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Compliance Review of Allina Health System and Medica Health Plans

Volume 1
Overview

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I.

ALLINA HEALTH SYSTEM: OVERVIEW

1.1. Minnesota Health Care Market.

Minnesota's health care market is highly concentrated.[1] This concentration has occurred on both a horizontal level - with mergers between HMOs - and on a vertical level, with mergers of HMOs, hospitals and/or physicians' practices to create health care "systems."

The three largest Minnesota HMOs are Medica Health Plans ("Medica"), HealthPartners and Blue Plus, which have a combined market share of over 90% of all HMO enrollment statewide. Medica and HealthPartners are almost evenly matched at 38.9% and 38.5% respectively, and Blue Plus is third at 13.8%.[2] The HMO penetration rate in Minnesota is approximately 28% of its population.[3] Medica, HealthPartners and Blue Cross and Blue Shield of Minnesota ("BCBSM") also control approximately 85% of the patient market for insureds, HMO enrollees, and self-insureds. (Exhibit 1).

The market share of these companies is not evenly distributed throughout the health care market. For instance, BCBSM insures almost 90% of the Medicare supplement policies sold to seniors (Exhibit 2) and 80% of the rural population. (Exhibit 3). Medica provides coverage to approximately 45% of participants in state-funded programs, such as general assistance and medical assistance. (Exhibit 4).

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[1] *See* Health Economics Program, Minnesota Department of Health, issue Brief 98 -04, Consolidation in Minnesota's HealthCare Market (1998)

[2] Allan Baumgarten, Minnesota ManagedCare Review 1999 Part Two, at 14

[3] Allan Baumgarten, Minnesota ManagedCare Review 1999 Part One, at 4.

The hospital market in the metropolitan area is also highly concentrated. About 50% of a market that formerly consisted of over 30 independent hospitals is now controlled by two large systems - Allina and Fairview.[4] If HealthEast is included, the three largest hospital systems account for 60% of the metropolitan market.[5] While hospitals outside the Twin Cities have not consolidated to the same degree as those in the metropolitan area, there has been a steady decline in the number of rural hospitals. Since 1983, over 31 rural hospitals have closed while another 19 are in financial trouble.[6]

Physician practices have also experienced a high rate of consolidation in recent years, both in the Twin Cities and in the rest of Minnesota, with small practices merging into larger ones, with formations of loose associations among practices and with the vertical integration of physician groups into hospital systems and HMOs.[7] One of the largest physician groups in the metropolitan area is Allina Medica Clinic, which employs approximately 500 physicians. (Exhibit 58).

The concentration in the health care industry is the result of a dramatic wave of mergers. For instance, Group Health was the first HMO formed in 1957 to serve the employees at the University of Minnesota.[8] The federal HMO Act of 1973 resulted in the

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[4] Health Economics Program, Minnesota Department of Health, Issue Brief 98 -04, consolidation in Minnesota's Healthcare Market 3 (1998). *See also* Allan Baumgarten, Minnesota ManagedCare Review 1999 Part Two, at 6.

[5] Allan Baumgarten, Minnesota ManagedCare Review 1999 Part Two, at 5.

[6] Minnesota Planning Implications of Rural Minnesota's Changing Demographis 6 (July 2000). *See also* Health Policy and Systems Compliance Division. Health Economics Program, Minnesota Department of Health, Minnesota Healthcare Market Report 124-126 (1995).

[7] Health Policy and Systems Compliance Division, Health Economics Program, Minnesota Department of Health, Minnesota Healthcare Market Report 163 (1995).

[8] Health Policy and Systems Compliance Division, Health Economics Program, Minnesota Department of Health, Minnesota Healthcare Market Report 154 (1995).

development of many other HMOs, including MedCenters Health Plan, Share Health Plan, Blue Plus, Physician's Health Plan and Central Minnesota Group Health Plan.[9]

In 1983 MedCenters Health Plan acquired the Nicollet-Eitel Health Plan, resulting in an entity which controlled 22% of the HMO market by 1985.[10] Three years later two smaller HMOs - First Plan HMO in Two Harbors and Coordinated Health Care in St. Paul - became affiliates of BCBSM.[11] In 1988 Central Minnesota Group Health Plan became an operating subsidiary of Group Health.[12] At the same time BCBSM absorbed Coordinated Health Care and shortly thereafter Minnesota Health Plans, Inc.[13]

In 1991 Share Health Plan and Physician's Health Plan merged to form Medica, resulting in an entity that had 480,000 enrollees in 1991, the largest HMO in Minnesota.[14] Group Health and MedCenters then merged to form HealthPartners in 1992.[15] The resulting HealthPartners' holding company had over 570,000 enrollees and revenue of approximately $850 million.[16]

The consolidation of the health care market is not limited to HMOs and insurers. In the early 1990s HMOs began a series of "vertical" integrations with the acquisition of

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[9] Allan Baumgarten, Minnesota ManagedCare Review 1999 Part One, at 5.
[10] Health Policy and Systems Compliance Division, Health Economics Program, Minnesota Department of Health, Minnesota Healthcare Market Report 154, 156 (1995).
[11] Health Policy and Systems Compliance Division, Health Economics Program, Minnesota Department of Health, Minnesota Healthcare Market Report 154 (1995)
[12] Allan Baumgarten, Minnesota ManagedCare Review 1999 Part One, at 5.
[13] Allan Baumgarten, Minnesota ManagedCare Review 1999 Part One, at 5.
[14] Office of Technology Assessment, ManagedCare and Competitive Health Care Markets: The Twin Cities Experience 27-29 (July 1994). *See also*, Minnesota COACT and the COACT Education Foundation, Strangled Competition a Critique of Minnesota's Experiment with Managed Competition 9-11 (July 1995).
[15] Office of Technology Assessment, Managed Care and Competitive Health Care Markets: The Twin Cities Experience 29 (July 1994).

hospitals and clinics. In December of 1993 HealthPartners merged with Ramsey Health Care, which consisted of a hospital, a multi-specialty physician group and an education and research unit.[17] The same week this merger was announced, Medica announced a merger with HealthSpan Health Services Corporation to form Allina.[18]

In 1976 there were 35 hospitals with about 10,000 acute care beds in the metropolitan area.[19] In the 1980s the metropolitan hospital market underwent a series of mergers, resulting in almost all metropolitan hospitals being owned by one of four multi-hospital systems - Fairview, Health One, HealthEast and LifeSpan.[20] HealthEast was formed in 1986 as the result of a merger of five hospitals.[21] In 1987 the Fairview System acquired St. Mary's Hospital and shortly thereafter acquired the University of Minnesota Hospital.[22] At the same time Health One and Health Central - two existing multi-hospital systems - merged to become Health One Corporation. This trend continued into the

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(Footnote Continued From Previous Page)

[16] Health Policy and Systems Compliance Division, Health Economics Program. Minnesota Department of Health, Minnesota Healthcare Market Report 155 (1995).

[17] Office of Technology Assessment, Managed Care and Competitive Health Care Markets: The Twin Cities Experience 31 (July 1994).

[18] Glen Howatt, *Medica Merging with HealthSpan to Become Allina*, Start Tribune, December 8, 1993, at 1A. *See also* Office of Technology Assessment, Managed Care and Competitive Health Care Markets: The Twin Cities Experience 30-31 (July 1994).

[19] Office of Technology Assessment, Managed Care and Competitive Health Care Markets: The Twin Cities Experience 26 (July 1994).

[20] Office of Technology Assessment, Managed Care and Competitive Health Care Markets: The Twin Cities Experience 26 (July 1994).

[21] Office of Technology Assessment, Managed Care and Competitive Health Care Markets: The Twin Cities Experience 26 (July 1994).

[22] Office of Technology Assessment, Managed Care and Competitive Health Care Markets: The Twin Cities Experience 26 (July 1994).

1990s, when Health One Corporation merged with LifeSpan to form HealthSpan in 1993.[23]

1.2. Allina Health System: Structure

Allina Health System ("Allina") is a complex web of approximately 45 for-profit, taxable non-profit and non-profit tax exempt corporations, joint ventures, trusts, partnerships, unincorporated operating units, operating divisions and limited liability companies. A copy of its organization chart is attached as Exhibit 5.

Allina was formed in July of 1994 through the merger of Medica and HealthSpan Health Systems Corporation ("HealthSpan"). On the medical side, Allina operates at 19 hospital and 48 clinic locations, manages four nursing homes and operates imaging, ambulatory surgery, mental health and transportation systems. On the insurance/HMO side, it operates Medica, Medica Insurance Company, Medica Health Plans of Wisconsin, and Allina Self-Insured, Inc., which acts as both a Third Party Administrator ("TPA") and a Preferred Provider Organization ("PPO.")

1.3. Allina Health System: 1994 Merger of HealthSpan and Medica.

As noted above, Allina was created in 1994 with the merger of Medica and the HealthSpan Health System. According to Allina executives and newspaper clippings in 1994, the principal motivation for the merger was the Minnesota Care Act, which essentially called for the creation of three Integrated Service Networks ("ISNs") in Minnesota. The Minnesota Care Act contemplated the establishment of three ISNs - two

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[23] Office of Technology Assessment, Managed Care and Competitive Health Care Markets: The Twin Cities Experience 27 (July 1994). According to the OTA report, "[t]his was the first merger that generated public debate over whether the consolidation of the hospital market in the Twin Cities had gone too far." *Id.*

in the metro and one in rural Minnesota - through which all health care was to be delivered. While Minnesota Care was discarded by policymakers in the mid to late 1990s, it succeeded in causing a consolidation of the Minnesota health care market which now has only three major health plans and less than twenty clinics that dominate its health delivery system.

Gordon Sprenger, chief executive officer of Allina, stated that the principal motivator for the HealthSpan leadership in pursuing the merger was so that HealthSpan hospitals and clinics would become one of the three surviving ISNs. He also stated that the ISN would hopefully create greater patient volume and reimbursement from Medica. Medica's motivation to complete the merger was that, by owning hospitals and clinics, it would also be one of the three surviving ISNs. It was also hoped that the HMO would be in a better position to manage and control the delivery of health care.

There were two major structural issues that needed to be resolved with the creation of Allina.

The first issue related to Medica, which in 1994 was a non-profit corporation controlled by United Health Group, Inc. (formerly United Health Care Corporation) (hereinafter "UHG"). Mr. Sprenger stated that, as a condition of affiliation of HealthSpan with Medica, HealthSpan required that Medica develop independence from UHG. There appear to have been three reasons for Medica to become independent. First, the HealthSpan delivery system would have difficulty participating in the health care management of Medica if Medica was controlled by UHG. Second, the structure of Medica, where it essentially was a shell corporation managed by UHG, resulted in the HMO having administrative costs far higher than other HMOs. A 1996 survey by Ernst

and Young compared several HMOs and found Medica's administrative expenses so high and structure so unusual as to not lend itself to an "apples to apples" comparison with other HMOs. (Exhibit 6). Third, there was significant skepticism in the medical community, as evidenced by the *PHP Oversight Committee vs. PHP* lawsuit in 1988, that Medica was a front group for UHG and not "patient friendly."

The second issue related to HealthSpan, which had not yet integrated its operations. Indeed, the merger of LifeSpan and Health One (which was just previously created by the merger of Health One and Health Central) to create HealthSpan had not been completed at the time HealthSpan was to merge with Medica to form Allina Health System.

Rather than act as a unified delivery system, HealthSpan was a collection of hospitals and clinics that competed as much as collaborated with each other. There is reported to have been little integration among HealthSpan hospitals and clinics as to care coordination, demand management, contracting, physician relations and medical economics. The hurdles to integration are claimed by physicians and executives to be the result of strong community ties by each hospital and strong ties between physician groups and particular hospitals.

The executive office of Allina from 1994 to 1998 symbolized Allina's ambiguity as it relates to an integration of its services. During this period of time the Allina Board chose "co-leaders" where Dr. James Ehlen of Medica and Mr. Gordon Sprenger of HealthSpan shared the leadership of the organization. Physicians and executives on both "sides" of Allina stated that the "co-leaders" symbolized unwillingness by the Board to

deal with the issue of whether the company was driven by its delivery system or its HMO system.

1.4. Medica HMO: Operational History From 1994 through 1998.

Prior to the Allina merger in 1994, Medica was a financial success. In 1993 it was managed under a comprehensive full service administrative contract by UHG. At that time, Medica employed only a skeleton staff and management of the company was undertaken by UHG. In 1993 Medica recorded 6,591,120 member months of service (Exhibit 7) and revenue in the amount of $975,915,628, (Exhibit 7) with a net profit of $39,138,250. (Exhibit 10). As noted above, a condition of the Allina merger was that Medica had to start becoming "independent" of UHG by amending its long-term administrative services contract with UHG to permit the transfer of approximately 415 UHG employees to Medica. (Exhibit 8) These employees would perform some of the "non-core" functions performed by UHG under its management contract. Medica and UHG amended their agreement so that, while Medica would directly employ this staff at a payroll previously paid by UHG, UHG would still retain its profit margin on these employees for the duration of the contract, which was estimated to be $10 million per year. (Exhibit 9).

At the time of the merger, Medica had its largest net worth (surplus) in its history and had just completed the most profitable year in its history. (Exhibit 10).

In 1994 Medica had approximately 581,853 members who had health coverage through an HMO policy, insurance policy, self-insured plan, or a government plan issued or administered by Medica. (Exhibit 11). As previously noted, one goal of the merger was that Medica would increase its policyholder base so that it could feed more patients

to the HealthSpan "side" of Allina. Because Medica had a large net worth at the time of the merger, Allina adopted a strategy to increase Medica's market share by offering policies at a discount to new policyholders. (Exhibit 12). In 1995 and 1996 Medica grew its policyholder base by offering competitively lower premium policies. This growth initiative was a success, and the company grew, exclusive of its PPO, from 581,853 members in 1994 to approximately 850,000 members in 1997. (Exhibit 13). With its PPO included, Medica grew from 813,000 to 1,050,000. (Exhibit 14). Since 1997 Medica has lost about 100,000 members in its insured, self-insured and government programs. (Exhibit 15, Exhibit 63, page 2). If one includes the PPO, total Medica members have remained stagnant at about 1,050,000 during this period of time. (Exhibit 14, Exhibit 16).[24] By offering a lower premium in 1995 and 1996 to grow membership, however, Medica incurred a net loss in its income for 1996, the only year in the past decade where it lost money. (Exhibit 10). Once the company secured its enrollment level at the 850,000 population in 1997, Medica pursued an aggressive pricing, underwriting and cost cutting strategy to make this new business profitable. (Exhibit 17). Medica retained the actuarial firm of Reden and Anders to review Medica's pricing and underwriting strategies. On December 10, 1997 Reden and Anders issued an opinion that stated:

> "Based on our review, we did not find any issues that were contributing to Medica's poor financial results that had not been identified by Medica. In addition, it appears that many of the steps that Medica's management team has taken in 1997 will result in significant improvement in financial results in 1998." (Exhibit 18).

[24] The PPO members should be separated from Medica's other business because it essentially is a "rental" of the Allina network fee schedule. The services performed by Medica are simply to adjust the charges of the Allina network providers on behalf of another insurer or administrator.

The need to aggressively underwrite and price its policies in 1997 was a major priority for Medica. Medica's premium was already higher than HealthPartners and BCBSM, (Exhibit 19), and it was approximately 15% higher than the national average premium (Exhibit 20). If Medica increased its rates too rapidly the more profitable patients would likely terminate coverage and switch to the lower priced BCBSM. Medica's HMO membership decreased from 630,000 in 1997 to 460,000 in 1999 when it raised premiums from $135 on a per member per month ("pmpm") basis to $165 pmpm. (Exhibit 19). Seventy-five percent of these enrollees terminated Medica due to its high cost (Exhibit 21), and two-thirds of the enrollees went to BCBSM. (Exhibit 22). Notwithstanding this loss of enrollees, Medica was able to continue its pace of profitable years. The enrollment and net profit of Medica since 1993 is as follows:

Year	HMO, Insured, Self-Insured and Government Member Months (but not PPO)	HMO Profit (Exhibit 10)
1993	6,591,120	$ 39,138,250
1994	6,982,234	19,306,493
1995	8,479,586	22,727,246
1996	9,908,192	(2,898,807)
1997	10,192,022	6,753,400
1998	9,875,000	12,331,043
1999	9,491,370	3,748,708
2000	8,928,000	28,574,337

1.5. The HealthSpan Side of Allina.

There has never been a true integration of the Allina hospital system. Physicians assert that each of the hospitals, rather than being managed through central management, competes with the others for business. Executives note that specific physician groups maintain primary identity with particular hospitals and specialists within their community. Physicians have also complained that equipment is not purchased in a timely fashion by a remote administrative staff. Nurses and administrative staff complain about the inability to get responsive feedback from Allina's administration. A major problem in Allina's administration of 500 physicians - who live in separate communities and have separate ties to hospitals, patients and specialists - is the overhead associated with trying to "integrate" the physicians into a centrally managed organization. At present the clinics have about a 65% overhead cost and the Allina Medical Clinic as a whole lost $42 million per year. (Exhibit 28).

Former executives report that by the end of 1997 there was a growing frustration within Allina as to the concept of "co-leaders." The Allina Board had to select an individual chief executive officer and, accordingly, sometime in 1998, Mr. Sprenger was designated the chief executive officer of Allina. Dr. Ehlen then retired from the organization, leaving with a very lucrative and generous severance package amounting to several million dollars.

By 1998 the lack of integration between the HealthSpan "side" - whose mission was to care for patients - and the Medica "side" - whose mission was to save money - was very obvious.

For instance, even though the Allina Medical Clinic ("AMC") is one of the largest physician clinics in the metropolitan area, and even though the Allina hospitals have the largest market segment in the metropolitan area, Medica has not increased its utilization of these providers (Exhibit 23). The HealthSpan "side" of Allina reports that the amount of its revenue coming from Medica in 1997 was 17.6% and that it has steadily declined to 16.3% in 1998, 16.1% in 1999 and 15.7% in 2000. (Exhibit 24). In addition, the percentage of revenue paid by Medica to the HealthSpan side of Allina remained flat at about 21% during this period of time. (Exhibit 25).

Indeed, Medica retains only 31% of total admissions within the Allina system, substantially less than integrated provider-owned plans which typically retain between 70% and 80% of total admissions. (Exhibit 26 Pages 1,2 and 3). While Allina-owned AMC is one of the largest clinics in the metropolitan area with approximately 500 physicians (Exhibit 58), AMC only receives 15% of Medica's outpatient referrals. (Exhibit 27). In part because of this, AMC sustains losses to the system which are then "adjusted" because of the high referral of AMC physicians to Allina hospitals. (Exhibit 28).

This lack of synergy is surprising because Medica has expended millions of dollars in "referral fees" and other "upcharges" to physicians who, in exchange for their fees, were supposed to refer patients to Allina hospitals. For example, in February, 1998 Allina's Finance Committee approved a "bridge agreement" with Aspen Medical Group, P.A. ("Aspen") whereby Medica paid $8,000,000 to Aspen in exchange for Aspen's physicians agreeing to refer Medica's patients to Allina facilities. (Exhibit 29). Medica then entered into a long-term contract with Aspen, paying it almost $12 million at the

commencement of the contract, $7.9 million the second year of the contract, and $1.5 million in "enhanced payments" each year thereafter (Exhibit 30). Medica then established an "Aspen Steering Committee" as part of its core committee structure (Exhibit 31).

In 1999 Allina retained Deloitte & Touche to analyze the integration of Allina Health System and Medica.

Deloitte & Touche reportedly advised the Allina management that both "sides" of Allina - the Medica "side" and the HealthSpan "side"- were "sub-optimizing" their performance under the merged organization. In other words, the affiliation between the HMO and the hospital system was detrimental to the performance of each entity. The evidence supports this conclusion. For instance, the Allina affiliation was detrimental to Medica in that Medica expended large sums of money to encourage non-affiliated physicians to refer business to Allina hospitals. (Exhibits 29, 30 and 31). Such referral fees are not in the interest of Medica or its policyholders. While Medica has categorized such expenditures as medical expenses, they in fact are marketing expenses designed to induce physicians to refer business to the HealthSpan "side" of the organization.

Former Allina executives state that the concept of "unwinding" the merger and acknowledging its failure was not likely to win favor with the executives who engineered it. Deloitte & Touche materials suggest that Allina could either "unwind" the merger or, in the alternative, pursue a strategy whereby the respective "sides" of Allina would operate aggressively in their respective markets, pursuing integration only when it made economic sense to the combined organization. In spite of the obvious conflicts of interest

between Medica and the HealthSpan "side" of Allina,[25] the Allina officials continued their attempt to "integrate" or synergize the relationship of the HMO, the physicians and the hospitals. In February of 1999 Allina set forth a business goal of establishing key relationships with physicians who, in exchange for "upside financial opportunity" from Medica, commit, among other things, to use Allina's hospitals and clinics. (Exhibit 32). In July of 2000 Allina restated the goal of Medica to contract with key physicians by offering an "enhanced economic position" to "committed physicians" in exchange for increased market share for Allina. (Exhibit 33). Such a relationship was apparently achieved with a cardiology clinic that receives referrals from Allina primary care providers in exchange for its referrals to Allina hospitals. (Exhibit 34).

While Allina executives in February of 2001 indicated that efforts at such integration had failed (Exhibit 35), they continue to develop plans to establish "enhanced fee schedules" for certain key physicians and discuss how such fund transfers could occur between the HealthSpan "side" and Medica. (Exhibit 36).

1.6 Medica HMO: 1999 - 2001.

At the same time Allina recognized that the integration of its hospital/physicians with the HMO was failing, it needed to resolve its relationship with UHG. The management contract with UHG was up for renegotiation in 1999.

As noted above, UHG performed all of the management and administrative functions of Medica up to 1994 and performed all of the core "insurance" functions from

[25] The HealthSpan "side" of Allina operates in large part through two non-profit corporations, Allina Health System and Allina Medical Clinic.

1994 to 1999. (Exhibit 37). In order to become independent, Allina needed to negotiate a contract where it would assume more of the core insurance functions of an HMO.

In 1999 UHG charged Medica approximately $80 million annually for its base administrative service, and $135 million annually for all of its services. (Exhibit 38). This meant that in 1999 UHG received approximately 10% of the total revenue of Medica, which was approximately $1,371,734,000. (Exhibit 39). At this point UHG still performed all Medica's core insurance functions, such as health plan accounting, information systems, electronic data interchange services, claim adjudication, claims administration, underwriting, actuarial, billing, collections, receivables and enrollment. (Exhibit 37). While Medica had grown to almost 800 employees (Exhibit 40) the only core functions it performed related to health provider contracting, utilization review and consumer assistance, much of which was with hospitals and provider clinics owned by Allina. (Exhibit 37). Thus, in spite of Medica's employment growth and consequent growth of payroll, it was still dependent upon UHG for its core insurance functions.

By 1997 Medica was researching its options with regard to the performance of these core functions. One option was to renegotiate the UHG contract, deleting the $10 million of "foregone profit" UHG still received annually from the functions that Medica assumed in 1994. (Exhibit 9). Another option was for Medica to contract with a competitor to UHG, such as EDS of Dallas, Texas, which could perform the services at a much cheaper price. (Exhibit 45). Yet another option was for Medica to purchase or lease its own computer equipment and software applications and hire its own personnel to perform the core HMO functions on its own. (Exhibit 41).

The fees UHG charged to Medica were far above market price. (Exhibit 42). Indeed, Allina itself reported that UHG's costs were between 35% and 72% higher than the highest industry benchmark. (Exhibit 43). Accordingly, it was reasonable for Medica to retain a third party to review the alternatives available to Medica instead of contracting with UHG. Given the economic importance of the issue, however, Medica should have made certain to contract with an independent third party that did not have relationships with UHG or any other conflict of interest. Rather than doing so, however, the Medica executives contracted with Andersen Consulting, Inc. (Exhibit 43), an affiliate of Arthur Andersen and Company, which are the auditors for UHG. (Exhibit 44). In light of this affiliation, Andersen Consulting could hardly be in a position of claiming independence from UHG. Not surprisingly, after receiving advice from Andersen Consulting, Medica executives did not seek competing bids from other firms. (Exhibit 41). Medica also did not seek bids with regard to "insourcing" such functions. Indeed, Medica officials simply renegotiated with UHG for a five-year contract. (Exhibit 41). This seems particularly strange given that UHG charged Medica an MIS fee 35% to 72% higher than the highest benchmark fee surveyed in the nation (Exhibit 45), and a claims processing fee that was 26% to 40% higher than the highest industry benchmark. (Exhibit 46). Further, Medica identified UHG service deficiencies that cost Medica over $10 million (Exhibit 47). The behavior of Medica management as it relates to UHG is bizarre. Even though the Medica negotiation team stated that Medica should issue an RFP and evaluate vendor responses if Medica desired the "needed changes" in the structure and pricing from UHG, the Medica management instructed the negotiation team to even avoid the appearance of seeking other bids:

"Medica management's current approach is to try to accomplish this renegotiation without soliciting proposals from other service providers due to the associate costs, time implications, and potential ill will with UHC. *But the negotiation team realizes that issuing an RFP and evaluating vendor responses may be necessary in order to secure the needed changes in structure and pricing from UHC. Management prefers to avoid this situation if at all possible.*" (Exhibit 48).

In 1999 Medica entered the negotiations with UHG identifying the need to lower the UHG fee due to:

1. The $10 million in annual foregone profits retained by UHG on the services insourced by Medica in 1994 (Exhibit 50 and Exhibit 9),
2. The insourcing by Medica of underwriting functions in 1999 which UHG estimated to be $3 million per year (Exhibit 51),
3. The excessive prices charged by UHG compared to other companies (Exhibit 50 and Exhibits 42, 45, and 46), and
4. The poor performance of UHG that according to Medica caused more than $10 million in costs. (Exhibit 47).

In the end, Medica agreed to a management contract which essentially reduced the UHG fee for core services from $76 million to $68 million. (Exhibit 52). However, this reduction does not come close to meeting the reduction criteria set forth above, which would require at least a $15 million reduction.

Perhaps as disturbing as the refusal of Medica management to solicit competing bids is the engagement letter of Deloitte & Touche. The engagement letter is dated February 1, 1998, more than one year before negotiations commenced on the renewal of the UHG contract. Even though the terms of the UHG contract were unknown, and even though the terms of the existing UHG contract were abysmal for Medica, and even though Deloitte & Touche knew that Medica did not solicit the necessary bids to obtain

the "needed changes," the Deloitte & Touche engagement letter committed the firm to issue a Fairness Opinion letter about the deal and also committed the firm to issue a Fairness Opinion letter pursuant to an outline of statements which is attached to the engagement letter. (Exhibit 48).

1.7. **The Use of Consultants: 1998 - 2001.**

At this point in time, a little more than four years since the merger, the Allina executive team was in transition. Dr. Ehlen had left the company. Mr. Sprenger, the newly appointed chief executive officer, was widely known to be considering retirement, and had assumed the position of president of the American Hospital Association. As president of the trade group, Mr. Sprenger stated that he needed to dedicate most of his time to that venture. Meanwhile, David Strand, an attorney with no reported operational experience in an insurance company, an HMO or a hospital system, acted as the chief operations officer of Medica.

Because its senior executives had no operational experience with an insurer or HMO, Medica contracted with consultants to deliberate and report on issues normally addressed by most insurance executives.

In 1997 Medica retained Karen Vigil, affiliated with Deloitte & Touche in California, to analyze the pricing and underwriting of policies for Medica. In an interview Ms. Vigil could not identify any company where she participated in a successful "turnaround." She acknowledged that she previously undertook only two "business reviews" while an accountant. She indicated that she had been employed by Wellpointe, a California insurer, for approximately 20 months, where she helped prepare the company's financial statements for a public offering. Ms. Vigil also stated she was

employed at Premera Health Plans in Washington for approximately three years and eventually held the position of president of a subsidiary company for a very short period of time. (Exhibit 53).

Having at least some insurance experience, Ms. Vigil's duties quickly evolved from simply reviewing the Medica pricing strategy to becoming its "chief operating officer."

In the fifteen months following January 1, 1998, virtually every member of Medica senior staff was replaced (Exhibit 54). Medica then paid millions of dollars to Deloitte & Touche, a firm with which Ms. Vigil maintained an office in Los Angeles, to "advise" Medica. In addition, Ms. Vigil authorized payments of millions of dollars of Medica's money to other consultants, including Kris Campbell, a consultant who served as Ms. Vigil's "personal coach" since 1994, and to other West Coast image consultants who had no knowledge of health insurance and no knowledge of the Midwest health care market.

After two years of Ms. Vigil's consulting work, the Medica staff, in December of 1999, raised several questions to the Medica executives about excessive consulting work, excessive spending, and the lack of meaningful change in the UHG contract. (Exhibit 55).

After spending millions of dollars on "consultants" who "coached" these executives, within less than one year the second round of executives was replaced with a third round in late 1999 and 2000. (Exhibit 54).

Almost all of the executives in the third round, hired by late 2000, are from other states and lack familiarity with the Minnesota health care market. Interviews of executives demonstrated a remarkable ignorance with regard to the history of the

company or the Minnesota health care market. Executives were unfamiliar with the financial history of Medica. No Medica executive was aware of the number of years the HMO made a net profit during the last decade. Most executives thought that Medica's only profitable year was 2000. Most executives thought Ms. Vigil undertook a $100 million "turnaround," turning the company from a $50 million loss to a $50 million gain. In fact, Medica lost money only one year, which was under $3 million in 1996. (Exhibit 9). In 1998 Medica had $12 million in income which increased to $ 28 million in 2000. (Exhibit 9). The medical officers who were in charge of "managing" the Allina physicians and Medica network are not licensed to practice medicine in Minnesota. The executives were ignorant of any difference in the mission between a not-for-profit HMO and a for-profit HMO, believing that the profit incentive should remain the same for either type of organization. None of the executives indicated awareness of the "sub-optimizing" issue resulting from the Medica/HealthSpan merger.

Meanwhile, it appears that since 1998 Medica has been spending approximately $20 million per year on consultants who have had past affiliations with Ms. Vigil. (Exhibit 56).

It is noteworthy that the management does not issue "Request for Proposals" for such consulting contracts. Further, most of the consulting services were not contractually defined either in scope of service or amount of fee. In addition, the invoices Medica received from the consultants were generally not documented, and in many cases they were paid without any substantive review. Indeed, it appears that Ms. Vigil, who has been affiliated with many of the consultants in the past, simply ordered the invoices to be paid.

1.8. Executive Expenditures.

There appears to be no monitoring of expenditures for executive perquisites. The expenditures for travel, receptions and meetings reflect a cavalier attitude by some executives concerning the use of assets of the non-profit organizations.

1.9. Captital Investments.

The books and records of the companies indicate there will be substantial need for capital investments for the HealthSpan "side" over the next five years. At least one internal analysis projects a need for almost $700,000,000 in capital investments for the hospitals alone. (Exhibit 57).

Medica also asserts that it needs additional capital investments over the next five years of $215 million, although curiously $70 million of this "capital" expenditure appears to be for "strategy," presumably from more consultants. (Exhibit 57).

The hospitals' request for more capital investment would, previous to the mergers, have been financed in large part by community support for the non-profit hospitals. Physicians and community leaders indicate that this support has evaporated with the centralization of the HealthSpan/Allina system. Indeed, the Allina Foundation principally receives its support from Medica, not the public. (Exhibit 58, Exhibit 59). Rather than contributing to its hospitals, the Allina Foundation subsidizes personnel and projects at government agencies and the Chamber of Commerce. (Exhibit 60). Because the Allina Foundation has failed to replace this source of revenue, the hospitals are forced to rely on treatment fees paid by insurers and HMOs, 80% of which comes through Medica, BCBSM and HealthPartners. Assuming that other hospitals in the metropolitan community are still maintaining an independent fund-raising source, the differential in

health care fees among Allina and the other hospitals may not earn sufficient profits to pay for the capital investments needed by these hospitals. (Exhibit 61).

1.10. Conflicts Between Non-Profit Corporations.

Allina Health System is composed of 45 different entities, most of which are non-profit organizations governed by a Board of Directors and managed by executives who have a fiduciary duty to the mission of the organization and its stockholders.

Allina is the parent organization of an intertwining web of companies that have interlocking boards under Allina's control. (Exhibit 58). The board of directors of each company is effectively appointed by the board of Allina Health Systems. In turn, the Allina board is essentially self-perpetuating because it elects its own members. (Exhibit 62).

The interests of these non-profit organizations conflict with each other. For instance, the object of a non-profit organization which owns hospitals ought to be to ensure safety and financial stability in its hospitals. The interest of a non-profit HMO, however, is presumably to make certain that premiums are efficiently utilized on behalf of its members for quality health care. The goals of Medica and Allina have clashed in a variety of ways over the past several years.

For instance, Medica operates as a TPA for self-insured plans. Since 1993 employers have switched from insured and HMO plans to self-insured plans, and HMOs have been able to market themselves as TPAs for such plans. (Exhibit 63). In addition, Medica rents access to its physician/hospital network (a "PPO") under the name "SelectCare." (Exhibit 64).

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While it would serve Medica's interest to charge a fee that included a profit for such services, it generally operates the PPO function as a "channeling" vehicle for Allina. (Exhibit 64). Medica basically charges health plans and TPAs a fee less than competitors for PPO work in order to build up patient volume for Allina. (Exhibit 64) While Medica does not benefit by charging a smaller fee for PPO work, the HealthSpan "side" gains marketshare from the referral of patients. (Exhibit 64)

A more serious concern is that Medica [redacted]

As noted earlier, the conflict of interest between Medica and Allina also arises out of Medica's payment of referral fees to providers in exchange for referral of patients to

Allina facilities. (Exhibits 29, 30). Such referral fees unnecessarily lowers Medica's income in order to increase Allina's income.

Yet another conflict between Medica and the HealthSpan "side" of Allina exists when Medica "prefunds" payments to Allina. (Exhibit 68). Each year Medica prepays Allina facilities for medical costs. Such "prepayments" benefit the HealthSpan "side" to the detriment of Medica. Such a continuous and uninterrupted cash flow over the years is effectively a cash investment by Medica. Medica currently prefunds Allina for about $30 million. This prefunding has the potential to misrepresent to Allina bondholders the credit worthiness of Allina, costs Medica lost investment income of at least $1.8 million per year, and subordinates Medica's own interest of safety and solvency to Allina's need for cash.

Another conflict of interest arose in March of this year when Medica amended its contract with Allina to raise the reimbursement rates to Allina hospitals and clinics. The sole basis for the amendment was due to Allina's cash flow needs. (Exhibit 69). It is noteworthy that the Medica staff was apparently so uncertain about its negotiation position with Mr. Strand (the COO of Allina) that it held a staff meeting on whether it could "negotiate" with him. (Exhibit 70). It is hardly in the interest of Medica or its members to unfavorably alter the terms of the agreement which had been signed just months earlier on January 1, 2001. (Exhibit 70).

Yet another conflict occurred at year-end 1999, when Mr. Strand and Ms. Vigil told Medica and Allina executives that, in order to mask Medica's large administrative ratio, Allina must pay for millions of dollars in administrative fees incurred by Medica.

In order to cover up this expenditure, the executives were told that Medica should pay additional "medical" fees to Allina.

The conflicts between these organizations will continue to occur. For instance, Medica has a small number of Medicare members, in large part because this business has been so unprofitable. (Exhibit 71). Over 90% of Minnesota seniors are covered under a supplemental contract with BCBSM, which is the main insurance product sold to seniors. (Exhibit 71). While Medica may lose money on its senior business, the HealthSpan "side" of Allina enjoys great profits from the treatment of Medicare patients. (Exhibit 72). Medicare patients are a group which will grow in size and profit potential for health providers. (Exhibit 73). Even though Medica previously withdrew from the senior market due to excessive losses, (Exhibit 71), the Allina consultants appear ready to get Medica back into the senior business (Exhibit 74).

The clash of interests between these non-profit corporations appears to be irreconcilable and the use of one self-electing board and one executive staff is inappropriate and incapable of meaningfully addressing these irreconcilable differences.

1.11 **Overview Summary.**

It is apparent that the Allina and Medica boards of directors and the Medica and Allina chief executive officers and chief operating officers substantially failed at the two fundamental structural goals that were the purpose of the 1994 merger. As noted above, one goal was for Allina to become an integrated health plan. This clearly has not occurred. Second, Medica was to become independent of UHG and more efficient in its administration. In fact, UHG still controls the core "insurance" functions of Medica, and Medica is paying higher administrative fees than it paid in 1994. (Exhibit 75).

The review of Allina and Medica's books and records, and interviews of staff, indicate mismanagement in the following areas:

1. Entertainment, Travel and Conferences. Medica executives have authorized millions of dollars in executive prerequisites that are not in furtherance of the corporation's non-profit mission.

2. Administrative Fees. Allina management has made no attempt to follow up on its 1994 mission to assume independence from UHG. Further, it has increased, not decreased, the administrative costs of the HMO.

3. Consulting Fees. The lack of insurance and business experience by Medica executives has caused it to expend extraordinary consulting fees with questionable outcomes, costing tens of millions of dollars each year.

   A. Consultants were retained who clearly lacked the independence necessary to give objective opinions.

   B. Medica retained many consultants without a specific contract and without identification of any "product" to be received by Medica as a result of the consulting project.

   C. Medica appears to have made no attempt to research or interview competing consultants as to expertise on a given subject or as to fees to be charged. Rather, consultants were generally retained because of a prior relationship with Ms. Vigil.

   D. The professional fees and expenses of the consultants generally were not documented or itemized. In many cases Medica executives never reviewed the invoices.

4. Executive Compensation. Allina failed to ensure that the compensation of its officers was established and reviewed in the manner required by its own governing documents and applicable laws.

5. Governance. The Allina board of directors has failed to monitor the actions of the executives of the company as it relates to the above issues.

6. Conflicts of Interest. There are numerous and irreconcilable conflicts of interest among the non-profit corporations and the communities they serve.

7. Accounting. The books and records of the many Allina corporations are co-mingled in one bank account, and the existing consolidated audit report is virtually meaningless, particularly as it relates to the smaller organizations.

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