NONPROFIT HEALTH INSURERS:

The Financial Story Wall Street Doesn't Tell.

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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

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For decades, community-based nonprofit organizations[1] 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.

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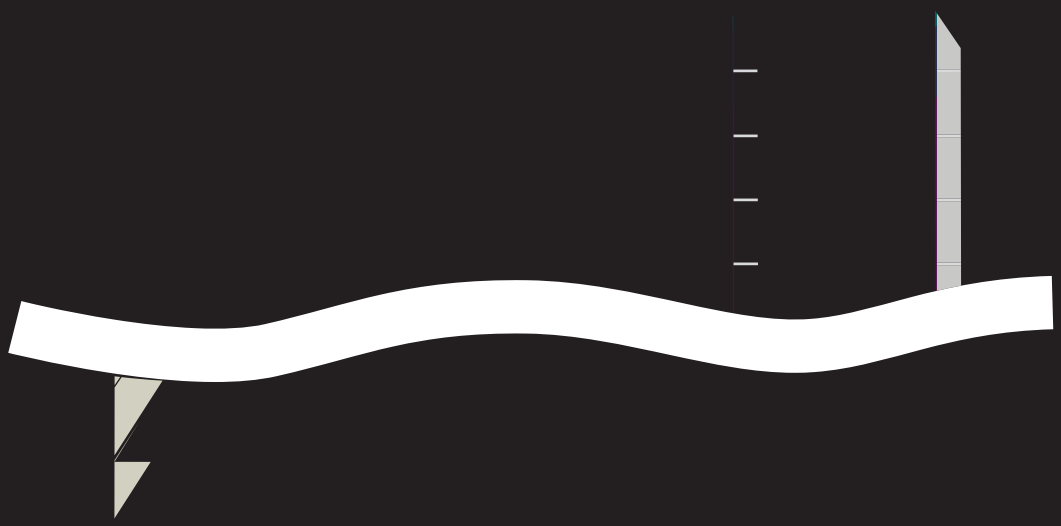
However, when you go beyond Wall Street reports, you find that nonprofit health insurers continue to be a robust, vital component of the health care financing industry. These companies do not necessarily require equity capital to fund the future. Their investments in service delivery, product development, 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.



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.

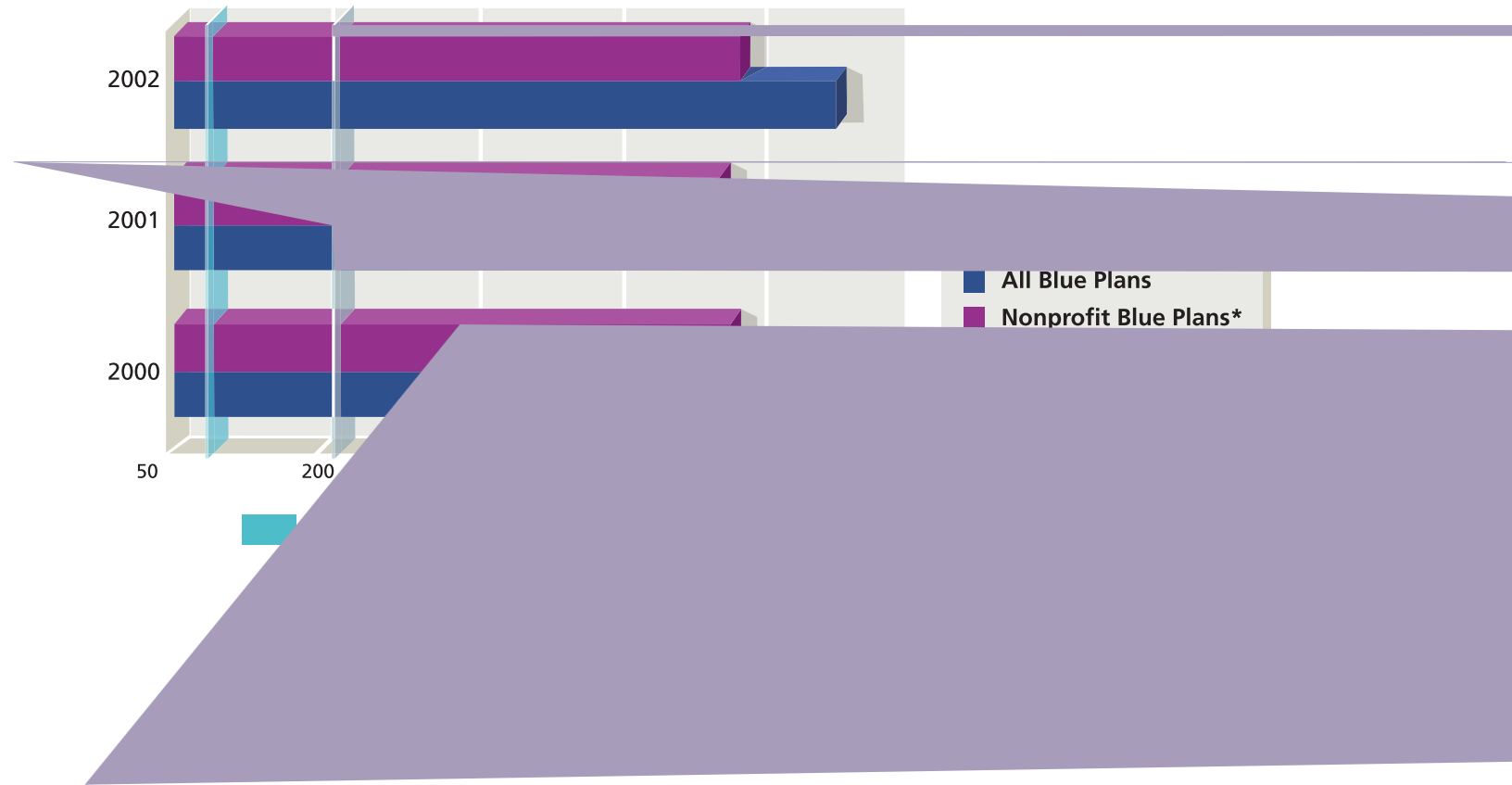
In 1998 the National Association of Insurance Commissioners (NAIC) adopted a risk-based capital formula for managed care organizations, MCO-RBC. This formula measures the adequacy of a health plan's capital position in relation to the risks associated with issuing insurance contracts, investment portfolio, 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[5]. 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[6] 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[7], 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.

[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.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