

BLUE CROSS CONVERSION:

**Policy Considerations Arising From
A Sale of the Maryland Plan**

Carl J. Schramm
Baltimore, Maryland

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This report was completed prior to the announcement by CareFirst on November 21, 2001 that it would be acquired by WellPoint. This proposed transaction has no material bearing on the conclusions reached herein.

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DATA NOTES

1. Data in this report were obtained from insurers' annual reports, from the Blue Cross Blue Shield Association, 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.

2. Companies analyzed include twenty-one independent non-profit Blue Cross plans, seven consolidated non-profit 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. Where exhibits show a number of observations in each category, that number is noted. The number of observations in each category differs in some instances because data were unavailable.

3. During the period of this study, 1997 - 2000, several Blue plans altered their corporate forms. The exhibits show each entity's corporate form as of its most recent annual report.

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

5. Multiple year periods were used to calculate averages in order to avoid potentially misleading single year fluctuations. Each plan's results were compiled on a yearly basis, and an overall average was calculated for the cited years.

Executive Summary, Findings and Recommendations

CareFirst is a holding company organized by the Maryland Blue Cross Blue Shield plan and is the owner of the Blue Cross Blue Shield plans of Delaware, the District of Columbia, and Maryland. Over the past five years, CareFirst has been reconfiguring and repositioning itself in the region's health insurance marketplace by acquiring neighboring Blue plans, restructuring its target markets, and gradually backing away from its traditional role as Maryland's insurer of last resort.

For more than a year, it has been common knowledge in the political arena and the health insurance industry that CareFirst is actively interested in being acquired by a for-profit insurer. Because the disappearance of CareFirst would have significant effects on the health care marketplace in Maryland, it is inevitable that public debate will commence. This report was commissioned by The Abell Foundation to inform and support that debate. It is intended to point community inquiry to the issues and facts that should be widely discussed and carefully considered before any conversion of Maryland Blue Cross is sanctioned. This study raises many more questions than it settles.

CareFirst declined to cooperate in this study. Citing concerns that an inquiry could be disruptive to a possible merger transaction, it informed The Abell Foundation that it would not participate. As a result, analysis of CareFirst's current performance data was not possible, nor was any inquiry into its motivations in pursuit of a merger with a for-profit entity. Critical questions about CareFirst's retreat from serving the individual and small group market for health insurance in Maryland could not be put to management. It was not possible to discuss with management the evolution of CareFirst's strategic blueprint, the apparent absence of which is an important issue to emerge from this study.

The community interest in the conversion of CareFirst into a for-profit insurer is based on the existence of Maryland Blue Cross Blue Shield, since its inception in 1937, as a special participant in the State's health care system. The plan was founded by Maryland's charitable hospitals to enable people to "subscribe" to a hospital care insurance plan. Patients' ability to pay through the plan, in turn, buttressed hospital solvency. As a sign of Maryland Blue's unique role as a partner with the State to ensure access to affordable coverage for Marylanders, Maryland has sheltered the plan from income and premium taxes that other insurance carriers must pay. In addition, Maryland's Health Services Cost Review Commission (HSCRC) has granted the Maryland Blue plan certain differentials in the payment of hospital charges that reward the plan's assumption of risks in providing "substantial, available and affordable coverage" (the SAAC differential) to individuals who otherwise might be unable to obtain health insurance. In many respects, the citizens of Maryland have relied on Blue Cross as the insurer of last resort, to provide coverage to persons who could not buy protection from other carriers, and have been allied with the company since its founding.

As Maryland's largest health insurer, Blue Cross is the single most influential force in the State's health care economy. It insures over two million people in Maryland, and has annual revenues of nearly five billion dollars. More important than its statistical profile are the special expectations that arise from its unique history and status as Maryland's Blue plan. Blue Cross of Maryland was founded in the Great Depression when thousands of Marylanders were without work. Worry about whether they could afford care kept many people from medical attention and the charitable care burden threatened the very existence of many hospitals. Given the weakened condition of today's economy, it is particularly timely to consider the future of health insurance in Maryland without a Blue Cross plan. As people lose jobs, slide down to lower paid jobs, and watch spouses become unemployed, the need for available and affordable coverage may be as

critical today as in previous periods of high unemployment and economic uncertainty.

In the past several years, Maryland Blue Cross has declared that it no longer wants to be regarded as the State's insurer of last resort, and has withdrawn from the Medicaid and Medicare HMO programs. Both of these programs provided comprehensive benefits to poor and elderly citizens and, in the case of the Medicare HMO, important drug coverage. Likewise, CareFirst now is in the process of using its multi-state system of HMOs as the basis to exercise its right to withdraw from the HMO market for individuals and small groups in Maryland. This step has brought forth an unusual declaration from Maryland's Insurance Commissioner, Steven B. Larsen, that the plan is choosing to bolster its profits by effectively rescinding the coverage of thousands of less healthy Marylanders. This retreat from that part of the market that most needs available and affordable insurance sheds light on the limits of the regulatory authority of the State's Insurance Commissioner.

Looking at CareFirst purely as a business, it is hard to identify the strategic vision or plan under which the company is operating. In the past few years, it has been an acquiring plan, buying two of its neighboring plans. The plan has attempted, unsuccessfully, to become a publicly-traded, for-profit company. It also has asked the General Assembly to permit it to change form to become a mutual company, an action frustrated by the legislature. Now, it appears that the plan has offered itself up for sale. It is impossible to discern from the public record whether potential buyers have approached the plan or whether management is seeking offers. It is not hard to see, however, that management is attempting to change its relationship with the market in order to make the plan more attractive to a potential buyer.

For thirty years, Maryland has pursued innovative, explicit policies that have resulted in lower rates of health care cost inflation, reductions in overall health

care spending, and protection of the State's hospitals from bad debt which, in turn, has permitted Maryland hospitals to provide care to anyone regardless of ability to pay. In return for several forms of significant government support, Maryland Blue Cross has participated in this public/private policy partnership by sustaining a market for individuals and small groups that has kept the number of Marylanders without private insurance lower than it otherwise would have been. CareFirst's withdrawal from providing coverage to this market segment could precipitate a crisis in the entire health care financing system in Maryland. Other carriers may be unwilling or unable to shoulder the burden of providing coverage to individuals and groups once covered by Blue Cross and may follow CareFirst out of the market. As a result of the inevitable increase in the number of citizens without insurance coverage, economic balance among hospitals and insurance companies, managed through the HSCRC, could be in jeopardy. The loss of Maryland's commitment to a system that protects the poor and the otherwise uninsurable, while providing a predictable environment for the State's hospitals and insurance companies, would be an intolerable price to pay for CareFirst's corporate ambitions.

FINDINGS

1. Blue Cross of Maryland, the principal asset of CareFirst, is a quasi-public entity created to provide non-profit health insurance to Marylanders. By tradition, Blue Cross provided open enrollment coverage for individuals and persons with medical profiles who otherwise would be uninsurable. It also has provided affordable coverage for individuals and small groups.

- a. Blue Cross of Maryland was founded by the State's charitable hospitals in order to advance their charitable purpose, *i.e.*, providing care to those who could not pay for it while remaining solvent. All of Maryland's hospitals continue to operate as charities.

- b. When chartering the Maryland plan by special legislation, the Maryland General Assembly established charitable expectations, including a requirement that the plan would operate as a non-profit, non-stock entity. These expectations continue in Maryland statute.
- c. The Maryland Blue plan and its parent have retreated from the charitable nature that once characterized the plan. The plan disclaims its historic status as insurer of last resort. It has retreated from offering HMO products that are particularly affordable to individuals and small groups.
- d. Maryland statute does not contain a "charities act" which would impose special statutory charitable fiduciary standards on Blue Cross management and directors.
- e. Blue Cross enjoys exemption from premium and income taxes because it has acted as a charitable entity by performing a public service that otherwise would fall to the State.

2. CareFirst's management appears to be offering the company for sale. In an attempt to make the plan more attractive to a potential acquirer, it has retreated from those higher risk parts of the market in which the need for insurance products is most acute. In so doing, the plan may precipitate an availability crisis that will force other carriers to exit the Maryland market.

- a. Over the last five years, CareFirst has attempted three different business strategies that would have resulted in major transformations of the company. Because it is the largest carrier in the State, its peripatetic pursuit of one strategy and then another creates costly instability in the insurance market.
- b. CareFirst has ample reserves that exceed the minimum established by the National Association of Insurance Commissioners by approximately 500 percent. Neither a merger nor conversion to for-profit form is necessary to protect either the company's assets or its market position, now or in the foreseeable future.

- c. In 2000, the plan enjoyed a State premium tax exemption of approximately \$13 million and also was exempt from Maryland income tax. In addition, the plan enjoyed an implicit subsidy of \$31 million through the SAAC differential, the difference between the reduced amounts that CareFirst has been permitted to pay for Maryland hospital admissions and the actual cost of the plan's coverage of hard-to-insure individuals in Maryland. Since 2000, a portion of that subsidy has been used to fund a short term prescription drug program mandated by the General Assembly.
- d. CareFirst's recent decision to exit the individual HMO market may force Maryland's remaining carriers to provide additional coverage to the individual and small group market, and may, in turn, cause these carriers to withdraw, with the result of even fewer coverage options in this market.

3. There are no economic or business reasons why Blue Cross of Maryland should be sold. Similar transactions involving other Blue Cross plans have not benefited the communities in which those plans operate by achieving lower premiums or better service. The percentage of premiums that is paid out for medical claims is significantly lower in for-profit plans than non-profits.

- a. Conversion of Blue plans does not result in demonstrable economic efficiencies. Profit margins for smaller non-profit plans and for consolidated non-profit plans, *e.g.*, CareFirst, are higher than for larger plans and for investor-owned plans.
- b. For-profit Blue plans return significantly fewer dollars to providers of care than do non-profit plans. A significant portion of the profit margins of investor-owned Blue plans result from lower payment rates to health care providers.
- c. Profit levels in health insurance companies are highly tied to local market knowledge. This is particularly true in the large case market that is the majority of any Blue's book of business. Local market knowledge

becomes attenuated in larger, geographically dispersed, insurance companies.

- d. Many Blue Cross plans are prospering as independent non-profit entities.
- e. There is no evidence that consumers benefit from the consolidation of non-profit Blue plans or from conversion to for-profit status. In many regulatory considerations of the conversion process, this subject is never contemplated.
- f. Many Blue plans have excessive surplus. Excess surplus capital is among the most attractive assets of a non-profit plan because the acquirer usually is able to use the assets of the acquired plan to pay for all or part of the transaction.
- g. Plans believe they must consolidate to fend off competitive threats from larger insurance entities that could enter their markets and compete. In Maryland, there is little evidence that competitors have sought or will seek to enter the market. Among other factors, the HSCRC's uniform "all payer" rate system, under which payment rates are uniform and carriers may not bargain down rates with individual hospitals, has deterred other carriers from entering Maryland to compete with Blue Cross.
- h. CareFirst is the predominant carrier in each of its three markets and enjoys market penetration higher than most Blue plans. CareFirst's accounts are disproportionately stable groups that are less sensitive to price than other customers, *e.g.*, state and local government employers.
- i. Information systems, including member enrollment, claims adjudication, and processing systems, are very difficult to integrate in consolidated companies. As a result, many large health insurance companies maintain multiple legacy systems. No economies of scale result.
- j. While publicly-traded insurance companies have easier access to capital, the price of that capital remains closely related to the performance of the business.

- k. Acquiring plans generally make immediate changes to improve the profitability of the acquired plan including downsizing of its labor force and reducing the medical loss ratio.

4. If Blue Cross of Maryland converts from non-profit to for-profit status, the methods used to value the public's claim on the assets of the plan are critical. In many conversion transactions in other states, the transfer prices recovered have been significantly less than the values that the Blue plans represented to the new owners. Many communities effectively have made generous gifts of their quasi-public Blue plans to management and private investors.

- a. Conventional methods of calculating the transfer price of Blue plans overlook the value of the benefits conveyed to the plans by governments, hospitals, and others in exchange for its community functions, including open enrollment for individuals and small groups.
- b. Conventional means of calculating a transfer price are not appropriate when the business being acquired is organized as a charity.

5. If the proceeds of the sale of the Maryland plan are placed in a foundation, as currently contemplated in State law, such proceeds should be applied to supporting the availability of insurance to individuals and small groups, that part of the market that Blue Cross has served as part of its charitable, quasi-public mission.

6. Blue Cross has contributed to the success of Maryland's unique approach to health care policy as it relates to financing acute hospital care. Maryland has controlled health care costs, protected hospitals from uncompensated care, and supported a hospital market in which there is no discrimination in the provision of care based on ability to pay. The continued development of this policy will be more difficult without a locally domiciled, non-profit company.

RECOMMENDATIONS

1. As a matter of statute, the General Assembly should recognize private insurance companies as the predominant means of providing coverage to the citizens of Maryland. State health policy should reflect the joint goals of keeping total health care spending within acceptable limits, providing adequate rates to the State's hospitals, and maintaining a viable market for private health insurance. Carriers should be able to make sufficient profits and maintain adequate reserves to protect policyholders and providers as well as ensure solvency. State policy also should take as its goal the expansion of private coverage. The General Assembly must reexamine its mandated benefits in the context of the goal of expanded coverage through basic coverage plans. Blue Cross of Maryland should play a critical role in developing products to advance this policy.

2. The General Assembly should provide direction to the Insurance Commissioner and/or the Attorney General as to the charitable obligations of the Maryland Blue plan. Standards should be established in statute and regulation, including explicit standards as to the fiduciary responsibilities of plan management and directors.

3. The General Assembly should expand the authority of the Insurance Commissioner to permit oversight of the operations of the Maryland plan to ensure that the company's management and directors are conducting business in the best interest of the market.

4. The Insurance Commissioner should possess the authority to remove and appoint directors of the plan if reserves fall below minimum requirements, or if the plan's performance falls below established standards for efficient management, or if the plan violates market conduct rules.

5. The Insurance Commissioner should be empowered to establish standards of performance relating to efficiency, medical loss ratios, customer satisfaction, and timely payment to hospitals and doctors.

6. The Insurance Commissioner should be authorized to conduct comparative studies of efficiency and operations and be required to report such results to the General Assembly.

7. The Insurance Commissioner should require that Blue Cross articulate its long-term corporate intentions and describe how its management decisions will impact the insurance market in Maryland.

8. The Insurance Commissioner should be empowered to inquire periodically of the plan's directors regarding their perspective on the plan's commitment to non-profit operations.

9. In the event of an acquisition of CareFirst by a for-profit insurer, the Insurance Commissioner should value the plan using a community economic value approach that accounts for the donative nature of the plan's assets, the gain or loss to the welfare of the community, and the value of the plan as a going-forward business.

10. CareFirst is an attractive acquisition candidate from a market perspective because it possesses strong reserves, predominant market penetration, and control of three markets. In determining the transfer price, the Insurance Commissioner should assume an informed and aggressive "defensive" posture. Many states have succeeded in bargaining the transfer price upwards by significant amounts.

11. If a sale of CareFirst is approved, the General Assembly or the Insurance Commissioner should require that the transfer price be paid in cash, not stock of the acquiring company.

12. If the General Assembly or the Insurance Commissioner is persuaded to take part of the consideration in stock of the acquiring company, the State also must require downside protection against declines in stock price.

13. In determining the value of the plan, the Insurance Commissioner must evaluate the financial condition of the acquiring firm and its likely condition on a going-forward basis. The inquiry should involve a thorough test of pro forma assumptions, evaluation of management competence, and the firm's long-term strategic plan. The State must take care to avoid endorsing a company whose future problems could be Maryland's to solve.

14. The General Assembly should direct the Insurance Commissioner to inquire as to the reasonableness of severance and employment arrangements for plan management in the event of a transaction. Such inquiry should include whether executives or directors will receive payments related to the completion of a transaction, including shares in the new company, from an acquiring company, and the terms of employment for any members of management and/or directors who continue as employees or directors of the new company. All matters pertinent to proposed compensation should be disclosed to the public. In addition, no downside protection of the value of insiders' stock held in a post-deal lock-up should be permitted.

15. When attempting to sell a private company, directors often protect themselves from shareholder suits based on fiduciary expectation by holding an auction. The Insurance Commissioner should be empowered to require this form of disposition if he or she determines that it would be the appropriate means by which to determine and realize the true market value of the plan.

16. The General Assembly should direct the Health Services Cost Review Commission to establish the SAAC differential for CareFirst and other carriers on an audited cost basis such that the differential reflects the actual cost of SAAC policies to the carriers. The General Assembly should authorize appropriate incentive payments to Blue Cross and other carriers to encourage their participation in the SAAC program.

17. Because debt markets are not open to the non-profit plan, the General Assembly should consider expanding the scope of a public agency, possibly the Maryland Health and Higher Education Facilities Authority, to permit CareFirst to sell revenue bonds in the event that the plan needs capital from time to time.

18. The Insurance Commissioner should be empowered to facilitate the sale of either the D.C. or Delaware plans should CareFirst determine that the company needs capital, provided that the Commissioner determines that such a transaction is in the best interest of the public.

19. The Insurance Commissioner should have the authority to regulate the use of the Blue Cross Blue Shield trademark in the State in the event that an acquirer withdraws from the State, is sold to a company determined not to be acting in the best interest of the insurance market, or fails.

20. The General Assembly should direct that any foundation that receives proceeds from a sale of CareFirst should treat the proceeds as a corpus and distribute only the equivalent of an annuity payment at prevailing interest rates.

21. The General Assembly should direct the foundation to apply the proceeds narrowly, in the spirit of the *cy pres* doctrine. The foundation should use its assets only to support the individual market, the small group market, or other

groups that are determined to be in need of subsidies in order to access health insurance.

22. The General Assembly should direct any foundation that receives proceeds from a sale of CareFirst to hold sufficient reserves for a period of ten years to fund the start up of a new non-profit community carrier in the event that the parent company is unable, for any reason, to meet market conduct standards imposed by the Insurance Commissioner.

23. If CareFirst is sold, the Insurance Commissioner should require the acquirer to provide acceptable and affordable products to the individual and small group market. The company should be required to provide a product for a substantial portion of the uninsurable population. The company also should be required to operate in concert with the newly-funded foundation to establish product offerings that might be subsidized jointly by the company and the foundation.

Chapter 1: History of Blue Cross and the Development of Health Insurance

Maryland Blue Cross Founding and Early History

No less a figure than Benjamin Franklin, who established America's first hospital on the monastic foundation model of England and France, set in place an important part of our social contract. Hospital care in the United States was to be a matter of private charitable initiative rather than state sponsorship. The typical hospital operated as a charitable institution, and care was given with little regard to ability to pay. Hospitals were viewed as a special part of the community's support system, often organized by religious or ethnic groups as a means of providing care for specific populations. Because charitable contributions were central to hospitals' continued existence, hospitals customarily were provided with special status under the law. Like the state, hospitals could not be sued for many events that would have been actionable in the for-profit sector. Hospitals were exempt from state and local taxes. Many laws protecting employees did not apply in the hospital industry. Hospitals were regarded as special and economically fragile entities deserving of special protections, and also as providing vital services to the community that otherwise would fall to the state.

The idea of a community hospital payment plan emerged in the Depression, when a sixth of the nation's hospitals failed. In 1931, when Dr. Justin Ford Kimball, a former school superintendent, became head of Baylor Hospital, he noted that many of the institution's accounts receivable were attributable to schoolteachers whose incomes would never permit them to pay their hospital bills. Hoping to improve the predictability of the hospital's revenues, Dr. Kimball devised the first "hospitalization plan" in the country and offered it to the public school teachers of Dallas. Under this plan, 50 cents a month bought 21 days of care. Once planted, the seeds of "Blue Cross" quickly gained national attention as local hospital associations sponsored these plans. In time, physician organizations around the country sponsored similar plans that became known as Blue Shield.

Between the first articulation of the idea in Texas and the charter of Maryland Blue Cross in 1937, forty other cities had followed the lead of the original plan in Dallas. By 1937, these new community plans had enrollments of 1.6 million people. The *Evening Sun*, commenting on this number in the style of Depression-era journalism, observed:

These figures are messengers of cheer to those who have noted the financial distress into which thousands of employed, self-supporting people have been plunged by unexpected illness. Without reserves of money sufficient to meet such emergencies, they have been faced with the necessity of either going into hopeless debt or accepting charity.

Maryland Blue Cross had its origins in a letter circulated among the Baltimore Hospital Conference in late December 1933. A committee of the Conference, reflecting the thinking of the directors of the University of Maryland and The Johns Hopkins hospitals, outlined a community-based non-profit hospitalization plan much like the one established at Baylor.

Fifteen Baltimore hospitals each contributed \$1000 to capitalize Maryland's Blue Cross plan, which was established by an Act of the General Assembly. Such incorporating statutes for specific entities are rare and the legislature's action reflected the special corporate status sought by the plan's organizers. This State-created entity was to be a company unlike others. The legislature granted a charter that, among other things, stated, "*There shall be no capital stock of the Corporation and it shall be operated as a non-profit organization.*" At the close of its first six months of operation on March 31, 1938, Maryland Blue Cross had 15,632 subscribers and a cash surplus of \$347. Monthly premiums for single individuals were seventy-five cents, and family coverage cost two dollars.

Every Blue plan was established to provide payments to hospitals in an environment in which, early on, commercial insurance companies believed there was no market. Although there was rare and isolated availability of commercial health insurance as early as 1909, the concept had no broad-based appeal to the

insurance industry, primarily because it correctly perceived non-profit hospitals as charities that would absorb the losses generated by patients who were unable to pay for services. If hospitals did not pursue patients for non-payment, and patients were not legally obliged to pay, the industry reasoned, adverse risk selection into a customer pool would be pronounced. That is, the only purchasers of health insurance would be people who believed that they were likely to be sick and who felt morally obliged to honor a hospital's bill. In this case, when assessing the financial viability of health insurance in the early part of the twentieth century, commercial carriers concluded correctly that the dislocation of supply and demand for health insurance would flow from unequal knowledge: sick people know something more than the insurance company that undertakes to protect them.

Thus, the idea of Blue Cross emerged both as a protection for individuals, and a solution to hospital solvency. For nearly the first twenty-five years of existence, Blue Cross plans did not operate on an insurance model. As community service organizations sponsored by non-profit hospitals, the plans were thought of as community resources, an experiment with a new part of the civic fabric, and as entities devoted to making the cost of health care a less worrisome part of the everyday life of the citizens. Their primary and stated objective, however, was to make more secure the revenue flow to hospitals in order that hospitals could maintain financial predictability in the face of the performance of their historical charitable missions.

Because hospitals were so innately charitable in character, it is not surprising that the health insurance plans that they invented focused on minimizing deficits. Reflecting the culture of their founder hospitals, Blue Cross plans were designed in every respect to mirror hospital culture and operate as charitable institutions themselves. Thus, coverage was priced such that the plan's income would be just sufficient to pay for the care of the predictable number of "subscribers" that would be hospitalized in a given year. As noted, the monthly premiums for

individuals and for families were equal; there was no adjustment for age, sex or medical condition. This approach was called "community rating" because the cost of care in the community determined the price to every covered person. Simply, anticipated claims were divided by the number of subscribers to arrive at a price per person. Coverage was the same for all individuals, initially 21 days of inpatient care per year, with the hospital receiving payment directly from the plan. (The term "third party payment," now common in health insurance, derives from this practice.) Plans paid the prices that hospitals set. Modest reserves were held only to smooth seasonal variances in claims.

Until the onset of government health insurance in the mid-1960's, all Blue Cross plans approached their task in a manner reminiscent of mutual benefit societies or the mutual assurance plans developed by many fraternal and ethnic groups. Like their parent hospitals, Blue Cross plans were treated from the first as tax-exempt organizations. They were not subject to income taxes at either the state or federal level, and were exempt from state premium taxes. Income on their reserves was untouched as well. Reflecting the non-profit ethos of their parent hospitals, Blue plans operated with strict controls on administrative costs. To dampen any competitive impulses among plans, the plans created the Blue Cross Blue Shield Association (BCBSA) to oversee formally drawn market boundaries; plans that use the Blue Cross trademark cannot compete with one another in the same geographic market. Thus, Maryland Blue Cross owned the geographic market of the state, less Prince George's and Montgomery counties that were part of the District of Columbia plan's franchise.

Blue Cross Faces Market Challenges

The special status of Blue Cross plans began to change in response to four forces. The first was World War II, when the War Labor Board began to regulate wages. Because of wartime demand for production, severe pressure in the labor market caused employers to compete by offering non-wage benefits to workers. This period birthed the five-day workweek and the paid two-week vacation.

Employers also began to pay Blue Cross premiums directly, effectively providing health care coverage to their employees. This was the single most important change in health care financing in U.S. history. Employer payment removed the individual from the price implications of medical care, and employer-paid insurance permitted hospitals to shift costs to employers. This shift was the initial fuel in the inflation of health care costs.

The second force to affect the Blue Cross model was the entry of commercial insurance companies into the emerging market for health care coverage. Seeing the extraordinary growth of Blue plans once employers assumed the burden of purchase, traditional insurance companies moved quickly to develop health products. These companies, mostly skilled in life insurance, immediately applied underwriting and pricing practices that challenged the Blue Cross community rating model. Using what essentially was a casualty model, commercial carriers began to evaluate risk and underwrite accordingly, setting different prices to reflect the risk inherent in a group or likely to emerge given the medical histories of individuals in a group. The "experience rating" approach to pricing was a profound assault on the Blue Cross method, where every person was charged the same price. In a few years the commercial carriers made huge gains in market share, and Blue plans had little choice but to abandon their commitment to community rating. Community rating set Blue plans in the unenviable position of being "stuck" with known higher cost risks that were or would be rejected by commercial carriers. The demise of the community rating method caused Blue Cross an identity crisis that plagued the plans for years. While they proved able to compete using experience rating, Blue plans would continue to chafe at the practices of commercial competitors unfettered by the Blue's historic charitable missions. This feeling was exacerbated by the expectation that the Blues would provide the market with open enrollment plans for individuals, small groups, and high-risk individuals, often uninsurable in the commercial side of the market. The Blues became known, by comparison, as the insurer of last resort, an obligation imposed by statute in a number of states.

The third force that changed Blue Cross was continuing inflation in health care costs. Ironically, that inflation was exacerbated by the very success of the insurance system that the Blues had been so instrumental in creating. As has been observed again and again by economists who study pricing theory in all market sectors, once an individual is insulated from the actual costs of goods and services, and therefore is less price sensitive, pricing behavior undergoes a radical change. Predictably, insurance coverage caused hospitals and doctors to change their pricing strategies. Hospitals, starved for capital and under constant pressure to absorb new technology, began to raise prices. Physicians, knowing that their insured patients did not have to reach into their own pockets, began to raise prices. Further, by inaugurating a system of paying for the subcomponents of a hospital stay or office visit (the famed \$4.00 aspirin), the industry itself stimulated cost increases; hospitals and doctors became skilled in breaking medical encounters into more and more reimbursable sub-parts.

This procedure-based approach to reimbursement proved to be a further catalyst to the development of medical technology. In 1950, medicine was unable to intervene in thousands of deadly diseases that now are commonly prevented or dealt with in short order – and medical care accounted for less than four percent of GDP. Since the 1960s, new diagnostic and surgical procedures, and enormously effective drugs, have radically altered society's expectation of conquerable disease and reasonable life expectancy. Because insurance shields the individual from the cost of technology, the demand for the latest and most expensive medical attention has pushed spending on health care in 2000 to over 14 percent of GDP.

The fourth factor that changed Blue Cross was the inauguration of federal programs to finance health care for the elderly and the poor. As a response to the growing inability of older Americans to afford increasingly expensive care and the growing burden on the charitable hospitals to care for the poor, government

stepped in. In 1965, as one of the “Great Society” programs supported by the unprecedented tax revenues from the expanding post-war economy, the Congress established the Medicare program under which Social Security beneficiaries became entitled to health care subsidies. The Congress then created a similar health care entitlement for the poor with the means-tested program known as Medicaid. States have primary responsibility for structuring and administering the Medicaid program, but half of the costs of the program are contributed from the federal treasury.

Blue Cross benefited in two ways from the governments’ assumption of responsibility for the elderly and the poor. First, the charitable antecedents of the health care system were obscured and, relatively quickly, consigned to the dustbin of history. The elderly and poor populations that had put the strain on the charitable assets of hospitals suddenly were covered by government insurance. As a result, the long-standing expectation that Blue Cross would operate as the insurer of last resort was greatly mitigated. Suddenly, much of the pressure on Blue plans to devise ways to cover marginal groups disappeared. The plans also benefited from the new business of administering the new programs on behalf of the government. In many plans, the business of administration of government claims produced more claims than the plans’ own insured population. The government reimbursed Blue plans on a “cost plus” basis that produced significant new revenue for many Blues; in addition, being the government’s agent in a local market produced yet more market recognition and legitimacy.

Public Payment for the Elderly and the Poor Changes Medicine

Unintended consequences of statutory policy-making is a theme that continually arises in health care. The payment method established in the Medicare statute required the government to reimburse hospitals for all the reasonable costs of treating publicly insured beneficiaries. Suddenly, all kinds of services that were contributed as part of charitable care were priced separately and charged to the government. One example was the clinic services of physicians to indigent

patients. Once donated as part of a doctor's professional obligation and in exchange for privileges in the hospital, hospitals and doctors now were able to charge Medicaid for professional attention. Of even greater importance, however, was Medicare's decision to reimburse hospitals for the cost of replacing capital. Permitting hospitals to include depreciation and interest expense for the cost of technology and buildings proved to have profound consequences. Instead of turning to the community in capital campaign drives, hospitals were able to go to the public bond market and sell debt supported by future revenues. Not only did this shift remove hospitals from the financial discipline imposed by the community to keep hospital infrastructure roughly in line with the community's ability to pay, it also forced hospitals to raise prices to produce income statements and balance sheets to appeal to bond holders. As a consequence of the payment system devised by Congress, hospitals lost the incentive to behave as charities, had new incentives to engage in capital spending that led to building excess bed capacity, and began to behave more like profit-making organizations.

With public funding came the requirement that hospitals keep federally-specified uniform charts of account. With this transformation came the prediction that, in time, the government would establish payment norms for clinical services. In time it did. The theory of payment norms was that the government performed rigorous cost accounting and that the prices paid by the government reflected true costs. In fact, this was never the case. Nonetheless, Blue plans and commercial insurance companies soon followed this pricing structure and began to pay hospitals the same rates paid by government.

Controlling Inflation

Inflation was the catalyst for government's assumption of the role of health insurer. In turn, the government's presence touched off a wave of inflation that dwarfed all previous episodes of price increases. This inflation emerged in three ways. The most powerful was the demand-push inflation created by millions of persons having access to medical attention under publicly insured

circumstances. Second was the upward adjustment in hospital and physician price schedules, as described above, that took place without any supervision on the part of government and that insurers were helpless to stop. Finally, the cost of new capital investment in both infrastructure and technology began to rise at unprecedented levels. The magnitude of this cycle of inflation cannot be overstated: during the 1970s, annual rates of hospital cost inflation exceeded 15 percent.

In the face of this extraordinary inflation, the federal government instituted curbs on hospital and physician spending. Starting with relatively crude regional limits on per diem reimbursement, the government developed more and more sophisticated means to quantify the hospital "product," including the infamous "diagnosis related group" (DRG) method that, over time, was adjusted for the severity of a patient's condition and other factors. Because the states were concerned about the impact of their new Medicaid obligations on their budgets, many imposed public utility type regulation on their hospitals. Maryland pioneered the way with its Health Services Cost Review Commission (HSCRC), which began setting hospital prices in 1974. By the 1980s, in the face of unrelenting inflation, private insurance companies, including Blue plans, devised approaches to satisfy employer-customers who were chafing at spiraling premium rates and were beginning to openly discuss a government-sponsored health system. Health maintenance organizations (HMOs) emerged as a new mechanism of cost containment and insurance companies, including Blue plans, began to buy and build hundreds of HMOs. Insurance companies then conceived "managed care." An ill-defined term, it established a system of administrative and medical checkpoints aimed at reducing demand for care before admission to the hospital and to limit care once a person was hospitalized. Managed care techniques initially were applied to indemnity products. When HMOs could no longer deliver lower rates of premium increases (in fact, they were shadow pricing indemnity products), the techniques of managed care were used in HMOs to limit the medical attention provided.

As the drive to contain costs intensified and the landscape of service and payment mechanisms grew increasingly complex, more and more opportunities for profit seemed to emerge. The first HMOs were decidedly non-profit entities. They were run as cooperatives where doctors practiced under a set of incentives designed to focus on keeping their patients healthy. HMO physicians were not paid on a fee-for-service basis but were salaried employees. As the demand for HMOs grew, however, newly formed HMOs organized as for-profit companies. For-profit hospital holding companies emerged – a natural development once capital costs were covered in government reimbursement formulae. Government's attempt to control costs by encouraging more outpatient care promptly resulted in tens of thousands of physicians reorganizing their practices on a corporate model to supply increasingly sophisticated diagnostic and surgical procedures outside of the hospital. Managed care created opportunities for companies that provided prospective, concurrent and retrospective case review, demand management, and claims auditing.

By the late 1970s, the for-profit organizational form was well established on the American health care scene, and the profit motive repeatedly received the federal government's imprimatur. During the Carter administration, the President endorsed HMOs as the future of health care delivery. The Congress obliged by requiring large employers to offer an HMO alternative, in addition to indemnity plans, to their employees. In 1981 the Reagan administration announced that it would rely on competition, not regulation, to reform the health care system. Overnight, fueled by the thinking of several theorists, the federal government sought to bring the for-profit business model to the health care sector. The encouragement of for-profit HMOs was among the most visible outcomes.

A Charitable Culture Changing

As often happens at moments of change in intellectual fashion, organization rhetoric shifts well ahead of the underlying realities of the business. It became

fashionable throughout the hospital industry to adopt business metaphors. References to community service missions came to be regarded as quaint. The community was now a "marketplace." Hospitals declared themselves to be "market competent" and hospital boards worried about branding and customer satisfaction as well as vertical and horizontal integration. During the late 1980s, some Blue Cross plans began to resist the non-profit community mission that had been their historic ethos. Like many non-profit hospitals that were adopting for-profit vocabularies, some plans began to define themselves as "entrepreneurial," and to reject the traditional Blue Cross non-profit model as passé.

The plans seeking to distance themselves from their parent hospitals found support from an unexpected quarter. Legal activists, concerned that Blue plans and hospitals might engage in price fixing, mounted successful campaigns around the country to break the historic ties between Blue Cross and the community hospitals. By charter, the boards of Blue plans had included representatives of their founding voluntary hospitals. While it was unlikely that trustees from hospitals or physician groups were likely to engage in price fixing conspiracies, the idea prevailed that hospitals no longer should take part in the governance of Blue Cross plans. By the end of the 1970s, Blue Cross plans and the community hospitals that had put them in place had decoupled and were beginning to view each other more as market adversaries than as voluntary health organizations whose missions were to act jointly in the community's interest. Some Blue plans were unhappy with this outside imposition of a shift in their identities. Some continued to work closely with their community hospitals, remaining true to their historic ideals as partners with hospitals in making the health system work in a rational, cooperative way.

Blue plans faced another external challenge to their identity. Commercial carriers, believing that the Blues as competitors showed no particular evidence of more socially conscious behavior than did they, began to argue that the special tax treatment enjoyed by the Blues was an unfair market advantage. The Blues'

federal tax exemption became the subject of a political struggle in Congress in the 1980s. Eventually, the Congress agreed that the Blues had grown so strong, and had adopted marketing, underwriting and pricing practices so similar to commercial insurers, that they should be subject to federal income taxation. In 1987, the corporate earnings of all Blue Cross plans nationwide became taxable by the federal government.

Surging inflation drove a vast volume of money through the health care sector in the 1970s and 1980s. With the enormous expansion of budgets and resources, the charitable culture of non-profit hospitals and Blue plans began to further erode. The public face of Blue Cross began to change as plans built expensive new buildings, became major forces politically and, in some cases, began to look like locally based conglomerates owning and operating businesses far beyond their geographic markets. Many plans appeared to be exuberant with cash flow and growth, and some greeted the repeal of their federal tax exemption as a green light to behave like for-profit companies. Various Blue plans formed subsidiaries to do business in life insurance, computer consulting, financial services and credit cards.

As Blue plans began to behave like major corporate actors, a number were, in reality, on increasingly shaky financial ground. Throughout the 1980s, many Blue plans were losing market share to commercial insurance companies and HMOs. In others, there was poor control of claims costs and expenses. Many plans' only income derived from non-underwriting gains, *i.e.*, income on investments. In addition, many Blue plans were so secure in customer relationships that they were slow to innovate to control costs. Blue plans continue to enjoy a disproportionately high share of the insurance market of public employees, often including state and local governments, school boards, and public universities, where there is less price sensitivity to premium increases. Blue plans also have enjoyed strong ties to unions, perhaps because of union preferences for non-profit over for-profit firms. The failure to respond to market

signals – and to react with timely controls on costs – is widely believed to be the reason that most of the Blues found themselves in trouble by the late 1980s. By 1988, many Blue plans were losing both membership and money, and the BCBSA established a financial “watch list” because of its concern over the adequacy of plan reserves.

A Crisis of Public Confidence

In 1990, the West Virginia Blue Cross plan went bankrupt. This failure caused great alarm among insurance regulators and concern that regulation of the health insurance industry was not adequate. Further, other Blue Cross plans could not or would not move to save the West Virginia plan. As a result, the BCBSA withdrew its trademark and the plan collapsed. Concerned that other plans might not be financially sound, U.S. Senator Sam Nunn convened his permanent investigations sub-committee. That inquiry, which was initiated over solvency, became interested in the corporate diversification and the allied businesses of some Blue plans. Committee members worried aloud that weak claims paying ability might be linked to imprudent investments in tangential enterprises that appeared inconsistent with the mission of non-profit health insurance plans.

The most dramatic parts of the hearings came as the focus turned to the lifestyles and compensation of Blue Cross executives. In a relatively short period of time in the late 1980s, chief executives of plans in Michigan, New York, Maryland and the District of Columbia had engaged in practices that offended public expectations of how non-profits should operate. As reserves were eroding or being invested in “for-profit venturing” (as the president of one plan put it), and when those plans were seeking rate increases to cover shortfalls in reserves, one CEO was enjoying a plan-owned yacht, another a skybox at a major league stadium, and another many trips on the Concorde to oversee the plan’s foreign investments. In yet another plan, a member of the board of directors was the beneficiary of a no-bid construction contract with the plan. One plan had used its funds to settle a paternity claim against the CEO. The unfolding drama also

focused on base salaries, bonuses, and benefits that seemed out of line with the non-profit, public service image promoted by the plans. Pressed by the Congressional attention, several of the boards of the Blue plans under investigation discharged their CEOs, and the BCBSA quickly moved to establish new standards as a condition of using the Blue Cross trademark. Among the new BCBSA requirements prompted by the Nunn hearings were:

- Plan participation in a state guaranty fund or an alternative arrangement to protect beneficiaries in event of insolvency.
- New standards of solvency. (In time, BCBSA would drop its solvency standards in favor of the Risk-Based Capital Standards developed by the National Association of Insurance Commissioners (NAIC).)
- Plan compliance with the Model Holding Company Act promulgated by the NAIC, which requires consolidated reporting of subsidiaries on the parent's balance sheet as a means of making sure that related business activities are in full view of directors, regulators and the public.
- Disclosure of management's financial transactions to plan trustees.
- Restriction of plans' subsidiary activities to businesses related to health insurance.
- Adoption of codes of conduct related to conflicts of interest, compensation, entertainment expenses, and other business conduct.

Interestingly, the scandals may have served to further speed the drift to a for-profit culture within the Blues. For all of the Congressional attention and public outcry, little was produced in the way of altered statutory guidance to the plans to suggest what was expected of them. The hearings had aired the worst of the non-charitable excesses of some specific Blue plans, but the perception among the Blues seemed to be that the underlying business of the Blues was found to be sound enough not to merit federal intervention. Thus, while the Nunn hearings revealed erosion in the Blues' commitment to serving as their community's special non-profit plan including, in some instances, their retreat from their traditional roles as insurer of last resort, the Congress did not intervene

to set higher expectations. Indeed, Congress demurred to self-regulation by the BCBSA, even though its new self-imposed standards failed to meet Senator Nunn's expectation of strong enforcement provisions.

Clinton Health Finance Reform

Shortly after the Nunn hearings, the Clinton campaign to nationalize health care financing failed, taking with it any discussion of providing a system of federal coverage for the uninsured. Every failed legislative initiative of major proportion leaves behind a detritus of concepts that influence the future, and the Clinton plan was no exception. The administration had so emphasized the role that big insurance companies would play under its plan – anointing Prudential, Cigna, Aetna and Metropolitan as the survivors that would manage the new federally-mandated program – that it appeared to many that the template for the future of health insurance was large and commercial. Mrs. Clinton had met privately in Wyoming with these companies, meetings that were notable for the absence of any Blue Cross plans.

The Clinton experience was traumatizing to many Blue plans. In retrospect, it may have been that the Clinton health agenda was being developed at a time that the public image of the Blues from the Nunn hearings had cooled the administration's interest in the Blues. It may also be that the administration, by temperament inclined towards non-profit organizations, did not view the Blues in that light, but rather merely as smaller versions of private insurance companies. This perception was further advanced by commercial insurers that painted the recent history of the Blues as evidence that the plans were not competitive. To add to the confusion, at the same time that the BCBSA was lobbying the administration with the message that the Blues' brand of non-profit insurance was to be preferred in any national scheme, some Blue plans were suggesting that their non-profit form was outmoded and that they were ready to be seen as commercial carriers. Whatever the reasons, some Blue Cross plans came to believe that they had to grow to survive.

Blue Cross Consolidates

A generational change came upon the leadership of Blue plans during the late 1980s and early 1990s. The executives that had been inculcated with Blue values by the progenitors of the Blue Cross concept were giving way to managers recruited to run large 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 of the BCBSA's exclusive geographic market agreement, which restricted inter-plan competition, the only road to growth was acquisition or merger.

1990 appears to have been the beginning of the Blues' movement to consolidate. After the collapse of the West Virginia plan, Cleveland Blue Cross took over the Charleston plan, renaming it Mountain State. This transaction appeared ambitious from a market expansion perspective, but the tenor of the take-over had the old-fashioned tone of protecting Blues' subscribers. Cleveland Blue Cross provided going-forward coverage for the beneficiaries of the defunct plan, but did not assume the liabilities, which left West Virginia hospitals to absorb the largely-uncollectible debt.

In 1989 a tectonic shift in the process of Blue Cross conversion came with the decision by Indiana Blue Cross 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. One view held that the move was a betrayal of the core values of Blue Cross. The other was admiring of the bold move against the BCBSA and its codes of non-profit conduct. Some proponents of the latter view were more explicit, believing that non-profit, one-market Blue plans were outmoded, and that the future belonged to more aggressive, entrepreneurial companies that looked more like their commercial competitors.

The next earthquake came in the early 1990s when Blue Cross of California, already having formed a for-profit subsidiary, relinquished its non-taxed status. The California plan was in the midst of a successful make over into an entity known as WellPoint, which it had developed as a for-profit network of HMO and preferred provider organizations (PPO). 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 non-profit 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 Blues plan conversion.

Learning from California's initiative, other Blue plans concluded that they would have to achieve sufficient critical mass in order to achieve similar success. Constrained from growing and competing Blue-against-Blue, they chose the course of pairing up. Consolidation was underway. During the decade of the 1990s, the number of independent Blue plans fell sharply, from 67 in 1995 to 47 in 2000. As of the end of 2001, the number is 45.

Exhibit 1.1: Four Types of Blue Cross Blue Shield Plan Consolidations

Affiliated Non-Profits	Non-Profits Merged Into Single Corporations	Merged Then Converted To Investor-owned For-Profit	Converted to Investor- Owned For-Profit; Then Acquired or Became Acquired
The Regence Group	CareFirst, Inc.	Anthem Insurance Co., Inc.	Cerulean Companies
BS of Idaho	BCBS of Delaware	BCBS of Connecticut	BCBS of Georgia
BCBS of Oregon	BCBS of Maryland	BCBS of Colorado	(acquired by WellPoint)
BCBS of Utah	BCBS of D.C. (GHMSI)	BCBS of Kansas	
BS of Washington		BCBS of Kentucky	Cobalt Corporation
	Excellus, Inc.	BCBS of Indiana	BCBS United of
	BCBS of Central NY	BCBS of Maine	Wisconsin
	BCBS of Utica-Watertown NY	BCBS of Nevada	
	BCBS Rochester NY	BCBS of New Hampshire	RightCHOICE
		BCBS of Ohio	BCBS of Missouri
	Health Care Service Corporation		(acquisition by WellPoint anticipated)
	BCBS of Illinois		
	BCBS of Texas		
	BCBS of New Mexico		Trigon Healthcare, Inc.
			BCBS of Virginia
	Highmark, Inc.		(attempted acquisition of Cerulean Companies)
	BC of Western PA		
	BS of Pennsylvania		
	BCBS of West Virginia		
			WellPoint Health Networks
	Premera Blue Cross		BC of California
	BCBS of Alaska		(acquired Cerulean Companies)
	BC of Washington		(anticipated RightCHOICE acquisition)
	MSC of Eastern Washington		

Exhibit 1.1 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 non-profits. There is no common ownership; the plans simply work together in ways that are intended to improve productivity and profitability. The Regence model is structured such that plans may join or withdraw, as the Illinois plan recently did.

The second approach to consolidation, exemplified by CareFirst, is to merge non-profit plans together into a single non-profit corporate entity. A third approach similarly merges two or more non-profits into one corporate entity, but does so as a first step in planned-upon conversion to a for-profit, publicly traded company. Anthem, which began life as the Indiana Blue Plan, over the course of six years, brought together nine plans and, on October 30, 2001, took the company 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. In California, conversion was the necessary first step to acquire 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 has 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" process. Anthem, the now-public consolidator of nine plans, 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 so.)

A large number of Blue plans have purposefully 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 as non-profit community plans serving specific geographic areas. Some plans, *e.g.*, Michigan, are forbidden by statute from buying other plans or selling itself.

Blue Cross of Maryland's Recent History and Its Potential Conversion

With the departure of its former chief executive in the wake of the Nunn hearings, the Maryland Blue Cross board turned to William Jews, a local hospital administrator, to run the plan. Mr. Jews took over a plan that had been injured by scandal and had suffered financially. The plan had lost its focus in part because its management had been dealing with a long and complex investigation and the public relations problems that ensued. The Nunn hearings had diverted management's attention from day-to-day issues and, as a result, many operating parts of the plan had eroded. Sales were down and commercial competitors were using the recent failure of the West Virginia plan to suggest that Maryland Blue Cross was not financially stable.

Maryland's new management inherited both good and bad news. Its predecessor management had established an HMO competency that proved to be an important part of the plan's competitive positioning. The bad news was the challenge of small group reform. In part because of significant inflation in health care premiums and the onset of a recession, small businesses throughout the nation were caught in an insurance availability crisis. In Maryland, this created considerable political pressure. The Maryland General Assembly took up the issue in 1993 (HB 1359). Outside forces weighed in to support the bill, including the Health Insurance Association of America, the national association of commercial health insurers, which had embarked on a program to reform the small group market as a means of self-preservation.

The 1993 legislation reformed the underwriting requirements in the small group insurance market – groups of between 2-50 eligible employees. It required guaranteed issue, guaranteed renewal, modified community rating (around rating bands with allowance for age and geography), and a standard comprehensive benefit plan. The legislation also authorized the Insurance Commissioner to require a non-profit health service plan operating in the small group market to file new rates for its health benefit plans if the loss ratio of the non-profit health service plan was less than 75 percent or if its expense ratio was more than 18 percent. Under the bill, HMOs and insurers were held to a minimum 75 percent loss ratio and a maximum 20 percent expense ratio.

The 1993 legislature also created a new state agency that would prove to be significant in the life of Blue Cross of Maryland. The Health Care Access and Cost Commission (HCACC) was charged with consolidating data on the State's health care system, modifying the standard benefit plan in the small group market, identifying trends regarding payment and coverage, reporting periodic findings on such issues as access to care and coverage, and making recommendations to the General Assembly on the State's health financing policy. HCACC took a special interest in the operation of Maryland's individual and small group market.

Also in 1993, in response to the Nunn hearings, the General Assembly enacted a series of changes to the statute governing non-profit health plans, including a requirement that Blue Cross obtain the approval of two-thirds of its certificate holders (the buyers of the insurance contracts; typically an employer, not a covered employee) prior to any sale.

The first indication that Maryland Blue Cross management was thinking about changing its corporate form emerged in 1994 when the company proposed a conversion into a combination of mutual and for-profit entities. The proposal called for the sale to the public of \$50 million of stock, and placement of its

managed care plans and HMOs under the control of a for-profit company. This was the same approach taken by Wisconsin in creating a for-profit subsidiary. Maryland's Insurance Commissioner, Dwight K. Bartlett, rejected the plan, finding that it would violate the 1937 Maryland statute that had created Blue Cross as a non-profit insurer and would result in "profit-making as the dominant motivation" of the plan.

In the 1997 legislative session, Maryland Blue Cross sought legislation that would permit a conversion. The proposal itself was defeated but, in the alternative, the General Assembly established the Maryland Health Care Foundation to receive the plan's "charitable assets" in the event of a conversion. The "charitable assets," defined as the value of the Maryland plan including all of the accumulated assets, would revert to the public. These 1997 legislative enactments were among several options presented over the next few years to the General Assembly in which the Maryland Blue plan seems to have been looking for another identity – as a for-profit company, as an acquirer of other Blue plans and, finally, as a consolidated set of plans prepared to become an acquired plan.

The 1997 legislative session gave signs that all was not well in the relationship between Blue Cross and the State of Maryland. Two major issues gave rise to the General Assembly's concerns. The first issue had its roots in the early days of the State's experience with hospital rate setting when the HSCRC, the hospital rate setting agency, recognized the unique costs incurred by Blue Cross and other carriers who offered coverage to the individual market. In recognition of the higher risk population that would comprise this pool – in fact, recognizing that Blue Cross was functioning as an insurer of last resort when needed – the HSCRC established the SAAC differential under which Blue Cross, in effect, paid a discounted price for the hospital services rendered to its insureds. The differential rate initially was set at four percent to reflect the estimated value of the bad debt protection that was provided to hospitals as a result of having more

people insured. By 1997, however, the General Assembly was concerned that Blue Cross was accepting the benefits of the SAAC differential without returning equal economic value to the market.

There was strong suspicion that Blue Cross had restricted its SAAC products so severely that the four percent differential on all hospital payments was significantly more than the economic benefit received by the market from the SAAC program. As a result, the legislature enacted HB 553 to establish a means to set improved benefits for the SAAC product. The General Assembly's concerns also arose from the work of HCACC, which had embarked on its 1993 legislative mandate to gather and analyze data on health financing trends. Following the recommendation of the task force created under HB 553, HCACC proposed regulations to adopt a small group minimum standard benefit package for SAAC products. Blue Cross opposed the standards, arguing that any such standards would undermine the stability of the individual and the small group markets. Over Blue Cross's objections, the regulations eventually were given life for the open enrollment season of 2000. Blue Cross requested a 47 percent increase for the new small group product, which the Insurance Commissioner denied. At the same time that legislators and regulators believed that more State pressure was necessary to compel Blue Cross to provide products consistent with the intent of the SAAC discount and its other obligations, the perception was growing that Blue Cross was resistant to oversight of its market conduct.

This same issue was more formally addressed by the General Assembly in 1999 when it created a task force to study the non-group health insurance market in general and the SAAC products in particular. The task force, which included the Insurance Commissioner, Steven B. Larsen, and representatives of the HSCRC and HCACC, concluded that the HSCRC differential rate should be reduced from four to two percent to more accurately reflect the cost of the insurance products that Maryland Blue Cross was actually selling to the SAAC market. In addition, the task force recommended audits to ensure that the benefit being received by

carriers actually was being used to fund losses related to the offering of SAAC products.

The view that CareFirst was attempting to avoid its community obligations was furthered by its 1999 retreat from offering the Medicare Plus Choice program in rural areas of the State. This program was developed in response to the federal government's view that moving the Medicare population into HMO-type programs would control costs. Blue Cross of Maryland obliged and provided an HMO enrollment option for seniors that included drug coverage. Blue Cross completely withdrew from the program in 2000. It completed its departure from public programs with its withdrawal as the largest managed care organization in the State's Medicaid 1115 waiver, Health Choice.

At the end of 1997 the Maryland plan acquired the Blue Cross plan of Washington, D.C. Maryland Blue Cross advocated the acquisition on the grounds that it needed to be larger in order to fend off competition, that it needed the combined resources of the two plans, and that economies of scale would produce savings that would permit investment in infrastructure, particularly information technology. CareFirst was created in January 1998 to operate as an "upstream" holding company for the two Blue plans. The D.C. acquisition was followed in 1999 by the acquisition of the Delaware plan.

By these acquisitions, it appears that Maryland was executing a strategy first outlined by the previous management of the D.C. plan. Prior to being discredited, the CEO of the D.C. Blue plan had outlined a strategy by which that plan would take over Maryland and Delaware. The strategy was unique in one important regard: unlike other Blue Cross mergers or commercial plan acquisitions, where proximity of one market to the next seldom had been observed, Maryland consolidated plans with contiguous geographic markets. Given the importance of local market conditions, the Maryland Blue Cross strategy of buying the plans on each of its "shoulders" made great sense.

Although the markets are somewhat different, they are adjacent and the cultures of medical practice are much more similar than not. One need only consider the reach of Aetna's acquired domain, which extends across the entire United States.

Even as Blue Cross of Maryland was accumulating its neighboring plans there was constant discussion in the industry that the plan itself might be the object of acquisition. One of the concerns often voiced by Maryland legislators was that the plan was buying plans as part of a strategy to sell itself. This view began to emerge in 1999 as the plan "floated" the notion that it might be purchased. By 2000, some Maryland policymakers, looking at the consolidation of insurance companies, began to see the sale as inevitable. CareFirst had missed its moment. It could no longer aspire to be a consolidating plan. Companies like WellPoint and Anthem had too much of a head start.

The growing concern about the receding community spirit of the Maryland plan returned to the General Assembly in 2000 when the legislature took up the recommendations of the HCACC study of the SAAC differential that it had mandated in 1999 (HB 43). Under intensive lobbying from CareFirst, the General Assembly left the four percent differential in place, but simultaneously enacted legislation (SB 855) that tied the SAAC to a new senior drug benefit. The carriers that offered SAAC products and were receiving SAAC differentials (principally the Maryland Blue plan) also were required to fund a prescription drug subsidy plan in those rural parts of the State in which the company previously had offered Medicare Plus Choice to seniors. In the 2001 session, by HB 6, the General Assembly improved the benefits for seniors in the prescription drug program passed in 2000 and lowered the premiums. Perhaps most important, the legislature expressed its intent that half of the four percent SAAC differential was to be used to fund the program.

In 2001, the legislature evidenced what now appears to be a further erosion of confidence in the future of Blue Cross of Maryland. Clearly anticipating the sale of CareFirst and disallowing the possibility that it would become a consolidator of other plans, the Assembly passed HB 1042. This bill as originally drafted would have established the authority to take the State's share of the proceeds of a CareFirst sale, the "charitable assets," and use them to establish a new insurance vehicle, the Maryland Health Insurance and Assistance Fund. Establishment of the Fund would have allowed the State to distribute some of the monies that otherwise would have flowed to the previously-created Maryland Health Care Foundation. As proposed, HB 1042 would have structured the Fund as a new insurance vehicle that would have operated as an insurer of last resort. Under intense lobbying from Blue Cross, the Fund was eliminated and, instead, the legislation established the Maryland Health Care Trust to hold the charitable/public assets of a converted non-profit health service plan or non-profit HMO pending distribution of those assets via an act of the legislature. The Maryland Health Care Foundation is named trustee of the Trust.

In this same bill, however, the legislature removed from State law a key component of its 1993 requirement that had required Blue Cross to obtain the approval of two-thirds of its certificate holders (employer-purchasers) in order to sell the plan. Discussions of this repeal were tied closely to the General Assembly's continuing interest in the receipt of promised monies from CareFirst in the event of a sale.

The most recent event marking the relationship between CareFirst and the State reveals yet more clearly the manner in which the company's recent conduct is viewed. In the summer of 2001, because it was losing money in two of its Maryland HMOs, FreeState and Delmarva, CareFirst decided to combine these plans with its D.C. subsidiary, Capital Care. The newly created entity, Blue Choice, did not offer open enrollment as FreeState and Delmarva had been required to do, and medical exams were required of individual applicants. This

option was legally available to CareFirst because of its previous acquisition of the D.C. plan – a consequence unanticipated by the regulators and legislators who had approved the 1997 consolidation.

It was estimated that this action cost about 22,000 Marylanders their health care coverage and that at least 7,000 persons previously insured by FreeState or Delmarva were unlikely to pass physical exams for coverage under Blue Choice. This, in turn, caused public policymakers to worry about an insurance availability crisis – that a rush by newly-uninsureds to other carriers honoring the open enrollment requirement in Maryland would create sufficient pressure on those other insurers to provoke their withdrawal from the State's insurance market. The Insurance Commissioner found CareFirst's decision in violation of the spirit of the State's health insurance reform laws, which had been designed to guarantee coverage, but was unable under his statutory authority to stop the company from proceeding. Commissioner Larsen took the unusual step of calling the behavior of CareFirst to the attention of the leaders of the General Assembly via a public letter in which he characterized the CareFirst actions as an attempt to improve the profitability of the company "at the expense of thousands of less healthy former FreeState members." The Commissioner, reflecting on his previous approval of the merger of the D.C. and Delaware plans, stated that he did not support consolidation that would result in the non-renewal of thousands of Maryland residents through Blue Cross's ability to engage in "selective withdrawal" from Maryland, an option legally open to it because of its ownership of a D.C. plan.

CareFirst further provoked the Commissioner by refusing to commit to participation in the SAAC program beyond July 2002. In response, the Commissioner has pointed to the many subsidies given to CareFirst as a justification for the expectation that it would remain in the SAAC program. CareFirst's move to retreat from its promises to provide coverage to the individual and small group markets exposes the shortcomings of the

Commissioner's authority. He cannot compel the company to undertake specific risks. In referring to CareFirst's actions as violative of the spirit of various Maryland laws, Commissioner Larsen is calling attention to a new culture of the plan that appears to be his abiding concern.

CareFirst's decision to exit the market for individuals and small groups is confrontational. Its refusal to commit to future participation in the SAAC program certainly stands to improve the company's bottom line, but it also may have the effect – surely understood by CareFirst management – of driving other carriers to withdraw from the individual and small group market, thus creating an availability crisis in these market segments. CareFirst's strident posture may have been assumed for political reasons, namely, to force the General Assembly to capitulate to its attempt to convert to a for-profit or be sold rather than deal with additional actions by the insurer that will have the effect of further disrupting the State's health insurance marketplace.

Conclusion

The history of Blue Cross of Maryland is as interesting as any corporate journey ever surveyed. The company began as the creation of charitable hospitals, granted the special imprimatur of the State. It was a pan-charitable organization, established to further the philanthropic purposes of its founders. During the last decade Blue Cross plans across the country have initiated profound reorganizations that have transformed the Blue Cross ideal. A number are now publicly traded, providing insurance in multiple states. In recent years, the Maryland plan has sought to become a for-profit and a mutual company, has consolidated two plans and, less than three years later, has put itself up for sale. These moves do not belie any long-term strategic vision, and this zigzag history is not benign in that it has been accompanied by a continuous retreat from its obligations to that part of the market that Blue Cross has traditionally served, namely, individuals and small groups. Recently CareFirst has used its multi-state status as a consolidated plan to reduce its obligation to these markets in

Maryland. With any further retreat from serving the special needs of the Maryland market, CareFirst will have converted itself into a for-profit company in all but organizational form.

Chapter 2: The Terminology and Concepts of Conversion as a Business Transaction

“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, whereby 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 non-profit or as a converted investor-owned company, or a commercial company, a traditional title given to for-profit entities organized either as stock companies owned by investors or as mutual companies owned by policyholders.

“Affiliation,” as used in this report, describes the coming together of non-profit plans to form an operating entity in which the assets of the partners are not joined. This is a relatively rare occurrence, although the technique can be used as a first step toward conversion. From time to time the term “consolidation” is used to describe the generic process by which Blue plans have come together.

Conversion Concepts

There have been a number of significant mergers and acquisitions of non-profit health insurance plans, but these transactions seldom have been the subject of careful analysis. When such transactions have been written about in investment banking industry overviews, interest group reports and industry opinion articles, most articles have espoused a point of view rather than a neutral analytic approach.

The concepts involved in any insurance company merger or acquisition are complex. In Blue Cross mergers and acquisitions, this complexity is exacerbated

by the lack of experience with the behavior of non-profits in the world of for-profit mergers and acquisitions. Because little objective analysis exists, the verbiage surrounding Blue Cross conversions sometimes slips into a jumble of concepts and arguments to support one or another aspect of a particular transaction.

What is the reasoning of corporate executives when considering whether to buy another company, or to sell a business to another entity? Does this reasoning process differ between for-profit mergers and acquisitions and the transactions being undertaken or contemplated by non-profit Blue plans? Generally, three ways of analyzing business sales and purchases can be employed. These analytic tools, which can be characterized as *deal analysis*, *business analysis*, and *strategic analysis*, can be helpful in understanding the merger and acquisition activity of Blue Cross plans. Fundamentally, *deal analysis* requires that a transaction meet minimum standards for “making the deal work.” This perspective focuses mainly on fairness and price, and tends to evaluate the combined entity at the time of the combination. In *business analysis*, the focus is whether the deal makes sense for both companies over a longer term. *Strategic analysis* typically is more subjective, and brings creative elements into play with quantitative measures to assess the “big picture” of the future prospects of the completed business combination.

Deal Analysis. Of course, other than in a distress sale situation, any transaction must meet minimum standards for “making the deal work” for both the buyer and the seller. Such standards are a small universe of rules that have emerged among investment bankers to ensure that any proposed transaction will not harm the acquiring firm or, at least from a legal perspective, its shareholders. Typically, selling and buying management determine the sale price through negotiations. The proposed price is tested to ensure that it is “accretive,” that is, that the earnings contribution of the acquired company, when offset by the costs of the transaction, will have a positive impact on the consolidated income of the combined company. Collateral issues relate to other opportunities for savings,

for example, from the acquisition of a direct competitor. In such cases the potential for reducing redundant costs would be examined. Calculations of accretion often reflect various assumptions regarding reductions in costs and economies of scale in the combined entity. Similar calculations attempt to value the combined enterprise in the eyes of the shareholders. Thus, in the combination of two publicly-held companies, an accretive transaction is expected to produce an increase in the value of the combined enterprise – measured in terms of the market value of the stock of the combined entity – that is greater than the value of the sum of the two enterprises standing apart. In other words, the new whole should be greater than the sum of the old parts.

In any transaction between publicly-held companies, the firm that is being bought seeks an independent expert to ratify management's view that the acquisition price reflects fair value for the company. A "fairness opinion" is vitally important for the selling firm because acquisition transactions almost always produce immediate economic reward for its management. Key managers of a selling company, working under strong incentives to get a sale done, seek to protect themselves from subsequent shareholder claims that management "sold out" shareholders' interests at too low a value in order to profit personally.

In the process of deal analysis, pro forma forecasts always are performed to project growth of revenue, expenses, and gross and net profits for the combined entity. Necessarily, many assumptions are made regarding how the merged company will function. Revenues are projected using various price and demand assumptions by market and by product, expense forecasts employ assumptions about the expected synergy effects, and scenarios are developed about pre- and post-tax earnings. The assumptions underlying the transaction are described in some detail so that investors can judge whether the forecasts are more or less conservative in their description of the likely return on invested capital.

History suggests that pro formas have proven on average to be generous views of the future of combined companies. This is not surprising given that pro forma forecasts are paid for by the acquirer, have become a ritualized part of the transaction, and are legally less important than the fairness opinion. Pro formas also tend to fade into history once the joined entity begins to operate. Generally, they do not operate as a promise to investors, and thus cannot be used in claims against either the buying or selling firm except in a case of intentional or knowing fraud.

The elements of deal analysis set forth above are routinely applied to the acquisition of one publicly-held company by another. As a practical matter, when a to-be-acquired firm is privately-held, deal analysis applies only to the publicly-held acquirer. Either the owners of a privately-held company are satisfied or the deal does not take place.

How does deal analysis apply, however, when the company to be acquired is, like Blue Cross, neither publicly-held nor privately-held? How do we quantify the elements of deal analysis for the acquisition of a company, like Blue Cross, which was conceived and operated for many years as a community service and which has been the beneficiary over many years of significant public largesse?

For two reasons, deal analysis in such a situation looks very similar to the acquisition of a public company. First, the value of the charitable assets of the non-profit plan must be articulated in order to assure the stakeholders – in this case, both policyholders and the taxpayers who have provided years of financial benefit – that the price of the acquisition is fair. Second, because management generally will benefit personally from such an acquisition, a neutral opinion as to the value of the company must be sought to protect officers and directors from the charge that they breached their fiduciary duty by approving a deal at a given price. Because of the size and scope of Blue Cross's health insurance coverage

in the State, pro forma forecasting also will look similar to that performed in anticipation of the sale of a publicly-held company.

As the review of its elements shows, deal analysis fundamentally is static and relates principally to the workability of the combination at the time of the deal. Because of these limitations, other methods of analysis often are employed to evaluate the advisability of business combinations.

Business Analysis. Business analysis is a more dynamic analytic tool. From the perspective of the companies involved, business analysis queries whether the proposed merger will pass a number of economic tests that, on balance, portend the likely success of a new entity. Instead of the more ritualized process of deal analysis that is biased toward producing support for a proposed transaction, business analysis focuses on the viability of the combined company at the end of a finite period, for example, three years. Business analysis often is a more realistic assessment than deal analysis in that it allows that a bad deal could result in a loss of capital.

As in deal analysis, analytic protocols are applied. The first test examines whether there are economies of scale that will apply to the combination that neither firm alone otherwise could realize. Is there an organic synergy that is clear and easy to execute? The second inquiry concerns whether the combined firm will have stronger protections against competition – sometimes known as “barriers to entry” to competitors – as a direct result of the combination. A third test examines whether the combination will be able to effect advantageous price setting. A fourth condition relates to the ability of the combination to influence market demand. Are markets expanding in a way that the combined firm can exploit market conditions better than each firm standing alone? Finally, is there a higher proportionate yield to invested capital as a result of the consolidation?

In the midst of a proposed conversion, the component tests of business analysis often are not carefully scrutinized. Unlike deal analysis, business analysis often yields a number of reasons to reconsider the wisdom of a transaction.

Strategic Analysis. Strategic analysis is the name given to the often non-rational forces that influence deal making decisions. These forces can overwhelm the relatively mechanical application of deal analysis, and also can overtake the tougher dynamic tests of business analysis and the application of economic models. The term itself is alluring in its promise of business prescience; it lives up to its promise when the analysis is correct – one would say, for example, that Bill Gates displayed a certain knack for strategic analysis in the 1970s – but looks like mere guesswork in failure. Is the CEO of the acquiring entity right about how the market for health insurance might shift? Is management correct in its assumptions about the future role of government in the health sector? Will demographic trends, patterns of disease, or characteristics of employment in the market served by the firm play out as predicted? Is there a shift in the firm’s environment that will work to the advantage of a combined company? Are economic conditions going to lower interest rates, affect enrollment, increase product demand, limit premium increases? Can assets that are not directly complimentary now be assembled and wisely brought together because of a shift in technology?

Strategic analysis can add to – or overcome – more traditional analysis of business combinations to supply the creative spark that propels new business synergies. It often is less a “standard” by which to examine a deal than a “hunch” that there is a deal to be made. Many deals are made on intuition because no quantifiable business arguments or economic proofs can be advanced to support the proposed action.

The Application of Analysis

These types of analysis have been applied to examine most mergers or acquisitions of Blue Cross plans. Most Blue plan transactions have relied most heavily on deal analysis. This report looks more to the perspective of business analysis, a more rigorous approach that forces a focus on the transaction not as one event but, rather, on the longer-term consequences. The strategic aspects of the transaction also will be examined. In addition to the examination of these traditional modes of analysis of Blue plan mergers or acquisitions, this report also advances a new analytic model, the community economic value model, as an appropriate means to evaluate Blue Cross transactions.

Chapter 3. Consolidation and Conversion in the Health Insurance Industry

Is a merger with or acquisition by a new for-profit parent necessary for the survival of Maryland Blue Cross? Do economic factors argue for a merger or an acquisition? The likely result of such a transaction is the loss of Maryland's major non-profit health insurance plan, its largest carrier, and the entity that in the past has stood in the role of insurer of last resort. As such, the "burden of proof" required to justify such a corporate transformation is higher than that imposed on a transaction involving a privately owned or commercial insurance entity. As discussed, Maryland citizens have a serious interest in the outcome of the transaction; thus, the rationale for this proposed move by Blue Cross, particularly as those reasons relate to the future, must be carefully examined.

Trends in Health Insurance Consolidation and Conversion

As detailed in Chapter 1, the last ten years have seen a non-stop process of deal making among Blue Cross companies, among commercial health insurance companies, and between Blues and commercial companies.

Exhibit 3.1 shows merger and acquisition activity of some of the largest health insurance companies in recent years. This activity reflects the recent and radical shift in the views of the future of health insurance as a business. Shortly after the failure of the Clinton health reform plan in 1994, many health insurance carriers appear to have changed their long term thinking on the soundness of the market on a going-forward basis. Some organizations decided to stake their futures on health insurance, while others with long and successful experience in the industry threw in the towel.

Exhibit 3.1: Mergers and Acquisitions Among the Largest Commercial Companies

All numbers in millions

Company Name	Total Revenue (2000)	Enrollment	Mergers and Acquisitions
Aetna	\$26,818.9	18.1	U.S. Healthcare; New York Life's NYLCare managed health business; Prudential and Equitable's health care business.
UnitedHealth Group	\$21,122.0	8.6	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	\$19,994.0	15.0	EQUICOR; Healthsource; Equitable Life Insurance. Expanded to China, Mexico, India, Brazil, Poland and other countries in the 90's.
PacifiCare Health Systems	\$11,497.3	3.7	Harris Methodist Health Plans; QualMed Washington Health Plans; ANTERO Health Plans; FHP International.
Humana	\$10,514.0	6.5	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	\$9,076.6	5.4	Western Universal Life Insurance; Occupational Health Services; California Compensation Insurance; CareFlorida Health Systems; Intergroup Healthcare; Thomas-Davis Medical Centers; Managed Health Network.

For decades, Aetna not only was one of the “big five” in commercial health insurance, but also was a multi-line insurance company with an enormous pension, casualty and reinsurance business. In 1994, the company began a process of selling off other lines of business, including its highly profitable American Reinsurance subsidiary, and now is singularly devoted to health insurance. Concurrently, other “big five” health carriers decided that health insurance was not their future. Metropolitan Life, the nation’s largest health insurance company, acquired the Traveler’s health business in 1994, and then sold all of its health business to United Healthcare in 1996. Prudential, Equitable, Travelers, New York Life and John Hancock also walked away from

enormous health insurance market presence to concentrate on other lines of business. Over a period of just six years, Aetna successively acquired U.S. Healthcare, by then one of the largest for-profit HMOs, and the health units of Equitable, Prudential, and New York Life. Of the “big five” of only ten years ago, only Aetna and Cigna remain in the health insurance business.

Arguments for Blue Cross Conversion

Large commercial carriers were not alone in their merger activity of the past decade. As outlined in Chapter 1, a significant number of Blue plans also joined in the trend. Four principal rationales are common to all past attempts to convert Blue plans to for-profit companies. They appear in various filings made with state insurance commissioners, in public filings with the Securities and Exchange Commission, and in offering documents circulated by Blue plans in the course of offering initial and subsequent rounds of stock in public markets. In the case of Maryland Blue Cross, these arguments have been made in several fora, including before the State’s Insurance Commissioner when the plan argued for approval of its acquisition of the District of Columbia and Delaware Blue plans.

Efficiencies Can Be Achieved Through Economies of Scale. The most commonly advanced – and apparently most persuasive – of the arguments for consolidation among Blue plans has been that bigger entities provide the advantages of economies of scale. In classical economic terms, scale economies relate to the marginal return on each additional unit of production. This argument suggests that as a company becomes larger it can spread overhead costs among more units of service sold, thereby achieving a higher rate of return on invested capital.

This accretive argument is simple and appears self-evident. Economies of scale generally is the first argument in any deal justification – that with the addition of the acquisition candidate the acquiring company will be able to achieve a critical mass such that the costs of goods sold per unit will drop and earnings and

internal rates of return per share therefore will rise. Simply, bigger is better because it is more profitable.

Competition Can Be Met Successfully Only Through Growth and Conversion. Many Blue plan consolidations rest on the assumption that smaller, locally focused plans will face unbeatable competition from larger, previously merged entities or commercial behemoths, and that this disparity will result in the eventual ruin of smaller plans. In support of this proposition, some industry leaders cite examples of large employers that have switched to “one stop shopping” rather than purchasing health plans in each geographic market in which they do business. Whether such examples constitute anecdotal evidence or a real trend, industry perception is that the new world of employer service will demand larger health insurance companies.

Needed Capital Cannot Be Obtained by Non-Profits. In advocating conversion to for-profit companies, Blue plans consistently have emphasized that their non-profit status handicaps their efficient acquisition of capital. Non-profit companies cannot raise capital through the normal channels of debt and equity because investors and lenders are not interested in companies where there is no opportunity for investment returns and where the assets are charitable in nature and hard to collateralize. Generally, Blue plans have pointed to three major areas of need for capital: marketing and sales, improvements to operating systems and new infrastructure (especially information systems), and build-up of reserves in order to ensure their fiscal stability.

In any business, growth relates to successful marketing. In order to compete, Blue Cross plans must be able to mount sales and marketing campaigns to expand their market penetration. In the health insurance business, the ability to expand sales often is related to product innovation to meet the not insignificant importance that “benefit fads” can play among large employer purchasers. Marketing resources are needed to innovate and sell. Advertising also is key to

such efforts, and resources are needed to mount large-scale product introductions and to supply sales support. This is arguably more complex in many Blue plans; relative to most carriers, Blue plans use numerous, often competing, distribution channels, commonly including direct marketing forces. Additional resources permit the growth and improvement of a plan's marketing team, and also its ability to offer stronger incentives to its distribution partners.

Intuitively, improving operating systems is a logical and laudable goal. Because the overarching determinant of profitability in health insurance is account retention – in a typical company, the costs of case acquisition and initiation mean that profits often do not flow until the third or fourth year – it would seem logical that improved customer satisfaction and, therefore, account retention and profitability, would flow from better claims adjustment, more accurate provider credentialing and payment systems, and new systems to improve interaction with customers. Insurance companies routinely set ambitious goals for improving customer satisfaction as a means of improving retention and profitability, and tend to see improvements to operating systems as a necessary, and expensive, step in that process.

In addition, the advocates of specific Blue Plan conversions have argued that, in order to meet more aggressive health insurance competition in the future, their organizations must undertake significant spending on new infrastructure, especially information systems. The current argument cites the need to build information systems to accommodate the data and privacy requirements of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). The specters of enormous information technology spending in the immediate past include Y2K, electronic medical records, automatic claims adjudication, and "on-line" payment. The Blues 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 is largely dependent on the underwriting cycle, an industry-wide 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 higher risks to enter its pool. This is the “soft” side of the underwriting cycle. In time, of course, the poorer risks prove more expensive to cover, thus forcing the company to increase its price and reject bad risks at renewal time. This is the “hard” side of the cycle.

Any company’s ability to play the cycle reflects the level of reserves and surplus on hand. Playing the cycle presents many opportunities for danger. One of the most difficult challenges is that the underwriting cycle is very poorly understood; there seldom is agreement on when it begins, when the price trough is at hand, and when the cycle has concluded. If a company is caught not increasing its prices fast enough as the cycle hardens, 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 aggressively use price as a means of improving market share.

Attracting Management Talent Requires Parity in Compensation.

Conversion also is advanced as a solution to the problem of attracting the management talent needed for Blue Cross plans to succeed in the future. Generally, plans have argued that management needs the incentive of participating in equity, e.g., stock option plans, in order to grow the enterprise value of the company. Some managers in non-profit 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 value of the organization.

Examining the Arguments for Conversion

These arguments for Blue plan conversion have reached near-canonical status because they repeatedly have been effective in persuading decision makers of the advantages of conversion. They are being recycled, in Maryland and elsewhere, because they are successful, not necessarily because they are sustainable from a factual perspective. It is important to objectively assess the operation and validity of each of these four common themes. Preliminarily, however, it is important to understand the environment in which these themes are sounded.

The Conversion Belief System. Many transactions are driven by belief systems. Once proponents come to believe that a certain course for the company's future is (a) inevitable, (b) future oriented, (c) the only way to save the company, or (d) all of the above, the mantra of the deal can bring neutral questioning to a halt. Potential upsides are emphasized and potential downsides, perhaps even subconsciously, are minimized or ignored.

Everyone is familiar with the unwelcome contests for corporate control, called "hostile" takeovers. Such episodes are instructive in the health insurance community, in which the majority of mergers and acquisitions have been "friendly," *i.e.*, uncontested. In a hostile takeover, the belief system is challenged. The takeover candidate, the target company, is skeptical of the belief system that has been constructed by the acquiring company. The target may not believe that a combined entity will be more efficient, or that capital access will be easier as a merged and larger entity, or that capital costs will be lower. The target also may believe that it could be better prepared to meet the future alone or with a different partner, or that the strategy of the acquiring

company is dangerous to the welfare of a joint company and its shareholders. In the 1980s, the heyday of hostile takeovers, literally hundreds of advertising pages of the *Wall Street Journal* were devoted to the attempts of contesting parties to persuade each other's shareholders of the validity of their belief systems.

Likewise, experienced investors with a stake in a corporate merger know the wisdom of challenging the belief system advanced by management for the sale or acquisition of a company. They recognize that selling management is in a "sell" posture, that buying management is in a "buy" posture, and that each is supported in its certainty of purpose by a team of investment bankers. Everyone wants to "do the deal." As successful dealmakers repeatedly tell us from the shelves of airport bookstores, there is excitement, energy and optimism inherent in the prospect of creating a new entity that will be more than the sum of its former parts. In addition, both management teams typically have strong financial interests in a successful transaction: for the acquiring team, bonuses for a growth in revenues and/or earnings of "X" percent; for the selling team, the triggering of employment agreement terms that may make future compensation immediately payable and/or agreements with the new owner that may provide for continuing employment and bring participation in the new company's stock plan. Investment banking advisors have strong incentives – their success fees – in seeing a transaction through to completion.

Seasoned investors recognize these elements of momentum. Because they are being asked to join the "buy" side of the transaction by committing their capital, they test every argument for its validity. The logical first question relates to opportunity costs – *is this the best use of my money, or are there better opportunities for gain?* The dispassionate investor's analysis is both absolute – *is this a good deal that makes sense?* – and relative – *are there better deals to be had?*

Maryland's public policymakers, in considering the terms of a sale that would involve the return to the State of the Blue plan's charitable assets, are in much the same position as an acquisition candidate that is being wooed by a potential acquirer. Maryland's "seller" status is even more clear in the event – as has been postulated – that the State would take shares in an acquiring company in exchange for its release of Blue Cross from its quasi-public obligations. In such a case, the State would be a holder of the acquiring company's stock with an interest in its future performance. Policymakers must analyze and test the proponents' belief system and arguments to determine if today's bargained value represents a fair exchange for the future services that might otherwise be rendered to the State by a non-profit Blue plan.

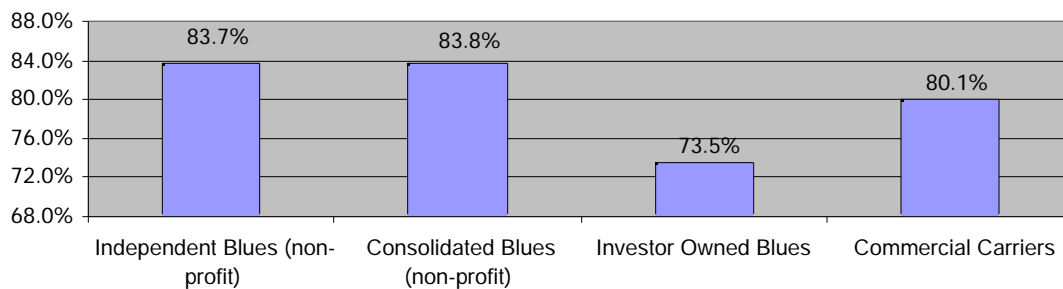
Scale Economies – Is Bigger Really Better? There is significant evidence that scale economies do not operate in the health insurance industry with the same force as in other industries.

Non-profit and for-profit health insurers display very interesting differences in internal operations. Of particular interest is the amount paid out in claims as a percentage of revenue. Revenues consist of premiums paid in, in addition to income realized from investments. Thus, the higher this ratio, the higher percentage of revenues that are paid out on behalf of insureds. As shown in Exhibit 3.2, two trends emerge. Overall, non-profit, independent Blue plans and consolidated non-profit Blue plans have the highest claims cost ratios, averaging an 84 percent payout. Commercial carriers pay out an average of 80 percent. Investor-owned Blue plans, *i.e.*, those that have consolidated and converted to for-profit form, average 74 percent. In the journey from independent, non-profit Blue plan to consolidated, for-profit Blue plan, the claims cost ratio declines, on average, ten percent.

Why might this transition in corporate form result in a lower percentage of revenue being paid out in claims compensation? The most important reason is

pressure exerted by shareholders to achieve earnings. The data suggest the power of this relationship. Indeed, investor-owned Blue plans appear to be required to demonstrate to the capital markets that their claims costs compare favorably with other publicly-traded insurers. In the drive to achieve stock price performance that is superior to commercial carriers, the converted Blue plans appear ready to reduce claim payout. Adding to the pressure on lower claims costs is the fact that overhead in investor-owned and commercial companies is significantly higher than in non-profit plans. In the same four year period, administrative expense as a portion of premium revenues was 13 percent in independent non-profit Blue plans; in the consolidated non-profits the figure was 13.4 percent; in the investor-owned Blue plans, 23.4 percent; and in commercial carriers, 15.3 percent. Higher regulatory costs, investor relations costs, and communications costs characterize investor-owned companies.

Exhibit 3.2: Percent of Total Revenue Spent on Health Care Claims, by Organizational Type (1997-2000)



Independent Blues (non-profit), n=19; Consolidated Blues (non-profit), n=7; Investor-owned Blues, n=4; Commercial Carriers, n=10.

Economies of scale also may be mitigated in Blue conversions because the health insurance industry presents particular post-merger integration challenges. Perhaps the most powerful evidence that economies of scale do not necessarily mean higher profits comes from a review of 2000 earnings, the most current available data, for Blue companies across the size spectrum. Exhibit 3.3 shows that the smallest Blue plans have slightly higher earnings.

**Exhibit 3.3: Comparison of Ten Smallest BCBS Plans to
Ten Largest BCBS Plans, All Organizational Types**

Smallest Blue Cross Blue Shield Plans by Enrollment

All numbers in millions

Company Name	Enrollment	Total Revenue (2000)	Income after taxes	Earnings after taxes	Percent of total revenue spent on claims
Idaho Blue Cross	0.30	\$377.9	\$5.1	1.34%	*
North Dakota Blue Cross Blue Shield	0.40	\$628.6	\$24.9	3.95%	87.18%
Montana Blue Cross Blue Shield	0.43	\$365.6	\$1.7	0.47%	87.20%
Pennsylvania Blue Cross Blue Shield Northeastern	0.55	\$860.1	\$21.5	2.50%	86.59%
Rhode Island Blue Cross Blue Shield	0.56	\$1,353.0	\$58.8	4.35%	85.11%
Oklahoma Blue Cross Blue Shield	0.56	\$687.1	\$4.6	0.66%	86.77%
Hawaii Blue Cross Blue Shield	0.62	\$1,188.1	\$4.7	0.40%	*
Kansas City Blue Cross Blue Shield	0.81	\$722.0	-\$3.7	-0.51%	78.15%
Arkansas Blue Cross Blue Shield	0.86	\$789.8	\$11.2	1.42%	85.73%
Premera Blue Cross	1.20	\$2,130.4	\$38.0	1.78%	83.36%
Average	0.63	\$910.25	\$16.67	1.64%	85.01%

Largest Blue Cross Blue Shield Plans by Enrollment

All numbers in millions

Company Name	Enrollment	Total Revenue (2000)	Income after taxes	Earnings after taxes	Percent of total revenue spent on claims
Cobalt Corporation	2.80	\$642.70	-\$40.0	-6.22%	77.45%
RightCHOICE	2.80	\$1,078.3	\$35.5	3.29%	71.27%
Tennessee Blue Cross Blue Shield	2.90	\$3,633.4	\$51.3	1.41%	87.72%
CareFirst	3.00	\$5,056.3	\$63.8	1.26%	88.48 %
The Regence Group	3.05	\$5,341.3	\$55.5	1.04%	88.73 %
Empire Blue Cross Blue Shield	4.00	\$4,240.2	\$190.4	4.49%	80.81%
Florida Blue Cross Blue Shield	5.00	\$5,070.0	\$73.0	1.44%	79.35%
Anthem Insurance Companies	7.00	\$8,771.0	\$226.0	2.58%	74.69%
Health Care Service Corporation	7.00	\$10,463.6	\$173.8	1.66%	87.08%
WellPoint Health Networks	7.70	\$9,229.0	\$342.3	3.71%	75.15%
Average	4.53	\$5,352.58	\$117.16	1.47%	81.07%

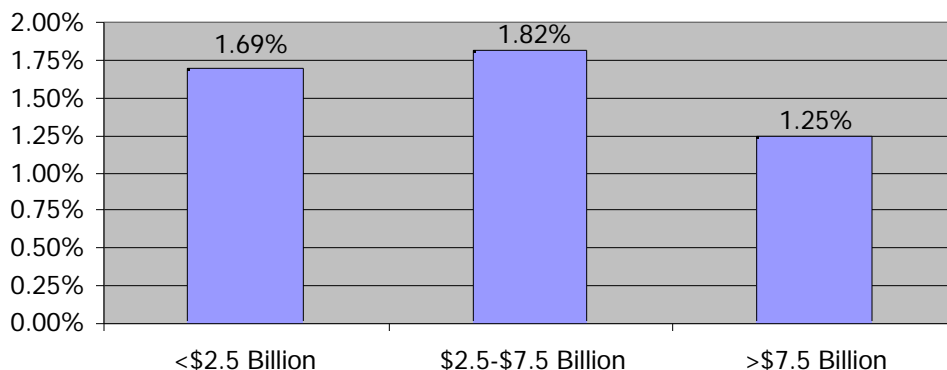
Note: Only BCBS plans that have published 2000 financial data are included in this analysis.

* Indicates data not available.

Numbers may not sum due to rounding.

The profit margin information shown in Exhibit 3.4 is similarly instructive. The data suggest that optimal profitability may be in mid-size Blue plans, with total annual revenue between \$2.5 – \$7.5 billion, rather than in the largest plans with annual revenue over \$7.5 billion. In other words, over the most recent four-year period, the data point to a peak in efficiency in mid-size plans that is lost in very large plans. All of the largest plans represent multiple acquisitions and operate over widely dispersed market areas; as later discussed, these factors may inhibit the expected efficiencies of scale economies.

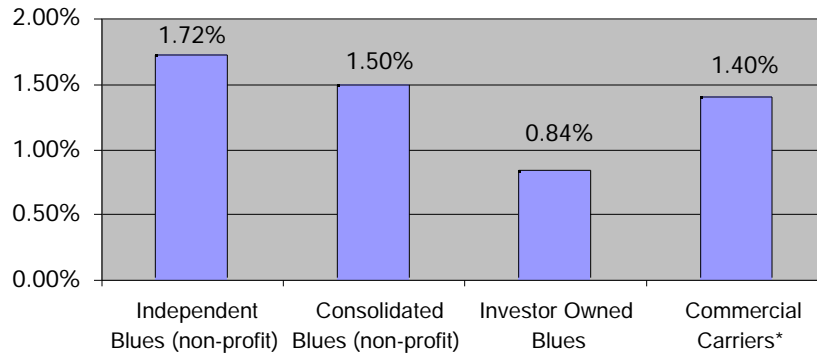
**Exhibit 3.4: Earnings of Non-Profit BCBS Plans
by Total Revenue (1997-2000)**



Number of BCBS non-profit plans used in analysis=28

When comparing profit margins by organizational type, another interesting pattern emerges. See Exhibit 3.5. Average earnings were highest in independent, non-profit Blues (1.72 percent), followed by consolidated non-profit Blues (1.50 percent), and commercial carriers (1.40 percent). Consolidated for-profit Blue plans had the lowest earnings of all types of insurance carriers during the 1997 – 2000 period (0.84 percent). Across Blue plans, the data show 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, Blue plans actually become less, not more, profitable.

**Exhibit 3.5: Earnings by Organizational Type
(1997-2000)**



Independent Blues (non-profit), n=21; Consolidated Blues (non-profit), n=7; Investor-owned Blues, n=5; Commercial Carriers, n=10

*Several of these commercial insurers are multi-line companies that do not disclose profit figures by division; thus, profit figures reported are for all lines of company insurance.

Bigger plans are not necessarily more efficient than smaller plans, perhaps in part because mergers require the blending of idiosyncratic sales and product distribution strategies, radically different approaches to underwriting, operating and information systems, and differing institutional histories and relationships with providers and regulatory authorities across fifty states.

Virtually every health insurance company uses a different strategy to take its product to market. Some sell directly, some through brokers, some through agents. Many companies rely on benefit consulting firms to bring larger employer business to them. 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, *e.g.*, short-term transition products for college graduates. If product marketing approaches mesh, then scale economies can be achieved. If they overlap or conflict, scale economies may be unrealized or, worse, the integration of multiple systems will require significant and expensive re-tooling.

Just as sales and distribution approaches vary, the underwriting machinery of every company is tailored to meet the demands of its distribution network. Companies respond to the underwriting cycle, by which the quality of their risk pool is maintained by adjusting price – often on the spot – in order to acquire, retain or reject a prospective policyholder or group. Sales and underwriting personnel work hand in glove; the sales force pushes for more relaxed pricing and coverage in order to boost sales, while underwriters look to the long term interest of the company as they pick, choose and price proposed cases. Bringing any two companies together can upend the culture of a company's sales and underwriting relationships and operations. 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 sets of sales and underwriting functions. Two simple examples illustrate this dilemma: a company that has relied on independent agents will face difficult trouble and defections in its field force if, after a merger with a direct sales carrier, it continues direct customer sales. Likewise, a company that has a very strict underwriting culture will alienate and lose independent agents, particularly large producers, if it will not accommodate their occasional requests for lower prices or more relaxed admission to the company's risk pool.

Adjudication and payment processes and policies also vary across companies. In the claims management process, adjudication is the key to control of claims payment. The process includes checks for eligibility and contract coverage, authentication of the nature of the claim in terms of the procedures performed, and calculation of the appropriate payment, which includes determining any co-payment obligation of the individual and any discount that the carrier enjoys with the provider of services. Adjudication systems have developed over time to reflect the unique market circumstances faced by individual companies. Each reflects the accumulation of years of decisions. Each company crafts its products – its policies – differently. Most companies have hundreds of “standard” policies “pre-filed” with a state's insurance commissioner, to be used as market

conditions change. To make matters more complex, a company's sales and underwriting units routinely negotiate with clients to change standard policies and, in large cases, professional benefit consultants represent employers to fashion changes in coverage to meet the contemporary needs of specific clients.

Payment systems and philosophies also vary greatly from company to company. Each carrier adjudicates reasonably quickly; experience suggests that the processing of routine claims ranges from seven days to two months. In most companies, roughly 80 to 90 percent of claims fall within this category. The remaining 10 to 20 percent are more complex, and necessarily more expensive, because they require more human intervention. Once an adjudication is complete, the company may hold or "age" the payment to earn income on the float. Payment policy often can be critical to a company's profit margin, and can emerge as an area of concern in mergers because of conflicting internal policies on claim payment times. In addition, some state regulators impose fines for unacceptably slow payment.

Like sales, distribution and payment systems, the specialized hardware and software vital to the functioning of any carrier varies significantly among companies. Most company's systems have been developed as custom applications, and each company's system is designed to accommodate continuous modifications to policies, new rules for claims adjudication, and changing co-payment arrangements. It is not an exaggeration to say that, within a few months of a claim system's installation and adjustment, it becomes nearly impossible to integrate 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.

In fact, both independent and consolidated non-profit Blue plans have argued that extraordinary capital requirements for operating systems and information technology compel their conversion to for-profit form in order to provide access to the capital markets. The need for capital to accomplish technological innovation is not unique to the health insurance industry; other industries, however, seldom have advanced this need as a reason to transform corporate ownership structure.

The health insurance industry was one of the first to adopt computer technology in the early 1960s. Both commercial and non-profit carriers have invested tremendous sums in information technology. Notwithstanding these expenditures, any consumer can appreciate the technological difference between dealing with his or her insurance company and other companies that have mastered the use of technology in their businesses. Federal Express can locate your package in minutes. Many insurance companies cannot locate your claim in weeks. Many carriers cannot accept a doctor's bill submitted on line, and have only modest abilities to apply automation to even the first few simple steps of claims adjudication. Physicians and hospitals complain that they constantly must resubmit bills because insurance companies have inadequate systems to track payments. It also is common for a carrier to pay claims for services rendered to a former employee months after the employee has left the employer who provided the coverage.

Although analysis of various companies' customer complaint records and disciplinary histories may permit inferences as to which individual companies have better or worse technological capacity, there is no evidence to support the conclusion that investor-owned insurers, as a group, use technology any more effectively than do non-profits. In that the commercial carriers have access to capital, one would presume that they would evidence a notable advantage in this area. Given this lack of data, and the industry's poor record of managing its

technology, infrastructure improvement seems an unpersuasive reason to support conversion to for-profit form.

Even were the industry able to effectively deploy new technology to improve operating systems, there is no evidence that these improvements would result in better customer service or increased profit. One conundrum of the modern world of health insurance is that significant improvements in customer service have been shown to mean little to account retention. Employers move their employee groups using price as the near exclusive reason for change; beneficiary satisfaction often does not enter into the picture at all. Discernable improvements in customer satisfaction require very significant levels of spending, much of it on human interaction. The complexity of health insurance transactions makes automated, credit card-types of inquiries very difficult. Beneficiaries make multiple claims for coverage throughout the year, and each claim must be tested as to eligibility, contract coverage, nature of the procedures and therapies, amounts of co-insurance assessed under the policy, whether the claim is an indemnification payment to the beneficiary or a third-party payment to the provider, and what discounts apply to the charges set by the provider. Even when carriers perform well on these inquiry and payment functions, there is little evidence that beneficiaries value them. When presented with multiple plan options by their employers, it has been shown that employees routinely will change carriers, switching away from carriers with high levels of customer satisfaction, for as little as \$12 to \$15 per month out-of-pocket difference. Expensive technology to improve customer service is an appealing thought, but does not necessarily translate into higher profits.

The less tangible factor of corporate "reputation" also holds the potential to disrupt economies of scale. There are pronounced differences in the manner in which various companies deal with hospitals, doctors and other health care providers. Aetna presents an example. In the 1980s Aetna developed a negative reputation among providers, especially physicians, for what was viewed

as an aggressive approach to forced price reductions. Whether deserved or not, Aetna's reputation flowed over into its acquisitions such that the good reputations of some acquired companies, like New York Life's health business, was lost to the preexisting reputation of Aetna. (Aetna recently appointed a physician as CEO – in part, many industry observers believe, to rehabilitate its reputation with doctors.) A similar retarding force to merger economies of scale can be a company's reputation with state insurance regulators. An experienced commissioner is likely to have a perception of the volume and nature of a company's regulatory violations and customer complaints, and its integrity in dealings with its customers. In some circumstances, a regulator may have very definite opinions about the competency or honesty of a company's management. With respect to matters of reputation, whether with providers, regulators, agents, brokers or customers, the reputation of the merged entity tends to gravitate to the lower of the reputations among its major component parts. Once a post-merger "downgrade" is in effect, it is more difficult for the merged entity to reflect the positive financial aspects of a component's better reputation.

Finally, the achievement of planned-upon economies of scale is largely dependent on the accuracy and sufficiency of forecasted events. It is estimated that over 70 percent of corporate merger and acquisition transactions do not perform at the level promised or anticipated in the pro forma forecasts. It should be humbling to prognosticators to recall, for example, that the current wave of premium inflation, certainly one of the hallmarks of the insurance market today, was virtually unseen, and certainly unpredicted, three years ago. Likewise, the provider revolt, which currently is exerting enormous pressure on insurance company earnings, is an unprecedented phenomenon that was not even observed, much less anticipated, two years ago when the Sutter system successfully pressured WellPoint into major concessions in payment levels. In the summer of 2000, Philadelphia Children's Hospital is reported to have gained increases in rates amounting to over \$100 million by confronting carriers with the threat of backing out of their managed care networks. Recently, Aetna backed

down from a threat by a maternity hospital in Atlanta to withdraw from the Aetna HMO system if its rates were not significantly increased. Another case in point is the recent decision of the partners in Regence, the affiliation of non-profit plans, to halt the proposed merger with Health Care Service Corporation. When that merger was first announced, management had projected that reduced operating costs, especially the costs of claims processing, would flow from the combined operations; however, a financial analysis completed just before the merger was to be finalized showed that the cost of bringing the systems together would be prohibitive and that each company would be more efficient keeping its own systems in place.

No one, perhaps least of all those with financial stakes in the successful completion of a conversion transaction, can guarantee the future in an industry as complex as health insurance. Given the myriad and unexpected variables that can influence the health insurance world, forecasted economies of scale should be viewed with a measure of skepticism.

Size and For-Profit Status Are Not Necessarily Determinative of Competitive Advantage. Like politics, all health care is local. All successful health insurance firms have developed specific strategies that acknowledge and are designed to take advantage of the special characteristics of each market in which they operate. As such, the threat of market challenge by consolidated national companies to a local plan's market position is not as practically possible as many carriers seem to believe. Maryland is a good example of this market specificity. One reason that few major carriers have attempted to penetrate the Maryland market is the State's hospital rate setting system. It is impossible for companies whose profits depend on extracting volume discounts from medical providers to prosper in a state in which such discounting is not permitted by law. Maryland's rate setting system is by no means a unique barrier to entry; nearly every health care market in the country has idiosyncrasies that have similar effects.

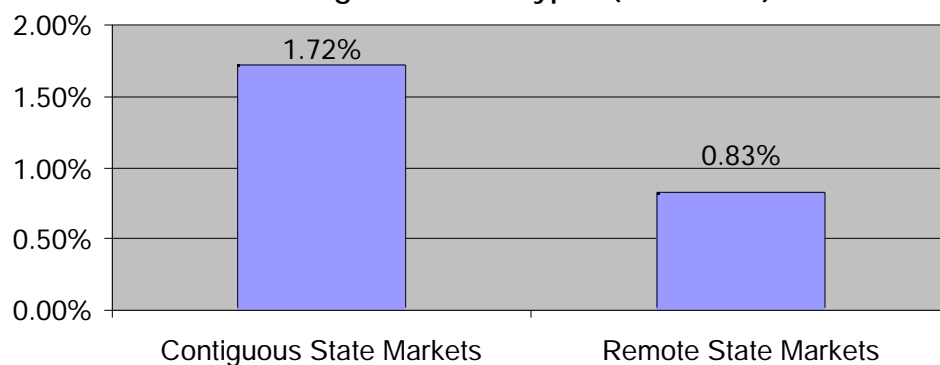
Even large insurance companies that operate in multiple markets have rather well-focused, market-specific strategies and are continually mindful of the value of understanding local conditions. They use such information to hold and grow market advantage as if they were locally based. Among the local market characteristics that vary widely are hospital organization (investor-owned hospitals are much more common in the Southeast than anywhere else in the country); the organization of medical practices (clinic practice is a common form of medical practice in Wisconsin and Minnesota, but not in Maryland or Pennsylvania); and the preference of the market for various insurance products (indemnity protection is higher in the Northeast than the West, where capitated coverage is much more common). 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 (Illinois historically has made it more difficult for Golden Rule to do business there). The Michigan legislature has given additional statutory protections to Blue Cross, perhaps in part because the Blue Cross workforce was organized by the United Auto Workers, which also is a major Michigan Blue client. Consumption patterns among consumers also vary from place to place. Inpatient stays on the East Coast are significantly longer than on the West. Hospitalization rates vary significantly from place to place, as does the incidence of various medical procedures, *e.g.*, hysterectomy.

A story makes the point. In the late 1980s, Metropolitan Life, then the country's largest health insurance company, decided to develop a national managed care strategy and to consolidate all of its managed care experts in one locale to perform case management on a national basis. It terminated its entire force of local market specialists. Earnings took a precipitous dive, and the company realized that its development of managed care around local markets had been central to profitable operations. Some industry observers believe that Metropolitan's decision to sell its health insurance line sprung from its inability to

rebuild its cadre of local market specialists. Indeed, the history of any commercial carrier's business growth shows patterns of great geographic concentration and no presence in other markets.

These considerations point to a hypothesis, namely, that health insurance companies succeed best where their understanding of local market conditions is highest. Indeed, profitability seems to be related to concentration in single markets. Exhibit 3.6 suggests that expansion into remote geographic markets risks profitability. As such, the threat of new competition to any set of market incumbents, regardless of how well capitalized, must be put in perspective.

Exhibit 3.6: Earnings of Companies Operating in Contiguous and Remote State Markets, All Organizational Types (1997-2000)



Contiguous State Markets, n=33; Remote State Markets, n=10.

The Availability of Capital Depends on Ownership and Performance. A consolidated plan that has gone public has more convenient access to capital than a non-profit company. This truism is not, however, an argument against the long term viability of non-profits. Most non-profits have substantial capital accounts reflecting retained earnings from years in which the plan has met its statutory capital requirements and can allocate profit to its surplus. Surplus can be accumulated and invested, and can yield both overall enterprise profit and protection for future lean years. To some extent, a non-profit can compensate for

its lack of access to capital through the flexibility that it has to hold and manage its capital without pressure from investors to declare dividends or otherwise maximize return on investment. This gives a non-profit greater latitude to act in the interest of the overall corporate mission and its beneficiaries.

In the for-profit world, it is important to distinguish between the *price* of capital and *availability* of capital. A for-profit company may have access to capital in the public market, but this is an ephemeral benefit if the cost of the capital is prohibitively high. The interest rate at which funds are available from lenders, and the amount of control – the price – demanded by investors in exchange for their capital, will depend on their evaluation of a number of factors internal to the company, and also on a range of market forces.

A for-profit entity may run at a loss but still obtain capital if lenders or investors believe that management has the ability to grow the business and earnings at rates needed to pay down debt and reach expected investment returns. The price of available capital is related directly to the going-forward assessment of the return that the company will be able to deliver to the shareholders, that is, on the faith that investors have in management to deliver future profits. While any company's ability to raise capital fundamentally is specific to the company, the performance of other major players in the same economic sector, and the sector in general, also can be very influential.

For-profit status hardly is the *deus ex machina* of access to capital. It may be necessary, but it certainly is not sufficient. The availability and cost of capital depend on other factors including investor confidence in management's future performance, industry sector performance, and the performance of the capital markets in general.

Management Compensation Does Not Correlate with Enterprise Success.
Blue Cross plans have asserted that their organizational forms must change in

order to retain and recruit talented management through the offer of equity gains. Across all industries, executive compensation is a complex and highly charged subject. While compensation for rank-and-file individuals in most large companies is carefully calibrated and exquisite justifications often exist for each pay grade, at the executive level it is difficult to discern a rationale either by comparisons within the same organizations or comparable positions in other companies in the same industry. Again and again, studies show little relationship between executive compensation and company performance. Exhibit 3.7 compares executive compensation with 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 non-profit entity with an understanding of the limits on compensation, the argument for for-profit parity, in some cases, takes on the guise 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 non-profit 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.

Why Health Insurance Mergers Produce Sub-Optimum Companies

Why does the conversion trend persist when there is sufficient evidence to suggest that combined, for-profit plans are not necessarily stronger or more efficient organizations, nor ones in which capital is both more accessible and cheaper? Despite seventy years of success, fifty of which involved competing with for-profit companies, the for-profit form now is seen as the inevitable, indeed the required, way to operate a Blue plan.

**Exhibit 3.7: CEO Compensation and Value of Unexercised Stock Options
for 2000, Compared to Company's Return and Performance**

All numbers in millions

Company Name	Enrollment	Total Revenue (2000)	Earnings After Taxes	Market Cap	5 year stock performance	CEO Total Compensation	Value of CEO Stock Options (Unexercized)
Aetna	18.1	\$26,818.9	.47%	\$4,477.6	-6.0%	\$4.03	\$25.03
Cigna Corporation	15.0	\$19,994.0	4.94%	\$11,584.6	82.1%	\$9.48	\$43.39
UnitedHealth Group	8.6	\$21,122.0	3.48%	\$20,297.2	206.0%	\$54.13	\$357.87
WellPoint Health Networks	7.7	\$9,229.0	3.71%	\$7,175.6	273.3%	\$11.13	\$64.61
Humana	6.5	\$10,514.0	.86%	\$2,112.2	-33.8%	\$1.87	\$0.06
Health Net	5.4	\$9,076.6	1.80%	\$2,862.5	1.0%	\$.67	\$6.46
PacificCare Health Systems	3.7	\$11,497.3	1.40%	\$733.3	-73.8%	\$.73	\$10.18
Sierra Health Services	1.8	\$1,393.0	-14.35%	\$204.9	55.3%	\$.71	\$.88
Coventry Health Care	1.7	\$2,604.9	2.32%	\$1,450.9	125.0%	\$2.23	\$15.02
Oxford Health Plans	1.5	\$4,111.8	6.45%	\$2,453.7	-54.0 %	\$.85	\$115.4

The belief system that supports the view that consolidation is the preferred destiny for most companies does not easily accommodate contrary views. Accrued experience points to the certainty that some predictable percentage of acquisitions will fail to produce positive scale economies or other evidence that demonstrates the wisdom of the merger in the first place. Notwithstanding, deal

analysis continues to disregard or fail to adjust for the likelihood that the promised performance may not result.

What are the principle reasons that consolidations falter? Financial analysts have chronicled five difficulties most commonly encountered by companies that have grown through merger. The first is the lack of management practice or skill in bringing companies together. Some companies have demonstrated that they are much better than others at integration, and capital markets recognize and value that skill. Most companies have little or no practice at integration and have established no corporate guidelines for handling mergers. Health insurance companies present particularly difficult merger challenges, as discussed above. Indeed, the complexities of bringing together health carriers often are so enormous that one often finds a portfolio approach invented post-merger: instead of integrating, the acquiring company develops a new strategy of running the acquired companies as divisions, keeping them in separate "silos." Inherently, this approach disrupts the synergies that were advanced to justify the combination.

The failure of expected results also is explained by flaws in strategy – it was not well developed, was wrong, failed to account for some environmental force, etc. In other words, the fit did not make sense. Sometimes the strategy/fit problem manifests in channel conflict in distribution, sometimes it relates to non-complimentary products, often it evolves from contorted executive personnel arrangements that leave executives of combined managements in warring camps as to how and where to steer the combined entity.

The third explanation for merger failure is communications obstacles. This often means that decentralization did not work because no plan was instituted to effectively distribute operating power or decision making in a larger scale entity. Finally, a critical factor can be the failure to anticipate systems integration problems, which can result not only in failed savings but in unexpected

expenditures. As discussed above, most internal support systems in health insurance companies, like claims and underwriting, and including technologies and operating systems, are not easy to integrate.

The most powerful and potentially most dangerous implication of the “consolidation is destiny” belief system is that it does not allow for a discussion of the alternative case, namely, what a company’s destiny might be were it to remain an independent entity. Deal analysis seldom takes into account the probability of achieving the described post-merger performance and never offers an analysis of the probability of significant underperformance. Disclosures to potential shareholders, such as the SEC’s Form S-1, describe investor risk in very formal and stylized terms. They do not effectively lay out the statistical probability that an investor’s money might be imperiled by the known areas of dangers in any merger. For example, it is seldom possible to discern among the stated risk factors that acquiring management has failed to meet pro forma estimated earnings in previous mergers, that the acquiring management has no experience in integrating companies, or that similar mergers in the industry have failed to produce expected results.

The Non-Profit Case

We have considered the arguments and belief system of proponents of consolidation and conversion in general, and also the data that suggest that consolidations do not always work as predicted. In fact, most health insurance mergers appear to produce sub-optimal companies. This raises the question of the future of the non-profit form.

The history of regulatory policy in the United States shows that regulation most often appears in industries in which there is a perceived risk that market forces will not produce socially acceptable results, most often because suppliers could use market practices to disadvantage relatively powerless consumers. That is, government steps in to supervise markets that, if left to their own devices, would

produce consumer abuse. Under this formulation, it is not surprising that health insurance is the most regulated of all insurance lines. Despite the presence of regulation, there are undeniable indications of new types of market failure in health insurance in Maryland today. The most important indicator is the large number of persons who cannot or will not buy health insurance, an estimated 400,000-plus in the State. Most of these people are “near poor” and do not qualify for government coverage. Some are people caught without insurance because they are out of the labor market for an extended period of time and find the cost of COBRA, the federal-mandated transition insurance, too high. Others are small business owners or employees in small businesses, or self-employed persons, for whom the cost of coverage simply is out of reach. There also are those who cannot qualify for coverage because of preexisting medical conditions that cause them to be excluded risks.

In addition, inflation in health care and health care premiums is an issue that is approaching a critical state. Inflation has proven to be the single most important factor that motivates health insurance carriers to use more restrictive underwriting and to institute managed care procedures as a means to limit claims costs. The number of individuals covered by health insurance invariably declines with each new wave of inflation, and insurance company profits generally climb in periods of inflation. These two forces mean that affordable care is least available just when the market needs it most, yet also when companies can make more money.

The constant pressure for health insurance market reform in the political arena also tells us that market failure is perceived as a likely risk. Health insurance reform is a perennial issue in elections and is a constant subject of discussion in the Congress and in state legislatures. There is a widely shared perception that the market for health insurance does not operate fairly or well, and that government intervention is needed.

If market failure remains a major risk in the health care and health insurance markets, why is the non-profit form not the most appropriate way to organize an insurance company? What advantages, if any, are created or maintained by the presence of a non-profit in the marketplace? The most important positive attribute of a non-profit is that it does not have to include a return on shareholder equity in its premium price. As a result, non-profit management can operate at superior loss ratios and has the freedom to accumulate and apply surplus in a manner beneficial both to its corporate health and to its policyholders, *i.e.*, by offering better coverage at lower prices. Simply put, Blue Cross plans, when equally efficient at other management functions, should always have a competitive price advantage over their commercial rivals.

If a plan is charging prices equal to or higher than its commercial competitors it should be able to accommodate poorer risks as well. Blue plans traditionally have offered coverage to many people who could not be insured in the commercial market. Of course, if this higher risk population is too large and too sick, a non-profit plan's performance may be inferior to a commercial carrier that bears no such risks. A non-profit plan's reserves in excess of the statutory amount can be used as a savings account to be employed to provide such coverage to the community.

The competitive advantage of freedom from earnings requirements has been so historically compelling that, as discussed in Chapter 1, 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 operated 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 non-profit Blue plans began to form for-profit subsidiaries, however, that argument lost plausibility and the exemption fell in 1987.

It stands as a testament to the continued value of the non-profit form of Blue plan that many such plans continue to be successful in many parts of the nation, and that many, such as Florida and Arkansas, affirmatively have determined that the non-profit 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 non-profit status as a particular strength in dealing with the local market and with their regulators and legislatures.

Conclusion

At the critical junction of decision making on the future status of Maryland's non-profit Blue Cross plan, it is important that policymakers and management step back from the momentum of the deal to consider the special case of non-profit insurance plans, their special role of service to the citizens of the State, and their potential market advantages. To accomplish this impartial evaluation of the transaction, it is vital that decision makers behave like knowledgeable and skeptical investors to test the assertions and assumptions of the proponents of conversion and weigh all the available evidence.

Chapter 4. Valuing Maryland Blue Cross and Managing the Value After Sale

Although there have been a significant number of Blue plan conversions, the conceptual framework used by regulators and legislators is still developing. No settled law or principles consistently are applied to these transactions; indeed most of the conventional approaches to business valuation are inapplicable to a determination of the worth of a non-profit health plan.

Three important issues surround asset transfer in any conversion of a community organization that was founded on charitable principles. Who owns a Blue plan? Is valuation of assets an appropriate measure of the real value of the plan to a community when the plan is being acquired by a for-profit entity? How should the proceeds of a sale be managed to assure the continuation of the social welfare objective for which the Blue plan was founded?

Conversion History

Exhibit 4.1 shows the value assigned to formerly non-profit Blue plans and the manner in which the receiver of those proceeds chose or was directed to apply the converted charitable assets of the plan. In many of the early Blue conversions, purchasers presumed that they could assume the assets of the plan without paying for them. When Blue Cross of California established WellPoint in 1993, the plan transferred its assets to the new company. When WellPoint went public, Blue Cross, the owner of WellPoint's equity, initially contended that none of the plan's assets belonged to the public or to charitable beneficiaries. In time it offered to contribute \$100 million to a new foundation. After a prolonged battle with the California legislature, WellPoint contributed stock to charitable purposes that came to exceed \$3 billion in value. In 1996, when Blue Cross of Georgia converted from non-profit to for-profit status, none of its assets were transferred to the public domain. Only a legal challenge a year later resulted in the disgorgement of \$80 million and the establishment of the Georgia Healthcare Foundation, an entity with the stated purpose of improving health care for all

Georgians. In other conversions, *e.g.*, Connecticut and Kentucky, a strong case can be made that the acquired or converted plan's assets were significantly undervalued.

These stories tell a lot. They suggest that the managements of Blue plans have not necessarily recognized or acknowledged that the plan's assets belong to the public, and that the ownership of Blue plans is treated, often by design, as ambiguous. The Georgia story also suggests that the value received by the public in the form of an \$80 million foundation may not have been related to the actual value of the on-going business that the plan sold and the new owners took. Pre-conversion, Blue Cross of Georgia had revenues of \$1.3 billion in 1996 and net income of \$17.5 million. Finally, the broad and ambiguous mission of the new Georgia foundation does not ensure that affordable insurance is or will be available.

As this vignette illustrates, the thinking about Blue Cross conversions lacks the level of rigor required to give comfort to those on the selling side of a transaction. The absence of a rigorous approach to valuation may flow in part from the fact that the historic model for Blue plan sales has been the sale of charitable hospitals to for-profit hospital holding companies. In hospital transactions, the questions of ownership, value and continued charitable use of the proceeds are much easier to answer. If a specific religious group founded the hospital, the owner is easily identified and the proceeds revert to the church or the order that has equitable title. In a secular community hospital founded by a group of citizens, ownership of the assets – and, therefore, the proceeds of the sale – default to the state on behalf of the public. For hospitals, valuation is relatively simple, primarily because the advent of Medicare and Medicaid mandated uniform accounting systems. A hospital's balance sheet reveals at least one solid view of its value, namely, its book value, and a premium generally is added to reflect the buyer's strategic interest in the property. The bargaining is left to

the hospital trustees, who are bound by their fiduciary duty to maximize the assets.

Exhibit 4.1: Conversion Foundations: Initial Corpus and Purpose

Company Name	Conversion	Proposed settlement	Final settlement	Purpose
BC of California	Non-profit to WellPoint	1993 \$100M	1996 \$2.6B	Focus on medically underserved populations; provide services for public health, community health.
			1996 \$640M	Focus on access to care, underinsured and uninsured, public health and community health.
BCBS of Colorado	Sold to Anthem	1999 \$100M	1999 \$155M	Promote and serve the health needs of Coloradoans.
BCBS of Connecticut	Sold to Anthem	1997 \$0	1999 \$41M	Foundation to be set up in Fall, 2001.
BCBS of Georgia	Non-profit to publicly traded company	1996 \$0	1998 \$80M	Improve health care for all Georgians.
			2001 \$124M	
BCBS of Kentucky	Sold to Anthem	1993 \$0	1999 \$45M	Fund unmet health needs of Kentuckians.
BCBS of Maine	Sold to Anthem	1999 \$90-100M	2000 \$80.5M	Foster improved access to health care and improved quality of health care to medically uninsured and medically underserved persons within the state.
BCBS of Missouri	Non-profit to publicly traded company	1994 \$0	1998 \$13M, 15M shares of stock	Improve health care services for the uninsured, underinsured and underserved.
BCBS of New Hampshire	Sold to Anthem	1999 \$70-80M	1999 \$83M	Improve the health of people of New Hampshire.
BCBS United of Wisconsin	Non-profit to publicly traded company	1999 \$250M	2000 \$250M	Donated \$250M to Medical College of Wisconsin and University of Wisconsin medical school. 35 percent of funds to be used for public health projects.

A hospital's worth at the time of sale generally is a static measure reflecting assets and goodwill, but not its value as an ongoing business. The hospital generally will continue to do what it did before the ownership change. The community has lost the charitable organization, but usually not the function it performed. State attorneys general, who typically oversee such transactions for secular community hospitals under state *cy pres* statutes, often require that the proceeds be directed to a foundation to further some charitable purpose, and also may impose additional, specific charitable obligations on the new owner of the facility.

The hospital conversion model is not a good analog to Blue plan conversions. Preliminarily, the ownership of a Blue plan is more diffuse. Also, as a result of its formation as a pan-charity, a Blue plan touches the lives of many more people in a community. By design, each community has only one non-profit Blue Cross plan. While all hospitals are significant enterprises, even the smallest Blue plan is enormously larger and more influential in an area's health care economy. A significant part of the budget of every hospital in the State flows through a plan as large as Maryland's. As such, a non-profit insurer has a completely different value as an ongoing business than does a hospital.

Who Owns Blue Cross?

As discussed in Chapter 1, Blue Cross of Maryland was established by fifteen hospitals as a means of providing health coverage in circumstances of market failure, thus imbuing the plan with a special non-market function. The legislature, doing the will of the charities that formed Blue Cross as their charity, made it even more of a public entity than any of the charitable hospitals that had brought it into being, and also more of a non-profit entity. A hospital might strive for a profit to meet shortfalls. Blue Cross was to hold reserves sufficient to see it through tough times. If it made too much money it was expected to rebate or to lower premiums to its subscribers. Indeed, the very language used to describe

those it served – “subscribers” – suggests the stake in ownership that its beneficiaries, as members of the public, might expect.

The scope and reach of Blue Cross in the State also distinguishes it from any of the charities that formed it. Because the Maryland plan was relatively late to form, the Blue Cross model was quite well established by the time that it was incorporated. Experience in other cities already had demonstrated that the plan would control many more dollars than any of its founding hospitals would command.

The issue of ownership bears directly on whose interests will be maximized when the issue of value arises in the course of the transaction. We have seen that some plans, at the time of conversion, have been accorded a significantly lesser value than that quickly achieved for the shareholders of the acquiring corporation. In part, this is a consequence both of the perception of Blue plans and the methods used to value the plans. What scant literature that has developed on the issue of valuing Blue plans is ambivalent on the issue of whether a Blue plan is a charitable entity. Disregarding their foundation as the handiwork of bona fide charities, and the significant subsidies provided by government and others to their operation, most commentators have focused on the fact that many Blue plans have come to operate as “near-for-profit” insurance companies, and thus form the view that Blue plans should be valued using methods common to corporate mergers and acquisitions. This perspective may have emerged for lack of any other viewpoint; it also may be that the valuation methodologies employed by investment bankers in early Blue plan transactions simply filled the vacuum and became an accepted template for subsequent deals. Neither the absence of an appropriate methodology to establish value nor the current commercial robustness or behavior of Blue plans, however, should obscure the underlying reality: these non-profit insurers owe their existence to the charitable impulse and funding that brought them into being, and to the public financial sustenance that they have received over many years.

The Mechanics of Conversion

State regulators and legislators have learned from the experiences of California, Georgia, and other states. Now, when a state's Blue plan is transforming itself into a for-profit entity or a for-profit subsidiary is being created, value must be determined to satisfy policymakers. In most states, the controlling regulatory authority on matters involving insurance companies is the insurance commissioner. The commissioner generally is interested in assuring an orderly transaction and preserving the stability of the insurance market after the merger. Generally, insurance commissioners have not focused their attentions on the dollar amount that transfers from a plan to some new foundation or foundation-like entity. In states in which a "charities act" exists, it typically has fallen to the state's attorney general to see that the price paid at conversion is maximized and "fair." In addition, because the funds flowing from a converting plan as a return of charitable assets have become so significant, the matter has become a political issue, with members of the legislature bargaining the acceptable "value" of the plan before permitting conversion. In the past, legislatures have threatened to halt deals, as the New York legislature has with respect to the for-profit conversion of the Empire plan. In other instances, *e.g.*, California, the legislature was responsible for setting an acceptable payment level for the original Blue assets.

Once the regulatory/political process has determined a satisfactory value, a vehicle to receive and administer the funds generally is established. Exhibit 4.1 shows the philanthropic purpose of a number of Blue plan successor foundations. This table suggests that many of the foundations focus their work on the inadequacies of the health delivery system. At the direction of various state officials, proceeds of past Blue transactions have been routed to new foundations or existing foundations, often with direction to target specific problems, *e.g.*, teenage pregnancy, violence, care of the elderly, communicable diseases. Other states have directed proceeds directly to the state's general

fund, or to specific uses, *e.g.*, a one-time disbursement to two Wisconsin medical schools to fund research. If the State accepts stock in the acquiring company, it establishes a new, temporary “conversion” foundation to receive the stock in the new acquiring company, to manage the disposal of the stock, and then to convey the proceeds to an operating foundation that will carry out the specified charitable program. Generally, in order to assure a stable market for the stock, a post-conversion foundation disposes of stock on a schedule or under rules established at the time of the transaction.

The Valuation Process: What is Blue Cross Worth?

When plans merely affiliate without merging assets, there is no reason to establish a value of any of the corporate partners. Likewise, valuation is unnecessary when a plan merely becomes a mutual company without any conversion of assets. While it may be argued that “mutualizing” creates a change in ownership – giving ownership to current policyholders without recognizing past policyholders – there is no “liquidity event,” such as the sale of stock, so no economic value need be assigned. It is only in the event of a transaction such as conversion to for-profit status or a true merger of plans, whether the plans are for-profit or non-profit, that a liquidity event occurs and value must be established.

In any acquisition, the same valuation analysis may yield very different results when performed by a buyer or a seller. The goal is to reach a number at the time of the transaction, the transfer value, that represents a fair and reasonable value to the sellers, one that takes into account a fair return on capital. The transfer value may include both the static value of the company, *i.e.*, its net assets and goodwill, and the plan’s ability to achieve a continuing stream of revenue into the future. To accurately calculate the transfer value, the acquirer’s perspective also must be considered; that is, while the seller will determine a price that it deems fair – in the case of Blue plans, often with significant political input – the value to the acquirer of a “going concern” is likely to be substantially higher.

In a Blue plan acquisition, if a foundation is established to hold stock in the acquiring entity, the foundation's wealth is tied directly to the success of the acquiring entity. In this event, the going-forward strength of the acquirer must be carefully established; moreover, because the acquiring company will continue to control a significant share of the market for insurance, in many cases the predominant share, the transfer value should take into account the financial strength of the acquirer, including the effect of the acquisition on the long term strength of the new holder. As such, state policymakers should be alert to the potential of a failure of perhaps even the largest carriers in their market.

In past conversion or consolidations of Blue plans, variants of five established methods have been employed to determine transfer value. Often, several approaches have been used to judge the value of a Blue plan and a composite value has been established. In general, three types of analyses may be used to measure the worth of a company – its value as a generator of future income, its value as reflected in comparable transactions, and the value of its assets. Some of the methodologies employed focus on quantitative measures of the plan being acquired, *i.e.*, the intrinsic value of the business as a going concern. Others are more aptly thought of as appraisal methods, *i.e.*, the value of comparable transactions to determine what the market has indicated that value might be.

What follows is a brief overview of the valuation methodologies that have been employed in Blue plan transactions, a critical commentary on the appropriate use of these various measures in determining the transfer value, and a proposal for a more appropriate valuation approach.

In valuing Blue Cross plans, it is often the case that several of the following methods have been taken together to develop a hybrid value. In employing any of the methods, many assumptions are made regarding such critical factors as the future discount rate, the behavior of capital markets in the short and long

term, and the pricing and underwriting trends in the health insurance markets in which the company operates. Thus, although the process may appear coldly mathematical, it actually is enormously dependent on the judgment and perspective of the evaluators. From the seller's side, the valuation/appraisal process must be approached in a defensive posture; it is, after all, the seller's obligation to defend the value of the plan against the buyer's estimates, which inevitably are intended to reduce the value of the plan both as it stands and into the future. The buyer and seller may reach much different conclusions based on any of the following valuation techniques.

Discounted Cash Flow Analysis. DCF is a future income approach to valuation. Simply, this approach focuses on the earnings of the business, takes an anticipated stream of income determined for an appropriate number of years into the future, and discounts the total stream to present value. The calculation results in a net figure that reflects future revenues adjusted for future expenses. DCF requires that assumptions be made about market growth, product demand, pricing, underwriting gains and losses, general inflation, unemployment rates, medical trend factors, and regulatory/legislative actions, among many other factors. History indicates a great deal of volatility in several of these variables, most particularly medical care cost inflation. In order to select an appropriate discount rate, this method also requires assumptions about the future behavior of the capital markets. From the seller's perspective, if shares in the new entity are part of the payment to be made, DCF analysis must adjust for the obvious expenses of expected returns to equity holders, *i.e.*, dividends, and also must incorporate adjustments for the various risks of failure to meet forecasted results.

Income Capitalization Analysis. Income capitalization or capitalized return analysis divides future earnings by a capitalization rate. Ideally, earnings estimates reflect the nature of the business as a stable going-forward entity. The capitalization rate is the return required to make worthwhile the risk of operating the business. The capitalization rate normally is derived from an appropriate

discount rate, and the company's expected average annual compound growth rate is subtracted from its discount rate to yield the capitalization rate. The rate correlates positively with risk; riskier business prospects demand higher required returns.

Simple Comparison Analysis. This market test, also sometimes known as an acquisition analysis, looks at the transfer prices in recent sales of comparable companies. What price reflects where willing buyers and willing sellers will meet in a free market? This test is understood by anyone who has bought a house. It establishes a rough view of the relationships between price and various characteristics, *e.g.*, net assets, recent earnings, growth, market concentration. While this analysis seldom is directly referenced in formal considerations of Blue Cross transactions, it appears to play a significant role. Previous transactions cannot go unnoticed.

Capitalized Historic Earnings Analysis. The fourth valuation test also is a market value test that looks to the values of similar publicly-traded companies for which value can be inferred from stock prices. In this test, the focus is applied to earnings. First, an earnings per share multiple is calculated for the seller, assuming some arbitrary number of shares. This figure then is referenced against comparable companies' "fair market value per share," a measure that has been developed and is published by each stock exchange. By comparing the earnings of the subject company to the fair market price per share of comparable publicly-traded companies, the analysis derives a measure of value as to how the market might treat the subject company's earnings.

Adjusted Book Value Analysis. ABV is an inherently conservative method of analysis that focuses on the value of the assets owned by the entity that is to be acquired or converted. Two approaches can be used. The tangible asset book value test is the more conservative because it considers only "hard" assets, for example, investments, inventory at cost, adjusted receivables, appraised

value of buildings, and the depreciated value of improvements, software and the like. A more liberal "economic" book value test includes "softer" assets such as patents, inventory at market value, goodwill and deferred financing costs. The book value approach is simple; it captures the value of a business by determining the "market" value of the sum of its parts if the parts were to go to the market today. Book value is well understood as a point of reference. For example, stock analysts often note that the market capitation of a stock is "below book value," which often is seen as an indication that the stock is undervalued. Of the five valuation methods, discretion is most limited in ABV because the standards for most assumptions are set by the American Institute of Certified Public Accountants.

Rethinking Valuation of Non-Profit Blue Plans

None of the five commonly used methods for valuing a business applies with ease to the special problems of valuing a non-profit health insurance business. The DCF test, for example, is most appropriately used in evaluating a business in which cash flow is more important than net income, future revenue is likely to fluctuate, and the time horizon of the investment is short. It is a test often relied upon by investors in smaller companies. The income capitalization method requires reliable future earnings projections to be of any real utility, a condition that does not characterize many health insurance businesses. Comparable analysis and capitalized historical earnings analysis, the market tests, both are disabled by a lack of comparable companies. Unlike three bedroom houses in a given neighborhood, the number of observations is so small and Blue plans so different from one another that there can be no true comparables in relevant time periods. The adjusted book value test is most accurately applied in heavily capitalized industries. Blue plans do not own industrial infrastructure; they are composed of people, insurance contracts, practices and reputations, as well as trademarks. In Blue plans, these intangibles are more important than tangible assets. In addition, the present value of asset tests is extremely conservative

and is applied most commonly to business for which the future is thought to be bleak.

In fact, traditional valuation methods are antagonistic one to the other. One set attempts to say what the future value is today, another what the past value has been, and another to declare comparable current value. None of these tests is appropriate to the circumstances of a Blue plan sale. Their use is premised on the misapprehension that a Blue plan is a business like any other business. Each of the valuation methodologies ignores the history of the accumulation of value in a plan, and none can quantify value for the role that local non-profit plans pay in shaping the health care economy in their regions – a valuable asset that an acquiring company does not recognize as “value” and may not be able to optimize post-transaction.

The traditional models of valuation are key elements of deal analysis, the analysis performed to evaluate the financial feasibility of a deal. (See Chapter 2.) The investment bankers advising each party – the acquiring company and the plan that will be acquired – rely on these tools to advise their clients whether or not to go forward with the transaction. In transactions involving Blue plans, insurance commissioners typically have engaged their own investment bankers to assist in evaluating the deals, and the commissioner’s advisers also will use these tools to advise their regulator-client whether or not to approve a proposed conversion.

The greatest force working in any acquisition process is the buyer’s motivation to protect and enhance itself. The deal must make sense from the perspective of the buyer’s investors, *i.e.*, it must be accretive in the near term or be part of a persuasive growth strategy in the longer term. Once the buyer believes that it can make a transaction work at the value that it has developed, and proposes that deal to the seller, the burden shifts to the seller to analyze the terms of the

proposed transaction. Ideally, the seller should seek to maximize its return on the transaction.

In a for-profit company, the seller's management and directors would own significant stock of their company and would strive to get the best price for the company not only because of their fiduciary responsibilities but also to maximize their personal wealth. In a non-profit transaction, management may instead have incentives related only to the closing of the deal, irrespective of price. For example, incentives called success fees, or change-of-control fees, may be paid upon the completion of the transaction, and may or may not be related to the price. Where there is no return to the non-profit's management or directors for achieving a higher price, the incentives operate simply to get the transaction done. Of course, if management and directors are to hold stock in the new company, their interest potentially becomes allied with the acquiring company. Obviously, these circumstances are a breeding ground for conflicts of interest. The sellers can become uncritical adopters of whatever valuation model that the buyer may propose. Along these same lines, it should be noted that the investment banking advisers often receive additional fees if the transaction closes. Thus, the advisers themselves may have a financial interest that is skewed more toward finality than price.

The Community Economic Value Model

A new approach to Blue plan valuation – one that is driven by economic, not financial, perspectives – should be considered as an alternative to traditional valuation methods. A community economic valuation model can examine the origin of the current and future value of the plan, discern the appropriate beneficiaries of that value, and assess the appropriate means to return that value and preserve it for the beneficiaries. In contrast to the deal analysis methods that seek an acceptable value that will get the transaction done, an economic method can examine the nature of the capital invested and its present value with regard to an equitable claim from the current owners, the likely efficiency of the

successor entity (an accretive analysis with a different perspective on risk), and the risks associated with an altered ownership structure (a community welfare risk). A community economic approach to valuation considers the gain or loss to the social welfare that the transaction will have on the community.

Return on Invested/Contributed Capital. Because Blue plans, including Maryland's, received their initial capital from non-profit hospitals, it would be historically accurate to conceive of those founding hospitals as having a special claim on the plan's assets. In addition, all Maryland hospitals might properly claim to have supported the accumulation in wealth in the plan because, prior to the advent of hospital rate setting, many hospitals granted discounts – sometimes as much as 14 percent – to Blue Cross but not to other carriers. These discounts, of course, added to the plan's market advantage, its reserves, and, ultimately, its value.

Employers and customers also have contributed to the plan's ability to build reserves and surplus. At inception, the corporate philosophy of Blue Cross plans was to hold reserves sufficient to cover short-term fluctuations in claims, and to use any additional reserves to lower premium costs. In the 1990s, Blue plans all over the nation began to change their reserving and surplus policies, which had received unfavorable attention in the Nunn investigation. The decade started out with BCBSA, as an industry self-regulating entity, setting standards for claims paying ability – 60 days as the threshold for financial health, 30 days as the trigger for the BCBSA "watch list." The decade came to a close with the NAIC instituting formal risk-based capital (RBC) standards for imposition by state insurance commissioners, thus institutionalizing reserve standards in state regulatory oversight. By 2000, many plans, including the Maryland plan, had amassed reserves that were significantly higher than the NAIC requirements. Some plans had in excess of 1000 percent of RBC minimums. Given that the chartering documents of non-profit Blue plans contemplated a reserve policy that would keep on hand only those reserves sufficient to manage claims fluctuations,

it can be argued that at least some portion of the plan's surplus beyond RBC represents overpayments by subscribers. Such surpluses could be viewed as appropriately owned by employers and individuals who, at least from the RBC perspective, paid excessive premiums. Courts currently are considering such claims against two Blue plans.

Of course, the State and federal governments have granted significant support to Blue Cross in direct and indirect ways over many years. The most obvious support has come in the form of two important State tax exemptions. Commercial insurers, including mutual companies, are taxed on all health premium income; Blue Cross is not. Similarly, Maryland does not treat Blue Cross corporate income as taxable. Until 1987, all Blue plans nationwide also were exempt from federal income tax. These concessions have had a direct impact on the plan's costs of doing business and have contributed to its ability to build reserves and surplus.

The Maryland Blue plan also has enjoyed a particular benefit in the form of more direct support through two significant discounts granted to it by the HSCRC. Early in its history, the HSCRC awarded Blue Cross a discount for prompt payment and non-contest of hospital bills. In 1974, the agency established the SAAC rate differential, which permitted the Maryland plan to pay less than a hospital's approved reimbursement rate and apply those savings to subsidize the Maryland Blue's provision of affordable coverage for individuals and small groups in the State. (See Chapter 1.)

The magnitude of these direct and indirect subsidies is significant. It is estimated that the premium tax exemption exceeded \$13 million in 2000, and that the income tax exemption resulted in a revenue loss to the State of at least \$5.8 million. The net SAAC discount was estimated at \$31 million for 2000. The Maryland plan's 2000 fiscal year net earnings were in excess of \$63 million, of which more than \$55 million derived from investment income from its

accumulated reserves. The case can be made that the plan operates at a positive margin only because of public support and investment income of reserves that may be, in part, excessive.

Thus, the founding hospitals, hospitals that granted discounts to Blue Cross, employers and customers who paid premiums, and the State and federal governments all have provided significant financial support to Maryland Blue Cross across a span of nearly 70 years. Although complex, the calculations of the present value of such past economic capital contributions and tax expenditures could be accomplished. If there is to be a conversion, those who made the investment in Blue Cross of Maryland should benefit from the returns.

Efficiency of Successor Entity and Related Risk. An economic analysis of any proposed transaction must evaluate the successor entity from the perspective of the current equity holders. In the case of Maryland Blue Cross, this evaluation should be performed from the perspective of the beneficiaries discussed above. This is particularly important if the transaction involves taking stock in the acquiring company as full or partial payment. As discussed, pro forma analysis takes into account the future of the acquiring company after a merger. The pro forma generally is viewed as the weakest part of any deal analysis, principally because not enough usually is known about how the proposed economies of scale will be realized.

Chapter 3 describes the complex of hoped-for efficiencies that would result in an acquisition that is accretive to the earnings of the acquiring company; however, the evidence of scale economies or synergies in health insurance mergers or consolidations is mixed at best. On one hand, success of several of the mergers is incontrovertible: WellPoint and UnitedHealth Group are examples of companies that have delivered continued earnings growth with expansion; on the non-profit side, the consolidated performance of Anthem (a non-profit company until November 2001) suggests its management's skill at integration. In investor-

owned plans, however, it appears that the medical loss ratio, the percentage of a plan's premium income that actually is paid out to doctors and hospitals as claims costs, is significantly lower. The acquisition of a plan as large as CareFirst would have a significant impact on the financial performance of a new parent. If economies of scale can be effected, the value of the equity of the parent could grow significantly. If efficiencies cannot be realized, however, the parent faces the erosion of its market capitalization and profit. Reduced claims expenses are likely in any event. One of the inherent uncertainties faced by the citizens of Maryland is the ability of a new for-profit parent to manage effectively. If it cannot, the outcome could influence the fiscal soundness and viability of the acquirer of CareFirst, the repercussions of which would settle on all Maryland citizens.

If any of the transfer value of CareFirst is taken by the State in the form of stock in the new entity, real risks emerge with respect to the State's capture of the value of the plan's assets. If the State's stock is not protected from erosion in value by a "collar," the State must scrutinize even more carefully the records and plans of new management, and the details of the transaction. The State, on behalf of itself and other beneficiaries, must be satisfied that the risk-adjusted return on investment is acceptable, and then that the going-forward potential outweighs the risk of failing to achieve the pro forma projections. While financial analysis at the time of the deal seldom accounts for the possibility of underperformance in the operation of the new entity, economic analysis can be brought to bear to establish the likelihood of achieving the projected scale economies. The risk of underperformance to the State and the beneficiaries, which involves not only financial underperformance but, even more important, service underperformance and market dislocation, is too high to let the inapplicable mantra – "let the market prevail" – decide.

Risk of Welfare Loss. Economic analysis strives to understand a transaction from both the perspective of the market and the institutions involved.

There are market gains and risks to the community that must be considered and quantified *a priori*. If the market for insurance is improved as a result of a transaction, community welfare is enhanced. Market improvements would result if the price of insurance goes down, the quality of care improves, and consumers are operating as a spur to insurer efficiency because they have access to more market information. Such an outcome would free up both State and private funds for other uses – education, public infrastructure such as roads and bridges, and investment in private business – that increases net welfare. In a transaction from non-profit to for-profit, if the need for investors' profit is not offset by efficiency gains in the combined for-profit entity, the impact on net welfare will be negative.

If the medical loss ratio declines because scale economies are not achieved, then fewer dollars are recycled in the community as a result of the transaction and the community suffers a welfare loss. This type of loss may presage other welfare risks, the most important of which could be a reduction in insurance capacity in a market and higher prices. Will the acquirer continue to offer coverage to as many people? If the company decides to scale back or withdraw certain coverage, how will the State develop other means of coverage? Economic analysis can take into account the cost of replacing an insurance source as large as Blue Cross. The scenario of a large non-profit carrier's retrenchment from a market cannot be dismissed nor its costs minimized: alternate carriers are slow to move into markets where a market-dominant carrier is in the process of reducing capacity. The costs of entry, and expanding capacity to reach a break even level, is very high, and such an investment is fraught with the risk that the established dominant carrier will reverse its decision to withdraw. This scenario raises the specter of the State having to step in to fund new health insurance capacity because no competitors will enter the Maryland market. In addition to this welfare loss, the costs of market disruption – search costs, replacement costs, higher prices in bidding on short-term insurance capacity – would be imposed on the local economy.

In addition to the risk of welfare loss from withdrawal, there also is potential for loss because market concentration can engender higher prices. Notwithstanding the regulation of premiums at the state level, consolidated companies that control a preponderate share of a market in a state can affect price. Experience shows that the lack of competition can adversely impact service quality as well.

The presumed welfare benefit is the continuation of Blue Cross as a non-profit institution. In fact, the welfare benefit would be maximized by requiring that Blue Cross abjure its current “near-for-profit” behavior and return to its non-profit roots. To conclude otherwise requires an objective demonstration that Maryland citizens will be net better off if their non-profit carrier ceases to exist and an investor-owned entity takes its place. Put differently, a change in the form of Blue Cross should be preceded only by strong and reliable evidence that the risks to the community are outweighed by the potential price and service advantages provided by a for-profit successor, and also by the successor’s guaranties of corporate conduct on a going-forward basis that would continue to support the community. If the market for health insurance is still fundamentally dysfunctional in many ways – and the unrelenting problem of uninsured citizens suggests that it is – then the need for a non-market, subsidized alternative will continue.

Specifying the Community Economic Value Method

As shown above, the capital base in Maryland Blue Cross is donative; it is neither invested nor earned capital. As such, that capital base must be valued using an approach such as the community economic value method. The standard is calculated by establishing the present value of the public and charitable contributions to the plan, plus its current assets, plus the present value of the local plan as an ongoing entity. Likewise, welfare gains and losses from a transaction also enter the equation; if the medical loss ratio declines because of dividend obligations and is not offset by efficiency improvements that reduce

overall premiums, community loss results. Unlike the conventional valuation approaches applicable to for-profit businesses, the community economic value method looks to current assets (contributions of capital and current balances) as well as to the future value to the community of the entity as an ongoing business.

The process of specifying community economic value begins by establishing the present value of the donative assets. Using plan records, hospital records, and public tax records, one could establish the present value of the initial capitalization, the voluntary hospital discounts provided to the Maryland Blue plan, the tax exemptions, and finally the discounts and differentials provided by the HSCRC. The value of these donative assets then could be reduced by the value that has been returned to Maryland citizens as subsidized coverage. For example, that part of the differential that represents the cost of coverage provided to the individual SAAC market should be subtracted from the total approved differential granted to determine the portion that should be treated as a contribution to capital. Once the present value of the donative capital is determined, the value of current assets is established and added to the going-forward value of the business. Finally, the likely welfare loss to the community is estimated. Welfare loss is established by devising appropriate measures for each area in which community welfare might be diminished by a sale. One obvious measure would be the reduction in the medical cost ratio after a sale to a for-profit plan.

Legal Standard for Use of Proceeds; Charitable Purposes of Resulting Foundations

Most states' laws do not specifically contemplate the sale of a non-profit charitable organization to an investor-owned company. As we have seen, hospital conversion models are not analogous. The most salient direction comes from the common law doctrine of *cy pres*, which also is enshrined in statute in many states, which speaks to the disposition of the assets of a charity that is going out of business. The doctrine is very clear: when a charity ceases to exist,

its remaining assets are to be devoted to advancing the specific charitable intent of the original organization.

With respect to the foundations created by the conversion of Blue plans, the standards of *cy pres* seem to have been set aside. While the foundations funded with these proceeds have focused on health care, only about half seem to contemplate continuation of the availability of affordable insurance in the market once served by the non-profit insurer. The foundations created by some Blue plan conversions were developed as an afterthought to the transaction, sometimes as a result of litigation. In Maryland, the foundation now designated by statute to receive funds in the event of a Blue plan conversion has engaged a consultant to advise on programmatic focus of future grants. As we have seen, other states' foundations have elected to support a wide spectrum of health-related activities. Though the mission statements of these foundations all pertain to improving access and availability of health care, a deeper look into their grant activity unveils little, if any, focus on the continuing need for access to affordable health insurance. Infrastructure grants, research studies and peripheral services, such as call centers to enable consumers to make informed health care decisions, are common. Much of the work undertaken by these foundations traditionally has been the responsibility of government, and the fact that these foundations target such programs may represent government's desire to reduce demand on its general fund obligations. Certainly those foundations that take on direct government responsibilities such as extending the federal Children's Health Insurance Program, subsidizing prescription drugs, or paying for health care for the uninsured, are providing direct services that otherwise would fall to the state. Whatever the activities, the foundations do not fill the void left by the departure of the insurer of last resort.

Why has the concept of *cy pres* been abandoned in these instances? There is a significant population of uninsured individuals in every market in the U.S., and a continuing need for health coverage. Because, historically, Blue plans made an

affordable market for many citizens, especially small businesses and individuals, a strict application of the *cy pres* standard would bring significant resources to bear on the problem of continuing coverage. As the creators of those post-conversion foundations that focus on health insurance replacement appear to have recognized, however, even the enormous sums that now form the initial corpus of such foundations cannot serve for very long as an adequate source for the purchase of health insurance for higher risk individuals and groups.

What, then, should be done with the proceeds in order to effect the original purpose of Blue Cross and to fill the void left by its conversion? One alternative might be to place all of the proceeds in a foundation that would work with one or more insurance companies in Maryland to subsidize a product for the uninsured market. This approach would require very careful coordination with the Insurance Commissioner, and perhaps should be controlled by the Commissioner. Aggressive regulation of prices, products and reserves would be required to ensure that the foundation's subsidy would pay only that portion of risk expenses that were strictly related to non-normal risk in the pool. The fund balance would have to be carefully invested and a minimum balance would have to be maintained as a discipline on the bargaining process. In essence, the foundation would be managed as an annuity.

A second approach might be to support insurance product innovations devised by State government, employers, and providers to create new means to extend insurance protection for the uninsured. The insurance industry could be a party to such innovations, which could include, for example, the creation of a small set of uniform benefit programs. This would immediately curtail the expensive process of continuous plan modifications engaged in by carriers as a means of competing with one another; in addition, the market could be more efficiently ordered, thus saving enormous administrative costs. Individual beneficiaries could understand coverage more easily, and individual and small group buyers could be placed in appropriate and much less expensive pools. The State might

relax mandatory benefit requirements for such products, and the foundation then could subsidize the purchase of insurance for policyholders who would use the least expensive providers.

In yet another approach, the foundation could create a new non-profit insurance plan that would operate in the same manner in which the Maryland Blue plan originally worked. Initially, this alternative could be used to operate a risk pool for the individual and small group market, using the current SAAC differential monies as a part of the premium income flow to the new plan.

Searching for Status Quo Ante

Much of the discussion that has shaped the formation of post-conversion foundations has reflected a notion that, in the end, Blue Cross plans did nothing special. The charitable objective of those foundations that do not focus on insurance-related matters suggests how Blue plans had come to be viewed by the time that conversions came into being: in the minds of the policymakers, a “near for-profit” Blue plan was just another part of the health care delivery world such that its disappearance meant only that an undifferentiated actor had passed from the scene and that any health-related purpose would be a fitting use of the proceeds.

The *cy pres* doctrine forces us to return to a world gone from our times, when Blue Cross was a special community resource. To return to the intention of the plan’s founders provokes our review of the slow process by which Blue plans gradually were able to forsake their charitable mission. The concept of *cy pres* requires a return to the *status quo ante*: How did the plan behave? What did the plan do? What values did the plan observe over most of its life? Under this standard, the objective of a new foundation would be much different. It would be devoted to providing a charitable form of health coverage. It would promote non-profit coverage. It would seek to advance community approaches to establishing coverage, ones that were fair to providers and to subscribers. It would be Blue Cross redux.

Chapter 5. Blue Cross and the Future of Maryland Health Care

Since the beginnings of science-based medicine in the United States, Maryland has been at the forefront of health care innovation. The University of Maryland Medical School was one of the earliest sites of clinical training linked to basic research. Its Davidge Hall is the oldest medical teaching building in the nation. With the founding of The Johns Hopkins Hospital, followed by its medical school, Baltimore came to be seen as a world center of innovation in surgery, medicine and preventive health. Proximity to these institutions has yielded some of the strongest community hospitals in the world. Maryland medicine is a resource that distinguishes our State in every way.

Maryland's place in health care policy also is unique and reflects a unique set of circumstances. Its hospital association is alone in the nation in having as its board members not hospital executives but trustees, members of the community's deep-rooted leadership. Over time, Maryland's civic leadership, legislature, and governors have enjoyed a tradition of working on health-related problems in a cooperative way. Perhaps because Maryland has not suffered a tradition of legislative mandarins, ideas from outside of government have not been dismissed as coming from unschooled amateurs. The idea for our hospital payment system, for example, arose in the private sector. Maryland's system has been much studied and commented upon in health care circles and produced many initiatives used by other states and the federal government. Maryland has created a novel health care financing environment that relies on cooperation from highly interdependent partners, that is, hospitals, the Medicare and Medicaid programs, commercial insurers and, of course, Maryland's Blue plan.

A Public-Private Regulatory Initiative; the Health Services Cost Review Commission

Maryland's innovation in hospital financing began some 35 years after the founding of its Blue plan, at a time that the economics of health care were producing another crisis for hospitals, employers and individuals. The

extraordinary inflation in costs that followed the enactment of Medicare and Medicaid had placed tremendous strain on hospitals to hold down prices and on carriers to control premium costs. The inflationary spiral was fueled by an unexpected and rampant demand for care – much of it delivered to newly insured populations – and by new technology that promised interventions and cures not thought possible just a short time before. These forces translated into higher unit prices at hospitals and a tremendous demand for new capital to build, expand, and equip hospital facilities. Health care cost inflation was particularly severe in Maryland, where hospital costs already were much higher than in surrounding states, and rising faster. Blue Cross, the State's largest insurer, was under tremendous pressure to keep premium costs low.

A coalition of civic leaders – most of them trustees of Maryland hospitals – began to fear that some hospitals would close if the situation became much worse, that employers would no longer be able to extend coverage to their workers, and that Blue Cross was at risk of financial failure. They understood that Medicare and Medicaid had spurred the inflationary pressures, but that these programs paid only for the costs of their beneficiaries and did not contribute to payment for hospitals' uncompensated care to the uncovered near-poor. In considering this complex financial scenario, these leaders soon were joined by high-ranking State officials who were worried about the explosive growth of Maryland's Medicaid obligations and the potential need to raise taxes to pay for the program. Hospital cost inflation represented a true intersection of private and public interests.

In a 1971 act, the General Assembly established the Health Services Cost Review Commission as an independent regulatory body. The enabling statute was astutely drafted such that the HSCRC, working with the hospital industry, had wide latitude to seek innovative solutions. The statute provided that hospital rates would be based on the reasonable costs of producing services but, unlike many regulatory statutes that define detailed elements and methodologies, left the determination of the reasonable cost standard to the HSCRC. Under its enabling legislation, the Commission could craft rate models to set incentives for hospitals to reduce or eliminate certain costs. The statute also wisely directed

that rates were to be set equitably, without undue discrimination, thus freeing the HSCRC from the requirement to set rates that were equal across a “class” of hospitals. Further, the Commission was free to discriminate in rate setting, *i.e.*, to reward efficient hospitals with rates that might otherwise have been contested as discriminatory.

From the outset, the Commission approached the problem of hospital rate setting from an economic, not an accountancy, perspective. The point was to manage, not measure, costs. One of the HSCRC’s key attributes was a focus on the outcome, rather than the process, of regulation on hospital rates and the market for insurance. The HSCRC made a singular advance, and one that had enormous implications for Blue Cross, when it determined that those paying for health care – insurance companies, the Blue plan, the State and federal governments through Medicaid and Medicare, and individuals without health insurance – all would pay the same price. Hospitals no longer would have to engage in internal cost-shifting practices that inevitably led them to seek patients covered by certain payers.

The HSCRC did not embrace the conventional “command and control” approach of regulating details, opting instead for incentive-based regulation to develop a market in which hospitals could benefit by operating more efficiently. Among the standards developed by the Commission was the idea of paying a hospital on the basis of a patient’s admitting diagnosis, which was later modified to include adjustments for case severity and other factors. This approach shifted the focus from cost accounting for service sub-component to the manner in which care was produced for each patient. Attention was paid to a hospital’s global budget; hospitals could keep savings that resulted from operating efficiencies and use those savings in any manner that they believed to be their competitive advantage. Most important, the HSCRC system protected the State’s hospitals from the potential financial ruin of uncompensated care. Because a hospital’s reasonable bad debt exposure was built into its HSCRC-approved rates, it was made whole for care provided to patients who did not qualify for Medicaid or Medicare but who had no private insurance. The great benefit in this system was

that it ended discrimination in hospital admission and care based on ability to pay.

Necessarily, the success of any regulatory scheme depends to a large extent on the consent of the governed. Any regulatory agency can be dismantled more quickly than it was formed. Hospitals have sustained the Commission because of its bad debt protections, albeit with complaints about rate inadequacy. The Commission's continued existence hinges on its ability to deliver relative cost savings as measured by the difference between what employers and other payers, especially Medicare, now pay for care versus what they would pay absent rate setting.

Maryland Blue Cross and Rate Setting

After initial resistance to the formation of the HSCRC, the Maryland Blue plan has for most of its life been content to have the Commission in place. While it lost its special discounts from hospitals to the HSCRC's all-payer regimen, it soon realized that rate setting offered protection from out-of-state competitors. Because the all-payer rule prohibited commercial carriers from bargaining discounts from hospitals, many carriers found Maryland an unattractive market to enter. As time passed, not only the Maryland Blue plan but other carriers operating in the State saw that the all-payer system created a certain stability in the insurance market. Rate setting also offered protection from perpetual and costly experimentation with trends in insurance products, a number of which have been expensive and untested fads.

From time to time, insurance companies suggest that lower premium prices would result if rate setting were abolished. If companies could bargain payment arrangements directly with hospitals, they believe, prices would come down on the basis of volume. Insurance companies also have argued that, without the HSCRC, they would be able to more effectively pursue managed care protocols. This argument posits that the Commission, by establishing inclusive rates, gives cost protection to hospitals in determining appropriate therapeutic regimens for given conditions. As we have seen in recent years, however, managed care in

the hands of certain insurance companies and HMOs has delivered cost savings largely by curtailing access to care, often specific aspects of a therapeutic approach. Finally, managed care commonly involves the right of the insurance company or HMO to steer cases to specific hospitals, an attribute of modern insurance practice that is largely absent in Maryland.

The Maryland Blue plan has of late become a more active participant before the HSCRC, appearing at hearings to resist hospital rate proposals. Some observers believe that the Maryland Blue Plan would like to see the Commission brought to an end. Perhaps without rate setting, the Maryland plan believes that it would be able to bargain lower rates on a hospital-by-hospital basis by channeling patients to – and away from – specific hospitals. The plan could lower its claims costs by establishing payment methods by which a hospital would accept risk by bargaining “all-in” case rates from the plan. There is evidence that the Maryland Blue plan has attempted to move in this direction – to push against Commission policy – by proposing to two Maryland hospitals that they request alternate rate making approval from the HSCRC. The proposal would have a given hospital enter into a direct contract with CareFirst, under which CareFirst would pay the hospital a fixed rate. No hospital has yet agreed to advance this idea, perhaps because hospitals understand that such an approach would require them to assume downstream risk in the provision of care. Hospitals also have expressed concern that the Blue plan, with its superior data resources covering the entire provider market, would be able to force them into unfair price bargains by threatening public disclosures of comparative shortcomings. Many of the State’s hospitals believe that the current efforts of CareFirst to resist increases in hospital rates is meant not only to improve its own financial health by holding down claims costs in order to become a more attractive acquisition candidate, but also might be designed to make hospitals “cry uncle” and seek abandonment of the HSCRC because its rates are inadequate. Others believe that the only motivation for such an active resistance to hospital rate proposals – a position not commonly taken in the past – is to ensure that the rate base for a future owner is low enough to make the plan’s environment acceptable to potential buyers.

Goals for the Future of State Policy

The future of Maryland's health care system is gathering increasing attention. Many hospitals believe that HSCRC-set payments are not adequate, most particularly that revenues are insufficient to sustain bond ratings that enable hospitals to secure capital for facilities replacement and expansion. From the State's perspective, the Medicaid program continuously breaks budget targets, and program growth will only be exacerbated by recession. The number of uninsured citizens not eligible for Medicaid remains high and is growing. Finally, insurance premiums are rising for employers at rates similar to those in other markets. In Maryland's rate setting environment, the increasing discordance between insurance premiums and hospital and physician payments raises particular concern. The potential sale of the Blue plan only adds to the growing intensity of interest in the future of the Maryland health financing system.

Three objectives exist to guide the future of Maryland's health financing policy. The first is control of inflation, the single most destabilizing force in the health care system. If inflation spirals out of control, the relation of all of the entities that play a role in the health care system will change dramatically. Hospital bad debt could cause some hospitals to face bankruptcy. CareFirst would have to raise rates disproportionately and underwrite risk more cautiously, thus adding to the availability crisis. Following CareFirst, which already has begun to withdraw from portions of the individual and small group market, other carriers could retreat. Employers might decide they are unable to offer benefits. Enormous pressure would fall on State government to invent wide-ranging solutions, perhaps involving a State-run insurance program. Maryland has been home to a vocal group of health reformers, among them highly credible professors, physicians, public health workers and labor unionists, who long have advocated that Maryland become the first state to socialize health insurance.

State policy also must protect the poor and those who have no health care coverage. Most U.S. hospitals have a powerful incentive to avoid treating such patients. While it makes perfect financial sense to avoid the uncovered, there is

reason to avoid treating Medicaid patients as well: in other states, Medicaid reimbursement falls well below the price paid by non-governmental insurers, and in some cases well below a hospital's actual costs of treatment. Outside of Maryland, hospitals must cross-subsidize Medicaid care from the gains in treating fully insured patients. When the margin on private pay patients is not sufficient to support this practice, hospitals attempt to "demarket" their services to the poor to avoid treating uncovered individuals. In Maryland, where hospitals are protected from bad debt related to free care, hospitals routinely take all comers and treat such patients as if they were fully insured. This non-discriminatory treatment, so basic to Maryland's view of how its hospitals should work, is a continuing policy goal in this State.

The State also must ensure an orderly and stable environment for its hospitals and the insurance companies that do business here. Preliminarily, the hospital market must be ordered such that there is no additional overcapitalization to further fuel inflation; for the past 40 years, the State has had excess hospital bed capacity, an expensive luxury. Hospitals should be secure, however, in their ability to raise capital for needed rebuilding and modern technology. Likewise, a stable set of insurers must be available to sell coverage to the State's employers, individuals and small businesses.

The HSCRC is the lynchpin in the comprehensive State policy that focuses on the access to and cost of acute medical care, and the continued existence of this policy relies on a shared commitment to these goals by all of the involved parties – hospitals, insurers and regulators. Although hardly perfect, the rate setting system leverages government authority at the most critical point in the health care financing system. At a given moment, the system must balance competing views of how the goals might best be achieved. Precisely because each entity is advancing its own economic interests vis-à-vis other entities, the success of the system also requires a considerable degree of good will and adherence to a longer term view of the overall benefit to be achieved. Otherwise, the temporary advantage of one party can be pushed to the point where the joint welfare of all parties is at risk. If any one actor calls it quits, the system will collapse. The

General Assembly could not ignore the political pressure of insurers or the hospital industry if either made a concerted effort to kill the rate setting system.

A Blue Cross Transaction in the Maryland Policy Context

In this environment, what are the implications of the sale of the Maryland Blue plan to an out-of-state, investor-owned parent? What impact might such a transaction have on the future of the public policy goals that Maryland has embraced? What options are open to policymakers as they consider a proposed transaction?

It is not surprising that a discussion of the sale of Maryland's largest non-profit carrier causes worry among those who are charged with developing the State's health care policy. If the State's Blue plan is sold to a for-profit parent, it is certain that the plan would reevaluate the special part that it has played in the State's hospital regulatory scheme and the role that it accepted – until lately – in the insurance market as the provider of subsidized coverage to individuals and small groups, the insurer of last resort. An investor-owner also would have to rethink participation in the SAAC program. If past is prologue, the medical loss ratio in the CareFirst acquisition will be under enormous pressure. For-profit entities have institutional antipathy to rate setting in general, and it is not likely that a large for-profit company will eagerly accede to HSCRC direction on such seemingly small matters as prompt claims payment (which can interfere with the aggressive management of float, often a significant profit center for commercial insurers), much less on larger issues such as managed care payment protocols (which can curtail a carrier's ability to limit costs by limiting eligible therapies). Without CareFirst's cooperative role relative to the HSCRC, the delicate balance upon which the rate setting system relies is likely to be imperiled. In many ways, the ultimate questions posed by the sale of CareFirst is whether the HSCRC can continue and enhance its effectiveness in a market in which all insurance companies are investor-owned. This can only occur if CareFirst's new parent will assume the community duties expected of Maryland health insurers.

There also is little doubt that a conversion transaction could cause Maryland government to reconsider its expectations of Maryland's Blue plan. Should the new parent determine to take CareFirst yet further down the path of declining to supply the market with a SAAC subsidized product, the General Assembly would be forced to reexamine how best to serve the individual and small group markets. While other carriers might be persuaded to expand their commitments to the program, their market penetrations might not be sufficient to effect the policy objectives of the legislature. The State could find that more vigorous action is required, *e.g.*, a new tax to establish a premium stabilization fund or other such arrangement to support the individual and small group market, or a more radical solution such as the creation of a State-owned and managed insurer.

One cannot think about the future of Maryland's experience in health policy without wondering if a non-profit insurance plan has been a necessary condition of its success. Historically, the scale of the Maryland Blue plan, as well as its public service behavior, made it a critical partner in the State's health policy system. CareFirst not only is the largest health insurance company in the State, it also is the most significant single force in the State's health care economy, and it is intimately bound to the success of Maryland's comprehensive State-wide hospital financing policy.

Relative to hospitals, the insurance side of state health policy has been neglected. A comprehensive approach to making insurance more affordable does not result automatically because the HSCRC is successful in keeping hospital budgets under control. As suggested above, the number of hospitals has more to do with the global cost of care than the Commission's rates. Likewise, the basic insurance product as mandated by State statute has more to do with the availability of affordable insurance than the SAAC differential. If State policy genuinely seeks to support a private market for affordable insurance, it must, for example, examine the benefit mandates that all insurance companies must include in nearly all policies. To develop a next generation of health leadership, the Governor, the legislature, the HSCRC and the Insurance Commissioner should restate the objectives of State policy regarding health

insurance. Basic and flexible coverage should be the objective so that the largest number of Marylanders can buy coverage and private insurance carriers, including the Blues, can experiment in an environment where the State is a partner in risk. Executive, legislative and civic leadership should articulate the objectives of State policy and the steps needed to achieve those objectives. A comprehensive policy will equally weigh hospital capacity, physician supply, hospital budget requirements, and the insurance market environment, including profit goals that will sustain all the private health risk capacity that the State needs.

Maryland's way is to worry about our health care system in a manner that many other states do not. Maryland remains committed to advancing an enlightened and prudent health policy that includes an orderly hospital system and a predictable insurance market. To do so, there must be information and certainty about the future of CareFirst and the role that it will play in Maryland. By inviting corporate suitors, CareFirst has invited questions about the motivations and rationales for its acquisition by a for-profit, the efficiency of its operations, and the impact of such a change on the State's citizens and economy.

Carl J. Schramm

Mr. Schramm is an economist who specializes in health care, insurance and health information technology. He is the founder and CEO of Greenspring Advisors, Inc. From 1973 to 1987, he taught at Johns Hopkins, where he founded and directed the Center for Hospital Finance and Management. Mr. Schramm was president of the Health Insurance Association of America from 1987 to 1992, and then served as executive vice president of Fortis, Inc., an international insurance and financial services company. He was founder of HCIA in 1984, and co-founder of Patient Choice Health Care in Minneapolis in 1999. Mr. Schramm is a fellow of the New York Academy of Medicine. He holds a Ph.D. from the University of Wisconsin and a J.D. from the Georgetown University Law Center.