Amicus Curiae Brief by the Alliance for Advancing Nonprofit Health Care in Support of the Washington State Insurance Commissioner's Denial of Nonprofit Premera Blue Cross' Application to Convert to For-profit Status.

I. Identity and Interest of Amicus Curiae.

The Alliance for Advancing Nonprofit Health Care is a nonprofit corporation dedicated to advancing the interests of nonprofit health care organizations through advocacy, public education, research, and the provision of performance improvement tool to its members. Incorporated in 2002, the Alliance's sole purpose is to preserve and enhance the abilities of nonprofit healthcare organizations to serve society and their individual communities.

The Alliance brings together a wide range of nonprofit health care organizations – hospitals, health insurers, nursing homes, malpractice liability insurers, home care providers, and others – that share these common goals. The Alliance has engaged in substantial research on the effects of conversion of nonprofit health care organizations to privately held for-profit companies. Based upon its experience and involvement in this issue nationwide the Alliance believes that its perspective will help the court to

appreciate the value of nonprofit health care in serving the interests of Washington citizens and to understand the consequences of conversion on the efficient and effective financing and delivery of health care.

II. Statement of the Case.

The underlying facts and procedural history leading to the Insurance Commissioner's decision are fully set out in the Brief of Respondent at 2-13, the Brief of Washington Intervenors at 5-20, and the Brief of Petitioners at 6-14. For purposes of this amicus brief, the Alliance focuses on the Commissioner's determination that denial of conversion furthered the interests of Premera's subscribers, the insurance-buying public, and the general public. (CL 2-3)

In particular, the Commissioner determined that "premiums in the individual and small group markets will likely increase in the Eastern Washington counties in which Premera has market power as a consequence of" conversion. (CL 7, 8) The Commissioner also concluded that "Premera's medical loss ratio will likely decrease as a consequence of Premera converting to a for-profit company," (CL 9-10), and that Premera's tax burden and its expenses as a public company, including but not limited to

executive compensation, would likely increase as a result of conversion. (CL 11-12)

Premera has petitioned for review of the Insurance Commissioner's final order. This court has accepted direct review of its petition pursuant to RCW 34.05.518.

III. Statement of Issue.

The parties dispute whether the Washington Holding Company Act authorizes the Insurance Commissioner to consider whether Premera's proposed conversion plan is in the public interest, fair and reasonable. The Alliance does not address this issue of statutory construction under RCW ch. 48.31C, but presumes for purposes of this brief that the Commissioner has the statutory authority to reject a change of control based on conditions of financial stability, the interests of subscribers and the public interest under RCW 48.31C.030(5)(a)(ii)(C)(I-IV). This amicus brief focuses on the history and to economic effects of Blue Cross/Blue Shield conversions to address the Commissioner's conclusions that Premera's conversion plan was not fair and reasonable to subscribers and contrary to the public interest.

IV. Argument.

To the extent the public interest is a relevant consideration in

the Insurance Commissioner's refusal to approve the conversion of Premera to a for-profit company, this court should hold that the Insurance Commissioner has substantial latitude in broadly defining that public interest, as he did in this case, to consider the effects of conversion not just on Premera's subscribers, but on the availability of affordable health care to all the citizens of the state of Washington. The Alliance has compiled a substantial body of published information on the effects of conversion on cost, efficiency, and benefits to the community, including the underserved and needy. That data supports the Commissioner's determination that a Premera conversion to a for-profit entity would result in higher premiums, the loss of local control, higher administrative expenses, and reduced access to health care for those most at risk.

A. History of Conversion of Blue Cross Plans.

Blue Cross dates from the early years of the Great Depression, when nonprofit hospitals sought to develop a community focused prepayment mechanism for health expenses. Blue Cross prospered and grew rapidly during the boom years following World War II, paralleling the rise in labor union influence, when health care benefits became a common fringe benefit of

employment.[1]

During the 1960's and 1970's Blue Cross plans faced aggressive competition from commercial carriers that had entered the market using a property casualty model for assessing risk. The Blues benefited from an experience-rated model, as well as from an industry agreement enforced by the national Blue Cross/Blue Shield Association that protected plans from competition in their assigned territories. This allowed each Blue plan to dedicate itself to the needs of a specific region and allowed each plan to develop a brand image based on its knowledge of the needs of its beneficiaries, its community's hospitals and physicians.[2]

However, during the 1980's commercial carriers gained market share by promoting products that appeared responsive to rapid inflation in health care costs and that pressured physicians and hospitals to charge lower fees, and marketing themselves to large multi-state employers. A new generation of executives, many of whom came from banking or commercial insurance, sought to improve the performance of the Blue plans, but were constrained by BCSBA's exclusive geographic market agreement from competing against other Blues.[3]

Conversion[4] and consolidation[5] began in earnest beginning

in 1989, when Indiana Blue Cross, through a for-profit subsidiary purchased the American General Insurance Company, to compete against other Blue plans for health insurance business outside of Indiana Blue Cross's territory. In the early 1990's Blue Cross of California relinquished its nontaxed status, forming a for-profit subsidiary known as WellPoint, and developed a network of HMO and preferred provider organizations that succeeded by focusing on the underserved individual and small-group markets. In 1996, California Blue Cross disappeared altogether when it absorbed itself into its for-profit, publicly held subsidiary. In 2004, WellPoint itself merged into Anthem Insurance Co., Inc., which began as the Indiana Blue Plan and brought together the plans of eight states before going public in 2001.[6]

The California conversion prompted other Blue plans to conclude that they needed to consolidate in order to survive. As a result of conversion or consolidation, the number of independent Blue plans fell from 67 in 1995 to 42 by the end of 2003.[7]

Although there have been no significant health plan conversions in the last few years, the pace of consolidation in the health insurance industry shows no signs of letting up. Following the WellPoint-Anthem merger in 2004, United Health Systems, Inc.

and PacifiCare Health Systems, Inc. announced on July 7, 2005, a plan to merge in an $8.1 billion cash and stock deal. The combined entity would be the nation's largest health carrier with expected 2005 revenue of $59 billion.[8]

Clearly, for-profit health insurers continue to have an incentive to combine into larger, multi-state entities. The history of Blue Cross and Blue Shield conversions and the trend of industry consolidation supports the Commissioner's determination that "based upon the experience of other converted plans . . . there is a high likelihood that if Premera converts to a for-profit company, it will be acquired by a national insurer such as Anthem or WellPoint." (FF 47) Because, as discussed below, local ownership correlates highly with community-oriented benefits, *see*

on taxes, executive compensation and administrative expenses and less money spent on health care. The Commissioner's findings are supported by the available research on the profitability, operating margins and expenses of nonprofit versus investor-owned health care plans.

Investor-owned for-profit health insurers experienced higher profit margins than their not-for profit counterparts, but those profits do not necessarily reflect increased efficiencies. At the end of 2002, investor-owned health insurers reported an average net margin of 3.7%, or almost double the 2.0% reported by nonprofit Blue Cross and Blue Shield plans.[9] A study comparing for-profit managed care companies with Blue CrossBlue Shield plans found that the average profit margin for publicly traded managed care companies was 4.4% in 2002, approximately twice the margin experienced by Blue Cross Blue Shield plans.[10]

Although it is axiomatic that a for-profit entity faces pressures to maximize net income, the published data support the Commissioner's determination that an investorowned Premera would face pressure to increase its net income and operating margins at the expense of its subscribers. (FF 69) The profits earned by investor-owned insurers reflect the fact that they pay out

a lower percentage of premium dollars for health care claims than do nonprofits. Without the demands of investors to fund dividends and to maintain stock price, the nonprofit plans were able to generate positive margins while paying out a much greater percentage of their premiums in health care claims.

For instance, a 2003 study determined that nonprofit plans reported significantly above average medical loss ratios, average to below average expense ratios, along with significantly below average profit margins.[11] The U.S. Government's Center for Medicare & Medicaid Services reported in 2003 that the Blues spend one third less of their revenues on sales, general and administrative expenses than do their publicly held peers.[12] Thus, the medial loss ratio, or the ratio between medical expenses paid to the amount of money taken in by a plan from members, excluding investment income, averaged almost 84% for nonprofit Blue plans, compared to 74% for for-profit Blue plans and 80% for commercial insurers during the years 1997-2000. During the same period, nonprofit Blues reported that the ratio of administrative costs to total premium revenues averaged 13%, commercial insurers averaged 15%, while the for-profit Blues reported a ratio of 23%.[13]

As the Commissioner found here, executive compensation is

a significant factor in the higher administrative expenses experienced by for-profit insurers. Although executive compensation for nonprofit Blues has also risen in the last decade, those increases do not come close to the levels of compensation paid by for-profit insurers.

For example, between 1993 and 2003, payments to WellPoint's CEO in terms of salary, bonuses and option grants, rose over 1,500% from $1,383,000 to $19,260,000 million. The CEO of Anthem received $15.9 million in total compensation in 2002. Even in the absence of consolidation, conversion can result in significant compensation increases. The CEO of the Trigon Healthcare, Inc., the converted Virginia Blues plan, received a 203% increase over his pre-conversion compensation.[14] It is far from clear that such largesse is justified as numerous studies have shown little correlation between executive compensation and a company's performance.[15]

Because nonprofit insurers are more administratively efficient than their for-profit counterparts, nonprofit plans have been able to keep premiums lower than those of comparable for-profit plans operating in the same market. In a study comparing various for-profit and nonprofit plans in New York State, for instance,

for-profit premiums were 8.8% higher in 2002 than those of nonprofit plans in the downstate market, and premiums increased 10% for nonprofit plans, while the for-profit insurers' premiums increased 14.2% over the prior year.[16]

The financial strength of nonprofit Blue plans compared to plans adopting a for-profit business model is also reflected in their risk-based capital ratios. This formula measures the adequacy of the health plans' capital position compared to the risks associated with its insurance obligations, its investment portfolio and other business contingencies. At the end of 2002, the average Blue plan risk-based capital ratio was 623%. For nonprofit Blue plans, the figure was 17% higher, at 727%.[17] With higher risk-based capital ratios, nonprofit Blues are better able to weather unfavorable underwriting results and better able to maintain lower operating margins because they have less need to generate capital through premiums.

The benefits of a financially strong health plan are not limited to ensuring long-term solvency and survival. Financial strength also correlates with customer satisfaction. Thus, a 1998 study of 82,000 Medicare managed care enrollees found that the strongest predictors of customer satisfaction were tax status and affiliation,

with for-profit plans having significantly worse scores with respect to customer service and access criteria.[18] Similarly, customers of for-profit HMOs reported greater dissatisfaction with administrative barriers, delayed care, unmet need, and high out-of-pocket expenses.[19]

C. Nonprofit Plans Participate In Serving The Needy And The Community At Large To A Greater Degree Than For-Profit Plans.

Any consideration of the public interest must take into account the state's most needy citizens and other community needs.. As insurers transition to a for-profit model, their focus is increasingly on commercial product development and profitability and less on safety net and public programs for the poor and uninsured or on improvements in health status and quality of life for the broader community.

Data from the first three years of this decade indicate that publicly traded health insurers decreased their participation in Medicare Plus Choice, the federal government's managed care option for Medicare that was created in 1997.[20] A study of plans in New York showed that nonprofit plans had a far greater degree of participation in state-sponsored safety net programs than did for-profit counterparts, with 88% of the enrollment in New York

State-sponsored programs, compared to only 12% of safety net membership enrolled in for-profit plans.[21] Similarly the nonprofit plans enrolled 73% of the elderly in the Medicare Plus Choice product line, while only 27% were enrolled in Medicare Plus Choice through for-profit insurers.[22]

A study of community benefits provided by managed care organizations found that locally controlled HMOs spent five times more on formal community benefit programs than did HMOs that were subsidiaries of larger corporate entities.[23] Local control and nonprofit status are the most significant factors in determining a plan's involvement in the community, as measured by such indicia—indicators? as supporting services to persons of low income and philanthropic initiatives that benefit the entire local population, beyond the plan's enrollees.[24]

IV. Conclusion.

The Commissioner's public interest findings in this case are supported by the history of Blue Cross Blue Shield conversions, as well as recent studies showing that conversions to for-profit status do not translate into any benefits to subscribers, or to those most in need of health care benefits.

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[1]*See* Robert Cunningham III and Robert Cunningham Jr., "*The Blues: A History of The Blue Cross and Blue Shield System*" (1997).

[2]Schramm, "*The Diseconomies of Blue Cross Conversion*" 3-4 (2004) ("Schramm"), reprinted at http://www.healthleaders.com/news/whitepapers/63732/wp_AANPHC_020705.pdf

[3] Schramm, at 3-4.

[4] Conversion refers to the process by which a nonprofit becomes a for-profit plan, usually converting to a publicly owned entity.

[5] Consolidation is the process of several Blue plans combining together, either before or after converting to for-profit status. For instance the nonprofit corporation Premera Blue Cross consists of the combined nonprofits that were formerly Blue Cross Blue Shield of Alaska, Blue Cross of Washington and MSC of Eastern Washington. A more informal consolidation occurred under the "Regence" name, where the Blue Cross plans of Idaho, Utah and Oregon agreed to affiliate with the King County Blue Shield Plan, continuing as separate nonprofits, but working together to improve productivity.

[6] Schramm, at 5

[7] Schramm, at 5

[8] "*United Health, PacifiCare Edge Up In Deal's Wake",* Insurance News, July 7, 2005. http://www.insurancenewsnet.com/asrticle.asp?=l&lnid+293825686

[9]Barrish, "*Nonprofit Health Insurers: The Financial Story Wall Street Doesn't Tell*" 3 & n.2, reprinted at http://www.nonprofithealthcare.org/SusanBarrishWhitePaper.pdf

[10] CMS, "*Health Care Industry Market Update*" 115-16 (March 24, 2003) reprinted at http://www.cms.hhs.gov/reports/hcimu/hcimu_03242_003.pdf ("CMS")

[11]Conning Research & Consulting, "*Blue Cross Blue Shield Plans, Roaring Back?"*, cited in Barrish, n. 9, *supra*.

[12] CMS, "*Health Care Industry Market Update - Managed Care"* at 16, March 24, 2003. http://www.cms.hhs.gov/reports/hcimu/hcimu_03242003.pdf.

[13] Carl Schramm, "*Implications for Health Care Providers Resulting From A Sale of Kansas Blue Cross Blue Shield",*Health Affairs, 2001; Vol. 10.

[14] Bell, "*How Much Is Too Much? Executive Compensation Following the Conversion of Blue Cross and Blue Shield Plans From*

Nonprofit to For-Profit Status", reprinted at http://www.consumers_union.org/conv/docs/ExecCompAcknow.pdf.

[15]McGeehan, "*Is CEO Pay Up or Down? Both*," New York Times, April 4, 2004.

[16]Treo Solutions, "*Cost Commitment and Locality: A Comparison of For-Profit and Not-For Profit Health Plans"* (2003), reprinted at http://www.nonprofithealthcare.org/AllianceTreoReport-1-23-04.pdf ("Treo")

[17] Barish at 6. The lowest reported ratio for a nonprofit Blue plan was 257%.

[18] B. Landon et al, "*Health Plan Characteristics and Consumer Assessments of Quality"*, Health Affairs 2002, Vol. 20 No. 2 at 281.

[19] H. Tu and J. Reschovsky, *"Assessment of Medical Care By Enrollees in For-Profit and Nonprofit HMOs,"*New England Journal of Medicine, 2002; 346 (17) 1288-93.

[20]CMS at 41.

[21]Treo at 10.

[22]Treo at 4.

[23] Schelsinger et al., *A Broader Version for Managed Care, Part 3: The Scope and Determinates of Community Benefits,*Health Affairs, May/June 2004 210 at 216.

[24]Schlesinger et al, *"Measuring Community Benefits provided By Nonprofit and For-Profit HMOs"*, Inquiry Vol. 40, No. 2. *Seealso*, Schelesinger, et al, *"A Broader View of Managed Care, Part 3: The Scope and Determinates of Community Benefits"*, Health Affairs, May/June 2004 at 216 ("Local control and nonprofit ownership were the two most consistently important factors, being associated with broader involvement under all four community benefit perspectives.").