

September 30, 2002, *Final Draft*

## **Case Studies of Four Blue Cross Conversions**

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in connection with the proposed conversion by Blue Cross and Blue Shield of North Carolina

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This document will become part of a larger report to the North Carolina Department of Insurance, but the main part of the report has not yet been written. This document contains only a summary of information from other states. It does not contain any conclusions or recommendations about the proposed conversion in North Carolina, nor does it necessarily reflect any positions or views of the Department of Insurance.

## **Methodology**

At the request of the North Carolina Department of Insurance, four case studies were conducted of Blue Cross plans that have converted to for-profit status. The focus in these case studies is on the impact (if any) of conversion on the accessibility and affordability of health insurance and health care. California, Georgia, Missouri, and Virginia were chosen for these case studies because these are the four states where Blue Cross conversions similar to that proposed in North Carolina (conversions to non-mutual stock ownership) have been in place for several years.

These cases studies consist of confidential interviews and a review of published literature and available documents. Nine to twelve subjects were interviewed confidentially in each state by Mark Hall, consisting of 2-3 insurance agents, 2-3 regulators, 1-2 consumer advocates, 2-4 provider representatives, and 1-3 industry observers. A consistent set of topics was raised in each set of interviews, but the particular topics differed somewhat according to each type of interview subject. Also, these interviews were unstructured in order to pursue different lines of inquiry according to each subject's perspective and base of knowledge.

Databases of 1-2 leading newspapers in each state were searched for relevant articles. Literature searches were also performed in academic journals (health policy and economics) and in selected industry publications (e.g., *Modern Healthcare* and *BNA Health Policy and Health Law Reports*). Web sites for the respective regulatory agencies and Blue Cross plans were also searched for relevant information and documents. And, documents were obtained, when available, from some interview subjects, mainly regulators. Standard qualitative research methods were used to compile, interpret, and report these sources of information.

Despite the extent of these efforts, these case studies provide only a limited window into the issues they explore. Insurance markets are hugely complex, these are large states, and the relevant questions cover a number of years. Moreover, each state is different, so findings from these others states do not necessarily reflect what might occur in North Carolina. Therefore, this effort is necessarily incomplete and inconclusive. In particular, obtaining a better view of the impact of conversion on insurance premiums would require interviewing more insurance agents in different parts of these states and focusing more on the individual market rather than the group market, which was the primary focus of most of these agent interviews.

A note on terminology: in each case report, after the relevant corporate institutions are introduced, the particular insurer of interest is referred to simply as Blue Cross, abbreviated BC. The use of this term in each case report refers to the particular company in that state, and not to Blue Cross or Blue Shield plans generally or in other states, unless otherwise indicated.

## **California**

### History

January 1993, Blue Cross of California transferred most of its managed care business to its for-profit subsidiary, WellPoint, and sold 20% of its stock in an initial public offering. Under pressure from regulators, BC agreed to fund two foundations with stock valued at over \$3 billion. It completed its conversion in May 1996.

### Interview Subjects

Twelve subjects were interviewed, including three agents (one in a rural area), three government officials, one patient advocate, one large purchaser, two provider representatives, and two industry observers.

### Market Structure

California is a highly competitive market with several insurers that are market leaders, two of which are nonprofit. Kaiser is the largest insurer overall, about twice the size of Pacificare and BC. Blue Shield, which is nonprofit, is also a significant size, as are several other for-profit managed care plans. Overall, BC's market share is about 18%, but it is the largest insurer in the small group and individual markets, and is said to dominate the individual market, where it has twice the enrollment of the next largest insurer and half the market in many parts of the state.

### General Corporate Culture and Conversion Impact

Questions about BC's corporate culture prompted many comments. All agreed that its corporate culture has changed dramatically since the late 1980s, when its current chief executive officer was brought in to turn around a very large organization that was nearly bankrupt. Then, BC was noted for being very socially oriented, more so than Blue Shield. But its "community rating mentality" has disappeared. The same is true, however, for Blue Shield, and to a large extent Kaiser, and for many other Blue Cross plans across the country, including nonprofit ones. Nevertheless, many people commented that BC of California stands out as being especially profit oriented and aggressive in its business strategies, even compared to its non-Blue competitors. According to one very vocal critic, "They're profiteers, commercial barons, and they're upfront about it. That's what's so disgusting."

Whether this change was caused *by* the conversion, or instead was the cause *of* the conversion, or indeed would have happened regardless of the conversion, was subject to differing views. The impact of the conversion itself is testified to by BC's CEO in the following passage from a published interview:

There is no question that the pressure for economic performance and thus accountability to investors is very real. . . . Stock analysts who follow companies want them to perform to their calculated profit estimates every quarter. Having said that, though, I do not think there was any real big impact when Blue Cross of California converted its managed care business from not-for-profit to for-profit. We had learned our lesson in the early 1980s about losing money. We were very focused on economic success, on financial strength, and the market we served was also very focused because there had been bankruptcies in California. So there was almost no change in how we behaved. We were one of the most profitable plans in the United States. However, when we became publicly held, and

listed on the stock exchange, for the first time ever there were incredible pressures for achieving our goals for quarterly earnings.

Most interview subjects, however, thought that the conversion was only a continuation of the changes that were begun in the late 1980s that turned around BC's financial performance. Some subjects noted that BC's culture is uniquely tied to the forceful personality of its CEO. In the words of one observer, "In many ways, WellPoint is Len Schaeffer, culturally. It's very much his company."

Overall, most interview subjects were philosophical about the conversion. They saw it as part of the tapestry of changes that have swept the health care industry in the past decade, but not the main catalyst of these changes. One patient advocate thought that, on balance, the conversion was good for public policy because of the tremendous benefits from the foundations, discussed below, and because of his belief that BC would have behaved in largely the same way even if it had remained nonprofit "in name only." However, one outspoken opponent said flatly allowing conversions is "one of the biggest mistakes" California has made in health policy because it adds an extra layer of expense that makes insurance more expensive and drives up the number of uninsured.

#### Profitability and Rate Increases

Financially, BC has been enormously successful. Its enrollment has increased rapidly, especially in the small group market, where it has doubled following conversion. Its operating margin ranges from 9-10%, and its medical loss ratio is roughly 75%, 10 points or more lower than other major competitors.

There is no indication that this financial success is, in general, due to greater rate increases than competitors. Most subjects attributed BC's healthy profit margins to its aggressive bargaining over payment rates with providers and its tough underwriting policies, as discussed below. One knowledgeable observer noted that in California's fiercely competitive market, BC could not have possibly increased its enrollment this much if it were not priced very attractively. Agents interviewed said that BC's rates for group products are similar to or slightly lower than competitors', except for Kaiser's -- which is an entirely different type of health plan -- or some small health maintenance organizations with much smaller networks. Observers explain that BC's financial success has come from its ability to offer good rates, broad networks, and a choice of benefit designs to small groups and individuals, at the same time that it pays the lowest rates to providers and has a healthy block of business. One industry analyst said that BC uses its market power to drive down medical costs rather than to increase insurance rates. Indeed, keeping rates affordable is a key to its strategy since having more enrollment gives it greater market power in negotiations with providers. However, one subject said that BC's rate increases have been excessive in the individual market recently.

BC has not achieved profitability through lower administrative costs. Instead, its administrative costs have increased substantially following conversion, from about 8% in 1994 to around 14-15% in recent years.

#### Provider Contracting

In general, BC has pursued a contracting strategy that seeks to have networks that are as broad and inclusive as possible rather than selectively contracting with some but not all providers. This is especially true for its preferred-provider-organization network. In contrast, its HMO contracting often involves exclusive arrangements with a large provider network that includes only a portion of the area's providers.

From many sources, it appears that BC is "notorious" for its tough negotiating stance with providers. One subject captured the general sentiment well by saying that "without a doubt, BC is the plan most hated by providers, far and away." It was the first health plan to aggressively use its market clout to take advantage of excess provider capacity and force provider rates as low as possible, often lower than Medicare pays. Various sources, mostly but not entirely provider-related, said that BC is "ruthless," "hardnosed," and "plays hardball" in its provider negotiations. A number of provider groups and organizations have sued BC over payment issues.

This story has taken a noticeable turn more recently, however. Several large hospital chains have refused to accept BC's offered rates and taken a tough negotiating stand that has led either to a temporary break in the contract, or an eleventh-hour resolution that creates great uncertainty about whether a break will occur (for instance, agreement being reached after termination letters have been mailed out.) In other instances, providers in rural areas have flatly refused to sign HMO contracts.

There were conflicting views on the consequences for the public from these tumultuous negotiations and contractual terminations. In the view of many subjects, this process has been "enormously disruptive" causing tens of thousands of people to switch providers, albeit often only temporarily. In the view of some subjects, however, disruptions have not been that significant since, in all of the prominent instances, the parties eventually reached agreement, although sometimes after a break in coverage or after notices of contract termination had been sent out to members.

There were also conflicting views on whom to blame for the turmoil. There was general agreement that, several years ago, BC was the driving force in contract negotiations. More recently, however, most subjects thought that providers had gotten the upper hand by realizing that BC needed them more than they needed BC. The attitude of regulators about this was "a plague on both your houses." But regulators also noted that disruption from patients having to find new providers is a problem that affects other insurers, some much more than BC. It is a problem that is much more widespread arising from the collapse of large physician networks than it is from managed care contracting. However, in one such instance, regulators had to enjoin BC from requiring over 100,000 of its members to immediately leave their physicians who were part of a medical group that was in receivership and that regulators were still attempting to keep operational. Regulators said that BC's abrupt move was "shocking" and "endangered the health" of patients.

#### Underwriting and "Last Resort" Issues

BC has a reputation as an aggressive but fair underwriter. Two agents said that BC is "in the market for the long run" and "bends over backwards" to write and keep as much business as possible. Others felt that BC was more "sophisticated" at selecting good risks and segmenting risks than most other insurers, and that its acumen in this regard is one of the keys to its success,

something that other insurers are “envious of.” It is notable that BC is the strongest in the market segments that have the most medical underwriting, and weakest in those that have the least. Also, in 1998, BC changed its rating for Medicare supplemental policies to a method that increases the rates as the member ages.

Some subjects opined that BC “crassly” manipulates benefit coverage and product design to enhance favorable risk selection and risk segmentation. One source said that California has strong protections against the worst forms of market practices known as “churning,” so he did not believe BC was abusive in this regard. Two other subjects, however, said that BC actively uses product design techniques to select favorable risks.

Around the same time as the initial conversion, California established a high risk pool for uninsurables, which displaced any “last resort” obligations that might have existed. BC serves as the administrator for this pool. In other respects, BC is notable for its strong presence “across the board” in public insurance programs that serve the poor and high risk populations. In this regard, it is “about the best” of all private insurers, even Kaiser. It is a participating carrier in the CHIP program, where it has 200,000 members, and it has a strong and rapidly growing presence in Medi-Cal, the Medicaid HMO program, where it is by far the largest private plan with over 700,000 members. One subject noted that previously in Oakland County, there were no private obstetricians who would take Medi-Cal patients. Women could only go to a hospital or public clinic. Now patient access is greatly expanded because of the strength of BC’s network in Medi-Cal. Although no one thought that BC is participating in public programs as a public service, it was noted that BC appears to be willing to stay in public programs that have only a thin margin, in order to defray overhead and increase its market share.

#### Product Lines and Geographic Coverage

BC maintains a statewide PPO network, which is the broadest of all insurers. Geographically, it has stopped selling its HMO products in some rural counties where providers who dominate the local market have refused to contract. It has raised its rates in other rural counties where dominant providers demand large payment increases. Otherwise, it continues to market all of its major products statewide, and it is especially strong in the individual and small group markets.

BC is known for being a continuing innovator in product design, a “visionary” that is “always five steps ahead” of the competition. For instance, it has been at the forefront of the new wave of “consumer-directed” plans that have greater patient cost sharing, and of “tiered” network plans which build multiple levels of co-pays and deductibles into a PPO structure. Also, it has developed a product for Indian tribes, and it has introduced a very low priced “bare bones” type policy in the individual market with a \$5,000 deductible and limited benefits, which it is targeting to lower income uninsured segments of the Hispanic population, among others. As noted above, however, some skeptics believe that frequent changes in product design may result in greater risk segmentation. Also, concern was expressed that the bare bones policy may not offer adequate protection or may mislead less sophisticated purchasers.

BC has withdrawn its Medicare HMO products from a number of counties, but it did not have a large enrollment and the impact was much greater when other insurers also withdrew. BC no longer serves as a Medicare contractor for claims processing.

### Utilization Review and Customer Service

BC receives high marks for its customer service, which subjects noted has improved noticeably in recent years. At one point, BC lost its National Committee for Quality Assurance accreditation, but now it is restored. The Pacific Business Group on Health's quality ratings place BC in the middle of the pack, exactly the same as Blue Shield and only a bit below Kaiser. In the complaint figures published by regulators, BC has about the same number of complaints in 2001 as it did in 1995, but it has many more members now, so the overall rate is substantially lower. Compared to other insurers, BC is among the lowest of the major plans, lower than Blue Shield, close to Kaiser, and much lower than Cigna, HealthNet, and Pacificare. Agents also gave BC good marks for customer service.

### Foundation Activities

There was widespread enthusiasm for the role the two foundations have played in health policy statewide: "absolutely wonderful," "huge positive benefits," "major impact." Their missions include improving access for the underserved, and one foundation in particular has devoted much of its funding to support low income clinics and to help subsidize the high-risk insurance pool. However, two subjects felt that the foundations have not made full use of their resources. One thought that, for awhile, the foundations "lacked focus" but lately have improved. Another felt that one foundation had little to show for all the money it had spent.

One subject noted that the fact that the foundations were initially funded with BC stock created a "win-win" situation in which the better BC was at earning profits, the more good the foundation could do. However, now the foundations have divested themselves of the BC stock.

## **Georgia**

### History of the Conversion

Blue Cross and Blue Shield of Georgia converted from a mutual form in February 1996 to for-profit company called Cerulean. After litigation, members eventually received \$5,900/share. Legislation enacted the prior year did not require a foundation, so a citizen group sued. Another suit was brought by shareholders. There were allegations that the conversion was structured as a “friendly” (non-arms length) buy-out to avoid revealing the fair market value. There were also allegations the investors had political ties which facilitated regulatory approval. These issues and the lawsuits received much publicity, and Georgia is often held up as an example of a transaction where the public did not get a fair deal. This climate may have created a certain amount of defensiveness or lack of objectivity on the part of regulators who were interviewed, since the same insurance commissioner remains in office. However, this contentiousness also may have affected the views of natural opponents of BC who were interviewed.

In July 1998, the citizen group lawsuit was settled with the agreement to create a foundation with 20% of the new corporation’s stock, which at the time was valued at \$40-80 million. At the same time, WellPoint of California announced a deal to purchase BC. However, the sale was held up by the shareholder lawsuit, which did not settle until October 2000. The sale went through March 2001. The foundation was then worth about \$120 million.

### Interview Subjects

Nine subjects were interviewed: two regulators, two consumer advocates, two insurance agents (one urban, one urban and rural), two representatives of provider organizations, and one industry observer.

### Market Structure

BC is by far the largest insurer, with about 30% of the overall market, 35% of the HMO market and 25% of the PPO market. In the HMO market (which is larger than the PPO segment and where most new business is being sold), BC’s share is about twice the next largest insurer (Kaiser), and three and four times the size, respectively, of the third and fourth largest insurers (Aetna and United). So, BC’s HMO is about as big its next three competitors combined. BC’s overall enrollment is about two million, up substantially since the conversion. Most enrollment growth has come in the HMO segment, where BC’s market share has gone from 11% to 35% in five years. The PPO business is older and higher risk, and BC’s market share has held steady in that segment.

### General Conversion Impact and Change in Corporate Culture

Most subjects felt that the original conversion had no major impact on BC’s corporate culture and market behavior. However, many felt that the sale to WellPoint has had a discernible effect. According to one subject, BC “changed its stripes” in the early 1990s when it brought in a new management team, the “crowd from Connecticut,” mostly from commercial insurers, whose mission was to “turn around” BC and make it profitable by becoming more “business-like” and moving it toward managed care. This was a big change in corporate culture, from a time when BC was much more provider oriented. Now, it is seen as no different than other commercial insurers, which has caused “great angst” in some quarters. But most subjects said that these changes were all in place prior to the conversion, and that business practices remained essentially

the same following conversion, since the management team remained the same. Several subjects said, however, that when WellPoint replaced the CEO and senior management, BC became somewhat more difficult to deal with and less responsive to working out problems. However, some subjects felt that operations and attitudes are essentially the same under WellPoint as before. Other issues related to WellPoint are noted below.

In general, there appears to be no substantial negative impact on accessibility and affordability from the conversion, in the various areas surveyed below. However, several subjects said they see no advantages flowing from conversion, and there was no apparent need for access to equity capital. Instead, the predominant view among these subjects was that the conversion enriched senior management, who received “golden parachutes” from the WellPoint buyout.

#### Profitability and Rate Increases

Since 1997, BC has steadily increased its operating margin 1-2 percentage points a year. In 2001 (the first year under WellPoint), the operating margin jumped four percentage points. In most years, this improvement came mainly from lower administrative expenses, but in 2001 the medical loss ratio also decreased two points, to 86.5%. The medical loss ratio also decreased 1.5 points in 1998, but has remained fairly steady most years since 1997.

There is little or no indication that BC has achieved its increased profitability through higher rate increases. One regulator said that BC rate increases have “pretty much followed” medical cost trends, and do not stand out as higher than other insurers. Regulators see no indication that the conversion has resulted in higher rates, although they have not systematically studied the issue, and not all rates are reviewed or require approval. Agents who were interviewed thought that BC’s group rates were competitive or among the best in the market. One agent said that, for new small group business, she sells more BC than anyone else, and when her current clients shop the market for better deals, they usually find that BC has the best rates for HMOs. However, several sources said that rates are increasing noticeably more for PPO coverage, and BC appears to be not trying to increase its PPO business or trying to move its PPO enrollment to HMOs.

#### Provider Contracting

At the time of the conversion, BC claimed it needed more capital to expand its managed care provider networks. Whether or not new sources of capital were needed for this, it is indeed the case that BC’s provider networks have expanded considerably following conversion, more than doubling, according to company sources. It contracts with most hospitals and physicians in the state, and it is the only statewide managed care plan. There have been few or virtually no major disruptions in provider networks due to failed negotiations or provider terminations. However, in a few instances, hospitals with dominant market power have refused to contract or have insisted on an exclusive contract that excludes competing hospitals. One subject complained that BC had failed to use its considerable market power to stop giving one prominent Atlanta hospital exclusive contracts that force people to travel much farther to obtain urgent hospital care.

We heard conflicting accounts of the extent and use of BC’s market power against providers. Some sources said that BC is able to obtain deeper discounts than other insurers, which accounts for its growing profitability. BC apparently has switched its payment method under PPO and indemnity contracts from a percent of charges to a fee schedule based on Medicare rates, and some subjects complained that it is now paying hospitals no more than, or less than, Medicare.

Others said BC's discounts are not that much deeper than other insurers, or have not gotten deeper, except for perhaps following the WellPoint acquisition.

The main provider issues, according to several sources, relate to "fair business practices" and "prompt payment." A hospital source said that BC is no worse in this regard than other insurers, and none of the large fines the DOI has issued against insurers for these issues have gone against BC. However, the physician association has sued BC over its use of a payment methodology that they claim prevents physicians from knowing the actual rates they are owed.

No issues were raised concerning other contracting issues such as "most favored nation" or "all products" clauses.

#### Underwriting and "Last Resort" Issues

We heard no complaints that BC has become more difficult or aggressive in its underwriting practices following conversion. Some said that it is "in the middle of the pack," but others said it is somewhat more lenient. For small groups, BC rates up higher risks only 50%, whereas other insurers rate up 100% by using different rating factors more aggressively. One subject said that BC still has a bit of a reputation as a "last resort" insurer where it may be possible to get coverage for someone turned down elsewhere. Several times BC has helped to "clean up messes" caused by troubled or failing HMOs, by absorbing their enrollment. Also, BC carries more of the burden for HIPAA conversion enrollment than other insurers because this enrollment is assigned to carriers pro rata to their market share. However, both prior to and following conversion, BC had no role as a "last resort" carrier other than what is required by laws that apply to all carriers.

#### Product Lines and Geographic Coverage

BC has not dropped or pulled back in any major product lines following conversion, and it remains active statewide. In particular, it is still actively increasing its enrollment in the individual and small group markets. In a recent year, its nongroup enrollment grew 26% and its small group enrollment grew 14%. Also, it has the largest Medicare HMO plan in the state, and it is one of only two insurers to not pull out of the Medicare HMO market, although it is "taking a hard look" at this product on a year-to-year basis.

#### Utilization Review and Customer Service

Georgia does not publish complaint statistics, but BC does not stand out in the minds of regulators or consumer advocates as being a more difficult insurer. It has a top rating from NCQA. In terms of utilization management, BC is viewed as being "in the middle of the pack." According to consumer advocates, BC, like other insurers, "is a pain" and doesn't go "out of its way to help patients."

In some respects, BC is seen as easier than other insurers to work with in addressing problems, at least until the WellPoint acquisition. Previously there were people at BC whom agents or advocates could reach to take a look at particular cases and try to resolve them. This personal attentiveness has worsened somewhat under WellPoint, however, according to two sources.

BC remains cooperative and responsive in the view of regulators. It has not fought the DOI on major legislative or policy issues. One observer noted that BC has strong reasons to remain in

good political graces of public officials in order to continue receiving a large contract to administer the public employee health insurance program.

Foundation Activities

The foundation's purposes include helping the medically underserved. However, the foundation is not expected to fund direct medical care or direct subsidies for insurance, since it will have only about \$5 million a year to spend. This is viewed as too little to have much impact through direct services. Therefore, the focus is likely to be on efforts to make systemic changes or to target selected areas such as social services for the disabled or prescription drugs.

## **Missouri**

### History

In August 1994, after Department of Insurance approval, Blue Cross and Blue Shield of Missouri put 80% of its assets in a for-profit subsidiary, RightChoice, and issued an IPO. In May 1996, the DOI withdrew its approval, saying it was misled about the facts. The DOI and attorney general each filed suit to challenge the conversion. Initial court rulings favored the regulators, but the courts would not approve the settlement that called for using RightChoice stock to create a foundation. The trial court wanted RightChoice to be sold in order to get its full value. The Missouri Supreme Court upheld the parties' freedom to settle the case as they wanted. In January 2000, the foundation was created, valued at close to \$500 million because the stock tripled in price shortly after the settlement was approved. In November 2000, BC converted entirely to for-profit. In January 2002, California-based WellPoint purchased RightChoice. The increase in stock value made the foundation worth almost \$1 billion.

### Interview Subjects

Eleven subjects were interviewed (some subjects had served multiple roles): four consumer advocates, two industry observers, four current or former regulators, two insurance agents (one urban and one rural), one former hospital administrator, and two representatives of physician organizations.

### Market Structure

United is the largest insurer, with about 20% of the overall health insurance market statewide, and 30% of the HMO market. There are two BC plans, one in Kansas City, which remains nonprofit, and the St. Louis plan (RightChoice), which converted. The St. Louis plan does not cover the entire state, and does not compete head to head with the Kansas City plan. The St. Louis plan has less than 10% of the state's HMO market and is only the third or fourth largest HMO. It is the largest PPO, with about 20% of that market (which is about three times the share of United, the next largest PPO competitor). BC's market share is growing for PPOs, but not HMOs. BC is the largest insurer in the individual market.

### General Corporate Culture and Conversion Impact

The general consensus is that the conversion itself did not change the corporate culture at BC. Instead, the culture began to change in the late 1980s and early 1990s with a new management team brought in to address the company's financial troubles. Its conversion is seen as a continuation of a change to increasingly behaving like any other commercial insurer. Several subjects said that BC had begun behaving like a for-profit plan before the conversion, and would likely have continued to do so despite the conversion. Notably, BC had created several for-profit subsidiaries prior to moving most of its assets into one of them, so that a for-profit "culture was already in place," according to one subject. As another subject put it, the conversion was the effect of a change in corporate culture, rather than its cause. And yet another subject commented that BC is no less socially oriented than it was before, only now perhaps it feels less guilt.

This change in culture resulted in a number of specific behavior changes, noted below. At a more general level, however, subjects noted that BC became much less socially oriented in its legislative and public policy positions. Regulators said that BC began to oppose it more often and actively on various regulatory and legislative issues. Consumer advocates agreed, noting

that at one time BC was the only major insurer to “come to the table” to discuss systemic reform such as solutions to the uninsured or the problems created by risk segmentation. But, now, it is like any other commercial insurer that just looks out for its own interests in the public policy arena and tries to protect its ability to make money.

On balance, several consumer-oriented subjects said that the conversion was good for public policy because it produced a large foundation that can promote social welfare, whereas BC would likely have continued to behave in this fashion regardless of conversion. One industry observer noted that BC’s profit-oriented ways had resulted in a huge increase in the value of the foundation, which greatly expands its ability to do good. However, one seasoned advocate argued forcefully to the contrary, saying that conversion was a very discouraging “watershed” event that ratified or cemented the flaws of the current system and “gave up the ghost” of any realistic hope for systemic or fundamental reform. He expressed skepticism, noted below, about how much the foundation could actually accomplish.

#### Profitability and Rate Increases

Following conversion, BC has steadily increased its operating margins and lowered its medical loss ratios. Interview subjects thought that loss ratios were lowered through provider discounts and more aggressive medical underwriting and utilization management. No one thought that BC’s rate increases were higher than its competitors for group products, and there is no evidence that conversion resulted in higher rates. The two agents interviewed consider BC’s recent rates to be highly competitive, especially in the small group and individual markets.

BC’s medical loss ratios have dropped about five percentage points in the past three years. For its PPO products, loss ratios are about 78% overall, 67% in the individual market, and 81% in the group market. These loss ratios are lower than most of its major competitors and significantly lower (about five points) than the nonprofit Kansas City plan.

#### Provider Contracting

There are no significant complaints that BC is using market power to drive down provider rates lower than other insurers. Observers noted that in Missouri, BC does not have more market power, and may have somewhat less, than other major insurers in the state.

One subject noted that BC no longer is willing to subsidize public goods and unprofitable services by hospitals, but this change began before the conversion and would have happened regardless of the conversion. Conversion “merely accelerated the process” that was already underway.

#### Underwriting and “Last Resort” Issues

Missouri has a high risk pool that is funded by all health insurers, so BC does not (and did not) have explicit obligations as an “insurer of last resort.”

Several subjects said that, overall, BC’s underwriting practices are “fair” and in the “middle of the pack,” no better or no worse than some other insurers. One agent noted that BC is less aggressive in rating up small groups than other insurers. However, in a couple of respects, subjects noted BC’s underwriting policies have made it more difficult for higher risk subscribers to obtain coverage. Two subjects said that BC is more aggressive than other insurers or much

more aggressive than it once was in turning down coverage for individuals, although as a result its individual rates are very attractive for those who qualify. Its individual rates are also lower because it does not include maternity coverage unless purchased as a rider. Those who don't need this coverage can avoid it and pay less, unlike United which spreads the cost of this coverage across all its policies.

Regarding HIPAA conversion coverage, BC claims that it does not have to offer its individual HMO plan in counties where it does not actively market the plan due to having an insufficient network. However, regulators insist that BC must offer this coverage wherever it maintains an active license for the product.

#### Product Lines and Geographic Coverage

BC has retained all of its major product lines, and continues to cover its entire service area in the state. However, profitability concerns have caused it to pull back in several respects. First, it was one of the first major plans to pull out of the Medicare HMO market, and it did so across the state rather than in selective counties, as other insurers did. BC also withdrew from the Medicaid HMO business.

Second, BC has been unable to maintain adequate provider networks for its HMO products in rural counties, and so has stopped actively marketing that product there. (However, its PPO products remain active in all counties). We heard conflicting accounts of this situation. One regulator said this is due to providers with market power refusing to take HMO contracts, and the problem equally affects other HMOs. Another regulator, however, thought the problem was more severe for BC and was due to providers' not agreeing to BC's demands for deep discounts. However, this regulator said the problem was not related to conversion and had been an issue prior to conversion.

Finally, shortly after conversion, BC canceled individual coverage for an association plan with the Farm Bureau. Members were moved either to underwritten individual plans, or to the state's high risk pool. This resulted in very large rate increases (double or triple) for several hundred members and produced a flurry of complaints and negative press. News articles at the time suggested this decision was made for profitability reasons, but current regulators believe it was an unavoidable move required by Missouri's new small group rating rules which prevented insurers from continuing to rate association groups on an experience rated basis. In any event, similar terminations resulting in large disruptions have not occurred subsequently.

#### Utilization Review and Customer Service

Agents thought that BC's utilization management policies are no better or worse than other insurers, and that it has a reasonable customer service track record. However, complaint ratios published by the DOI indicate that BC's complaint rate is roughly 20-30% higher than average, higher than most other major insurers, and several times higher than the Kansas City BC plan.

One regulator said BC was no better or no worse to deal with than other insurers. Another regulator commented that BC had become more difficult to deal with over the years and less responsive in resolving problems, but this has improved under new management that came in a few years ago. It should be noted that the CEO prior to and during the conversion process was convicted of criminal fraud relating to certain transactions and served a jail sentence, and there

were “issues of trust” relating to this CEO.

Foundation Activities

The foundation’s purposes are focused on addressing unmet needs of poor and underserved populations by “seeking out the holes in the safety net provided by private and public health care interests.” However, it is unclear whether this purpose will be accomplished through funding direct care and subsidizing insurance. One informed subject thought that direct services like this were not likely, but another was concerned they would be funded to the detriment of support for more systemic improvements and reforms.

## **Virginia**

### History

In January 1997, BC in Virginia converted from a nonprofit mutual form to a for-profit publicly traded stock company called Trigon. At the same time, it paid \$175 million to a state-run trust fund. On July 31, 2002, Indiana-based Anthem purchased Trigon for \$4.2 billion.

### Interview Subjects

Eleven subjects were interviewed, including two regulators, three agents (two specializing in small group coverage, one in individual coverage), one patient advocate, three representatives of physician groups, one representative of the hospital community, and one person with a competing insurer.

### Market Structure

BC is the dominant insurer in the state, with 37% of the insured premium dollars statewide and about half of the individual market. (It does not cover the area of Va. near D.C.) Many subjects noted its “extraordinary” market power, with comments such as the “only game in town” and “huge market share.” Several subjects independently used the phrase “800 pound gorilla.”

### General Corporate Culture and Conversion Impact

There was no consistent indication that the conversion has sharply changed BC’s corporate culture. Instead, several subjects noted this culture had changed in years prior to the conversion when BC changed from nonprofit to a mutual form and the current management team came on board. One agent, who originally opposed the idea of the conversion, said she was pleased with how BC has behaved post conversion. Another observer noted that BC is very conscious about how it is viewed from a political standpoint by the public, the press, and regulators, which constrains its behavior. Several subjects noted that BC is still active in trying to craft workable solutions to public policy and regulatory issues. And another said, “To their credit, they’ve tried really hard to stay in touch with the community, even more than before.” However, one subject noted that BC now has to “dance the dance for financial analysts, investors; they have to perform.” Another said that BC doesn’t “really care what people think because they don’t have to” due their size. And another said that BC projects an “arrogant” attitude in which it “like[s] to be perceived as caring about the community,” but the feeling isn’t genuine.

### Profitability and Rate Increases

BC has performed very well financially following conversion. Its enrollment and profits have grown steadily, and its web site notes that it has exceeded Wall Street expectations every quarter since it went public. Its operating margin in 2001 was 4.7%. Its medical loss ratio is around 81%, which is better than most of its competitors, who are closer to 90%.

Views differed on the extent to which BC’s financial performance is due to rate increases or to other factors. Several subjects thought that rate increases are part of the picture and that BC’s group rates are somewhat higher than its competitors. Most, however, felt that its rates are competitive and that it had achieved greater profitability through more careful medical underwriting and more aggressive provider negotiations, as discussed below, as well as lowering administrative costs. Regulators do not track rates in Virginia and so could not express an opinion on this issue. Agents said that in the initial years following conversion, BC’s rate

increases were low, in the mid-to-low single digits, perhaps a bit lower than other insurers. Although its recent rate increases have been much higher, around 20% for group products, so have other insurers', so BC's rates appear to be tracking medical cost trend. Agents said that when their group clients look for a better deal, half the time they find one with another insurer, but just as often clients with other insurers will switch to BC.

#### Provider Contracting

There are several indications that BC has used its market power to bargain aggressively with providers. Two years after the conversion, it changed its basic physician contract to include a "most-favored nations" clause, which requires providers to give BC a discount at least as large as they give any other insurer. This and other contractual issues caused a major dispute with the provider community, and produced regulatory scrutiny, which led BC eventually to change the most objectionable features of the contract.

Disputes have also arisen with hospitals. A year or two after conversion, BC moved to impose a uniform fee schedule for outpatient hospital procedures. This and other pricing policies caused intensive negotiations with several hospitals, nearly leading to contract termination, but ultimately the two sides reached agreement. In several other instances, however, hospitals pulled out of BC networks, or BC awarded an exclusive contract, forcing a large number of people to change where they receive care.

More recent indications are that some providers are asserting their market power against BC. Several physician groups have refused to continue in BC's HMO network, which has caused some disruption for members. Recently, an anesthesia group dropped out of both the HMO and PPO network. Also, a hospital chain affiliated with an HMO has declared that it is switching which unaffiliated insurer it will give its lowest rates to because it is concerned that BC is becoming too dominant in its part of the state.

#### Underwriting and "Last Resort" Issues

Agents and regulators commented that BC is "fair" in its underwriting practices and consistent with its major competitors, although not as liberal as it once was. In one respect, it was noted that BC is somewhat more lenient in rating small groups than some of its competitors. It rates up small groups with health problems only twofold rather than the fourfold spread some insurers use.

Following conversion, BC has continued to serve as "insurer of last resort" by offering an individual policy on a guaranteed issue basis. This was required by statute, even after conversion, with the proviso that BC may cease doing so with 24 months advance notice. BC continues to pay a reduced premium tax to help subsidize this product. It appears that the full extent of the tax concession is applied to reduce the rates for the product, which is not otherwise subsidized by BC. (The guaranteed-issue individual product also is sold to subscribers eligible under the Health Insurance Portability and Accountability Act, so BC's HIPAA policy is significantly lower in price than that of other insurers.)

Approximately 11,000 people are covered by this open enrollment policy, which BC makes efforts to publicize, and which most subjects were well aware of. This is down from over 100,000 people prior to the conversion, but regulators believe that most of this drop is due to

enactment of the small-group reform laws. A representative rate recently quoted by an agent was \$500/month for a 56-year-old female, for a policy with a \$750 deductible. This is an 80/20 indemnity plan (with higher cost sharing for prescription coverage) that has a \$1 million lifetime maximum and a 12-month pre-existing exclusion period. The same rates apply to open enrollment and to HIPAA conversion eligibles, except that HIPAA eligibles are not subject to the pre-existing condition exclusion. Subjects commented that it is helpful to have this plan available, although it is very expensive, especially when the condition that makes someone ineligible for other coverage is not covered for the first 12 months.

#### Product Lines and Geographic Coverage

BC has not pulled back in any geographic areas and there are no complaints that it is not actively marketing. It still offers all of its major product lines, and it is still prominent in the individual and small group markets, where much of its enrollment growth has come from.

BC dropped its Medicare HMO plan a couple of years ago at the same time that most other insurers did, which affected 2,700 subscribers. It also terminated its contract as a Medicare claims processor. Furthermore, it appears BC has scaled back or exited from the state's Medicaid HMO program, although details are sketchy on this point.

BC terminated coverage for about 100,000 people in surrounding states covered by Mid-South Insurance, a company it had acquired previously. The reason it gave is that it was the expense of maintaining managed care networks in rural areas of these other states. This action did not affect Virginia policyholders.

#### Utilization Review and Customer Service

BC received positive comments about its customer service, with several subjects saying it is one of the better insurers, or the best, to deal with. Regulators do not publish complaint rates, but BC has a top NCQA rating. However, two subjects were rather critical, one who said that BC is the "company that everyone loves to hate."

According to news reports, in 1998 BC adopted a requirement that all hospital admissions receive prior authorizations, even patients admitted through the emergency room. This caused much controversy with physicians who felt that patients would be harmed by delay in transferring emergency cases, so BC changed its requirement.

#### Foundation Activities

None of these subjects was aware of what activities have been funded by the \$175 million paid to the state-run trust fund. The common assumption is that this money went to supplement the general state budget.