

The Impact of Blue Cross Conversions on Accessibility, Affordability, and the Public Interest

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FOR-PROFIT ORGANIZATION IN HEALTH CARE DELIVERY has been a major public policy issue least since at least the 1980s, driven by the growth of for-profit hospital chains and a wave of conversions by nonprofit hospitals. As significant as these events have been, however, they pale in comparison with the potential impact of conversions by Blue Cross and/or Blue Shield plans (which we refer to generically as Blue Cross, abbreviated BC). Because Blue Cross plans are the largest health insurer in almost every state (or substate region where they operate), these conversions could remake the corporate landscape of health care finance. Although BC plans no longer hold the overwhelming market share they enjoyed 50 years ago (when they commanded more than two-thirds of the commercial market; see Blackstone and Fuhr 1998), their share still is considerable. Blue Cross controls at least half the individual market in 33 states and more than a third of the group market in 29 states (Chollet, Kirk, and Chow 2000; McCann 2003). Because BC plans are locally based and have historical roots in the hospital industry and medical profession, they are enormously influential in political and health policy circles. They are one of the most important groups of private institutions in the nation's health care system, and they have the same status in most states.

Access to investor capital is one corporate motivation for conversion (McCann 2003). Another is to facilitate the acquisition of, or merger with, other entities, which itself requires additional capital. Therefore, it is difficult to disentangle the two motivations. Blue Cross plans have a

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variety of possible incentives to merge across state lines, such as achieving economies of scale, serving multistate employers, spreading risk across markets and regulatory structures, expanding products and services, and defending against the widespread consolidation of for-profit commercial carriers (Grossman and Strunk 2001). Critics of conversion are concerned, however, that another strong motivation for conversion may well be the private benefit to Blue Cross managers.

The string of Blue Cross conversions is bookended by the largest Blue Cross plans in the two largest states: BC of California, starting in 1993, and Empire BC in eastern New York, concluding in late 2002. (In both instances, one or more other BC plans in the same state have not converted.) Over this ten-year span, Blue Cross plans in 13 other states have converted to for-profit status, and most of these have merged into two large holding companies: Wellpoint, which owns the plans in three states, and Anthem, which owns the plans in nine states. (In October 2003, Wellpoint and Anthem announced plans to merge.) As a result, by March 31, 2003, more than one-quarter of Blue Cross subscribers nationwide belonged to a for-profit plan, a total of 21.5 million members. Conversion proposals are currently pending in Washington State and Alaska and were rejected recently in Kansas and Maryland. In North Carolina, the BC plan withdrew its conversion proposal in July 2003 after more than a year of regulatory review proceedings. Although a core of Blue Cross plans insist that they will remain nonprofit, if these trends continue the trademark may become dominated by for-profit plans.

Blue Cross conversions usually result in battles on one or more of three fronts: legislative, regulatory, and judicial. In the initial round of conversions, the focus of these fights was on legal issues regarding the charitable status of BC plans and issues regarding the economic value created by conversion. In more recent conversions, however, Blue Cross plans conceded that they were subject to the law of charities and proposed turning over their entire value to a foundation. As a result, conversion battles are focusing more on the public policy implications of conversion. Opponents of conversion, including public interest advocates and health care providers, have tried to block conversions under statutes that require conversions to be in the interest of either the public or policyholders, or at least not contrary to these interests.

This public policy focus requires regulators to determine whether conversion will raise insurance rates, reduce coverage, disrupt provider

networks, reduce subsidies for the public goods aspects of health care, and lead to other negative effects. Thus, in February 2002, the insurance commissioner in Kansas rejected a proposal by Anthem to buy the BC plan there because she found this would likely increase rates substantially for individual and small-group insurance, a finding sustained by the Kansas Supreme Court. In Maryland, in March 2003, the insurance commissioner rejected an acquisition bid by Wellpoint, in part because the record was insufficient to predict its effect on the availability and accessibility of health insurance and because BC's board did not consider these factors before accepting the bid. In New York in 2002, the insurance commissioner approved the conversion of Empire BC, but only after setting conditions that subject it for several years to greater scrutiny of individual and Medigap rates than that given to the rates of other for-profit insurers. The state of Virginia, where the BC plan had converted in 1997, also addressed public interest factors in a July 2002 order approving its acquisition by Anthem, by conditioning its approval on Blue Cross's not moving its operational units out of state. In North Carolina, the BC plan withdrew its conversion proposal in July 2003, partly because of indications that the commissioner of insurance was considering greater oversight of rate increases following any conversion. Finally, Washington State is evaluating various health policy issues in considering the conversion proposal of its BC plan (which also serves Alaska).

In each of these proceedings, regulators have had to decide whether conversion and/or acquisition would change the BC plan's pricing, design, and marketing of its products; its contracts with providers; its medical underwriting; its customer service and managed care practices; and its broader role in public policy and regulatory affairs. Regulators have also evaluated whether the benefits from a new foundation would offset any detriments from conversion. Because these issues are complex and difficult to assess, we review the available evidence and information, drawing primarily on studies and analyses conducted in connection with the conversion contests in 2002 and 2003. We begin by describing the pressures created by conversion to increase profits and lower the medical loss ratio, and then we discuss in detail each of the major components of the medical loss ratio: premium rates, product offerings, underwriting practices, utilization management, and provider payment rates. We conclude by considering broader public policy factors, including the foundations created by conversion.

Conversion As an Event versus Conversion As a Process

In order to gauge the impact of conversions on the public interest, we must first clarify what constitutes a conversion. One view, which we call “conversion as an event,” is that conversion is a discrete set of corporate transactions that alters the corporate form. Conversions can take several forms (McCann 2003). The most straightforward one is to change from a nonprofit corporation or mutual insurer to a publicly traded stock company. For-profits can also be privately held, however. In addition, conversions can occur as a freestanding event or can be part of, or be quickly followed by, an acquisition by a larger company or a merger with a peer company. Finally, all of the above can apply to either an entire Blue Cross corporate structure or only a portion of one by forming a holding company that mixes nonprofit and for-profit entities.

Another view is that conversion is a longer planning and strategic process that begins several years before the actual legal event of conversion. We call this “conversion as a process.” This view is supported by the fact that, anticipating conversion, BC plans usually begin to change their operations well before conversion in order to enhance the value of stock when it is first sold to the public. A leading industry adviser, for instance, recommends that before conversion, a Blue Cross plan should “develop a for-profit culture, . . . tighten its medical management, hit its earnings targets and shore up its operating surplus—or leave its conversion plans on the shelf” (Fluegel 2002, 3). Because this process may begin several years before the actual conversion, assessments may miss a conversion’s true impact if they focus only on the one or two years immediately preceding conversion.

Rather than choose between these two views, our analysis takes into account both views. Under the extreme version of the process view, many changes likely to result from conversion will have already occurred by the time of conversion, so that the date of conversion could be mostly a nonevent. Any changes in corporate behavior in anticipation of conversion might, however, fairly be counted as one of the consequences of the conversion process overall. Also, regulatory and public scrutiny while seeking approval for conversion may have a restraining effect on the behavior of BC plans seeking to convert. Therefore, one way to balance these two contrasting views is to assume that any profit-driven changes

in behavior leading up to conversion are likely to continue and intensify after conversion.

Purpose and Methodology

To evaluate the public policy impacts of a conversion proposed by Blue Cross and Blue Shield of North Carolina, the North Carolina Department of Insurance requested in 2002 that we conduct case studies of the Blue Cross plans that had converted to for-profit status in California, Georgia, Missouri, and Virginia (Conover and Hall 2003). These states were chosen because they each had freestanding Blue Cross conversions (not initially part of an outside acquisition) that had been in place for several years. These conversions occurred as follows:

- In January 1993, Blue Cross of California transferred most of its managed care business to its for-profit subsidiary, Wellpoint, and sold 20 percent of the Wellpoint stock in an initial public offering. Under pressure from regulators, BC agreed to fund two foundations with stock valued at more than \$3 billion. It completed its conversion in May 1996 when Wellpoint became the parent company for all corporate assets.
- Blue Cross and Blue Shield of Georgia converted from a mutual form in February 1996 to a for-profit company called Cerulean. Litigation by citizen groups was settled in July 1998 with an agreement to create a foundation with 20 percent of the new corporation's stock, which at the time was valued at \$40 million to \$80 million. At the same time, California-based Wellpoint announced a deal to buy Cerulean. The sale was delayed by a shareholder lawsuit, which did not settle until October 2000, with an agreement to pay policyholders \$5,900 per share. The sale was completed in March 2001. At that point, the foundation was worth about \$120 million.
- In August 1994, Blue Cross and Blue Shield of Missouri put 80 percent of its assets in a for-profit subsidiary, RightChoice, and issued stock. In May 1996, the state's department of insurance and attorney general each filed suit to challenge the conversion. In January 2000, the suits were settled with an agreement to use RightChoice stock to create a foundation valued at nearly \$500 million. In November 2000, Blue Cross and Blue Shield of Missouri converted entirely

to for-profit. In January 2002, Wellpoint purchased RightChoice, resulting in an increase in stock value that made the foundation worth almost \$1 billion.

- In January 1997, Blue Cross and Blue Shield of 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.

We based our case studies in each of these states on confidential interviews and a review of the published literature and available documents. In each state, we interviewed nine to 12 subjects, including two or three insurance agents, two or three regulators, one or two consumer advocates, two to four provider representatives, and one to three industry observers. We also interviewed four national experts on Blue Cross plans and insurance markets across the country, including a health policy analyst and a consultant for Blue Cross plans (both of whom believe that Blue Cross plans should remain nonprofit) and two market analysts who consult with major for-profit and nonprofit national health plans. We covered the same general topics in each set of interviews, although they differed somewhat according to the type of interview subject and each individual's perspective and knowledge.

We also searched the databases of one or two leading newspapers in each state for relevant articles, as well as those of academic journals (health policy and economics) and industry publications such as *Modern Healthcare* and the Bureau of National Affairs' *Health Policy Reporter* and *Health Law Reporter*. In addition, we looked at the Web sites of the regulatory agencies and Blue Cross plans for relevant information and records. We also obtained documents from some interview subjects, mainly regulators and advocacy groups, and from pending or recent conversion proceedings in other states, including Kansas, Maryland, New York, and North Carolina. Finally, we used standard qualitative research methods to compile, interpret, and report this information.

General Profitability

Blue Cross plans typically claim that their operations will not be affected by conversion, except perhaps that the new profit orientation will

increase their incentives to reduce administrative costs. We evaluate these claims first by analyzing possible changes in overall incentives to generate profits and then by looking separately at each of the components of profitability. Our aim is to determine whether conversion changed Blue Cross's management and operations in ways that were either favorable or unfavorable for accessibility, affordability, and the public interest generally. We look beyond the stated intentions of particular BC managers and instead focus on the fundamental incentives created by conversion, the market and regulatory structures in which these incentives function, and the track records of earlier BC conversions.

Profit Pressures

It almost goes without saying that conversion from nonprofit to for-profit status increases the pressure to generate more profits. As one nonprofit proponent noted, for-profit insurers have a "legal, ethical, and fiduciary duty to maximize profits for shareholders." An expert on corporations law explained that the main objective of for-profit managers is, and should be, "shareholder wealth maximization," whereas the goals of nonprofit managers are defined by "their particular constituencies." A published authority points out that "shareholder wealth maximization is not only the law, it is also a basic feature of corporate ideology" (Bainbridge 2002, 417). This is not necessarily a negative observation, for an incentive to increase profits can produce better customer service, more product innovation, and greater efficiency through lower overhead and better control of medical costs. Also, if a conversion foundation is created, higher profits will raise the value of the stock held by the foundation (although Blue Cross Blue Shield Association rules require these foundations to divest themselves of their BC stock within ten years). But profit incentives also can have some negative consequences for the public interest, which we discuss later.

Although not-for-profit organizations also have good reasons to generate profits in order to pursue their mission, for-profit conversion intensifies profit incentives because the managers of publicly held companies are highly sensitive to how their operations are perceived by the investor community. A national expert explained that for-profit insurers "will have to get their 15 percent growth and their return on equity to keep

[stock] analysts happy.” An observer in Virginia said that Blue Cross there has to “dance the dance for financial analysts and investors; they have to perform.” The pressure this creates was explained by Leonard Schaeffer, the long-time CEO of Wellpoint, which owns for-profit BC plans in California, Georgia, and Missouri:

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, . . . there was almost no change in how we behaved [following conversion]. We were [already] 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. (Iglehart 1995, 135)

In our interviews, a market analyst pointed out that these pressures affect the entire management team across a wide range of activities, in part because managers benefit directly from stock incentives. He explained that these effects are not always very visible, since “there are a zillion ways to target more profitable business segments” through incremental decisions about underwriting, marketing, claims payments, and the like.

Some industry analysts we interviewed observed that the investor community is not satisfied simply with achieving a profitable plateau, because investors look for continual improvements in financial results. Although for-profit managers may speak in terms of hitting certain targets, the targets tend to be reset to encourage continuing growth in profits. As one industry adviser put it, for-profit insurers basically just “try to make as much money as they can.” National experts noted that in contrast, nonprofit BC plans have an expectation or legal requirement of not accumulating too much surplus. Since they cannot pay out their earnings through dividends, at some point if they are successful they may reach a stage where it is not necessary to continue earning more profits. Some BC plans have even paid back excess surplus to policyholders in the form of rebates or rate reductions, often under pressure from regulators and sometimes as a result of policyholder lawsuits.

The effect of profit incentives is borne out in the comparative financial performance of for-profit and nonprofit BC plans nationwide (table 1). Over the most recent five years for which data are available (1997–2001), the underwriting gains of for-profit BC plans were roughly

TABLE 1
Blue Cross Blue Shield Plan Profitability by Ownership Status, 1997–2001

	Percentage of Revenues				
	1997	1998	1999	2000	2001
Underwriting Profits					
For-profit plans ^a (minimum)	-11.9	-3.7	-6.3	-4.7	-0.6
For-profit plans (maximum)	3.7	4.5	3.9	4.0	4.4
For-profit plans (unweighted average)	-2.8	0.3	-0.5	0.9	2.9
For-profit plans (weighted average)	-0.2	1.4	0.7	2.1	3.3
Nonprofit plans (weighted average)	-1.3	-2.0	-0.4	0.3	2.1
Total Profits (includes investment income)					
For-profit plans (unweighted average)	0.7	3.0	1.7	2.3	5.0
For-profit plans (weighted average) ^b	3.4	4.5	3.3	4.1	6.5
Nonprofit plans (weighted average)	1.4	0.5	1.7	1.9	3.6

Notes: Estimates are based on compilations by Ernst and Young of data from source shown. All figures, including minimums and maximums, represent the performance of the overall corporate entity rather than individual plans within it. That is, we did not examine separately the individual performance of all eight plans making up the Anthem network.

^a For-profit plans examined in this analysis include Wellpoint Health Networks, Inc., Blue Cross of Missouri Group, Blue Cross Blue Shield United of Wisconsin, Anthem Insurance Company Group, and Trigon Healthcare, Inc. (Wellpoint acquired Blue Cross of Missouri Group in 2002, so for the period shown, these were separate plans.)

^b The for-profit weighted average is skewed somewhat by the much-better-than-average performance of Wellpoint, which is also by far the largest plan. If conversion is viewed as a “roll of the dice” in which there is an equal chance of ending up with the average performance of any of the five for-profit companies we examined, then the unweighted averages may be a better measure of what might be expected following conversion. When using unweighted averages (i.e., treating each company equally), underwriting profits overall are lower than when using weighted averages.

Source: NAIC (2001). Analysis of data by authors and Ernst and Young.

one to two percentage points higher than those of nonprofit BC plans, and overall profits, including investment income, were 1.5 to 4.0 percentage points more (before taxes, using weighted averages). (This conclusion is confirmed by most, but not all, of the similar recent analyses we reviewed, each of which used somewhat different metrics, data sources, and/or sampling frames.)

This consistent pattern over five years indicates the potential of stock ownership to motivate management to improve financial performance. This potential is also seen in the profit trends of the four BC plans that underwent freestanding conversions several years ago. When Blue Cross of California first began converting, it was nearly bankrupt, but after it

converted, its overall profit margins have consistently been among the highest in the industry. Blue Cross in Georgia steadily increased its operating margin one to two percentage points a year following its conversion, prior to Wellpoint's acquisition. In 2001, the first year under Wellpoint, its operating margin jumped four percentage points. Profitability has also improved steadily in Missouri and Virginia following conversion. In Missouri, Blue Cross's net income rose almost 600 percent from 1998 to 2000, and in Virginia, the press reported in 2001 that the BC plan had exceeded Wall Street's expectations every quarter since it went public.

These statistics do not prove, however, that for-profit status is a guarantee of profitability. In the national comparative data reported in table 1, at least one for-profit plan lost money on underwriting in each of the five years, and profitability levels were relatively modest overall (compared with before-tax profits in 2000 of 8.4 percent in manufacturing and 9.1 percent for nondurable goods manufacturing). Even the most profitable plans made only 3.7 to 4.5 percent on underwriting, reflecting the competitive industry in which these plans operate. And, even when adding investment income, the plans' profitability as a group was only 6.5 percent in the best year (2001). Finally, this track record does not prove that these particular for-profit plans had higher profits than they would have had if they had remained nonprofit, since almost all BC plans have become more profitable in recent years (Cunningham and Sherlock 2002). However, the consistency and level of profitability achieved by these converted plans suggest that conversion has improved profitability compared with the performance of most nonprofit BC plans over the same time period (Schramm 2001a).

Comparing Nonprofits with For-Profits

Acknowledging that conversion increases profit incentives does not, however, determine the impact of these incentives on how BC does business. In large part, the differences are fairly subtle because nonprofit insurers also are under many of these same financial pressures. Both national and local experts explained to us that all Blue Cross plans are much more market oriented in the current environment than they were ten to 20 years ago, regardless of their corporate form. The advent of managed

care in the 1980s made health insurance markets much more competitive, forcing all BC plans to abandon ways of doing business that once made them markedly different from commercial insurers. BC plans were once run by providers, and they voluntarily used business practices like community rating that were much more accommodating to people with medical problems. Now, however, such notable features are historical artifacts, gone from virtually all BC plans around the country.

In each of our conversion study states, interview subjects explained that financial problems had caused their BC plan to “change its stripes” in the years before conversion, by bringing in new management that had a much more market- and profit-oriented business approach. Conversion was seen as a continuation of this change toward behaving more like any other commercial insurer, though it was not the main catalyst of these changes. Therefore, when conversion actually took place, most of our subjects found that it caused little or no noticeable change in how the BC plan did business and that the BC plan would have continued to behave in largely the same way even if it had remained nonprofit, since it was under the same management team. As several subjects put it, the conversions in these states were the *effect* of a change in corporate culture, rather than its *cause*, since the management team that pushed for the conversion had already instituted a for-profit culture before the conversion.

We do not conclude from these sources, however, that conversion made no difference in how BC plans operate. We did *not* use our state-focused case studies to compare converted BC plans with nonprofit plans in other states that did not intend to convert. Had we done so, the consensus among industry experts is that we could have detected differences in their corporate ethos and business strategies. For instance, we spoke with one highly knowledgeable industry adviser who worked at and with both for-profit and nonprofit health plans, including both BC and non-BC plans. He said that there is a “subtle but important difference” between nonprofit and for-profit health insurers: “In a very fundamental way, they operate differently.” Other market-oriented analysts noted that nonprofits have “more flexibility to consider community needs.” In the view of one observer, for “nine out of ten individual decisions” regarding pricing, underwriting, provider contracting, and so on, “they’ll decide the same thing, but the issue is, what is the

impact of the one-in-ten decision where they will differ? The difference can be significant.” In California especially, many people commented that Blue Cross stood out as being especially profit oriented and aggressive in its business strategies, even compared with its non-BC competitors.

Academic researchers also have looked at potential differences between nonprofit and for-profit health plans, comparing the performance of each type of health maintenance organization (HMO). Some studies favor nonprofit HMOs (Himmelstein et al. 1999; Kuttner 1998; Landon et al. 2001; Nudelman and Andrews 1996; Schlesinger, Mitchell, and Gray 2003; Tu and Reschovsky 2002), whereas others find few or no differences (Blustein and Hoy 2000; Born and Simon 2001; Feldman, Wholey, and Town 2003). Overall, although the evidence is mixed, it suggests that members of nonprofit HMOs are more satisfied and receive better service and a somewhat higher quality of care than do members of for-profit HMOs, and that nonprofit HMOs provide somewhat more community benefits. However, more limited evidence also indicates that for-profit HMOs have *lower*, not higher, premiums (Feldman, Wholey, and Christianson 1998; Wholey, Feldman, and Christianson 1995) and that the profit levels of these two types of HMOs are not substantially different (Bryce 1994; Feldman, Wholey, and Town 2003).

We hasten to note, however, that these findings do not resolve the issue before us, since they look only at HMOs, not at health insurers generally or Blue Cross plans in particular, which have a unique market status and operate in somewhat different market and regulatory environments than do pure HMOs. More important, such studies typically do not account for significant differences among patients enrolled in different types of plans. In Medicare HMOs, for example, the people in for-profit plans are much poorer and less educated than their counterparts in not-for-profit plans (Blustein and Hoy 2000). Of even greater importance, only one of these studies compares plans before and after a conversion. All the others compare nonprofit HMOs with for-profit HMOs. Since many of the nonprofits are BC plans and most of the for-profits are not, these studies provide only limited insight into differences resulting from the conversion of a BC plan. Finally, evidence of financial performance from many years ago is of questionable relevance in today's marketplace. Therefore, we return to the path on which we began: examining the changes that are likely to result from increased pressures to generate profits.

Administrative Costs and Medical Loss Ratios

If profit goals were met entirely through lower administrative or overhead costs, few public policy issues would be raised (the main impact being lower commissions for insurance agents or the loss of some insurance jobs). Historically, there is some evidence from the 1980s or earlier that nonprofit BC plans may have been less efficient than their commercial for-profit counterparts, resulting in their competitive advantage benefiting management and employees through higher salaries, larger staffs, and more pleasant working conditions (Blair and Vogel 1978; Frech 1976, 1980), but this literature is very dated and other studies during this period found no difference in efficiency (Mennemeyer 1984; U.S. GAO 1975). Regardless, shareholders' profit expectations might make BC plans focus more on lowering administrative costs. Conversion, however, usually also results in the plan's having to pay higher state premium taxes. Also, BC plans that convert in order to pursue acquisitions or raise capital for new ventures will incur new overhead costs associated with these activities.

In principle, merger or acquisition can make a plan more efficient through economies of scale. But evidence of economies of scale in health insurance is mixed, in part because it is difficult to isolate pure economies of scale from differences in efficiency, especially given the many different administrative functions that insurance companies must perform (see Feldstein 1999, 179–80). An early multivariate study using data from the early 1970s did find economies of scale for commercial insurance plans but not for Blue Cross or Blue Shield plans (Vogel and Blair 1975). But a follow-up study using data from 1958 to 1973 suggested that economies of scale were smaller than previously believed and that none existed in the administration of Medicare claims, possibly because the latter used cost-based reimbursement, thereby diminishing the incentive to hold down costs (Blair and Vogel 1978). A multivariate analysis of 1986–1988 BC data showed that size within a state appears to provide a substantial administrative cost advantage.¹ More recent data appear to show no large economies of scale across state lines among commercial insurers (Blackstone Group 2002) or BC plans (Schramm 2001b), which Schramm attributed to difficulties in consolidating distribution, marketing, claims handling, and provider relations within geographically diverse managed care companies

(Schramm 2001b). Both the Blackstone Group and Schramm analyses, however, are based on observing raw differences in expense or profitability ratios across plans of different sizes, without adjusting for market or plan characteristics that might drive these results. In any event, it is noteworthy that conversion alone confers no size advantage: Only conversion coupled with merger might, and nonprofit plans can merge without converting.

In sum, there are no well-documented efficiency benefits from merger or acquisition among BC plans.² In California, Wellpoint's expense ratio has been essentially level since 1997, and there is contradictory evidence for earlier years, with one source even indicating that BC's expenses may have increased after its initial conversion. One analysis found that Blue Cross of California's administrative costs are almost four percentage points higher than expected, based on how its operations compare with those of other national HMOs (Feldman, Wholey, and Town 2003).

In Georgia, Missouri, and Virginia, where the converted BC plans did not acquire other plans following conversion, they were more successful in lowering their administrative expenses after converting (before merging later). Nevertheless, there is no reason to believe that a profit-maximizing company will be content with the profits gained solely by reducing administrative expenses. Instead, industry analysts maintained that for-profit insurers can be expected to improve profits in every way possible. These other methods are included in the insurer's medical loss ratio, which is the portion of premium revenues spent on paying medical claims. In general, the loss ratios of for-profit BC plans are about five to ten percentage points lower than those of nonprofit BC plans.³ In California, several observers reported that Wellpoint's enviable profit level was achieved following conversion mainly by lowering its medical loss ratio (MLR), which is ten or more percentage points lower than that of other major competitors in the state. In Georgia, BC reduced its MLR by three to four percentage points following conversion. In Missouri, BC's MLR has dropped about five percentage points in the past three years. And in both Missouri and Virginia, BC's MLR is significantly lower than that of most other major insurers in the market.

Comparisons of the MLRs of insurers with different blocks of business can be misleading, since MLRs are typically much lower for individual and small-group insurance, due to the higher overhead costs of selling to and servicing smaller units. Still, it is fair to observe *changes* in loss ratios within a single BC plan following conversion or to compare the loss ratios

of similar plans, such as those of different BC plans with similar mixes of group and nongroup business. From these multiple perspectives, it appears that conversion tends to lower medical loss ratios. Therefore, we next turn our attention to the factors that affect the MLR. In no particular order, these are premium rates, product offerings, underwriting practices, utilization management, and provider payment rates. The following sections explore each of these factors to determine how the greater profit incentives created by BC conversions have affected them and whether these effects raise concerns about accessibility, affordability, and the public interest generally.

The Possibility of Lower Rates

We first consider whether conversion will result in *lower* prices for health insurance. This is theoretically possible if equity is a more efficient source of capital than debt or retained earnings. For-profit health insurers generally maintain substantially lower, but still adequate, levels of reserves than do nonprofit BC plans (Blackstone Group 2002; Conning and Company 2000). One explanation for this is simply that nonprofit BC plans have nowhere else to put their earnings, since they cannot pay dividends. A second is that publicly traded plans like to have fewer reserves in order to show investors a better return on equity, given the same income. Third, a nonprofit health insurer's primary source for raising capital is through operating income, which creates a greater need for a buffer against price wars and downsides in the underwriting cycle compared with that of publicly traded companies, which can raise capital when they need it by issuing more stock. (Although both nonprofits and for-profits can also raise capital by issuing debt when they need to finance improvements or operations, debt capital does not meet regulators' demands for adequate reserve levels because of the associated interest costs and repayment obligations.) For these reasons, conversion can relieve the pressure of having to increase premium income to meet capital needs.

Despite these possibilities, the national experts we interviewed did not think that, by itself, improved access to equity capital was a compelling reason under current conditions for financially healthy BC plans to convert. One national expert thought that BC plans with a strong market share should have no trouble raising the capital they need for business innovations, even though they are nonprofit. Another expert noted that in recent years, most for-profit health insurers chose to raise capital through

debt rather than equity, and another expert observed that in the last few years, for-profit insurers' primary need for major amounts of capital was for new acquisitions, not for improving operations (Blackstone Group 2002).

Another reason that conversion might result in lower premiums is a theory advanced by Feldman, Wholey, and Town (2003) that people have inherently less trust in for-profit health insurers and so the market compels these insurers to charge lower prices for equivalent products in order to overcome this reluctance to buy from them. Feldman, Wholey, and Town (2003, 2) presented evidence consistent with this theory in an analysis of HMO conversions over 15 years, which concluded that "HMOs reduce their premiums by a small but significant and permanent amount [about 4 percent] when they convert to for-profit ownership." This analysis has a number of significant methodological limitations, however, that make its findings of questionable relevance to current BC conversions.⁴ Feldman and his colleagues analyzed only HMO conversions, not conversions by preferred provider organizations (PPOs), which are BC's dominant plan type. Also, two-thirds of the conversions in this study were carried out more than ten years ago, and most of them resulted from health plans that were in financial distress and were not market leaders. The current market conditions for BC plans are substantially different. Finally, these analysts were unable to measure or control for changes in covered benefits or the composition of risk pools. Therefore, the lower premiums they detected may have reflected fewer benefits or more aggressive risk selection rather than lower prices or profits.

The Limited Evidence Regarding Higher Rates

Regarding the potential for *higher* rates, none of the states we studied indicate that conversion has resulted in substantially higher rates overall. Most insurance agents, regulators, industry observers, and even patient advocates thought that the converted BC plans were pricing their products in line with their competitors, that higher medical costs have been the primary drivers of BC's rate increases, or that conversion did not cause rates to rise. One keen observer of the California market, for instance, said that keeping rates affordable was key to BC's business strategy there because it wants a larger market share in order to have more bargaining power in negotiating with providers, so it tries to increase its

profit margin by lowering provider payments rather than increasing its premiums. Moreover, even those interview subjects who thought conversion could or might have caused rates to rise spoke only in terms of modest one-time increases rather than sustained increases year after year that amounted to large, double-digit price differentials. There was broad agreement that the major factor driving group rates was rising medical costs and that, in general, competition was effective in restraining rate increases that are significantly greater than medical cost trends.

The sole quantitative analysis we were able to find compared Blue Cross of California's average HMO premium revenues with the "expected" value of average HMO premiums based on a prediction equation derived from examining all HMOs in the United States from 1986 to 2001. The company's HMO premiums were lower than predicted before conversion. In the two years afterward, from 1996 to 2000 (1997 data were missing), its HMO premiums were higher than expected but returned to lower than expected in 2001 (Feldman, Wholey, and Town 2003). These analysts interpreted this to mean that Blue Cross of California once was a low-priced HMO, became a high-priced HMO after conversion, and now may have returned to being low priced (although this last conclusion is based on only a single year of data). Earlier we cited some of this study's limitations, and accordingly, we do not give these assessments more weight than those of our interview subjects. But they are consistent with the story that Blue Cross initially built up its membership base with lower premiums, which then gave it additional market power that it was able to exploit several years after conversion, but that more recently competition has forced it to slow the growth of its premiums. This study also is consistent with the story that Blue Cross historically used its competitive advantage as a nonprofit at least partially to benefit consumers through lower premiums, as opposed to benefiting management or providers of care.

Regardless of how we resolve the postconversion evidence in any particular state, it sheds little light on what we can expect to find in other states facing Blue Cross conversions, because as several national experts stressed, each market is different. For instance, in two of the states we studied (California and Missouri), the converted BC is not the overall market leader, as it is in most states. Also, our interviews focused mainly on rates in the group market and did not examine each market segment separately, including the market for individual health insurance

and Medicare supplemental insurance, in which a particular BC plan might dominate. Therefore, the conclusions from our study shed little or no light on these particular market segments.

The second important caveat that national experts stressed is that it is “impossible to prove” what factors have driven rate increases and to what extent—even after the fact, looking back in time, much less looking forward. Documenting exactly what happened is especially difficult because the regulators in the states we studied do not track insurance rates, so our main source of information was the informed views of market participants and observers. Even these highly knowledgeable subjects often had difficulty drawing conclusions.

Nonprice Impacts

This section reviews the possible impact of conversion on a host of non-price factors that affect profitability, including product offerings, geographic coverage, underwriting, managed care, and provider contracting.

Insurer of Last Resort

Historically, Blue Cross plans were usually the insurer of last resort in their state, meaning that they offered some type of coverage for people who were medically uninsurable and could not find coverage elsewhere. Blue Cross originally offered last-resort insurance as part of its corporate mission, but eventually many states explicitly tied this undertaking to the BC plans’ nonprofit status and their exemption from some or all premium taxes. In more recent years, however, legislative developments in many states have relieved Blue Cross plans of this role, by either requiring other insurers to perform a similar function or meeting this need through a high-risk pool funded by industrywide assessments. According to the trade organization Communicating for Agriculture (testimony to Congress, January 29, 2002), BC plans still act as an insurer of last resort in only six states and often to only a limited extent: Maryland, Michigan, North Carolina, Pennsylvania, Rhode Island, and Virginia.

Accordingly, a change in BC’s last-resort status is usually not an issue in conversion proceedings. So far, this has been true even when the BC plan still serves a last-resort function, because the function is often limited in a way that makes it consistent with for-profit status. Virginia is the

only state so far where a BC plan had a last-resort role when it converted, and it has continued to serve in that role. Likewise, in North Carolina, the BC plan pledged to continue offering its last-resort product after conversion, and the Maryland BC plan said that conversion would not affect its last-resort role. In Virginia and Maryland, however, the last-resort obligation is directly subsidized by an earmarked premium tax reduction, so that the plans are in the same financial position regardless of whether they offer a last-resort product. In North Carolina, the BC last-resort policy has fewer than 100 subscribers and costs the company less than \$100,000 a year because it is priced at about \$20,000 a year per subscriber. Therefore, the loss of an insurer of last resort is rarely or never a concern in a BC conversion.

Product Offerings and Geographic Coverage

This section considers whether BC conversion has positive or negative impacts on product offerings and geographic coverage. We divide our discussion between major product markets, such as individual and small-group, and secondary product markets, such as Medicare supplemental and association health plans, and between product markets generally and geographic markets, such as rural versus urban areas.

In states where BC conversions have been in place for several years, the conversion has not resulted in Blue Cross's pulling out of *major product* markets. In particular, these BC plans have remained committed to individual and small-group markets, and they have continued to cover their entire geographic regions. To the contrary, remaining strong statewide and in the individual and small-group markets are the key business strategies of these BC plans.

Regarding *geographic* coverage, several interview subjects suggested that as nonprofit companies, BC plans are under pressure from the public and regulators to operate statewide, but as for-profits, this social conscience may weaken, resulting in gaps in rural markets. But such a change in orientation could occur regardless of conversion. Moreover, there is little or no evidence that converted plans have changed their basic orientation toward statewide coverage. In our interviews, the worst we heard was that the converted BC plans in some states had withdrawn their HMO products from rural counties but had not left these counties altogether, and the accounts differed as to whether this was the fault

of the BC plans or of dominant providers refusing to enter into HMO contracts with any insurer.

Regarding *secondary product* offerings, we detected only minor or scattered concerns. In several states, we heard similar accounts of the BC plans' failure to maintain provider contracts for their HMO networks in some rural counties, but these BC plans had not pulled out of these counties entirely. In Missouri, there were concerns about BC's closure of pools for trade or business associations, leading to steep rate increases for some members, but regulators there said this had resulted mainly from BC's need to comply with new federal and state laws that prohibited the particular form of association group-purchasing arrangements that existed then. Blue Cross in Missouri 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. In both Missouri and Virginia, it appears that the BC plans withdrew from the Medicaid HMO program after conversion, but details are sketchy. In a November 2001 report, Bear, Stearns—a leading investment analyst—noted favorably that Anthem planned to exit Medicare HMO markets nationally and that Anthem had “minimal” participation in the states' Medicaid managed care programs. The report explained that investors “view the low exposure to Medicaid as important, given the deteriorating fiscal condition of many state budgets.”

In California, a few interview subjects criticized Blue Cross for refusing to participate in the small-group purchasing cooperative and attributed this to its desire to avoid higher risks. Others, though, attributed this to BC's view of the purchasing cooperative as a threat to its strength in the small-group market and its desire to compete directly against the cooperative rather than to join it. Many sources in California praised BC for being “about the best” of all private insurers—including nonprofit insurers—in its participation in low-income government programs. Blue Cross of California is by far the largest participant in the state's Medicaid managed care program; it administers the state's high-risk pool, and it is a major participant in the Children's Health Insurance Program for low-income children. These sources thought that BC was making a profit from these government programs; otherwise it would not be participating. But they also added that BC seemed eager to have this business, even though the profit margins were slim, in part because this gave it more leverage with providers in negotiating lower payment rates for their commercial products. Blue Cross of California 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.

In the private market, interview subjects said Blue Cross of California is known for being a continuing innovator in product design, a “visionary” that is “always five steps ahead” of the competition. As we note later, however, some skeptics believe that frequent changes in product design may result in greater risk segmentation. In addition, some people expressed concern that Blue Cross’s bare-bones policies may not offer adequate protection or may mislead less sophisticated purchasers.

On balance, there is no strong evidence that conversion has had a substantial negative impact on Blue Cross’s major product or geographic availability. Culling specialized products and focusing marketing efforts geographically are widespread practices, even at nonprofit plans, as is the normal give-and-take in provider negotiations. Although provider negotiations may intensify following conversion, as we discuss later, for-profit plans have profit-driven incentives to continue offering and improving their principal products and to maintain at least some presence statewide. The one significant basis for concern we detected would be if BC plans failed to offer their normal products at reasonable prices as replacement coverage for subscribers who are displaced when older or secondary products are closed out.

Underwriting and Other Risk Selection Practices

Another way that BC plans might try to increase profits is by more aggressively or selectively distinguishing between lower and higher subscribers. There are several ways to engage in risk selection, including product development and marketing, but the most direct method is through underwriting. Being able to identify and accurately price each individual or group according to its particular health risks gives an insurer a competitive advantage. This explains the historical move by all BC plans from community rating to experience or risk rating. Many people see this movement as contrary to the public interest because it undermines the pooling of risk that keeps insurance affordable for less healthy people who need it the most. Alternately, more accurate risk selection makes health insurance more affordable for lower-risk people, which might encourage more people overall to buy insurance. Because

both views of the public interest are credible, we report our findings on the potential for conversion to change underwriting and other risk selection practices so that these findings can be evaluated from either perspective.

According to interviews and other sources (Cunningham and Cunningham 1997; Friedman 1998; Grossman and Strunk 2001), the time has passed when BC plans were much more lenient underwriters than other insurers, and underwriting practices and policies at nonprofit BC plans are now broadly consistent with those of for-profit insurers. Areas where large differences once existed have now been usurped by legislation. For instance, federal law prohibits all insurers from turning down any small-group purchaser, and most states require all insurers to use consistent rating practices that limit how much more they can charge the highest risks relative to the lowest.

In states with BC conversions in place for several years, we heard some, but not a great deal of, concern about the conversion's leading to more aggressive underwriting or risk selection practices. In most states, our interview subjects thought that the converted BC plans were "in the middle of the pack" in their underwriting or even somewhat lenient. For instance, in two states, subjects reported that the converted BC had not raised rates for higher-risk small groups as aggressively as other insurers had.

The most criticism came from California, where Blue Cross has a reputation as an aggressive but fair underwriter. Several subjects felt that BC was more "sophisticated" than most other insurers at selecting good risks and segmenting risks, and that its expertise in this regard was one of the keys to its success, something that other insurers were "envious of." Two subjects thought that BC "crassly" manipulates benefit coverage and product design to enhance favorable risk selection and risk segmentation. Similarly, in Missouri, some subjects observed that BC no longer includes maternity coverage in its individual policies unless purchased as a rider, unlike United, which spreads the cost of this coverage across all its policies. In California, it also is noteworthy that in 1998, BC changed its rating for Medicare supplemental policies to a method that increases the rates as the member ages.

On balance, there is some basis for concern about conversion resulting in further tightening of various underwriting practices, but these practices are too subtle and complex to determine which ones are due to conversion and which have evolved from market-driven business practices.

Therefore, for the most part, changes in various underwriting practices in response to increased profit pressures is one of the difficult-to-quantify tradeoffs that must be weighed against the potential benefits of conversion.

*Customer Service, Utilization Management,
and Community Focus*

There is little or no evidence that conversion has had an adverse effect on customer service or managed care practices, and indeed, conversion may well have improved the performance of some BC plans in these areas. We found no strong indication that conversion has caused BC plans to drop their service levels or to intensify their managed care restrictions. An analysis of HMOs serving federal employees found that conversion did not significantly change customer satisfaction scores for three HMOs (Feldman, Wholey, and Town 2003). In California, BC has improved its customer satisfaction noticeably in recent years and now has one of the best ratings of the state's largest plans. In other states, converted BC plans are seen as being more "in the middle of the pack." However, problems were noted in Missouri, where BC's complaint rate is higher than that of most other major insurers and several times higher than that of the nonprofit BC plan in Kansas City. (For a somewhat different analysis, focused on Wellpoint, see Delmarva Foundation for Medical Care 2003, which concluded that the complaint records of the converted BC plan in California were worse than the state average but that in Missouri the plan received an average number of complaints.)

One issue of concern, raised several times in our interviews, is that conversion makes BC plans vulnerable to acquisition by a larger out-of-state company. Wellpoint, which is based in California, acquired the converted BC plans in Georgia and Missouri. Anthem recently acquired the converted BC plan in Virginia, and it owns BC plans in eight other states, mostly in the Midwest and Northeast. Some market observers and participants felt that acquisition could be bad for policyholders since it diverts capital and attention away from improving products and customer service in the plan's home state. Two market analysts thought that outside ownership "tends to change" how "community-oriented" management is, making it less likely to be "swayed" by local concerns. They believed that this attitude could result in a "different perspective," under which management is less amenable to making concessions regarding

pricing, underwriting, and maintaining certain risk pools. According to one market analyst, this local/outside difference is a bigger factor than the nonprofit versus for-profit corporate form in shaping corporate attitudes and policies.

None of our case studies allowed us to pursue this issue in depth, and Georgia was the only state where we conducted any interviews after an outside acquisition. There, several subjects said that the *original* conversion did not affect Blue Cross's corporate culture and market behavior. But many felt that the sale to Wellpoint had had a discernible effect. For instance, one person said that BC had become more difficult to deal with and less responsive to working out problems. Other interview subjects, however, felt that its operations and attitudes were essentially the same under Wellpoint as before.

Provider Contracting

The final concern is whether conversion causes Blue Cross plans to change how they contract with physicians and hospitals, for instance, by demanding lower payment rates or limiting the number of providers in a network. Before evaluating this issue, however, we need to determine whether this is a matter of broader public interest or a concern mainly of providers. In any market, suppliers generally seek the highest feasible price for their services, and buyers want to pay the lowest. Often, there is no public policy problem with allowing the give-and-take of market forces to determine the outcome. In an ideal world, Blue Cross serves as a purchasing agent for its subscribers, who want convenience and freedom of choice but also do not want to pay too much for health care. To the degree that a BC plan can use its market power to reduce payments to providers, the public will benefit, even though hospitals and physicians will be paid less than they might prefer—assuming some of these savings are passed on to consumers. There is no compelling public interest in paying providers more than the amount needed to supply the “right” amount of medical care to consumers. This theoretical analysis suggests that it is not necessarily contrary to the public interest for BC to bargain hard with its providers or even to fail to reach an agreement with some providers.

In actual health care markets, however, there is the risk that a dominant insurer will behave as a “monopsonist” (i.e., a monopolistic buyer) with respect to providers of health care. Monopsonists generally wish to pay lower prices than would prevail under perfect competition, resulting

in less adequate services being supplied than is optimal for social welfare. This might be seen, for instance, in provider contract terminations that cause disruptions in patient service or critical gaps in the provider network that compromise optimal care or perhaps make insurance unavailable in some regions. Moreover, even if perfect competition prevails, driving down provider payments might be contrary to the public interest if this made it impossible for hospitals to serve members of the community without insurance or to continue offering essential services that are not fully compensated and so need to be cross-subsidized by “excess” payments through private insurance. These unprofitable but essential medical services are called “public goods” in the jargon of economics, and competitive markets tend to underproduce public goods. We next review the available evidence to determine whether concerns about changes in provider contracting implicate any of these public policy issues.

Historically, there is some evidence that BC plans used their market power and other competitive advantages to benefit providers who tended to dominate BC boards (Arnould and DeBrock 1985; Arnould and Eisenstadt 1982; Eisenstadt and Kennedy 1981; Frech and Ginsburg 1978; Hay and Leahy 1984; Kass and Pautler 1981; McCann 2003). These studies imply that when competitive advantages were not diverted to plan administrators through higher administrative costs, the benefits apparently went to providers in the form of higher reimbursement. But more recent evidence from the 1980s shows that a greater BC market share is associated with lower provider payments (Foreman, Wilson, and Scheffler 1996).

In the most recent years, BC plans’ relationships with providers, especially hospitals, have been deteriorating nationally, as they have been increasingly assertive about exercising their market power, which has resulted in more contract terminations. Such terminations are more common in large markets than in medium and small markets, which is encouraging, since it implies that even if terminations increase in frequency, this will not usually result in geographic-access barriers. In some of the states we studied, especially California, we heard about several instances of hospital contract terminations with BC that disrupted patient care. But we also heard differing accounts of which side was at fault and whether this was due to conversion or was the result of market turmoil that would have occurred in any event. In addition, complaints of this nature were not registered very strongly in Georgia or Missouri (see also Delmarva Foundation for Medical Care 2003 regarding Maryland). In

Georgia, the number of physician and hospital contracts for both PPO and HMO products roughly doubled after its conversion in 1996; BC of California also saw a general rise in its physician and hospital contracts for PPO and HMO products between 1994 and 2000 (Accenture 2002).

Other Public Policy Issues

Political and Social Orientation

In addition to the particular areas of concern addressed so far, we inquired more broadly into whether conversion affected Blue Cross's role in the political, community, and public policy arenas generally. BC is often the single most influential private institution in a state's health care delivery system and usually also wields considerable political power within state government. If conversion were to produce a major change in the orientation toward health care public policy issues, this could have a significant, and perhaps profound, effect on a state's future health policy.

Similar issues arise in the regulatory arena. Several national experts noted that it was "easier to regulate" nonprofits and to "get them to work for the public good," since you can "ask more of nonprofits" in regard to pricing and access for vulnerable risk groups. One pair of experts, who had researched health insurance markets nationally, reported, for example, that "several plans noted regulators' expectations that the Blues accept the enrollees from plans that have gone bankrupt" (Grossman and Strunk 2001, 51). The question, then, is whether a converted BC continues to be as amenable to this kind of regulatory pressure or persuasion.

In Missouri, several interview subjects noted that after conversion (but before Wellpoint's acquisition), the legislative and public policy positions of the BC plan there had become much less socially oriented. One seasoned advocate emphasized that conversion was a very discouraging "watershed" that ratified or cemented the flaws of the current system and "gave up the ghost" of any realistic hope for systemic or fundamental reform. In Maine, Community Catalyst, a national opponent of BC conversions, has criticized Anthem because after its out-of-state acquisition of BC in Maine, Anthem began to press the state to loosen various restrictions on rating and product design.

We heard a different account in Virginia (before Anthem's acquisition). There, one observer said that BC was very conscious of how it was viewed from a political standpoint by the public, the press, and the

regulators, and that this constrained its behavior to some extent. Several people thought that BC was still trying to craft workable solutions to public policy and regulatory issues in Virginia. But two cynics maintained that BC in Virginia did not “really care what people think because they don’t have to,” due to their size, and that BC “like[d] to be perceived as caring about the community” but the feeling was not genuine.

Considering these differing views, there is some basis for concern that conversion may affect BC’s role in political, regulatory, and public policy affairs. Although it is impossible to gauge the extent of this concern, even in qualitative terms, perhaps the best guess is the view expressed by one expert, who believed that whatever political constraints and social orientation existed before conversion would remain in a lesser form, though still to some extent, considering the BC plans’ size, history, and ties with their communities. Conversion, however, had made it much easier for BC plans to be acquired by a larger, out-of-state plan, such as Anthem or Wellpoint, which this expert thought might reduce the degree of local community involvement or responsiveness.

Increased Taxes and Foundation Benefits

One health economist has noted that “health ownership conversions hold out the possibility for unlocking community assets and making them available to finance new socially beneficial initiatives” (Robinson 2000, 67). When weighing the balance of public interest considerations flowing from conversion, it is critical to consider the benefits from the tremendous endowments of conversion foundations, as well as the public benefits that come from the additional taxes that a for-profit BC usually must pay. In recent conversions, BC plans often propose putting most or all of their initial stock into a new foundation devoted to health policy goals statewide. On account of the strength and size of most BC plans, this can create a very large foundation that can do a lot of good. In California, where two foundations were created and are worth more than \$3 billion, our interview subjects expressed strong enthusiasm for the role of these foundations in health policy statewide: “absolutely wonderful,” “huge positive benefits,” “major impact.” Some observers pointed out that a foundation funded by the health insurer’s own stock creates a “win-win” situation because the better BC is at earning profits, the more good the foundation can do since the more its stock is worth. (This relationship, however, lasts only as long as the foundation owns the stock, and such

foundations usually are required to divest themselves of Blue Cross stock after a few years.)

Despite this tremendous potential, it is not clear that the revenue stream from these foundations is enough to directly offset all the possible affordability and accessibility consequences of conversion. Accordingly, these foundations need to be viewed in proportion to the very large size and influence of the BC plans that converted, and therefore in relation to the magnitude of these potential impacts of conversion. On a pro rata basis, foundation funding usually amounts to only a few tens of dollars per BC subscriber each year, so only a minor impact on every BC subscriber (such as a rate increase of 1 percent) could match this benefit.

A second consideration is whether foundation funds will be spent on improving accessibility and affordability or instead will be used to promote health in other ways that do not directly counteract the potential impacts of conversion. An extensive analysis of BC conversion foundations, conducted for Maryland's insurance administrator, reported that although only a "relatively negligible portion" (1.8 percent) of BC foundation funding goes "toward programs that provide subsidies for health insurance," one-third of foundation funding directly supports the delivery of care through grants to clinics and hospitals (LECG 2003). Most notable is the California Endowment, which spent more than \$100 million over four years to support low-income clinics and to help subsidize the state's high-risk insurance pool.

These foundations are not viewed, however, as permanent sources of support for significant numbers of people who cannot afford or obtain health insurance or health care. The bulk of BC conversion foundation funding (roughly two-thirds) has gone to research, public policy advocacy, and education (LECG 2003). Likewise, most of the people we interviewed saw the primary goals of these large foundations as heightening community awareness of health policy issues, mobilizing support for legislative action, funding research that generates information and ideas for the public policy arena, and funding pilot demonstration projects. Although these are worthy activities, their impact on alleviating the plight of those affected by higher premiums or tougher underwriting policies is uncertain. As one observer commented about the California Health Care Foundation:

In a profound bit of irony, [it] used funds flowing from the conversion in a recent research effort which found that an increasing number of non-poor people in California have dropped or been dropped from

health insurance. The money to finance the research was previously available for community rating of insurance premiums.

Moreover, most BC conversion foundations have pursued many objectives other than accessibility and affordability. “For example, [these] foundations have moved into areas such as violence prevention, environmental health, youth smoking and substance abuse prevention, and basic research, analysis, and healthcare database development of healthcare information” (LECG 2003, 40). The same is true for hospital conversion foundations, which, according to one national expert, have “redefined themselves to have broader public health purposes than providing direct patient care . . . [or] subsidizing health insurance for uninsured workers and their families” (Kane 1997, 233). In New York, most of the proceeds from the Empire Blue Cross conversion did not go into a foundation but instead will be spent on health care workers’ salaries and various state-funded health care programs, which will exhaust these funds within two or three years (Robinson 2003; Strom 2002). Although the goals are health related, they are a far cry from what advocates had originally hoped. Similarly, the conversion foundation in Wisconsin funds medical research, and in Virginia a small trust fund was created to defray state budget items.

To the extent that foundations pursue goals other than directly subsidizing the accessibility and affordability of health care, it is difficult to weigh a foundation’s benefits against a conversion’s accessibility and affordability detriments. This observation is not meant to detract from the very real public benefits of pursuing other health-related purposes; it is meant only to observe that these broader purposes prevent an apples-to-apples weighing of the pros and cons of a conversion. Therefore, a better strategy is to minimize, to the extent feasible, a conversion’s direct and predictable negative impacts on affordability and accessibility and then to look to the foundation’s broad range of potential benefits to offset the less observable, more dispersed, and less preventable conversion impacts.

Conclusion

We did not detect any major negative health policy effects so far from freestanding conversions of Blue Cross plans in the states where they have occurred. This conclusion is confirmed by a systematic survey of the foundations created by BC conversions, in which foundation officials

“indicated little evidence that [the conversions in their state] resulted in any major adverse impacts on the relevant populations.” The study’s authors concluded that “at a macro level, previous BCBS Plan conversions do not appear to have caused massive disruptions in their respective state’s healthcare . . . delivery systems” (LECG 2003, 33).

The absence of definitive proof of major harm does not mean, however, that conversions are necessarily neutral or beneficial. As we have stressed throughout this article, there is considerable uncertainty about the actual effects of previous conversions due to the complexity of the issues and limitations in available data. Also, each state is different, so even if the historical record is clear elsewhere, it is difficult to predict confidently what the actual effects will be in another state.

One clear effect of conversion is to increase profit incentives. Therefore, the areas of greatest potential concern can be mapped according to the main components of profitability: rates, administrative costs, and medical claims. Conversion may result in higher insurance rates in those market segments where BC plans hold considerable market power and are subject to less aggressive rate regulation. Conversion also tends to result in a lower medical loss ratio, which can be achieved by tougher negotiating with providers and more refined underwriting and risk selection practices. Conversion can also have offsetting positive effects, such as improved operational efficiency and customer service. The largest potential benefit is to unlock considerable wealth that can be devoted explicitly to health-related charitable purposes. However, the result of clarifying the business mission and social expectations of Blue Cross plans is to fundamentally alter the organizational form of the largest, and often dominant, nonprofit institution in health care finance and delivery. This is a sobering step, one that almost certainly will not be undone once it is taken; therefore, it should not be taken without carefully considering the competing health policy implications.

ENDNOTES

1. A national study of BC plans using data from 1986–1988 found that a 10 percent greater plan size is associated with a 1.66 percent lower administrative cost ratio and that a 10 percent greater market share reduces administrative cost ratios by 6.9 percent (Foreman, Wilson, and Scheffler 1996). These relationships also are documented in confidential data developed by Accenture for CareFirst, as reported by the Blackstone Group (2002). Of equal importance, the Foreman study found that a 10 percent greater market share reduces premiums by 6.2 percent but that size per se does not significantly reduce premiums.

2. An analysis of data for 1997–2000 for many, though not all, BC plans found the following administrative expense ratios (AERs): (1) independent not-for-profit plans ($n = 19$) = 13.0%; (2) consolidated not-for-profit plans ($n = 7$) = 13.4%; and (3) for-profit plans ($n = 4$) = 23.4%. As a comparison, the AER for ten commercial plans also studied was 15.3% (Schramm 2001b). However, caution is in order in comparing expense ratios, since without adjustment, plans with a high level of administrative-services-only business (ASO) will appear to have high expense ratios if the administrative costs for ASO activities are included without any counterbalancing premiums or revenues. As an illustration, Anthem's AER for 2000 was 21.2% without adjustment but fell to 15.3% when compared with operating revenue and "premium equivalent" revenue for ASO accounts (see table 5–11 in PriceWaterhouseCoopers 2002). A recent compilation by the Blackstone Group (2002) showed an adjusted AER for Wellpoint of 10.8%; for Anthem, 14.1%; and for Cobalt, 9.4%. The sharp contrast between these figures and those reported by Schramm strongly suggest that his are unadjusted and therefore may be misleading as an indicator of plan performance.
3. According to one source (Schramm 2001a), for 1997–2000, MLRs for selected BC plans were as follows: (1) independent plans ($n = 19$) = 83.7%; (2) consolidated plans ($n = 7$) = 83.8%; and (3) for-profit plans ($n = 4$) = 73.5%. As a comparison, the MLR for ten commercial plans also studied was 80.1%.
4. In addition to the points noted in the text, the database used did not include actual premiums or rates. Instead, these analysts constructed premiums by dividing total annual premium revenue by member months of coverage. These constructed measures approximate companywide pricing rather than pricing in discrete market segments. Thus, for example, a shift in an HMO's mix of coverage from large employers to small employers would register an apparent increase in premiums even if the literal premiums for the two groups remained identical.

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