THE AIS REPORT
on Blue Cross and Blue Shield Plans

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Health Reform Update

Repeal of Antitrust Exemption Could Trigger Lawsuits, End Consolidation — or Do Nothing

Blue Cross Blue Shield plans are among the most prolific insurers in forming joint ventures and launching cooperative products. The pending health reform proposal from Sen. Patrick Leahy (D-Vt.) to make health insurers subject to federal antitrust laws could target such arrangements between Blues plans. But antitrust experts disagree on whether it would have a chilling effect on joint ventures and increase insurers' vulnerability to lawsuits — or have little impact at all.

Leahy on Dec. 1 said he would file an amendment to the Senate's reform bill, the Patient Protection and Affordable Care Act (H.R. 3590), to repeal the health insurance and medical malpractice insurance industries' exemption from the McCarran-Ferguson federal antitrust law. He said the amendment would "prohibit the most egregious anticompetitive conduct — price fixing, bid rigging and market allocations — conduct that harms consumers, raises health care costs, and for which there is no justification." A similar provision is included in the House's reform bill (H.R. 3962).

The original intent of the McCarran-Ferguson Act of 1945 was twofold, explains Jeffrey Kraft, a partner in the Chicago law firm Neal, Gerber & Eisenberg LLP. It was intended to codify states' authority to regulate insurers, and to improve insurance

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Blues Plans Build On-Site Health Clinics To Help Reduce Employee Medical Costs

In an attempt to cut employee health care costs by millions and boost productivity, some Blue Cross and Blue Shield plans are opening on-site medical clinics. Such clinics allow employees access to care where they work at lower out-of-pocket costs, and include treatments for illness and primary care and pharmacy services.

In November, Highmark Inc. opened two work-site health clinics with attached pharmacies, allowing its 10,000 employees on-site access to health coverage at no cost or reduced costs. The insurer says it expects the centers to save $5 million over a five-year period. Highmark follows BlueCross BlueShield of Tennessee (BCBSTN), which opened an on-site clinic and pharmacy for employees earlier this year. Horizon Blue Cross Blue Shield of New Jersey's three in-house clinics at its Newark, N.J., headquarters and its Wall and Mt. Laurel offices, which were opened in 2005 *(The AIS Report 10/05, p. 12)*, saved it a total of $560,625 (see table, p. 2) in 2008 alone.

Highmark opened its Pittsburgh headquarters clinic on Nov. 20 and its Camp Hill, Pa., office on Nov. 6. Company spokesperson Leilyn Perri tells *The AIS Report* that the insurer invested $1.5 million in the medical centers, and expects them to save $200,000 through lower health care costs and higher employee productivity in its first year, and $5 million in five years. The work-site clinics will offer Highmark employees primary care, vaccinations, physical therapy and pharmacy services.

continued

It's not the company's first foray into in-house employee health programs. Perri says Highmark published a February 2008 study in the *Journal of Occupational and Environmental Medicine* "that showed that for every $1 that we spent on wellness, we saved $1.65." The study found the employee-wellness program saved the insurer $1.3 million during a four-year period.

According to Highmark, a study conducted by research firm Fuld & Co. found that "worksite health centers can offer employers immediate savings of 10% to 30% on health care costs. The facilities generate savings by reducing costs for health care services, increasing productivity among the workforce and improving the overall health and well being of the employee population."

Rich Little, vice president of compensation and benefits at Highmark, says the plan expects the clinics to produce similar results. He asserts that Highmark's success with these programs will make the clinics appealing to the plan's large customers.

The clinics are operated by Take Care Health Systems, a division of Walgreens Co.'s health and wellness division. Other companies, like Comprehensive Health Services, Inc. (CHS) — which BCBSTN contracted with — offer on-site clinics, but Perri says Highmark chose Take Care because it has "a proven track record of implementing and operating on-site health centers, and their company provided us with expertise and experience, as well as a strong case for return on investment."

Little says Highmark did a "return-on-investment study with Take Care, and one of the things they cited was a Rand study in September that showed the costs of providing services at a facility like this are about 30% to 40% cheaper than a primary care office or an urgent care clinic and 80% cheaper than the emergency room."

Perri explains that the clinics aren't available to employees' dependents, because the centers "are located in secure areas of our buildings. Logistically, it would be difficult to have employees' family members access the facilities, for we would need to modify our security procedures." The plan determined, he says, that based on the "geographic location of our employees' homes…it would not be cost-effective to add medical and security staff to gain what was expected to be minimal utilization" by family members. However, the work-site pharmacies' services are available to dependents, he says.

Highmark Offers Incentives to Workers

Highmark does not intend for the clinics to replace employees' primary care physicians, but wants them to access the care when they need it while at work, Perri explains. To encourage use of the health centers, he adds, employees in its PPO products will have no copayments "at the health centers in 2010. Because of IRS regulations around HSAs [i.e., health-savings accounts], we are not able to offer waived copays to employees who are in Highmark's qualified HDHP [i.e., high-deductible health plan]."

Little said Highmark is testing on-site clinics internally at first, and asserts that health insurers should

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Horizon BCBS of New Jersey's 2008 On-Site Health Clinic Savings

Based on 7,457 Visits

Productivity Hours Saved		Cost Savings
Per Employee	**Total**	**At $30 Per Hour**
2.5	18,688	$560,625 Total

SOURCE: Horizon Blue Cross Blue Shield of New Jersey, December 2009.

try progressive and potentially cost-saving health care strategies at the workplace. "This is a step in that process of going out and trying to get people engaged in taking care of themselves," he contends. However, he says these clinics are viable only for larger employers with more than 100 workers.

BCBSTN spokesperson Mary Thompson says CHS partnered with CVS Caremark Corp. to offer a full-service health center, including pharmacy services, at the company's new Chattanooga headquarters. CHS's HybridHealth clinic began serving BCBSTN's 4,500 employees on June 29. "The feedback to date has been very positive," Thompson says. But she adds that the clinic and pharmacy are new offerings, and no formal surveys or studies related to them have been conducted at this point. The center is available only to BCBSTN employees, she says.

Employees receive discounts to use both the worksite clinic and the pharmacy, Thompson explains. Employees using the clinic have a reduced copay for services "or a discount for charges incurred by those with a HDHP," and the pharmacy offers discounts on generic copays and extended-day supplies. She adds that employees may fill prescriptions for dependents at the pharmacy.

Services available at the clinic include treatment for common illnesses, immunizations, vaccinations, allergy shots, medical exams, lab tests, consultations and condition management, discounted health screenings, and discounted generic prescriptions and over-the-counter medications.

Stuart Clark, CHS's commercial business operations executive vice president, contends that having an on-site clinic "translates into higher participation rates by employees, a healthier and more stable workforce and significant cost savings for employers" (see story, this page).

continued

Tenn. Blues' Partner Says Don't Expect Quick ROI From Clinics

When describing return on investment for on-site health clinics, "There has been a trend in our industry — a shortsighted and unfortunate trend — to hype or 'pump up' the ROI and therefore present shortened capital recovery periods," warns Stuart Clark, executive vice president of commercial business operations at on-site health clinic vendor Comprehensive Health Services, Inc. (CHS). In June, CHS opened a clinic offering primary care and pharmacy services (through a partnership with CVS Caremark Corp.) at BlueCross BlueShield of Tennessee's headquarters (see story, p. 1).

In an interview with *The AIS Report*, Clark says that hyping the ROI potential of on-site health centers has become more common as vendors unfamiliar with "the realities of the savings drivers and payback period" enter the market. He explains that "first-year capital costs and other startup costs are usually not recovered until well into year 2, and many times are not recovered until year 3."

In year 3 and later, savings attributable to on-site clinics can be significant, Clark says. He cautions that prior to establishing an on-site clinic, certain analyses related to which programs will be most beneficial for the target population must be made. "The only way to determine what programs are most appropriate for that population is to use validated analytical methods that take into account geographic location, industry type, population health status, benefit design implications and local medical community dynamics," he contends.

CHS is "seeing a recent and significant interest by health plans to partner with on-site providers to deliver these services where it is feasible," according to Clark.

Clark says CHS's tracking of clinical and financial outcomes compares "the employer's population that uses the health center versus those who do not." He contends that the comparison of the two groups "often tell a dramatic story and justify the cost of the program." Health insurers, he says, often do not track that information and therefore "cannot prove financial sustainability of the on-site program." He adds that large employers require economic feasibility metrics of an on-site program.

"It is rare to have a facility launch cost more than $1 million," unless the center will serve more 6,000 to 7,000 people, according to Clark. He says the costs of building a new health care center generally range from $250,000 to $500,000. He adds that other startup costs for on-site clinics include recruiting, training and information systems.

E-mail Gwyn Walcoff for Clark at gwyn@keenanpr.com.

Horizon's clinics are managed by I-trax, Inc. subsidiary CHD Meridian Healthcare, and are staffed by a registered nurse or a nurse practitioner. Horizon spokesperson Daniel Emmer says the clinics serve about 5,000 employees, but not their dependents. According to Emmer, employees visiting the health centers are not charged copays, and "a first dose of several prescription drugs are provided by the clinics." In addition, the Newark clinic has a pharmacy, and nurse practitioners at its Newark and Wall locations are on hand to write prescriptions.

Call Perri at (717) 302-4243, Thompson at (423) 535-7694, Emmer at (973) 466-4805 or Gwen Walcoff for Clark at (410) 570-0392. ✧

More Than 20% of Mass. Blues HMO Providers Agreed to AQC Contract

With the Nov. 27 addition of Caritas Christi Health Care System, more than 20% of the providers in Blue Cross and Blue Shield of Massachusetts' (BCBSMA) HMO network have signed its alternative quality contract (AQC) since the beginning of 2009. It's too early to tell how much the AQC will help control rising medical costs while providing adequate payments to providers, since they are in only the first phase of transitioning from traditional fee-for-service (FFS) payments to the AQC and its global payment system (GPS). But at least one provider group says the new payment system likely will be adequate.

BCBSMA spokesperson Jenna McPhee contends the AQC "is the most promising way to slow the rate of growth of health care spending and to improve the quality of care provided to our members." The AQC was developed in an attempt to reduce the impact of increased medical costs, which continue to rise about 10% annually, according to BCBSMA. The insurer has contended that AQC will help bring annual medical cost increases in line with the consumer inflation rate of 3% to 4%. The state of Massachusetts and other Blues plans have expressed significant interest in the AQC, according to McPhee. In fact, Massachusetts may use the model to develop a GPS for the state *(The AIS Report 8/09, p. 1)*.

Under the AQC, providers receive an annual global payment for each patient, adjusted for age, sex and health status. The payment increases annually in line with medical inflation, and providers receive a pay-for-performance (P4P) bonus for achieving nationally recognized measures of quality, effectiveness and patient experience. The performance incentive can be as much as 10% of the provider's global payment.

The insurer said Caritas is the largest community-based hospital network in New England "and brings the highest number of physicians from any organization into the AQC to date." The five-year contract with Caritas will add 1,100 providers serving roughly 60,000 enrollees to the AQC, according to BCBSMA. The contract is estimated to be worth $1.5 billion.

AQC Contracts Exceed 2009 Expectations

"Provider adoption has occurred at a much faster rate than expected," says McPhee. In August, the plan only had about 17% of its HMO network signed to the AQC *(The AIS Report 8/09, p. 1)*. About 3,400 providers who serve 270,000 HMO members are now participating in the AQC. That's about 25% of BCBSMA's total HMO membership, she explains. She adds that "we are continuing discussions with providers about joining the AQC and expect the momentum to continue in 2010."

The AQC is currently limited to provider groups that serve at least 10,000 BCBSMA HMO members and meet the performance benchmarks necessary to participate, McPhee explains. Most participating practices are small practices that have organized into groups for contracting purposes, she states. She adds that the plan is "looking to expand it to our PPO in the future."

Provider groups that signed up for the AQC this year are now transitioning to the GPS. New England Quality Care Alliance (NEQCA) CEO Jeff Lasker tells *The AIS Report* that the interim payment mechanism is FFS-based, with a budgeted target for the year. "We don't have final data but it looks good. It looks like we should be on our budgeted target, if not better" this year, he says. "We'll have a better idea in April after all the claims [for 2009] are submitted," he asserts. However, he admits that unplanned expenses like the H1N1 "swine flu" could affect the group's budget.

Of the payment amounts contracted, Lasker says, "I wouldn't say they're generous, but they're probably adequate." He adds that "we're optimistic that we can do OK, at least in the early years" under the AQC. Under the GPS, provider payments will still be made on an FFS basis, he explains. But if the provider group exceeds budgeted costs related to BCBSMA HMO patients in a year, it will owe BCBSMA the difference. If the provider group spends less than expected, then BCBSMA will pay the difference in a reconciliation payment. The first GPS reconciliation will occur in September 2010, he says. NEQCA, which now serves about 45,000 BCBSMA HMO members, was one of the first provider groups to agree to the AQC *(The AIS Report 2/09, p. 6)*. A new affiliation with Highlands Healthcare Associates IPA that starts Jan. 1 will add

45,000 BCBSMA HMO members to NEQCA's patient rosters and the AQC, according to Lasker.

As NEQCA prepares to fully implement the AQC, its first efforts have been on meeting the performance quality measures, Lasker says. Providers "pretty actively have been trying to get patients in for certain screenings and tests" related to meeting the AQC's performance requirements. BCBSMA has helped the group identify which patients need additional services to help NEQCA meet its targets, Lasker explains. He says many of the 32 quality measures included in the AQC are process measures like cancer screenings, outcomes measures, treatment results and patient experience measures.

McPhee says participating provider groups also "are currently working on managing pharmacy expenses by working with patients to use lower-cost, clinically equivalent medications, avoiding unnecessary emergency-room visits, and increasing patient education for patients with chronic illness which can result in fewer hospitalizations." And she contends that all are examples of how the AQC will help to reduce costs.

Lasker says there are still some issues to be worked out with the AQC, particularly that "various administrative services need to become adaptable to the GPS." For instance, he thinks that preferred provider radiology services at NEQCA should not be subject to prior authorization. That and the referral management system are some areas of the GPS that need more flexibility, he contends.

AQC-contracted provider groups thus far include Mount Auburn Hospital and the affiliated Mount Auburn Cambridge Independent Practice Association; Hampden County Physician Associates, LLC; Tufts Medical Center and its affiliated NEQCA; Signature Healthcare Corp., including Brockton Hospital; Lowell General Hospital and the affiliated Lowell General Physician Hospital Organization; South Shore Hospital and the affiliated South Shore Physician Hospital Organization; Atrius Health; and Caritas Christi Health Care.

Caritas Christi did not respond to requests for comment.

E-mail McPhee at Jenna.McPhee@bcbsma.com or Julie Jetty of Tufts at jjette@tuftsmedicalcenter.org. ✧

Anti-Health Reform Efforts by BCBSA, N.C. Blues Hit Roadblocks

The Blue Cross and Blue Shield Association (BCBSA) and Blue Cross Blue Shield of North Carolina (BCBSNC) have come under fire for separate efforts to oppose health reform legislation. BCBSA temporarily took down its advocacy Web site, Get Health Reform Right, amid allegations that the page incentivized players of online games to send letters to their elected

officials opposing health reform bills. Meanwhile, BCBSNC was criticized by state elected officials for advocacy efforts that include automated phone calls to members telling them to oppose health reform legislation.

As the Get Health Reform Right ads came to light on Dec. 9, BCBSA responded by temporarily taking down the site. It has since restored the site, with a notice stating: "All participation in Get Health Reform Right is strictly voluntary. Get Health Reform Right does not provide any form of compensation to individuals who take action through our website. The messages you send to Congress through this website reflect your personal views and opinions."

The Get Health Reform Right Coalition includes, among others, America's Health Insurance Plans, the Healthcare Leadership Council, the National Association of Health Underwriters, the National Association of Insurance and Financial Advisors and the National Retail Association.

The ads, which appeared on FaceBook, incentivized players of online games with "virtual currency," according to Gawker.com, which first reported the ads. Players can get virtual currency in the form of reward points by accepting third-party offers, such as those from Netflix. A company serves as a middleman that brings together the advertiser, the game maker and the users. Dan Porter, CEO of OMGPOP, an online gaming community Web site, provided the ads to a Gawker.com reporter.

According to *The Huffington Post*, one of the ads asked viewers if they want to "tell Congress to get health reform right!" If they responded "yes," then they were taken to the coalition site and its automated letter-writing campaign that expresses opposition to a government-run insurance plan.

BCBSA released two statements related to the incident. The second, posted on Dec. 12, states, "The coalition members of Get Health Reform Right have recently learned that unauthorized ads claiming to be from the coalition appeared on certain social networks in an effort to incentivize individuals to contact their elected officials." The association says the coalition "does not pay or incentivize people in any way to communicate to Congress their opposition to government-run healthcare. Under the terms of the contract with the advertising network, the use of incentivized ads is strictly prohibited." BCSBA contracted with Web Clients, LLC

William Jews Keeps Up the Fight for his $18 Million Severance Package

Former CareFirst BlueCross BlueShield CEO William Jews may get his full severance package from the plan, despite continued efforts by the Maryland Insurance Administration (MIA) to block it. A Maryland Circuit Court judge rebuffed MIA's most recent attempt to deny Jews the $17.6 million severance package promised by CareFirst. This battle has been going on since CareFirst terminated Jews in November 2006, following his failed attempt to take the company public and the dissolution of CareFirst's partnership with Blue Cross and Blue Shield of Delaware *(The AIS Report 12/06, p. 10)*.

On July 14, 2008, Maryland Insurance Commissioner Ralph Tyler (D) ordered CareFirst to cut Jews' compensation package in half, to nearly $9 million. After a four-day hearing, he ruled that CareFirst's severance package violated a 2003 Maryland law limiting executive compensation at CareFirst "to that which is 'fair and reasonable…for work actually performed for the benefit of' CareFirst." The law was passed following Jews' failed attempt to convert CareFirst to a for-profit entity and sell it to WellPoint, Inc. for $1.4 billion. The deal would have included up to $39 million in bonuses for Jews.

Maryland Circuit Court Judge Timothy Martin, in his Nov. 10 opinion, wrote that "the commissioner blurred his role and overstepped his authority in his scope of inquiry and in the basis for his reasons." While Martin admitted that the severance agreement was "enormous," he asserted that "the amount alone cannot and should not be the sole fact which is determinative of this case." Despite the 2003 law, Martin said, Commissioner Tyler's actions were not legislatively mandated.

"We feel that Mr. Jews now has been given a fair hearing, and it has resulted in a very fair decision," Jews' attorney, Andrew Graham, told *The Baltimore Sun*.

MIA now has appealed the ruling to Maryland's Court of Special Appeals, says agency spokesperson, Karen Barrow. At this point, she says, MIA is waiting for the court's decision before deciding whether to take further action against Jews' severance pay.

Call Barrow at (410) 468-2007 or Graham's office at (410) 752-6030.

to advertise its Get Health Reform Right site. Web Clients spokesperson John Ardis said the company did not place any ads incentivizing viewers.

As of Dec. 14, BCBSA was still trying to figure out who was responsible for the Web advertisements, spokesperson Jeff Smokler tells *The AIS Report*. He adds that an outside legal team is looking into who placed the advertisements and what legal actions can be taken.

BCBSNC Lobbying Efforts Draw Lawmakers' Ire

A group of 20 North Carolina legislators sent a letter to North Carolina Insurance Commissioner Wayne Goodwin (D) and Attorney General Roy Cooper (D) asking them to investigate BCBSNC's lobbying efforts against federal health reform. In the Nov. 26 letter, the 19 Democrats and one Republican asserted that BCBSNC, in trying to "maintain its dominance and control of the state health care market,…spent thousands of dollars paid by policy holders asking them to mail a pre-printed postcard to Senator Kay Hagan (D) urging her to oppose health care reform and has engaged in automatic robo-calls urging policy holders to act on the mailings." They maintained that the plan is "engaging in a blatant political campaign utilizing the premiums paid by their customers.…Even if there is no apparent violation of existing statutes, we think this is bad public policy that deserves further scrutiny."

The legislators expressed concern that BCBSNC used a prior business relationship exemption to violate the intent of the Do Not Call Registry to engage in political advocacy. They asserted that "we also believe Blue Cross Blue Shield has potentially broken the automatic dialing statute by not providing the contact information of the unsolicited caller in this recorded message."

BCBSNC spokesperson Lew Borman said the company received an inquiry from Cooper's office and is cooperating. But he asserted that BCBSNC thinks it is within its rights to speak out on the issue.

"We have said, from the beginning, that we believe it's important that North Carolinians understand the impact a government-run health plan and increased taxes could have on their health care choice. We believe we have a right to participate in the debate."

The insurer came under scrutiny earlier this year for its advocacy efforts when a planned advertising campaign opposing a government-run plan was leaked to the press *(The AIS Report 6/09, p. 8)*.

Visit www.gethealthreformright.org. Call Smokler at (202) 626-4818 or Borman at (919) 765-3005. ✧

High Medical Costs Drive Down Hawaii, Mass. Blues' Earnings

Third-quarter 2009 results for two not-for-profit Blues plans were significantly lower than for the same period in 2008 because of higher-than-expected medical costs. Hawaii Medical Service Association (HMSA) and Blue Cross and Blue Shield of Massachusetts (BCBSMA) are the only not-for-profit Blues plans that have publicly reported third-quarter 2009 results thus far. At least one analyst doesn't expect things to improve for not-for-profit Blues plans for the rest of the year.

HMSA reported a loss of $23 million for the most recent quarter, driven by a 98.3% medical cost ratio (MCR). That's down from net income of $5.1 million for the previous year's quarter. BCBSMA saw its income fall 70% from $57.6 million for last year's third quarter to $17.1 million for the most recent period. Not-for-profit plans are not required to submit specific quarterly or annual statements to the Securities and Exchange Commission, and therefore the available data for the specific plans varies widely.

HMSA said its total underwriting loss was $32 million, but investment income of $7.9 million helped to offset it. Of the $411.1 million the plan collected in third-quarter 2009 revenue, benefit expenses accounted for $403.9 million. For the previous year's quarter, revenue was $389.8 million and benefit expenses were $371.7 million.

Steve Van Ribbink, HMSA's executive vice president and chief financial officer, explained that the high MCR "does not leave enough to cover operating costs without using investment income and funds from the HMSA reserve."

The plan's reserve levels fell over $100 million to $381.4 million for the most recent quarter, from $489 million for the third quarter of 2008. At the same time, membership saw a smaller drop to 682,383 members as of Sept. 30, 2009, from 697,574 on the same date in 2008.

BCBSMA's net income for the third quarter included $8 million in investment income, more than double the $3.5 million the plan recorded for the same period in 2008. Although the insurer recorded positive results for the third quarter, BCBSMA said it had experienced a $53.2 million net loss for the first nine months of 2009.

Allen Maltz, BCBSMA's chief financial officer, said that "a rise in the utilization of medical care associated with the flu and elective procedures, and high claims costs associated with newly insured individuals have all played a role in our results to date." He added that medical costs were negatively impacted by

an extended flu season and H1N1, which has resulted in increased office visits, use of antibiotics and other prescriptions for flu-like symptoms, lab tests and chest X-rays.

Membership at BCBSMA fell slightly to 3 million on Sept. 30 from 3.1 million on the same date a year ago.

Analyst Predicts More Underwriting Losses

In Oppenheimer & Co. Inc.'s Nov. 30 not-for-profit Blues plan financial update, equities analyst Carl McDonald wrote that "nearly half the Blues lost money on an underwriting basis in the first half of 2009. Things aren't likely to get better in the second half of the year, either." He said that Blues plans "will be impacted by the same cost pressure hurting commercial plans right now, as well as the normal seasonality of high-deductible products." But he added that the Blues won't benefit from improved performance in Medicare products in the third quarter as commercial health plans have, because they don't have the same exposure.

According to McDonald, the average underwriting margin for not-for-profit Blues plans was only 0.6% in the first half of the year, down 60 basis points from the 1.2% underwriting margin reported in 2008. He said the change was driven by an average 90-basis-point deterioration in MCR, to 87.5%. Despite the underwriting losses, Blues plans have seen a big improvement in investment income, which reached $889 million for the first half of 2009, compared with the $887 million they reported for full-year 2008, McDonald said.

At the same time, Oppenheimer research showed, Blues plans' average risk-based capital (RBC) likely rose to 708% at the end of this year's second quarter, from 696% in RBC at the end of 2008. That's still a far cry from the 783% in RBC plans had at the end of 2007. He maintained that the current RBC levels are at their lowest levels since 2004. According to McDonald, "the combination of lower net income, investment write-offs, and higher premiums has resulted in a significant decline in the risk-based capital of the non-profit Blues over the past year and a half."

Call HMSA spokesperson Laura Lott at (808) 952-7566, BCBSMA spokesperson Tara Murray at (617) 246-4851 or McDonald at (212) 667-6558. ✧

Not-For-Profit Blues Plans May Embrace For-Profit Subsidiaries

Don't expect more not-for-profit Blues plans to attempt to convert to for-profit status anytime soon, say industry experts. However, not-for-profit Blues plans increasingly may operate like for-profit plans: They will buy or start for-profit subsidiaries to expand into new markets and maximize payback to the parent company while retaining their not-for-profit status.

Tom Wilson, president of executive consulting firm The Wilson Group, tells *The AIS Report* that "I don't think there's going to be a movement toward publicly traded conversions." But he contends that not-for-profit plans will likely adopt more complex organizations where a not-for-profit Blues plan holds a for-profit subsidiary. He says not-for-profits and for-profit insurers alike are under intense regulatory scrutiny, but not-for-profits don't have to report as much about their for-profit subsidiaries. He also asserts that having for-profit subsidiaries allows the plans to capitalize on both their "mission and margin."

Joseph Marinucci, a director in the financial institutions ratings group at Standard & Poor's, tells *The AIS Report*, "I think [not-for-profit Blues plans] always acted like for-profit companies. They are businesses." He explains that the not-for-profit status allows them to be tax-exempt in the marketplace. That and the "issue of being non-investor-owned perhaps affects some of their strategies in the marketplace. But for the most part their competition in large extent is for-profit" — and Blues plans have to compete with that.

John Mancuso, managing director of The Bostonian Group, says that Blues plans will "create a for-profit management company subsidiary, then lease management services back to the nonprofit subsidiaries of the broader organization and often to organizations outside the network."

Marinucci says that Blues plans have used for-profit subsidiaries to conduct business because of the flexibility such arrangements allow. The units can allow them to form joint ventures with other Blues plans, he explains. Prime Therapeutics, the pharmacy

Third-Quarter 2009 Results for Two Not-For-Profit Blues Plans

	Blue Cross and Blue Shield of Massachusetts		Hawaii Medical Services Association	
	2009	2008	2009	2008
Net Income (Loss)	$17.1 million	$29.3 million	($23 million)	$5.1 million
Investment Income	$8.0 million	$3.0 million	$7.9 million	$23 million
Total Membership (as of Sept. 30)	3.0 million	3.1 million	682,383	697,574

SOURCE: Company financial statements, complied by Atlantic Information Services, Inc.

benefits management company owned by 11 Blues plans, is an example of such a venture.

For-profit subsidiaries, Marinucci says, also could allow a plan to move into a new market or enhance its product line. If a plan is structured as a not-for-profit HMO and wants to enter the PPO market, implement a blended product structure or offer life insurance, it might make sense to open or purchase a for-profit subsidiary, he says. Such a subsidiary would allow the plan to extend its product segments. What's more, underwriting rules could differ between the PPO market and HMO market, making a for-profit subsidiary the best choice.

Blues plans "are kind of like fiefdoms," says Marinucci. He says that most often, "a not-for-profit Blues plan will start up or buy a for-profit subsidiary to buy into a new part of the market." However, when Blues plans create a non-Blues-branded subsidiary to compete in a market occupied by a fellow Blues plan, they typically don't work out, he says.

Looking forward, Marinucci says, the pace of Blues plans purchasing or starting for-profit subsidiaries is likely to remain consistent with historical trends. He observes that "there might be potential for deal-making going forward." Some companies, according to Marinucci, have placed a lot of attention on leveraging their for-profit subsidiaries. He also predicts plans may buy unregulated "companies in the marketplace to enhance value." Such companies could include payment processors or units that serve similar marketplaces, which offer some diversity and core competency enhancements, he says.

continued

HEALTH REFORM BRIEFS

◆ **The American Legislative Exchange Council (ALEC) is supporting state-level constitutional amendments that could subvert national health reform efforts.** ALEC, a conservative advocacy group, said Nov. 23 that South Carolina is the 24th state to submit a state constitutional amendment modeled after ALEC's Freedom of Choice in Health Care model act. The bill "preserves the rights of individuals to pay directly for medical care…and prohibits any individual from being penalized for not purchasing government-defined insurance," according to ALEC. Joan Gardner, executive director of state services at the Blue Cross and Blue Shield Association (BCBSA), is a member of the ALEC Health and Human Services task force that produced the model legislation. Other states that have or plan to intoduce such legislation include Alabama, Alaska, Arizona, Florida, Georgia, Indiana, Kansas, Louisiana, Michigan, Minnesota, Missouri, Mississippi, Montana, New Hampshire, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Utah, West Virginia and Wyoming. Call ALEC spokesperson Jorge Amselle (202) 742-8536.

◆ **BCBSA commissioned a Dec. 3 report produced by Oliver Wyman, Inc., which estimated that average annual medical claims would be 54% higher five years after implementation of the Senate Patient Protection and Affordable Care Act (H.R. 3590)**. The figure, according to the report, excluded the impact of medical inflation. That would translate into average premiums of $4,561 for single coverage and $9,669 for family coverage in today's dollars — representing premium increases of $1,576 and $3,341, respectively. Jason Grau, a principal at Oliver Wyman, Inc., contended that the individual market today "is quite a bit healthier" than is the overall insurance market. He predicted the Senate bill would lead to a less healthy nongroup market as a disproportionate number of older and sicker individuals enroll in coverage while younger and healthier people choose to remain uninsured. Call BCBSA spokesperson Jeff Smokler at (202) 626-4818.

◆ **Nearly 20% of people who have coverage through an employer would be affected by a tax on so-called "Cadillac" insurance policies** (e.g., those that exceed $8,500 for individuals and $23,000 for families), according to a report released Nov. 30 by the Congressional Budget Office. While CBO estimates that most people will switch to lower-cost coverage to avoid the penalty, those who opt to keep their high-premium policies would also pay a higher premium than under current law, according to CBO. Sixty-three percent of 465 employers surveyed in November said they would reduce benefits rather than pay the proposed 40% excise tax on benefits that are deemed too generous, according to results of a survey released Dec. 3 by consulting firm Mercer, LLC. To see a copy of the CBO report, visit www.cbo.gov/doc.cfm?index=10781.

Operating a not-for-profit plan with a for-profit subsidiary could facilitate conversion to for-profit status in the long term, according to Marinucci. "You could eventually use those downstream for-profit subsidiaries to effect conversion."

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N.C. Providers Are Upset by Contract Change Proposed by N.C. Blues

After providers complained, Blue Cross Blue Shield of North Carolina (BCBSNC) withdrew a proposed addendum to its provider contracts that would have allowed the plan to change the contract without significant advance notice. The addendum also would have made contract changes serve as termination if the provider did not agree. A physician group contends the clause is illegal — but the Blues plan could still reintroduce a similar provision. Spokesperson Lew Borman says the insurer has amended the contract.

The North Carolina Medical Society (NCMS) said it has not yet seen a new addendum. It and other provider organizations sent a letter to North Carolina Insurance Commissioner Wayne Goodwin (D) in late October requesting he halt the contract changes. All parties were to meet at the end of November to discuss the proposed changes but have not yet met.

The medical society contended that the changes were being made before new state legislation, S.B. 877, takes effect on Jan. 1, 2010. That law protects providers from "arbitrary changes to contracts without consent from doctors," according to the letter sent to Goodwin.

In the letter, NCMS contended the addendum would allow the plan to change provider contracts without giving 90 days of notice or allowing providers the ability to object to such changes. This would allow the plan to make dramatic reductions to reimbursements without adequate notification, the group said. NCMS said it understands that the plan can end a contract if a provider objects, but argued that establishing "immediate notice of termination places a chilling effect on the providers' ability to express his/her concern about a contract amendment."

An AMA spokesperson contends that the *Love et al. v. Blue Cross and Blue Shield Association et al.* settlement requires Blues plans to provide a 90-day notice of contract changes. "There does seem to be an issue that [BCBSNC] hasn't complied with the settlement. There have been no complaints to AMA as of yet, but they may be brewing in the background," he says.

NCMS spokesperson Mike Edwards says NCMS has not seen an amended contract. The insurance commissioner's office says there are still some scheduling issues to be worked out before a meeting can occur.

BCBSNC says nothing has changed so far. However, it told *American Medical News* that the addendum was in full compliance with its negotiated provider agreement and is compliant with most of the new legal provisions. The insurer added that it amended its contracts to ensure compliance with the new law.

Call Edwards at (800) 722-1350, ext. 105 or BCBSNC spokesperson Lew Borman at (919) 765-3005. ✧

Exemption Repeal May Do Little

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products by, for example, allowing property and casualty carriers to develop joint underwriting guidelines or create standardized insurance products.

Kraft has helped structure many joint ventures for both Blues plans and other insurers. For example, he has helped set up alliances to bid on federal procurement programs such as Medicare, to promote Web portals and other Internet technology, to jointly own and operate ancillary products and to offer services internationally.

"Blues plans have really maintained their own distinct operations, and we have really sought to insulate them from what antitrust regulators call the 'spillover effect,'" Kraft says, when joint-venture partners gather to "talk about things they shouldn't talk about."

In setting up such deals, "the provisions of the McCarran-Ferguson Act have largely been irrelevant," he says, and "the repeal of the McCarran-Ferguson Act would largely not impact these types of joint ventures." Instead, Kraft explains, the alliances are governed by "the Federal Trade Commission or Department of Justice guidelines — whether merger guidelines or specific antitrust guidelines — for collaboration among competitors." And since Blues plans "may or may not be competitors among themselves,… for safety's sake, we use the guidelines as if they were."

Some critics have pointed to the use of the Ingenix database of "usual, customary and reasonable" (UCR) charges for paying providers as an example of antitrust activity by health insurers. Excellus BlueCross BlueShield, HealthNow New York, Inc. and WellPoint, Inc. all reached settlements with New York Attorney General Andrew Cuomo (D) over the UCR database sold by UnitedHealth Group subsidiary Ingenix. The insurers agreed to stop using the database to set out-of-network rates, and pledged to reprocess some

claims and contribute startup funds to establish a new database *(The AIS Report 3/09, p. 1)*.

J. Robert Hunter, director of insurance at the Consumer Federation of America and a former Texas insurance commissioner, cited UCR in his Oct. 14 testimony calling for repeal of the antitrust exemption before the Senate Judiciary Committee, which Leahy chairs. He contended that use of the UCR database demonstrates that "collusive activity goes well beyond price fixing and deeply into other aspects of insurance, such as claims settlement practices."

But Kraft says UCR does not qualify as a joint venture. The Ingenix database is a service that other insurers subscribe to — "but it's not necessarily something they have jointly developed and controlled," he explains.

John Miles, a principal at the Washington, D.C., law firm Ober Kaler, contends that the exemption has had "a very limited effect" on health insurers — and says repeal also will have little impact. He adds that some congressmen who support repeal "have supplied some of the most misleading information I've ever heard," citing as an example Leahy's claim that repeal would lead to lower health costs. "If there were a history of…say, CIGNA [Corp.], Aetna [Inc.] and United[Health Group] getting together and fixing premium rates [or] raising premium rates together,…repealing the exemption would be important," he says. "But there's no history of that."

Repeal Could Spur Onslaught of Lawsuits

One effect of the repeal could be an onslaught of lawsuits against health insurers, warns Stephen Paul Mahinka, a Washington, D.C.-based partner at law firm Morgan, Lewis & Bockius LLP. "The concern over the loss of exemption is not that we won't be able to do something we used to be doing," he explains. "It's that we'll be exposed to a whole lot of frivolous lawsuits." The financial exposure from such lawsuits, no matter how poorly founded, "leads to a tremendous pressure on people to settle…even if they think ultimately they wouldn't be found to be liable." Mahinka calls such an outcome "legalized extortion."

Kraft agrees that "there's always the risk that people will toss out the repeal of the McCarran-Ferguson Act as, in and of itself, indicating that the insurance companies were cloaked with this protection. And once the cloak was taken off, anything they did together is subject to attack." But, he contends, "that type of argument shouldn't survive very long."

Some critics of the health insurance industry contend that a repeal of the antitrust exemption would allow for much stricter enforcement of antitrust laws, since federal regulators have more resources than do state officials. In calling for repeal in a recent paper for the Center for American Progress, antitrust attorney David Balto pointed to "high levels of concentration in practically every market to the point where there are only one or two dominant insurers in many states." Balto, a senior fellow at the center, contended that the McCarran-Ferguson exemption leaves antitrust and consumer-protection enforcement to the states, which frequently lack sufficient resources to rein in powerful national insurers.

State Regulators Can Be Tough

Some Blues plans may be surprised to hear about the weak state insurance regulatory system, given the spate of proposed mergers, acquisitions and for-profit conversions that have been disallowed by state officials. They include Anthem, Inc.'s proposed acquisition of Blue Cross Blue Shield of Kansas, rejected in 2003 by then-state Insurance Commissioner and now HHS Sec. Kathleen Sebelius; WellPoint, Inc.'s proposed purchase of CareFirst, Inc., disallowed in 2003; and Premera Blue Cross' proposed conversion, denied in 2007.

Balto testified at a U.S. Senate Judiciary Subcommittee hearing in 2008 against the proposed merger between Highmark Inc. and Independence Blue Cross *(The AIS Report 2/09, p. 1)*.

Pennsylvania Insurance Commissioner Joel Ario contends that state regulators can be even tougher than federal agencies. Speaking to *The AIS Report*'s sister publication *Health Plan Week*, Ario says that although the Department of Justice didn't determine any competitive problems with the proposed Highmark/Independence merger, his office said the merged entity would be required to operate under either the Blue Cross or Blue Shield trademark. Agreeing to drop one of the trademarks would have allowed another Blues plan operator, such as WellPoint, Inc., to enter the market. The two companies dropped the proposed merger in January 2009 rather than agree to such a deal.

"We were more aggressive than the federal agencies…and states are often in a better position to regulate" local health plans, he tells *HPW*. "I don't think [repealing the exemption] will do much to change the status quo."

For more information, contact Hunter at loonlakeme@aol.com, Mahinka at smahinka@morganlewis.com, Miles at jjmiles@ober.com or Rosanne Placey for Ario at rplacey@state.pa.us. ✧

NEWS BRIEFS

◆ **Independence Blue Cross said it will lay off about 200 people in the next several months.** Since June, the plan has announced 855 layoffs. "As of October, we have an operating income and net loss, and we do not expect to make the annual operating margin goal," said Independence CEO Joseph Frick in an annual report distributed to employees Dec. 10. He attributed the loss to higher-than-expected medical costs and the recession. Spokesperson Liz Williams said employees would not get bonuses in 2009 because the plan's operating margin target was not met. Contact Williams at liz.williams@ibx.com.

◆ **Small businesses buying coverage from Blue Cross and Blue Shield of Massachusetts for 2010 may see their rates jump from 20% to 45%**. "We just got a batch of renewals for BCBS for January, and they are ugly," said Jim Edholm, president of Business Benefits Insurance. He contended that the plan "has had a very long run of success with rates, and this is just the inevitable catch-up." However, he says some new tiered products the plan is rolling out will likely be very competitive. View Edholm's blog at blog.group-insurance-guide.com.

◆ **Ken Ross, commissioner of Michigan's Office of Financial and Insurance Regulation, on Dec. 7 approved dramatically reduced Medigap rate increases for Blue Cross Blue Shield of Michigan (BCBSM).** Attorney General Mike Cox (R), who had challenged BCBSM's proposed 36.7% rate increase *(The AIS Report 6/09, p. 10)*, praised the final ruling, which limited rate increases to 3.8%. Cox's office said the reduced rate increase would save about 200,000 Michigan seniors $86 million in the first year alone. He had contended that BCBSM shouldn't be able to raise "rates because it was failing to meet its statutory obligation to subsidize seniors' insurance costs for Medigap policies." Ross, in his ruling, said BCBSM must subsidize Medigap rates by a full $182 million. Call OFIR spokesperson Jason Moon at (517) 335-1700 or Cox spokesperson Matt Frendewey at (517) 373-8060.

◆ **The Medical Association of the State of Alabama and more than 20 specialty physician organizations and physician practices filed formal complaints against Blue Cross and Blue Shield of Alabama,** alleging that the insurer has not followed the terms of a class-action litigation settlement. The complaint alleges that the Alabama Blues plan is not complying with the *Love et al. v. Blue Cross and Blue Shield Association et al*. settlement in a number of ways. Among them, it has failed to give providers sufficient notice of pending substantial fee-schedule changes it had planned, it never formed a specialty physicians' advisory committee as required by the settlement agreement and has not paid for certain claims, according to *American Medical News*. Call Alabama Blues spokesperson Koko Mackin at (205) 220-2713.

◆ **In California's first PPO report card, issued by Insurance Commissioner Steve Poizner on Nov. 17, no PPO achieved a four-star rating.** Anthem Blue Cross, a WellPoint, Inc. subsidiary, received only two stars, falling behind Aetna Inc., CIGNA Corp.'s CIGNA HealthCare of California and Health Net of California. The state's Department of Managed Health Care already provides a report card on HMOs, but the state lacked any such tool for PPO-based plans, according to the commissioner's office. Blue Shield of California was unable to participate this year because of "technical issues," the department said, adding that the insurer expects to participate next year. Rating criteria included asthma care, cancer screenings, diabetes treatment and pediatric care. Call Poizner's press office at (916) 492-3566.

◆ **PEOPLE ON THE MOVE:** Blue Cross Blue Shield of Michigan said that **Jeanne Carlson**, CEO of Blue Care Network, will retire at the end of February 2010. The company will announce her successor before she leaves next year.…WellPoint, Inc. subsidiary Empire BlueCross BlueShield appointed three new executives. **Patrick O'Keefe** joined Empire as vice president and general manager for its downstate small group and middle markets; **Tom Canty** was promoted to vice president and general manager of labor, municipal and jumbo accounts; and **Ethel Graber** was named vice president and general manager of its upstate and mid-Hudson accounts.…**Lauren O'Brien** joined Independence Blue Cross as its chief accounting officer. She previously was the chief financial officer and chief risk officer at Blue Cross Blue Shield of Delaware.

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