EXECUTIVE SUMMARY

For several years, Wall Street investment firms have campaigned for conversion of not-for-profit health insurers to investor ownership, arguing that an infusion of equity capital is critical to insurers’ survival. However, closer examination of the financial performance and capital position of not-for-profit health plans shows that:

- The lower operating margins reported by not-for-profit health very likely reflect the organizations’ corporate missions to serve their communities by minimizing the cost of coverage and their ability to invest all gains back into the company for the future benefit of their customers. Their investor-owned counterparts must generate higher margins to give shareholders a return on their investment.

- Compared with investor-owned insurers, not-for-profit health plans use a significantly higher percentage of the customers’ premium dollar to pay health care claims. A lower percentage goes for administrative expenses.

- Over the past ten years, not-for-profit health plans have succeeded in using operational and investment gains to build and retain a strong capital position - stronger than that of investor-owned companies - while investing heavily in infrastructure, product development, and market growth.
INTRODUCTION

For decades, community-based nonprofit organizations’ were the chief source of health insurance coverage. The recent wave of highly publicized initial public offerings of health insurers, including a number of Blue Cross and Blue Shield Plans, has led some to conclude that the nonprofit health insurer is an endangered species on the brink of extinction. Wall Street (and investor-owned companies) has been championing health carrier conversion to investor ownership both as a source of fees for themselves and as a requirement for company survival, bringing access to capital for investments in technology and market growth, an avenue to economies of scale, and a bottom-line orientation.

However, when you go beyond Wall Street reports, you find that nonprofit health insurers continue to be a robust, vital component of the health care financing industry. These companies do not necessarily require equity capital to fund the future. Their investments in service delivery, product development, and growth can continue to be funded through a combination of gains from operations and investment portfolios, accumulated reserves, access to alternative capital sources, and intercompany alliances that share development and/or operational costs.

This paper offers an overview of the financial position and performance of nonprofit health plans. It presents related issues to consider by organizations contemplating conversion to investor ownership and by regulators who have to approve the conversion.

1 In this paper, the terms “not-for-profit” and “nonprofit” include all non-investor-owned organizations, such as mutual insurance companies.
EXHIBIT 1: NET MARGIN AS A PERCENTAGE OF REVENUE FOR NONPROFIT BLUES, PUBLIC BLUES AND PUBLIC NONBLUES


STRONG PERFORMANCE IS ... ?

Recent investment analyst reports on the health insurance industry have taken a consistent position: nonprofit health plans under-perform compared with publicly held ones, and without access to the capital markets, nonprofits will lack sufficient resources to make the critical investments in technology and product development necessary to remain competitive. However, these reports tend to rely on a limited set of financial statistics, such as earnings per share, net margins, medical loss ratio, and market growth. They overlook the effects of a corporation’s market and financial position, strategy, and business philosophy on its operating results.

When the analysis is broadened to relate quarterly/annual operating results with corporate strategy and mission, it appears that many nonprofit health insurers are well positioned to fund the accomplishment of long-term business plans, including necessary infrastructure investments, without requiring access to the capital markets.

Historically, the health insurance industry was considered a low-margin business. A health insurer that averaged 1-2% annual gain over time was considered a good performer. Margins have grown since the late 1990s, fueled by the rising number of publicly traded insurers (as well as companies planning to convert) and extraordinary investment portfolio performance. Over the past three years, investor-owned, or public, health insurers have reported increasingly larger net margins. As Exhibit 1 shows, by December 31, 2002, the publicly traded health plans tracked by Sherlock Company reported an average net margin of 3.7%, almost double the 2.0% reported by nonprofit Blue Cross and Blue Shield Plans2.

... many nonprofit health insurers are well-positioned to fund ... long-term business plans ... without requiring access to the capital markets.

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2 Blue Cross and Blue Shield system data are used as a proxy for the nonprofit health plan segment, in view of the size of the system (42 enterprises covering the United States and Puerto Rico, generating annual revenue of $163 billion in 2002, and serving 85 million customers) and the availability of aggregate, systemwide data.
The lower margins of nonprofits do not necessarily signal that these companies lack the underwriting and financial disciplines, effective medical management programs, or innovative product design to achieve higher margins. One must consider the operating results in relation to the differing missions and related business strategies of investor-owned and nonprofit health plans. Like any other public company, investor-owned health plans must be committed to maximizing shareholder value. The investment community demands that these organizations consistently generate profits sufficient to support the company’s operating demands as well as provide competitive (if not superior) returns to shareholders in the form of stock prices and repurchases and/or dividends.

A nonprofit health plan’s primary goal is to serve its community by conscientiously conducting its business to control medical and administrative expenses. In addition, as a not-for-profit company does not distribute earnings to stockholders, it retains all financial gains (“profit”) for future internal investments. Its financial reserves (and related investment income) will fund, for example, new information technology, product development and introduction, and medical management innovations. The reserve also provides a financial cushion during periods of underwriting downturns (when annual premiums are not sufficient to cover health care claims and related administrative expenses) by subsidizing the level of premium rate increases necessary to recoup the operating losses, and ensuring the timely and appropriate payment of all obligations (health care claims, payroll, vendor invoices) and, ultimately, the solvency of the health plan.

In a 2003 study, “Blue Cross Blue Shield Plans, Roaring Back?,” Conning Research & Consulting analyzed a subset of Blue Plans of various corporate structures. Conning found that nonprofits’ reported significantly above-average medical loss ratios (also known as “benefit expense ratios,” the percentage of premium dollars used to cover customers’ health care expenses), average to below-average administrative expense ratios, and below-average to significantly below-average profit margins. Without the demands of Wall Street, it appears that nonprofits adopt business and pricing strategies that generate sufficient operating margins and that they pay out a greater percentage of premiums in health care claims.

EXHIBIT 2:
AVERAGE EXPENSES/PROFIT FOR PUBLICLY TRADED MANAGED CARE COMPANIES

Percentage of revenue

Source: Health Care Industry Market Update – Managed Care (March 24, 2003), CMS
Notes: Historical figures from company reports and analyst models. Companies include Aetna, Amerigroup, AMS, Anthem, Cobalt, Centene, CIGNA (health, life, disability operations only), Coventry, First Health, Health Net, Humana Mid-Atlantic Medical, Oxford, PacificCare, Sierra Health, UnitedHealth, WellChoice, and WellPoint. All figures exclude one-time charges and adjust for FASB 142, which eliminated amortization of goodwill in GAAP estimates effective 1/1/02.
The Centers for Medicare & Medicaid Services (CMS, formerly HCFA) found that publicly traded managed care companies increased their profit margin from 1.8% in 1999 to 4.4% in 2002. As shown in Exhibit 2, the higher margins were achieved mainly by reducing the percentage of premium used to pay health care claims.

The Blue Cross and Blue Shield Plan data presented in the CMS report indicate that, in aggregate, significantly more of the Blue premium dollar goes toward customers’ health care services and less goes toward administrative expenses than among publicly traded insurers. Exhibit 3 includes data for all Blue Plans. Based on publicly available data, investor-owned Blues report lower benefit expense ratios and higher administrative expense ratios than nonprofit Blues do. That is, at publicly held Blues, less of the premium dollar is used to pay for health care services. Given this difference, if Exhibit 3 included only the nonprofit Blues, the differences between the investor-owned and nonprofit companies would be even more noteworthy. (Note: Exhibits 2 and 3 are not directly comparable because Exhibit 2 is the averaged data for the listed public companies and Exhibit 3 consolidates, not averages, Blue Plan data.)

*“Health Care Industry Market Update – Managed Care” (March 24, 2003).*

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**EXHIBIT 3:**

**CONSOLIDATED EXPENSES/PROFITS FOR BLUE CROSS BLUE SHIELD PLANS**

Percentage of revenue

![Bar chart showing consolidated expenses/profits for Blue Cross Blue Shield Plans from 1999 to 2002.](image)

Source: Health Care Industry Market Update – Managed Care (March 14, 2003), CMS

Notes: Historical figures from BCBS Association. Includes data for both publicly traded and nonprofit Blues. Negative “other net expenses” occurs when investment income exceeds other expenses in that category.
The higher a company’s risk-based capital ratio, the more financial flexibility it has to invest in new initiatives and technologies and in customer growth. As a not-for-profit company does not distribute earnings to stockholders, it retains all financial gains (“profit”) for future internal investments.

The adequacy of a company’s operating margin should also be analyzed in light of the entity’s capital position, a perspective typically neglected by Wall Street when evaluating health insurers.

In 1998 the National Association of Insurance Commissioners (NAIC) adopted a risk-based capital formula for managed care organizations, MCO-RBC. This formula measures the adequacy of a health plan’s capital position in relation to the risks associated with issuing insurance contracts, investment portfolio, and other business contingencies. The higher a company’s risk-based capital ratio, the more financial flexibility it has to invest in new initiatives and technologies and in customer growth.

It is also better able to weather financial losses associated with unfavorable underwriting results (financial losses incurred when claims and related administrative expenses exceed premiums collected).

The NAIC has established a minimum RBC level that triggers regulatory action: 200% of the Authorized Control Level, or ACL, is the first step in an early warning process; at 70% of ACL, state regulators are mandated to assume control of the entity. However, the formula does not establish a target or a maximum level of reserves. An individual health plan must determine how much capital it should accumulate above regulatory action levels to ensure that its long-term business strategy can be supported.

For Blue Plans, unlike the rest of the industry, the capital requirement generated by the MCO-RBC formula was not a new concept. The Blue Cross and Blue Shield Association had adopted a similar approach for all its domestic licensees in the early 1990s that encouraged Blue Plans to be well capitalized. By year end 2002, as shown in Exhibit 4, the average Blue Plan risk-based capital ratio was 623%; the average for nonprofit Blue Plans was 17% higher, at 727%.

These figures indicate that most of the Blue nonprofits have been quite successful in implementing a capital-building and retention strategy - without access to the capital market - while adding 3.8 million new customers, a 7.7% increase in three years, and making significant infrastructure and product investments critical to maintaining market leadership. The higher RBC position may also partially explain the lower operating margins reported by nonprofits. A strong capital position means less need to generate capital through operations, resulting in less margin built into premium levels.

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5 The Blue Cross and Blue Shield Association’s minimum licensure requirement is 200%.
6 RBC-MCO ratios for not-for-profit Blue Plans ranged from 257% - 2082% as of December 31, 2002.
7 Per BCBS Association enrollment reports.
SUMMARY

When considering the appropriateness of converting a nonprofit health insurer to investor ownership, it is critical that all decision makers develop a full understanding of a health plan’s financial performance and position beyond just operating-margin statistics. A thorough review includes answering the following questions:

- How does the company's actual performance (e.g., underwriting margin, net margin, premium levels, administrative and medical loss ratios) compare with forecasted performance? Does the company have the discipline to achieve its forecast?
- What is the company’s mission, and how well aligned are its business practices, pricing policies, and performance results to ensure that the mission is achieved?
- What changes in pricing policies, product design, and business practices would be required to increase operating margins? How would key stakeholders (e.g., customers, potential customers, the medical and hospital communities, state regulators and legislators, competitors) respond?
- What is the company's MCO-RBC position? Will the company be able to generate sufficient capital from operations and its investment portfolio to fund the future? If not, what are the options to reduce the cost of the strategy and/or raise the capital shortfall?

... it is critical that all decision makers develop a full understanding of a health plan’s financial performance and position beyond just operating – margin statistics.

EXHIBIT 4:
YEAR-END MCO-RBC RATIOS

<table>
<thead>
<tr>
<th>Year</th>
<th>All Blue Plans</th>
<th>Nonprofit Blue Plans*</th>
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</thead>
<tbody>
<tr>
<td>2002</td>
<td></td>
<td></td>
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<tr>
<td>2001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RBC percentage

Source: BCBS Association

* Includes data for all nonprofit and mutual plans that were not pursuing conversion as of year end 2002 and permit BCBSA to publish results.
SUSAN R. BARRISH

Ms. Barrish is a consultant to the health insurance industry, advising executive management on the development and execution of strategic initiatives. Previously she was a Senior Vice President at the Blue Cross and Blue Shield Association, the central coordinating body for Blue Cross Blue Shield Plans. As the architect of the Association’s brand protection program, she guided the establishment and implementation of consistent, high standards for the 200 independent Blue Cross Blue Shield licensees that generate annual revenue in excess of $162 billion and serve 85 million customers. She also led the Association’s financial, actuarial and federal tax services and related policy and advocacy efforts at the National Association of Insurance Commissioners (NAIC), the IRS and the U.S. Treasury Department. Prior to joining the Association, Susan was in hospital financial management at several large, urban teaching hospitals.

Ms. Barrish holds a Bachelor of Science in Accounting from American International College (Springfield, Massachusetts) and a Masters of Business Administration from Cornell University (Ithaca, New York).

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