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MUTUALIZATION OF BLUE CROSS AND BLUE SHIELD OF MICHIGAN: HEALTHY FOR MICHIGAN?

by Daniel P. Webber

Introduction

Blue Cross and Blue Shield of Michigan (BCBSM) wants to become a mutual insurance company. Michigan's attorney general likes BCBSM just as it is--a strictly regulated health care insurer. The push and pull over the merits of mutualization involves sweeping financial implications for Michigan's insurance industry, health care providers, and consumers.

BCBSM contends that restrictive state regulations together with increasing competition in the health care industry are driving "the Blues" toward financial disaster. It claims that private insurance companies have an undue advantage because they are free to diversify into business ventures and more profitable insurance lines. Becoming a mutual insurer would place BCBSM under the same insurance code regulations that govern its competitors and, according to the Blues, allow it to offer the employee benefit and investment plans that its members desire.

Michigan Attorney General Frank Kelley strongly opposes mutualization, charging that any financial problems the Blues may have stem from poor management, not restrictive regulation. He maintains that BCBSM was created solely to make health care services available and affordable to everyone, not to offer diversified types of employee benefit and investment plans. Under current regulations, BCBSM cannot deny health care coverage to an applicant. As a mutual insurance company, however, it could deny coverage to anyone except those individuals applying for Medicare supplement insurance.

The question of BCBSM's legal status can only be decided by the state legislature and the governor. To win mutualization, the current law regulating BCBSM, Public Act 350 of 1980, must be repealed or amended extensively. The legislature and governor will agree to set the Blues free if they are convinced that mutualization will (1) improve its financial condition, (2) do so without jeopardizing the health or financial well-being of its members, (3) allow for undiminished access to health care for consumers in general and older people in particular, (4) result in no significant increase in health care costs, and (5) create no BCBSM monopoly of the insurance services industry in the state.

History

During the 1930s, very few commercial insurance companies in America offered health care insurance. Most companies felt that they did not have sufficient actuarial information to risk offering health care coverage. Because the Great Depression left many people unable to afford health care, many hospitals and other health care providers could not collect payment for services and found themselves in serious financial trouble.

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To ensure that more hospital bills would be paid and that more individuals would have access to affordable hospitalization, the Michigan Hospital Association (MHA) established in 1938 the Michigan Society for Group Hospitalization, which later became Michigan Blue Cross. The society, modeled on similar organizations that had been established in other states, offered prepaid group coverage to Michigan employers of 25 or more people. The concept of prepaid group coverage was an innovative break with traditional insurance plans that had reimbursed policyholders for expenses incurred.

Blue Cross plans throughout the nation operated successfully, but many parties felt that legislation authorizing the plans was needed to provide stability and secure the public's confidence. Consequently, the MHA and the Michigan State Medical Society (MSMS) worked with the state legislature to draft two bills regulating the new system of health care coverage, one governing hospital coverage and one governing physician care coverage.

In May 1939, Governor Luren D. Dickinson signed into law public acts 108 and 109. P.A. 108 allowed for the formation of a Blue Shield plan for physician care, and P.A. 109 governed the Blue Cross plan for hospital care. An article published in the Detroit Times on May 9, 1939, captured the legislative intent:

> Health insurance designed to give Michigan families of moderate income low cost medical and hospital care through small monthly payments was authorized under two new laws placed on the statute books today.
>
> The measures, which had the backing of the state medical association, do not set up the health insurance plan, but authorize insurance companies to inaugurate health insurance systems.
>
> "I signed these bills with much satisfaction because they form the foundation of a new service which will afford to families of moderate income the assurance of adequate medical attention and hospitalization," said Governor Dickinson.
>
> "Under present conditions, the very poor and the very rich are looked after. The poor are provided for through relief agencies and special appropriations for the care of the indigent. The rich have no trouble meeting the fees of the high priced specialists.
>
> "The new plan will aid the 'in between' groups who are not rich enough for adequate medical care yet not poor enough for relief."

In 1940, the MSMS created the Michigan Medical Service, which offered a prepayment plan for physician services and was later to become Michigan Blue Shield.

The two acts gave the insurance commissioner responsibility to ensure the solvency of the plans. In addition, P.A. 109 provided that the "rates charged to subscribers for hospital service...are subject to the approval of the Commissioner of Insurance." P.A. 108 did not regulate rates for physician services.

In the economic boom following World War II, many traditional insurance companies saw the potential for profit in group health insurance. The health

care industry grew quickly as more and more insurers across the country began to offer plans similar to those being offered by the Blues. The market also expanded to include groups smaller than 25 persons and individuals unable to participate in group coverage.

Skyrocketing health care costs in the 1970s led many employers to develop new forms of health care coverage. Many employers established their own group plans, processing the claims themselves or entering into administrative-services-only contracts (ASOs) with the Blues, commercial insurers, or third-party administrators (TPAs). In an ASO, the insurer processes claims but does not underwrite or share risk in assuring that the premium rates sufficiently cover payments for medical care. Meanwhile, health maintenance organizations (HMOs) and preferred provider organizations (PPOs) were gaining popularity as alternatives to "traditional" health care coverage.

Health care insurance, almost nonexistent as late as 60 years ago, is now widely available from a great variety of sources. As the health insurance industry grew and became more competitive, the role of BCBSM in the industry became less clearly defined. Legislation (P.A. 350) designed to clarify the role of the Blues in Michigan's health care market was signed into law in 1980, but it has not ended debate on many issues connected with the Blues.

Public Act 350 consolidated and modified public acts 108 and 109 of 1939. It did not go into effect until August 1985 because it was challenged in court by the Blues. According to BCBSM,

> Public Act 350 . . . contained provisions that effectively gave the state administrative control of the company. . . . It will not cut health care costs. It will saddle the corporation with even more anticompetitive rules and regulations than it has now.[1]

But according to the attorney general,

> Seven years ago BCBSM went to the legislature asking for a new enabling statute and got one: 1980 P.A. 350. The legislature worked for two years on that statute and BCBSM participated every step of the way. BCBSM shook hands on that statute and then turned around and sued the state.[2]
>
> In April [1985], BCBSM lost their suit before the state Supreme Court and this Monday [October 7, 1985] they lost before the U.S. Supreme Court.

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[1] Blue Cross and Blue Shield of Michigan, Conversion of Blue Cross and Blue Shield of Michigan to a Nonprofit Mutual Insurance Company, 1985, p. 8.

[2] The Blues point out that their proposed changes were limited to restructuring the board of directors and that the final product, on which they never "shook hands," contained many new and onerous regulatory requirements.

> 1980 P.A. 350 is finally in effect and what is the BCBSM response?--to avoid it altogether by becoming a mutual insurance company.[3]

As the attorney general's conclusion makes clear, BCBSM's dissatisfaction with P.A. 350 has fueled its drive to become a mutual.

P.A. 350 or Mutualization?

P.A. 350 spells out what BCBSM may and may not do, stipulating the types of health care plans it must offer, the procedures it must follow to obtain approval of new plans and rates, and how its finances must be administered. The act's major provisions are summarized in Exhibit 1.

EXHIBIT 1

SUMMARY OF PUBLIC ACT 350

1. The Blues are required to offer health care coverage to all Michigan residents.
2. The board of directors is limited to 35 members, of whom at least 75 percent must be consumer representatives. (The previous board had 47 members, consisting of 59 percent consumers and 41 percent health care providers.)
3. The Blues are prohibited from selling any type of insurance other than health.
4. The Blues are required to develop health care provider plans that assure access, high quality care, and cost containment. The plans must include an appeal process for aggrieved providers and assure reasonably prompt payment to providers. The plans must be reviewed by the insurance commissioner to assure they meet the requirements in the act.
5. The rates for nongroup subscribers must receive prior approval from the insurance commissioner.
6. The system used to determine group subscriber rates must be reviewed for approval by the commissioner every three years. The commissioner must assure that the rates are equitable, adequate, and not excessive.
7. Each line of coverage offered by the Blues must be self-supporting, with the exception that rates for senior citizens and individuals may be subsidized by other lines.
8. The Blues must establish a formal subscriber complaint reduction process.
9. Claims must be paid promptly or the Blues must pay 12 percent interest.
10. The Blues must receive approval from the insurance commissioner before offering subscribers new types of health care packages and plans.
11. The Blues are required to provide coverage for substance abuse treatment; for patients in state mental hospitals; for reconstructive surgery following a mastectomy; and for subscribers' unmarried dependents who are mentally retarded or physically handicapped.
12. The Blues must maintain a contingency reserve with a target level of 11.5 percent of the previous year's total incurred claims and incurred expenses. (The reserve may fluctuate between 7.5 and 13.8 percent.)
13. The Blues may not set subscriber rates using age or area factors.

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[3] Stanley D. Steinborn, "Say Yes to Michigan and No to Mutualization," Michigan Department of Attorney General, p. 2.

The Blues' management argues that these provisions put the corporation at a competitive disadvantage with other insurers because strict regulation by the insurance commissioner impedes its ability to develop and market alternative insurance plans. Blues' chairman John McCabe contends that the growth of HMOs and PPOs has cut into the corporation's income. And he has consistently stated that current regulation forces the corporation to absorb significant underwriting losses for nongroup subscribers, since the insurance commissioner has not approved the rate increases necessary to make such plans self-sufficient.

The Blues' major complaints concerning P.A. 350 are summarized by Donald G. Puscas, BCBSM president, in the company's 1986 annual report to its customers:

> . . . Michigan insurance regulators have taken a narrow view of the legislation under which BCBSM markets its products and services.
>
> This has excluded us from the packaged life/health market, from age- and area-rated coverage, and other business. No such restrictions apply to our competitors. Nor are they forced to charge their group customers a subsidy for some nongroup lines of business, as we are.
>
> Our effort to seek equal regulation will continue.
>
> Without it, we have no hope for a future as a growing, financially sound corporation. Equal regulation would guarantee us nothing--except an equal chance to serve customers.
>
> And that's all we want.

Blues management argues that to achieve "equal regulation," the corporation must be restructured as a mutual insurance company so it can compete in the following ways:

- Sell any kind of insurance except life insurance and establish a life insurance subsidiary if it so chooses
- More easily organize and/or invest in other businesses, such as other insurance companies
- Establish health care plans without having to seek approval of the insurance commissioner
- Establish rates for group subscribers without approval of the insurance commissioner
- Be free to select its own governing board without the requirement of 75 percent consumer representation
- Deny coverage if it so chooses, with the exception of Medigap individual coverage
- Use age and area factors to determine rates
- Sell medical malpractice insurance

But the attorney general disputes these grounds for mutualization. Kelley insists that the corporation's purpose is to provide low-cost health care insurance to all those who need it. He contends that mutualization is not required to enable BCBSM to compete in the health care coverage market. In a 1985 brochure, he cited the following factors as evidence that BCBSM can and does compete successfully:

- The Blues' contracts with doctors and hospitals for a health care discount "worth hundreds of millions of dollars each year" in return for a guaranteed volume of business
- The Blues' large market share
- Recent increases in BCBSM membership
- The Blues' own HMOs, PPOs, and ASOs, which are "regulated on the same basis as all others"
- The Blues' increases in assets and contingency reserves during the past decade[4]

Medigap and the Subsidy

There is little doubt that in 1987 the need for affordable health care coverage for middle-class members of the work force is being satisfied by the Blues, employer self-insured plans, HMOs, PPOs, and commercial insurers. There are other segments of the population, however, whose health care coverage needs are not being met. Among them are low-income senior citizens requiring affordable Medicare supplement coverage and individuals without access to group coverage but having a medical condition that makes the cost of insurance coverage or medical care prohibitive. The extent to which BCBSM should assume the responsibility of subsidizing coverage for these individuals is a question that policymakers must answer before a decision on mutualization is made.

The Blues argue that they are in a financially precarious position as a result of two conditions: increased competition in the health care market and losses incurred in providing a large share of coverage to high-risk individuals, especially senior citizens in need of Medicare supplemental insurance--Medigap.

The Medicare program began in 1965 as a federal health insurance program for people age 65 and older and for some disabled people under age 65. The program was not designed to pay the total cost of medical care. Costs not paid by Medicare include deductibles for both hospital and physician services, inpatient hospitalization beyond certain lengths of stay, dental care, eyeglasses, and long-term nursing home care.

While the amount of Medicare deductibles has increased significantly since the program began, increases in Social Security benefits, which are used to pay out-of-pocket expenses, have not kept pace. According to a 1984 report from the Insurance Bureau entitled "Medicare Supplement Insurance," the

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[4]Department of the Attorney General, The Truth About Mutualization, 1985.

deductible for the first sixty days of hospitalization rose from $40 to $356 between 1966 and 1984, an increase of 790 percent. During the same period, the average Social Security benefit received by senior citizens rose from $84 a month to $430 a month, an increase of only 412 percent.

Since it has become more difficult for seniors to pay the portion of medical costs not covered by Medicare, many have purchased Medigap policies. The Insurance Bureau estimates that 76 percent of all Medicare recipients are also covered by a Medigap policy. In Michigan, laws intended to promote the availability of Medigap policies require all private insurers selling health policies in the state, as well as BCBSM, to offer individual Medigap insurance policies to anyone who applies.

Over a third of Medigap policyholders have individual policies, which are more expensive than group policies. The Blues argue that the laws governing rates for individual Medigap coverage are stricter for BCBSM than for all other health insurers in Michigan, resulting in an unfair disadvantage that costs the Blues hundreds of millions of dollars and threatens their ability to compete for more profitable policies.

Private insurers base their rates on the number and average risk of Michigan policyholders they cover. They file a premium rate with the Insurance Bureau, which has 30 days to approve or reject it. If the bureau takes no action within that time, the rate is automatically approved. The Blues, in contrast, must obtain the insurance commissioner's approval before their rates can be offered to policyholders. In other words, private insurers can generally set their own individual Medigap rates, while BCBSM must seek prior approval from the insurance commissioner to offer such policies.

This requirement for prior approval prevents the Blues from making their individual Medigap coverage a self-sustaining line of insurance. That is, the Blues' individual Medigap rates do not reflect the cost of benefits for that type of coverage, as is the case with private insurance policies. As a result, many private insurers offer individual Medigap rates that are much higher than those allowed for the Blues, although there are a few private individual Medigap plans comparable with Blues' plans. See Exhibit 2 for a comparison of Medigap individual rates.

Due to their comparatively low rates and high level of name recognition among Michigan residents, BCBSM writes 85 percent of all individual Medigap policies. Since their Medigap rates do not fully cover their benefit costs, P.A. 350 allows the Blues to subsidize those rates with the premiums of policyholders under age 65. The law allows a subsidy of up to one percent of the Blues' total annual premium income. The subsidy was more than $33 million in 1985 and about $39 million in 1986. The Blues contend that in spite of the subsidy they continue to lose money and that their losses are solely attributable to the high costs of individual, mostly Medigap, policies.

Losses from individual coverage have occurred every year since 1977, totaling $334 million, and are primarily responsible for overall underwriting losses, according to BCBSM. In 1986, individual lines suffered a $40 million loss, slightly lower than the 1985 loss of $42 million. These losses, BCBSM argues, are eroding the Blues' contingency reserves, which were almost $5.5 million lower in 1986 than they were in 1985. (See Exhibit 3.)

The Blues maintain that their losses on individual and Medigap coverage will force them to raise their group rates to an uncompetitive level. They do

EXHIBIT 2

SAMPLE OF ANNUAL PREMIUMS FOR COMPARABLE INDIVIDUAL MEDICARE SUPPLEMENT POLICIES, 1987[a]

Insurer	Annual Premium (for a 65-Year-Old Policyholder)
BCBSM	
HMO-Service Area	$506.00
Non-HMO Area	469.80
Aetna Life & Casualty	800.00
Bankers Life & Casualty	371.00
Blue Care Medicare Plus[b]	360.00
Mutual of Omaha	529.32

[a]The policies generally cover all Medicare deductibles and copayments but any additional benefits and services may differ. Individual policies should not be compared on the basis of premiums alone.

[b]BCBSM program available from all seven of its HMOs.

EXHIBIT 3

BCBSM CONTINGENCY RESERVES

Year	Amount	Percentage Change	Percent of Previous Year's Payments and Expenses
1980	$249,428,006	--	10.2%
1981	194,077,000	-22.20%	7.1
1982	227,970,000	17.46	7.8
1983	336,766,000	47.72	11.1
1984	384,620,000	14.21	11.7
1985	409,865,000	6.56	12.2
1986	404,402,000	-1.33	10.3

SOURCES: BCBSM Fact Book, various years. Percentage changes calculated by Public Sector Consultants.

not want to use surpluses from most lines to subsidize losses from a few lines. They are also concerned that as the cost of the Medigap subsidy is spread among fewer and fewer customers due to the growth of their ASO business, which now comprises 55.5 percent of their revenue, those customers will either leave BCBSM for a private insurer or opt for self-insurance. Instead, the Blues would prefer that each line, including those for senior citizens and individuals, be financed based only on its own risk. This is the method used by mutual insurance companies. As an alternative, the Blues have proposed a risk-sharing or pooling approach whereby all insurers would bear a fair share of the responsibility for providing Medigap coverage. Those insurers covering more than their share, namely BCBSM, would receive a subsidy from the pool; those covering less than their share would be required to make payments to the pool.

Attorney General Kelley, however, disputes the Blues' claim that they should not have to insure more than their share of high-risk individuals, asserting that it is BCBSM's "public purpose" to provide health care to those who need it most:

> BCBSM was not created to compete with private business. In the 1930s there was little health insurance available. BCBSM was created to fill a gap--to meet that need. Although times have changed, the need has not. We still need a carrier to serve those who cannot afford or obtain private insurance.[5]

Market Share

There are generally two methods of measuring the market share of insurance companies: the percentage of population covered and the percentage of premium dollars paid. Exhibit 4 shows the Blues' membership as a percentage of the state population over the last decade. It reveals that for every year during the last ten years, BCBSM has enrolled over half of the residents of Michigan as members, despite fluctuations in the state's economy and population.

The Blues have also been predominant in the collection of premium dollars in Michigan. In 1985, the latest year for which figures are available, they collected 70 percent of the premiums paid; the next highest competitor, Delta Dental Plan of Michigan, collected only 4.25 percent of the premiums paid. (See Exhibit 5. These figures do not include HMO, ASO, or TPA business.) The Blues collected 70 cents of every dollar paid for traditional health care insurance policies in the state, and the next nine largest company shares combined totaled only about 14 cents of every dollar. (See Exhibit 6.)

When determining the market share of BCBSM based on percentage of premium dollars paid, it is important to look at the figures for ASO and TPA contracts as well as those for traditional plans. According to a 1986 Insurance Bureau report, the Blues are highly competitive in the ASO and TPA contract business: "Looking at the total servicing fees collected by ASOs, TPAs, and BCBSM, we can see that Blue Cross/Blue Shield has captured a major segment of the

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[5]Department of Attorney General, The Truth About BCBSM Mutualization.

EXHIBIT 4

BCBSM POPULATION SHARE, 1977-86

Year	State Population (in thousands)	Percentage Change	BCBSM Total Membership (in thousands)	Percentage Change	BCBSM Market Share
1977	9,157	--	5,450	--	59.5%
1978	9,202	4.71%	5,330	-2.20%	57.9
1979	9,249	5.11	5,270	-1.13	57.0
1980	9,262	0.14	5,100	-3.22	55.1
1981	9,210	-0.56	4,950	-2.94	53.7
1982	9,115	-1.03	4,689	-5.27	51.4
1983	9,050	-0.71	4,636	-1.13	51.2
1984	9,075	2.76	4,639	0.06	51.1
1985	9,088	0.14	4,846	4.46	53.3
1986	9,145	0.63	4,860	0.29	53.1
Ten-Year Change	-12	-0.13	-590	-10.33	-6.4

SOURCES: Department of Management and Budget and BCBSM.

EXHIBIT 5

SUMMARY OF THE TEN LARGEST ACCIDENT AND HEALTH CARRIERS IN MICHIGAN, 1985 (TRADITIONAL COVERAGE)[a] (dollars in thousands)

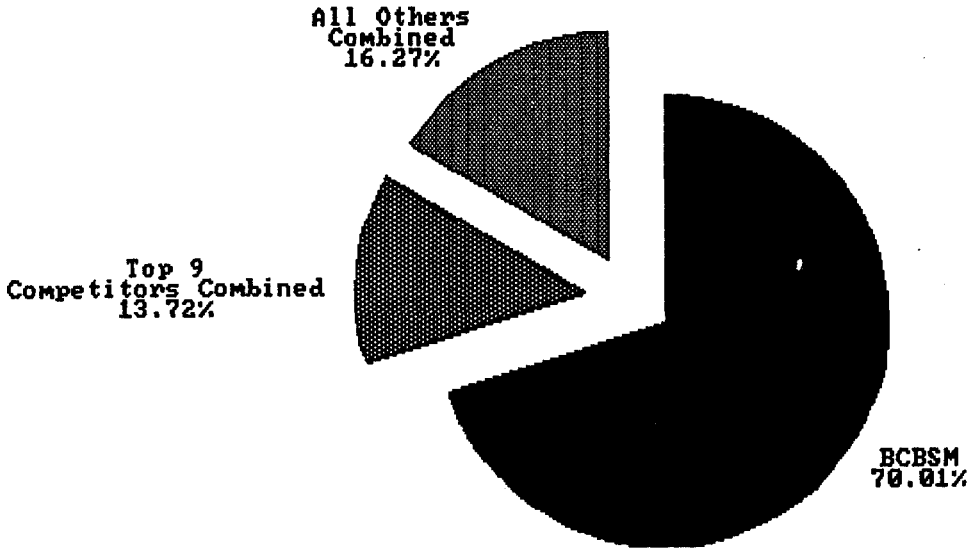
	Company	Total Admitted Assets	Capital and Surplus	Michigan Casualty Premiums	Michigan Casualty Loss Incurred	Percent of Market Share
1.	Blue Cross and Blue Shield of Michigan	$ 1,121,915	$ 373,087	$3,343,695	$3,117,317	70.01%
3.	Delta Dental Plan of Michigan	91,814	57,895	202,822	188,338	4.25
3.	American Community Mutual Insurance Company	105,264	31,752	117,641	85,804	2.46
4.	Prudential Insurance Co. of America	91,139,140	2,428,581	64,665	46,098	1.35
5.	Aetna Life Insurance Company	37,889,119	1,076,453	62,224	53,420	1.30
6.	Connecticut General Life Insurance Company	22,245,808	1,107,942	45,526	25,719	.95
7.	Bankers Life and Casualty Company	1,256,802	160,473	41,915	29,449	.88
8.	Metropolitan Life Insurance Company	76,494,165	2,691,271	41,377	33,940	.87
9.	Travelers Insurance Company	25,571,766	870,575	41,063	31,939	.86
10.	Provident Life and Accident Ins.	2,578,814	403,133	38,027	32,345	.80

SOURCE: Michigan Insurance Bureau 1985 Statistical Report.

[a]Excludes ASO, TPA, and HMO figures.

EXHIBIT 6

TRADITIONAL HEALTH CARE COVERAGE: BCBSM
MARKET SHARE BASED ON PREMIUMS PAID, 1985



SOURCE: Michigan Insurance Bureau.

NOTE: There are over 600 insurers licensed to sell health policies in Michigan.

business in 1985."[6] Out of a total of approximately $140 million in service fees collected in 1985 (including TPA contracts), the Blues received about $94 million, or 63 percent. (See Exhibit 7.) Their share of ASO business grew from 38.8 percent in 1982 to 64.2 percent in 1985 (not including TPA fees). (See Exhibit 8.)

Competition is increasing in the HMO market, and here, too, the Blues are strongly represented. There were 24 HMOs operating in Michigan in 1986, serving a total of 1,315,428 members. The Blues operate seven HMOs, which had a total of 441,433 members, or about 33.6 percent of the total HMO membership for that year. The Blues' HMOs also account for 34 percent of all HMO revenue in 1986.

Either way one measures market share--population share or premium dollar share--the Blues are strongly represented, demonstrating that they are active and successful competitors in Michigan's health care coverage market.

What will happen to the health care coverage market in Michigan if BCBSM is allowed to become a mutual insurance company is difficult to predict. But if the Blues are able to establish a Medigap individual insurance pool and are permitted to market other types of insurance, such as life, their commanding position in the Michigan insurance market will be strengthened.

In fact, their market share may be strengthened anyway as a result of public acts 252 and 253 of 1986. Until 1986, only Blues' offices could sell Blues' coverage. Now all licensed insurance agents can market health care coverage offered by BCBSM, HMOs, dental care corporations, and TPAs. The Blues support the new laws because they make BCBSM's various health benefit products more accessible to small businesses and individuals and may lower some rates as a result of increasing competition. On the other hand, opponents of the new laws argued that BCBSM would increase its market share by using agents and thus decrease competition.

Probably the most important reason for the Blues' high market share is their contract relationship with hospitals and physicians. The Blues have traditionally negotiated with hospitals for "discounts"--the difference between what hospitals charge and what Blue Cross agrees to pay for services to their members. The Blues say they earn the discount by paying hospitals on a prospective reimbursement basis. Hospitals receive weekly reimbursements based on the size of their operating budgets, which cannot exceed a predetermined budget screen reviewed quarterly by a Blues reimbursement committee. This system assures smooth cash flow during variations in patient load and accounts receivable.

In return for providing a steady flow of income to hospitals, the Blues reimburse at only about 83 percent of the normal cost of services charged by providers. Since the Blues receive such a large discount on hospital and physician care, they can pass the savings on to their customers through lower premium rates. This discount is a powerful marketing tool. Other insurers generally pay closer to 100 percent of the health care costs charged by

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[6] Insurance Bureau, Department of Licensing and Regulation, The Role of BCBSM In the Expanding Non-Traditional Health Benefits Market, 1986, p. 3.

EXHIBIT 7

TEN LARGEST COMPANIES
ASO AND TPA CLAIMS PAID, 1985
(dollars in thousands)

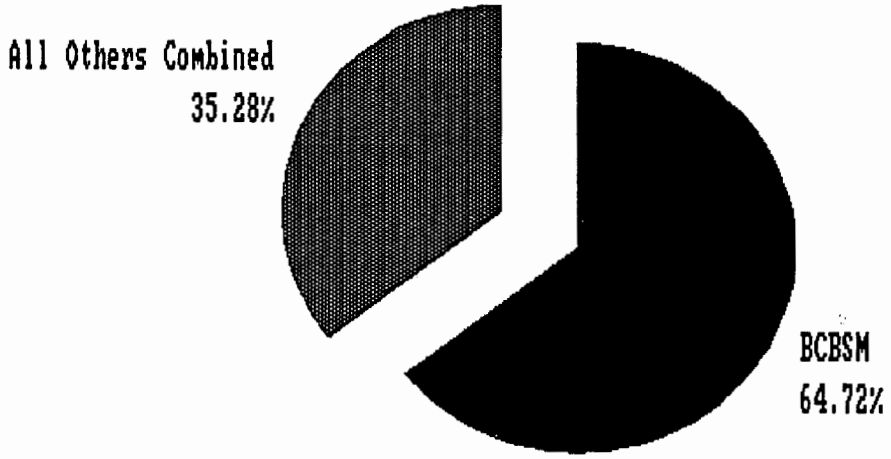
	Company	Claims Paid	Percent of Total
1.	Blue Cross and Blue Shield of Michigan	$1,414,235.0	64.21%
2.	Aetna Life Insurance Company	172,759.1	7.84
3.	John Hancock Mutual Life Insurance Company	163,300.0	7.41
4.	Connecticut General Life Insurance Company	59,728.1	2.71
5.	Prudential Insurance Co. of America	46,617.5	2.12
6.	Pension and Group Service, Inc.	37,736.3	1.71
7.	Total Group Services, Inc.	35,000.0	1.59
8.	Travelers Insurance Company	29,386.4	1.33
9.	Midwest Benefits Corporation	27,350.0	1.24
10.	Northern Group Services	21,478.0	0.98

SOURCE: Michigan Insurance Bureau.

[a]Includes TPA claims paid.

EXHIBIT 8

BCBSM MARKET SHARE ASO AND TPA CONTRACTS (CLAIMS PAID), 1985



TOTAL ASO AND TPA CLAIMS PAID: $2,202,400,400
BCBSM ASO CLAIMS PAID: $1,414,235,000

SOURCE: Michigan Insurance Bureau, "The Role of BCBSM," pp. 10-13.

providers, since they cannot offer a guaranteed volume of business as the Blues can.

Since its inception, BCBSM has captured a large share of the traditional health insurance market in the state. It has also created seven HMOs, organized one PPO, and entered into a large number of ASO contracts. Insurance Bureau figures indicate that the Blues are very active in the new health care plan markets as well as the traditional fee-for-service markets. Nearly all of the state's major corporations and associations are BCBSM subscribers or ASO customers: General Motors, Ford, Chrysler, Michigan Bell, K-Mart, Meijer, the State Bar of Michigan, and the State of Michigan, to name only a few. BCBSM also acts as fiscal intermediary for the state's Medicare recipients.

Some parties contend that BCBSM would monopolize the health care insurance market in Michigan if it became a mutual company. Others contend that it is already a monopoly. The Blues challenge both claims, citing the large number of insurers authorized to sell health policies in Michigan (over 600); the number of non-Blues HMOs (17); and the number of insurers and TPAs with administrative service contracts (over 70). They also remind their critics that in a 1973 federal lawsuit charging BCBSM as a monopoly, the judge found that "the market share attributed to Blue Cross is not sufficient to earmark monopoly power."[7] Its market share in 1973 was "between 50 and 60 percent."[8] Neither the attorney general nor the Insurance Bureau has ever formally filed antitrust charges against the Blues.

Conclusion

Despite its large market share, BCBSM contends that current state regulation places it at a disadvantage in the marketplace, endangering its financial health and its ability to provide subscribers with affordable health care coverage. It argues that "equal regulation," or mutualization, is the only solution to the corporation's financial problems.

Seeking an impartial outside opinion, the Blues retained the consulting firm of Booz-Allen and Hamilton to study its competitive situation and advise it about the question of regulatory equality. This 1987 study acknowledges that the decrease in the Blues' share of the state market over the last ten years (6.4 percent) was in part due to increased competition in the health care industry. It also points out that the company is "especially vulnerable to loss of market share since 35 percent of its business comes from just three customers [General Motors, Ford, and Chrysler]." The study further indicates that BCBSM's regulatory environment presents obstacles to its efforts at product diversification and financial improvement and advised it to "secure equal regulatory treatment" since the "present situation is likely to prove inhibiting as competition intensifies."

Although Booz-Allen did advise BCBSM to diversify into new products and services, it also recommended that the Blues reequip themselves to cope with

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[7] BCBSM, Conversion, p. 23.

[8] Ibid.

increasingly complex customer needs and reestablish financial soundness by eliminating losses. In sum, the firm concluded:

> How and when BCBSM responds to the competitive challenge--and to what extent it is allowed to do so by state regulators--will determine whether or not the company has a significant role in Michigan's future.[9]

To evaluate BCBSM's claims and decide the question of mutualization, one must answer three preliminary questions: (1) Does regulation under P.A. 350 prevent the Blues from competing effectively in the health care coverage market? (2) Are the Blues in financial trouble as a result of regulation? (3) Are there better means than mutualization by which the Blues can improve their competitive position?

1. Does P.A. 350 prevent the Blues from competing?

Although P.A. 350 prohibits the Blues from selling types of insurance other than health, it does give BCBSM the freedom to offer many different forms of health care coverage, and BCBSM has used that freedom to diversify extensively. In addition to selling traditional prepaid group coverage providing fee-for-service reimbursement, it operates seven HMOs, offers a PPO alternative, and paid more than $1.4 billion in claims under ASO contracts with self-insuring organizations. Blue Care Network, BCBSM's HMO subsidiary, began selling dental coverage through its Dental Care Network in 1983, in direct competition with Delta Dental Plan. The dental program has grown from 1,100 members in 1983 to 23,249 members in 1986.

BCBSM has also formed a holding company, Michigan Medical Service, which operates five for-profit subsidiaries and reported a net profit of $1.5 million in 1986. Diversitec offers information management and computer consultant services, plastic card embossing, and conference center services. Blue Ribbon offers cost containment programs, risk management services, and sales of BCBSM health policies through insurance agents. H.C. Real Estate manages the facilities of BCBSM around the state and offers services in real estate development, engineering, construction management, and office design and even has its own office furniture subsidiary, RamCo, Inc. Tower Management Company helps subscribers finance copayments and deductibles by means of a health credit card program and provides cash management and investment services; it also recently entered the leasing business. Health Service Company has established Central Insurance in the Cayman Islands to provide the Blues with reinsurance for its HMOs, and Blue Ribbon has established Business Group Insurance in the Bahamas to provide the Blues with reinsurance for other types of coverage.

In all of its health care services, BCBSM has proven to be a strong competitor, accounting for a predominant share of the health care coverage market, measured both in terms of population and of premium dollars.

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[9] Booz-Allen and Hamilton, The Business Environment Confronting Blue Cross and Blue Shield of Michigan, 1987, p.4.

2. *Are the Blues in financial trouble as a result of regulation?*

P.A. 350 requires the Blues to maintain a contingency reserve of between 7.5 and 13.8 percent of the preceding year's total incurred claims and expenses, with a target of 11.5 percent. These reserves have grown in recent years, except for a $5.5 million (1.3 percent) reduction in 1986. (See Exhibit 2.) At year-end 1986, the Blues' reserve was at 10.3 percent--or $404.4 million--up from 7.1 percent in 1981.

The Blues take issue, however, with the use of contingency reserves alone as a measure of financial strength, since reserves cannot be quickly converted into cash. At year-end 1986, the Blues' cash and short-term investments totaled $352.5 million, of which only about $13.5 million--equal to about two days' claims and administrative payouts--were in cash. BCBSM argues that in recent years the loss of groups that became self-insured has resulted in severe restrictions on its cash flow; these restrictions are not reflected in any contingency reserve measure. Individual coverage subsidies, it further contends, are draining cash reserves. The Blues use cash reserves to earn interest income and to capitalize new ventures such as its HMOs. But BCBSM was able to capitalize seven HMOs and many other successful subsidiaries in recent years, and its investment income traditionally represents only a small portion (an average of 1.3 percent in the 1980s) of its overall income.

Despite subsidiary investments and lower cash reserves, the Blues' contingency reserves have grown in this decade. The Insurance Bureau's annual report for 1985 put the Blues' year-end total unassigned reserves at about $373 million, "indicating strong financial health." Measures other than contingency reserves also show the financial health of BCBSM. Its own figures show increases in total income every year since 1979, from just over $2 billion in 1979 to nearly $4 billion in 1986. (See Exhibit 9.) Total assets climbed by 65.5 percent from $800 million in 1982 to more than $1.4 billion in 1986--an increase of more than $100 million per year.

Given BCBSM's strong market share, healthy reserves, and growing assets, it is difficult to see how its condition can be characterized as "financially troubled." All available measurements indicate that they are thriving.

. *Are there better means than mutualization by which the Blues can improve their competitive position?*

If the Blues want to become more competitive, methods other than mutualization, such as better service, may achieve this goal. A 1986 survey by the Michigan State Employees Association showed that 98 percent of the members surveyed felt BCBSM's service was not as good as that of Aetna, the association's previous insurer. One percent said the Blues' service was equal to Aetna's, and zero percent said they had received good service from the Blues. The attorney general, moreover, reports:

> The threat hangs over BCBSM that the federal government will drop BCBSM as its Medicare fiscal intermediary. This has nothing to do with regulation. It has to do with incompetence and poor management.[10]

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[10] Steinborn, "Say Yes," p. 7.

EXHIBIT 9

BSBSM INCOME AND COSTS, 1979-86
(dollars in thousands)

	Income				Costs of Services				
Year	Subscribers	Investment	Total	Percentage Increase	Benefit Payments	Operating Expenses	Cost as a Percentage of Subscriber Income	Total	Percentage Increase
1979	$2,234,656	$51,735	$2,286,391	--	$2,114,643	$141,427	6.2%	$2,256,070	--
1980	2,355,305	23,846	2,379,151	4.1%	2,310,578	133,466	5.6	2,444,044	8.3%
1981	2,640,043	36,297	2,676,340	12.5	2,579,968	151,723	5.7	2,731,691	1.2
1982	2,921,224	42,928	2,964,152	10.8	2,767,622	162,637	5.5	2,930,259	7.3
1983	3,099,527	56,865	3,156,392	6.5	2,878,096	169,500	5.4	3,047,596	4.0
1984	3,285,282	53,327	3,338,609	5.8	3,077,492	213,263	6.4	3,290,755	8.0
1985	3,343,695	37,203	3,380,898	1.3	3,117,317	238,336	7.1	3,355,653	2.0
1986	3,905,534	30,111	3,935,645	16.4	3,648,854	292,254	7.5	3,941,108	17.4

SOURCE: BCBSM Fact Book, 1983 and 1986 (percentages calculated by PSC).

There has been speculation that General Motors may at some point drop its contract with BCBSM and use its own subsidiary, Electronic Data Systems, to process claims.

Although the Blues consider accounts such as these crucial to their financial viability, the company seems reluctant to acknowledge that the surest way to retain these accounts is to provide customers with better service than the competition can provide. Mutualization does not guarantee good service.

Mutualization could, however, have detrimental effects on Michigan residents in a number of ways. First, by allowing BCBSM to package health coverage with any other type of insurance coverage, it would put the Blues' competitors at an even greater disadvantage than they are at present given the Blues' ability to offer volume discounts.

Second, mutualization would ease restrictions on the Blues' investment plans, greatly increasing the proportion of their investment income to total income. This would make the Blues more vulnerable to fluctuations in interest rates and could necessitate premium rate increases. Third, mutualization would remove the restrictions of P.A. 350 on the composition of the Blues' board of directors, almost certainly leading to less consumer representation. Fourth, by freeing BCBSM of the legal obligation to make coverage available to every Michigan applicant (with the exception of Medigap coverage), mutualization could force many residents with individual policies into the growing ranks of the uninsured.

Finally, mutualization would allow BCBSM to base its rates on age and geographical location rather than use the community rating system in place

under P.A. 350. If location is used as a factor, a Detroit resident may pay significantly higher premiums, for example, than a resident of Mt. Pleasant for the same coverage because health care is generally more expensive in southeastern Michigan than it is in the rest of the state. Under the present community rating system, younger and healthier members help pay for the higher health care costs of the elderly and rates are based on community health experience rather than the health care costs of a particular region. Opponents of mutualization maintain that the community rating system promotes the Blues' social function of supplying affordable health care coverage to all who need it.

The potential disadvantages of mutualization are too numerous and substantial to make it arguably the best way to improve the Blues' competitive position. Public Sector Consultants suggests that an improvement in service will accomplish that for BCBSM much more directly and effectively than mutualization.

The three preliminary questions yield the following answers--(1) under P.A. 350, BCBSM is a strong competitor; (2) BCBSM is financially sound; and (3) mutualization cannot substitute for good service and competent management, and it could have several detrimental results for Michigan residents. Public Sector Consultants concludes that BCBSM's claims are not strong enough to warrant repeal of P.A. 350 and conversion to a mutual insurance company. Mutualization is not needed to secure the Blues' financial soundness; further, it would not support or advance the BCBSM social mandate to ensure that all Michigan residents have access to affordable health care coverage.