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Medica: Conflicts of Interest with Allina

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MEDICA: CONFLICTS OF INTEREST WITH ALLINA

Section 2.1 General.

Allina Health System is a complex myriad which includes 19 hospitals, 48 medical clinics, one HMO, two insurance companies, a preferred provider organization, a third party administrator, a home health care service, a transportation service, an equipment company, nursing homes, three foundations, printing companies, and a web service entity.

The organizational chart provided by Allina (Exhibit 1) masks the complexities of the 50 separate legal entities within the Allina Health System. These legal entities include a variety of organizations including:

- Nonprofit tax exempt organizations,
- Taxable nonprofit organizations,
- For-profit organizations,
- Joint ventures,
- Trusts,
- Partnerships,
- Unincorporated operating units of Allina (with separate Boards of Directors),
- Operating divisions of Allina (with no separate Boards of Directors),
- Limited liability companies.

Several of the nonprofit organizations are tax exempt under Section 501(c)(3) of the Internal Revenue Code. Section 501(c)(3) of the Internal Revenue Code exempts from federal income tax those corporations organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary or educational purposes. The promotion of health has been affirmed by courts and the IRS as a "charitable purpose" for purposes of Section 501(c)(3). This "promotion of health" can include the creation and operation of hospitals, clinics, and other health care providers, as well as the advancement of medical research. Allina states that the following entities have a tax-exempt status under Section 501(c)(3):

- Allina Behavioral Health Services,
- Allina Medical Clinic, f/k/a Allina Medical Group,
- Allina Health System (the parent company),
- Allina Health System Foundation, f/k/a Allina Foundation,
- Medical Health Plans of Wisconsin,
- Mt. Sinai Foundation,
- Sister Kenny Foundation,
- United Hospital Foundation,

In addition, Medica HMO is a nonprofit tax-exempt organization. Medica, however, is tax exempt under Section 501(c)(4). Neither a charitable organization exempt under Section 501(c)(3) nor a social welfare organization which is tax exempt under Section 501(c)(4) may be operated for private gain. The chief difference between the two is that a charitable organization is prohibited from engaging in propaganda or otherwise attempting to influence legislation as a "substantial part" of its work. While a social welfare organization may do so, a contribution to such an organization will not be deductible for purposes of the income, gift or estate tax.

Section 2.2 Allina Health System.

Allina Health System is filed as a nonprofit corporation exempt from taxation under Section 501(c)(3). Allina Health System directly owns and operates several separate entities, including Abbott Northwestern Hospital, Buffalo Hospital, Mercy Hospital, Unity Hospital, Owatonna Hospital, River Falls Area Hospital, United Hospital, New Ulm Medical Center, Cambridge Medical Center, Fridley Convalescent Home and Phillips Eye Institute. (Exhibit 1) Because it directly owns these facilities, the primary corporate responsibility of Allina Health System is to assure the prudent and safe operation of these hospitals and nursing homes.

Allina Health System is the result of a series of hospital mergers from 1983 to 1994. (Exhibit 2) In 1983 the company was known as Health Central, Inc., which was a collection of hospitals in Anoka County and rural Minnesota. In 1987 Health Central merged with Health

One Corporation, which owned United Hospital. In 1988 Health One merged with Metropolitan Hospital and Mount Sinai Hospital. In 1993 Health One merged with LifeSpan Corporation, which owned Abbott Northwestern Hospital. The company changed its name to HealthSpan at the time of the merger. One year later, in 1994, HealthSpan changed its name to Allina as part of its affiliation with Medica.

Allina Health System is governed by its articles of incorporation (Exhibit 3) and its bylaws (Exhibit 4). Pursuant to these documents Allina is governed by a Board of Directors, with 20 directors elected at large and up to eight ex-officio directors. As with most other Allina entities, the director terms are three years and no director shall serve more than three consecutive three-year terms. The articles and bylaws permit up to 50 percent of the directors being doctors of medicine or osteopathy. Up to 49 percent of the directors may also be "interested directors," including any members of Allina's management service and any physician directors who provide services in conjunction with Allina or any of its health plans, hospitals or clinics. The president and chief executive officers of Allina typically serve as ex-officio members. Seven of the members also serve as directors on the Board of Medica HMO. Attached as Exhibit 5 is a list of the Board members for the year 2000-2001.

Allina's entire business is managed by the Board of Directors. The Board has the power to control all corporate functions of Allina, including the election of other directors, the election of Allina's president, the election and removal of corporate members, as well as managing and evaluating the operations of all Allina operating units. (Exhibit 3).

The Board of Directors also elects the "corporate members." Because the Board of Directors has the core power of the company, the corporate members of Allina have nominal authority other than to approve some amendments to the Allina articles of incorporation, such as

a merger or consolidation of Allina, a sale, lease or transfer of Allina's property or assets, or a planned dissolution of the company. (Exhibit 3). The Allina bylaws are silent as to the total number of corporate members that are elected to serve.

Each of the hospitals listed above are considered to be unincorporated operating units of Allina. Allina has established an operating unit board for each hospital, and the Allina board reserves to itself the election or removal of the directors of each operating unit board. The Allina board also has final approval on all amendments to the bylaws of an operating unit board, final approval of an operating unit's strategic plan, capital budget and operating budget, final approval of any plan of merger or consolidation, final approval of capital expenditures, and final approval over the selection, appointment and termination of an operating unit's chief executive officer (who in turn has authority to have and replace all other officers).

As noted above, the corporate operation of Allina Health System is approximately 17 hospitals and three nursing homes. The corporate operations reflects its corporate history, which is a series of mergers involving these hospitals and nursing homes.

In addition to operating the above hospitals and nursing homes, Allina Health System acts as a holding company which owns and controls dozens of other organizations.

Allina executives commonly divide the Allina conglomerate into two parts: the "delivery side" (or "HealthSpan") and the "health plan" side or ("Medica").

The HealthSpan side is composed of health provider groups such as Allina Health System (the hospitals and nursing homes); Allina Medical Clinic (over 500 primary care physicians); the Allina Foundation, a 501(c)(3) organization; Allina Hospitals and Clinics Community Pharmacies, Inc.; Abbott Northwestern PHO, a nonprofit corporation; Allina Behavioral Health Services, a nonprofit corporation; Allina Specialty Associations, Inc., a nonprofit corporation;

Apple Valley Building Associates, a partnership; Burnsville Specialty Care Center, a nonprofit corporation; c4Health, Inc., a for-profit corporation; Hastings Surgery Center, an LLP; HealthSpan Integrated Provider Network, a nonprofit organization; HealthSpan Medical Management, a nonprofit organization; HealthSpan Services Company, a for-profit corporation; Kuljetti Print Systems, a nonprofit organization; Mobile Imaging Services, LLC; Mount Sinai Foundation, a tax exempt organization; Physicians Neck and Back Clinic, LLC; Print Services, Inc., f/k/a Marudas Business Forms Company, a for-profit corporation; Regional Imaging Services, LLC; St. Francis Regional Medical Center, a joint venture; Sherman Street Medical Condominium Association, Inc., a nonprofit corporation; Sister Kenny Foundation, a nonprofit corporation; Suburban Imaging, LLC; Twin City Oxygen Company, a for-profit corporation; United and Children's Ambulatory Surgical Center Association, a partnership; United Hospital Foundation, a nonprofit organization; West Health, Inc., a joint venture; West Suburban Health Campus, Inc., a partnership; and Woodbury Ambulatory Surgical Center, LLC.

These corporate entities own, control and staff 17 hospitals, three nursing homes, 47 clinics, with over 20,000 employees. It controls approximately 30 percent of the hospital market in the Minneapolis/St. Paul metropolitan area.

Section 2.3 Medica Health Plans.

The health plan side of Allina is composed of four corporations: Medica Health Plans, Medica Insurance Company, Medica Health Plans of Wisconsin and Allina Self-Insured, Inc.

The core health plan is Medica Health Plans. Medica is a nonprofit organization that is exempt from taxation pursuant to Section 501(c)(4). Medica is governed by its articles of incorporation (Exhibit 6). Medica provides health coverage to approximately 750,000 members. Medica generates about 50 percent of the revenue of the entire conglomerate.

Medica was originally created as Physicians Health Plan of Greater Minneapolis in December of 1974. In 1980 the company changed its name to Physicians Health Plan. In 1993 the company merged with Share HMO and changed its name to Medica Health Plans. (Exhibit 7).

Allina has the sole right to elect or remove four of the seven members of the Medica Board of Directors, to approve strategic plans and capital budget, to approve any merger or consolidation, and to select Medica's president. (Exhibit 6). The consumer members, while having a participatory role, have very limited authority as it relates to the governance of Medica. For instance, the voting rights of consumer members are limited to voting for the three "consumer" members on the Board of Directors. (Exhibit 6). No consumer member may sit on the Board of Directors, however, unless he or she is first "ratified" by Allina. (Exhibit 6). The consumer members are considered to be non-voting members for all other purposes, including board vacancies or board removals, election of officers, or any amendments to the articles of incorporation or bylaws.

At present the president of Medica also serves as an "ex-officio" director. While there are seven members on the Medica Board of Directors, over the past ten years there has been considerable disruption on its board. Since 1993 over 40 individuals have served on the board. (Exhibit 8).

Medica's financial statement is consolidated with three other companies to form the health plan side of Allina. The second company is Allina Self-Insured, Inc. ("ASI"), which is a taxable nonprofit corporation. It was originally formed as Select Care in 1983. ASI operates the Preferred Provider Organization ("PPO") which essentially offers the Medica Provider Network, enhanced with additional Minnesota providers, to insurers, national provider networks, union

trust funds, and self-insured plans. (Exhibit 9). The benefit provided by ASI to these clientele, who do not have their own health provider network in Minnesota, is to adjust or discount the fees of its providers for such clientele. While the PPO adjusts claims for about 250,000 enrollees, its net profit is usually under two million dollars.

The ASI Board is composed of directors elected by the HealthSpan Medical Management Board of Directors ("HSMM"). The president of ASI also serves as an ex-officio member of the Board. HSMM is a taxable nonprofit corporation which is governed by the Board of Directors appointed by Allina, its sole member.

Finally, the third and fourth corporations are Medica Health Plans of Wisconsin and Medica Insurance Company. Medica Health Plans of Wisconsin is a nonprofit tax-exempt corporation that has one voting member, Allina Health System. Medica Insurance Company is a for-profit insurance company. Neither of these companies have built up a policyholder base and neither of these companies generate much revenue for the conglomerate.

Section 2.4 The Medica Mission.

Medica is licensed as an HMO pursuant to the Minnesota HMO Act, Chapter 62D. The Legislature enacted the HMO Act for the expressed purpose of achieving greater efficiency and economy in providing health care services. Indeed, the very purpose of an HMO is set forth in the HMO enabling statute:

> Faced with a continuation of mounting costs of health care coupled with its inaccessibility to large segments of the population, the Legislature has determined that there is a need to explore alternative methods for the delivery of health care services, with a view toward achieving greater efficiency and economy in providing these services. Minn. Stat. 62D.01, subd. 2.

In other words, Medica has a clear statutory mission, which mission has been frequently repeated by Medica officers to the public, to manage health care costs and try to keep premiums

down. (Exhibit 10). The Minnesota Council of Health Plans, of which Medica is the largest member, describes "managed care" as follows:

> "The goal of managed care techniques is to direct the limited money that is available toward the right care, provided at the right time, in the right setting and at the right price." (Exhibit 11).

Section 2.5 The Allina Mission.

In contrast to the Medica side of the conglomerate, the multitude of corporations and legal entities which comprise the health delivery system, or the HealthSpan side, of Allina has a different mission. The statutes and regulations which regulate hospitals, nursing homes, physicians and other health providers make it clear that the primary mission of the delivery side is to act as caregivers to patients. The mission statement and activities of Allina also reflect expenditures that are broader than the health care of Medica patients. (Exhibit 12). For instance, Allina touts that it makes considerable contributions to the community, such as sponsoring the orchestra, celebrity golf tournaments, charitable events for other foundations and corporations, and grants for government studies. Indeed, Allina made frequent contributions to the Attorney General's Office prior to January 1, 1999 under the guise of a charitable donation. (Exhibit 13).

Allina Health System emphasizes the difference of its mission with that of Medica in its own Community Investment Reporting Guide, where Allina describes itself as follows:

> Allina Health System, as a not-for-profit, tax exempt organization, has a special relationship with the State of Minnesota and its citizens. We benefit financially through our tax exempt status. In return, we are obligated to serve the interests of the community as a whole, not just individual patients and plan members. (Exhibit 14)

Allina owns and controls several hospitals and nursing homes. It also owns nonprofit corporations which employ hundreds of doctors and thousands of employees who are engaged in patient care. The mission of the Board of Directors and officers of Allina Health Systems is

clearly to make sure that the hospitals, nursing homes and the organizations it owns and controls are adequately capitalized and financed to serve the need of patients. (Exhibit 15 & 16).

Putting it simply, the mission of the Allina Health System and Medica HMO are different and at times conflicting.

Section 2.6 The Duties of the Officers and Directors of Nonprofit Corporations.

It is clear that the primary purpose of Medica, as set forth in the statutes and by its own public statements, is to manage health care dollars and to contain premium costs. In contrast, the primary purpose of the HealthSpan side of Allina, governed by the directors and officers of Allina Health System, is to provide care to patients and maintain quality hospitals and clinics. Actions by the officers and directors of either corporation which defeat these goals are clearly impermissible.

The Medica public relations staff, not its officers or its lawyers, recently prepared a memorandum for the company officers and directors on their duties. The public relations ("PR") staff noted that the directors and officers are:

> ...legally responsible for making sure the organization remains true to its mission, safeguards its assets and operates in the public interest. (Exhibit 17).

The PR staff also pointed out that the duties of an officer and director include the duty of care, the duty of loyalty and the duty of obedience. The PR staff noted that officers and directors must give undivided allegiance to the organization and can never use information obtained as an officer or director except in the best interest of the organization. The PR staff also noted that officers and directors must be faithful to the organization's mission and not act in the way that is inconsistent with it. (Exhibit 17).

The PR staff notes that it is in the public's trust that the organization manages its funds to fulfill the organization's mission. (Exhibit 17).

The PR staff delineated ten basic responsibilities for the officers and directors of a nonprofit corporation, all of which are set forth in Exhibit 17. The PR staff noted that the officers and directors must be prudent stewards of the corporation's resources, must make sure that financial controls are in place, must monitor the ethical norms of the officers, must follow the mission statement of the organization, and must make sure that the chief executive has the moral and professional support needed to further the goals of the organization. (Exhibit 17).

Being a nonprofit corporation, the directors and officers of both Medica HMO and Allina Health Systems owe a fiduciary duty to each corporation to act in good faith, with honesty in fact, with loyalty, and in the best interest of the corporation. Minn. Stat. Section 317A.361. Two months ago the Minnesota Court of Appeals reviewed this fiduciary duty owed by a director and officer to the corporate membership in the case of *Shepherd of the Valley Church vs. Hope Lutheran Church of Hastings*, _____ N.W.2nd ____ (Minn. Ct. App. 2001). The *Shepherd* matter arose out of an intracongregational dispute that resulted in a faction of the Shepherd congregation voting to separate and create the Hope Lutheran Church, and to transfer Shepherd's church property to Hope. Intimately involved in this action was the former vice president of Shepherd named Collins, who became president of Hope. The Court of Appeals specifically discussed the high degree of the fiduciary duty owed by an officer and director to the membership of a nonprofit corporation:

> ...as the bearer of a fiduciary duty, the law imposed on Collins the highest standard of integrity in his dealings with the other officers of SOTV and the entire SOTV congregation, not just those who are members of the Hope faction.

While nonprofit corporations are generally governed by legal principles which are similar to those applied to traditional, for-profit corporations, the courts have drawn important distinctions. In *Manhattan Eye, Ear and Throat Hospital vs. Spitzer*, 715 N.Y.S.2nd575

N.Y.Sup. 1999) the court noted the unique characteristics of a nonprofit that justify close scrutiny of its directors' actions:

> Not-for-profit corporations operate under legal regimes designed for traditional for-profit corporations. However, fundamental structural differences between not-for-profit corporations and for-profit corporations render this approach incapable of providing effective internal mechanisms to guard against directors' improvident use of charitable assets. For example, in the for-profit context, shareholder power ensures that Boards make provident decisions, while in the not-for-profit context, this internal check does not exist. To put it another way, a nonprofit corporation has no "owners" or private parties with a pecuniary stake to monitor and scrutinize actions by the directors.

Section 2.7 Conflict of Interest: Referral Fees.

In 1993 Aspen Clinic, composed of approximately 120 providers at nine locations, received $10 million from Blue Cross Blue Shield of Minnesota ("BCBSM") as part of a joint venture in which Aspen would be managed by BCBSM. (Exhibit 18). In 1994 BCBSM paid Aspen, one of the largest multi-specialty clinics in the metropolitan area, an additional $14 million in exchange for agreement not to sell the clinic to a third party. (Exhibit 18).

By 1997 Aspen had grown to 160 physicians and appeared to be in trouble again. In June of 1997 it was announced that Aspen was negotiating with Fairview Hospitals concerning a merger with and/or acquisition by Fairview. (Exhibit 18).

The negotiations with Fairview were never completed and by late 1997 Allina and Aspen commenced their own negotiations. According to the February 26, 1998 minutes of the Allina finance committee, Gordon Springer and David Strand had been negotiating for a long-term transaction with Aspen. (Exhibit 19). Mr. Strand noted that Aspen had suffered significant operating losses in 1997 and 1998. The proposal was that Medica enter into a "bridge" agreement which would provide the clinic with sufficient cash and credits from Allina/Medica to allow it to remain a viable provider. Under the "bridge" agreement, Medica would invest cash, pool credits and lease allowances of approximately $8 million in March of 1998. (Exhibit 19).

During that month the parties would then negotiate for a long term (ten year) agreement whereby Aspen would agree to be a provider for all of Medica's health plan products and would use Allina facilities for services delivered to Medica enrollees. On May 23, 1998 Aspen and Medica entered into an agreement where Medica made a series of payments to Aspen in exchange for the referral of all Medica patients by Aspen to Allina owned hospitals. (Exhibit 20). Medica made commitment for the following payments:

A) "Care management fees" of $1 million for performing case management and utilization management services (such as determining the eligibility and coverage of a patient);

B) "Infrastructure support" to the clinic in the amount of $500,000 per year;

C) Payment of the lesser of $4,500,000 or the clinic's losses for the first quarter of 1998;

D) Payment on behalf of the clinic of $500,000 to an accounting firm;

E) Payment of $6,500,000 as a "fee enhancement" to assist the clinic in "transitioning" under the contract;

F) Interest free loans of $2,200,000 and $1,100,000 to help the clinic with "cash flow" (at an eight percent interest rate, Medica effectively imputed about $250,000 in interest to the clinic, which at the time was in a financial crisis that effected its ability to pay back the loan). (Exhibit 20).

Thus, Medica paid Aspen approximately $13 million in 1998 and $1,750,000 in 1999, which payments were in large part designed to build up patient referrals to Allina.

In March of 2001 Meredith Matthews, the chief medical officer of Allina (not Medica), evaluated the relationship between Allina and Aspen. The memorandum prepared by Dr. Matthews essentially states that Medica currently pays $1.5 million in enhanced payments over and above the fee schedule with Aspen because of the exclusive referral of Medica patients

to Allina facilities. (Exhibit 21). The memorandum also notes that the contract with Aspen for 2001-2003 still had not been negotiated.

It is the mission of Medica HMO to manage health care costs. Minn. Stat. § 62D.01, subd. 2; Exhibits 10-11. Prudence in the expenditure in the premium dollar will potentially lower the premium, the co-payments and the deductible payments of Medica members. The duty of the directors of Medica is to honor the mission of the Health Maintenance Organization. The directors of Medica, however, are also directors of Allina Health System, which has a mission to make sure that its hospitals and clinics are financially sound.

The conflict of interest between Medica HMO and Allina becomes clear as it relates to the Aspen transaction. In this case Medica is the clear loser, as it paid $13 million in 1998 and $1.5 million each year thereafter simply for additional referrals to Allina. It is not in the interest of Medica that premium dollars be utilized for referral fees on behalf of a nonprofit corporation that operates hospitals. Allina is the clear winner in the transaction, as it receives an additional volume of patients from the Aspen Clinic yet does not have to pay additional compensation to Medica.

The Medica management has claimed that the Aspen transaction was beneficial to Medica because Aspen reduced its fees with regard to services provided to Medica patients. This justification has little merit, however, as Exhibit 19 appears to indicate that there was no adjustment in the 1998 Aspen fee schedule. Indeed, the 2001 fee schedule is currently being negotiated between the parties.

The directors and officers of Medica HMO also serve as officers and directors of Allina. The officers and directors of Medica clearly compromised their duty of loyalty, their duty of obedience, and their duty of care to the mission of Medica HMO.

Medica has also entered into a "most favored nation" relationship with other physicians and clinics. Attached as Exhibit 22 is a list of approximately 19 clinics that are targeted as "most favored nation" clinics that will receive additional referral fees in exchange for surgical work on Medica patients being performed at Allina facilities..

Once again, Medica is the loser in these transactions. Payment of such additional fees unnecessarily raises premiums, co-payments and deductible payments of Medica members. Allina of course is the winner, as it is able to obtain greater revenue from the services provided.

These transactions clearly do not further Medica's mission of managing health care costs to achieve efficiency and economy in providing health care.

Section 2.8 Conflict of Interest: Crisscross Transactions.

Allina, Medica and the other organizations share a "central business office" ("CBO") through which certain services and/or products are provided by the holding company. Each entity pays the CBO, known as the "Allina service office," a monthly installment of the projected services it expects to receive.

While a CBO is not unusual in a large company, where the CBO separately bills each operating division for services provided, it is unusual that such intra-office accounting should occur between separate and distinct corporations, some for profit and some nonprofit. What is particularly troublesome is that all of the companies, processing in aggregate over $3 billion, use the same checking account. As a result, there is little ability to independently verify whether a transaction written out on the one checking account has been allocated to the appropriate entity. Rather, all checks are issued from the same account, and the only track on the transaction is the accounting entry that is made. In this age of computer technology, it is not difficult for such

tracking to become confused if a computer entry is modified. Thus, the validity of the financial statements becomes dependent upon the credibility of the officers of the nonprofit corporations.

It appears that the officers of Medica and Allina are willing to engage in crisscross transactions between the companies in order to confuse its members and the government. For instance, in late 1999 it became obvious to management that Medica's administrative expenses were extremely high and would be subject to criticism from the board of directors, regulators and policyholders. Accordingly, Mr. Strand and Ms. Vigil, the chief executive officer and the chief operating officer of Medica, respectively, held separate meetings with senior staff of Medica and Allina where they told the staff that Allina would not bill Medica for the balance due by it to the CBO. In exchange, Medica would pay an additional payment to Allina for additional services supposedly provided by its hospitals to United Behavioral Health.

At year-end 1999 Medica owed $7 million to the CBO. The purpose of the above crisscross transaction was apparently to lower the administrative ratio of Medica. The transaction makes it clear that the officers of Medica and Allina were able to use the assets of one company to pay for the liabilities of another, and that they were able to misrepresent the transaction and consequently the financial operations of both Medica and Allina to their respective boards of directors, the policyholders and the state.

The above transaction, not documented in writing, and is known only because of the statements of independent witnesses. It is unknown whether other crisscross transactions have occurred between these nonprofit corporations which effect the financial statement of one of the companies.

The above transaction constitutes a serious breach by the officers of their duties of loyalty, of care and of obedience to the mission of each company.

Section 2.9 Conflict of Interest: Prefunding Arrangements.

In 1998 Allina Health System needed capital for improvements to its hospitals and clinics. Because it did not have sufficient cash flow to support such capital improvements, the company and certain subsidiary corporations formed a Credit Group which entered into a Master Trust Indenture with Norwest Bank Minnesota, which acted as the trustee for the issuance and repayment of $150 million in bonds. (Exhibit 23).

It is apparent that Allina will need to raise more money in the public market in the near future. Allina Health System manages approximately 12 hospitals, a nursing home, and 50 clinics with over 500 physicians. The advanced medical technology, equipment and facilities necessary for these operations are capital intensive. (Exhibit 25). Allina acknowledges that "capital is the key to Allina's survival" (Exhibit 24), and projects a need for $700 million in capital expenditures over the next five years. (Exhibit 25). Allina also acknowledges that the earnings/cash flow of the total Allina enterprise is insufficient to generate the required capital. (Exhibit 24). Allina has been advised that the hospital's division and Medica must attain operating margins higher than past performance, with Medica needing to maintain a two percent operating margin in order to pay for the financing of such capital improvements. (Exhibit 24).

In order to help Allina Health System be able to cash flow its current bond obligations, Medica advances approximately $30 million to Allina to "pre-fund" Allina's accounts receivable. (Exhibit 26). This pre-funding arrangement is referred to as "paying to date of service," which means that Medica is paying for services rendered for which it has not received an invoice and for which it has not received the necessary documentation which, in the normal course of business, an insurer should review in order to determine whether the treatment is reasonable and necessary.

Allina acknowledges that the pre-funding arrangement is necessary because Allina's cash flow position is insufficient to maintain its bond rating. (Exhibit 26). The financial impact of the transaction is that Medica loses, at an eight percent investment rate, approximately $2.4 million in investment income. (Exhibit 26). As important, Medica is at risk by essentially "loaning" Allina $30 million at a time that Allina admittedly has an insufficient cash position to justify its bond rating. (Exhibit 26).

Allina acknowledges that this pre-funding arrangement is not typical. (Exhibit 26). It also acknowledges that the $30 million "pre-funding" would not likely be considered an admitted asset with insurance regulators. (Exhibit 26). This in part is because, since Allina is an affiliate and has insufficient cash flow to maintain its bond rating, the entire $30 million "loan" may technically be at risk. (Exhibit 26).

The above transaction clearly is not to the interest of Medica. At an eight percent investment rate Medica loses approximately $2.4 million in investment income. Medica also places $30 million of its equity at risk if Allina should default on its obligations. It also severely compromises Medica's responsibility, which other insurers and HMOs undertake in the normal course of business, to review a health provider's invoices before payment in order to determine if the services were reasonable and necessary.

The officers and directors of Medica, by permitting Medica to engage in a pre-funding transaction with Allina, have compromised their duty of loyalty, of due care and of obedience to the mission of Medica.

Section 2.10 Conflict of Interest: Upcharging on Invoices.

As noted above, Medica pre-funds Allina's services, which essentially means that it pays for services rendered by Allina without reviewing and receiving an invoice. The review of a

health provider's invoice to determine the reasonable need of the service provided is a core function of an HMO or insurer. Indeed, Select Care, an affiliate of Medica, claims that it saves approximately 25 percent of invoiced services from health providers by engaging in such utilization review. (Exhibit 9).

The need to review such invoices is particularly important if the health provider is under investigation for making errors in the coding of physician services. This is precisely the case with Allina in the mid-1990s. In 1994 Allina's predecessor organization, Health One, entered into a stipulation agreement with the Office of Inspector General as it relates to upcharging by its transportation division. (Exhibit 27). As part of that settlement Allina agreed to undergo periodic audits by its own auditor to determine if its service charges are in compliance with its contracted obligations to the government. (Exhibit 27). The directors and officers of Medica are aware that the Office of Inspector General is currently investigating Allina as it relates to upcharge errors discovered during these compliance audits by Deloitte and Touche, Allina's auditors. (Exhibit 28). The officers and directors of Medica are also aware that Allina publicly concedes that it overbilled the federal government approximately $19 million in services, but publicly argues that this overcharge should be reconciled with approximately $19 million in "undercharges" by Allina. (Exhibit 28) Regardless of whether Allina's argument concerning the reconciliation of overcharges and undercharges is credible, it is obvious that Allina has a significant problem with regard to coding for its services. In such a circumstance, it is clearly to the interest of Medica's mission that it review in detail the invoices of Allina affiliates before payment is made to make sure that proper management of services is being undertaken.

By permitting Medica to pay a health provider before receiving the invoices, in a situation where the health provider is under a grand jury investigation as it relates to invoicing

errors, the Medica Board of Directors and officers are violating their duties of loyalty, of care and of obedience to the mission of Medica.

Section 2.11 Conflict of Interest: Fee Schedule Modification.

A critical function in the operation of an HMO is the contracting and credentialing of health providers. As noted by the Minnesota Council of Health Plans:

> The goal of managed care techniques is to direct the limited money that is available toward the right care, provided at the right time, in the right setting and at the right price. (Exhibit 11).

The Minnesota Council of Health Plans further describes managed care as follows:

> Managed care is a way for employee health plans, government programs and health plans to simultaneously improve quality and reduce costs by becoming more actively involved in directing payments where they will do the most good in negotiating lower fees." (Exhibit 11).

A key component to negotiating lower fees is to have a contract with the health provider which defines the utilization review process of the HMO. In addition, the contract locks in the price of services to be provided by the clinic, which is a critical component in calculating the premium of an HMO. Indeed, Medica executives state that provider charges are the leading cause of increased premium being charged to members. (Exhibit 29).

Allina affiliates provide approximately 20 percent of the health payments of Medica. (Exhibit 30). Accordingly, the payments to Allina, and the contracts upon which such payments are calculated, are clearly an important component in the calculation of Medica's premium.

The "negotiation" between Allina, as a health provider, and Medica, as an HMO, resulted in an agreement for the Allina fee schedule which was to take effect on January 1, 2001. The agreement was binding on both parties. The agreement also established a fee schedule between SelectCare, a preferred provider organization affiliated with Medica, and Allina.

In spite of this contractual commitment by Allina, it gave notice to Medica on January 31, 2001 (31 days after it took effect) that it would reopen the contract and "renegotiate" the fee schedule. (Exhibit 31). Aaron Reynolds, the Chief Financial Officer of Medica, states that the "renegotiation" is due to the "cash needs" of Allina. (Exhibit 32). The ability of Medica to negotiate the fee schedule with Allina, which controls the appointment of a majority of the Medica board and the appointment of Medica's president (who in turn appoints all other officers of Medica) is questionable. Indeed, the dubious ability of Medica to manage its health care costs as billed by Allina is underscored by a March 19, 2001 Medica document, where Medica staff raised the question of whether it was even in a position to negotiate the terms dictated by Mr. Strand, Allina's Chief Operating Officer, in his January 31, 2001 directive. (Exhibit 33).

The fee schedule dictated by Allina provides in 2001 for a fee increase of [redacted] percent over that contained in the January 2, 2001 agreement. (Exhibit 33). It also provides for a fee increase of [redacted] percent for the year 2003 which is over and above the contract that was effective on January 1, 2001. (Exhibit 33). The above price modification underscores that the governing structure of Allina and Medica creates an environment where the officers and directors of Medicare cannot realistically negotiate with Allina on an arm's length basis. Simply put, the ability of the officers and directors of Medica to be loyal to the HMO mission of managing costs is severely compromised under the current governing structure.

Section 2.12 Conflict of Interest: [redacted]

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Section 2.13 Conflict of Interest: Charitable Giving.

As noted in the bond offering of Allina Health System in 1998. Medica HMO is not part of the Allina Credit Group because of regulatory concerns. (Exhibit 23). The HMO statutes and regulations make it clear that Medica should not place its policyholder reserves (its net worth) at risk for use by the Allina Health Providers.

The Allina Foundation is a separate nonprofit corporation which is controlled by Allina Health Plans. According to the bond offering prospectus:

> The Allina Foundation resulted from the 1996 merger between HealthSpan Community Trust Fund and the Medica Foundation. ... Historically, the

Foundation has received its funds from the investment earnings and statutory reserves from Medica. (Exhibit 23).

It is apparent that the dependence of the Allina Foundation on Medica continues. On January 31, 2001 Medica pledged another $2 million to the Allina Foundation. (Exhibit 41). Five days later, on February 5, 2001, Allina Health System announced that it would initiate three projects for 2001. (Exhibit 42). The first project is to hire Dr. Nicole Lurie to report directly to Jan Malcolm, the Commissioner of Health, on developing a "Minnesota Model for Prevention." The second project is to contribute $150,000 to the Minnesota Chamber of Commerce which will administer a CHAT game that will "educate" Minnesota employees about the costs, tradeoffs and priorities inherent in health care spending. The third project is to contribute $200,000 to the Minnesota Department of Public Safety to launch a Day One Center, which will provide battered women and families access to immediate services with one phone call. (Exhibit 42).

In addition, there appears to be a fourth project, which is a contribution to the Department of Public Safety to encourage safe driving habits on Minnesota highways. (Exhibit 43).

It is noteworthy that Medica's directors and officers have not adopted any principles as it relates to charitable giving. Rather, Medica appears to simply turn over its funds to an Allina controlled foundation which makes its own determination on how to spend Medica's funds. It is noteworthy that the memoranda discussing the charitable projects for the year 2001 emphasize that the projects will give broad exposure to Allina. (Exhibit 43). No similar exposure is given to Medica. It is difficult to surmise why these charitable transactions are beneficial to Medica members, particularly where the membership is faced with repeated and steep increases in health premiums. At a minimum, if such giving is necessary in order for Medica to maintain its tax exempt status, its own board of directors should be responsible for how the funds are expended.

The abdication by the directors and officers of Medica as it relates to charitable giving of the members' premium appears to violate their duties of loyalty, of due care and of obedience to Medica.

Section 2.14 Conflict of Interest: Senior Population.

The aging of the Minnesota population (Exhibit 44) may likely raise the greatest conflict between the interests of Allina Health System and the interests of Medica. On the one hand, Medica has suffered severe losses in the past with regard to its Medicare insurance and HMO products. On the other hand, the hospitals owned by Allina Health System generate their highest income from the treatment of Medicare patients. The financial stability of Medica and its mission of trying to contain the increasing cost of health premiums demands that its board of directors and officers be independent of pressures from Allina Health System, which currently controls the HMO.

In 1998 Medica issued four different health plans to 69,000 Medicare recipients, which collectively incurred $3.81 million in operating losses for the company. (Exhibit 45). Although Medicare policies accounted for less than 6.5 percent of Medica's total enrollment in 1999, it provided 23 percent of its revenue and was responsible for 20 percent of its net *operating* loss. (Exhibit 46).

The original policy issued by Medica to senior citizens is described as a Medicare Risk policy. A senior who purchases a Risk policy essentially directs the Health Care Financing Administration ("HCFA") to pay a monthly premium to the HMO. The senior also pays the HMO a monthly premium. In exchange for the premium payments from both HCFA and the policyholder, Medica assumes all risks of HCFA in insuring the senior citizen pursuant to the terms of the Risk policy. The HMO may not bill back HCFA for any losses sustained on the

policy. In 1998 the Risk policy was issued to 33,127 seniors and had incurred a loss of $2.45 million. The company was no longer selling it except in a limited manner in four metropolitan counties. (Exhibit 46). By the year 2000 the company reduced its participation to three metropolitan counties.

Another product Medica sells to seniors is known as the Select policy. The Select policy is a standard Medicare supplement policy, offering either a "basic" or an "extended" plan. Under a Select policy the health provider sends a bill to HCFA for services rendered to the Medicare recipient and HCFA pays a percentage of the services pursuant to an established fee schedule. HCFA then forwards the balance of the bill to Medica which then pays a portion of the balance owed to the provider. In 1998 almost 89 percent of this market was dominated by BCBSM. (Exhibit 47). Medica was the next highest underwriter with about eight percent of the business. (Exhibit 47). In 1998 Medica issued the Select policy to 13,214 members and incurred an operating loss of $2.92 million. (Exhibit 45). While the Select policy was sold on a statewide basis, the marketing effort was substantially reduced. (Exhibit 48 & 52).

The third policy issued by Medica is known as a dual option policy or a MSHO. If a senior is so impoverished that he or she is on medical assistance and cannot afford a Medicare Supplement policy, the state ends up paying substantial money for the co-payment of health care not covered by HCFA under the Medicare Act. Accordingly, it becomes advantageous for the State of Minnesota to pay the HMO for a policy and to collect the Medicare benefit. In 1998 Medica issued only 1,852 policies to MSHO enrollees but made a $1.852 million profit (almost $1,000 per member per year!) on the policy. (Exhibit 45).

Finally, Medicare issues a "cost" policy to 20,782 enrollees and essentially broke even on the sale of the policy. (Exhibit 45).

In December of 1999 Medica projected that, as the age of its Medicare policyholders increase, the health care cost of its Risk policy will escalate. (Exhibit 44). It questioned the long-term viability of its Risk product due to the advancing age of the policyholders (Exhibit 44), and the inability of Medica to raise the premium without suffering adverse selection (where only the seniors in ill health would be willing to pay the high premium while the healthier, lower cost, seniors will purchase a different policy elsewhere). (Exhibit 44 & 49). The losses on the Risk policy were projected to triple in 1999. (Exhibit 50).

In December of 1999 Medica gave an extremely poor review of the Secure product. It noted that in 1998 the Secure product accounted for six percent of the total seniors' revenue, 25 percent of the senior membership and nearly 80 percent of the operating losses. (Exhibit 48). The company described its care management and underwriting of the Secure policy as poor (Exhibit 51) and noted that it was projected to lose another $2.9 million in 1999. (Exhibit 48). In December of 1999 Medica noted that "robust marketing of the Secure product was discontinued in 1997 when the product became unprofitable." (Exhibit 52). It also noted that, while Medica's Secure "basic" product was already priced 17 percent and 28 percent over HealthPartners and BCBSM, respectively (Exhibit 53), it still needed to increase rates in order to chase away high loss customers. (Exhibit 54).

Accordingly, the company proposed to decrease the senior enrollees by increasing rates in geographic areas such as St. Louis County and Chisago County which had high loss ratios. (Exhibit 54). With regard to new membership, the company proposed to initiate rigid underwriting criteria where only "best in class" would be underwritten. (Exhibit 55). The company also proposed to adopt a retroactive underwriting technique where policies would be rescinded if the applicant made a misrepresentation on the application. (Exhibit 55). The

company proposed to add a number of broad questions to the application which would enable the company to prevail in arguing that a policyholder had made a misrepresentation. (Exhibit 56). The company also proposed to lower broker commissions (Exhibit 57), to reduce its provider network (Exhibit 58) particularly in the greater metro area and in Duluth (Exhibit 59) and perhaps even restrict the senior network to Allina providers. (Exhibit 59). In short, in December of 1999 the company projected continued losses for the senior market in 2000 (Exhibit 60) and noted that, because its rates are higher than HealthPartners and BCBSM, it will continue to have more losses due to an unfavorable risk pool. (Exhibit 61). The company concluded that the losses were due to insufficient rates, high medical costs, unfavorable product design, poor underwriting, weak market penetration, high administration costs and high taxes. (Exhibit 49). The company acknowledged that its rates were already higher than HealthPartners and BCBSM, both of which had made a profit in the Medicare market in 1998. (Exhibit 61).

In summary, it is clear that Medica has had a difficult time obtaining profitability in the senior market. Its historic experience with the Risk policy was abysmal and its experience with the Select policy was also unfavorable.

While the company projected the sale of approximately 1,000 new policies in 2000, it was also implementing a pricing, underwriting and provider network strategy with the goal of reducing the number of existing policies issued to senior citizens. (Exhibit 62).

The above observations were reported by Medica in December of 1999. During the next six months Allina Health System also undertook its own market segment study with regard to the profitability of senior citizens at its hospitals. Its analysis concluded that senior citizens were the most profitable patients for the hospitals (Exhibit 63) and noted that the senior population will increase over the next several years. (Exhibit 64). The company noted that the Medicare patient

not only generated higher revenue per hospital stay (Exhibit 63) but also that the services needed by seniors aligns well with Allina's expertise. (Exhibit 65). Allina's conclusion was that the Medicare patient is the prototypical patient desired by the conglomerate and that it is in the best interest of Allina to solicit more seniors. (Exhibit 66).

Thus, during the first six months of the year 2000 there was a clear conflict of interest between Allina Health Systems and Medica as it related to the Medicare patient. Medica steadily lost money on Medicare policies while Allina Hospitals clearly made money on the treatment of Medicare patients. Accordingly, it is assumed that the Medica directors and officers should have been trying to reduce loss exposure in the senior market in 2000 while the Allina directors and officers should have been trying to increase its treatment of the senior market. The conflict of interests between Allina Health Systems and Medica HMO was resolved with a predicable outcome. At the end of year 2000, less than one year after the dire evaluation made by Medica as to its Medicare market, the HMO concluded that Medica's Medicare profitability is projected to improve as the plan transitioned away from risk-bearing products. (Exhibit 67). This is interesting because in December of 1999 Medica noted that its greatest losses came from the non-risk Secure policy. (Exhibit 48).

One wonders whether Medica's decision to re-enter the senior market is due to a thoughtful and knowledgeable rejection of conclusions it made less than one year before, or whether the decision to enter the market is due to pressure from Allina Health System to increase its population of Medicare patients. Because of the continuing pressures by Allina Health System on Medica, and because of the conflicts of interest discussed earlier in this text, there is substantial concern that Medica is selling its policies not to lower premium costs or to manage health care costs but simply to channel more profitable patients to the Allina Hospitals.

Section 2.15 Conflict of Interest: c4 Health.

c4 Health is a company that proposes to use the Internet to offer a health product directly to consumers. (Exhibit 68) c4 Health proposes that its services will be utilized by commercial insurers which offer medical spending accounts to consumers. (Exhibit 69). Under the c4 Health proposal the commercial insurer will offer the consumer the ability to determine the best physician for his needs, balancing geography, convenience, expertise and price, from a c4 Health website. (Exhibit 70). The c4 Health website will include a chart where providers post their co-payment levels and can set different co-pays for different times and days of the week to level out their patient load. (Exhibit 70). c4 Health proposes that each consumer will transfer his or her medical data to the c4 Health database so that providers selected by the consumer can review the information and assist in making recommendations as to the appropriate physician to see or treatment to obtain. (Exhibit 70). c4 Health will allow online appointment scheduling, online physician correspondence, online prescription refills, integrated billing, automated patient visit registration by physicians, instantaneous verification of patient enrollment (for the physician), and a reduced fee schedules. A more detailed description of c4 Health is attached as Exhibit 70.

It is apparent that a substantial amount of capital has been expended in developing the software for c4 Health. According to an Allina memo dated December 13, 2000, funds were committed by the Allina Board of Directors in March of 2000 to create the business model for c4 Health. (Exhibit 71). The total financial commitment of Allina and its affiliates is not known.

In June of 2000 David Strand, the Chief Operating Officer of Allina, sent a voicemail to Karen Vigil, the Chief Operating Officer of Medica, which discussed the manner in which the c4 Health transaction should be structured. (Exhibit 72). According to the voicemail, Mr. Strand and Ms. Vigil wanted the c4 Health corporation to be set up as a for-profit corporation and not as

a nonprofit corporation. (Exhibit 72). Even though the Allina minutes in November of 2000 indicate that the capital expenditure for technology to establish c4 Health was made by Allina. In March of 2000, Mr. Strand stated in the June 23, 2000 voicemail that c4 Health is a Medica subsidiary. Mr. Strand also proposed that c4 Health be a for-profit activity because "there is also an opportunity for individuals to have a private equity interest, which could conceivably come around this Health E team stuff if it were to play out." (Exhibit 72). Mr. Strand emphasized that it was important for the officers to be careful about the accounting to make sure that the individual stockholders are protected from any claim that it was usurping the investment activity of Allina or Medica. (Exhibit 72).

While the work for c4 Health was completed in March of 2000 (Exhibit 71) and while in June of 2000 Mr. Strand and Ms. Vigil decided to structure c4 Health as a for-profit corporation owned by Medica, the December 13, 2000 memo to Allina indicates that Allina (not Medica) owns the company. (Exhibit 73). According to Allina's minutes, on November 30, 2000 c4 Health filed to become a for-profit corporation under the Delaware General Corporation Law. (Exhibit 74). As part of this action, Allina Health System received 4,862,500 shares of common stock at $1 per share. The stock was issued in exchange for a contribution of $4,500,000 in intellectual property assets and $362,500 in cash. (Exhibit 74).

The documents make no reference as to whether stock options were issued to the officers of c4 Health, who also are officers of Allina Health System: Gordon Sprenger, David Strand and David Pryor.

The ease with which the ownership of c4 Health technology was transferred from Allina to Medica and back to Allina should be of major concern to the directors and officers of each company. It should also be a major concern to the directors of Medica and Allina that there was

discussion by the officers of Medica and Allina that private stock should be issued to individuals, presumably the officers of c4 Health. While it is unknown whether stock options were issued, it does not appear that any discussion regarding the issuance of such stock options to officers of either Allina or Medica had ever been discussed at a board meeting of either company.

While the entire transaction regarding the establishment and creation of c4 Health technology and its corporation is unknown, it is known that a conflict of interest appeared between Allina and Medica with regard to the source of the funds that were invested and the ownership of the technology that was created.

Section 2.16 Conflict of Interest: General.

The State has reviewed the minutes of the board of directors of Allina and Medica. It is apparent that both boards meet at the same time and conduct all of the activities for both companies at the same time. It is apparent that the decisions of Medica are being made by the Allina Board and are simply being ratified by the Medica Board which are, as noted above, appointed by Allina. Indeed, the minutes of the Allina Board relegate Medica to simply being a "division" of the company. (Exhibit 75). The environment in which the Allina and Medica board meetings are conducted appear to be such that the directors and officers of Medica cannot and do not exercise independent judgment as to the best interests of the statutory mission of Medica.

It is also noted that one checking account is used for all of the corporations. The difficulty with using one checking account is that a computer entry is the basic evidence of proper allocation of expenditures. The use of one checking account means that a simple computer entry can modify the ownership of an asset or liability and can modify the source of an expenditure or receipt of revenue. The use of one checking account presents a high potential for

abuse for the wide variety of for-profit and nonprofit corporations entangled in this conglomerate.

Section 2.17 Conflict of Interest: Pharmaceutical Rebates.

Section 2.18 Conflict of Interest: Stop Loss Commissions.

Section 2.19 Conflict of Interest: Medformation Referrals.

Section 2.20 Conflict of Interest: Other.

Section 2.21 Conflict of Interest: Conclusion.

There are obvious conflicts of interest between the statutory mission of Medica as a nonprofit HMO and the stated mission of Allina Health System. The current corporate structure of the Allina Health System conglomerate where the management of Medica is controlled by

Allina, raises substantial questions as to whether the officers and directors of Medica can make decisions in the best interests of its enrollees.

During the three-year period that was the subject of the review at least the following conflicts of interest were discovered as it relates to the following transactions:

1) The payment of referral fees by Medica to health providers who in turn referred patients to Allina Hospitals.

2) The use of crisscross transactions between Medica and Allina in order to mask the true administrative costs of Medica HMO.

3) Medica adopting a technique of "pre-funding" approximately $30 million to Allina facilities even though they have not yet received an invoice to review to determine whether the services were reasonable and necessary.

4) The payment of fees to Allina prior to reviewing invoices, at a time when Allina is under investigation for upcharging invoices.

5) The unilateral decision by Allina to modify the fee schedule that was in existence between Medica and Allina in January of 2001.

[redacted]

7) The transfer by Medica of approximately $1 million per year to Allina for purposes of charitable giving.

8) The decision by Medica to re-enter the senior market only months after it determined that it was losing substantial sums of money in the senior market, at a time that Allina was making large income from the senior market.

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9) The transfer of the technology and corporate ownership of c4 Health between Allina and Medica.

If anything is clear about the health care market in Minnesota, it is that employers and policyholders are extremely frustrated with the high premium increases they have paid over the past several years. The above transactions were all undertaken to the detriment of Medica as a nonprofit HMO and have significant impact on its financial statement. Given the fact that the statutory mission of Medica is to manage costs and control the rising cost of health care premiums, it appears to be inappropriate for Allina Health Systems to be controlling the management of Medica.

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