



DISPELLING THE MYTH

Why Conversions of Blue Plans To For- Profit Don't Make Economic Sense.

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SUMMARY OF FINDINGS

The analysis presented here relies on five years of data (1997 to 2002) on the financial performance of Blue Cross plans and, for comparison, commercial insurance companies. Companies analyzed include twenty-one independent Blue plans, seven consolidated nonprofit Blue plans, five investor-owned Blue plans (the proposed Anthem purchase of WellPoint occurred in 2003, and each company is treated separately here), and ten commercial health insurance carriers. The principal findings are as follows:

- Conversion of Blue plans does not result in demonstrable economic efficiencies. Operating margins for smaller nonprofit plans and for consolidated nonprofit plans, such as CareFirst, exceeded those for larger plans and for investor-owned plans.
- Many of the intended or supposed efficiencies that are expected with consolidation are hard to achieve. The hardest seems to be integration of information-processing systems among consolidated entities. In the commercial health insurance segment of the industry, many firms

still maintain legacy data systems five years after mergers. No economies of scale are observed.

- Most nonprofit Blue plans continue to operate with sound margins and can be expected to do so and to compete with other firms, in part because of their special ties to various customer segments, their geographic market share, their relationships with state governments, including insurance commissioners, and the particular brand identity enjoyed by local Blue plans.
- Operating margins in health insurance companies are highly tied to local market knowledge, which becomes attenuated in larger, geographically dispersed insurance companies.
- Although publicly traded insurance companies have easier access to capital, the price of that capital remains closely related to the performance of the business. It is axiomatic that publicly traded companies can raise capital more readily than Blue plans, but stockholders have expectations of reasonable returns on capital. The returns on capital will determine whether investors will continue to support the stock and make future capital available to the company.

- It appears that one of the first principles of conversion is to ensure that the initial offering price of the stock understates the value of the company. This ensures returns to the initial investors and managers. Understated initial value also provides upward movement in the apparent value of the company in the future.
- Half of the nation's Blue Cross plans have been consolidated and converted to for-profit companies. This process has gone on with minimal interest or comment from the public policy establishment whose principal interest is expanding coverage to all Americans. In markets where for-profit insurance predominates, a form of corporate organization has been lost that, by a tradition reflecting its unique history, has provided lower-cost coverage and embraced a corporate identity infused with service to the public.

INTRODUCTION

The acquisition of WellPoint by Anthem and the acquisition of Oxford by United place several questions in high relief about the economics of nonprofit health insurance and the future of Blue Cross/Blue Shield. The overarching question is whether nonprofit health insurance will remain a competitive organizational option.

The Blue Cross and Blue Shield plans are synonymous with health insurance in the United States, having played an integral role in our nation's health care system since their origins in the late 1930s and early 1940s. During the past decade, a significant number of Blue plans have converted to for-profit status and/or have consolidated formerly independent nonprofit plans.

This report analyzes some of the issues surrounding consolidation and conversion. In particular, it examines the arguments that nonprofit Blue plans must convert to for-profit status to maintain their competitive position in the marketplace and, indeed, to survive as corporate entities. As conversion was first tested and proved to be practicable for Blue plans, the overwhelming weight of reports and analytic documents that emerged was supportive of the trend. In retrospect, this outcome seems predictable, given that the commentary was developed by consulting firms engaged by plans to support their intended course of action and by investment banking firms, which are central to any financing strategy involving public investors. However, no academic analysis that could have provided an objective assessment has ever been undertaken.

This report stands as a different perspective on the question of Blue Cross plan merger and conversion to for-profit status. As intimated above, the existing literature on this question is intended to

be supportive of all aspects of the process of conversion to for-profit status, it encourages without qualification the transformation of Blue Cross as a national system of health insurance into a collection of highly concentrated publicly traded companies. As will be seen below, an objective analysis of the financial experience of consolidated plans that have converted to public ownership finds that the presumption that such steps are necessary to the continued existence of Blue Cross plans is ill-founded. Moreover, from the perspective of public policy, we find ourselves observing in retrospect the transformation of a great part of the nonprofit Blue Cross system to the for-profit form without informed debate. Blue plans have historically provided the nation's leadership in public policy relating to health financing. Blue Cross has historically taken the lead in offering proposals on expansion of coverage for the uninsured, implications of health care inflation on coverage, and development of innovative coverage. Conversion of Blue plans has quieted the most sophisticated voice outside government that concerned itself with public issues related to health care financing. **Investor-owned companies cannot provide public policy leadership that would be at odds with the interests of their shareholders.**

HISTORY – BLUE CROSS AND THE MOVEMENT TO CONSOLIDATION AND CONVERSION TO THE FOR-PROFIT FORM

Blue Cross was developed by social entrepreneurs in the early years of the Great Depression. Conceived by the nation's nonprofit hospitals, the idea of a community-focused prepayment mechanism for health expenses caught on rapidly and soon became the primary model for what was to become known as health insurance. (Before the creation of Blue Cross, traditional insurance theory suggested that the problem of moral hazard made illness an uninsurable risk.) Blue Cross prospered and grew rapidly. With the coming of World War II, health benefits became a fringe benefit, and commercial carriers entered the market. Using a property-casualty model for assessing and managing risk, they soon became an aggressive competitor with Blue plans that continued to use a community-rating model for pricing.

Throughout the 1960s and 1970s, commercial and Blue Cross plans fought aggressively for market share. Adoption of the experience-rated model helped Blue plans compete with the threat posed by commercial insurance companies. In addition, an industry treaty enforced by the Blue Cross/Blue Shield Association (BCBSA) protected plans from competition in their assigned territories. The division of markets geographically helped plans in another way. It provided each plan with an identity tied

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“Constrained from growing and competing Blue-against-Blue, they chose the course of pairing up. Consolidation was underway.”



to dedication to the particular needs of a specific region. Thus, the brand image of each Blue plan included its knowledge of the needs of its beneficiaries and the unique histories of its community’s hospitals and doctors. Unlike national commercial competitors, which operated on national models of managing health insurance, Blue plans projected an image of concern and competence focused on local market circumstances.

Notwithstanding these advantages, in the 1980s, many Blue plans appeared to be wandering from their heritage. Success had bred a satisfaction that presented a new kind of threat. Commercial carriers were gaining market share with products that appeared responsive to health care cost inflation, which had reached acute levels. Employers were drawn to commercial carriers that were more willing to experiment with innovative delivery mechanisms such as HMOs. Blue plans, more closely connected by their history to hospitals and physicians, were slow to set themselves in a position that was adverse to providers. The Blues lost further market share to large employers who, operating in many states, found dealing with one carrier more efficient and convenient than dealing with a different Blue plan in each locale. Large employers were also seeking to avoid costs related to insuring employees in high-benefit states, where Blue plans were often compelled to sell plans mandated by state regulators. Commercial carriers held the

promise of providing third-party administrative services under ERISA provisions to self-insuring employers who operated in multiple states. In the late 1980s, the Blues also lost a federal tax advantage when Congress determined that there was no justification for treating the Blues’ premium income differently than that of commercial carriers.

A generational change in the leadership of Blue plans happened during the late 1980s and early 1990s. The executives who had absorbed Blue values by those who created the Blue Cross concept were giving way to managers recruited to run what were now very large insurance organizations. Certainly the poor competitive performance of the Blues versus large commercial companies during the 1980s helped to usher out the older generation of Blues leadership. Many of the new executives came from banking, others from commercial insurance, yet others from HMOs. With this new leadership came a new view of the potential of the Blues. Poor past performance, coupled with the Clinton administration’s apparent bias in favor of the giant commercial companies, suggested to this new leadership that bigger plans would be more successful. Because the BCBSA’s exclusive geographic market agreement restricted competition between plans, the only road to growth was acquisition or merger.

The 1990s brought the beginning of the Blues’ movement to consolidate. After the West Virginia plan collapsed,

Cleveland Blue Cross took over the Charleston plan. This transaction appeared ambitious from a market expansion perspective, but the takeover had the old-fashioned tone of protecting Blues' subscribers.

In 1989, a tectonic shift in the process of Blue Cross conversion came when Indiana Blue Cross decided to buy American General Insurance Company in Dallas. The Indiana plan had established a for-profit subsidiary, the Associated Insurance Company, and was now competing as a commercial company in the health insurance business in the territories of other Blue plans. Within the BCBSA, Indiana's move into the commercial side of the business to compete with Blue Cross colleagues was met by at least two different views. Some analysts held that the move betrayed the core values of Blue Cross. Others admired the bold move against the BCBSA and its codes of nonprofit conduct. Within this latter group, some were more explicit, believing that nonprofit, one-market Blue plans were outmoded and that the future belonged to more aggressive, profit-maximizing companies that looked more like their commercial competitors.

The industry's earthquake came in the early 1990s when Blue Cross of California, already having formed a for-profit subsidiary, relinquished its nontaxed status. The California plan was beginning its conversion into an entity known as WellPoint, which it had developed as a for-profit network of HMO and preferred

provider organizations (PPOs). WellPoint focused heavily on the individual and small-group markets, a segment that few other plans wanted to serve. Its strategy was to gather large enough numbers in these segments to make risk pools work, and to keep costs under control by channeling its beneficiaries to the WellPoint network of hospitals and doctors. Running ahead of the storm of Clinton health reform, California Blue Cross sought to garner resources to expand and become a national player. The nonprofit plan absorbed itself into its for-profit, publicly held WellPoint subsidiary in 1996. The success of the carefully watched IPO appeared to demonstrate that investors would support a Blue plan conversion.

Of course, the concept of conversion from nonprofit to for-profit was not created out of whole cloth; few things are. Conversion of nonprofit Blue plans followed the path of the "demutualization" of many of the nation's life insurance companies. Demutualization was crafted, in some instances, out of economic necessity. Although the industry had flourished with both stock insurance companies and mutuals (owned by their policyholders), in the 1980s a number of mutuals began to seek a conversion. The mutuals persuaded state insurance commissioners and legislatures that the companies needed access to capital markets if they were to compete with banks, financial facilities specializing in credit (e.g., G.E. Capital), and mutual fund companies, as much

for scale advantages in managing portfolios as for preserving their shares of consumer markets. (The economic necessity argument, ten years later, is implicitly challenged by the continued existence of very successful mutual companies, such as New York Life and Northwestern Mutual Life.)

Watching the California Blue Cross initiative, other Blue plans concluded that they would have to achieve sufficient critical mass in order to enjoy similar success. Constrained from growing and competing Blue-against-Blue, they chose the course of pairing up. Consolidation was underway.¹

During the 1990s, the number of independent Blue plans fell sharply, from 67 in 1995 to 47 in 2000. At the end of 2003, the number was 42 on the way to 41 with the Anthem acquisition of WellPoint.

SEVERAL APPROACHES TO CONVERSION

The concepts involved in any insurance company merger or acquisition are complex. In Blue Cross conversion, this complexity is exacerbated by a lack of experience with the behavior of nonprofits in the world of for-profit mergers and acquisitions. Because little objective analysis exists, the vocabulary surrounding Blue Cross conversions sometimes slips into a jumble of concepts and arguments to support one or another aspect of a particular transaction.

¹ The term "consolidation" is used to describe the generic process by which Blue plans have come together.

“Conversion” encompasses several forms of organizational transformation in which Blue plans have been involved. Most commonly, Blue plans undergo a conversion of legal form. A plan can convert from a charitable entity to a mutual company or to a for-profit organization. In the process of acquisition, a plan may cease to exist altogether. Conversion typically takes place as part of a merger transaction, where two entities join together to form one, or by an acquisition, where one plan (the buyer-acquirer) purchases another plan (the seller-acquired). The

acquirer might be another Blue plan operating as a conventional nonprofit or as a converted investor-owned company. BCBSA rules essentially forbid acquisition of a Blue plan by any organization other than another Blue plan. Thus, conversion is the process by which a nonprofit becomes a for-profit plan, usually involving a simultaneous conversion to public ownership.

As part of the conversion strategy, a plan that intends to convert often accumulates other plans, a process called consolidation.

Consolidation is the bringing

of several plans together. It may take place before or after converting to for-profit status. When it is undertaken before conversion, its purpose is to accumulate a significant volume of business that would appeal to public investors as a large company. Consolidation before conversion usually involves voluntary mergers where the unification of ownership is not complete. Rather, a looser confederation of entities exists, although one central management, the initiating plan, can be clearly identified. Interestingly, in several cases,

Exhibit 1: Four Types of Blue Cross Blue Shield Plan Consolidations

Affiliated Nonprofits	Nonprofits Merged into Single Corporations	Merged, Then Converted to Investor-Owned For-Profit	Converted to Investor-Owned For-Profit
<p>The Regence Group BS of Idaho BCBS of Oregon BCBS of Utah BS of Washington</p>	<p>CareFirst, Inc. BCBS of Delaware BCBS of Maryland BCBS of D.C. (GHMSI)</p> <p>Excellus, Inc. BCBS of Central NY BCBS of Utica-Watertown NY BCBS of Rochester NY</p> <p>Health Care Service Corp BCBS of Illinois BCBS of Texas BCBS of New Mexico</p> <p>Highmark, Inc. BC of Western PA BC of Pennsylvania BCBS of West Virginia</p> <p>Premera Blue Cross BCBS of Alaska BC of Washington MSC of Eastern WA</p>	<p>Anthem Insurance Co., Inc. BCBS of Connecticut BCBS of Colorado BCBS of Kentucky BCBS of Indiana BCBS of Maine BCBS of Nevada BCBS of New Hampshire BCBS of Ohio</p>	<p>Cerulean Companies BCBS of Georgia (acquired by WellPoint)</p> <p>Cobalt Corporation BCBS of United of Wisconsin (acquired by WellPoint)</p> <p>RightCHOICE BCBS of Missouri (acquired by WellPoint)</p> <p>Trigon Healthcare, Inc. BCBS of Virginia (acquired by Anthem)</p> <p>WellPoint Health Networks BC of California (acquired Cerulean Companies) (acquired RightCHOICE)</p> <p>WellChoice, Inc. (Empire BCBS)</p>

conversion to a publicly held company has been justified as necessary to accomplish consolidation. In postconversion consolidation, the publicly held plan purchases or acquires nonprofit plans and brings them into the existing company.

For purposes of clarity, here we treat conversion as either a condition precedent or a product of consolidation. Thus, here, consolidation is seen as the most important aspect of the process of conversion. Conversion, of course, is the more important corporate event because it involves the transfer of ownership from a community asset to a private asset.

Exhibit 1 shows four ways in which consolidation of plans has taken place. The first form of consolidation is best exemplified by Regence, an affiliation of the Blue Cross plans of Idaho, Oregon, Utah, and some counties in Washington State. In the Regence model, the four plans affiliated and agreed, for the time being, to continue as nonprofits. There is no common ownership; the plans simply work together in ways intended to improve productivity and profitability. The Regence model is structured such that plans may join or withdraw.

The second approach to consolidation, exemplified by CareFirst, is to merge nonprofit plans under a single nonprofit corporate entity, in this case leaving a potentially viable corporate form in place in the event that a conversion attempt fails, as it did in 2002. (It appears that legislation passed by the Maryland legislature may trigger

a “deconsolidation.”) A third approach similarly merges two or more nonprofits into one corporate entity but does so as a first step in a planned conversion to a for-profit, publicly traded company. Anthem, which began life as the Indiana Blue Plan, brought together nine plans over the course of six years and, on October 30, 2001, took the combined entity public.

The fourth approach is to convert a Blue plan into a for-profit in order to function as a platform on which to consolidate plans. This was the route taken by Blue Cross of California (now WellPoint) and Blue Cross of Virginia, known as Trigon before being acquired by WellPoint. In California, conversion was the necessary first step to acquire the health insurance business of several other commercial carriers, including Massachusetts Mutual and John Hancock, as well as two Blue Cross plans, Georgia and Missouri, that previously had converted to publicly held companies. Trigon had demonstrated its interest in the acquisition of other plans as well, first in Georgia (where it lost a bid to WellPoint) and through its exploration of the acquisition of Maryland Blue Cross.

Along the route to going public, all plans have transformed their corporate forms. The Wisconsin plan formed a publicly traded subsidiary, United Wisconsin Services, as did the Missouri plan in creating RightCHOICE. Other plans have reorganized into mutual companies as a first step to becoming stock companies through the “demutualization”

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“Some organizations decided to stake their futures on health insurance; others with long and successful experience in the industry decided to exit.”



process. Anthem, the now-public consolidator of ten plans (including WellPoint), was a mutual company, and Trigon also became a mutual company in its transition to publicly held status. “Mutualization” permits a Blue plan to define the ownership interest in the company by taking ownership away from the amorphous “public” and putting it into the hands of specific policyholders, who then can benefit from a conversion of their policy interests into shares. (The Florida Blue plan is a mutual company that has stated its intention to remain one.)

A large number of Blue plans have purposely determined not to enter into consolidating transitions. It appears that the managements of these plans believe that they are best positioned for the future by remaining nonprofit community plans serving specific geographic areas. Some plans, such as Michigan, are forbidden by statute to buy other plans or sell themselves. Maryland has created a statutory prohibition on the sale of the Maryland assets of CareFirst for the next five years.

CONSOLIDATION IN COMMERCIAL HEALTH INSURANCE

While the last decade has seen a nonstop process of deal making among Blue Cross entities, the commercial sector was also active. This activity reflects very different views of the future of health insurance as a business. Shortly after the failure of the Clinton health reform plan in 1994, health insurance carriers

appear to have changed their long-term thinking about the health business. Some organizations decided to stake their futures on health insurance; others with long and successful experience in the industry decided to exit.

Exhibit 2 shows the six companies that descend from commercial origins and are committed to health insurance today. The exhibit gives evidence of the exodus during the last decade of companies that many believed were destined to control the entire health insurance market. As the 1990s opened, there were five giant commercial carriers. For decades, Aetna not only was one of the “big five” in commercial health insurance but also was a multiline insurance company with sizable pension, casualty, and reinsurance businesses. In 1994, the company began a process of selling off various lines of business, including its highly profitable American Reinsurance subsidiary, to focus on health insurance. Concurrently, other large commercial carriers decided that health insurance was not their future. Metropolitan Life, the nation’s largest health insurance company, acquired the Travelers health business in 1994 and then sold all its health business to United Healthcare in 1996. Prudential, Equitable, Travelers, New York Life, and John Hancock also walked away from large health insurance market presence to concentrate on other lines of business. Over just six years, Aetna successively acquired U.S. Healthcare, by then one of the largest for-profit

Exhibit 2:
Mergers and Acquisitions Among the Largest Commercial Companies
 (All numbers in millions)

Company	Total Revenue (2002)*	Enrollment	Mergers and Acquisitions
Aetna	\$19,878.7	13.7	U.S. Healthcare; New York Life's NYLCare managed health business; Prudential and Equitable's health care business.
UnitedHealth Group	\$25,020.0	9.0	Health Partners of Arizona; Principal Health Care of Texas; MetraHealth Care Plan of California (joint venture between Metropolitan Health and Travelers); HealthWise of America; Community Health Network of Louisiana. Attempted to purchase Humana, but deal collapsed.
Cigna Corporation	\$19,348.0	13.1	EQUICOR; Healthsource; Equitable Life Insurance. Expanded to China, Mexico, India, Brazil, Poland, and other countries in the 1990s.
PacifiCare Health Systems	\$11,156.5	3.1	Harris Methodist Health Plans; QualMed Washington Health Plans; ANTERO Health Plans; FHP International.
Humana	\$11,261.2	6.6	Physician Corporation of America; ChoiceCare; Advocate Health Care; Memorial Sisters of Charity; EMPHESYS Financial Group. Agreed to be purchased by UnitedHealth Group, but deal collapsed.
Health Net	\$10,201.5	3.9	Western Universal Life Insurance; Occupational Health Services; California Compensation Insurance; CareFlorida Health Systems; Intergroup Healthcare; Thomas-Davis Medical Centers; Managed Health Network.

* Revenue for 2003 appears in the Appendix.

HMOs, and the health units of Equitable, Prudential, and New York Life. Today, only Aetna and Cigna remain in the health insurance business. Concurrent with the exodus of large carriers, numerous smaller insurance companies abandoned the health lines or the reinsurance lines that supported health care.

ARGUMENTS FOR BLUE CROSS CONVERSION

Four principal arguments are advanced to support conversion of Blue plans to for-profit,

publicly traded companies. They were first developed in the demutualization process. They are not difficult to understand, and they have been remarkably effective in influencing insurance commissioners and members of legislatures, the two entities that hold the power to release Blue plans from their traditional organizational form as community service corporations.

The four arguments are used in six settings. The arguments are first encountered in documents prepared for various hearings before state insurance

commissioners considering conversion proceedings. Commonly, the same arguments are made before legislative committees in states where statutory changes are necessary to permit conversions or, as in Maryland, the legislature becomes concerned about the conversion as the application is being considered in the state's regulatory/administrative forum. The arguments often appear in documents prepared as expert testimony by investment banking firms. Inevitably, such firms are engaged either by the plans or

by the insurance commissioners to advise on the question of conversion and on the value of plan assets. The same arguments also appear in various industrial studies prepared by investment banking firms as part of their ongoing interest in attracting investors to health insurance stocks. And, of course, the arguments appear in public filings made with the Securities and Exchange Commission by plans that are about to market shares. They also appear in documents circulated by Blue plans in the course of offering initial and subsequent rounds of stock to public markets as a means of convincing investors of the potential for returns on owning the plan's stock.

▲ Efficiencies Can Be Achieved through Economies of Scale

The most commonly advanced and most persuasive of the arguments for consolidation has been that bigger health insurance plans benefit from economies of scale. In classical economic terms, scale economies are present when the average production cost of a unit of service declines as more units are produced. This argument suggests that, as a company becomes larger, it can spread fixed costs among more units of service sold, thereby achieving a higher rate of return on invested capital as well as lower production costs and higher margins.

The potential benefits of scale should emerge from several advantages of size. In health insurance, the first relates to

bargaining power over suppliers – namely, providers of care to the insured population. Volume discounting has been the single most important skill set developed by health insurers over the last 25 years. A second advantage of size is the ability to diversify the company over geographic markets and across product lines. Both factors, theoretically, should contribute predictability to the company's future. Finally, companies that have grown by consolidation should be able to enjoy economies related to shared services including legal, marketing, accounting, claim processing, and product development.

Perhaps economy of scale is the first argument advanced because it seems self-evident. Common sense suggests that, when two entities are joined, the acquiring company will gain some improved critical mass such that the costs of goods sold per unit will drop and earnings will rise. Simply, bigger is better because it will prove to be more profitable.

▲ Competition Can Be Met Successfully Only through Growth and Conversion

A corollary of the economies-of-scale argument is the proposition that smaller, locally focused plans will face unbeatable competition from larger, previously merged entities or commercial behemoths. The argument runs to the extreme – that the disparity in size will result in the eventual failure of smaller plans. Only large plans

or companies that operate on a national platform will be able to survive the market challenges of the future.

In support of this position, some industry leaders cite examples of large employers that have insisted on “one-stop shopping” rather than purchasing health plans in each geographic market in which they do business. It is argued that large employers insist on convenience in contracting for coverage and that they seek the stability that, allegedly, only larger plans can offer.

▲ Nonprofits Cannot Obtain Needed Capital

As noted, the most important of all arguments, as first demonstrated in the case of the demutualizing life insurance companies, is the need for access to capital markets. In advocating conversion to the for-profit form, Blue plans consistently have emphasized that their nonprofit status handicaps the efficient acquisition of capital. By definition, nonprofit companies cannot raise equity capital. To create working capital, they must apply to the insurance commissioner to set rates that produce sufficient surpluses over statutorily required claims reserves.

The ability to raise capital in equity markets enables acquisition of other plans and permits a given plan to achieve efficient size and thus secure its competitive future (see previous argument). It has been common to argue, further, that a given plan's lack of access

to capital markets threatens its continued existence as a competitive entity – that the need for internal working capital to equip the plan to compete against bigger, better-capitalized plans is so great that without costly improvements to systems and enhanced approaches to marketing, the plan will be unable to continue.

The argument that only larger companies can survive compels the world to be divided into acquiring plans and acquired plans. Ambitious plans – first-movers, if you will – are those that seek to grow through external acquisition. In this strategy, the acquiring plan must use cash, stock, or both as currency in pursuit of new acquisitions. Every Blue plan that has converted to for-profit status had gone public or planned to go public as a means of acquiring other plans.

Generally, Blue plans have pointed to four major areas where capital is necessary for survival against competitors – acquisition, marketing and sales, improvements to operating systems and new infrastructure (especially information systems), and the development of surplus that permits competitive behavior in price setting.

Capital for marketing and sales is not a unique claim among Blue Cross plans. If an idiosyncratic case can be made for health insurance, it is the importance of devising new marketing strategies to support the continuous but marginal product innovation required to satisfy “benefit fads” among large employer customers.

Although advertising and the improvement of sales forces are a continuing need, the sales costs in health insurance, particularly large case carriers, are smaller than in many other lines of insurance and certainly less than in other industries.

Spending on infrastructure is a more credible argument in health insurance. Because the overarching determinant of profitability in health insurance is account retention, expenditures related to improving customer satisfaction through improved service deserve attention and capital. Better claims payment and adjustment systems, more accurate provider credentialing, and more accurate underwriting and pricing are keys to customer retention. The health insurance industry has invested heavily in such information-related systems. While the case seems intuitively clear, history shows an ongoing series of data needs requiring capital. Currently, many companies are attempting to develop systems to accommodate changes in the market resulting from the Medicare drug amendments of 2003. In addition, some companies are gearing up for patient-directed plans. Most are continuing to adjust their data-handling architecture to accommodate the data and privacy requirements of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Past information technology investments, some of which seem questionable in retrospect, include preparation for Y2K, the coming of electronic medical records (which have largely not yet arrived),

“Better claims payment and adjustment systems, more accurate provider credentialing, and more accurate underwriting and pricing are keys to customer retention.”



“Pricing for market expansion by focusing on the underwriting cycle presents many opportunities for danger.”



automatic claims adjudication, and on-line payment. Many companies and plans have argued that their continued ability to compete depends on the ability to make these expenditures, which are not feasible within their cash-limited structures. Thus, the argument goes, conversion is necessary in order to obtain the capital to stay competitive.

Companies also need capital to compete on price. At any given moment, pricing and profit in a health insurance company depend largely on the underwriting cycle, an industrywide phenomenon that reflects the level of competition for market share among companies. When a company decides to expand its market share, it lowers prices and/or reduces its underwriting standards to permit more risk to enter its pool. In time, of course, the poorer risks prove more expensive to cover, forcing the company to increase its price and reject bad risks at renewal time. Any company's ability to “play” the cycle reflects the level of reserves and surplus on hand.

Pricing for market expansion by focusing on the underwriting cycle presents many opportunities for danger. One of the most difficult challenges is that the cycle is very poorly understood; there is seldom agreement on when it begins, when the price trough is at hand, and when the cycle has concluded. A compounding danger exists in unpredictable changes in the rate of inflation in medical claims costs. If a company is caught not increasing

its prices fast enough as the cycle shifts, it can sustain large losses that require the “cushion” of adequate reserves. Indeed, many insurance companies have sustained irreversible losses by being too aggressive on price or by lowering underwriting standards and then finding themselves unable to recoup those losses in the next round of pricing. Obviously, greater reserves are necessary if a company wishes to use price aggressively as a means of improving market share.

▲ Attracting Management Talent Requires Parity in Compensation

Conversion is also advanced as a way of attracting management talent needed for Blue Cross plans to succeed in the future. Converting Blue Cross plans have argued that management needs the incentive of participating in equity, as in stock option plans, in order to align its goals with the organization's (assuming that the pre-eminent goal of the organization is profit). Some managers in nonprofit Blue plans have argued that even if their paychecks are commensurate with those of executives in similarly sized for-profit corporations, they are disadvantaged because they cannot capture the return on their talent and hard work through equity ownership that is tied to the growth in the intrinsic value of the organization.

EXAMINING THE ARGUMENTS FOR CONVERSION

Each of these arguments has been subjected to analysis to determine whether the underlying premises and experience provide support for the contention. The analysis presented here builds on work by the author, completed in 2002 under the sponsorship of the Abell Foundation of Baltimore. That work was commissioned to provide an empirical foundation for the formation of public policy related to a hypothetical conversion of the Blue plan that serves Maryland.

The analysis reported below is for the five-year period 1997 to 2002, the most recent year for which complete data are available.

Data in this report were obtained from insurers' annual reports, from the BCBSA, from reports filed with the

U.S. Securities and Exchange Commission, and from filings with various state insurance commissioners. Periodicals and financial publications were used to confirm and supplement these data.

Companies analyzed comprise twenty-one independent nonprofit Blue Cross plans, seven consolidated nonprofit Blue Cross plans, five investor-owned Blues, and ten commercial health insurance carriers. By reason of the small sample size of the consolidated and investor-owned Blues, aggregated results should be interpreted with caution. The number of observations in each category differs in some instances because data were unavailable.

During the five-year period of this study, several Blue plans altered their corporate form. The exhibits show each entity's corporate form as of its most recent annual report, 2002.

Companies report financial information in differing levels of detail. For example, some Blue plans report each revenue source and others aggregate revenue sources. To the extent possible, data from each plan were converted to a common format for purposes of comparison.

▲ Economies of Scale

Using the data described above, the analysis suggests that scale economies do not operate in the health insurance industry with the same force as in other industries. Perhaps the most powerful evidence that economies of scale do not correlate with higher profits comes from a review of 2002 earnings, the most current available data for Blue companies across the size spectrum. Exhibit 3 shows that smaller plans have higher earnings than larger plans.

The data suggest that optimal profitability may be in midsize Blue plans, with total annual revenue between \$2.5 and \$7.5 billion, rather than in the largest plans, with annual revenue over \$7.5 billion. In other words, over the most recent five-year period, the data point to a peak in efficiency in midsize plans that is lost in very large plans. All of the largest plans represent multiple acquisitions and operate over widely dispersed market areas; as discussed below, these factors may inhibit the expected efficiencies of scale economies.

When comparing earnings by organizational type, another interesting pattern emerges, as Exhibit 4 shows. Average

**Exhibit 3:
Earnings of Nonprofit BCBS Plans by Total Revenue,
1997-2002**

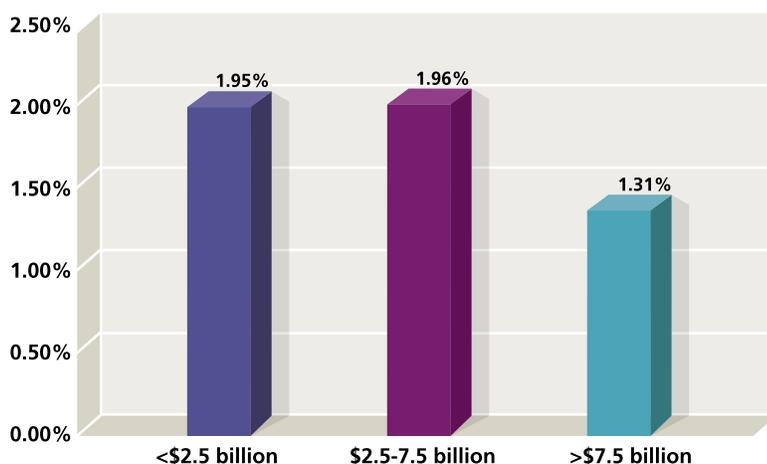
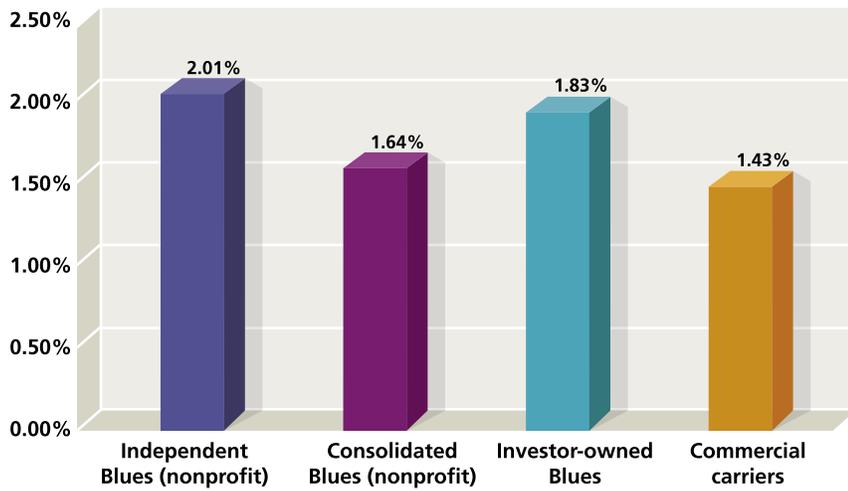


Exhibit 4: Earnings by Organizational Type, 1997-2002



earnings were highest in independent, nonprofit Blues (2.01 percent), followed by investor-owned Blues (1.83 percent) and consolidated Blues (1.64 percent). Commercial carriers had the lowest earnings of all types of insurance carriers during the 1997-2002 period (1.43 percent). Across Blue plans, average profit margins dropped as plans became larger and converted to for-profit enterprises. These data appear to indicate that, in the process of growing larger and becoming public, at some point Blue plans actually become less, not more, efficient.

What accounts for the reverse scale effect that is observed in health insurance? This is a central question because it goes to both the business strategy issue and the public policy issue of whether Blue plans, as regulated entities, formed as not-for-profit community service corporations, should see conversion to for-profit status as a practical avenue to survival or readiness

for the future. What follows is a discussion of postmerger problems that appear in health insurance.

Return on Capital. In considering conversion where external capital is required, long-term return on capital is, oddly, often overlooked. Once investors have advanced capital, there must be predictable returns through dividends charged against earnings. Thus, invested earnings in an investor-owned situation must reflect dividends expected on capital – a situation entirely absent in traditional nonprofit Blue Cross plans.

Information Systems. The most important operating barrier to scale economies in merged health insurance companies is the difficulty of bringing information systems together. As noted, insurance companies are at the highest end of commercial entities in the importance that information plays. Every underwriting, claims and provider decision is based on detailed statistical models,

many of which have the benefit of many years of mathematical study in each company. Each company's system reflects designs that accommodate its historical views of growth, expected profitability, and its approach to customer service. In addition, throughout its life, every company continually modifies policies as required by state insurance regulatory agencies. Each company must also constantly modify internal rules on claims adjudication, including changing copayment arrangements to reflect the nature of the thousands of policies that change with each renewal as the market dictates.

It is not an exaggeration to say that, within a few months of an insurance system's installation, it becomes nearly impossible to integrate it with another company's system. When health insurance companies combine, it is quite common for the merged companies to support numerous "legacy" systems running side by side. Compatibility is literally unheard of, successful integration is rare, and reconfiguration to a common system is very expensive. Although many merged companies profess competence and achievement in merging data systems, such claims seldom reflect unqualified success.

Different Sales and Distribution Strategies. In combining insurance companies, the culture of how each approaches its market presents significant barriers to achieving economies of scale. Some health insurance companies

sell directly, some through brokers, some through agents. Many rely on benefit consulting firms. Firms also target specific populations, so much so that the market for health insurance is rather formally stratified, ranging from companies that sell only to large groups to those who sell only specific health insurance products. If marketing approaches overlap or conflict, scale economies may be unrealized or, worse, the integration of multiple systems and cultures will require significant and expensive reorganization. A company that has relied on independent agents will face substantial difficulties if, after a merger with a direct-sales carrier, it continues direct customer sales.

Different Approaches to Underwriting. The fourth traditional barrier in merging insurance companies is successfully combining sales and underwriting personnel who have been trained to work within a very specific culture and philosophy. To the extent that a philosophy of underwriting is a company's most important characteristic, any merger requires enormous attention to the manner and means of integrating the sales and underwriting functions.

▲ Competition Requires Conversion and Growth by Merger

The second argument advanced for conversion is that competitive pressures require plans to merge merely to achieve size. Here, size is not sought for internal economic efficiencies, as it is in

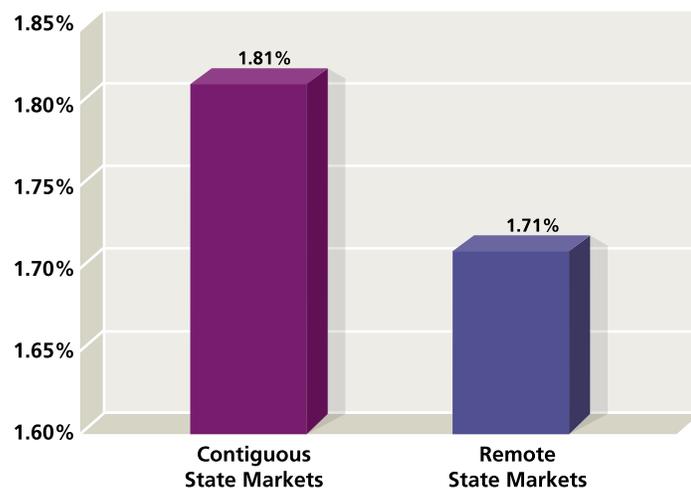
the economies-of-scale argument just discussed. Rather, in the second argument, conversion is the first part of a drama demanded by market conditions. In the first case, economies of scale are cited simply on the presumption that larger firms are inherently more efficient. In the second argument, external competitive forces in the market are seen as requiring size as the only response. As will be discussed in the conclusion, the evidence from other industries, accumulated over decades, that market conditions compel mergers as the only way to survive in a market of consolidating companies has proved wrong much more often than it is found to be correct.

In the case of health insurance companies, the data suggest an unconsolidated company, operating in one market area, can produce higher margins than a company serving many markets spread over a wide geographic area.

Indeed, operating margins seem to be related positively to concentration in single markets or adjacent markets, as suggested by Exhibit 5. Put differently, to extend operations to geographically remote markets puts operating margins at risk. This observation suggests two things. First, higher operating margins are related to depth of knowledge or experience in dealing with local market conditions. Second, if local market experience is the deciding variable, the long-term threat imposed by outside competitors may be overstated. The higher margins in contiguous markets may also suggest, from a policy perspective to be explored below, that well-financed outside competitors may not be successful in the long run but manage to disrupt a market in significant ways while trying to achieve market share.

The importance of local market knowledge is often discounted in the process of

**Exhibit 5:
Earnings of Companies Operating in Contiguous and Remote State Markets, 1997-2002**



attempting to gain size through consolidation. In fact, as in politics, all health insurance is local. Among the local market characteristics that vary widely are hospital organization (investor-owned hospitals are much more common in the Southeast than elsewhere in the country); the organization of medical practices (clinic practice is a common form in Wisconsin and Minnesota but not in Maryland or Pennsylvania); and the preference of the market for various insurance products (indemnity protection is more common in the Northeast than the West, where capitated coverage is typical). Some state insurance regulators are hostile to specific products (it traditionally has been easier to start an HMO in Texas than in surrounding states) and even to specific carriers. The Michigan legislature has given additional statutory protections to Blue Cross. Patterns among consumers also vary from place to place. Hospitalization rates vary significantly from place to place, as does the incidence of various medical procedures and length of inpatient stay.

The conclusion that profitability and efficiency do not depend on for-profit status is buttressed by an analysis conducted for the Maryland Insurance Commissioner by Roger Feldman, Ph.D. The study used a data set that consisted of annual observations on all HMOs operated in the United States from 1986 to 2001, including 61 that converted to for-profit status. The author found that investor-owned HMOs are

slightly less profitable than not-for-profit HMOs, though the difference was not statistically significant. Additionally, the act of conversion was uniformly associated with negative effects on operating margins, though again none of these findings was statistically significant. Perhaps most notably, the study found that for-profit HMOs have higher administrative ratios, by 1.57 percentage points on average, than not-for-profit HMOs.

▲ Availability of Capital

A well-performing publicly traded consolidated plan has more convenient access to cheaper capital than a nonprofit company. But how important are new sources of capital for the continued operations and long-term health of Blue plans? Easier access to capital markets should not be a consideration unless there is a need for more capital. The implicit assumption that capital from public equity markets is less expensive needs to be tested as well.

Most unconsolidated Blue plans have substantial capital accounts reflecting retained earnings from years in which the plan has met its statutory capital requirements and allocated positive margin gains to its surplus. Surplus can be accumulated and invested. Surplus in excess of the statutory minimum can be applied in ways that make the plan more competitive and can serve as protection against future lean years, when it can be used to buffer negative margins. To a large extent, a nonprofit can

compensate for its lack of access to capital generated in equity markets through the flexibility that it has to manage its surplus capital without pressure from investors or otherwise maximize return on investment. Public equity markets initially produce capital that seems like a liberating resource to many companies. At other times, however, capital that is underutilized will typically compel investors to disturb the strategic plans of a company in order to maximize their return. (Many corporate restructurings involving mergers, acquisitions, and forced sales originate when investors seek a higher return on capital.) Built-up capital in both Aetna and WellPoint that cannot be deployed effectively may provide an example. In a world where fewer large health insurance companies can be acquired, these companies may find it necessary to return capital to shareholders (as Microsoft did) or convince them that the company should diversify to other products or markets. In sum, the nonprofit plan has greater long-term latitude to act in the interest of the overall corporate mission and in the best interests of its customer base.

An implicit form of capital accumulation that characterizes the nonprofit is the tax treatment of its income and property. Most nonprofit plans are exempt from premium taxes and state income taxes. And, in some jurisdictions, nonprofit carriers are exempt from some state and local property taxation.

Our data indicate that, both for converting Blue plans and

for commercial health insurance companies, proceeds from the sale of stock are used to fund acquisitions and to cover the cost of integration of the acquired business rather than to develop the internal capacities to support organic, or “same store,” growth, see Exhibit 6. It appears that proceeds are used for acquisition at ten times the rate for operations. If these acquisitions were necessary to maintain competitive position, and if public capital markets were the only means available to effect these transactions, then this behavior would not be questionable. Given the

evidence, it appears that the public markets have been accessed largely for funding acquisition expenses that do not produce any true efficiency gains as might have happened if proceeds could have been applied to operating capital needs.

▲ Management Compensation

Converting Blue Cross plans commonly have asserted that their organizational form must change in order to retain and recruit talented management by offering equity and the potential for increased wealth from

options. Across all industries, executive compensation is a complex and highly charged subject. One observation is clear, however: numerous studies have shown little relationship between executive compensation and company performance.² Exhibit 7 shows executive compensation and company size, ownership, and performance. It is difficult to see any pattern.

Given that members of the converting Blues’ managements once accepted their positions with a nonprofit entity with an understanding of the limits on

² “Is C.E.O. Pay Up or Down? Both,” by Patrick McGeehan, *New York Times*, April 4, 2004.

Exhibit 6:
Application of Capital Raised for Operations and Acquisitions, 1997-2002
(All numbers in millions)

	Net Capital Raised for Operations			Net Capital Raised for Acquisitions		
	Equity	Debt	Total	Equity	Debt	Total
BCBS						
WellPoint	(\$344)	(\$124)	(\$468)	\$1,109	\$898	\$2,007
Trigon	(34)	296	262	0	0	0
Cobalt	0	0	0	59	0	59
RightCHOICE	0	(23)	(23)	0	0	0
Anthem	9	296	305	2,639	950	3,589
Total BCBS	(\$369)	\$445	\$76	\$3,807	\$1,848	\$5,655
Regional Non-BCBS						
Coventry	(\$172)	(\$54)	(\$226)	\$330	\$0	\$330
HealthNet	(111)	(376)	(487)	2,149	0	2,149
Humana	(28)	441	413	0	371	371
MAMSI	(161)	2	(159)	0	0	0
Oxford Health	(796)	314	(482)	0	0	0
Total Regional Non-BCBS	(\$1,269)	\$328	(\$941)	\$2,479	\$371	\$2,850
TOTAL	(\$1,637)	\$773	(\$865)	\$6,286	\$2,219	\$8,504

compensation, the argument for for-profit parity, in some cases, takes on the appearance of opportunism. The argument that conversion is a condition precedent to recruiting talented management also falters in the face of the performance of executives in well-run nonprofit plans. Whatever the relationship between management success and pay, it is fair to conclude that differentials in executive performance are not proportionate to differentials in compensation.

Moreover, examining returns to shareholders, there is no pattern in the insurance industry suggesting any correlation between return on invested capital and what CEOs of publicly traded companies make.

Recent actions by CALPERS objecting to the payments (in excess of \$600 million) to the officers of WellPoint on the conclusion of its sale transaction to Anthem make the case clearly. CALPERS is suggesting that such payments are excessive given the nonprofit history

of the underlying company. Moreover, given that much of WellPoint's apparent success was its ability to continue to grow through acquisition, the value to Anthem of WellPoint management may not be so clear. Anthem's challenge will be more one of same-store growth, and management skilled at acquisition may be of limited value.

Exhibit 7: CEO Compensation and Value of Unexercised Stock Options for 2002, with Company's Return and Performance (All numbers in millions)

Company Name	Enrollment	Total Revenue (2002)	Earnings after Taxes	Market Capitalization	5-year Stock Performance	CEO Total Compensation	Value of CEO Stock Options (Unexercised)
Aetna	13.7	\$19,878.7	-12.69%	\$7,156.7	16.0%	\$3.73	\$18.64
Cigna Corporation	13.1	\$19,348.0	-2.06%	\$6,460.4	-24.7%	\$1.14	\$6.40
UnitedHealth Group	9.0	\$25,020.0	5.40%	\$26,836.3	226.6%	\$9.46	\$501.56
WellPoint Health Networks	13.2	\$17,338.5	4.06%	\$10,860.9	190.4%	\$7.08	\$81.11
Humana	6.6	\$11,261.2	1.27%	\$1,614.1	-50.1%	\$1.65	\$2.30
HealthNet	5.4	\$10,201.5	2.24%	\$3,278.5	1.8%	\$1.53	\$18.85
PacifiCare Health Systems*	3.1	\$11,156.5	-6.79%	\$847.6	-51.6%	\$1.43	\$1.18
Sierra Health Services	1.2	\$1,278.6	2.85%	\$385.3	-44.4%	\$2.63	\$5.73
Oxford Health Plans	1.6	\$4,963.4	4.47%	\$2,376.2	108.3%	\$3.00	\$25.59
Anthem	11.1	\$12,990.5	4.23%	\$8,653.4	50.2%	\$6.86	\$9.04
Mid-Atlantic Medical Services	2.0	\$2,328.0	4.18%	\$1,890.5	243.2%	\$1.70	\$14.02

* 2001 compensation data.

THE CASE FOR REMAINING NONPROFIT

The data presented here suggest that a strong and credible case exists for Blue plans to remain in a nonprofit, community service mode as envisioned by their founders. In some ways, this finding is startling, given a decade of activity of consolidation of nonprofit plans, conversion to the for-profit form, and the sale of equity in the newly created entities to the public. This industrial transformation could not proceed without the production of a substantial literature devised to justify the process. However, as mentioned at the outset, virtually none of this literature is independent, objective, or disinterested. Indeed, the arguments in favor of Blue plan conversion have reached near-canonical status because they have repeatedly been effective in persuading decision makers of the advantages of conversion. Unfortunately, much of the debate has been dominated by research from investment banks, which stand to collect hefty advisory fees from any plans that decide to acquire or be acquired. Advising converting plans is even more lucrative, owing to the attendant underwriting fees. As a result, industry research in support of conversion emphasizes any potential upsides, while potential downsides are minimized or ignored. Yet, such studies have governed all the thinking surrounding the question whether it is, in fact, necessary for a given Blue plan to convert

to a publicly owned firm.

Given the findings reported here, the discussion can be seen as having another side – the equivalent of a null set, namely, that continued operation as a nonprofit entity is a viable and more efficient option and, as will be discussed below, one that may yield a higher welfare gain for society. The evidence that continued operation as a nonprofit may be the preferred course of action for plans that have not chosen to convert, and, by inference, that some or all of the accomplished conversions may not have been in the best interest of all parties, particularly consumers, enables us to make several cases that the nonprofit form is to be preferred.

Theoretical Basis. The most basic consideration springs from a substantial literature concerning whether it is in the best interest of society to encourage for-profit firms in all parts of the economy, especially the health care sector. Most of the institutions of health care were founded as nonprofit organizations, recognizing both the special nature of the service being provided (ultimately, the provision of life-saving care) and that the market would ration this kind of care on a price basis that would be inappropriate to the situation.

Reflecting the widely held view that health care should not be distributed by ability to pay, the nation's hospitals were organized as charitable or voluntary organizations. Hospitals were also seen as providing a public service. Based on legal precedent in English

law, the common assumption in the United States was that hospitals provided a quasi-public function, that if the private sector did not provide such attention, it might fall to government to start and fund hospitals. Thus, hospitals were seen as critical to the commonwealth but not really the responsibility of government. In fact, government encouraged the nonprofit model by treating the hospital as a fragile economic actor. Hospitals, as nonprofits, set prices at rates only sufficient to cover costs and often failed to collect sufficient revenues. Charitable hospitals were so named because they relied on the charitable contributions of the community to cover revenue shortfalls. Treating hospitals as charitable actors without financial reserves, the law immunized them from civil actions for liability, exempted them from taxation, and protected them from the operation of many labor laws, including the reach of the federal laws permitting unionization of hospital workers.

When hospitals devised a system of prepayment for individuals, they created a nonprofit organization, Blue Cross, to operate these "service plans." Reflecting the special nature of the service, these pre-payment plans enjoyed special corporate charters from the various states and were seen to operate as the state might if it provided a plan for the prepayment of care. Like hospitals, the Blue plans enjoyed special state benefits, including exemption from state

“Moral risk abounds in the health insurance market, putting enormous pressure on insurance companies to underwrite with aggressive criteria, an outcome that is antithetical to the public nature of the produce.”



premium and income taxes. As other insurance mechanisms emerged, the states invested their Blue plans with a special role often known as the “insurer of last resort,” looking to the Blue plan to offer products and coverage to persons who otherwise would find it hard to buy insurance. In some instances, state governments worked with plans to protect them from financial exposure for assuming a role colored with a further public purpose.

With the coming of Medicare and Medicaid, much of the financial justification that drove the charitable nature of hospitals – namely, caring for the elderly and the poor – was assumed by government. The risk of caring for indigent populations was lessened, and the conversion of some of the nation’s hospitals into what economists call “price-taking” organizations began. Publicly owned hospital companies bought up a substantial number of nonprofit hospitals. The conversion of many community hospitals into assets of huge hospital management companies occurred in a short period that coincided with the first decade of Medicare. There has been very little conversion since, suggesting that weaker community hospitals needed the ability to raise capital through public markets for poorer communities, mostly in the South. The result is that we have a national hospital industry made up of a significant majority of traditional charitable hospitals as well as a substantial number of converted hospitals owned by publicly traded companies: in

sum, a mixed industry.

In recent years, substantial academic attention has been paid to the for-profit/nonprofit issue in medicine and elsewhere. This dialog has led to a sophisticated sense among economists, academic lawyers, and policy makers that the nonprofit model continues to be the appropriate corporate form in three instances: where the nature of the good or service is imbued with a public welfare purpose (akin to a governmental interest); where market mediation is controlled by a price system that is irrational or produces suboptimal results likely where there is a moral hazard endemic to the good or service; and where there is no evidence that a net efficiency gain will emerge in a for-profit system. The health insurance market meets these criteria. The mere existence of Medicaid and Medicare, both public insurance programs, suggests the governmental interest in the marketplace. The presence of government regulation also points in this direction. There is little doubt that the price system is irrational or suboptimal in that it does not serve to police underlying costs – there is little evidence that consumer choices have any impact on prices charged by care providers. Moral risk abounds in the health insurance market, putting enormous pressure on insurance companies to underwrite with aggressive criteria, an outcome that is antithetical to the public nature of the produce. Finally, as indicated in the data presented here, there is no dispositive case that for-profit plans are more efficient.

Failed Mergers/Acquisitions.

If a strong theoretical case for conversion and consolidation cannot be mounted, the question becomes why so many Blue plans have taken this route. One answer springs to mind: that most mergers are not undertaken for what prove to be economically rational reasons. The history of mergers across industries is now well settled. Despite the justifications offered at the time of the merger (resting ultimately on either economies of scale or strategic synergies), in the majority of mergers, the promised benefits are never achieved and the mergers might be deemed failures.³

The weight of evidence shows that in only about twenty percent of cases have the predicted benefits described at the time of the merger as ex-ante justification for the deal been realized three to five years after the merger. The “proforma” plan presented by managements to the shareholders of publicly controlled companies nearly always overstate the potential savings and the likely expansion of value that shareholders might anticipate as a result of the strategic synergies described.

Much speculation surrounds the reasons that failed mergers are so common. The predominating reason is that one or both of the merging entities can no longer deliver organic growth within the company. Thus, the company seeks to compensate for its inability to grow internally by appearing

to grow through merger or acquisition. A more cynical view suggests that CEOs unable to deliver organic growth seek merger situations, often serial acquisitions, that bring with them a constant restating of the balance sheet. This accounting confusion may serve to cover the absence of a strategy based on industry innovation for acceptable growth that meets the expectations of shareholders.

Enormous pressure is built into financial markets to compel CEOs to undertake mergers and acquisitions. Investment banks continually present candidate companies and convenient industry rationales for acquisition. Corporate raiders are equally ready to punish success if a company begins to accumulate excessive cash on its balance sheet or the assets of the company appear to be undervalued. In such situations, corporate raiders will move to extract value from the component parts of a firm. Finally, there are fads in business that are often denied or covered over with the rhetoric of financial analysis. The record of clearly unprofitable mergers, noted above, suggests that many acquisitions and mergers arise when a wave of activity, in which firms begin to be joined, becomes evident. If there is contemporary authority suggesting that the merger of similar entities is inevitable (the authority most often supplied by investment banks), many CEOs are happy to jump into the action. (Indeed, many are held harmless under change-of-control provisions in their contracts.)

“Despite the justifications offered at the time of the merger (resting ultimately on either economies of scale or strategic synergies), in the majority of mergers, the promised benefits are never achieved and the mergers might be deemed failures.”



³ Robert R. Bruner, *Applied Mergers and Acquisitions*. New York, 2004.

“The competitive advantage of freedom from earnings requirements has been so compelling, historically, that rival commercial carriers exerted a great deal of political pressure to revoke the Blues’ federal tax exemption.”



The history of Blue Cross acquisitions/mergers is alive with all the suspect reasons that attend such transactions. In some cases, the plan being acquired appeared to see itself as incapable of generating internal growth in sales or profits. For acquiring plans, financial growth appears to be based on continual acquisitions and restated earnings more than apparent competence in absorbing acquisitions. The case of Blue Cross conversion cannot be examined without mention of the obvious personal gain to executives who oversee the conversion of a plan and its subsequent sale to public shareholders. Virtually all executives who have managed this process have benefited handsomely with stock options that have produced significant personal wealth. In a case where the company’s economic reasons are not obvious, one must ask whether personal opportunism is not an important motivation in the conversion. In most businesses, executives who manage a successful sale of their companies into the public market are well rewarded. In these cases, however, the underlying asset is privately owned. In the case of Blue plans, the underlying assets are colored with public ownership. The executives who sell the plan into the public market are not entrepreneurs who were at risk for creating the underlying asset in the first place. Personal enrichment of executives may explain more of the movement to convert Blue plans than any other single motive.

Practical Case against Conversion. In addition to the theoretical case and the observed frequent failure of merger acquisition as a strategy, there are practical reasons for Blue plans to retain a nonprofit organizational form. The first is that nonprofit plans are freer to develop and stick with strategies that, in the long run, operate to strengthen them and prepare them for a more competitive future. The much-bemoaned problem that plagues public companies is “managing to the quarter.” Pressure to improve earnings every quarter forces many companies into strategies that prove adverse to building long-term value in the company. Strategies relating to changing markets or the marketing strategy, adjusting the approach to underwriting, changing the composition of staff, focusing on long-term productivity, and planning capital spending are all influenced by the need to show short-term gains in per-share profitability. Publicly traded companies that set out to build a long-term strategy, one that requires capital investment over an extended period at the expense of dividends, do so at their own peril. Shareholders invariably punish companies that attempt to tell any story that does not translate into short-term earnings growth.

The issue might be seen from a different perspective, what might be termed the real cost of capital – the extra return that shareholders demand from a public company above what they would expect to receive from investing in risk-free government

bonds. Companies generally benefit by tapping the public equity markets because the cost of public equity is normally lower than that of private equity. This is due, among other things, to liquidity in publicly traded stocks. Nonprofit plans, in contrast, have no investors with a claim on profits, and so the cost of retained earnings is essentially zero. As a result, nonprofit managements can operate at superior loss ratios and have the freedom to accumulate and apply surplus in a manner beneficial both to their corporate health and to their policyholders – that is, by offering better coverage at lower prices. Simply put, nonprofit Blue Cross plans, when equally efficient at other management functions, should always have a competitive price advantage over their commercial rivals.

The competitive advantage of freedom from earnings requirements has been so compelling, historically, that rival commercial carriers exerted a great deal of political pressure to revoke the Blues' federal tax exemption. Repeal of the exemption was seen as a way for commercial companies to "level the playing field." For years, Blue plans were able to repel this attack on their tax status by pointing to their "good guy" roles in their local communities, where they provided access to insurance for hard-to-cover risks as insurers of last resort. Among other things, the Blues argued that money that otherwise would be paid in federal taxes was instead available to fund more affordable health

insurance. When some nonprofit Blue plans began to form for-profit subsidiaries, however, this argument lost plausibility, and the exemption fell in 1987.

A second practical consideration is the cost of regulatory compliance for firms operating in a publicly traded environment. This includes administrative expenses such as annual listing fees, auditing and legal fees, and other compliance costs. Estimates of the additional administrative costs for a public firm range from hundreds of thousands to millions of dollars, depending on the size of the firm. Rigorous new disclosure requirements and increased publicly imposed governance standards, such as the Sarbanes-Oxley Act, have raised compliance costs, suggesting that the estimates cited above may significantly understate the current costs faced by public firms. (One large financial services company estimates the annual incremental cost for publicly traded companies due to Sarbanes-Oxley in 2002 to be \$6 million per firm.) And, as mentioned above, with conversion the plan loses its tax exempt status.

It is interesting to note an obvious paradox: just as nonprofit Blue plans have increasingly attempted to seek the benefits of going public, the value of such benefits to the firm (not to executives who conceive and oversee the conversion) may have decreased, while the costs of entering the public equity markets increased. Unfortunately, although firms routinely scrutinize the cost

of borrowings – swapping expensive debt for cheaper loans when interest rates drop, for instance – they do not often apply this type of stringent thinking to the costs of being publicly listed.

A third consideration is that firms in a nonprofit mode can insulate themselves from time-consuming and expensive pursuit of industrial fads that appeal to stock analysts but may have no sustaining value to shareholders or to the converting company. Consider the mutual life insurance industry. During the bull market of the late 1990s, the lure of option wealth for executives and the prospect of fresh capital for expansion induced some well-known mutuals, including MetLife and John Hancock, to convert into stock companies. Two companies that chose not to convert were Northwestern and New York Life, both of which have subsequently been gaining market share at the expense of stockholder-owned companies. The CEO of New York Life observed that the ability of publicly traded insurers to raise new capital actually presents risk. In simple terms, he states, "The pasture turns brown when everyone jumps the fence."

One final, and perhaps compelling, practical argument against conversion is a consideration of the condition of many continuing nonprofit Blue plans. It stands as a testament to the continued value of the nonprofit form that many Blue plans continue to be successful in all parts of the nation and that many, such as Florida and Arkansas, have determined affirmatively that the nonprofit

form is best suited to their futures. Like Michigan, some plans have obtained statutory protection from takeover attempts. In other states, the plans rely on their nonprofit status as a particular strength in dealing with the local market and with their regulators and legislatures.

CONCLUSIONS AND POLICY DISCUSSION

The evidence presented here points clearly toward the conclusion that Blue Cross plans have a viable and comparatively strong future operating as independent entities. Notwithstanding a decade of conversion activity and the existence of a substantial literature produced by investment banking and accounting firms arguing the case for conversion, there is no evidence that for-profit plans operate more efficiently or that simply consolidating plans into larger entities produces higher operating margins. These findings are important because they bear on many issues relating to the future of the American health insurance industry.

Health insurance has long been regarded as a special case among financial and insurance services. The product is invested, by its very nature, with non-market identities. It is no mistake that the origins of health insurance, the history of Blue Cross, set the product in a non-market context. Traditional insurance companies treated sickness and disease as a condition that was uninsurable.

This determination not only captured the potential for moral hazard that attends the product but, more important, acknowledged that eventually illness and disease would be a part of the life of every insured and that the exposure in each case (unlike life insurance, where the contract reflected a fixed benefit) would vary in unpredictable ways. From an economist's perspective, these traits indicate a market that price-taking firms would not enter because the risks would be hard to calculate. Indeed, precisely because of this context of market failure, insurance for disease (health insurance) had to be developed by nonprofit entities.

As medical science progressed and physicians and hospitals developed effective interventions in the process of disease to reduce morbidity and mortality, access to health care emerged as an informal but nonetheless legal "right," and therefore, market mechanisms were seen as potentially inappropriate to its distribution. Although this issue is far from settled, the proposals of schemes to create government coverage of health care through various plans for national health insurance suggest the continuing view that health insurance is not securely settled as a market-mediated service. In other words, the market failure perspective is alive and well as regards health insurance.

With this in mind, two observations must be made regarding conversion of Blue Cross plans. The first relates to what might be called the market

dynamics of the last few years in health insurance. Before the first conversion of a Blue Cross plan, there was growing commentary, originating in the investment banking community, that consolidation would inevitably characterize the health insurance industry. (The same consolidation was seen as the future for the nation's hospital industry, which has seen insignificant consolidation, and the nation's physicians, who were to be "rolled up" into physician management companies – a trend that, once underway proved to have no economic rationale and failed rapidly.) In the early days of the Clinton administration, there were strong signals that only the largest health insurance companies would have a hand in managing the proposed health insurance reform plan. Indeed, the vision developed within the health insurance industry that giant consolidated plans would be the only survivors in a world that was seen as becoming more and more competitive. This vision, as noted, was abetted by the investment banking community.

Metropolitan Life, for one, developed a strategy of dealing with only large "national" employer accounts, focusing on a model where it would buy coverage from local HMOs across the nation. In the process, it forsook its indemnity experience and dismissed many people who had knowledge of specific geographic markets – how hospitals and doctors practice and set prices. When this strategy failed, the company

was unable to return to its past and decided it had to leave this line of business. Aetna sold many of its most profitable lines to concentrate on health. As it bought business and grew, the company soon discovered that health insurance was less profitable and that growth through mergers required special skills. Aetna also found an upper bound on size – it was difficult to cover 18 million lives – and at one point determined to reduce its pool to 12 million. (Both Aetna and Anthem have recently experienced very profitable quarters reflecting, in part, growing skill at targeting new cases and managing pricing decisions more effectively.) It was in this context that Blue Cross consolidation and conversion occurred. The thesis that bigger and publicly traded companies would be the only ones to survive had taken hold.

These organizational transformations, driven by opinion and not empirical research, produced market dynamics of enormous consequence. Once companies started to operate in wider geographies, a new sense of competition entered the market. Prices were bid down, many companies found they could not continue in various markets and abandoned them, and in some instances local carriers determined that they should leave the health insurance business altogether. It was in this environment that some Blue plans decided they must sell themselves to larger plans or else they would fail. But more interesting still is an examination

of the recent decision by WellPoint to sell itself to Anthem. Analysis of WellPoint's economics suggest that it was having trouble achieving organic, "same store" growth across its acquired companies although it had achieved such growth in California. Rather, it relied on continued acquisition as a means of attracting investors by showing expanding revenue over time with the implication that true scale economies would come with each successive merger. In other words, it is likely that what appeared to be the most successful of consolidating companies had reached the end of its ability to effect a case for consolidation. These market dynamics are likely to add up to a net economic welfare loss. That is, health insurance is likely more expensive as a result. Normally mistakes related to market consolidation are encouraged in a free-market economy. In a sector that has been characterized as a classic case of market failure, however, it should be no surprise that customers are probably worse off for all the corporate redefinition in the health insurance industry of the last decade.

None of these observations should be greeted as a case of first impression. The history of mergers and acquisitions across the entire economy might be described as being motivated by hope prevailing over experience. Notwithstanding the extraordinary rate of failure to produce anywhere near the expected economies of scale and market synergies promoted as companies come together, Wall

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Street continues to embrace most acquisitions as if the force of history made the particular deal necessary. “This one will work.” The health insurance industry is a particularly difficult terrain regarding mergers, for the diverse reasons examined above. Thus, although industry analysts and consulting firms will continue to advance rationales for further consolidation, it is likely that the failed mergers in this arena will be as high as the norm for all industries.

There are public policy dimensions in all this precisely because health insurance is seen as a special product. Abundant legislative, regulatory, and political interest in the topic is constant. Because the political will to impose (really, to pay for) a nationalized solution is unlikely to materialize, the continuing and important question for those who lead the nation’s health insurance industry is what course

should be steered to ensure that coverage can be provided in the most efficient and effective manner in a stable fashion over a long period. The answer requires the industry to consider whether driving the entire industry into a profit-making mode makes sense. There is no contesting the fact that, as health insurance takes on more of an identity as a profit-seeking, shareholder-owned industry, the value the industry delivers is being diminished from the customer’s perspective. Shareholders claim dividends, monies seen by many as better spent on health care for customers. The value proposition that distinguishes the nonprofit Blues model is that a larger share of every premium dollar is returned to customers in the way of health care coverage. In the long run, this dimension of the Blues legacy will serve the nonprofit companies well.

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**Appendix:
Revenues for Publicly Traded Companies,
2003**

Company	Total Revenue (2003)
Aetna	\$17,976.4
United Health Group	\$28,823.0
Cigna Corporation	\$18,808.0
PacifiCare Health Systems	\$11,008.5
Humana	\$12,226.3
Health Net	\$11,064.7

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