
June 7, 1993

Attendees:

Carol Walton, BPO
Gary Kavanagh, BPO
Ed King, BPO
Liz Cusick, BPO
Glenn Keidel, BPO
Kristie McCarthy, BPO
Jacqui Wilson, New York RO
Ted Shulman, New York RO
Tony Mazzarella, HCFA
Don Morchower, Empire Blue Shield
Harvey Friedman, Empire Blue Shield

Purpose:

As a result of the fiscal year (FY) 1992 Contract Management Action process, Empire Blue Shield was requested to meet with the Health Care Financing Administration (HCFA) to discuss performance problems and cost issues related to the carrier's administration of the Medicare program. The meeting, which was requested in an April 26, 1993 letter from the Bureau Director, was held in the HCFA Central Office on June 7, 1993.

Overview

Empire opened the meeting by informing HCFA of its interest and intent in improving performance. Although embarrassed by its past performance, the carrier was committed to "making things right". To that end, Empire indicated it was on target to meet each of the necessary performance activities in its FY 1993 corrective action plan (CAP). The carrier discussed in detail its performance relating to its CAP and provided the attached handouts outlining current contractor performance. With the possible exceptions of electronic media claims goals and correspondence and reviews issues, Empire anticipates no real problem with meeting HCFA's performance requirements in FY 1993.

A number of additional performance and cost issues were raised by HCFA during the meeting. The discussions of these issues are summarized below.

Release of Specialty Codes

The carrier's decision to release to physicians during the participation enrollment period only the top 100 specialty codes in FY 1992 was discussed. Empire was surprised by the written complaint registered last year by the New York State Medical Society, particularly since the carrier believes it has good rapport with this organization. Empire was strongly reminded, however, that this complaint was the result from an unhappy physician constituency. HCFA also noted that all carriers were expected either to release all codes or release only those which pertained to a particular physician. The decision to release the 100 most common codes was not an option afforded to carriers in FY 1992. Empire acknowledged that its decision on this issue "missed the mark".

Costs

Empire was informed that they needed to bring their costs down to at least the national average in FY 1994 and further, that HCFA cannot continue to subsidize large volume high cost contractors like Empire when other contractors are meeting HCFA's requirements for less money. HCFA informed Empire that its current FY 1994 estimate for the national average was $1.56 per claim. Empire agreed that it would meet the $1.56 national average for FY 1994.

Empire's Ability to Manage Change

Empire was informed that HCFA is concerned with the carrier's ability to manage change based on its historical performance and cannot tolerate a repeat performance experienced during Empire's transition in FY 1992 to the Medicare Metropolitan System (MMS) claims processing system. In light of Reconciliation legislation requiring major systems changes and with the coming of the Medicare Transaction System, HCFA is committed to insuring that Medicare program changes and transitions occur without interruption of service to the beneficiary and provider communities. HCFA strongly reminded Empire that it cannot manage its business with the intent of simply meeting Contractor Performance Evaluation Program (CPEP) requirements since the CPEP only measures acceptable performance.

Responsibility for Systems Problems

Empire described its problems with the implementation of its MMS system and its relationship with its subcontractor. Empire explained its rationale for selecting the MMS system but acknowledged that its decision may not have been a good choice. However, HCFA again reminded Empire that, as the prime contractor, it is accountable for the performance of its subcontractor. Subcontractor problems cannot be used by the contractor as an excuse for poor performance. HCFA provided Empire with several successful examples of smooth systems transitions for similar sized contractors.

Mistaken Medicare Secondary Payer (MSP) Payments

HCFA noted that the amount of mistaken payments made by Empire have been higher than anywhere else in the nation, and the amount of money owed to Medicare from Empire's private side business appears to be higher than anywhere else in the nation according to the HCFA/SSA Data Match statistics. Empire was asked to provide HCFA with its most recent Data Match statistics for mistaken payments and collections.

HCFA also expressed concern about alleged improper practices of sales representatives in Empire's private side business. The issue is allegations of misleading subscribers that Medicare is the primary payer rather than a secondary payer. Empire refuted this claim, asked for more specific information on the matter in question and promised to look into it further. HCFA agreed to this and asked that Empire provide HCFA with a written statement of its current MSP policy and practice. Mr. Morchower agreed to provide this.

Limiting Charge

HCFA is very concerned that limiting charge violations by physicians continue to be a problem in New York. HCFA noted that, while Empire in the past released initial letters to physicians who violated their limiting charges, Empire released only seven follow-up letters to persistent violators. HCFA indicated that the number of violators has not dropped, and the large number of overcharges in New York is an embarrassment to the carrier. HCFA noted that other carriers have been much more aggressive in efforts to resolve the number of violations. Empire staff at the meeting were not aware of this problem. HCFA directed Empire to further investigate this issue.

Summary

Empire was told that it must improve its service and its protection of Medicare trust funds and that good performance is not limited to CPEP areas and levels. HCFA concluded by stating that it viewed Empire Blue Shield as "being on probation".

Action Items

Empire	HCFA
o To provide HCFA with most recent statistics on how much MSP mistaken payments Empire has collected and how much Empire has demanded	o To provide Empire with specific examples of alleged MSP practices in its private side business
o To provide HCFA with a written statement that no improper practice is occurring on its private side business encouraging employers to bill Medicare as first payer rather than its private insurance	
o To investigate why Empire staff has not properly followed up on repeated physician limiting charge violators	

Attachment
Meeting Handouts

Deloitte & Touche

Memo

Date: May 12, 1992

To: FILE

From: Ruben D. Nava

Subject: **Empire Blue Cross and Blue Shield - Meeting with New York Insurance Department**

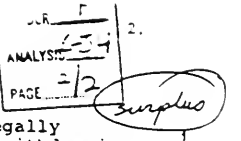
On May 4, 1992, I met with the following individuals to discuss Empire's financial position, rate increase applications and other matters. Al Cardone (Chairman and Chief Executive Officer of Empire), Gerry Weissman (Chief Financial Officer), Al Drewsen (General Counsel), John Lynch, Hinman & Straub (outside counsel for Empire), Salvatore Curiale (Superintendent of Insurance of the State of New York), Miriam Boggio (Deputy Superintendent) and Charles Henricks (Property Company -> Assistant Chief). ICS

Mr. Cardone opened the meeting by discussing the company's current financial position. As of 12/31/91, Empire had $144 million of statutory surplus which is below New York State statutory minimum. Mr. Cardone and Mr. Weissman proceeded to discuss 40 scenarios (attached) regarding the projected surplus position of the company. The scenarios were a combination of assumptions regarding:

- Community rate increase
- A community rating state legislation
- Demographic group legislation
- Product withdrawal
- Hospital differential

The community rated bill and the demographic bill are hereafter referred to as "significant legislation". The largest affects on projected surplus come from rate increase, legislation, and product withdrawal.

Superintendent Curiale's Order and Decision dated April 1, 1992 stated that in the absence of significant legislation, he would approve a 12.4% rate increase as of October 1. Certain of the scenarios in the attached analysis provide for the affects of both significant legislation and October 1 rate increase. Mr. Curiale said that if significant legislation is passed, he would rescind approval. Therefore, several of the scenarios are not likely, namely, scenarios 9-10-11-12-17-18-19-20.



Mr. Curiale also stated that although he is not legally empowered to prevent Empire from discontinuing or withdrawing certain non-profitable products, he would not endorse product withdrawal if significant legislation was passed. Assuming Empire would not withdraw products if significant legislation were passed, then scenarios 31-32-39 and 40 are also unlikely. If legislation is not passed, scenario 4 appears to be a likely outcome. If significant legislation is passed, scenario 30 appears to be a possible outcome.

In both of these scenarios, surplus is expected to be positive at December 31, 1992. In fact, in very few scenarios is surplus negative at December 31, 1992. Therefore, there does not appear to be substantial doubt as to Empire's positive position at December 31, 1992. I then discussed with Mr. Curiale the fact that Empire's surplus position at December 31, 1991 and projected surplus position at December 31, 1992 are below statutory minimum surplus and therefore, may affect our opinion on Empire's 1991 financial statements since the Insurance Department is empowered to take regulatory action such as department supervision of the company, liquidation of the company, etc. Mr. Curiale promised me that he has no intentions of taking regulatory action against Empire. In view of such assurances, I do not believe that there is substantial doubt about Empire's ability to continue as a going concern due to any regulatory actions.

Also attached is a copy of New York State Insurance Department's bulletin regarding Mr. Curiale's testimony on these subjects.

Sincerely,

Ruben D. Nava

MEMORANDUM

Date: March 2, 1993

To: FILES

From: Richard G. Gander

Re: Meeting With The New York State Insurance Department

On March 1, 1993 Ruben Nava, Lead Client Service Partner and I met with New York State Insurance Department Representatives Vincent Laurenzano, Chief of the Property Bureau and Charles (Chuck) Henricks, Assistant Chief Examiner to discuss items which could have an affect on our audit report relating to the 1992 financial statements of Empire Blue Cross and Blue Shield (Empire). At our request, Jerry Weissman, Chief Financial Officer of Empire attended the meeting.

We had requested this meeting with the Insurance Department because Empire's Reserve for the Protection of its Customers (Surplus) is below one half of the statutory reserve minimum established by the NYS Insurance Department. In addition, a regulatory examination of Empire, by the NYS Insurance Department is still in process, the findings of which could have an affect on our audit report.

The first item discussed dealt with the Insurance Department's ability to take control of Empire, or to put it under its' supervision, since Empire is below one half the statutory minimum established by the NYS Insurance Department. In response to this question, V. Laurenzano indicated that the Insurance Department had "no intention to take control of the company or put it into rehabilitation". V. Laurenzano further added that it has been the practice of the Insurance Department to grant Empire substantially all of the rate increases they had requested.

A related discussion transpired with respect to a $100 million ($93 million lump sum) which Empire would be receiving from the State later this month in settlement of a lawsuit brought by Empire and other insurers for the return of excess contributions to the State Malpractice Fund. While the accounting for this transaction was not agreed upon at the meeting, it was agreed that this event was a 1993 transaction which has little bearing on Empire's 1992 financial statements.

We asked the Insurance Department if they had reviewed, or had a problem with the three year plan (required pursuant to Insurance Law Section 4310(e) to restore surplus which was submitted by Empire to the Insurance Department in the fall of 1992. In accordance with Section 4310(e) any reductions to the statutory minimum authorized by the superintendent shall be restored within a period of not more than three years. While the Insurance Department indicated that they did not have a problem with the original three year plan, they did indicate that Empire was now required to submit a six year plan due to a change in the legislation enacted by the New York State Assembly in January of 1993. This change in legislation extends the time period for restoration of minimum reserves for Article 43 Corporations from three years to six years. Empire will be required to file a revised restoration plan sometime during the summer of 1993.

Arthur Andersen was engaged by the Insurance Department during September 1992 to perform a Financial/Management audit of Empire. The report resulting from this audit is due by May 1, 1993. In response to a question dealing with findings from this audit, C. Henricks indicated that the Department had one briefing with Arthur Andersen which was performed after Phase I of the project, which was approximately the middle of December. C. Henricks further indicated that a second briefing following Phase II was scheduled for tomorrow, March 3rd. Before leaving the discussion of this topic we asked if they wanted us to follow-up with them later this week. To this they indicated that they would bring it up at their meeting with Arthur Andersen on Wednesday and advise us accordingly.

At this point we asked if there was anything identified by the Insurance Department during its' regulatory examination which could have a significant effect on the 1992 financial statements of Empire. To this question C. Henricks replied that based upon his last discussion with the field examiner that there were certain matters in the area of Interplan activities and experience rated group business which had been identified. It was further C. Henricks' belief that the experience rated business items identified were more in the area of operations, quotation of rates and allocation of results, than financial areas which would have a material effect on the financial statements.

We closed the meeting by briefly discussing the Department's reaction to the recent court decision which set aside the current hospital surcharge reimbursement system. V. Laurentano indicated the Department has gone on record that they disagree and are currently appealing the decision.

Having no other items to discuss we adjourned the meeting.

622 THIRD AVENUE, NEW YORK NY 10017-6758

November 20, 1992

Donald L. Morchower, Chief Operating Officer
Victor Botnick, Vice President

We have completed a follow-up review of the audit concerns relating to the Physicians Provider File System. The scope of our follow-up review was to determine the status of corrective action taken to address the specific control weaknesses noted below, with the exception of dummy code usage. The status of the project to eliminate dummy code usage will be addressed under separate cover.

The following issues were noted in our report dated September 1991, that resulted in an inadequate opinion on the internal controls:

- The lack of minimum credentialing criteria to establish a physician as an authentic and current practitioner
- Failure to validate physicians' credentials on an ongoing basis against information from State licensing authorities and other appropriate bodies
- Untimely purging of the Provider File of inactive providers or entities who no longer have valid licenses required by the state, and
- 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.

Health Benefits Management Operations (HBMO) Management had advised that implementation of the recommendations to correct certain of the above mentioned concerns was dependent on the decision to establish a unit within the HBMO, along with the necessary funding, to credential and re-credential providers of service. However, neither the unit nor funding has been finalized to date. As a result, although some re-credentialing of certain providers has occurred as part of the project to eliminate usage of dummy provider codes, there has not been significant progress made to correct the concerns noted above.

As you are aware, the Corporation is committed to ensuring that optimum health care is administered to its subscribers and

ensure completeness, accuracy and validity of records input to the Provider File.

The Provider File is one of the most significant controls that the Corporation has at its disposal to ensure the accuracy and validity of claim payments, providers of services, and pricing procedures. It is therefore essential that the issues within this report are resolved as soon as possible. We will continue to monitor this function on an ongoing basis.

We would appreciate receiving your written responses to these issues within two weeks.

Maroa C. Velez
Vice President
Auditing

cc: Fred Barba, Vice President
Catherine Janowski, Vice President

File based on existing documentation standards, however, these standards do not meet the requirements of our previously reported recommendations, in that, minimum credentialing criteria have not been established, as noted earlier.

In addition, as part of the State license verification project undertaken to eliminate the use of dummy provider codes on the Provider File, PBA and Systems ran a New York State Department of Education - Division of Licensing Services tape of licensed doctors of medicine (MD) and doctors of osteopathy (DO) against the Provider File. The project plan required that the fallout of MDs and DOs not on the provider file or those who appear on our file but not on the State file, should receive letters requesting updated data/credentialing information. This task was completed on September 29, 1992. A decision is pending as to the action(s) to be taken if these doctors do not respond or if they do not submit adequate documentation.

In conjunction with this project, certain providers were "re-credentialed", i.e., requested to submit their current registration, DEA certificate and specialty documentation to add a new speciality; however, essential information pertaining to physician education, Board Certification, training, and experience was not requested due to lack of established minimum credentialing criteria as previously noted. Furthermore, there are no current plans to verify the supporting documentation against the records of the issuing agencies, hospitals and/or schools.

Recommendation

Management should validate and re-credential, as soon as possible, all existing physician records.

Purging of the Provider File

Finally, our review revealed that the existing file had not been purged since 1984. We recommended that the Provider File should be purged at reasonably scheduled intervals, allowing for an eventual time limitation for filing claims.

Complete purge specifications are currently being developed, and purging of the Provider File will follow the 1099 mailings for 1992.

Recommendation

Management should also ensure that the Provider File is purged at reasonably scheduled intervals. In conjunction with the purging procedures, management should institute ongoing comprehensive supervisory review procedures to

clients by providers who meet the standards of professional competence and personal integrity considered necessary to protect the public. To this end, the accuracy, completeness and effectiveness of the Provider File are of the utmost importance. Without such control, the Corporation may compromise its position, paying claims timely but honoring claims from physicians without sufficient information to establish the adequacy of their qualifications, and/or defaulting to the assignment of dummy code numbers to pay such claims. Consequently, the Corporation is vulnerable to paying fraudulent claims and invalid/non-existent providers of service. Furthermore, the Corporation's ability to adequately assess utilization review trends and to detect abusive physician practice is significantly hindered.

The status of corrective action is as follows:

Establishment of Minimum Credentialing Criteria

To date, minimum credentialing criteria e.g., licensure/registration, medical education and training, Board Certification, experience, malpractice history, etc. have still not been developed. The current credentialing standards are limited to obtaining a copy of the physician's state medical license, DEA certificate, and specialty documentation in certain cases.

Recommendation

We recommend that management expedite the final criteria for credentialing of providers, considering the current managed care environment, and implement the appropriate operating procedures.

Validation of Physicians' Credentials

Our prior audit revealed numerous problems with respect to the existing documentation supporting provider credentials. We noted that the PBA files were incomplete and that certain documentation was illegible. Furthermore, the physicians' credentials had not been validated against independent, external sources such as the American Medical Association or New York State Department of Education - Division of Professional Licensing Services.

We recommended that management validate and re-credential, as soon as possible all existing physician records. All applications and supporting documentation should be verified against the records of the issuing agencies, hospitals and/or schools.

Pending the establishment of the unit within HBMO, PBA Management continued to add new physicians to the Provider

memo

To Distribution

From Maroa C.Velez

Date February 25, 1993

Subject Dummy Code
Utilization
Status

Distribution:

Albert A. Cardone
Victor E. Botnick
Thomas A. Blumenfeld M.D.
Donald L. Morchower
Harvey W. Friedman
Gary W. Muller

We have completed our status update of the corrective action taken to establish appropriate databases necessary to eliminate the use of dummy coding to process claim payments. A project manager, responsible for the oversight and day-to-day management of activities/deliverables undertaken to eliminate the usage of dummy codes (including development, prioritization and monitoring of a task plan), has been assigned by senior management. This memorandum is intended to communicate the current status of the various initiatives underway and provide the project manager with areas of focus.

Brief Background

Over half a billion dollars in claim payments are being made on an annual basis using dummy provider/procedure codes. Dummy codes are utilized in virtually all the corporate claims processing systems with the exception of TOPPS (See Attachment A). Dummy provider coding (e.g., Pharmacies, Physicians, Psychiatrists, etc.) allows a claim to bypass established system edits for a valid provider number and pay a provider or subscriber, even though EBCBS has not validated the existence and licensing status of the provider. In addition to dummy provider coding, certain services, (e.g., Drug/Pharmacy, Durable Medical Equipment, etc.) are dummy coded at the procedure level which precludes pricing controls and medical necessity determination.

Status of Current Initiatives

The key to eliminating dummy codes is the development of adequate databases that will enable the claims processors to appropriately code claims and capture the necessary information. Our assessment of the current usage of dummy codes revealed that although corrective initiatives on the various databases have been undertaken, the extensive utilization of dummy codes in the

processing of claim payments continues and the risks therefore remain. Specifically:

- The provider files do not contain data/information necessary to support detail identification and verification of providers which service our subscribers. Furthermore, minimum credentialing criteria for providers has not been established. The credentialing criteria will ensure that the necessary quality measures are considered as the provider databases are being developed.

  Health Policy management has agreed to establish minimum credentialing standards for professional providers (including specialty providers), as well as, institutional providers. Health Policy and Managed Care management will work together, to research the available information from the various licensing authorities to determine the best source of information to populate/validate the provider databases in an expeditious manner and the cycle in which updated information is issued to ensure that the databases are maintained current. Core Processing Services and Systems will support licensing file/record comparison activities.

- New York area Providers (In-area) - The New York area (in-area) provider file is still in need of extensive clean up.

  Various initiatives were undertaken to ascertain the validity of New York State providers specifically, a comparison with N.Y. State Licensing Services data was performed for MDs and DOs, however, this effort revealed a significant number (25,000) of non-matches. This indicates that the existing Provider File contains extensive non-current data and may in fact include unlicensed providers. Requests for updated credentialing information were sent to all providers where the data did not match.

  Applications/supporting documentation have been returned and the Provider File updated, where appropriate. A significant number of providers have not responded to Empire's information requests. In addition, numerous applications have been returned by the Post Office as undeliverable. Follow-up action is necessary to at least establish the validity of these providers and their licensing/certification status.

  Managed Care management has agreed to credential/re-credential all providers once credentialing criteria and/or license validation methods have been established. The clean up of the New York area provider file should be given the highest priority.

Once the provider files are updated/cleansed, a claim payment policy decision needs to be made regarding what action should be taken if a provider does not respond to requests for credentialing data, (e.g., suspend or reject all claims). Current policy for in-area claims is that payments will be made to subscribers if the providers are not included in our Physicians Provider File and they do not respond to requests for credentialing information. In such cases, "unapproved" provider numbers have been assigned by the Provider Register Group (since May 1991) to in-area providers whose credentials have not been validated except for private duty nurses, pharmacies, and outpatient departments. This procedure provides an audit trail of payments, but it does not prohibit payments for services by potentially invalid/unlicensed providers.

- Out-of-New York Area Medical Providers - Empire does not have a database for providers that practice out of the New York area. Research by area management has revealed that there is no existing national database for physicians which can facilitate an automated feed to an Empire national provider file/database. As result, most claim payments to subscribers that were serviced by "out of area" providers are not validated prior to payment and are processed using dummy codes. An action plan is needed to address the development of a national database of all medical providers. Management is currently investigating the purchase of a directory of physicians in the United States, available from the American Medical Association.

- Institutional - Institutional claims are the costliest. The development of a national institutional database which includes out-of-area facilities should be prioritized and may be easier due to the fact that there are a limited number of hospitals servicing Empire customers.

- Pharmacy and Drugs - Dummy codes continue to be used to process the vast majority of routine drug claims. Possible solutions include the migration to DPS as a third party payment vendor or the development of a drug database to enable detail coding by Empire claims operations. The current plan (of the Marketing area) is to work toward migrating most of the Community Rated business to DPS by June 1993. This would address the largest portion of the drug processing volume.

- DME - Dummy codes continue to be used in durable medical equipment claim payments, although significant progress has been made to eliminate their usage. A database now exists which details all of the necessary equipment/services codes, and detail coding will be implemented shortly.

- Other - A cost/benefit analysis of the elimination of dummy codes needs to be performed on each of the "other" in and out-of-area dummy coded specialty providers and categories of services. (See Attachment B) Once completed, an action plan needs to be developed to establish the necessary databases and claims payment policies.

Impacts/Risks

- Provider files are relied on by nearly every processing and support area within the company and contain data critical to Empire's daily business transactions. Failure to properly maintain these files could result in significant and unnecessary administrative expenses.

- Explanations of Benefits (EOBs) are not issued for dummy coded claims, thus eliminating critical checks and balances for fraud detection.

- Utilization review is virtually impossible since the claim payments are all "lumped" together. Due to the lack of systemic data, manual hardcopy claim analysis is required.

- Abusive use of dummy coding to facilitate employee fraud or to improve performance statistics is highly possible due to the well known lack of back-end/detective review of the dummy code utilization data.

- Dummy procedure coding limits Empire's ability to review the medical necessity/appropriateness of the procedure (e.g., quantity, frequency and duration analysis; upcoding and medical appropriateness reviews), and also limits the imposition of pricing controls over billings.

- Inaccurate records of payments to providers may result in erroneous 1099 reporting.

We will work with the project manager and continue to monitor the status of the dummy code activities/deliverables on an ongoing basis.

cc. Fred Barba
Catherine Janowski
Gloria McCarthy
Eric Schlesinger
Jerry Weissman

ATTACHMENT A

Summary of Dummy Code Initiatives

System	Category	1991 $ Paid	Dummy Usage Y/N	Action Y/N	Comments
	Medical Claims				
MCS	In Area Providers	-	Y	Y	• NYS license file match (MDs & DOs only) • Unique "unapproved" provider numbers are being assigned
MCS	In and Out of Area Other Specialty Providers	13,173,241 (See Attachment B)	Y	N	
MCS	Out of Area Providers *	95,134,497	Y	Y	• 1099 file match • AMA directory of licensed physicians to be obtained
MCS	Pharmacy/ Drug	120,710,522	Y	Y	Migration to DPS under evaluation
MCS	Durable Medical Equipment	15,587,271	Y	Y	Database to facilitate coding has been designed
MCS	Other Services/ Procedures	13,813,666 (See Attachment B)	Y	N	
MCS	**Subtotal**	**258,419,197**			
EDS/ NASCO	Medical	77,620,188	Y	N	• AMA directory to be obtained
TBS	Medical	27,514,229	Y	N	• AMA directory to be obtained
	Hospital Claims				
ICS	Hospital	93,226,324	Y	N	
EDS/ NASCO	Hospital	15,890,476	Y	N	
TBS	Hospital	32,084,019	Y	N	
	Total	**504,754,433**			

* Includes in area providers which were not assigned unique, "unapproved" provider numbers

ATTACHMENT B

1991 MCS Dummy Code Usage Providers

Categories of In and Out of Area Other Specialty Providers	1991 Payments *
Christian Science	$ 93,322
Psychologist	1,529,777
Social Workers	417,344
Midwives	9,768
Physiotherapy	1,530,756
Visiting Nurse	1,033,496
Private Duty Nurse	7,785,628
Chiropractor	773,150
Subtotal (Other Specialty Providers)	$ 13,173,241
Categories of Other Services /Procedures	**1991 Payments ****
Hospital	$ 2,620,134
Laboratory	1,949,910
Diagnostic	5,254
Occ. Therapy	39,173
Speech Therapy	44,898
Ambulance	466,867
Optometrist	335,338
Outpatient	8,352,092
Subtotal (Other Services/Procedures)	$ 13,813,666

* Method of reimbursement depends upon type of contract /service (e.g., UCR, charges, fee schedules).

** Method of Reimbursement is charges.

NATIONAL EMPIRE CONTROL ACCOUNTS

CANCELLATIONS 1988 TO PRESENT

ACCOUNTNAME	CANC DATE	PRODUCT	NATIONAL CONTRACTS
ADT Security Services Inc	07/01/89	Hospital	8,456
American Bureau of Shipping	01/01/89	Hospital	1,101
Animed Inc	07/15/90	Hospital	205
Broadcast Music	04/01/88	Hospital	446
C T Corporation	04/01/88	Hospital	882
Chase Manhattan Bank	01/01/91	Hospital/Drug	22,598
Citibank N A	01/01/91	Hospital	28,969
Clarkson Industries Inc	01/01/91	Hospital	281
College Entrance Exam Board	07/01/90	Hospital/Basic	170
Conrans	09/01/92	Hospital	235
Coopers and Lybrand	01/01/92	Hospital	7,475
Culbro Corp/Moll Tool & Plastic Corp	01/01/89	Hospital	1,632
Cushman and Wakefield	01/01/88	Hospital	2,478
D C A Food Industries	07/01/88	Hospital	362
Dah Chong Hong Trading Corp	01/01/89	Hospital/Maj Med/Dental	282
Diamandis Communications Inc	01/01/91	Hospital	800
Dictaphone Corp	01/01/89	Hospital	2,865
Direct Press/Modern Litho	08/01/90	Hospital/Major Medical	162
District 65 Security Plan	12/31/91	Hospital	23,805
Drexel Burnham Lambert	08/01/89	Hospital/Major Med	7,325
E F Hutton and Co Inc	03/01/88	Hospital	14,306
E M Industries Inc	10/01/91	Hospital	578
Ebasco Services Inc	07/01/89	Hospital	5,089

NATIONAL EMPIRE CONTROL ACCOUNTS

CANCELLATIONS 1988 TO PRESENT

ACCOUNTNAME	CANC DATE	PRODUCT	NATIONAL CONTRACTS
Eden Park Nursing Home	07/01/91	Hospital/EMB	1,156
Felton Worldwide Inc	08/01/91	Hospital	39
Fischbach Corporation	05/01/91	Hospital	1,144
Fleet/Norstar Bank Inc	01/01/90	Hospital	6,099
Four M Corporation	06/01/89	Hospital/Major Med	727
GHI-Federal	01/01/89	Hospital	57,652
Goldman Sachs & Co	01/01/93	Hospital	6,239
Golub Corporation	01/01/91	Hosp/Basic/Maj Med	3,965
H Kohnstamm & Co Inc/Universal Food Corp	01/01/89	Hospital	90
Helme Tobacco Company	01/01/91	Hospital	250
I M I Systems Inc	01/01/92	Hospital	201
Institute Electrical&Electronic Eng	01/01/91	Hospital	370
International Nickel Corp	06/01/89	Hospital/Drug	943
Irving Bank Corp	01/01/89	Hospital	6,502
J P Morgan & Co Inc	12/01/92	Hospital	6,333
J Walter Thompson & Co	01/01/93	Comprehensive	1,271
Manufacturers Hanover Trust	01/01/93	Hospital	9,994
March of Dimes Foundation	01/01/89	Hospital/Medical/MajMed	1,887
Metropolitan Broadcasting Corp	04/01/90	Hospital	173
Morse Diesel Inc	01/01/88	Hospital	459
N W Ayer Inc	05/01/91	Hospital	838
National Westminster Bank Retirees	01/01/93	Hospital/Medicare Supl	1,141
Neighborhood Cleaners Association	11/01/91	Hospital/EMB	1,340

NATIONAL EMPIRE CONTROL ACCOUNTS

CANCELLATIONS 1988 TO PRESENT

ACCOUNTNAME	CANC DATE	PRODUCT	NATIONAL CONTRACTS
New York Farm Bureau	07/01/92	Hospital/EMB	8,272
Ogilvy & Mather Inc	01/01/90	Hospital	1,190
Olympus Corporation	01/01/90	Hospital	257
Pall Corporation	06/01/89	Hospital	1,355
Panalpina Inc	10/31/92	Hospital/EMB	814
Photocircuits Corp	04/01/92	Hospital	778
Plessey North America Corp	06/01/88	Hospital	975
Plymouth Lamston Stores	10/01/88	Hospital	305
Rapid American Corp/Riklis Family Corp	02/01/89	Hospital	680
Regional Data Center Inc	09/01/90	Hospital/EMB	233
S E Nichols Inc	12/01/88	Hospital/Medical/Maj Med	1,563
Schenkers International	01/01/92	Hospital/EMB	900
Schenley Industries Inc/Guinness AmerInc	06/01/89	Hospital	472
Sid Harvey Industries	06/01/91	National Wrap	793
Simmonds Precision	04/01/88	Hospital	3,310
Sony Music Entertainment Inc	09/01/92	Hospital	5,475
Southern Container Corporation	09/01/89	Hospital/Basic/Major Med	360
The Associated Press	02/01/91	Hospital	3,674
The Bank of New York Co Inc	01/01/90	Hospital	9,229
The Chubb Corporation Active	01/01/92	Hospital	5,200
The Chubb Corporation Retirees	01/01/93	Hospital	1,191
The Dun and Bradstreet Corp	01/01/91	Hospital	14,517
The Equitable Bag Co	01/01/89	Hospital/Medical	155

NATIONAL EMPIRE CONTROL ACCOUNTS

CANCELLATIONS 1988 TO PRESENT

ACCOUNTNAME	CANC DATE	PRODUCT	NATIONAL CONTRACTS
The Hearst Corp	07/01/90	Hospital/Wraparound	2,844
Transkrit Corporation	03/01/93	Hospital	386
United Welfare Fund Amal Union	06/15/91	Hospital	14,078
Veeco Instruments Inc	02/01/90	Hospital	1,116
William Morris Agency	09/01/88	Hospital	517
Xertex(National Sonics)	02/01/90	Hospital	64
Ziff Communications Company	03/01/89	Hospital	1,811
TOTAL ACCOUNTS 76			321,829

L STRASSBERG OCT 7 1988

TO: HECTOR GREFALDA
DICK FREDERICK

FROM: PAT BLAIS
FRANK HEBERT

RE: TEFRA/DEFRA PAYMENT LIABILITY

DATE: SEPTEMBER 21, 1988

About two years ago a decision was made to process only balances from Medicare EOB's when Medicare paid primary (in error) in Tefra/Defra cases. The rationale behind this was, if we had paid our liability in full, and Medicare paid the primary liability in error, this would cause duplicate payment to the subscriber. At that time, Medicare was not recognizing these cases very readily.

However, we feel this payment rationale needs to be adjusted for several reasons. First, the subscriber is paying for coverage assuming that we will pay our primary liability. If we are only paying a balance after Medicare when Medicare paid in error, we are then collecting a premium for full coverage, however, only paying partial benefits. Therefore, we are recommending that when we identify a subscriber who is eligible for Tefra/Defra that we will pay our liability as primary carrier despite the fact that a Medicare EOB is attached to the claim.

Please let us know at your earliest convenience what your thoughts are about this procedure. Dick, we are seeking your input since it affects groups administered by your team's. We will then have to draft a policy and payment procedure to all examiners. We are currently holding a few claims pending this decision.

Thank you.

fmjp

cc: Managers

Dick Frederick
Pat and Frank could quite understand this out of the basics that page the group FIRST, IT'S NOT THE SUBSCRIBER. SECOND, IT IS NOT THE PREMIUMS TO OVERPAY A BENEFIT TO A SUBSCRIBER. CONTRACTUAL LIABILITY. IF MEDICARE ERRONEOUSLY PAYS AS PRIMARY, THE CHECK PAY A SECONDARY

OCT 2 3 RECD

cc MAV

ERROR CONFIDENTIAL

October 24, 1985 CONFIDENTIAL

TO: Managers
Debbie Reynolds
Chris Wong

FROM: Pat Blaisdell

SUBJECT: TEFRA/DEFRA Payments

Please see a copy (which I trust you will keep confidential) of a memo sent by Frank and I to Hector and Dick. Dick passed this on to Les Stressberg, Actuarial, and you will see at the bottom the response that Les had to Dick.

In essence, he is stating that we should continue to only pay balances if Medicare has made a payment incorrectly as a primary. We will, therefore, continue making payments on these claims as we have been. (Frank and I are aware that it is not the subscriber that is making payment for this coverage, but rather the group. This was just worded incorrectly by us.)

Debbie, please be sure that we continue to train in the same fashion. I trust that we are following these procedures for medical as well as institutional processing. We do know, however, that we have several letters pending in our department from Medicare Part A stating that they are requesting refunds. These letters should continue to be held since we are awaiting an answer from T.C. Westcott's area.

If you have any questions, please contact me immediately.

/cew
Attachment

cc: Hector Crefelos
Dick Frederick

000868

AFFIDAVIT

STATE OF NEW YORK)
: ss.:
COUNTY OF NEW YORK)

MAROA C. VELEZ, being duly sworn, states:

1. I am Vice President in charge of the Audit Division of Empire Blue Cross and Blue Shield ("Empire").

2. The New York State Department of Insurance, through Paul Altruda, Esq., has requested that I submit this affidavit setting forth a portion of a conversation I had on June 16, 1993 with Jerry Weissman, Empire's Chief Financial Officer.

I have previously told representatives of the Insurance Department in an interview on June 21, 1993 of the entirety of this conversation as well as a number of other matters leading up to it. In accordance with the Department's request, this affidavit does not set forth my complete knowledge of the events leading up to this conversation or its entire contents.

3. The conversation in question took place during the morning of June 16 in my office at Empire. Mr. Weissman and I were the only ones present. The subject of the conversation was the discrepancies between the community-rated and experience-rated losses as reported in the market segment reports included in Empire's internal financial statements as compared to those figures reported in the annual statements. Mr. Weissman 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.

4. Immediately after the conclusion of my conversation with Mr. Weissman, I went to meet with Harold Vogt, Chairman of Empire, and recounted the entire conversation, as well as certain other events leading up to the conversation. Mr. Vogt then directed me to provide this information immediately to Alan Drewsen, the

General Counsel of Empire, and I did so. I also promptly contacted by telephone Donald Morchower, the Acting Chief Executive Officer of Empire, and gave him the information as well.

Maroa C. Velez

Sworn to before me this date:
June 29, 1993

Notary Public

ELIOT SPITZER
Notary Public, State of New York
No. 31-4238393
Qualified in New York County
Commission Expires [illegible]
11/30/93

STATEMENT OF MAROA C. VELEZ
VICE PRESIDENT, AUDIT DIVISION
EMPIRE BLUE CROSS AND BLUE SHIELD

June 30, 1993

I am Vice President in charge of the Audit Division of Empire Blue Cross and Blue Shield ("Empire"), a position I have held since September 1989. Immediately prior to assuming my current position I was employed by Manufacturers Hanover Trust Company in New York, where I was Vice President and Audit Director from 1983 to September 1989. Prior to that, I was employed by the accounting firm then known as Deloitte Haskins & Sells, where I attained the position of Supervising Senior. I was born in Santiago de Cuba, Cuba and came to the United States in 1962 at the age of five. I earned a bachelor of science degree in accounting at Fairleigh Dickinson University. I am a certified public accountant.

I submit this statement to the Subcommittee, with its permission, in order to respond to a false allegation about my conduct contained in the report of the Subcommittee Staff. In that report it is alleged that Thomas Ward, an employee of Empire who formerly re-

ported to me, testified in a deposition taken by the Staff that I "attempted to hide the details" of a report dealing with the issue of dummy codes from the Subcommittee, the New York regulators, Arthur Andersen, and Towers Perrin because I "didn't want the adverse information getting out."

I wish to state categorically to the Subcommittee that the allegation is false and outrageous. During my tenure at Empire, I have always diligently worked to cooperate with state regulators, outside auditors of the company, and any inquiries by law enforcement agencies. In addition, I have attempted at all times to cooperate fully with the Subcommittee's investigation of Empire. Indeed, I testified before the Subcommittee on June 30 voluntarily, without subpoena, as I did in an informal interview with the Staff on June 3. At no time have I attempted to "hide" or otherwise suppress adverse information from any of these bodies.

With respect to the specific issue of dummy codes, during my tenure at Empire, I have on numerous occasions issued audit reports and other memoranda dealing in great detail with this issue and setting forth candidly my department's assessment of Empire's problems in this area and its need to make significant improve-

ments. By my calculation, there have been five audit reports issued between 1991 and the present dealing at least in part with the issue of dummy codes and ten additional memoranda on the topic. These reports and memoranda were distributed widely within Empire.

I and others working at my direction have specifically discussed issues and made available documents relating to the problem of dummy codes with the state regulators, Arthur Andersen, Towers Perrin, and the Staff of the Subcommittee. In addition, contrary to the Staff report, I never intended to convey to the Staff that a September 1991 audit report on this subject was "erroneous" or "sloppy" or that the issues raised were not important. I am proud of the work of my department on this issue and I stand behind it.

The testimony of Mr. Ward in his deposition, a copy of which I reviewed for the first time on June 28, apparently refers to a document which he erroneously characterizes as an audit report dated January 13, 1993, which he believes was never released. In fact, the January 13 document was an earlier draft of a February 25, 1993 memorandum which I did issue providing a status report on dummy code utilization. I do not even believe I saw a copy of the January 13 draft which was one of a

number of preliminary drafts worked on by my staff. My February 25 memorandum, which was provided to the Subcommittee and which in no way dilutes the substance of the earlier draft, was distributed to eleven officers of the company. My memorandum of that date was entirely consistent with my continuing effort to underscore and solve the problems arising from the use of dummy codes.

I find it particularly unfortunate that a charge this serious, carrying with it the potential to cause harm to my reputation and integrity, was published by the Subcommittee in its report, and highlighted in its oral presentation on June 25, solely on the basis of Mr. Ward's uncorroborated testimony without affording me the opportunity to respond to his charges and including my response in the report. Just as I met with the Staff on June 3 and testified before the Subcommittee on June 30, I would have been happy to have met with the Staff again to discuss Mr. Ward's allegations. I find it equally unfortunate that, in addition to issuing the report without giving me a chance to respond, the Subcommittee incorrectly reported Mr. Ward as testifying that I attempted to hide information from the Subcommittee. I have never done so and a review of Mr. Ward's testimony reflects that he never so testified.

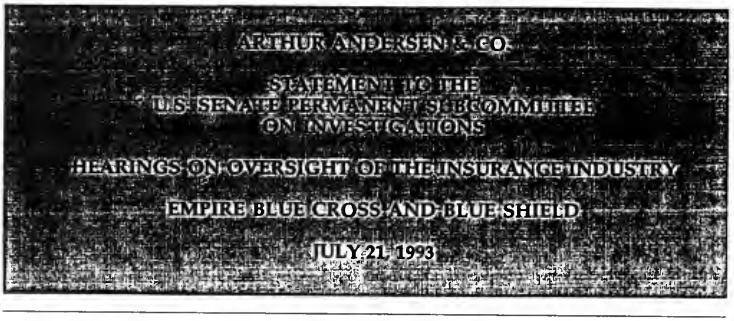
I stand ready to continue to cooperate with the Subcommittee and lend any assistance I can to its inquiry. I appreciate the opportunity to submit this statement and hope that it serves to repair at least some of the damage that has been done to me.

ARTHUR ANDERSEN

ARTHUR ANDERSEN & Co SC

Senate Permanent Subcommittee on Investigations

EXHIBIT # 81



Introduction

Arthur Andersen & Co. is dedicated to improving the effectiveness of the organizations with whom we work. In our engagement with the State of New York to perform a management and financial review of Empire Blue Cross and Blue Shield (Empire), our goal was neither to simply report on the financial health or vitality of Empire nor to engage in recriminations over past mistakes; rather, we sought to identify the strategic and operational challenges facing Empire and offer detailed recommendations to help meet them.

The report on the Management and Financial Audit of Empire performed by Arthur Andersen & Co. dated April 30, 1993 (the Report) has been submitted in its entirety to the New York State Senate and Assembly Committees on Insurance and Committees on Health and to the U.S. Senate Permanent Subcommittee on Investigations. In light of the recent questions and conflicting information surrounding Empire which have been raised in various public arenas, we believe it is important to explain the methodology of our work, to clarify our conclusions and recommendations and to distinguish our mandate from that of the investigation performed by the Senate Permanent Subcommittee on Investigations.

The Terms of Engagement: Independence and Objectivity

In passing the Community Rating Bill (Chapter 501 of the Laws of 1992), the New York State Legislature authorized the Superintendent of Insurance to order an "independent management and financial audit" of Empire. In addition to broadly defining the scope of the audit, the law barred any organization that had performed work for Empire in the previous five years, "unless it was adequately demonstrated that such services would not compro-mise the organization's performance and objectivity." Arthur Andersen & Co. took significant, meaningful steps to satisfy both the letter and the spirit of this condition.

Before submitting a response to the State of New York Insurance Department's Request for Proposals, Arthur Andersen & Co. undertook a thorough review of work performed by both Arthur Andersen and Andersen Consulting for Empire during the past five years. This review also examined work performed for the National Accounts Service Company (NASCO) in which Empire holds a minority interest. We concluded that these past contacts created no conflict of interest for Arthur Andersen & Co. and would not compromise our objectivity or our independence.

Arthur Andersen & Co.'s past work for Empire was extremely limited. It consisted of three prior contracts of short duration which were narrow in scope and confined to a single part of Empire's organization. Arthur Andersen & Co. consultants assisted Empire staff in the complex exercise of transitioning major new National Account customers onto Empire's operational processing systems. Our work was confined to operational support for implementing new accounts after Empire management had determined both the pricing and services the new accounts would receive. As such, we were not involved in any management decision-making.

Moreover, our response to the Department's Request for Proposals fully and openly disclosed the nature and extent of the services Arthur Andersen & Co. previously provided to Empire. (A copy of the applicable part of our proposal is included as an exhibit to this submission.) In addition, Arthur Andersen & Co. representatives openly discussed our past work for Empire with senior Insurance Department officials before the Department formally accepted our proposal and assured them that our past relationship would not compromise our performance or objectivity.

Furthermore, all projects performed for Empire had been completed prior to our receipt of the Request for Proposal. In deference to the Insurance Department's concerns, Arthur Andersen & Co. prohibited any further engagements for Empire after accepting the engagement to perform the management and financial audit.

Finally, it is important to remember that Arthur Andersen & Co. was engaged by the State of New York Insurance Department -- not the management of Empire Blue Cross and Blue Shield -- and that we were compensated directly by the State of New York for this work. In addition, while our proposed fee involved a discount from our standard fee schedule, this was based on a conscious decision to make an investment in developing our staff and continuing our long-standing relationship with the State of New York, and was consistent with the rates charged on other projects we have performed for the State.

Scope of the Management and Financial Review: Looking Forward, not Backward

The scope of the "audit" required by the Community Rating Law was defined to encompass eight separate but related objectives. They were to:

1. Assess the financial status and market activities of the corporation;
2. Review the products and claims management costs of the corporation;
3. Assess the effectiveness of the organization and management of the corporation;
4. Review the corporation's strategic direction and the impact those strategies have on future financial performance and on the healthcare system in New York;
5. Evaluate the rate structure of existing products on the corporation;
6. Determine what changes, if any, need to be made in the legislative and regulatory environment to assure the financial viability of the corporation;
7. Identify and assess specific transactions to improve the financial viability of the corporation; and
8. Identify and evaluate possible improvements in the managed care strategies, operations and claims handling of the corporation.

This legislative mandate called for us to review Empire's business performance, identify the obstacles that have prevented the Company from operating successfully and recommend how these obstacles could be overcome. As with any similar project of this nature, we did not believe our mandate was to personalize our inquiry, assign blame to

individuals, or make broad generalizations about Empire's management or senior executives. In fact, we concluded that neither Empire nor its current or potential customers would benefit from such an approach.

This was reinforced by a series of "kick off" meetings with our clients -- representatives of the Insurance Department, State legislators and their aides responsible for insurance and health care policy -- held after we were engaged by the State. These meetings permitted an exchange of ideas on the overall objectives and approach of our assignment. Although certain individuals hoped for definite answers for controversial historical issues, the overriding theme that came from these sessions was that, regardless of the causes, Empire was a troubled company in dire need of help. The direction that came from those sessions (which we openly embraced) and which was repeated in our periodic meetings was to help fix the problem by identifying meaningful recommendations for change.

Methodology of the Review -- Not a GAAS Audit or a Criminal Investigation

Our methodology was a direct result of the forward looking nature of the financial and management review we were engaged to undertake.

Our proposal to the State of New York Insurance Department made clear that the financial and management review was not designed to be an audit in accordance with generally accepted auditing standards. Another independent public accounting firm has, for many years, been engaged to audit Empire's financial statement to comply with statutory reporting requirements and it alone is responsible for reporting on the fairness of those statements.

In contrast, the Arthur Andersen & Co. review was designed to evaluate the effectiveness of Empire's strategy, operations and products. As stated in the "Approach To The Review" section of the Report:

> This management and financial audit was not intended to be, nor was it performed in accordance with generally accepted auditing standards. Accordingly, no opinion is being expressed on the fairness of presentation of Empire's financial statements in accordance with generally accepted accounting principles. Rather, the 'review' encompassed all significant aspects of Empire ---its operations, its products, its financial condition, its management and its strategy -- with an overall objective to evaluate the viability and effectiveness of them.

Although we were well aware of the swirl of controversy surrounding the Company and its management, our methodology was no different than it would be for any project. Our Project Team (the Project Team) approached this assignment with the same independence, objectivity, thoroughness and skepticism -- in short, the same professionalism -- that Arthur Andersen personnel bring to any assignment.

Similarly, our review was not an attempt to write a definitive corporate history of Empire or investigate the causes of its dismal past performance for the purpose of identifying those responsible for past mistakes. Consequently, actions that would be appropriate to an investigation of the past were less important given our focus on the future. For example, the Arthur Andersen & Co. Project Team did not review the minutes of meetings of Empire's Board of Directors prior to 1991 or interview former Board members who were removed from the current challenges now facing Empire.

Our goal was different. Arthur Andersen & Co. was engaged to help our client identify ways to solve Empire's problems and enhance its future prospects; our role was not to assign blame. For instance, the Project Team was much more interested in meeting some current board members individually -- in confidential, candid, exchanges designed to hear their perspectives on Empire's strengths and weaknesses; its research then concentrated on testing those perspectives. The Report contained more than 120 detailed recommendations designed to improve virtually every aspect of Empire's operating performance and financial condition.

To be sure, developing the recommendations contained in our Report required us to analyze Empire's weaknesses and their underlying causes. But this was only a necessary starting point. The Subcommittee Staff report indirectly acknowledges as much:

> "The Arthur Andersen Report includes almost fifty pages of recommendations and conclusions. Many are quite detailed and deal with the minutia of insurance company operations. They will not be the subject of this section, although the entire report will be made a part of the Staff Statement's appendices and be part of the official files of the Subcommittee. Rather, the Staff's review focused upon a number of the most important conclusions of the Report that relate to the causes of the Plan's current financial dilemma" (emphasis added).

In fact, the conclusions that were "most important" to the Subcommittee Staff to determine "the causes of (Empire's) current financial dilemma" were not necessarily those most important to the Arthur Andersen & Co. management and financial review -- or those most important to Empire's future performance and viability.

Our approach focused on developing a course of action designed to correct operational problems and overcome other obstacles. Inherent in and fundamental to that approach is a prospective view --- one that seeks to put Empire on a path toward future financial viability. While we did address past practices of Empire's management, we did so in the context of understanding their impact on its current operating environment and future prospects.

The Project Team developed its findings through observation, analysis of data, and interviews with Empire personnel and others external to Empire. It found that the majority of Empire's personnel were open and honest about the Company. This honesty was characterized by numerous discussions highlighting Empire's shortcomings, weaknesses, etc. Nevertheless, representations made by Plan personnel were not the basis for its findings. The Project Team performed its own analysis of every issue it identified,

drawing on the internal talent available to Arthur Andersen & Co., the work of independent outside consultants to Empire and other individuals and organizations familiar with Empire or that have particular expertise in the health care or insurance markets.

The Project Team's review of Empire focused on developing a detailed, incisive, action-oriented report. It drew on all of the resources of Arthur Andersen & Co., including experts in Insurance, Healthcare, Real Estate, Marketing, Strategic Planning, Information Systems, Corporate Finance, Operational Analysis and Actuarial Services. It was thorough and comprehensive, entailing more than 14,000 hours of study, including tours and observation of the operating areas, review and analysis of more than 700 documents, and interviews with every segment of the health care marketplace affecting Empire's business -- employees, regulators, customers, competitors and providers. These included, but were not limited to, interviews with:

- more than 300 Empire employees;
- members of Empire's Board of Directors;
- employee benefit consultants;
- group administrators for various size groups;
- insurance brokers;
- representatives of the Greater New York Hospital Association;
- representatives of the New York State Consumer Protection Board;
- representatives of the State of New York Insurance Department; and
- New York State legislators.

In the process of its evaluation, the Project Team quickly discovered that, in many cases, the reasons for Empire's poor performance were generally accepted and understood. For example, Empire is plagued with a long-standing reputation for poor customer service. While its review devoted significant attention to exploring the scope of this problem and its consequences to Empire's financial viability, the Project Team devoted substantially more effort to identifying steps Empire must take to improve its responsiveness to customer needs and criticisms.

In other cases, the Project Team concluded that controversial issues which had received widespread public attention had very little impact on Empire's financial viability and, consequently, received much less attention in the review than the headlines may have implied. For example, while the Project Team investigated the issue of executive compensation, and concluded that the levels of compensation for various executive positions at Empire are reasonable (the basis for this conclusion is contained elsewhere in this submission), it also believed that the issue has gained importance far beyond its relevance to Empire's viability and financial health.

The task of identifying problems at Empire is far simpler than finding solutions to them. The Project Team quickly established that the strategic solutions to the true problems facing Empire are unclear and not widely recognized. Consequently, it devoted a substantial amount of research and inquiry to identifying the course Empire should take to improve its performance and operating results. Of the 400 pages of the Report, more than two thirds were devoted to charting that course. Arthur Andersen & Co. believes that such an approach most closely realizes the spirit of its legislative mandate.

Empire's Financial Viability and Future Prospects

We have been puzzled by the criticism that our "findings agree with [the] Plan." Arthur Andersen & Co. did not accept the engagement with the State of New York with the intention of becoming judges to a contest between Empire's management and its opponents. Nor did we draft the Report to provide ammunition to either side. The Report presents a balanced, objective view of Empire's operating environment, identifying progress that has been made and problems that require timely and significant action.

It is simply not correct to conclude that our "findings agree with [the] Plan." This wrongly suggests that the Project Team uncritically accepted management arguments and implies that it concluded that Empire's management bears little or no responsibility for the Company's poor performance. In fact, the Report very clearly states something quite different.

The Report contains a variety of strong and hard-hitting conclusions and recommendations. Some of them are consistent with positions expressed by Empire's management; others are consistent with positions expressed by Empire's critics. Still others identify critical issues which -- despite the maelstrom of public scrutiny directed at Empire -- have not been recognized or addressed. The major recommendations cover the following areas:

Empire's Management Approach and Structure. The Report concluded that Empire's management has failed to position the Company as a competitive player in New York's health insurance market. "Today, Empire is neither organized nor managed to become a market leader." In particular, our Report criticized the "autocratic" and "hierarchical" style of senior management and concluded that it had been "slow to appreciate the accelerating pace of change in the insurance market and even slower to respond to the ensuing challenges." Our Report recommends that Empire reorganize its operations into market-focused strategic business units and suggests that "the successful implementation of strategic business units and the re-engineering of business processes will require a change in Empire's management structure.". It specifically recommends separating the roles of the Chairman and CEO positions.

Unprofitable National Account Business. While we identified the significant economic and strategic benefits of this business, we stated that "if current Blue Cross Blue Shield initiatives are not successful, then many Plans, including Empire, will be forced to reconsider future participation in this market."

Management Information Reporting System. The Report recommends that Empire develop a comprehensive management information reporting system to improve management's ability to monitor the Company's financial and operational performance. This recommendation is based on our observations and findings that "the dissemination of management information within the organization tends to be done on a selective, non-coordinated basis. In general, there is an inadequate degree of communicating ;

-- Key business information necessary to manage the profitability of operations is not routinely or consistently communicated. This includes operational performance reports, enrollment reports, customer profitability information and budget reports.

-- Certain similar information is reported by more than one department and is not always consistent.

-- Cross-departmental sharing of information is inconsistent and inadequate."

Managed Care Initiatives. The Report indicates that "Empire must improve the execution of its managed care initiatives or risk losing a significant portion of its business." Additionally, it notes "to date, Empire has been behind the competition in the managed care arena with respect to both product development and delivery." The Report includes fourteen specific recommendations to improve Empire's managed care capabilities.

Information Processing Systems. The Report concludes "Empire has been late in introducing new systems (SIC) relative to the industry... and must complete the development and migration to new technology as quickly as possible." It contains 14 recommendations to facilitate a timely implementation.

Other key observations of risks and issues that may critically impact the future viability of Empire highlighted in the Report include:

Loss of Trademark. The Report highlights the risk that the Blue Cross Blue Shield Association may revoke Empire's right to use the Blue Cross Blue Shield trademark if Empire's reserves fall below certain specified levels.

Threat to 1993 Operating Plan. The Report indicates that Empire may not achieve its 1993 operating plan given its declining enrollment, critical strategic initiatives to improve operations and service, and the inherent uncertainty of the impact of the "demographic pooling mechanism."

Troubled Constituency Relationships. The Report addresses Empire's troubled relationships with key constituencies including its customers, the hospital community, doctors and other medical providers, benefit consultants, brokers, legislators and regulators and the need to re-establish these critical relationships.

Possible Loss of Hospital Differential. The Report highlights the risk that the New York State hospital differential and surcharge will be eliminated with the consequence that Empire may lose a very important advantage it currently maintains.

Analysis and Recommendations of Specific Issues

The Staff Statement of U.S. Senate Permanent Subcommittee on Investigations (the Staff Statement) raises a number of questions about the research and analysis performed by Arthur Andersen & Co. in connection with its Management and Financial Audit of Empire. Many of these questions have been addressed in previous sections and are a direct consequence of the different approaches taken by the Subcommittee Staff and the Arthur Andersen & Co. Project Team. Others reflect misunderstanding or confusion about the work actually performed by the Project Team and the depth and detail of its research.

Finally, in other areas, the conclusions of the Arthur Andersen & Co. Project Team simply disagree with the conclusions of the Subcommittee Staff. The following section attempts to clarify the confusion and explain the research and analytic path by which the Project Team addressed certain issues highlighted by the Staff Statement.

Cherry Picking -- Community Rated Pool of Insureds

For many critics of Empire, the issue of "cherry picking" is a subject of hot dispute. Empire's management claims that before the Community Rating Law was passed, the Company's social mission of serving as the insurer of last resort placed it at a competitive disadvantage in the insurance market. As a result of this mission, Empire could not refuse to insure anyone, while its competitors -- who could selectively accept applicants for insurance -- "cherry picked" Empire's least risky customers away by offering them lower priced premiums for comparable insurance coverage. Empire's critics claim that Empire has lost these customers because of other reasons, such as the Company's poor service.

In examining the debate over cherry picking, the Arthur Andersen & Co. Project Team objectively and critically examined the extensive data and analyses compiled by Empire (much of it at the Project Team's special request) in forming our conclusion that "cherry picking is a real phenomenon." These analyses included various compilations of the lapse rates, loss experience ratios and dispersion of loss ratios of Empire's small group customers to reflect relevant trends in the small group pool. Our review of this data included in-depth interviews and follow up discussions with actuarial and finance division personnel and management to understand and challenge the underlying methodology and assumptions of the analyses. Our conclusions reflect an independent interpretation of those analyses based on an informed understanding of the data contained in them.

More important, however, was our conclusion that the dispute over cherry picking has generated more heat than light. In fact, the Report concluded that the key issue which Empire must address moving forward is not whether and to what degree cherry picking has occurred, but rather what has happened to the overall composition of Empire's community rated pool of insureds. Based on the loss ratio, lapse rates and other actuarial trend analysis examined by the Project Team, it was very clear that the community rated pool had deteriorated dramatically from 1985 into the 1990's. As noted in the Report, this was apparent when comparing the loss ratio of canceled groups to the loss ratio of the entire pool. Regardless of the cause, Empire's pool of community rated insureds was becoming more and more risky -- or less and less healthy.

The deterioration in the pool was also highlighted in a study done by a nationally recognized actuarial firm. In addition, the deterioration of the pool was also evident when we reviewed the phenomenon of dumping; whereby groups transfer their coverage to other insurance companies, but re-enroll (dump) poor health individuals in Empire's small group pool. The Report also emphasizes the following additional reasons for the deterioration of the pool -- natural flight, high premium rates, decline in quality and quantity of new groups, heightened AID's occurrence and the formation of the incentive rated pool of insureds.

Empire's Experience Rated Business -- (Local and National Accounts)

As a result of the dichotomy that Empire faces in its role as both a "for profit" insurer for the experience rated business and its "not-for-profit" role as the insurer of last resort, some critics question whether Empire can adequately balance this hybrid and operate profitably. The key question raised by many is whether the "for profit" business of Empire (defined to include the Incentive, Experience and National Account business) is draining resources from the Company as a whole?

Empire's experience rated business includes groups which have 50 or more subscribers where the premiums charged are based upon a combination of the groups' historical utilization of healthcare services and estimates of the groups' future consumption of healthcare services. Empire's experience rated groups include two components, Local Accounts (those groups in which all enrollees are typically employed within New York State) and National Accounts (those groups in which the enrollees are geographically dispersed throughout the United States). As a result of the geographic dispersion of National Account enrollees, the servicing of these National Accounts is performed on a cooperative basis among several or many Blue Cross Blue Shield Plans, requiring these plans to communicate and coordinate various activities to provide a uniform level of customer service. Critics of Empire claim that Empire's experience rated business is draining resources rather than providing a subsidy for community-rated business (groups which have less than 50 enrollees).

As clearly stated in the Report, "in fact, Empire's experience rated business is not draining resources from the Company as a whole, but it is also not currently generating significant subsidies for the community rated business. With the exception of 1991, Empire's local experience rated business in recent years has generated a net gain approximating management's objective of providing a 1% subsidy (based on premiums) to Empire's community rated business." The National Accounts component of the experience rated business segment has incurred losses in recent years (1990-1992) and has therefore generated no subsidy.

These losses prompted the Arthur Andersen & Co. Project Team to intensify its analysis of the National Accounts component. Members of the Project Team interviewed Empire personnel, current National Accounts customers and employee benefit consultants who represent current and former National Accounts customers. In addition, the Project Team performed a detailed review of numerous internal and external documents, including but not limited to:

-- Customer profitability analysis reports for the major National Accounts;

-- Reports of external consultants regarding the operational issues for National Accounts;

-- A variety of comparative performance measure reports for the National Accounts market segment and Blue Cross and Blue Shield entities of similar size;

-- Financial analyses of the overall National Accounts profitability and overhead allocation methodologies

In addition to its financial and operational analysis of National Accounts, the Project Team closely examined the strategic implications of Empire either abandoning this market or continuing to participate in it. Based upon this financial, operational, and strategic analysis, the Project Team recommended that Empire should continue to participate in this business with a short-term focus of making this business self sufficient rather than simply abandoning this market segment and thereby potentially damage Empire's long-term position in the New York State marketplace. However, the Report clearly stated that if this business cannot be made to be self-sufficient, the management of Empire must re-evaluate its participation in this market and consider withdrawing from it.

Executive Compensation

As indicated in a previous section, significant public attention has focused on the levels of compensation paid to Empire's senior executive positions. The Report's conclusion that levels of compensation for executive positions is reasonable was based on a review of Empire's total compensation system for executive level employees and a comparison of Empire's compensation system with executives in comparable employment in both the profit and not-for-profit insurance sectors. In reviewing Empire's compensation system, the Project Team evaluated all relevant factors of Empire's operating environment. Those factors include Empire's legal status as a not-for-profit organization as well as the fact it is the largest healthcare insurer -- profit or not-for-profit -- in the State of New York, operating in a complex and competitive market.

The Project Team performed a comprehensive review of Empire's executive compensation levels. In fact, the team compared four independently conducted studies of executive compensation, including one of not-for-profit insurance companies, to determine whether compensation levels at Empire were appropriate. None of the studies of executive compensation in the private sector were provided by Empire. The studies included:

1. Ernst and Young 1991/1992 National Survey of Executive Compensation

2. Blue Cross and Blue Shield Association (Primarily not-for-profit)

3. Wyatt Data Services -1991/1992 Top Management Report

4. Mercer 1992 Fortune 1000 Compensation Report

In performing this review, the Project Team examined every aspect of executive compensation including all deferred compensation plans and other perquisites.

Although the Project Team concluded that levels of compensation for executive positions are reasonable, it also noted that the Report's recommendation to reorganize Empire into strategic business units should result in a company that requires fewer officers to operate effectively, thus reducing total executive compensation.

Fraud Detection and Prevention - Provider Identification

Fraudulent insurance claim schemes and abusive claims practices are perpetrated against all insurance companies. Although estimates of the financial impact of fraud and abuse varies, it is commonly acknowledged that by any measure, it is a significant risk to which all health insurance companies are exposed. Accordingly, the Project Team did not attempt to catalog and quantify historical cases of fraud. Consistent with its mandate, the Project Team's approach was to evaluate Empire's strategy and specific programs to combat fraud. The Project Team's objective was to determine whether Empire has appropriate and adequate programs in place to minimize its exposure to fraud and develop recommendations to enhance its efforts in this area.

Empire's activities to combat fraud include underwriting procedures and claims processing edits designed to identify potential abuse and the maintenance of special groups within the internal audit department to combat fraud (Program Security, Fraud Detection and Group Integrity units). In addition, Empire's system of internal controls are reviewed annually by the Company's independent public accountant in connection with their audit of Empire's financial statements.

In its review of the claims processing procedures utilized by Empire and in conjunction with a review of Internal Audit documents, the Project Team became aware of Empire's practice of paying certain claims without the provider submitting a provider identification number. The Project Team assessed the situation and agreed with Empire management on the serious potential for fraud abuse. It also agreed that this potential was mitigated to a large extent by the fact that insurance claims lacking provider identification numbers are checked for each of the following:

1) Ensure that the procedure performed by the health care provider (i.e. procedure code) was properly included on the claim form.

2) Ensure that the person for whom the health care was provided (i.e. subscriber) is a valid subscriber.

3) Ensure that the procedures provided by health care entities are covered benefits for the specific subscriber (e.g. the payment of medical bills to providers are in accordance with that subscribers specific benefits of their contract).

4) Ensure that reimbursements to providers are in accordance with the pre-established reimbursement criteria for the specific care given to the subscriber.

5) Ensure, based upon various criteria, that each claim is paid only once.

Consistent with its overall approach, the focus of the Project Team relative to this issue was to evaluate Empire's plan of action to obtain provider identification members in order to enhance its provider file and therefore reduce the number of claims processed without provider identification numbers.

Medicare Part A and Part B Contract Performance

In addition to Empire's insurance operations which provide insurance to private subscribers and employers, Empire also provides claim processing services to the Health Care Financing Administration in the processing of Medicare Part A and Part B claims. Some have questioned Empire's ability to provide these services to HCFA, pointing to a letter sent by HCFA to Empire threatening the non-renewal of the contract, and charge that the Project Team was not aware of these performance problems.

The scope of the Project Team's review included an examination of the nature of Empire's contractual relationships with the Health Care Financing Administration in its role as a contractor processing Medicare Part A and Part B claims. This evaluation highlighted the poor performance of Empire in the processing of Medicare Part A and Part B claims in comparison to other contractors. The Report specifically highlighted the fact that "Empire's Medicare Part A and Part B operations ranked in the bottom 20th percentile for the 1992 scoring period."

The Report also highlights the fact that "potential contract action against contractors who fall into the bottom 20th percentile can range from a letter requesting a corrective action plan to the termination of the contract." In completing its analysis of the Medicare Part A and B operating results and management plans for improvement, the Project Team obtained and reviewed the drafts of corrective action plans prepared by Empire management of Government Programs in response to Health Care Financing Administration requests.

Customer Service

A key component in retaining any customer in the health insurance industry is directly related to the levels of service provided to those customers. An insurance company's ability to service its accounts depends upon the complexity of the products being serviced, the account demographics, the management and staff personnel assigned to service that customer, and the computer systems used to process claims and customer service inquiries. Service level variances can be especially acute in the National Accounts area where support of specific accounts can vary widely on a plan by plan basis. Accordingly, service levels often vary on an account by account basis.

As a result of the Project Team's review of outside consultant studies of Empire's customer service, review of customer complaint letters and discussions with various Empire sales and account representatives, it quickly became evident that the lack of customer service provided to both subscribers and group administrators was a key factor in losing both large and small groups to other health insurance competitors. These observations were verified through the testimony given by customers during various rate hearings attended by representatives of the Project Team, the subsequent review of the

written testimony and interviews with group administrators. Rather than further catalog these conclusions by interviewing subscribers and former accounts which left Empire, the Project Team elected to develop recommendations to improve the current customer service environment. Implementation of these recommendations will help Empire retain its current book of business and ultimately provide the levels of service both subscribers and group administrators are demanding. The 13 major recommendations in the customer service section of the Report address the key customer service issues facing Empire.

Department of Health and Human Services/
Health Care Financing Administration (HCFA)-
Medicare Secondary Payor Liability

The Staff Statement identified what they believed to be a potential lawsuit against Empire regarding an alleged liability for payments made by Medicare which may be reimbursable from Empire, and suggested that if the Arthur Andersen & Co. Project Team had interviewed Medicare officials, additional information regarding that litigation would have been gained. In fact, our work approach provided the Project Team with the necessary insight and understanding of the issue.

During its review, the Project Team identified a program being executed by the Health Care Financing Administration to recover payments from numerous health insurance plans or health insurance companies, including Empire, for alleged improper claims made to healthcare providers. HCFA has submitted a large volume of claims to Empire alleging that Empire may be the "primary" health insurance carrier and may be responsible for reimbursement of these claims to HCFA.

As noted in the Report, the Project Team determined that Empire did not have any reserves established for this contingent liability as the total amount of potential claims could not be reasonably estimated. This was confirmed following consultations with other Arthur Andersen & Co. personnel (other than Project Team personnel) who have extensive experience with this specific issue. In addition, the recommendations contained in the Report focused on enhancing the current management information generated to facilitate management's understanding of such Medicare claims as well as identifying the need to increase the resources dedicated to processing claims submitted by HCFA.

Conclusion: A Road Map to the Future

In preparing its Management and Financial Audit of Empire, Arthur Andersen & Co. sought to offer guidance and direction to a troubled organization. The recommendations contained in the Report address each of the eight objectives identified by the legislation authorizing the management and financial audit. They detail the steps necessary to improve Empire's management and operations and set it on the course to becoming a successful competitor in New York State's health insurance market.

In the atmosphere of "piling on" that now surrounds criticism of Empire, we are concerned that attention has been diverted from preparing Empire to succeed in the future in favor of pointing fingers and placing blame. Many complicated, difficult decisions need to be made about the future direction of Empire's business in a fast changing marketplace. Unfortunately, serious debate over the shape of those decisions has hardly begun. When it does, we are confident that the Arthur Andersen & Co. Report will be an indispensable contribution.

STATE OF NEW YORK
INSURANCE DEPARTMENT

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Relevant Engagement Experience

Engagements Performed for EBCBS During the Past Five Years

In the period April 1991 to February 1992, Andersen Consulting, a separate business unit of Arthur Andersen & Co., S.C., performed three related projects for the National Accounts Division of EBCBS. The National Accounts Division, one of approximately nine market segments of EBCBS, sells "coverage" to national employers. The three projects were limited to assisting EBCBS personnel in the complex exercise of transitioning major new national accounts onto EBCBS's operational processing systems. Andersen Consulting has also provided consulting services for the National Accounts Service Company (NASCO) of which EBCBS has a minority interest. Refer to page 32 of this proposal for a description of the work performed.

We strongly believe Andersen Consulting's work does not compromise our firm's ability to perform or our objectivity because these projects were of a short duration, isolated to a singular area of EBCBS and focused on a support function.

8/27/93

Senate Permanent Subcommittee on Investigations

EXHIBIT # 83

ADDITIONAL QUESTIONS FOR THE HEARING RECORD

by Senator Sam Nunn

SALVATORE CURIALE
Superintendent of Insurance
State of New York

* * *

Authority and Powers of Insurance Department

1. Q. You have repeatedly stated that your Department had limited authority with respect to assuring that Empire was managed properly. The Chairman of the New York State Senate Committee on Health, however, seems to believe that you have rather broad authority. In a State Senate hearing April 22, 1993 State Senator Michael Tully listed your authority as falling into the following broad categories: 1) the power to issue, suspend or revoke licenses; 2) the power to require reports; 3) the power to make investigations and examinations; 4) the power to regulate finances; 5) the power to regulate business operations and procedures; 6) the power to establish rates; 7) the power to protect consumers; and 8) the power to impose penalties.
   - Can you tell us specifically what limitations there were on your authority prior to this year?
   - What specific types of action would you have wanted to take in previous years which you were constrained from taking?
   - To the extent that your authority was statutorily limited in previous years, did you ever attempt to have legislation introduced to expand your authority?

A. The powers of the New York State Insurance Department (Department), and mine as Superintendent, are strictly limited to those set forth in statute. Indeed, the Department's function, succinctly stated, is to administer the Insurance Law as promulgated by the Legislature. Though the Department must give full and fair measure to the terms of that law, it may not exceed its bounds.

At the heart of the law the Department administers is a central tension between the public's rights and interests, which the Department is charged to protect, and the rights and interests of private entities, which it is obliged to respect. Insurance is not regarded as a natural monopoly, and insurance companies are regulated accordingly. That is to say, competition and the relatively free play of market forces are encouraged to the extent practicable. They are encouraged because, within the limits the law provides, they are regarded as the most efficient and effective protectors of the public weal. For that reason, the regulatory scheme — though surely more detailed and comprehensive in New York than in any other state — is framed to create a zone within which companies may freely operate.

Thus, the law contains prescriptions, proscriptions and standards related to specific activities of the regulated entities, as well as a set of powers and sanctions to enforce what the law and regulations provide. All of the Department's actions are subject to challenge in a court of law, and if those actions are not well grounded in the statute's text, the Department will not prevail.

The law, however, gives the Department no authority over what are commonly referred to as "management decisions." These include such diverse actions as allocation of capital to various business activities, the development of data processing systems, the development of employee compensation or incentive plans, the purchase of furniture and fixtures or the hiring of consultants. Decisions such as these are left to management with oversight from the Board of Directors. The Department is neither staffed nor trained to direct these activities. If it were required to oversee them, the Department would need a high multiple of the staff it now has. That staff would have to receive training quite different from that of a regulator.

Although your enumeration of Department powers may seem to describe, particularly when so generally paraphrased, a seamless and infinitely nuanced, flexible regulatory scheme, the reality is quite different. The Department has, and exploits, the power to remedy specific infractions of particular provisions. But the Department does not substitute its judgment for that of management in matters that are corporate prerogatives. And the Department's remedies are often either too mild or too draconian for the wrong it seeks to redress.

Thus, for example, the first set of powers set forth in your question are those to "issue, suspend or revoke licenses". Although the Department licenses Article 43 companies such as Empire, it has no power to suspend or revoke their licenses, the Department can only liquidate or rehabilitate the company. The Department's reasons for hesitating to resort to such a 'remedy' for a health insurer covering nearly half of New York State's population should hardly require explanation.

Similarly, the Department's powers to examine and investigate are indeed considerable. But those powers, because they must make scrupulous provision for the constitutional rights of those examined, are often exercised in an adversarial context not suited to swift fact-finding or easy integration into management decision-making.

The Department's power to "regulate finances" reduces, principally, to the specific authorities to approve rates and to prescribe and enforce rules for the valuation and investment of assets and for the establishment and maintenance of reserves. The Department cannot, for example, choose which particular securities an insurer may purchase so long as the quite broad parameters of the Insurance Law are observed. Although the Department, of course, monitors companies' solvency (this is one of the Department's most important duties) it is nowhere empowered generally to "regulate finances" with respect to any entity under its jurisdiction. And although the Department's rate approval authority may seem to grant it considerable discretionary latitude, in fact the statutory mandate that rates be neither excessive nor inadequate shrinks the Department's "latitude" to a relatively narrow ambit.

Although you cite the Department's alleged power to "regulate business operations and procedures", this power — like the previous one — cannot be found in the law. The Department does, however, have certain discrete powers ancillary to such operations and procedures — e.g., oversight of the composition of Article 43 corporations' boards of directors and approval of policy forms and rates.

Finally, you cite the Department's powers to "protect consumers" and "impose penalties." Again, the Department has, and regularly exercises, the power to investigate and punish specific violations set forth in the law — e.g., unfair competition, unfair claims settlement practices or certain defined acts of discrimination. Here, too, these important regulatory tools allow the Department to keep companies on the right side of certain defined guidelines, but they do not enable it to cross those lines and substitute its judgment for management's on a day-to-day basis.

You conclude your question by asking if the Department has ever tried to introduce legislation that would give it the power to manage the entities it regulates. I have stated above that the Department is neither staffed nor trained to manage business organizations, particularly large complex ones such as Empire; nor do I believe it is appropriate for a government agency to do so. Therefore, the Department has not asked the Legislature for the power to oversee the day-to-day management decisions of regulated entities. I would note, however, that recently enacted legislation (effective April 1 of this year) does attempt to bridge the gap between the Department's traditional regulatory function and oversight of company management by authorizing the Superintendent to: 1) hire independent auditors to conduct management and financial audits of Article 43 corporations under certain circumstances; 2) direct compliance with recommendations arising from those audits; and 3) review the record of such compliance in subsequent rate proceedings. In addition, the measures proposed by me at the conclusion of my oral testimony to your Committee would strengthen the Department's oversight of companies' accounting, actuarial and internal control functions.

2. Q. I note that at the end of your statement you discuss actions you intend to take to "enhance the Department's oversight of health insurers."
   - Will you be able to take these actions through regulation?
   - If so, why has it taken the involvement of this Subcommittee before you have been willing to address these issues?

A. Most of the actions to be taken to enhance the Department's oversight of health insurers can be accomplished through the issuance of Department regulations under existing authority. Some legislative action will be required. The Department will propose that larger fines and more significant sanctions be imposed against individuals or companies that fail to adequately comply with the Insurance Law or recommendations in the Department's Reports on Examination. The Department's system of fines and penalties for violations of the Insurance Law has remained virtually unchanged for many years, despite the Department's attempts to increase the level of these fines and penalties through legislation. However, in the case of nonprofit corporations such as Empire, the subscribers ultimately pay any fines imposed through their premiums. In addition, the

Department's Frauds Bureau is in the process of expanding to more than double its present size. If still further expansion of the Department's Frauds Bureau appears to be warranted, this too would require legislative (budgetary) authorization.

Issue is taken with the suggestion that were it not for the Subcommittee's investigation of Empire the Department would not have suggested any changes in its procedures. On the contrary, the Department's procedures are continually being reviewed both internally and externally, and improvements are constantly being instituted in its examination and oversight procedures as circumstances warrant.

The Department was aware of many of Empire's management shortcomings for some time. Mr. Cardone and other key managers were called to task at meetings with the Superintendent and Department officials. Empire's managers committed to improve their operations and the Department was led to believe that good faith efforts at improvement were being made in several areas. In fact, there was evidence of improvement. At the same time, the Department focused on obtaining legislative changes that would result in long-term solutions to the health insurance problems New York State was facing.

Some of the company's "excesses" became apparent either gradually or by accident. Most of the wrongful actions of Empire that have been highly publicized and criticized were clandestine in nature and would have been virtually impossible to detect were it not for the recent admissions by a few Empire employees. Empire represents the most egregious case of management's lying to and/or misleading the Department, which even without the interest shown by this Subcommittee and the press, would have caused the Department to review both its oversight and the need to strengthen licensees' internal auditing procedures.

3. Q. The staff has learned that your predecessors in the job of Superintendent often called in the Board of Directors of an insurer experiencing specific financial or mismanagement problems. The Superintendent would then remind the Board of their liability as Directors of the insurer and detail the specific problems the Department had with the company. The Superintendent would then ask the Board to respond in writing to the issues raised by the Department including a detailed outline of how the Board intended to remedy the situation. If the Superintendent found the proposal acceptable, he would then set a deadline by which the Board must implement these changes. According to a former Department employee, this approach was extremely successful in motivating Boards to respond to specific problems.

- Did you ever attempt to approach Empire's Board of Directors in this manner?

A. Throughout 1991 and 1992, I and Department personnel met with Mr. Cardone and Empire personnel regarding numerous issues. Mr. Cardone, as Empire's Chairman of the Board of Directors, represented Empire's Board and its involvement. As Superintendent, I wrote to Empire's Board of Directors on April 14, 1993 and called the full Board into my office on April 30, 1993. At that time, I privately and publicly demanded that the Board exercise its responsibility and make the difficult

decisions that needed to be made in order to manage the company successfully and to restore public confidence in the company. My action was timed to coincide with a long-awaited management audit by Arthur Andersen & Co. which had been commissioned by the Legislature. The Board received the draft of that report on April 15, 1993. At my April 30, 1993 meeting I demanded that the offices of Chairman of the Board and Chief Executive Officer not be held by the same individual, and strongly recommended that the Board consider whether Albert Cardone should continue to serve Empire in either capacity. I believe that my action was responsible for Mr. Cardone's separation from the company less than 20 days later.

Thus was set in motion a complete change in the direction and management of Empire. This followed the implementation of New York's open enrollment and community rating law which I and the Department had been working towards since 1991. The law, which became effective on April 1, 1993, just two weeks before my action with the Board, requires all health insurers in New York that write small group and individual health insurance to accept everyone and prevents insurers from raising premiums on the basis of an individual group's claims experience. This law and the regulations implementing it drastically reduced New York's dependence on Empire as an insurer of last resort and gave all New Yorkers a choice of health insurers. Thus, in little more than a year and a half the Department was successful in enacting major health insurance reform inuring to the benefit of all New Yorkers, drastically decreasing the dependence of our citizens on any one health insurer, and changing the direction and management of Empire. My actions and the timing of my actions were designed to accomplish all these goals.

4. Q. The staff testified regarding some of the items Empire has purchased with subscriber funds including $255,000 in jewelry and grandfather clocks for service awards; $142,000 for lavish Board seminars; $20,000 for expensive luggage for Board members; $40,000 for Christmas parties and decorations; $14,000 for silver punch bowls which remain in storage; $9,700 for theatrical posters; and $20,000 for a Chippendale desk which also remains in storage. According to interviews with your staff, you have the authority to take action against Empire based upon "waste of assets."

   - Do you feel that such expenditures constitute a "waste of assets" and, if so, what have you done to curb such spending at Empire?

A. The expenditures cited in the Subcommittee's report, while certainly reflecting poor judgment in view of Empire's deteriorating financial condition, do not constitute a waste of assets in the technical legal sense of the term. A waste of corporate assets would consist of a material amount of expenditures for which the corporation received no benefit or that are clearly excessive when compared to normal business practices or needs. While the Department recognizes that non profit entities should be held to a higher standard than commercial enterprises with regard to expenditures for employee benefits and business-related entertainment and office decorations, reasonable expenditures for these items are normal and appropriate even for non profit corporations. The Department does not generally substitute its judgment for that of a Board of Dircctors in these matters. The Department does, however, ensure that statutory limits on spending are adhered to. In fact, Empire's expenses over the years have been well within the limits set by law.

5. Q.- What authority do you have to force an insurer such as Empire to restore reserves to the statutory level once an invasion has occurred?
- What steps have you taken with regards to Empire?

A. During 1987 Empire received permission to invade its statutory reserve fund, thereby reducing the prescribed level of total reserves and unassigned funds (surplus funds) at December 31, 1987 from $246.0 million, or 5.5% of 1987 premium income at the beginning of 1987, to $165.5 million, or 3.7% of 1987 premium income at the end of 1987. The actual amount of the invasion in 1987 was $80.5 million. This amount was to be restored over a three-year period. For the years 1988, 1989, and 1990 the amount of Empire's surplus funds increased. They reached $294.5 million at December 31, 1990, or 4.6% of 1990 premium income surplus funds. This represented an increase of $129.0 million over the reported surplus funds at December 31, 1987.

During this three-year period Empire did restore the amount of the authorized 1987 invasion, but it could not meet its new prescribed statutory reserve fund level, which increased to 7.5% of 1990 premium income or $476.6 million at December 31, 1990. While Empire had insufficient surplus funds to meet this new standard, its overall surplus fund position was actually stronger at year-end 1990 than at year-end 1987 (4.6% of 1990 premium income versus 3.7% of 1987 premium income). The statutory level of 7.5% was a goal that had been held in abeyance to keep rate increases at rational levels.

Any attempt to increase surplus funds and comply with the prescribed statutory reserve fund requirement was overwhelmed by the extraordinary underwriting loss of $216.6 million recorded in 1991, notwithstanding an average community-rated contract increase of 18.9% effective March 1, 1991. As underwriting losses continued ($227.1 million in 1992), the amount of Empire's surplus funds declined to $39.7 million at December 31, 1992 or 0.6% of 1992 premium income. However, a significant improvement has occurred during 1993 and with this improvement, due in part to the Superintendent's approval of an average community-rated contract increase of 25.5% effective January 1, 1993, Empire's reported surplus funds at June 30, 1993 were $230.3 million or 4.2% of projected 1993 premium income. As a result, Empire is making progress towards restoring the amount of its surplus funds to their prescribed statutory reserve fund level of $503.9 million or 9.2% of projected 1993 premium income.

It should be remembered that the Superintendent must continually balance the goal of increasing the level of reserves against the impact of higher rates on the availability and affordability of necessary coverage, especially with regard to residual market policyholders for whom coverage is available only from Empire. The Superintendent does not approve the rates of large group, experience-rated contracts. Empire needs to do all it can to increase its margins on experience-rated, large group contracts in order to rebuild its statutory reserves without unfairly burdening its community-rated policyholders.

Customer Service

6. Q. At the beginning of your statement you state that rather than being paralyzed by fear of regulating Empire, the Department proceeded to design a system in which any Empire subscriber who was unhappy with premiums, service, or the CEO's salary would have the option of going to another insurer. Yet this seems to put a great deal of the burden on the subscriber to detect outrageous premiums, unsatisfactory service levels, exorbitant salaries, and the like, and to take some action on his own in response.
   - Doesn't the Insurance Department have some responsibility to the subscribers to protect them in the first instance from these types of problems?

   - What is it that you have done in the past to address these issues on behalf of subscribers, and what do you intend to do under New York's new system to address these issues?

A. The Department does have a responsibility to subscribers in the first instance and carries out that responsibility in a number of ways, including:

- **Prior approval of policy forms and premium rates with public hearings held on applications for increases in community rates.**

- **General oversight of a Plan through the examination process.**

- **The handling of complaints through the Department's Consumer Services Bureau, comprised of 65 examiners and a clerical staff of 45, whose resources are devoted to resolving 45,000 annual consumer complaints and inquiries. The Department also responds to 200,000 telephone inquiries received annually from consumers concerning various insurance issues. Speakers are provided to groups and organizations in an effort to educate the insurance consumer on the various types of insurance available. Prior to the effective date of the community rating law (April 1, 1993), a special toll-free number was established in the Consumer Services Bureau to respond to questions about the new law and provide information as to which insurers and what products were available in particular geographic areas. Informational booklets were mailed to consumers. The number is still operative. Over 7,000 consumers have called and received assistance.**

- **Distribution of a general publication on health insurance, as well as specific consumer guides on Medicare Supplement and Long Term Care health insurance.**

- **Participation in numerous information sessions on health issues through organizations such as senior citizens groups and meetings with consumer advocacy groups.**

- **Proposing legislation to address health insurance problem areas and to provide greater protection for consumers such as the community rating/open enrollment law, and the regulations issued to implement the law.**

Prior to April 1, 1993, the health insurance system in New York State did not provide sufficient choice for the consumer because in many instances the only choice a consumer had was to purchase health insurance from Empire. Open enrollment and community rating now mandate that consumers have more options in selecting a health insurer. The Department was also granted new authority to review salary increases for senior level executives of Empire.

In addition to all of the above, the Department has the ultimate solvency protection responsibility. That responsibility is, as previously indicated, a delicate task when it comes to balancing rate increase requests (in a manner sensitive to consumer interests) against insolvency, which is the ultimate consumer threat.

7. Q. You state that, with respect to large group business, Empire had to deal with intense competition from commercial carriers who could "afford to lose money on their health business." This seems to mirror Empire's argument that they have lost their large accounts because of the commercial carriers' practice of using health insurance as a "loss leader." Yet the Staff's interviews with over forty large national accounts which cancelled their coverage with Empire reveal very different reasons for Empire's loss of this business. For example, 18 if (sic) those accounts left because of poor service at Empire. Among the comments the Staff received were:

-- Dealing with Empire is like dealing with a black hole. You never could get anyone to deal with your problems;
-- Difficult to get through to customer service and poor follow-up on complaints to supervisors;
-- Abysmal service;
-- They just couldn't do the claims processing; money wasn't the issue, we just wanted service on our claims.
-- They are a nightmare to work with.
-- Let me put it this way... I have a full crop of grey hair and every damned one of them came as a result of my dealings with Empire Blue Cross.

- Before making your comments about the intense competition from carriers who could afford to lose money, did your Department ever bother to contact any of the large group accounts that left Empire to determine their reasons for leaving?
- If not, why not?

A. The Department did not contact any of the large accounts that left Empire. The Department realizes that service may have been one of the reasons for an account leaving Empire, but that more likely there are many factors that go into the decision of a large account to leave a particular insurance carrier, including service, price, how well they manage care and personal relationships.

Having observed the large group health insurance business for many years, the Department was aware that the large group health insurance business was intensely competitive, with self-insurance being a significant alternative chosen by many large employers. An analysis of

accident and health direct premiums earned by New York commercial insurers clearly indicates that in many cases, if investment income was excluded, an underwriting loss resulted. Sales were made at initially bargain prices because the products and marketing were directed at large groups that were more likely to have younger, healthier risks. In addition certain competitors were in a position to offer other coverages that may generate profit and allow marginal pricing on the medical expense benefits.

The Department's statements with regard to the intense competition for large group business were made to explain that Empire could not automatically generate surplus by simply raising prices on its large group contracts. The intensely competitive environment of the late 1980's and early 1990's for this business made that a very tricky process. Increases might very well have resulted in Empire's loss of large group business that over time had been profitable. The permanent loss of profitable large group business would have jeopardized Empire's long-term ability to generate surplus to subsidize individual and small group contracts. The issues noted in question 9 below also relate to this question.

8. Q. Superintendent, the staff has testified that the 1987 market conduct report consisted of one-page within the report on the financial examination which was filed in 1991.
   - Did you think that one-page was sufficient to cover the customer service issues, sales and advertising, underwriting and rating reviews, and claims processing for an insurer of Empire's size?

A. The 1987 examination delved into the entire matter of the condition and affairs of Empire. As set forth in the "Scope of Examination" section of the 1987 report, many different matters were reviewed during the course of the examination. These items included financial condition matters and such diverse items as employee relations and welfare, reinsurance, territory and plan of operations as well as market conduct activities. The comments in the report do not necessarily reflect the examination work done relative to any particular item inasmuch as the format of the report is designed to present financial information, important descriptive material and descriptions of matters that represent departures from laws, rules and regulations or that are deemed as requiring special description.

Market conduct activities were dealt with extensively during the course of the 1987 examination. In the examination of Empire as of year-end 1987, the examiner-in-charge employed the following procedures used today in planning an examination:

- an examiner lists all the categories of items that are to be reviewed with priority designations;

- priorities are established based on such factors as:
  - findings during the preceding examination
  - recommendations from the Regulatory Unit requesting the examination which might have some special insight on matters arising between statutory examinations
  - analysis of complaints made to the Department's Consumer Services Bureau
  - media reports
  - matters brought to the attention of the Department by any other sources (sometimes even on an anecdotal basis).

When the examination was being planned, the Department's Consumer Services Bureau complaint files did not indicate a new or extraordinary trend in complaints against Empire. There were no special issues being reported by the media at that time. Nor were there any special matters coming to the Department's attention from Empire sources during the planning stages of the examination. However, the examiners delved into several different matters during the course of the examination only one of which, the use of customary and usual charges in computing reimbursements to insureds under the Plan's "Wraparound Plus" contracts, resulted in a matter requiring special mention in the report.

The examiners did review such market conduct areas as claims practices (specifically a random sample of medical-surgical, inpatient hospital and dental claims were reviewed for timeliness and accuracy of settlement), complaint handling (specifically complaints that originated through the Department as well as complaints made directly to Empire), accessibility by telephone to subscribers (specifically the viability of the number of telephone lines into Empire's general access number as well as the provider information outlet in Albany), the rating and classification of a sample of groups (specifically to determine if they were properly classified as community rated, incentive rated or experience rated), advertising (specifically for compliance with Department Regulation 34), and an analysis of Empire's fraud investigation procedures.

It is noted that subsequent to 1987 certain conditions changed at Empire and these will be reflected in the Department's imminent Report on Examination.

Cherry-Picking

9. Q. You testified that Empire was doomed because it writes only health insurance and functions as an insurer of last resort. At least nine other Blue Cross/Blue Shield plans are insurers of last resort yet none of them experienced the staggering losses which cherry-picking has allegedly caused for Empire. Additionally, all but two of these plans that are operating as insurers of last resort exceeded the minimum statutory reserve requirements for their states.
   - Can you explain why all insurers of last resort aren't experiencing the devastating effects of cherry-picking?

A. It is difficult to answer the question as to why other insurers of last resort outside of New York have not experienced the significant losses of Empire in their direct pay and small group lines of business without knowing the details of how such coverage is offered. In New York some of the other insurers of last resort have unique operations, such as the Rochester and Buffalo Blue Cross Plans where community rating is dominant and includes large employers. Other insurers of last resort in New York do not offer major medical coverage to direct pay subscribers. They market their products in a geographic area significantly different from the New York City area and their operating areas are less competitive and less broker dominated than the New York City region. The New York metropolitan area is unique with its high costs and large concentration of AIDS patients. There is also intense competition for the good risks in this very large market.

The answer to a number of questions would be needed in order to give a proper explanation, including such questions as:

— Do the other insurers of last resort have continuous open enrollment for individuals and small groups?

— Do these other insurers offer continuous open enrollment for major medical coverage to direct pay subscribers?

— Do these other insurers market in a geographic area similar to New York City which is a high medical cost area with a significant AIDS population?

— Do these other insurers have pure community rating or do they rate by age and sex?

— Do these other insurers have the same volume of individual and small group business as Empire?

These and other questions would have to be answered to give a complete explanation for the differences experienced by other insurers of last resort.

10. Q. As opposed to finding evidence of cherry-picking, the Staff uncovered evidence in Empire's own studies that tended to discount the importance of cherry-picking. For example, the staff reported:

> ...Empire's own small group cancellation study, dated January 1992, and using data provided by Gallup, shows that less than half (45.8%) of those groups that cancelled their Empire coverage in 1991 went to commercial carriers (sic). Indeed in Gallup's separate report, dated February 1992, it found that 36% of those that cancelled their Empire coverage no longer maintained health insurance coverage at all. Of those that did cancel Empire coverage for that provided by a commercial carrier, over 20% cancelled for reasons other than cheaper costs (i.e., for reasons other than being cherry-picked) -- 8% left because their business moved, was merged, or was sold; 7% left because of poor service by Empire, and 6% left because Empire cancelled them.
>
> The Staff also uncovered internal Empire audits which showed that "a large percentage of Empire's losses in some of its small groups were the result of groups and individuals who were never eligible for this insurance coverage in the first place."

- Were you aware of these internal studies and audits and their results?
- Do you agree that they strongly undercut the validity of Empire's cherry-picking argument?

A. The Department is aware of these studies. The Department strongly

disagrees with the Subcommittee staff's conclusion that these studies undercut the validity of Empire's argument with respect to the cherry-picking issue. In fact these studies substantiate the argument that Empire has been cherry-picked. Following is a summary of the findings of three of these studies:

- The Gallup Organization conducted a study of 801 small group community-rated policyholders that cancelled coverage with Empire during the first eight months of 1991. This is the study that is cited in your staff's report as evidence discounting the importance of cherry-picking at Empire. The Gallup study found that 291 (36%) of the groups that cancelled their policies with Empire did not replace the insurance coverage, i.e. they do not currently offer health insurance to their employees. The reason most often cited by these groups for the lack of insurance was cost. Of the 510 cancelled groups that maintained insurance coverage, 459 replaced the Empire policy with a policy offered by a commercial carrier. The study found that 78% of the 459 small group insureds that cancelled Empire for commercial carriers cited cost as the reason for cancelling, 8% moved or merged, 6% were cancelled by Empire and only 7% cited poor service. The study also found that the average premium for the new coverage was 25% less than Empire's, with 80% of the cancelling groups experiencing a 10% or greater cost saving. Clearly 45% of the 801 small group community-rated policyholders left for the cheaper rates of competing commercial carriers. It is unreasonable to deny that cherry-picking is a significant factor in Empire's problems.

- In July 1990 Empire conducted a survey of 98 small groups that cancelled coverage with Empire during the second quarter of 1990. This survey found that 82% of these groups that cancelled and replaced their health insurance with a competitor of Empire cited cost as the primary reason for cancellation.

- Empire engaged Milliman & Robertson, Inc. to review its community rated small group pool. The Milliman & Robertson report, dated October 9, 1990, provides additional evidence of cherry-picking or adverse selection with respect to Empire's small group business. The report's findings state: "We have concluded that Empire's small group pool is being hurt by competition and will probably deteriorate under current competitive conditions.... The deterioration is occurring because Empire's statutory hospital differential has been declining over the years, while at the same time, Empire's competition is using risk selection techniques that unravel Empire's community rated pool...we believe that the main threat to Empire's small group business is that Empire insures small groups as an "insurer of last resort", while its competition is "cream skimming" or "cherry-picking" the best groups." The report also indicates that there is evidence of a small group assessment spiral at Empire. The report defines assessment spiral as "the best groups are lured out of the community pool by insurers offering lower rates, and the remaining pool's experience declines. The declining experience forces rates to increase, which drives away even more of the better groups." The report also cites an Empire study that "the loss ratio of all small groups...over the 1985-1987 period shows that cancelled

groups had better than average loss ratios." The summary of findings of the Milliman & Robertson report contains the following statement which I believe sets forth the problems facing Empire. "In this report we have verified that aggressively-selective carriers will tend to attract the best risks- at Empire's expense. The American Academy of Actuaries testimony before the House Subcommittee on Health (April 3, 1990) makes clear that no amount of administrative efficiency, claim cost control, or managed care can, by itself, match the competitive advantages of cream skimming. Empire's 13% inpatient hospital differential and its other advantages are small compared to the savings that aggressive underwriting or pricing practices can produce."

In addition to these studies the Department is in possession of underwriting guidelines for small group policies of a number of commercial carriers. These guidelines indicate that there were numerous "blacklisted" industries and occupations as well as strict medical underwriting of small groups.

Arthur Andersen Report

11. Q.- In an interview with the Staff late last month, you told them that you thought that the Report prepared by Arthur Andersen was "professional." In light of the Staff's testimony that Arthur Andersen "did no independent studies or reports" to support their finding of cherry-picking; that they did not contact any of the large national accounts that have left Empire; that they had no empirical evidence to support their conclusion that Empire executives are underpaid; that they never contacted HHS regarding a potential $140 million owed by Empire over improper Medicare billing; that they were unaware of the AT&T lawsuit, of the Finkelstein case, or of the payments to uncredentialed physicians, do you still believe that Arthur Andersen conducted a "professional" management and financial audit on behalf of the state?
- Do you feel that perhaps New York should ask for its $2 million back from Arthur Andersen?

A. Arthur Andersen was retained to conduct a management and financial audit of Empire in order to correct management deficiencies and to improve Empire's overall future financial performance in the health insurance marketplace. In addition to interviewing over 300 of the company's managers (and eight members of its Board of Directors), Arthur Andersen met with employee benefit consultants (who advise on the purchase of group health insurance policies), group administrators, insurance brokers, representatives of the Greater New York Hospital Association, the New York State Consumer Protection Board, this Department and the New York Legislature. Arthur Andersen thus had the opportunity to meet with most of the persons who would be knowledgeable as to how Empire was conducting its business activities. This approach would appear to be at least as useful as anecdotal accounts related by what of necessity would be only a small sample of Empire's eight million subscribers.

Arthur Andersen's report, rather than a "whitewash" of Empire's faults and problems, is highly critical in many important areas, including Empire's treatment of its subscribers and health care providers:

"Customers generally do not feel that Empire provides the responses they require....

Professional employee benefit consulting firms have little regard for Empire's capabilities in comparison to its competitors....

The benefit consultants have a very low opinion of Empire's customer service capabilities....

Insurance brokers generally believe that Empire is a higher-priced alternative that does not provide good customer service....

Providers feel neglected by Empire."

Arthur Andersen criticized Empire's performance in many other areas, including the following: the autocratic nature of senior management; lack of appropriate internal communication to lower levels of management; a corporate culture that is reactive rather than proactive; delays in introducing new products; poor product design and sales follow-through at Healthnet, Empire's HMO; and failure to meet the competition in the use of computer technology.

Beyond these and many other criticisms, Arthur Andersen made over 100 specific recommendations to improve Empire's performance in virtually every area of its operations. Although the Department does not view the Arthur Andersen report as the final, definitive word on Empire's condition and performance, nevertheless, the Department believes it is irresponsible to summarily dismiss the report's findings. The report is a professional, diligent effort within a limited time frame to come to grips with many of the problems facing New York State's largest health insurer.

12. Q.- You have previously recommended that Empire replace its outside auditors, Deloitte & Touche, because of questions over the appearance of a conflict of interest. Given this position of yours, and in light of the previous work done for Empire by Andersen Consulting, do you feel it was appropriate to award the contract for the state's management audit to Arthur Andersen?

A. The Department recommended that Empire replace Deloitte & Touche because at least ten of Empire's managers, including its Chairman and CEO, had come to Empire directly from Deloitte. This raised a potential conflict of interest. On the other hand, Arthur Andersen's previous services for Empire, as described below, were on a relatively minor scale and did not raise conflict of interest concerns to a level that should have disqualified them.

Chapter 501 of the Laws of 1992 directed the Superintendent of Insurance to select a firm to perform a management and financial audit of Empire. In response to a "Request for Proposals" published in The New York State Register and - although not legally required - also directly mailed to some 80 firms, only eight firms submitted proposals. These were initially reviewed and evaluated by five senior staff personnel of the Insurance Department, all of whom are career Civil Service employees.

The proposals were evaluated against such significant criteria as: demonstrated competence in management review, statutory insurance accounting, actuarial science, and electronic data processing; previous experience on similar projects by auditor's proposed staff; a clear statement of the goals of the audit; whether the audit would cover the objectives of the statute; and whether services performed for Empire in the last five years would compromise the bidder's performance and objectivity.

With respect to potential conflict of interest, Arthur Andersen was one of four bidders that stated it had done work for Empire during the previous five years. The others were KPMG, Mercer and Towers Perrin. All four had reasonable explanations that their relatively modest earlier work would in no way influence their judgment in properly conducting a financial and management audit of Empire. The Department has no reason to believe that any of their statements were false or misleading.

A review of Empire's Annual Statements for the five-year period from 1987 through 1991 shows that Empire paid Andersen Consulting a total of $447,000, and an additional $371,000 in 1992. KPMG (and its predecessor firm, Peat Marwick) received $562,000 from 1987 through 1991, and an additional $129,000 in 1992. Mercer received $205,000 from 1987 through 1991, and nothing is indicated for 1992. Towers Perrin received $726,000 from 1987 through 1991, and an additional $369,000 in 1992. Of the four, Towers Perrin obviously received the most money from Empire during the period under review. The Department reviewers did not believe that the services performed by these four bidders, and the explanations that each offered of the type of work performed, should disqualify them under New York's statute.

By contrast, the amounts received by these four bidders pale when compared to Empire's payments to its outside auditor, Deloitte Touche (including its two predecessor firms, Touche Ross and Deloitte et al), which received $11,362,000 during the 1987-1991 period, and an additional $887,000 in 1992. Such a level of payment and services was viewed as clearly disqualifying within the statutory language. In fact, Deloitte Touche was not one of the eight bidders.

It should be stressed that the bidders for this management and financial audit operate nationally and internationally, and that one would expect all of them at some time or other to have their work challenged by private parties or governments. For example, Business Week of April 6, 1992 reported a $300 million lawsuit brought against Coopers & Lybrand by Florida insurance regulators alleging that Coopers & Lybrand failed to detect "phantom" transactions of Guarantee Security Life Insurance Company. The article also noted that Ernst & Young was a defendant in an SEC complaint alleging misleading audits of RepublicBank of Texas by its predecessor firm, Arthur Young. Similarly, Forbes, in its August 17, 1992 issue, reported that Price Waterhouse had rendered optimistic forecasts for First Humanics, a nursing home company that subsequently became bankrupt, with millions of dollars in bond losses. These were three of the remaining four bidders that had performed no services for Empire during the preceding five years.

Of the four firms that had not worked for Empire over the past 5 years, Ernst & Young had 22 Blue Cross plans as clients and performed services for 14 others, Coopers & Lybrand had about 16 Blues as clients, Price Waterhouse had about 8, and McKinsey & Co. had also conducted similar reviews at other Blue Cross/Blue Shield organizations.

The reviewers were thus faced with the reality that only a handful of firms in this country were of sufficient size, knowledge and experience to perform the management and financial audit required by the New York statute. It is clear that all of the firms that submitted bids had previous experience in auditing and reviewing other Blue Cross plans, which constituted significant support for their professed expertise.

It is also clear that all of the bidders faced a potential conflict of interest in that a favorable management and financial audit of Empire could possibly lead to future work with Empire or other Blue Cross Plans. The reviewers recognized that none of the firms could be certified as "pure", nor on the other hand was there sufficient evidence to disqualify any of them.

Finally, it is the Department's understanding that the statute did not require the consulting auditor to duplicate the duties of the Department by performing a full-scale financial examination, nor was it intended to uncover rate filing deficiencies, fraud, or conspiracies. The consulting auditors had no subpoena powers, nor could they take testimony under oath. The audit as described in the statute was primarily intended to uncover management deficiencies and to make recommendations that would chart a viable future course for Empire as New York's largest health insurer. In retrospect, the Department believes the Arthur Andersen audit complied with the New York statute. It furnished many valuable recommendations to improve the company's operations that were useful to both Empire and the Department. In fact, Empire has agreed to implement virtually all of them.

- What steps did you take to assure the independence of Arthur Andersen before awarding the contract to them?

A. The Department reviewers observed that Arthur Anderseo's previous work for Empire was performed by a subsidiary, Andersen Consulting. One of the reviewers spoke to a member of the proposed Arthur Andersen audit team about the nature of Andersen Consulting, and was advised that Andersen Consulting, as a subsidiary of Arthur Andersen, installed and/or modified systems. It was concluded from this conversation that this work for Empire was primarily an operational contract, with no substantive component that would constitute a conflict of interest.

It was also observed that Arthur Andersen had worked with the Department's Liquidation Bureau, which was favorably impressed with the quality of its work. In addition, approximately ten years ago, Arthur Andersen had, as a consultant, developed for the NAIC (and particularly for New York) a sophisticated statistical data monitoring system that continues to this day to be a useful tool to assure the quality of automobile insurance statistics collected by insurers and reported to the Department. More recently, Arthur Andersen completed an extensive data quality audit for the National Council on Compensation Insurance.

Arthur Andersen's written testimony submitted to your Subcommittee, which in significant measure was included in its proposal, states:

> Arthur Andersen & Co.'s past work for Empire was extremely limited. It consisted of three prior contracts of short duration which were narrow in scope and confined to a single part of Empire's organization. Arthur Andersen & Co. consultants assisted Empire staff in the complex exercise of transitioning major new National Account customers onto Empire's operational processing systems. Our work was confined to operational support for implementing new accounts after Empire management had determined both the pricing and services the new accounts would receive. As such, we were not involved in any management decision-making....
>
> Furthermore, all projects performed for Empire had been completed prior to our receipt of the Request for Proposal. In deference to the Insurance Department's concerns, Arthur Andersen & Co. prohibited any further engagements for Empire after accepting the engagement to perform the management and financial audit.

Finally, as Arthur Andersen's audit proceeded, there were several meetings to discuss progress on the report between that firm's staff and Department personnel, which gave the Department no reason to doubt the firm's integrity, professionalism or objectivity. Arthur Andersen also had separate meetings with members of the New York Legislature, none of whom expressed any reservations as to their objectivity, independence, competence or to the scope of the audit.

Department's Examination Procedures

13. Q. The Insurance Department examination of Empire for the period ending December 31, 1987 was not filed until more than three years later, in January 1991. The examination report for the period ending December 31, 1983 similarly took two to three years to file.
   - Why does the Department's procedure take so long to complete?
   - In light of the length of time it takes, is the financial information of any value three years after the fact?

A. Examinations are not routine audits. They delve into matters that are much more comprehensive and are designed to elicit a conclusion about the total condition and affairs of an examined entity. The Report on Examination is not the primary reporting mechanism for the financial condition of an insurer as of any given point in time. That is the responsibility of the reporting entity itself and is backed by the CPA certification requirement for the financial statements filed with the Department. The financial information presented in a report is more an indicator of the confidence a statement user can place on an insurer's own certified statement filings. If the Department were to be the primary source of financial condition presentation, there really would be little need for statement filings. The statutorily imposed, periodic nature of the examination process reflects this fact.

To complete an examination in a shorter period of time a substantial increase in Department resources would be necessary, at considerable expense to the consumer. This Department alone regulates over 1,000 insurer entities, almost 500 of which are domestically incorporated insurers.

Moreover, a substantial portion of the examination function deals with nonfinancial items. These include how the company is organized, where it operates, how it operates in the marketplace, how it complies with various statutory requirements relative to investments, reinsurance, holding company transactions, etc. The Report on Examination provides a framework to judge the insurer's effectiveness in the marketplace as against the standard of the rules established for obtaining and maintaining an insurer license.

The differences between an examination and a financial audit are significant. In a financial audit CPAs opine as to the fairness of the financial information presented. They apply broad materiality standards in arriving at their conclusions; that's the only way they could be issued "timely". This is appropriate to the goal of an audit—that the statements present a fair picture of where the entity is financially and how it got there. The goals of an examination are to use hindsight to assess the judgments made in presenting these financial pictures in order to see if the standards of adjudging "fairness" are appropriate and, more importantly, to set forth instances where statutes and formally issued rules and regulations have been violated.

Accordingly, the timeframes to meet these divergent goals are different. The audit's completion date must be closely related to the statement date or period covered by the statement or else it will be of little use. An examination's usefulness lies in its broader view of an insurer's operations and financial condition and does not require an absolute tie-in to a near-term examination date. Of course, it is the Department's desire to examine an entity as quickly and expeditiously as possible, but like most governmental agencies, whether operating on a federal, state or local level, there is the question of available resources. The scope of the examinations is so extensive that time is required to complete the examination properly. Empire is a complicated entity, the largest nonprofit in New York. Its examination is necessarily time consuming.

The examination process is a work in progress in that many problems are corrected as they are detected by the examiners during the conduct of the examination. There is no need to wait for the final report to take corrective action. The final report is only one product of the examination process and not the most important one.

Equally important, whether dealing with the Empire situation or any other examined entity, is the issue of due process. This right is frequently overlooked by critics of regulatory systems and has been overlooked in the critiques leveled at the state system of regulating the insurance industry. Although regulators have no personal interest in the outcome of a particular issue, regulated entities do, and are afforded statutory rights to challenge examination findings.

Notwithstanding any of the above, the Department is the first to admit that its administrative process governing the handling of examinations and Reports on Examination could be improved and strengthened. The Department has endeavored to put in place enhanced resources and procedures to accomplish the goal of completing examinations on a more timely basis; for example, targeted and limited examinations are conducted when warranted. In the last three years, the Department has received a substantial increase in budgetary funds for equipping the field examiner workforce with laptop computers as well as for expanding the examiner workforce itself. To some measure, and despite conditions in the workforce marketplace, the Department has been hamstrung in its efforts because Civil Service pay scales continue to lag behind those of the primary competitive areas, i.e., public accounting firms and actuarial consulting firms. Cutbacks not only affect the private sector; more often they affect the public sector to a larger degree.

14. Q. The examination for the period ending December 31, 1991 is still pending.
- This is obviously a very crucial time period. When do you expect to file this report?

A. I expect the December 31, 1991 Report on Examination of Empire to be completed by late September 1993. Before an examiner's report can be filed and available for public inspection New York Law requires that the company be given an opportunity to review the report and contest its findings. Therefore, in the absence of a challenge by Empire to the report's findings, I anticipate that the report will be filed by late October.

The last two examination reports stated that Empire had not been very cooperative with the examiners. The current examiner, Martin Schwartzman, told the Staff that Empire's cooperation is still a problem. Indeed, you have stated that Empire has been slow to provide information and has claimed that certain information did not exist when, in fact, it did.
- In light of this what steps do you intend to take with respect to Empire's cooperation with this and future examinations?

A. I have already taken action with respect to the lack of cooperation by Empire's senior management during this current examination. At a meeting of Empire's Board of Directors, held at my request at the offices of the New York Insurance Department, I urged the Board of Directors to consider removing Mr. Cardone from office. I subsequently urged the appointment of a new Chairman of the Board and a new CEO from outside the ranks of the existing Board and officers and the expansion of the Board to 25 members. I approved the appointment of Philip Briggs as the new Chairman of the Board and acting CEO of Empire. I also demanded the removal of Empire's Chief Financial Officer and have informed Mr. Briggs of several other individuals who may have misled the Department examiners. I expect Mr. Briggs to investigate this matter and to take action with respect to these individuals if warranted. The Department is proceeding with its own inquiry, the results of which will be part of its examination report.

The New York Insurance Law provides a number of sanctions for insurers that fail to cooperate with an ongoing examination. These are as follows:

- a proceeding in rehabilitation under Article 74 of the New York Insurance Law, if the failure constitutes a refusal to submit its books, papers, accounts or affairs to the reasonable inspection of the Superintendent
- imposing financial penalties
- removing an officer or director found to be dishonest or untrustworthy

The last can only be accomplished after notice and hearing and would result in an order to remove from office the offending individuals. Failure to comply with such an order would also be grounds for liquidation of the company. This result, which is the first alternative listed above, would be a sanction of last resort and not appropriate for Empire, a solvent not-for-profit corporation and the largest provider of health insurance in New York State. With regard to the second alternative, the Department has imposed financial penalties (fines) on not-for-profit health insurers, but the value of fines is limited because they tend simply to be passed on to policyholders. With respect to the findings of the current examination, I elected to advise the Board of the Department's findings and demand that appropriate action be taken. I believed that this course of action was the most effective and expeditious way to resolve the problem. The activities of certain officers of Empire are the subject of ongoing criminal investigations and the Department is cooperating with the authorities conducting those investigations. I am also considering recommending changes in the Insurance Law that would authorize the imposition of personal fines on officers and employees of insurance companies in addition to the insurers themselves for such violations of the Insurance Law as lack of cooperation.

Empire's Viability

15. Q. What would you do if Empire's reserves became negative?

A. The Department's close oversight of Empire's financial results would afford sufficient and timely warning of adverse financial developments. If it became apparent that Empire was on a hopeless downward spiral with no possibility of turnaround, Empire would be either rehabilitated or liquidated by the Department in order to preserve Empire's remaining assets and best protect the interests of subscribers and their families, hospitals and providers. Realistically, the Department would not stand by idly and permit Empire to deteriorate so far that it would endanger the health and hospital system of New York State.

In any event, if the worst happened, Empire, because of the new community rating/open enrollment law and previously introduced legislation, is no longer "too big to fail." The remaining insurers and plans would, over a relatively brief time period, absorb Empire's business.

A brief comment on Empire's current financial condition seems appropriate. As responded to in question 5, when Empire's surplus funds declined to their lowest level ($39.7 million at December 31, 1992), the Department was compelled to approve an average community-rated contract increase of 25.5% effective January 1, 1993. The reported improvement in Empire's surplus to $230.3 million as of June 30, 1993 renders the possibility of an imminent Empire failure remote.

16. Q. Mr. Curiale, the Subcommittee staff spent six months examining Empire's operations, conducting numerous interviews and depositions and reviewing thousands of documents. As a result they identified some serious problems within Empire, including:

-- an inability to properly execute the most basic functions of an insurance company, resulting in abysmally poor service to subscribers and providers;

-- a severe lack of internal controls leading to a high degree of vulnerability to fraud;

-- excessive expenditures for the benefit of senior officers and members of the Board of Directors;

-- a propensity on the part of the plan management to blame external factors for the plan's failings and to rely on external sources of relief to keep it afloat; and

-- inadequate oversight of management activities by the Board of Directors.

- Do you agree that these are problems that Empire needs to address and, if so, what do you, as the Superintendent of Insurance, intend to do to see to it that these problems are corrected?

A. The Department agrees that the problems that the Subcommittee identified and others that will be described in the Department's Report on Examination on Empire must be addressed by Empire's management. The Department is confident that Empire's new management of highly qualified individuals will take necessary steps to address these problems.

Implementation of the actions taken to correct these problems will be monitored by the Department as well as the Special Advisory Panel established by the New York Legislature this year. The Department's oversight of Empire will continue. The Department expects to begin a new financial condition and market conduct examination to encompass the two years ending December 31, 1993.

17. Q.- Does the New York Insurance Department have a plan for what it would do in the event it was forced to declare Empire insulvent?
- Do you have a liquidation plan?

A. Over the years the Department has had broad experience in liquidating and rehabilitating insurers when necessary. Procedures have been developed for the orderly winding up of a defunct insurer's affairs. With regard to Empire, this question was touched on in the response to question 15. The Department also points out that through the efforts of the Department no subscriber or claimant of any nonprofit health insurer has ever suffered a financial loss. During this Empire crisis the Department has also worked diligently to ensure that the citizens of Buffalo, New York were not harmed by the financial problems affecting WholeHealth Insurance Network. The 1992 year-end merger between Blue Cross of Western New York and WholeHealth Insurance Network provided WholeHealth's subscribers with needed financial security and guarantees the payment of all claims.

8/27/93

ADDITIONAL QUESTIONS
FOR THE
HEARING RECORD

By Senator William V. Roth, Jr.

SALVATORE CURIALE
Superintendent of Insurance
State of New York

* * *

1. Q. The New York Times on June 29, 1993, cited examples of testimony before your Department by Empire's former chairman in support of rate increases that used inaccurate profit and loss figures. You are quoted in that same article as stating that the erroneous figures played no role in your rate settings.
   - Can you explain this apparent inconsistency?

A. What has been lost in the discussion of inaccurate profit and loss figures is the fact that such figures, which appear in Annual Statements, are estimates of the previous year's profit or loss. Empire's former Chief Financial Officer, Jerry Weissman, apparently had for years calculated such estimates in a different fashion than calculated in the annual statement in order to determine the extent to which various market segments (such as national accounts) contributed to estimated profits and losses. Mr. Weissman has explained that he never saw a need to reconcile these two sets of estimates because the differences between the two were always marginal relative to Empire's huge book of business.

A rate filing is prepared at a different time and in a different manner than an Annual Statement. The rate filing includes actual, not estimated, payments of claims for years in which losses have been fully developed. In addition, estimates are prepared for each contract using trends established from each contract's developed losses. In other words, the rate filing to be effective April 1, 1992 relied on developed losses for the years 1989 and 1990. The 1991 figures had not been developed at that time. Empire derived loss trend factors for each contract based on the 1989-90 data and other factors (such as anticipated changes in contract benefits, medical care inflation, or hospital reimbursements). The Department reviews these trend factors for reasonableness. As of this date, it is still the position of this Department that the Annual Statement estimates played no role in the rate setting process, but we continue to audit the applicable filings.

An additional source of confusion has been the New York State Law requiring the Superintendent to consider the overall financial condition of nonprofit health insurers in approving rate adjustments. The requirement was added to the Insurance Law in 1986 essentially to provide the Superintendent with a means by which to adjust rate requests that may be justified by the developed numbers, but inappropriate due to the surplus position of a Plan. The Superintendent does this by reviewing the most recently filed financial statement. In Empire's case, the Department has never used this statute to raise or lower a rate that it felt was justified based on the developed numbers in the rate filing.

2. Q. In that same New York Times article, you are quoted as saying Empire had "created a firestorm that does not deserve to have been created" by reacting so strongly to the discovery of the two sets of profit figures.
   - Do you agree that Empire had an obligation to submit only accurate figures to the Insurance Department and to the New York Legislature?

A. I certainly agree that Empire has an obligation to submit only accurate figures to the Department and the New York Legislature, and I will not tolerate the filing of misleading or incomplete information by Empire or any other licensee of this Department. My remarks that you quote from The New York Times article were not an indication of my acceptance of misleading financial statement filings, or my dismissing such filings as unimportant. However my point was that the reaction of the then Chairman of Empire's Board unnecessarily raised doubts about Empire's financial viability and the appropriateness of recent rate increases granted Empire. As indicated from my answer to your first question, we would expect an insurer to always provide its best estimate of profit or loss, but even a less-than-best estimate—provided it is within the realm of reasonability—would have no tangible effect on consumers or the marketplace.

3. Q. I understand that the Insurance Department is currently reviewing Empire's financial filings.
   - If you determine that Empire failed to submit its most accurate figures, what steps do you intend to take in response?

A. If the Department's review of Empire's financial filings determines that false or inaccurate statements were filed, I will refer the matter to the appropriate authorities for possible criminal findings against the individuals responsible. In this regard the Department is currently cooperating with the Manhattan District Attorney's ongoing criminal investigations of the activities of certain officers of Empire. Furthermore upon completion of these investigations I will consider the possibility of pursuing a finding of untrustworthiness under the New York Insurance Law against the responsible individuals. If it were determined that false filings had any impact on the rates the Department approved, the Department would take that into consideration in reviewing and approving future rate filings.

4. Q. In 1989, the New York State Supreme Court upheld the Insurance Department's authority to require Blue Cross/Blue Shield plans to recoup the subsidies they provided to their HMOs. In Empire's case, that subsidy exceeds $100 million.
   - In the four years since that decision, what has the Insurance Department done to utilize this enforcement authority?

A. In 1988 the Superintendent directed three nonprofit health insurers to submit a plan that would result in the restoration of amounts expended in developing their line-of-business health maintenance organizations (HMOs) that were above actual start-up costs. The Superintendent's authority to impose such a directive was legally challenged and upheld in an order dated July 24, 1989. New York's Appellate Division affirmed this

Decision on December 13, 1990. The amount of prior subsidy of two of the affected nonprofit insurers, Blue Cross of the Rochester Area and Blue Cross and Blue Shield of Western New York, has now been fully repaid.

With respect to Empire and its line-of-business HMO, Empire Healthnet, this subsidy amount is now approximately $73 million. This amount reflects the HMO's underwriting gains of $8 million for 1992 and $6 million through June 1993, as well as previously approved start-up expenditures of $11.4 million and an allocation of Empire's investment income that is attributable to the HMO.

One of the regulatory tools used in Buffalo and Rochester to bring about repayment of the prior subsidy was to approve a higher rate than the amount necessary to meet the projected expenses of the HMO. In this way additional funds were generated from the HMO's subscribers which were used to repay the prior subsidies received from the insurer's non-HMO subscribers. In the case of Healthnet this same technique was used in 1988 when the Department approved an 11.4% rate increase rather than the requested increase of 8.25% and in 1989 when the Department approved a 22% increase rather than the requested 18.1% increase. However, the Department's ability to employ this technique was limited as Healthnet's rates were always among the highest of any HMO in its service area. In view of Healthnet's high rates and recent declines in enrollment (from a high of 187,000 in 1990 to 123,000 at year-end 1992) it was the position of the Department that any attempt to further increase Healthnet's rates in order to expedite payback of prior subsidies would only exacerbate its loss of enrollment and not produce any additional income. The Department will continue to monitor Healthnet's profitability and enrollment trends before imposing any plan to recoup the remaining subsidy.

5. Q. In your prepared statement, you pointed with pride to the passage in 1992 of community rating/open enrollment legislation. But let me quote to you from a letter published in the New York Times of June 29, 1993 from a self-employed single mother. She wrote that as a result of this legislation, her health insurance premium went from $3,700 per year to $7,200 per year, which she cannot afford. She said she wrote to you to complain, but received no response.
- What do you say to her complaint?

A. First, to comment in general on the community rating and open enrollment legislation, it should be noted that this comprehensive health insurance reform bill eliminated the underwriting and selection process used by insurers writing individual health insurance and health insurance to groups of 50 and under. In addition, the legislation required that individual and small group health insurance be community rated, that is, that all persons covered by a health insurance contract pay the same premium rate without regard to age, sex, health status or occupation.

The effect of the legislation is to move the State of New York to a health insurance system in which insurers spend less effort keeping people out of the system and more effort in bringing them into the system and competing on the basis of which insurer can best manage care, keep administrative expenses low, make beneficial arrangements with providers, and pay claims in the fastest and most efficient manner. The Department believes that other states and the nation are currently faced with the need for similar reform legislation.

During the commercial insurers' transition from selective underwriting and rating methods to a community-rated, open-enrollment marketplace, the Department received a number of inquiries and complaints from those adversely affected by the reform legislation. In answer to complaints such as the one you mentioned, the Department has pointed out that the movement to open enrollment and community rating had the result that approximately 5% of persons who were converted to community rating received double the rates charged prior to community rating. The Department also pointed out, however, that approximately 38% of the individuals converted to community rating received a rate decrease and that the average increase was approximately 18%. Consumers receiving significant increases were advised by the Department of a number of options, including the following:

— consider increasing the deductible or coinsurance factor so as to reduce the premium;

— consider switching coverage to an HMO which under the reform legislation is now required to accept individuals without underwriting; and

— shop the marketplace to determine if less costly coverage is available from another insurer.

It has also been pointed out to those who had previously benefited from selective underwriting and rating methods that such a methodology could result in substantial and repeated rate increases in the future for those with poor experience while community rating provides stability in rates by spreading of risk through a large community pool.

Admittedly a major systemic change in health care financing such as the one enacted in New York brings hardship to some and requires some difficult choices. However, such decisions must be made when the existing system is failing to address the needs of the public.

6. Q. The Insurance Department's report on Empire for the period ending 1984 (sic) criticized Empire for failing to cooperate with Insurance Department examiners and the Insurance Department's report on Empire for the period ending 1987 contained a similar criticism. Also, the Insurance Department's report on Empire for the period ending 1983 stated that three of the four recommendations from the previous report had not been complied with; and the Insurance Department's report for the period ending 1987 stated that five of the 1983' recommendations had not been complied with.
- What steps did the Insurance Department take in response to Empire's repeated failure to comply with these recommendations?

A. The Department's report on its 1980 examination of Empire was filed in February 1983. That report contained four comments and recommendations, two of which related to Board member attendance, one to compliance with the New York Abandoned Property Law and the fourth concerned an inadequate claims adjustment expense reserve. The 1983 report commented that Empire had complied with the latter recommendation, and incompletely complied with the recommendation as to the New York Abandoned Property Law, and that problems still existed relative to attendance of directors at Board and committee meetings. The 1983 report

on examination also had other comments and recommendations about the Board of directors, corporate emergency preparedness, cooperation with examiners, annual statement reporting, Empire's custodian agreement, the reporting of cash on deposit in the 1983 annual statement and deficiencies in the accounting of Empire's "Miscellaneous Accounts Receivable."

The problem of Board member attendance is endemic to an organization such as Empire due to the size of the Board and the continuing turnover. For instance, of the 40 directors listed in the 1983 report only 25 were still directors as of year-end 1987. Thus, it is difficult to enforce a recommendation of this type, since the examined entity often responds that it has substantially changed the directorate. The 1987 report notes a significant improvement in overall Board attendance with only two delinquent Board members. However, there was a continuing attendance problem with three of the Empire Board's 13 standing committees. Additionally, it was noted in the 1987 report that four of the terms of delinquent directors had expired just prior to year-end 1987 and that a fifth delinquent attendee had resigned from the Board. Furthermore, two of the committees with poor attendance did not exist as of the examination date, and their duties had been merged into a new single committee.

Further, seven members of the Board as of year-end 1987 were not members of the Board as of year-end 1991. Of the twenty Board members as of year-end 1991, the current examination date, five are no longer directors today.

The Department does indeed consider Board member attendance of high importance and monitors it closely. In fact, attendance has declined again during the current examination period and will be the subject of comment in the Department's Report on Examination. This situation, among others, has generated a new effort to restructure Empire's Board.

Concerning the Abandoned Property Law matter, the 1980 examination recommended certain follow-up procedures be implemented. Noting the filing date of that report, again February 1983, it is not surprising that complete compliance was not accomplished during the 1983 report's examination period. However, that report, filed in January 1986, did note that there was substantial compliance by January 1985 and that full compliance was expected some time during that year. The 1983 report also set forth problems with filings with the New York State Bureau of Abandoned Property for the years 1978-1980. No problems were described relative to the years 1981-1983. In light of this fact, the Department considered the matter as coming to a close by 1985. The 1987 report details problems not with the follow-up procedures, but with the filing of reports by Empire covering the period 1981-1984.

7. Q. Empire cited cherry-picking, rate suppression and fraud as the three primary reasons for its recent financial losses.
   - Do you share the company's views on this?

A. It is my belief that cherry-picking is one of the primary causes of Empire's recent financial losses. This position is based on the results of independent studies of Empire's small group business and the market conditions that existed in the small group area in New York. Furthermore the Department has reviewed the small group underwriting guidelines of a number of commercial carriers. These guidelines require strict medical underwriting and the "blacklisting" of certain industries and occupations.

This is not to deny the fact that many other causes contributed significantly to Empire losses. These include the existence of a system that led to adverse selection problems for insurers of last resort; the "dumping" of poor risks by commercial carriers; the high cost of health care, particularly in downstate New York; the intensification of competition for large group business by multiline commercial carriers; inadequate fraud controls; and poor or inadequate management.

With respect to what you term "rate suppression," it is certainly true that the Department did not always grant Empire its full rate request. Granting full increases over the past few years would not have solved Empire's underlying problems. Although such actions may have hastened the urgency with which meaningful solutions were developed, many more people would have been effectively deprived of health insurance by virtue of unaffordable rates.

8. Q. Did the Insurance Department attempt to independently verify Empire's cherry-picking claims when Empire sent in requests for rate increases?

A. First, it may be helpful to clarify what is meant by the term "cherry picking." The Department would define "cherry picking" as selective underwriting, i.e., the selection of only the better or best risks. If you use such a definition, no one would deny that risk selection was occurring. The law in effect prior to the community rating/open enrollment legislation permitted risk selection and age rating and thus necessitated a change in law to require all insurers to open enroll and community rate individual and small group business. During a public hearing on the Empire rate increase in September 1991 in New York City, there was credible broker testimony concerning the restrictive underwriting standards of the commercial insurers and the need for brokers to send more and more small groups to Empire because of rejection by the commercial insurers.

During the period when the open enrollment/community rating bill was being debated, the Department obtained and reviewed the underwriting rules of certain commercial insurers which revealed that there were lengthy lists of "blacklisted" industries and occupations, and strict medical underwriting of individuals and very small groups even after excluding those in "blacklisted" occupations and industries. In addition, it was verified that selective rating practices existed.

It became the Department's position that a fundamental change was necessary in the system. Permitting some insurers to underwrite health insurance risks and prohibiting others from underwriting, and allowing community rating and experience rating to exist as competing rating methodologies had led to an unworkable system requiring significant change.

The most compelling evidence of whether Empire was left with the oldest and sickest risks should come from the data submitted by all health insurers as required by Department Regulation 146 which established a demographic pooling mechanism and a specified medical condition pool. The demographic pooling mechanism requires each insurer to submit age and sex data with respect to persons covered by that insurer. Preliminary data submitted to the pool administrator indicate that Empire will receive money from the pool while commercial insurers and health maintenance organizations will generally pay money to the pool, indicating that indeed Empire has a relatively older and sicker insured population in its individual and small group community pools than do the commercial insurers.

9. Q. PSI staff reported that Arthur Andersen & Co., in compiling its report on Empire, made no independent effort to contact former Empire subscribers to verify Empire's cherry-picking argument and instead relied on information provided by Empire.
   - Do you agree with that assessment?

A. Although Arthur Andersen did not contact former Empire subscribers, it did conduct interviews with employee benefit consultants, group administrators and insurance brokers, all of whom would have had familiarity with the selective underwriting practices of Empire's major competitors.

Furthermore, Arthur Andersen's report cites "cherry picking" as one of several important market elements that contributed to Empire's losses, including: Empire's policy of open enrollment; Empire's rates, which were higher than its competitors' and which tended to drive away those groups with better loss experience; the diminishing contribution from Empire's legislated hospital differential, as Empire's business has shifted from hospital coverages to medical and comprehensive coverages; and disallowed rate increases.

10. Q.- Do you believe fraud is a significant factor in Empire's losses?
   - Isn't it true that until the Insurance Department's current examination of Empire, the Insurance Department never looked carefully at the issue of internal fraud at Empire?

A. The Department does not believe that fraud is the major cause of Empire's losses, but the amount of fraud losses is certainly significant. It is extremely difficult to quantify losses suffered by insurers that are caused by fraud.

Various governmental agencies and insurance industry trade associations have estimated that fraud affects 10% percent of total accident and health insurance paid losses. If that 10% figure were applied to Empire, the fraud losses would exceed $600 million.

Although there is no way to accurately quantify the amount of fraud, the Department does focus on the real issues raised by the subject of fraud, that is, Empire's internal controls. The Department looks for basic systems of internal controls to be in place at all insurers it regulates. These systems should permit the detection of claim and

enrollment fraud, while balancing the need for efficient and fair treatment of policyholders and claimants. Efficiency and fairness should extend to medical providers presenting their claims as assignees of policyholders.

It is not true that until the current examination of Empire, the Insurance Department never looked carefully at the issue of internal fraud. The Department had sought information regarding the Finkelstein case and the use of "dummy" codes well before the current examination. The Department's Frauds Bureau has since its inception been pursuing Empire health-care fraud cases based on the fraud reports the company files with the Department.

In addition, the Department had received complaints from subscribers in the 1980's of fraudulent practices by Medicare providers such as double billing and billing for services never rendered. In an effort to curtail this, Empire established (and still maintains) a fraud hotline for the public.

11. Q.- Does the Insurance Department receive copies of Empire's internal audit reports?
- If not, why not?

A. The Department does not receive copies of Empire's or any other company's internal audit reports. However it is standard examination procedure for Department examiners to review all internal audits conducted during the examination period. Reviewing internal audit reports at times other than during the examination period might well provide the Department with useful information. The Department will be reviewing its policy in the near future.

12. Q.- Did Empire inform the Insurance Department of the Health Care Financing Administration's concerns over Empire's poor performance as the Medicare intermediary or provide you with a copy of HCFA's letter to Empire on that matter?
- If so, when?

A. The Department has not been provided with a copy of Health Care Financing Administration's letter to Empire concerning Empire's poor performance as a Medicare intermediary.

13. Q. The Office of Inspector General of the Department of Health and Human Services is currently auditing Empire regarding the company's failure to comply with changes in the Medicare secondary payer laws. Although the audit is ongoing, interim reports indicate Empire may owe Medicare in excess of $150 million.
- Are you aware of this audit?

A. The Department is aware of the ongoing audit by the Office of Inspector General of the Department of Health and Human Services. Representatives of the Inspector General's office advised members of Department staff of the tentative findings with respect to Empire. The Inspector General's representative indicated that similar problems were found in their audits of all other Medicare intermediaries. Empire in its June 30, 1993 Quarterly Statement has established, for the first time, a

14. Q.- If the Insurance Department finds evidence of gross misconduct or a breach of fiduciary duty by an Empire official, what recourse does the Insurance Department have?

A. The Department may, after notice and hearing, find an officer or director "dishonest" or "untrustworthy" or both. Failure of the corporation to remove such an official following such a finding is cause for imposing monetary penalties and, as a last resort, seeking an order of liquidation.

15. Q. You concluded your statement by listing several ways in which you currently are enhancing the Insurance Department's oversight of health insurers.
- Will any of these changes require legislative action?

A. As observed in the answer to Senator Nunn's second question, with the possible exceptions of increasing the level of some of the Department's fines and penalties and of further expanding the operations of the Department's Frauds Bureau, it is believed that the actions the Department expects to take to enhance its oversight of health insurers can be accomplished through regulation.

The proposals to personally penalize (by fine) company officials who frustrate the Department's regulatory purposes and to personally fine and sanction officers who fail to comply adequately with the recommendations of the Department's examination reports would require legislation which the Department intends to propose.

16. Q. When do you anticipate these changes being implemented?

A. The Department is hopeful that the changes that can be implemented through regulation will be accomplished over the course of the next year. It is, of course, impossible to predict with any precision how much time will be necessary for changes to be implemented that require statutory authorization by the Legislature.

8/27/93

ADDITIONAL QUESTIONS
FOR THE
HEARING RECORD

By Senator John McCain

SALVATORE CURIALE
Superintendent of Insurance
State of New York

* * *

1. Q. Mr. Curiale, after a 2-yr. investigation of the problems relating to Empire and the actions of your Department, investigators of this Subcommittee termed your Department's performance "woefully inadequate" in your oversight of Empire Blue Cross and Blue Shield.

Subcommittee staff found that your Department's actions "evidenced regulatory forbearance which...bordered on favoritism."

The investigators criticized the NY State Insurance Department's "propensity...to reverse itself when such action would be to Empire's benefit," and "the failure of the Department to enforce its authority over Empire..."

- How do you respond to these charges?

A. The Department has acted aggressively and forthrightly within the powers conferred on it by the Legislature. The Department strongly disagrees with the characterization of the Department's performance as "woefully inadequate" or statements that the Department failed "to enforce its authority." The Department believes that these characterizations stem from an incorrect understanding of the Department's authority with respect to Empire. The issue of the Department's authority is treated more thoroughly in the answer to Senator Nunn's question 1.

The allegations that the Department evidenced a "propensity to reverse itself" appears to be related to a "Report on Examination" that was filed because of a miscommunication between Empire and the Department. All of the Department's reports are sent to the insurer being examined for objections and, if needed, conferences to discuss these objections before the report is filed. Since the reports are public documents once filed, the insurer is entitled to "due process" and has the right to contest the examination report before it becomes public. In this instance the draft was sent to Empire and objections were raised in a written reply. However, no conference was specifically requested by Empire, although the company desired one. A Department employee simply filed the report because of this lack of a specific request for a conference. When the communication was corrected the Department granted the conference. The same would have been done for any other insurer in any similar situation. A regulated entity has the right to fully discuss objections to the report before its release to the public in final form.

Even absent this lack of understanding between Empire and the Department, to characterize this single instance as a "propensity" is inappropriate.

2. Q. I find it very disturbing that after an exhaustive review of your oversight of Empire, Senate investigators found a willingness of your Department to "allow Empire to ignore Department recommendations and regulations with impunity" and that the New York State Department of Insurance underwent a "transformation...into an advocate on behalf of Empire."
   - Please comment on these assertions.

A. The Department has never permitted Empire to ignore its orders and directions on regulatory issues that the Department had the authority to enforce. Within the context of its examination report, the Department over the years has made a number of management suggestions that Empire's Board and officers, acting within their prerogative, have chosen to disagree with and ignore. The difference between regulation and management is discussed at length in the answer to Senator Nunn's first question. The Department has never been an advocate for Empire's management, but rather has been a vociferous advocate for Empire policyholders, many of whom are the oldest and sickest in New York State.

3. Q. Can you state any decisive or substantive actions you took with respect to Empire's excesses that the company actually followed through on before April of this year?

A. The use of the term "excesses" is ambiguous and general; accordingly, it is difficult to respond to this question. However, the Department has taken decisive and substantive action in a number of areas. For example, throughout 1992, the Department directed officials of Empire to appear at the Department to discuss Empire's failure to respond in a timely manner to consumer complaints filed with the Department and forwarded to Empire for response. Several meetings were held including two attended by Mr. Cardone. It was brought to Empire's attention that 37% of consumer complaints required at least three letters from the Department before a substantive response was received from Empire and that this failure to respond in a timely fashion was a serious matter that would not be tolerated.

As a result of these meetings, Empire instituted reforms in their correspondence unit including allocating additional staff to respond to complaints.

An analysis of the complaints received for the period January 1, 1993 to April 30, 1993 has shown a dramatic improvement during that period in that only 11% of those complaints now required a third letter. The Department is hopeful that still further improvement will be made in response time under Empire's new management.

4. Q. Concerns about your Department's ability to protect New Yorkers and cope with insurers in trouble are not just the findings of our Subcommittee's investigators. New York State's Comptroller issued a report in 1992 which found that your Department's "management did not always demonstrate a strong will to regulate." Furthermore, New York's Comptroller found that your Department's "management knew of insurer financial impairments years before rehabilitation or liquidation action was initiated."
   - How do you respond to these charges?

A. In the Department's judgment the Comptroller's Report contains criticisms of the Department that do not reflect an adequate understanding of the complexity of regulating a financial services industry for solvency in a competitive environment. The Comptroller's Report is an analysis by exception, which means that the Department's regulation of some 1,200 licensed and viable insurance organizations remains virtually unacknowledged, while the Comptroller's Report highlights a handful of cases that it contends raise questions as to regulatory oversight decisions made by this Department.

Furthermore, the Department believes that the Comptroller's Report is replete with erroneous conclusions, misleading half-truths and exaggerations, and outright misstatements. The Report overlooks an important consideration that cannot be minimized - that hasty action taken without responsible consideration of consequences to affected parties (i.e., insurers, policyholders, claimants, and the marketplace in general) is never desirable.

For example, if the Department had taken the abrupt steps suggested by the Report to liquidate various medical malpractice insurers in the mid-1980s based upon what then appeared to be massive malpractice insurer insolvencies, the cost to policyholders and guaranty funds would have been astronomical and the disruption to the marketplace severe (some $2 billion in additional premium costs to policyholders). Instead, working with the Legislature and the insurers, the Department averted a potential crisis by putting into place a program of reform legislation that by 1990 had helped rescue New York's medical malpractice system from catastrophe.

The Comptroller's Report also fails to consider the due process rights of licensees to challenge the findings of the regulator. Fortunately, the laws of this country do not permit a regulator to act as prosecutor, judge and jury. But the consequence for regulators is that it is exceedingly difficult - in the absence of overwhelming proof - to obtain an order of rehabilitation or liquidation in a contested case. The Report does not acknowledge the inherent subjectivity and imprecision of determining the many variables that demonstrate an insurer's financial condition. Each of these variables is affected by estimates that are themselves subject to varying expert opinion. The elements of regulatory judgment involved in the determination of an insurer's financial condition are so complex that an insurer can, through the courts, effectively prolong its own demise for years.

5. Q.- How many rate increases have you approved for Empire in the last three years?
- What were the increases?

A. The following rate increases were approved for Empire:

Effective Date	Requested Average Increase	Approved Average Increase
January 1, 1993	25.5%	25.5%
April 1, 1992	28.5%	14.2%
March 1, 1991	20.3%	18.9%

These increases affected only community rated business which represents approximately 27% of Empire's total business.

- Were you aware of extravagant and excessive spending by Mr. Cardone and other Empire executives when you approved these huge rate increases?

- Would you agree that expenditures such as a $20,000 desk, $142,000 for a weekend seminar, $58,000 in gifts from Tiffany's and Cartier, and $140,000 for limousines during a time that Empire lost $250 million are appropriate?
- Did you take any action to end these practices?

A. As noted in the response to Senator Nunn's question 4, the expenditures cited in the Subcommittee's report, while certainly reflecting poor judgment in view of Empire's deteriorating financial condition, do not constitute a waste of assets in the technical legal sense of the term. A waste of corporate assets would consist of a material amount of expenditures for which the corporation received no benefit or that are clearly excessive when compared to normal business practices or needs. While the Department recognizes that non profit entities should be held to a higher standard than commercial enterprises with regard to expenditures for employee benefits and business-related entertainment and office decorations, reasonable expenditures for these items are normal and appropriate even for non profit corporations. The Department does not generally substitute its judgment for that of a Board of Directors in these matters. The Department does, however, ensure that statutory limits on spending are adhered to. In fact, Empire's expenses over the years have been well within the limits set by law.

When reviewing rate increase applications the Department monitors the aggregate amount of actual and projected administrative expenses and detailed reviews are done in conjunction with the regular triennial examinations. The maximum aggregate amount of administrative expenses is limited by statute to 12.5% of annual premium income. During rate reviews the Department routinely questions administrative expenditures which exceed inflationary trends. In the past the Department has reduced requested rate increases in response to administrative expenditures that were judged to be excessive.

On a practical level the Department does not have the resources to root out this level of detail nor does it have the authority to micro-manage an entity should expenditures that are not technically a waste of assets be found. Entities such as Empire should be able to make decisions with respect to furnishing its offices and providing seminars. In the specific instance, as noted, Empire should have exercised better judgment. Historically, Empire's administrative expenses have been significantly lower, as a percentage of premiums, than for-profit health insurers.

Empire has recently imposed restrictions on the amount of its administrative expenditures and the total amount incurred in 1992 ($510 million) was slightly less than in 1991. Expenses incurred during the first six months of 1993 totalled $252 million and Empire has just announced plans to further reduce administrative expenses by at least $50 million during the next 18 months.

6. Q. Investigations determined that your Department allowed Empire to "ignore state regulations" governing HMO's and "failed to follow through" on your authority over Empire's HMO operation, which eventually drained the plan of $115 million in six years.
   - Is it true that your Department allowed Empire to continue to direct subscriber funds into their failing HMO ("HealthNet"), even though your Department was notified that Empire's Board of Directors objected?
   - If so, why?
   - Is it true that the Department reversed an earlier prohibition of donating subscriber funds to HMO's in this way?
   - If so, what was the justification?

A. As detailed in the response to Senator Roth's question 4, the amount of subsidy is approximately $73 million, after considering Healthnet's recent underwriting gains, approved start-up expenditures and Healthnet's share of Empire's total investment income.

The Department is not aware of any formal action by Empire's Board of Directors indicating objection or directing officers not to continue to direct subscriber funds into Healthnet.

The Department never directed Empire's Board to subsidize Healthnet. Instead, in the Department's Opinion and Decisions dated June 30, 1988 and March 31, 1989 the Department approved rates that were higher than those requested for the HMO in order to generate additional income from Healthnet's subscribers. In 1990 the Department directed Empire to correct various major errors in its Healthnet rate increase application and as a result the Department approved the 37.8% increase requested in the amended application instead of the 14.6% increase that was requested originally. In addition, when the Superintendent approved the foregoing increases he also specifically directed Empire's Board to review Healthnet's past inability to control medical and hospital costs and to institute corrective actions.

7. Q. Senate investigators contend that lobbying pressures from a prominent firm resulted in such a reversal.
   - Were you contacted by this firm (Hinman-Straub), and did you participate in any meetings with their representatives?

   Subcommittee investigators also testified that the Department also acquiesced to a lobbying effort by this same firm on whether to require a balance sheet on Empire's HMO.
   - Is this accurate?
   - Why was a balance sheet not requested?
   - Wouldn't a balance sheet have shown some of the serious losses that were occurring at HealthNet?

A. I am aware that members of the law firm of Hinman, Straub, Pigors and Manning, representing the Blue Cross and Blue Shield Plans of New York State, held meetings with former and present members of this Department on this subject.

I am aware that this issue was investigated during former Superintendent Corcoran's tenure and at that time certain members of this Department disagreed on the need to require a separate balance sheet for the line of business health maintenance organizations. In early 1988 a decision was reached and the affected nonprofit health insurers were notified that this Department would not impose a separate balance sheet requirement. The reasons for not requiring a separate balance sheet for the line of business health maintenance organizations (HMOs) included the following:

a. It would be an artificial statement since legally there is only one corporate entity.
b. It was impossible to allocate specific corporate assets to the HMO.
c. Line of business HMOs were already required to file annual and quarterly profit and loss statements including detailed schedules and exhibits.
d. The operating losses sustained by certain line of business HMOs were readily ascertainable from their annual and quarterly profit and loss statements.
e. The Department was prepared to and actually did impose higher premium rates than those requested in order to stop any additional HMO underwriting losses.
f. The Department would be requiring the submission of a plan that would result in the restoration of amounts expended in developing line of business HMOs that were above actual start-up costs.
g. The Department imposed a new requirement upon all HMOs that mandates the filing of a rate increase application if underwriting losses are sustained in any two out of three quarterly periods.

8. Q. The New York Supreme Court reportedly upheld your Department's authority to ensure that Empire recouped subsidies it paid to its failing HMO. Senate investigators have stated that no action has been taken in the ensuing four years.
   - Is this true?
   - If so, please state why.
   - Do these lost monies represent subscriber funds that will not be repaid?

A. The response to this inquiry is the same as that made to Senator Roth's question 4.

9. Q. The fact that Mr. Cardone was allowed to serve as both CEO and Chairman of the Board of Empire for five years has drawn much criticism.
   - When did you first raise this issue with Empire officials?
   - Is it not true that your office had the authority to direct Empire to change this situation?

- Is it true, as stated by Senate investigators, that your Department accepted the justification that Mr. Cardone was "representing subscribers" in his position on the Board?
- If so, isn't that inappropriate in light of N.Y. State regulatory guidelines?

A. I first publicly raised the issue of whether the offices of chairman of the Board and CEO should be held by the same individual in a letter to Empire Board members dated April 14, 1993, and again at a face-to-face meeting with them on April 30, 1993.

Up to that time my office had no independent authority to order separation of those positions. However, the Community Rating Bill signed into law in July, 1992 required that an independent financial/management audit of Empire be conducted. That legislation also gave the Superintendent the authority to direct the implementation of recommendations made by the auditor, if rejected by the Board of Directors, where the Superintendent finds the recommendation to be "necessary and reasonable." The Arthur Andersen audit report on Empire, a draft of which was furnished to the Department on April 15, 1993, recommended that the two positions be split. It was that recommendation in conjunction with the authority provided in the 1992 legislation, which became effective on April 1, 1993, that gave me the authority to require the split. In my meeting of April 30, 1993, I advised the Board that I would, in fact, direct that action if they did not implement the recommendation voluntarily. The Board subsequently split the two positions.

Prior to July 1, 1990, there was no provision in the law for allowing for an "officer/employee" director of a not-for-profit health insurer. At that time Albert Cardone was the CEO and Chairman of the Empire Board. The only categories of board member provided for under the law were "subscribers," "providers" and "public" members. Empire classified Mr. Cardone as a "public" member. In 1989 the Department advised Empire that it did not believe that an officer of the company could appropriately be classified as a "public member" of the board under the existing statute.

Legislation was subsequently introduced to provide for an "employee-officer" director classification for the Boards of not-for-profit health insurers. This was not an Insurance Department bill, but the Department did not object to it. It is a fact that in 1990 the Department had not yet reached the conclusion that it would be an inappropriate concentration of power for one individual to serve in the dual capacities of CEO and Chairman of the Board of a not-for-profit health insurer. Recent events have led the Department to reach that conclusion, particularly when the not-for-profit health insurer has a very large share of the overall market.

10. Q. A Department of Insurance report of May 22, 1990 ("Report of Examination") criticized Empire's cooperation with state auditors. Subcommittee investigators found that Mr. Cardone was able to amend a section of the final version of this report which he found objectionable. He accomplished this with a phone call to a Department official (Ms. Wendy Cooper).
    - Is this true?
    - Do you feel that it is appropriate that Mr. Cardone could amend a finalized public report critical of his organization with a simple

- Would it be accurate to say that this is evidence of undue influence by Mr. Cardone over officials at the N.Y. Department of Insurance?

A. The answers to the three questions are all "NO." The Report on Examination referred to in your question was tendered to Empire on April 16, 1990 pursuant to the provisions of Section 311 of the New York Insurance Law, which provides a defined administrative procedure to ensure that an examined entity, in this case Empire, is provided with certain due process rights. The result of the application of these procedures is the filing of the Report on Examination as a public document. Essentially, this procedure allows an insurer to present objections to the content of the report. If the objections cannot be addressed through discussion, there are provisions regarding the holding of a hearing, a quasi-judicial proceeding, for the purpose of effecting a final determination about disputed matters.

Empire responded to the report by a letter from Mr. Cardone dated May 3, 1990. Most responses to Reports on Examination are clear in their being characterized as either acceptance letters or objection letters. The Empire letter is not unequivocally either. The letter states: "Except for the following items, we are generally in agreement with your comments and recommendations...." The letter then details comments about five of the eleven report comments. Two of the comments offered by Mr. Cardone indicated they are comments only and not objections. Therefore, the remaining three comments represented what most would consider objections to the report. The three items considered as being "objections" related to:

- the propriety of a Plan officer sitting on the board of directors
- the lack of cooperation received by the examiner in the conduct of the examination.
- findings relative to settlement of claims under one of Empire's products as being not in accord with policy provisions.

Upon receipt of Mr. Cardone's letter, several members of the staff treated it as an objection letter. This included the examiner-in-charge and his supervisor, both of whom responded to Mr. Cardone's comments in detail. However, one person handling the report and in receipt of Mr. Cardone's letter did not consider the letter as being a formal objection whereupon, on May 22, 1990, this person took steps associated with placing the report on file as a public document. This action was relayed to Empire, as is the Department's normal procedure, on the same date. Upon receipt of this information, Mr. Cardone did telephone then Acting Superintendent Cooper to complain that the filing of the report should not have taken place inasmuch as Empire had not been afforded its due process rights considering it had objected to parts of the report.

An analysis of the actions taken led Department officials to conclude that Mr. Cardone was correct. Empire had indeed objected to the report and still had certain rights available to it at the time of the May 22, 1990 report filing. The merits of the objections notwithstanding, if the Department makes a mistake, it clearly has the obligation to admit to it and the duty to take appropriate corrective action. The Subcommittee staff apparently feel something nefarious happened relative to this set of circumstances but that is not a fair reading of the facts.

The only way a Report on Examination is changed is by a clear demonstration that the report is inaccurate. The suggestion that Mr. Cardone was able to amend the report with a phone call or that Mr. Cardone exhibited any undue influence is absurd.

11. Q. A Mr. Wayne (sic) Scharff of your Department stated in sworn testimony that while he could not recall who authorized the changing of the final report, you discussed with him how this information could make your Department look bad. Mr. Scharff said that you and other top Department officials agreed that he should explain it was done under his authority -- not with the approval of the "higher ups".
   - Is this an accurate statement?
   - Did you urge or encourage Mr. Scharff in any way to subsequently state that he approved of the modification requested by Mr. Cardone, though he could not recall having done so?

A. That is not an accurate statement. I never urged Michael Scharff to do anything but to tell the Subcommittee the absolute truth. The transcript of Mr. Scharff's testimony before the Subcommittee staff in no way contradicts that fact.

Questions 12 and 13 are answered together.

12. Q. Mr. Curiale, your Department raised concerns about the incestuous methods by which Empire's Board of Directors were elected.
   - Did you direct Empire to change this policy?

   Another concern of Senate Investigators was Empire's use of the Deloitte accounting firm as their internal auditor. Ten Empire executives, including the CEO, Mr. Cardone, were former Deloitte employees.
   - Did Empire ignore your recommendations to end this practice of using the Deloitte firm?
   - Did you take any decisive action to end the clear conflicts of interest inherent in the use of the Deloitte firm?
   - If so, when?

13. Q.- Is it accurate to say nothing was ever accomplished in these areas until the past several months?
   - In your view, how could your Department give any credence to audits by a firm that was the former employer of ten Empire executives?

A. It was recommended in the Department's Report on Examination of Empire as of December 31, 1987 that the Board of Empire undertake a study of the process of electing board members and propose a method that would evidence greater accountability of the board to the subscribers. Empire responded to this recommendation by informing the Department of the establishment of a new Committee of the Board called the "Committee on Subscriber and Public Affairs" which oversees five regional Subscriber Advisory Councils that regularly review matters of importance to subscribers such as cost containment, new products and customer service. While these actions may be helpful in ascertaining the subscribers' viewpoint the Department has continued to express concerns that certain major segments of Empire's subscribers are not currently represented on Empire's Board.

The Department examiner's recommendation contained in the 1987 Report on Examination on Empire was not adhered to by Empire. The selection of public accounting firms is an obligation of management. The Insurance Law does not provide the Superintendent with the authority to select or replace accounting firms, unless it has been established that there is fraud or some other impropriety with respect to the use of a particular accounting firm.

It is not an uncommon practice for large accounting firms to certify financial statements of companies in which former partners and employees of the accounting firm are employed. In view of the number of employees that were formerly with this firm, the use of this firm by Empire gives the appearance of a conflict of interest and impropriety concerning their audits. Given Empire's position as a not-for-profit health insurer it should avoid even the appearance of a conflict of interest. Insurers should periodically change public accounting firms rather than rely continually on the same firm to certify their statements. I have urged the Board of Directors of Empire to change auditors.

The accounting firm of Deloitte Touche is one of the major United States accounting firms. I have no evidence to suggest that Deloitte has compromised its independence or professional standards with respect to its audits of Empire.

14. Q. In the Spring of 1992 & 1993, you assured officials of Deloitte that you would not order the liquidation of Empire -- and that you would not even place the deeply troubled company under supervision! Deloitte then continued its questionable practice of issuing "unqualified" assurances about the state of Empire's finances.
- Why did you not order some form of state supervision of Empire?
- Wouldn't that have afforded some protection and confidence to the millions of customers of Empire?

A. It is not an uncommon practice for there to be a dialogue between independent auditors and regulators on many issues. The assertion that Deloitte's unqualified opinion concerning Empire's financial condition is a questionable practice is incorrect. The Department has no reason to believe that this firm compromised its professional duties in reviewing and certifying to the reliability of Empire's financial statements. In a situation, such as the one with Empire, it is not unusual that auditors, as part of their due diligence, inquire about facts that may affect their opinion of an entity as a "going concern."

Under New York Law the Department has the authority to place insolvent or impaired insurers into rehabilitation or liquidation. While Empire's surplus fell below the required statutory amount, at all times Empire had sufficient assets to meet all of its obligations in the ordinary course of business. Furthermore, because of its financial condition, Empire was under close supervision by this Department. The Department was and remains confident that Empire has the resources to meet its policyholder obligations. Placing Empire into rehabilitation was not necessary and would have done irreparable damage to its policyholders and the people of New York State. Such action by the Department would have disrupted the flow of claim payments (Empire issues 100,000 claim payments per day), caused a panic among its policyholders and a run on Empire, with

healthy insureds and large group business cancelling their policies, leaving Empire with the least desirable risks. This would have without a doubt resulted in the insolvency of Empire and losses to millions of policyholders.

15. Q. Mr. Curiale, I'm aware of a N.Y. State regulation which requires Empire to make contribution from its "experience rated" businesses to its less profitable "community rated" businesses. Your Department reportedly stated that Empire made no contribution in "90 and "91, and made only a small contribution of profits in 1992.
   - Why hasn't the Department enforced this policy?
   - Would this action by Empire impair their mission to serve segments of New York's population who don't have much access to health care?

A. Insurance Department Regulation Number 62 (11 NYCRR 52.40(g)), sets forth the following requirement:

"(1) Contracts of master group insurance may be experience-rated only in accordance with a formula or plan previously furnished to the department. Such formula or plan shall include a retention designed to provide for a contribution to surplus."

The contribution to surplus is measured in terms of underwriting gains.

The following chart sets forth the actual underwriting results for Empire's experience-rated business for the years 1987 to 1991. By using data submitted with subsequent rate filings the Department was able to substitute actual numbers for the estimates that were used in Empire's Annual Statements.

Year	Underwriting Gain or (Loss)
1987	$ 33,806,000
1988	58,301,000
1989	21,485,000
1990	12,796,000
1991	(1,404,000)
Total	$124,984,000

The Department has repeatedly voiced its concerns on the results of Empire's experience-rated business, particularly the 1991 underwriting loss and the estimated small underwriting gain of $2.9 million for 1992. When reviewing an application to increase the premiums of community-rated contracts we analyze the past and projected underwriting results on experience-rated contracts. The Department will not permit community-rated subscribers to subsidize the insurer's experience-rated subscribers and as the aforementioned results show this situation has not occurred at Empire. Experience-rated business is extremely price sensitive. The Department notes that of the 20 largest life insurers, only 6 reported an underwriting gain for their group accident and health business in 1992. These life insurers can justify such losses as they may be more than offset by profits on other types of business, i.e., group life; group disability; and pension plan annuities. In this State, nonprofit health insurers are prohibited from writing any type of insurance other than health.

16. Q.- Mr. Curiale, are you aware that Subcommittee investigators have testified that your Deputy Superintendent (Ms. Boggio) has passed information to Empire on what documents were being requested by our staff in carrying out their investigation?
- Did you know this was taking place?
- Have you ordered that this practice be stopped immediately?

A. Deputy Superintendent Boggio's integrity is above reproach. Your question implies that the investigation conducted by the Subcommittee was and is a matter of secrecy. It was not and is not. Deputy Superintendent Boggio is assigned to supervise the Property Companies Bureau. The Health Finance Unit which regulates Empire Blue Cross and Blue Shield (Empire) is part of the Property Companies Bureau. It is her responsibility to speak with Empire officials periodically on a variety of issues including matters dealing with finances and the welfare of Empire subscribers.

In her effort to efficiently coordinate the considerable requests for documents made by the Subcommittee she inquired whether public documents, such as financial statements and Opinions and Decisions, had already been provided to the Subcommittee by Empire. If the Subcommittee was already in receipt of the documents, the logical expectation would be that it would not be necessary to duplicate the effort. When the matter was raised with Subcommittee representatives, they then revealed that they preferred to get the same information from two sources so that it could be compared to test the veracity of those submitting the information. At no time did the Subcommittee indicate that there was any secrecy involved or that its requests should not be revealed or that any aspect of the Subcommittee's activities were not public and able to be discussed with anyone at any time. The extensive media coverage is evidence of these facts.

It would be impossible for the Superintendent or any manager to be privy to every telephone conversation that takes place. The conversation being noted here was an inconsequential, routine communication motivated not as part of some "revelation" but rather in an effort to be efficient.

Upon being advised of the Subcommittee's method of collecting documents, Deputy Superintendent Boggio proceeded to the best of her ability to arrange meetings, keep in continued communication with Subcommittee representatives and provide the Subcommittee with the information it requested. Your question refers to a "practice" that is to be stopped. The implied "practice" does not and has never existed.

United States Senate
COMMITTEE ON
GOVERNMENTAL AFFAIRS
WASHINGTON, DC 20510-6250

August 5, 1993

Mr. Philip Briggs
Chairman of the Board and Chief Executive Officer
Empire Blue Cross and Blue Shield
622 Third Avenue
New York, New York 10017-6758

Dear Mr. Briggs,

I am writing as a follow-up to the recent hearings that I chaired concerning the Empire Plan. As you are no doubt aware, the Staff and other witnesses highlighted a number of serious problems with the operations and management of the Plan by your predecessors.

Since you assumed your current positions at the Plan within days of the Subcommittee's hearings, I would like to extend the opportunity to you to provide a written statement for the record to supplement the testimony already provided by Messers. Morchower and Vogt. We have recently received correspondence and other material from Mr. Morchower, dated July 23rd, which raises some confusion as to the official position of the Plan concerning the staff's findings and also the significance, if any, that alleged "cherry-picking" by commercial insurers played on the financial condition of the Plan.

These views would appear to contradict recent statements that you have purportedly made to the press. You have recently been quoted in the press as having some doubts about the entire "cherry-picking" argument. In a particular New York Times article, dated July 20th, you were quoted as believing that the criticisms leveled at the Plan were "well deserved" and that "poor management" rather than cherrypicking "was Empire's chief problem".

In that same article, you are quoted as having developed a number of reforms that you plan to shortly implement. These reforms were not described in much detail but appear to address many of the criticisms leveled at the Plan by the Subcommittee's witnesses. Among other things, the Times reports that they include

a complete reorganization of the company and the institution of a "true merit-pay system for officers".

In light of the above, the Subcommittee would very much appreciate hearing from you on not only the problems of the Plan but also your proposals for future improvements.

I look forward to your response which I hope will be a candid and positive clarification of Empire's current state of affairs. If you should have any questions concerning this letter, please do not hesitate to contact either Eleanor J. Hill, Chief Counsel or John F. Sopko Deputy Chief Counsel of the Subcommittee staff at 202-224-3721.

Thank you for your continued assistance and best of luck in your new position.

Sincerely,

Sam Nunn, Chairman
Permanent Subcommittee
on Investigations

SN/jfsm

Empire
Blue Cross
Blue Shield

A member of the Blue Cross and Blue Shield Association an association of independent Blue Cross and Blue Shield Plans

622 Third Avenue, New York, NY 10017-6758, Telephone (212) 476-6051

PHILIP BRIGGS
CHAIRMAN OF THE BOARD
AND
CHIEF EXECUTIVE OFFICER

August 16, 1993

Senator Sam Nunn
United States Senate
Committee on Governmental Affairs
Washington, DC 20510-6250

Dear Senator Nunn,

Thank you for your letter of August 5. Since arriving on the scene on July 1, I have been learning about Empire Blue Cross and Blue Shield. I regret to say that, in my opinion, much of the criticism of Empire and its management is warranted. I also feel that most, if not all, of the Andersen Consulting report observations and recommendations are correct and should be acted upon.

As you may know, I came out of retirement and accepted this position with the understanding that I would act as Chief Executive Officer only until a fully qualified permanent CEO could be recruited to the position. The search for such a CEO has been my first priority and I am happy to report that, as of August 18, I hope and expect that an excellent new CEO will be elected by the Board. I have also focused on strengthening the Board. At the August 18th meeting, three new individuals will be elected to the Board, all of whom are distinguished and highly respected in their fields of endeavor. More new Board members are expected to be elected to the Board in the months ahead.

While awaiting the arrival of our new CEO I have been working on two major issues. The first has to do with making Empire more cost effective and competitive while strengthening its financial position. A tremendous amount of work needs to be done. There are many fine people working here but they are badly organized and managed, and morale is low. We are planning to reorganize the company along the lines recommended by the Andersen report and to completely change the management style of the company. We also see the need for substantial cost reductions and have already announced an administrative expense reduction of $50 million (approximately 10%). It is highly likely that management changes will take place as a result of the reorganization. We also anticipate that Managed Care will become more and more important in New York State and we need to assure that Empire has one of the best, if not the best, Managed Care

operation in the state. We are working on that. I expect that when our new CEO comes on board he will pursue these activities with vigor.

The other major issue is defining Empire's role prospectively. This is a highly complex question. Currently Empire is neither a government agency nor an independent insurance company. While it has received preferred treatment with regard to hospital charges and taxes, it has been burdened with giving interest free loans to hospitals, being insurer of last resort for the uninsurable and having restrictions affecting their ability to compete against other insurance companies. The law which became effective April 1, 1993, did change Empire's unique role as insurer of last resort for small groups but did not change the situation with respect to individuals. I am afraid that this will result in a continuing need for large rate increases for the community rated business unless some change can be made in this system. After our new CEO is in place, I hope to devote a considerable portion of my time to finding a solution to this very difficult problem. This is really a symptom of our national problems with regard to health care: How to provide all of the population with good quality health care at an affordable cost.

This letter presents a very abbreviated version of what I am trying to do. I would welcome an opportunity to visit with you informally to discuss the situation in more detail and to respond to any questions you may have. I will try to arrange such a meeting through your staff. In the meantime, thank you for your good wishes. It is a very difficult situation.

Sincerely,

Subject: Program
Issue No.: 15
Issue Date: June 25, 1993
Distribution: A

EMPLOYEE BULLETIN

Senate Permanent Subcommittee on Investigations

EXHIBIT # 89

The International Federation of Health Funds (FHF) is sponsoring a Travel Fellowship Program to stimulate employees of member plans to find out more about health care delivery systems in the countries of their fellow members. The FHF is composed of 170 member plans operating in over 20 countries, all of whom are independent non-governmental, not-for-profit organizations that provide their subscribers with health care and health insurance protection.

An FHF committee will select the two applicants who have proposed the most worthwhile uses of four week stays in the countries of fellow member plans to study selected aspects of health care delivery there. Winners will be awarded $2,000 fellowships by the FHF and that amount will be supplemented by Empire, as appropriate, to defray travel and living expenses during the study period. In addition, all usual salary and benefits will continue. Winners will be expected to produce a report on their studies for submission to the FHF and their local plan managements.

Each application must have the approval of the applicant's management to verify that, if selected, the successful applicant can be released for four weeks sometime during the period from September, 1993 through December, 1994.

Application information is available from Shari Albert, Leadership Development, 622 Third Avenue, 14th floor. Further details may be obtained from her by calling (212) 476-1147 or via Office Visions (PROFS) ID SXA5N1, and applications are due to her by July 16, 1993.

Donald L. Morchower

DONALD L. MORCHOWER
CHIEF EXECUTIVE OFFICER

The New York Times
WEDNESDAY, SEPTEMBER 22, 1993

INQUIRY BY EMPIRE FINDS FALSE DATA FILED ON FINANCES

AMOUNTS TO AN ADMISSION

Altered Figures Used to Obtain Insurance Rate Increases Over the Last 4 Years

By JANE FRITSCH

Empire Blue Cross and Blue Shield said yesterday that the results of an internal inquiry show the company filed false information with the New York State Insurance Department for years. The announcement amounted to an official admission by the company that allegations that it had been keeping double records and misstating its losses were true.

The company said it would probably refile the records for the last four years, a period during which the inaccurate figures were used to influence legislation overhauling the state's insurance industry.

The findings were the result of an internal inquiry ordered in June by the new management of Empire and directed by a former United States Attorney in Manhattan, Otto G. Obermaier. His report, which was made public yesterday, concluded that the company shifted losses from one set of accounts to another, ultimately overstating losses on its high-risk policies in each of the last four years by a total of $63 million.

'Not Acceptable'

"They are not acceptable numbers," Mr. Obermaier said at a news conference. He said that adjustments to financial data are not uncommon but that the alterations at Empire were "troubling."

"If it happens once, well, it happens," he said. "But hardly ever with these swings and hardly every year for four years in a row."

During those years, Empire lobbied heavily — and successfully — for a change in state law that forced its competitors to accept some of the high-risk customers that only Empire had previously been required to take. Using the exaggerated figures, some Empire officials had argued that the company was unfairly burdened with the state's worst insurance risks.

The figures were also used by Empire's chairman, Albert A. Cardone, who was later ousted, in impassioned testimony on behalf of a large rate

Continued on Page B4, Column 4

Empire Says Inquiry Found False Data Filed

Continued From Page A1

increase last year.

But Mr. Obermaier's report concluded that all of the company's filings in support of rate increases contained accurate figures, and the State Insurance Superintendent, Salvatore R. Curiale, reasserted yesterday that the increases were not granted on the basis of the false information.

During the four years in question — 1989 through 1992 — Empire won a series of large rate increases, all of which where approved by the State Insurance Department.

Empire's board of directors ordered the investigation in May after The New York Times requested an explanation for discrepancies between the official reports and a set of internal books obtained by the newspaper.

Discrepancies Found

In all, Mr. Obermaier's auditors, from the firm of Ernst & Young, found $83 million in discrepancies between the internal records, called the Black Book, and the reports filed with the state. While some of the discrepancies could be explained, they said, no justification could be found for $63 million in differences.

Mr. Obermaier said he has advised Empire to file amended financial statements for 1989, 1990, 1991 and 1992 with the Insurance Department to correct the record.

Altering of insurance data is 'troubling,' an ex-prosecutor says.

The inaccurate data were compiled and submitted to the state, the report said, by Empire's former chief financial officer, Jerry Weissman, who was dismissed in July. Mr. Obermaier said yesterday that several employees questioned during the investigation reported that Mr. Weissman instructed them to destroy documents concerning the discrepancies.

Mr. Obermaier declined to speculate on Mr. Weissman's motives and said neither he nor the auditors had tried to determine whether the inaccurate data were filed with the state to influence legislators who were considering the insurance overhaul at the time.

Empire, the state's largest medical insurer, lost $250 million in 1991 and 1992, according to the reports filed with the state, and its reserves fell to $40 million, far below the level considered safe by state regulators.

Shifted Between Accounts

But the inaccurate reports had no effect on Empire's bottom line. At issue in Mr. Obermaier's inquiry were losses that were shifted between accounts. The auditors found that losses on policies covering large businesses were instead attributed to the group of policies issued to individuals and small businesses, a group that includes the oldest and sickest New Yorkers.

Empire is free to charge whatever it likes for the business policies but must get state approval to raise rates for individuals and small businesses.

Mr. Obermaier said he had found no evidence that any laws had been broken but added that he was not hired to look for illegality.

With his report and accompanying documents, which weighed six pounds, he sought to underscore the stability of the company and to reassure customers that their rates were not affected by the financial irregularities. However, at its heart, the report confirmed allegations that fueled a growing crisis in confidence at the country's largest nonprofit health insurer.

'Gilding the Lily'

Most pointedly, the report provided elaborate support to state legislators who complained bitterly last spring, when they learned that they had received misleading information from Empire's executives and lobbyists.

Mr. Curiale, the Insurance Superintendent, who campaigned strenuously for the legislation, yesterday described the overstated losses as "gilding the lily" and said that Empire's losses were heavy even without the exaggeration. This year, Empire's finances have taken an unexpected turn for the better and no rate increase is likely in 1994, he said.

The Insurance Department will issue its own report on Empire soon, Mr. Curiale added. Both the United States Attorney's office in Manhattan and the Manhattan District Attorney, Robert M. Morgenthau, have begun criminal investigations of the financial discrepancies and have subpoenaed documents and computer files

Weil, Gotshal & Manges

Report of Special Counsel To The Audit Committee of The Board of Directors of Empire Blue Cross and Blue Shield

and

Related Reports of
Ernst & Young and
KPMG Peat Marwick

September 21, 1993

September 20, 1993

To The Members of the Board of Directors
Empire Blue Cross Blue Shield

I was retained in late June, 1993 to conduct an internal investigation concerning the Company's filings with the Insurance Department of the State of New York - both periodic reports and rate applications. Prior to my retention the Company had announced on June 16, 1993 that its internal auditors had uncovered "a discrepancy in a Schedule filed with the Superintendent of Insurance reporting on market segment performance for the years 1989, 1990 and 1991."

I divided the internal investigation into four parts. First, I recommended that the Board engage KPMG Peat Marwick to reaudit the Company's "Benefits Payable" liability for the most recent calendar year ended December 31, 1992. The purpose was to assure that the Company was adequately reserved for the expected claims of its subscribers for 1992 and that nothing untoward had occurred in the calculations leading to the establishment of that liability. Second, we undertook to ascertain what had occurred by interviewing the Company's employees. Third, I engaged Ernst & Young to review the Company's Annual

and Interim filings to identify and quantify any differences between the Company's internal records and its filings with the Insurance Department. Fourth, and most importantly we undertook to determine the impact of any such differences on the Company's rate applications in 1990, 1991, 1992 and 1993. (Rate applications are identified both in this report and in the Ernst & Young report by the year in which they are declared effective, not by either the year in which they were filed or the base year utilized.)

We have completed our work, as have Ernst & Young and KPMG Peat Marwick whose attached reports are an integral part of my own report.

My findings are:

1

Empire's applications for rate increases for 1990, 1991, 1992 and 1993 were not based upon, and were not affected by, any unusual or unexplained material adjustments to Empire's internal financial records. Rather, such applications were based upon financial records generated and maintained in the ordinary course of business.

We found no indication that anyone at Empire made any improper adjustments to financial data included in the rate applications for the years 1990, 1991, 1992 and 1993. We have found only one questionable item in any of the rate filings during this period. It was the inclusion in the 1991 application of the Community Rated administrative expense figure reported in Empire's 1989 Annual Statement (1989 was the "base year" for the 1991 application). The 1989 Annual Statement reported Community Rated expenses of $173

million, which figure is $7 million higher than internal records indicate. As discussed more fully below, we have determined that this $7 million difference resulted from adjustments made at the direction of former Chief Financial Officer Jerry Weissman in preparing the 1989 Annual Statement. (The $7 million difference is discussed at pages 4 and 15 of the Ernst & Young report.) We have been given oral explanations for this item and have located documentation indicating that adjustments were required to expense allocations between market segments in 1989, but have not found documentation to support these particular adjustments. The inclusion of this adjusted number in the 1991 rate application appears to have been incidental rather than an intentional effort to report inflated expense data; that is, the persons responsible for preparing that rate application followed the usual practice of obtaining administrative expense information from the Annual Statement. In all other respects the data in the rate filings can be traced to the Company's primary accounting data.

We also examined the trends calculations made in connection with the rate applications. These too were based on the Company's primary financial and accounting data and certain other relevant data. They were not based upon or affected by any unexplained adjusted amounts contained in the Annual Statements.

Section Two of the annexed Ernst & Young report describes the rate applications analysis in detail. A separate section of the Ernst & Young report entitled "Trends" describes the examination of the trends documentation for the 1992 and 1993 rate applications.

In connection with its review of the Rate Applications, the Insurance Department often requests additional information from the Company, including historical underwriting results for Empire's recent annual or interim periods. The underwriting results information provided in response to such requests of the Insurance Department, and cited by the Superintendent in a portion of his Opinions and Decisions, did include data to which the unexplained adjustments identified in Section One of the Ernst & Young report had been made.

II

The Company did not (and does not) maintain two sets of books. Following the Company's announcement of June 16, some press reports indicated that the Company kept two sets of books. I could find nothing to support such an assertion.

III

There were differences between financial information summarized in certain of the Company's internal reports (as collected in the so-called "Black Books") and corresponding information reported in the Company's Annual and Interim Statements filed with the Insurance Department during the period December 31, 1989 - December 31, 1992. There were no differences for 1993.

We found no indication that the Company's general ledger was in any way impermissibly altered or changed. The general ledger is the Company's primary accounting

record. The so-called "Black Books" are not the Company's "primary source data" for accounting purposes. They were first created in 1989 as a management tool by former Chief Financial Officer Jerry Weissman.

The Black Books consisted of a number of reports, many of which are generated on a monthly basis by Empire's accounting, budget and cost accounting, premium accounting and actuarial departments. They derive their name only from the color of the binders in which the reports were collected. In June of 1993, Empire changed the name and some of the contents of the Black Book. The new name given to this collection of reports is the "Financial Results" reporting package and continues to include underwriting results by market segment. The Black Books were not used in preparing the Annual (Interim) Statements.

It is not unusual for there to be differences between the internal reports and the Annual (Interim) Statements. Normal differences could and did arise for several reasons: First, the Black Book is completed prior to the Annual (Interim) Statements which necessitates adjustments to the latter, but not the former, to reflect updated data. Second, neither the Company's general ledger nor its internal reports allocate certain lines of business into either the Community Rated or Experience Rated market segments (whereas such lines of business are required to be allocated for purposes of preparing the Annual (Interim) Statements). Third, the Black Book and the Annual (Interim) Statements are prepared by different people independently (and differently as to market segment information) from the

same primary source records of Empire. (See Exhibits 2 and 3 of the Ernst & Young report.) Fourth, the Annual (Interim) Statements and the Black Books differ in their categorization of various items.

For these reasons, a direct comparison between the two for differences is not possible. We performed the appropriate procedures to allow a comparison between comparable information contained in or derived from the Annual (and Interim) Statements and the Black Books.

IV

Ernst & Young examined every difference between the Company's Annual and Interim Statements and the Black Books from year-end 1989 (approximately when Empire's Management began compiling Black Books) through June 1993 (the month in which the differences were discovered).

The differences found fell into four basic categories:

(i) Allocations: Certain differences were attributable to the manner in which certain results were allocated among market segments. We identified three general types of allocation-related differences.

a. The Black Book presents results for certain lines of business as "Other" results, and does not allocate such results to any market segment. However, the Company allocated such results among market segments for purposes of preparing the

Annual and Interim Statements, which require such allocation. Accordingly, market segment results differed as between the Black Book and Annual (Interim) Statements.

b. In 1989, two different employees in the budget and cost accounting department prepared expense detail, allocated by market segment, for the accounting department (which prepared the Black Book) and the actuarial department (which prepared Exhibits 5 and 5A to the Annual Statement). The market segment allocation provided to accounting was different from that provided to actuarial by $12 million, with accounting recording such expenses as Experience Rated in the Black Book, and actuarial reporting such expenses as Community Rated in the Annual Statement. We concluded that the allocation in the Annual Statement was more accurate, based upon underlying documentation.

c. The accounting department routinely posts litigation reserves to the Company's general ledger relating to estimated costs in connection with adjudicating claims. In preparing market segment reports for inclusion in the Black Book, the accounting department allocated the litigation reserves to the appropriate market segments based upon available information. However, the persons responsible for providing such information for the Annual (Interim) Statements failed to take into consideration the allocations made by the accounting department; accordingly, the differences in allocations resulted in differences in reported market segment results. In certain instances noted, the Annual Statement allocated

litigation reserves to Experience Rated claims, thereby underreporting Community Rated claims.

(ii) Timing differences: In several instances, financial information became available after the Black Book had been compiled for a particular reporting period. The Company properly reflected such after-acquired, updated information in the Annual (Interim) Statements, but such information was not recorded in the corresponding Black Book, causing a difference. The after-acquired information subsequently was recorded in the Black Book, but only for the following period.

(iii) The Use of Inappropriate Data: From September 1991 through January 1992, an employee in Empire's actuarial department relied on restated claims data in preparing Exhibits 5 and 5A and Exhibits 1 and 1A to the Annual and Interim Statements. We have concluded that the use of restated claims data in these circumstances (as opposed to incurred claims data) is inappropriate. (Restated claims results constitute paid claims and reserves for unpaid claims at the end of a reporting period which are updated, or "restated", to include additional actual claims data relating to that reporting period which becomes available after such period.) Although some at Empire believe that the use of such data in preparing Exhibits 5 and 5A (and Exhibits 1 and 1A) was appropriate, I have concluded it is not both because it is not requested by the Insurance Department for use in such Exhibits, and because it is inconsistent with the Company's practices both prior and subsequent to that period.

(iv) Unexplained adjustments: We identified and quantified certain differences for which no contemporaneous documentation or explanation could be found or may not have existed. Our investigation revealed that these items resulted from adjustments made to drafts of the Annual (Interim) Statements prior to filing at the direction of former Chief Financial Officer Jerry Weissman. For reasons set forth in paragraph 8, I have found such so-called unexplained adjustments inappropriate, with the possible exception of the $7 million difference in expenses in 1989 for which documentation or support may exist.

V

Ernst & Young found that the differences (both explained and unexplained) between Empire's Black Books and Annual Statements totalled approximately $43 million at year-end 1989; approximately $8 million in 1990; approximately $31 million in 1991; and approximately $1 million in 1992.

These differences primarily existed in Empire's claims data for its Community Rated and Experience Rated market segments. Empire reported Community Rated claims incurred of approximately $1.7 billion in 1989, $1.8 billion in 1990, and $2 billion in each of 1991 and 1992. As such, these differences in claims data amounted to approximately 3%, less than 1/2 of 1% and 1/100 of 1%, respectively, of each year's Community Rated claims.

The differences are discussed and tabulated in Section One of the Ernst & Young report. A tabular summary of the explained and unexplained differences is annexed as Table 1 to my report.

VI

I found no reason to reject or question the differences between the internal reports and the periodic filings which resulted from differences in allocations and timing (items (i) and (ii) of Section IV of this report.)

VII

I have concluded that the so-called "unexplained adjustments" described in of Section IV (iv) were inappropriate for the following reasons:

(i) they did not have the characteristics of typical accounting adjustments: contemporaneous documentation and rationalization;

(ii) they cannot be replicated without accepting totally the explanation proffered years after the adjustments were made;

(iii) they were made repeatedly year after year when the better practice would have been for the Chief Financial Officer to adjust the Company's procedures that generated the numbers so that the need for periodic adjustments would be eliminated;

(iv) they were always off-setting;

(v) they cannot be justified as always making the adjusted numbers more accurate;

(vi) they had the untoward consequence of significantly affecting (and always in the same way) the underwriting gains and losses of two

segments of the Company's business - Community Rated and Experience Rated. The unexplained adjustments always increased the Community Rated loss and decreased that of the Experience Rated business; and

(vii) several employees told Special Counsel that the former Chief Financial Officer instructed them in 1993 to destroy documents concerning differences between the Company's internal financial records and its periodic filings.

VIII

Since the Board previously made its decisions concerning the continued employment of certain individuals on July 15, 1993 (and announced in the Company's Press on the same day), I saw no need to explore at length the possible reasons for the so-called "unexplained adjustments" or the use of restated claims data. However, I have recommended to the Company's management that it file amended Schedules 5 and 5A of the Annual Statement for the years ended December 31, 1989, 1990, 1991 and 1992 eliminating the so-called "unexplained adjustments", and correcting certain misallocations of litigation reserves and the use of restated claims data. Additionally, The Superintendent of Insurance has been informed orally of our findings and will be furnished a copy of this report and the annexed reports of Ernst & Young and KPMG Peat Marwick so that his staff will be alerted promptly to the details of our findings.

IX

None of the differences between the internal reports (Black Books) and the periodic filings (Annual (Interim) Statements) had any impact or the Company's audited financial statements.

X

KPMG Peat Marwick's reaudit of the "Benefits Payable" liability of the Company's audited financials as at December 31, 1992 in the amount of $1,442,040,000 confirmed that it was presented fairly in all material respects. In arriving at its conclusion, Peat Marwick also satisfied itself that the Company's claim reserves were actuarially acceptable as of that date and also as tested by six months of actual experience.

Peat Marwick's conclusions are significant because they confirm that the Company had and has adequate reserves to meet its expected liability at year-end for claims received but not yet paid and projected claims by subscribers for health services already received but not yet reported to the Company and that the Company's reserves were calculated within reasonable actuarial limits.

These conclusions confirm those of Deloitte & Touche, the Company's regular independent certified public accounting firm, who previously had audited the Company's 1992 financial statements and in March 1993 expressed an unqualified opinion that such financial statements were stated in accordance with applicable accounting practices and presented fairly in all material respects the financial position of the Company. Deloitte &

Touche has not withdrawn or qualified its opinion for 1992, as it would be obligated to do under applicable professional accounting standards if it becomes aware of information which calls into question its prior opinion.

Respectfully submitted,

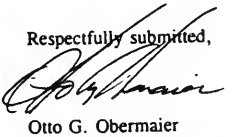

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Table 1: Summary Of Differences
Increasing (decreasing) Community Rated losses, in millions

	1989	1990	1991	1992
Explained	12[a]	(5+2) = (7)[b]	28-4 = 24[c]	(9)[d]
Unexplained	31	15	7	10
Total Difference	43	8	31	1

Notes:

a. Expenses allocated to Experience Rated in Black Book were allocated (correctly) to Community Rated in the Annual Statement.

b. $5 million relating to a litigation reserve was allocated to Community Rated claims in the Black Book (increasing Community Rated claims), but was allocated to Experience Rated claims in the Annual Statement; accordingly, Community Rated claims in the Annual Statement were $5 million lower than in the Black Book prior to the $15 million unexplained adjustment increasing Community Rated claims in the Annual Statement. Additionally, $2 million of expenses allocated to Community Rated in Black Book were allocated to Experience Rated (decreasing Community Rated losses) in Annual Statement.

c. A $28 million increase in Community Rated claims, which resulted from the improper use of restated claims data (not normally used in preparing the Annual Statement), was partially offset by a $4 million litigation reserve adjustment allocated to Community Rated claims in the Black Book (increasing Community Rated claims) but allocated to Experience Rated claims in the Annual Statement (thereby reducing the net increase in Community Rated losses to $24 million).

d. Documented adjustments totalling $9 million increasing Community Rated claims in the Black Book were allocated to Experience Rated claims in Annual Statement; accordingly, Community Rated claims in the Annual Statement were $9 million lower than in the Black Book prior to the $10 million unexplained adjustment increasing Community Rated claims in the Annual Statement.

Executive Summary

Introduction

Ernst & Young was engaged to assist Weil, Gotshal & Manges, as Special Counsel to the Audit Committee of Empire Blue Cross and Blue Shield ("Empire" or the "Company"), in analyzing certain financial information of Empire and to report our findings to them. Specifically, we were directed to (1) identify and quantify differences between certain financial data summarized in Empire's internal management reports, referred to by Empire as the "Black Book," and corresponding data reported in Exhibits 5 and 5A[1], or Exhibits 1 and 1A[2] to Empire's Annual or Interim Statements (commonly referred to as the "Blanks") filed with the State of New York Insurance Department ("the Insurance Department") for each of the years ended December 31, 1989, 1990, 1991 and 1992 as well as interim periods during the years 1990, 1991, 1992 and the first six months of 1993 (a total of twenty-four interim periods), (2) establish the extent to which such differences were documented or explained by Empire's records and (3) determine the extent, if any, to which undocumented or unexplained items were included or considered in preparing the financial information reported by Empire in its applications for rate increases which were approved, effective March 1, 1990, March 1, 1991, April 1, 1992 and January 1, 1993 by the Insurance Department (the "Rate Applications").

For each of the periods reviewed (except for the interim periods in 1993 for which there were no differences) differences (both explained and unexplained) exist between the Black Book and Exhibits 5 and 5A of the Annual Statement or Exhibits 1 and 1a of the Interim Statement.

However, we determined that the Rate Applications were prepared from, and with one exception agreed with, the Company's internal records generated in the ordinary course of business, and no undocumented or unexplained adjustments were made in connection with the preparation of the Company's Rate Applications.

The Black Book consists of a number of reports, many of which are generated on a monthly basis by Empire's accounting, budget and cost accounting, premium accounting and actuarial departments. The "Black Book" derives its name only from the color of the binders in which the reports were collected. While the Black Book was not used by Empire for purposes of preparing the Annual (Interim) Statements, each document was

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[1]Exhibit 5- Hospital Underwriting Gains and Losses by Enrollment Classification and Exhibit 5A-Surgical-Medical Underwriting Gains and Losses by Enrollment Classification. In 1992 the form changed to Exhibit 5-Underwriting Gains and Losses by Enrollment Classifications. In addition, the Insurance Department required that Empire file supplemental exhibits NY5, NY5A, NY5B, NY5C and NY5D which segregated Underwriting Gains and Losses by various enrollment classifications.

[2]Exhibit 1- Hospital Underwriting Gains and Losses by Enrollment Classification and Exhibit 1A-Surgical-Medical Underwriting Gains and Losses by Enrollment Classification. In 1993 the form changed to Exhibit 1, 1A, 1B, 1C and 1D.

prepared separately (albeit differently as to market segment information) with initial input being the same primary source records of Empire. There may normally be differences between the Black Book and the Annual (Interim) Statement because the Black Book (i) is completed prior to the Annual (Interim) Statements (which difference in time of preparation may necessitate adjustments to the Annual (Interim) Statements to reflect updated data), (ii) does not allocate certain lines of business into either the Community Rated or Experience Rated market segments (whereas such lines of business are required to be allocated for purposes of preparing the Annual (Interim) Statements), and (iii) the Annual (and Interim) Statements and the Black Books differ in their categorization of various items. For these reasons, a direct comparison between the two to identify and quantify differences is not possible. Instead, certain procedures must be performed in order to allow for a comparison between comparable information contained in or derived from the Annual (Interim) Statements and the Black Books.

In June of 1993, Empire changed the name and some of the contents of the Black Book. The Black Book is currently referred to as the "Financial Results" reporting package and continues to include underwriting results by market segment.

We identified and quantified, and reviewed supporting and explanatory documentation (where it existed) for, differences in each of the periods (except for the interim periods in 1993 for which there were no differences) between the respective Black Books and Exhibits 5 and 5A of the Annual Statements and Exhibits 1 and 1A of the Interim Statements. The differences we identified affected the reported underwriting gains or losses for Empire's Experience Rated and Community Rated businesses. However, because they were offsetting (i.e., each increase in one market segment was offset by a corresponding decrease in the other market segment), the identified differences did not affect Empire's total reported net underwriting gains or losses in its Annual (Interim) Statements or its annual audited financial statements, with two exceptions. The Interim Statements for October 1991 and August 1992 had differences of $12 million in premiums and $80 million in claims expense, respectively, resulting from documented adjustments made, and based upon data which became known, after the Black Book and Interim Statement had been prepared. Empire adjusted subsequent months' Black Books and Interim Statements which had the effect of eliminating these differences.

Underwriting gains or losses consist of three components: premium earned ("premiums"); claims incurred ("claims"); and expenses incurred ("expenses"). Differences in premiums were identified in two of the periods for which we compared the Black Book to the Annual (Interim) Statements. Differences for claims were identified in all periods except for November 1992 and the interim periods in 1993. Differences in expenses existed in all but six periods (December 1991, December 1992 and the periods in 1993).

The differences for each of the years ended December 31, 1989, 1990, 1991 and 1992 are summarized in Section One of this report. Differences for each of the interim periods, except for the periods in 1993 when there were no differences, are summarized in Section Three of this report.

Our procedures were directed toward identifying and quantifying the differences, determining the extent to which the differences were documented or explained and identifying the extent, if any, to which the undocumented or unexplained items were included in or considered in the preparation of Empire's Rate Applications.

Organization of the Report

Our report is divided into three sections:

Section One—Describes the procedures, findings and conclusions with respect to the differences between the Black Book and Exhibits 5 and 5A of the Annual Statement for each of the four years in the period ending December 31, 1992.

Section Two—Describes the procedures, findings and conclusions with respect to the Rate Applications.

Section Three—Describes the procedures, findings and conclusions with respect to the differences between the Black Book and Exhibits 1 and 1A of the Interim Statement for the interim periods during the years 1990, 1991, 1992 and the first six months of 1993.

Exhibits accompany each section to highlight and clarify the matters discussed.

Black Book vs. Annual Statement

The preparation of the Black Book is the responsibility of Empire's Accounting and Financial Reporting Department. The preparation of Annual Statements Exhibits 5 & 5A is the responsibility of Empire's Actuarial Department. The same primary source information is used by both departments in the preparation of the respective reports. During the course of our procedures we noted that financial information was presented differently by each department in completing the respective reports. Specifically, certain claims and expenses were allocated to market segments differently in the Black Book and Annual Statement to fulfill the respective presentation requirements. Certain of the adjustments and differences noted could be documented or explained by Empire. However, certain differences between the primary source data and the amounts included in the Annual Statements could not be explained and/or documented.

We compared Empire's detailed records to both the Black Books and Exhibits 5 and 5A of the Annual Statements. Certain of these records documenting or explaining the differences between the reports and primary source data were obtained from work files of former and current employees. In certain instances, records which might have established an explanation for differences between the Black Book and Annual Statements could not be located. In many of these instances, we prepared the necessary reconciliations, and identified or developed other "bridging" documents, to determine the nature and extent of the differences.

The results of our procedures indicated that the differences noted varied in nature and amount in each year as follows:

1989

In 1989, the differences related both to claims ($24 million) and expenses ($19 million). The effect was a $43 million increase in the Community Rated underwriting losses reported in Exhibits 5 and 5A of the Annual Statement, and a corresponding reduction in reported Experience Rated underwriting losses resulting in a gain.

1989 was the first year in which the Black Book was prepared and we were informed that difficulties were encountered by Empire's cost accounting department in preparing the 1989 Black Book. In the preparation of the Black Book for December 31, 1989, expense items approximating $12 million were allocated to Experience Rated expenses on a preliminary basis. Based upon a separate analysis, the $12 million of expenses included by the cost accounting department in Experience Rated results in the preparation of the Black Book was allocated to Community Rated results in connection with the preparation of Exhibits 5 and 5A of the 1989 Annual Statement. Based upon our review of Empire's accounting workpapers and discussions with Empire employees there exists documentation and explanation for these adjustments.

We were informed that an additional $7 million adjustment to expenses (increasing Community Rated underwriting losses) was made at the direction of Empire's Chief Financial Officer in preparing Exhibits 5 and 5A of the Annual Statement. We have confirmed that such an adjustment was made. We obtained documentation indicating that certain expense allocations during 1989 required adjustments between market segments. We also were provided a possible explanation for the $7 million adjustment. However, no contemporaneous documentation to support or explain this adjustment could be found nor was any current Empire employee able to identify any supporting documentation that may have existed.

The above two items comprise the $19 million difference attributable to expenses.

We were informed that an adjustment of $24 million, relating to claims, was made to Exhibits 5 and 5A of the 1989 Annual Statement at the direction of Empire's Chief Financial Officer. We have confirmed that such an adjustment was made. No contemporaneous documentation to support or explain this change could be found nor was any current Empire employee able to identify any supporting or explanatory documentation that may have existed.

1990

For 1990, we identified differences of approximately $10 million related to claims and $2 million related to expenses. The net effect was an $8 million increase in the Community Rated underwriting losses and a corresponding increase in Experience Rated underwriting gains as reported in Exhibits 5 and 5A of the 1990 Annual Statement.

The net difference of $10 million for claims resulted from documented adjustments made by the accounting department in preparing the Black Book which were made differently (by $5 million) by the actuarial department (decreasing Community Rated claims) in preparing the Annual Statement. This difference was offset by a $15 million adjustment increasing Community Rated claims which we were informed was made at the direction of Empire's Chief Financial Officer. We have confirmed that such an adjustment was made. No contemporaneous documentation to support or explain the $15 million adjustment could be found nor was any current Empire employee able to identify any supporting or explanatory documentation that may have existed.

Differences in expenses for 1990 amounted to $2 million resulting from $2 million in expenses included as Community Rated in preparing the Black Book which were included as Experience Rated (reducing Community Rated expenses) in preparing the Annual Statement. Based upon accounting workpapers and discussions with Empire employees there exists documentation and explanation for this difference.

In addition to differences noted in comparing the Annual Statement and Black Book between the Community Rated and Experience Rated results, we noted differences aggregating $90 million within the two market segments between the two enrollment classifications (Hospital and Surgical-Medical) presented in Exhibits 5 and 5A of the 1990 Annual Statement (Exhibit 12). These differences had the effect of increasing Hospital losses and decreasing Surgical-Medical losses within both the Community Rated and Experience Rated lines of business. We were informed that these differences arose as a result of adjustments made at the direction of Empire's Chief Financial Officer. No contemporaneous documentation to support or explain these adjustments could be found nor was any current Empire employee able to identify any supporting or explanatory documentation that may have existed.

1991

In 1991, substantially all of the $31 million difference related to claims. The effect was an increase in Community Rated underwriting losses and a corresponding reduction in Experience Rated underwriting losses as reported in Exhibits 5 and 5A of the 1991 Annual Statement.

A portion ($28 million) of the difference related to the use of restated claims results as of January 31, 1992 in preparing the Annual Statement.[3] Use of restated claims data—as opposed to incurred claims data—in connection with preparation of Exhibits 5 and 5A of the 1991 Annual Statement was inconsistent with Empire's accounting practice used in all other years reviewed and is not the type of claims information which is requested by Exhibits 5 and 5A. We were informed that an additional $7 million adjustment

[3]Restated claims results constitute paid claims and reserves for unpaid claims at the end of a reporting period which are updated, or "restated", to include additional actual claims data relating to that reporting period which becomes available after such period. Restated claims data is used by Empire in the ordinary course of preparing its rate applications. See Section Two.

(increasing Community Rated claims) was made at the direction of Empire's Chief Financial Officer. We have confirmed that such an adjustment was made. No contemporaneous documentation to support or explain this change could be found nor was any current Empire employee able to identify any supporting or explanatory documentation that may have existed. The effect of the foregoing was partially offset by documented accounting adjustments increasing the Community Rated underwriting losses in the Black Book by approximately $4 million which were not included in preparing the 1991 Annual Statement, resulting in the net difference of $31 million.

In addition to differences noted in comparing the Annual Statement and Black Book between the Community Rated and Experience Rated results, we noted differences aggregating $7 million, within the two market segments between the two enrollment classifications (Hospital and Surgical-Medical) presented in Exhibits 5 and 5A of the 1991 Annual Statement (Exhibit 13). These differences had the effect of increasing Hospital losses and decreasing Surgical-Medical losses within both the Community Rated and Experienced Rated market segments. We were informed by Empire personnel that these differences arose as a result of adjustments made at the direction of Empire's Chief Financial Officer. No contemporaneous documentation to support or explain these changes was furnished to us nor was any current Empire employee able to identify any supporting or explanatory documentation that may have existed.

1992

In 1992, the $1 million difference related to claims. The effect was an increase in Community Rated underwriting losses and a reduction in Experienced Rated underwriting losses as reported in Exhibit 5 of the 1992 Annual Statement.

The $1 million difference in claims is comprised of $9 million of documented accounting adjustments increasing the Community Rated underwriting losses in the Black Book which were not included in preparing the 1992 Annual Statement; offset by a $10 million adjustment to the Annual Statement (increasing Community Rated claims) which we were informed was made at the direction of Empire's Chief Financial Officer. We have confirmed that such an adjustment was made. No contemporaneous documentation to support or explain this change could be found nor was any current Empire employee able to identify any supporting or explanatory documentation that may have existed.

In addition to differences noted in comparing the Annual Statement and Black Book between the Community Rated and Experience Rated results, we noted differences aggregating $38 million, within the two market segments between the three enrollment classifications (Hospital, Basic Medical and Major Medical) presented in Supplemental Exhibits NY5, NY5A and NY5B of the 1992 Annual Statement (Exhibit 14). These differences had the effect of decreasing Hospital and Basic Medical losses by $29 million and $9 million, respectively, and increasing Major Medical losses by $38 million within both the Community Rated and Experienced Rated market segments. We were informed by Empire personnel that these differences arose as a result of adjustments made at the direction of Empire's Chief Financial Officer. No contemporaneous documentation to

support or explain these changes could be found nor was any current Empire employee able to identify any supporting or explanatory documentation that may have existed.

Black Book vs. Interim Statement

The processes used in preparation of the interim period Black Book and corresponding Interim Statement Exhibits 1 and 1A are substantially the same as those used for preparation of the annual Black Book and the Annual Statements Exhibit 5 and 5A. For the interim periods we compared Empire's records to both the Black Book and Exhibits 1 and 1A of the Interim Statements. We prepared the necessary reconciliations, and identified or developed other "bridging" documents to enable us to make appropriate comparisons and to determine the nature and extent of the differences between the two reports.

We identified numerous differences between the Black Book and the Interim Statements. In four of the periods the differences were attributable to the inappropriate use of restated claims results in the preparation of the Interim Statements. In twelve interim periods we identified adjustments which we were informed were made at the direction of Empire's Chief Financial Officer as to which we were not furnished contemporaneous supporting or explanatory documentation. There is documentation or explanations for all other differences.

In addition to the differences noted in comparing the Interim Statements with the Black Book between the Community Rated and Experience Rated businesses, we noted in the Interim Statements differences within the two market segments between the two enrollment classifications (Hospital and Surgical-Medical) similar to those discussed in connection with year-end Annual Statements for 1990 and 1991.

Rate Applications

Periodically, Empire submits a request to the Insurance Department to increase premiums for its Community Rated business. Empire's most recent rate increase request was filed in October, 1992 and was approved, effective January 1, 1993 ("1993 Rate Application"). The full rate increase requested, averaging approximately 25%, was granted. For the most part, these rates are in force today. However, certain rates were subsequently reduced (at the Insurance Department's direction) as a result of an approximate $100 million settlement in favor of Empire, relating to the New York State medical malpractice fund. Previous rate increases were approved effective April 1, 1992, March 1, 1991 and March 1, 1990.

We acquired an understanding of the process used by Empire to develop the Rate Applications. We also gained an understanding of the major components of the Rate Applications and the sources of key information used in their preparation.

Empire's 1991 underwriting results were used as the base year for the 1993 Rate Application. Similarly the 1992 Rate Application used 1990 as a base year, 1991 used

1989 and the 1990 Rate Application used 1988 as a base year. The base year is used to develop projections of net gain or loss and changes in reserves and unassigned funds (surplus) as of and for the two years subsequent to the base year in the Rate Applications.

Important components of these projections, which are provided in detail in the Rate Applications, involve the underwriting gains or losses for Community Rated business (i.e. premiums less claims and expenses).

The source of base year information for premiums, claims and expenses are: actual premiums as reported in the Annual Statement; claims, restated through the latest available interim date; and actual expenses as reported in the Annual Statement.

Restated claims information is used for base year purposes because it provides a more relevant indication of actual costs incurred on a per contract basis than does the claims data reported in the Annual Statement. This is because the claims data reported in the Annual Statement is affected by over and under accruals at the beginning and end of the year, while the restated claims data used in the Rate Applications is not affected by year-end accruals and therefore provides a better basis to project the increase in costs per contract.

For the key elements of the Rate Applications, we found, based upon the agreed-upon procedures applied, that Empire's internal data generated in the ordinary course of business agreed to the data contained in the Rate Applications, except that 1989 expenses (which totaled $173 million) included in the 1991 Rate Application reflect a $7 million adjustment (discussed in Section One) for which contemporaneous documentation could not be located.

The Rate Applications also include projections of future results of Empire's operations. These projections are based upon numerous trends and assumptions including future changes in enrollment, healthcare costs and investment income. Since we were engaged to determine if the unexplained items described in Section One were reflected in the Rate Applications, we applied agreed-upon procedures to the process and available documentation for the development of the claims trends for the Rate Applications. However, our agreed-upon procedures related to the trends did not include any relating to assessing the reasonableness of the judgments used in determining the trends. Accordingly, we cannot and do not express any opinion on the appropriateness of the assumptions used.

We noted no undocumented or unexplained adjustments in Empire's Rate Applications which would affect the projections in the Rate Application, except that the 1991 Rate Application included a $7 million undocumented adjustment (see above). We also were informed that in connection with the Rate Application process, the Insurance Department requested that Empire provide recent historical underwriting results. This data, which was provided by Empire, agreed with the Annual or Interim Statements previously filed with the Insurance Department which contained the unexplained adjustments identified in this report.

Conclusion

The Company has provided us with reasonable explanations and documentation with respect to each of the differences in reported premiums earned. While reasonable explanations and documentation also were provided with respect to certain differences as to claims and expenses, we have concluded that (i) the use of restated claims information in preparing Exhibits 5 and 5A of the 1991 Annual Statement and Exhibits 1 and 1A for the September, October and November 1991 and January 1992 Interim Statements was inappropriate, and (ii) certain differences as to claims and expenses were the result of unexplained adjustments which we were informed were made at the direction of Empire's Chief Financial Officer, as to which we were not furnished contemporaneous supporting or explanatory documentation nor was any current Empire employee able to identify any supporting or explanatory documentation that may have existed.

Rate Applications were prepared from Empire's internal records generated in the ordinary course of business and not from the unexplained adjusted amounts contained in Exhibit 5 and 5A of the Annual Statements or Exhibits 1 and 1a of the Interim Statements, except for the $7 million expense adjustment in the 1991 Rate Application noted above. Empire's trends used in the Rate Applications are derived from information generated in the ordinary course of business and not from the unexplained adjusted amounts contained in the exhibits to the Annual and Interim Statements.

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