Issue Brief
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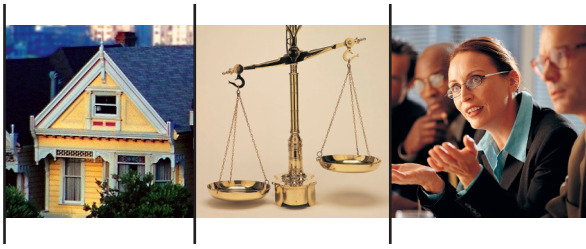

FOR-PROFIT CONVERSION AND MERGER TRENDS AMONG BLUE CROSS BLUE SHIELD HEALTH PLANS

by Joy M. Grossman and Bradley C. Strunk

Blue Cross and Blue Shield (BCBS) health plans, which insure nearly one in three Americans, historically have operated as local, nonprofit or mutual organizations.[1] However, since the mid-1990s, BCBS plans increasingly have converted to for-profit companies and merged with Blue plans in other states. State insurance regulators, charged with weighing the costs and benefits of conversions and mergers to consumers, often wrestle with the legal complexities of these deals, according to Center for Studying Health System Change (HSC) site visits to 12 nationally representative communities. Although state regulatory scrutiny has slowed the pace of conversions recently, conversion activity is likely to accelerate again as the political and regulatory landscapes shift and plans adapt conversion strategies. The limited evidence available from HSC site visits and conversion proceedings suggests that conversions and mergers have had neither significant negative nor positive effects on consumers.

For-Profit Conversions and Mergers Likely to Resume

Blue Cross and Blue Shield plans are either the largest or among the largest health plans in nearly every local health insurance market in the United States. As of June 2003, 88.3 million Americans were enrolled in Blue plans, a 28-year high. While the Blues have a long history of being based locally and operating on a nonprofit basis, a 1994 decision by the BCBS Association, which licenses the use of BCBS trademarks, to allow for-profit organizations to hold primary BCBS licenses set in motion a chain of for-profit conversions and mergers among Blue plans across state lines.

While only four of the 41 independent Blue plans are for-profit, these plans operate subsidiaries in 14 states and Puerto Rico and cover more than a quarter of BCBS enrollees. Two consolidator Blue plans have been key players in the transformation of the Blues: Anthem Inc., which owns Blue subsidiaries in nine states, and WellPoint Health Networks Inc., which owns Blue subsidiaries in four states. In October 2003, these two for-profit plans announced a merger to form WellPoint Inc. Subject to regulatory and shareholder approval, the deal is expected to close in 2004. Another Blue plan, Premera, has conversion applications pending in Washington state and Alaska.

Recent regulatory actions, however, have dampened what was expected to be a steady flow of plans applying for conversions and mergers, mirroring a similar response by plans to regulatory setbacks that occurred when BCBS plans first began converting in the mid-1990s. Nevertheless, it is likely that conversions and consolidation

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This Issue Brief is based on findings from four rounds of HSC site visits between 1996-97 and 2002-03 to the following 12 nationally representative communities: Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y. Reflecting national trends, the Blue plans operating in these communities fall into three groups: three plans are for-profit subsidiaries of either WellPoint or Anthem, nine plans are nonprofit and two additional nonprofits were actively considering conversion in 2002-03. This Issue Brief also draws on conversion and merger proceedings, interviews with industry experts and a literature review.

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among the Blues will resume. HSC's tracking of this transformation of the BCBS system nationally and through its site visits since 1996 (see Data Source) provides a unique opportunity to assess why some Blue plans have pursued conversions and mergers and others have remained nonprofits; the dynamic nature of the regulatory environment and its effect on plans' conversion decisions; and the potential costs and benefits of these deals to consumers.

Why Convert?

Clear differences of opinion exist among BCBS plan executives about the merits of converting and merging to compete effectively and maintain financial viability. These differences reflect variations in mission and business strategies, senior management perspectives about the best way to run the companies and the competitive environment.

The most commonly noted benefit of conversion is improved and more flexible access to capital through public markets. Capital can be used to improve operations and enhance competitiveness by financing information systems, product and network development, service improvements and clinical management strategies. Increased capital also can shore up the reserves of money-losing plans.

Some plans seek capital to fund acquisitions, which offer the opportunity to increase profitability by improving the acquired plan's operations and spreading fixed costs over a larger number of enrollees. While both for-profit and nonprofit organizations are able to raise capital for all of these purposes through debt financing, for-profits alone have the added flexibility to seek capital through the stock market.

Plan executives often believe that a for-profit compensation structure and regular shareholder pressure to meet performance targets provide incentives to improve efficiency. Consumer advocates and other conversion opponents suggest, however, that management's opportunities for increased compensation are the primary motivation to convert.

Conversion is a necessary step for nonprofit Blue plans that want to merge with a for-profit consolidator. By becoming part of a larger company, plans can draw on the capital, nationally recognized management expertise and best practices of parent companies such as WellPoint and Anthem. Some argue that scale economies are particularly important for local Blue plans competing against national commercial health plans, such as UnitedHealthcare or Aetna. Because of their smaller market size, local Blue plans may have higher per-enrollee costs than national plans and may not be able to offer similar services at competitive premiums.

While some Blue plans initially remained independent upon conversion to for-profit status, WellPoint or Anthem eventually acquired nearly all of them. Market observers expect that the recently converted WellChoice Inc., operating in the New York City area, and other plans that convert in the absence of a merger, will become part of the newly formed WellPoint, despite some plans' stated intentions to remain independent.

Why Not to Convert?

Not all senior BCBS executives favor conversions and mergers. Management at most of the nine nonprofit plans in the 12 communities expressed strong commitment to the traditional BCBS nonprofit mission to serve the local community. This mission includes assuring that as many people as possible have access to affordable, high-quality health care and that the company's earnings are reinvested for subscribers' benefit rather than distributed to shareholders.

These executives believe that they can compete effectively and maintain financial viability without converting and merging. Most Blue plans have large market share and often are the dominant plan in their geographic market with little competition from national insurers. The recent surge in preferred provider organization (PPO) enrollment at the expense

of health maintenance organization (HMO) enrollment has strengthened this market position. The Blues also typically have the largest provider networks, which are attractive to purchasers, and the plans' large market shares provide an advantage over other plans in negotiating provider payments.

Like health plans generally, most nonprofit Blue plans have improved their bottom lines over the past few years, reducing financial pressures to convert. Being nonprofit does not preclude developing lines of business that add to surpluses. For example, BCBS of South Carolina has a successful for-profit claims processing subsidiary that is a major contractor for federal insurance programs and other Blue plans.

Most of the nonprofit Blue plans in the 12 markets believe that, since they are not pursuing a strategy of acquiring other Blue plans, they have adequate access to capital through surplus reserves and bank loans. Some plan executives are skeptical that there are many gains from merging across state lines. They do not believe their plans would benefit from significant scale economies, and, unlike other health insurers, the Blues' exclusive market areas mean that mergers do not result in larger local market share or increased provider negotiating leverage. The success of the BCBS Association-sponsored Blue Card program that allows Blue plan enrollees to access other Blue plans' networks across the country also has reduced the need to consolidate to serve multistate employers.

The CEOs of many of these plans also strongly prefer retaining the leadership control they have as heads of independent nonprofits. They do not have to respond to shareholders' demands for regular earnings growth in a cyclical business or defer to management of an out-of-state parent company. Some plans that wish to remain nonprofit but have identified benefits to mergers for their plans have joined with other nonprofit plans through ownership or affiliation. At least six such nonprofit Blue parent organizations are operating today in 13 states and the District of Columbia.

Regulatory Environment Affects the Decision to Convert

Plans also must assess the likelihood of regulatory approval in deciding whether to pursue a for-profit conversion. Intense public scrutiny has been commonplace in review proceedings, and regulators have sometimes slowed the pace of these activities, altered their terms or even disapproved them altogether.[2] While regulators' mandates vary by state, most are required to make the following determinations in deciding whether to approve a proposed conversion and related merger:

- whether the assets of the plan are charitable and belong to the public, and if so, that the fair market value of the plan will be set aside for the public;[3]
- that the plan's management and board of directors will not gain financially from the conversion itself; and
- that consumers will benefit from, or at a minimum, will not be harmed by, the transaction.

The regulatory climate for conversions and mergers has been dynamic, shifting in response to state politics and other states' conversion experiences. Following the conversion of Blue Cross of California in 1996, a number of plans attempted conversions and mergers, but regulatory and judicial hurdles soon slowed the pace of such activity. Much of the scrutiny during this period focused on clarifying whether the assets of nonprofit Blue plans belonged to the public and, therefore, should remain in the public trust upon conversion as well as the value of those assets. Most conversions were approved once the plans agreed to set aside millions of dollars in the public trust, and it soon became standard for plans to propose upfront that assets be earmarked for charitable or public purposes.

As a result of this strategic change, regulators became more hospitable to these transactions, and the conversion and merger pace picked up in the late 1990s, despite the fact that most of these transactions continued to face significant delays as regulators and consumer advocates challenged terms of the agreements. Anthem, WellPoint and other plans began jockeying to acquire Blue plans across the country, often targeting specific regions and creating a frenzy of offers and counteroffers for plans seeking to merge.

More recently, the regulatory environment appears to have shifted again. Marking the first time a Blue plan conversion was rejected outright, the Kansas insurance commissioner denied BCBS of Kansas' proposal to convert and merge with Anthem in February 2002 because of concerns about higher health insurance premiums. Then, in March 2003, the Maryland insurance commissioner rejected CareFirst Inc.'s proposal to convert and merge with WellPoint because of concern, among other things, that the plan—the BCBS licensee for Maryland, Delaware and the Washington, D.C., area—was undervalued and the transaction contained improper executive bonuses. Following these decisions, BCBS of North Carolina withdrew its conversion application, and Horizon BCBS of New Jersey, which had been expected to file an application, abandoned conversion activities.

These high-profile events suggested to many that the regulatory climate was once again more hostile to conversions, increasing the likelihood that applications would be rejected. One state insurance commissioner offered an alternative interpretation, saying that regulators "have become more well versed in what the issues are and how to look at [them]. As a result, I think they are becoming more careful."[4]

While other plans are expected to forgo active consideration of conversions and related mergers in the short run, these activities are likely to resume, much as they did in the late 1990s. Anthem and WellPoint believe that the underlying factors driving conversions and mergers will remain compelling for some nonprofit Blue plans and that the newly combined company will be well positioned to resume acquisitions. Moreover, the experience in the late 1990s

suggests that the pace of conversion and consolidation is likely to pick up again with changes in the political and regulatory environment—such as turnover of elected officials—along with revised conversion strategies on the part of plans as they identify ways to satisfy regulators' concerns.

Consumer Impact

While Kansas is the only state to date to reject a conversion application on the basis of concerns about potential harm to consumers, regulators have invested significant effort in assessing the potential benefits and costs for consumers of for-profit conversion and related mergers with out-of-state plans.

Opponents of conversions and mergers usually highlight the potential for a number of negative outcomes. They claim that a for-profit plan is likely to enhance profitability by increasing premiums more than it would have as a nonprofit. Opponents also cite concerns that for-profit plans may impose stricter guidelines about which groups and individuals it is willing to insure based on their risk of incurring medical costs or pull back from certain geographic areas or market segments, such as Medicare supplemental insurance, that are unprofitable. Providers often claim that a for-profit plan would be more aggressive in payment negotiations, which in turn would diminish their ability to provide community benefits such as uncompensated care. And the advantages of the Blues' long-time local focus might be lost if a converting plan merges with an out-of-area partner and becomes less responsive and accountable to local needs.

The strength of these objections rests on the extent to which local, nonprofit Blue plans act differently than for-profit competitors in ways that benefit the public. In the past, many Blue plans were required by law or regulation to provide various types of public benefits, such as acting as insurer of last resort for high-risk groups and individuals who would otherwise have difficulty obtaining affordable health coverage. In exchange, Blue plans received special treatment such as tax breaks.

However, these requirements and benefits have diminished significantly over time. By the early 1990s, few Blue plans were required to serve as insurer of last resort because of regulatory and legislative changes, particularly those related to individual and small group market reform, that have leveled the playing field among all health insurers. Some Blue plans receive benefits, such as state premium tax breaks, but these benefits typically are available to all nonprofits and are not considered significant by market observers.

If today's nonprofit Blue plans play a public benefit role in their local markets, most do so in informal and ad hoc ways that are not mandated by law.[5] Such behavior is motivated in part by community expectations, which are shaped by the plans' regulatory legacies, large market shares and significant role in the local economies. Some industry experts suggest that nonprofits have more flexibility in considering community needs in making coverage decisions.[6] Nevertheless, executives of these local, nonprofit Blue plans report they must carefully balance demands to act in the public interest—for example, by voluntarily offering products to hard-to-insure market segments or accepting enrollees from bankrupt plans—with the pressure to maintain financial viability and compete against for-profit plans. While a local, nonprofit plan may find it is still good business to act as a good corporate citizen upon conversion (and merger, if any), it is possible its willingness to act voluntarily in the public interest could decline.

Conversions and mergers may provide important benefits to consumers. The increased focus on profitability could lead to greater administrative efficiency, which might offset the need to raise premiums to generate shareholder returns and lead to improvements in customer service and quality of care. Similarly, consumers could benefit if the plan draws on the expertise of a merger partner to improve its management and operations.

Conversions also release plan assets to be used to benefit the public more directly. In many cases, these assets have been used to endow charitable foundations with missions to support research and community health

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care programs. In total, more than $5 billion in assets has been set aside in conversion foundations. While these funds could be used to address concerns about access to affordable health insurance by subsidizing coverage, the amounts set aside, ranging from $100 million to a few billion dollars, typically are insufficient to have a major impact on coverage. In other cases, however, state policy makers have chosen to direct funds to other purposes rather than establish a foundation, despite protests from consumer advocates. For example, funds have been used to support state medical schools—as was the case in Wisconsin—and to increase wages for health care workers in New York. And in one case—Trigon BCBS in Virginia—funds went directly to the state's general fund without any requirement they be used for health-related purposes. Market observers noted that policy makers in some states, such as New Jersey and Washington, appeared to be more hospitable to conversions in recent years because they saw the charitable assets as a means to offset severe state budget shortfalls.

Limited Evidence of Positive or Negative Community Impact

Few studies of the impact of conversions and mergers on consumers have been available to guide regulators' decisions. Most conversions and mergers have not been in place long enough to assess their effects, and there is little reliable data to permit analysis. This obstacle is compounded by the fact that some market observers, such as those in Indianapolis and Cleveland where Anthem operates, contend that Blue plans that pursue conversion begin to "act like a for-profit" well before the conversion to attract investors and/or an acquisition offer. Also, it is inherently difficult to generalize about the impact of conversions and mergers because plan structures, market dynamics and regulatory environments differ greatly from one state to another.

Based on available information, there is little evidence to suggest that conversions and mergers have had either a significant negative or positive effect on consumers. Recent case studies of conversions in California, Georgia, Missouri and Virginia found no pervasive and consistent effects of conversion on a range of measures.[7] For example, the authors found that Blue plans, upon conversion, continued to operate statewide, offer products in the individual and small group markets and set competitive premiums. However, they did not find well-documented examples of efficiency gains from merger.

The authors also acknowledged the difficulties of fully capturing the effects of conversion. They noted, for example, that it is not possible to fully assess the impact of conversion on underwriting because of the "subtle and complex" nature of the practice, which makes it difficult to identify both what has changed and why.

In a market impact study conducted at the request of the Kansas Insurance Department as part of its review of BCBS of Kansas' proposed conversion and merger with Anthem, PriceWaterhouseCoopers consultants concluded that the only potentially significant negative impact was the chance that "premium rates would increase by 6 to 7 percent above the levels that might be expected in the absence of the Anthem purchase."[8] This report also noted that the plan had been losing money consistently for a number of years, and Anthem was expected to raise premiums to turn a profit. Meanwhile, the Maryland insurance commissioner found that CareFirst did not make a compelling business case for conversion and merger but could not complete an impact analysis, citing a lack of sufficient data from WellPoint to make a determination.[9]

Policy Implications

Available evidence suggests that conversions and mergers do not provide significant benefits to or impose significant costs on consumers, in large part because of the diminishing public benefit role of most nonprofit Blue plans. However, the considerable variation across states in how these plans are

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regulated and operated makes it difficult to generalize about these effects.

If state regulators make a determination, after weighing the available information, that the proposed transaction meets statutory requirements and is not likely to have serious negative effects on health insurance access and affordability, they face an important decision about how to regulate the health insurance market to ensure consumers' interests are protected and market viability is maintained. A more market-oriented approach argues for allowing the conversion and merger to proceed. This approach continues moving states along the path most have chosen in regulating health insurance, which is to create a more level playing field where any regulation that is needed is applied to all plans operating in the market. In the short run, to mitigate the potential negative effects of allowing conversion and merger of a large plan, some regulators have placed requirements on the plan, for example, to offer products to certain market segments, minimize premium increases or maintain local employment levels, typically for several years.

Alternatively, policy makers may decide that certain public policy goals, such as access to and affordability of health insurance, should be addressed by a particular organization such as a nonprofit Blue plan. In this case, regulators might oppose a conversion to preserve their ability to impose regulation through the nonprofit. In many states, however, this would represent a reversal in a long-term policy trend toward a more level playing field. Since most nonprofit Blue plans have not recently been required to provide public benefits, regulators may need to revisit how that plan has been operating and decide if more explicit requirements and monitoring of the plan are necessary to achieve their goals while not undermining the plan's financial stability. ●

Notes

1. Throughout, "nonprofit" is used to describe Blue plans founded as nonprofit health services corporations under special enabling legislation, whose assets typically are held in charitable trust for the public; and Blue plans founded as mutual benefit organizations, whose assets typically are owned by policyholders.
2. See Community Catalyst, *Blue Cross Blue Shield Update* (May 2003), *www.communitycat.org/acrobat/BCBS-5-03.pdf.*
3. Throughout, "assets" refers to both the tangible and intangible assets of a company, the value of which equals the company's fair market value. For a discussion of the variation and complexity in the laws surrounding nonprofit ownership and implications for asset distribution upon conversion, see Claxton, Gary, et al., "Public Policy Issues in Nonprofit Conversions: An Overview," *Health Affairs*, Vol. 16, No. 2 (March/April 1997).
4. "For-Profit Status No Longer On the New Jersey Horizon," *The AIS Report on Blue Cross and Blue Shield Plans*, Vol. 2, No. 9 (September 2003).
5. Grossman, Joy M., and Bradley C. Strunk, "Blue Plans: Playing the Blues No More," in *Understanding Health System Change: Local Markets, National Trends*, Paul B. Ginsburg and Cara S. Lesser, eds., Health Administration Press, Chicago (2001).
6. Hall, Mark A., and Christopher J. Conover, "The Impact of Blue Cross Conversions on Accessibility, Affordability, and the Public Interest," *The Milbank Quarterly*, Vol. 81, No. 4 (December 2003).
7. Ibid.
8. PriceWaterhouseCoopers, *Assessment of Market Impact on the Anthem, Inc. Purchase of Blue Cross Blue Shield of Kansas*, *www.ksinsurance.org/consumers/bcbs/public_testimony/kid/pwcmarket.pdf.*
9. Maryland Insurance Administration, *Summary of Key Points: Review by the Maryland Insurance Administration of the Application of CareFirst to Convert and be Acquired by WellPoint* (March 5, 2003), *www.mdinsurance.state.md.us /documents/CareFirstdecision-SummaryKeyPointsrev.pdf.*

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