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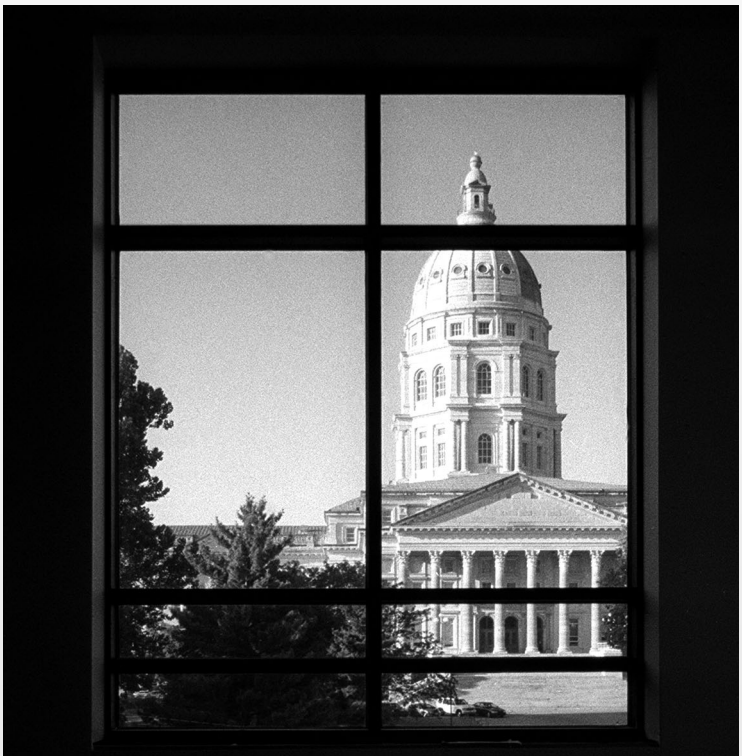

Health Care Consolidations and Conversions:

Market Trend or Market Failure?

Tuesday, March 26, 2002 • 8 a.m. — 10 a.m.
212 SW Eighth Avenue, Topeka, KS • Lower Level Conference Room

A DISCUSSION FEATURING

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Kansas Health Policy Forums are a series of interactive sessions for policy-makers examining a broad array of health issues. Forums present a wide range of expert views on current health policy issues followed by facilitated discussion and dialogue in a non-partisan, off-the-record, setting. Forum Briefs analyze issues, present relevant data and information, and are prepared in advance of each Forum.

Speaker Biography

Paul Ginsburg, Ph.D. is President of the Center for Studying Health System Change. Founded in 1995, the Center conducts research to inform policy-makers about changes in the organization of financing and delivery of care and their effects on people. Dr. Ginsburg previously served as the founding Executive Director of the Physician Payment Review Commission (now the Medicare Payment Advisory Commission). Prior to that, he was Deputy Assistant Director at the Congressional Budget Office.

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Introduction

The recent attempt by Blue Cross and Blue Shield of Kansas (BCBSKS) to convert from a mutual insurance company to a for-profit stock corporation and to sell all of its stock to Anthem Blue Cross and Blue Shield is representative of two trends in the health care marketplace: consolidation of health care providers and insurers and conversion to for-profit status. Consolidations and conversions by health care providers and health plans will likely continue into the future. Public policymakers need to weigh the effects of these market changes on the health and welfare of Kansans, and then consider how best to protect the public interest and how much regulation of the health services market is justified. The following Forum Brief is intended to provide background for the discussion that will take place March 26, 2002 at the Kansas Health Policy Forum.

For the past several years, the health care market has been in a state of dynamic flux. Two of the primary features of this rapidly changing marketplace are the consolidation of providers and insurers through mergers, acquisitions, and joint ventures and the conversion of not-for-profit providers and insurers to for-profit status. Often the decision to consolidate or convert is justified in terms of business necessity or strategic positioning. Providers and insurers consolidate to improve market share and reduce transaction costs. Likewise, they convert to for-profit status to improve access to capital[1] that will allow them to grow and to invest in technologies that support their core business.

There is little question that consolidations and conversions potentially benefit the health care providers and insurers who adopt these strategies, but do they offer equal benefits to the public at large? Do the benefits of provider and health plan size and efficiency flow to consumers in the form of better access, lower cost, and higher quality? Or do consumers finance the increased administrative costs of integration and coordination resulting from these structural changes and pay greater sums for services to finance profits and dividends? Are there circumstances under which market consolidation provides greater public benefits than competition?

What you need to know

- Consolidations of providers and insurers and conversions from not-for-profit to for-profit status are increasing in the health care industry.
- No clear evidence exists to define the circumstances under which consolidations and conversions harm or benefit consumers.
- The federal government, through its antitrust enforcement role, monitors the potentially harmful effects of health care consolidations; many states also have antitrust laws on the books.
- Several states have policies in place to review, approve and monitor health care conversions.

Little empirical evidence exists to indicate that all or most consolidations and conversions have similar outcomes. Instead, the evidence suggests that the outcomes of consolidations and conversions are highly idiosyncratic, depending largely on local circumstances. Nevertheless, the number of health care provider organizations and insurance companies in the marketplace is growing smaller and the proportion of them that operate as for-profit entities is growing larger. Should the market be permitted to continue under the current regulatory regime until a clear problem is uncovered, or should state legislators intercede to protect consumer interests? Where do consumer interests lie? In this Forum Brief we will discuss these issues, beginning with consolidations and moving on to the topic of conversions.

Consolidation in Health Care Markets

Consolidation occurs when two or more health entities collaborate or combine to form a system or a new organization with common strategic and/or operational goals. Market forces have led health providers and insurers to consolidate in a number of different ways. Mergers and acquisitions are the most permanent and visible forms of consolidation, but coalitions, networks, contracts, and joint ventures are also forms of consolidation.[2] In these latter forms, organizations share resources, and possibly assets, but they maintain their organizational autonomy. The positive effects of consolidation include reduction in excess capacity (typically hospital beds), resource sharing, improved coordination, and spreading of the fixed costs of administration. These benefits improve the efficiency of the "combined" entity, which improves its competitiveness (and hence its longevity in the community) and may result in lower costs to consumers over time.

Market consolidation may also have anti-competitive effects. As the number of provider organizations and insurance companies in a market decreases, the possibility increases that they will possess and use their market power. When a single firm dominates the market, it may increase costs to consumers without fear that a competitor with a lower price will draw away a substantial amount of business.

Types of Consolidation

There are two basic types of consolidation. Horizontal consolidation involves integration or collaboration among similar types of providers or firms. Hospitals collaborating with hospitals, physician clinics cooperating with other clinics, and insurance companies integrating with insurance companies are examples of horizontal consolidation. Vertical consolidation is the joining together of different types of providers and firms. Formal cooperation between hospitals and doctors and the development of an integrated system that includes hospitals, doctors, and insurers are examples of vertical consolidation.

Horizontal and vertical networks have become increasingly popular strategic adaptations to change in the health care market.[3] This is particularly true of rural health providers. Substantial federal, state, and private resources have been targeted to the development of rural health networks in the past 15 years. Kansas is a leader in rural health networking; approximately 80 rural hospitals in Kansas participate in approximately 20 rural networks.[4]

A wave of mergers among Blue Cross and Blue Shield Plans emerged in the 1990s.

Antitrust laws: State and national laws that prohibit health care and other providers from price-fixing or developing monopolies that would prevent consumers from having choices in terms of cost and services.

State action immunity: When not preempted by the federal government, specific activities will be safeguarded from federal prohibitions if a state clearly articulates a state policy immunizing the specific activities and actively supervises private activities.

Source: O'Connor, 1996; California Institute for Rural Health Management, 1998. [6, 7]

Until 1994, most mergers occurred within state boundaries, according to Blue Cross and Blue Shield Association rules. After a change in the rules, interstate mergers and acquisitions began to occur, shrinking the number of Blue Cross and Blue Shield Plans from 110 in 1986 to 45 by mid-2001. [8, 9]

Some view the consolidation of not-for-profit entities more favorably than the consolidation of for-profit firms. They argue that patients are vulnerable because they lack information about medical care that providers and insurers possess. They suggest that not-for-profit organizations are more trustworthy than for-profits, because they are less willing to exploit this informational imbalance to their own advantage. [10] When a combined for-profit organization is large and possesses some degree of power in a market, the question of potential trustworthiness becomes a more pressing issue. Potential trustworthiness is, of course, a subjective decision that is made, at least in part, on one's belief in the historical performance of the combined organizations.

The Public's Interest and Public Policy

Federal and state antitrust laws are written to promote and protect competition. They are based on the assumption that competition results in lower prices and higher quality. Consumers benefit when competing providers offer lower prices and higher quality in order to capture a desired share of the market.

The Federal Trade Commission and the U.S. Justice Department enforce federal antitrust laws, and the offices of state attorneys general enforce state antitrust laws. Although effective enforcement of antitrust laws is essential to a competitive

Figure: 1
Range of Collaborative Linkages

	Informal Affiliation	*Coalition/ Alliance*	*Cooptation*	*Contract*	*Joint Venture*	*Merger*
Definition	An informal relationship in which information or resources are shared through professional or personal network.	A formal relationship of parties with some shared interests.	The incorporation of representatives of external groups into the decision-making or advisory structure of an organization.	Legal and binding relationships with another organization.	A legal and binding relationship with another organization in which the parties share the cost and risk.	The fusion of two legal entities into one structure either through a merger or a buy-out.
Legal Relationship	Informal	Membership	Legal role in organization or Informal	Contract/ No assets	Contract/ Assets shared	Ownership

Source: Hoare, Katz, & Baldwin, 1991.[5]

market, "enforcement policy must be flexible enough to allow efficient new forms of organization to emerge." [11] In other words, anticompetitive behavior of collaborating partners must be monitored to protect the public interest, but policymakers also must be aware of the potential for collaborative organizational innovation in the marketplace to benefit consumers.

Federal antitrust enforcement to date has been modest. Federal regulators challenged approximately two percent of the more than 1,100 general hospital mergers that occurred between 1981 and 1996. The agencies have examined, but to date have not challenged, HMOs and physician mergers.[12] State antitrust enforcement agencies sometimes permit hospital mergers within a community to proceed subject to certain conditions. Conditions may include limits on future price increases, financial reporting requirements, and state agency monitoring for a set period of time.

If a state believes that the potential benefits of networking or merger outweigh the potential liabilities, it may provide a measure of immunity to providers engaging in potentially anticompetitive behavior. This shield is called "state-action immunity." Approximately one-half of the states have passed laws implementing state action immunity for some health service providers. Typically, state regulatory programs establish application procedures and approval criteria, and design a review process that ensures continued state supervision of approved activities.[13] The approval agency for health services antitrust exemption laws is usually the state health department or independent health-planning agency.

Kansas has two health care antitrust exemption statutes. KSA 65-4957, the Health Care Provider Cooperation Act, permits "cooperative agreements" between two or more "health care providers" that may have previously triggered antitrust enforcement, provided that the agreement is approved by the secretary of the Kansas Department of Health and Environment and the approved arrangement is monitored by the state. The law specifically sets out the beneficial and disadvantageous criteria the secretary must weigh in making the decision. The law also provides for the establishment of an independent panel of citizens to be appointed by the governor and the legislature to advise the secretary in his or her decision-making. KSA 65-472 states that members of a rural health network composed of "hospitals and other facilities…shall be considered to be acting pursuant to clearly expressed state policy as established in this act under the supervision of the state and shall not be subject to state or federal antitrust laws while so acting."

Conversion From Not-For-Profit to For-Profit Status

Health care providers obtain their not-for-profit status under section 501(c)(3) of the U.S. Internal Revenue Code, which exempts religious, educational, charitable, and scientific organizations from federal income tax. Considered charitable organizations, not-for-profit health care providers must permanently dedicate their assets to exempt purposes. If a not-for-profit organization should dissolve, its assets must be distributed for an exempt purpose (usually to another tax-exempt entity) or to the federal government or to a state or local government for a public purpose. Some states, for example Minnesota, require that all health maintenance organizations licensed in the state be operated as not-for-profit organizations.

Blue Cross and Blue Shield Plans historically have operated as not-for-profit organizations in an industry dominated by for-profit firms. According to Grossman and Strunk: [14]
"Each individual [Blue Cross] Plan developed locally and independently, with local representation on its board of directors. A defining characteristic of these early Plans and their leaders was their commitment to community service and the provision of public benefit. As a consequence, the Plans operated on a not-for-profit basis, accepted all persons who desired insurance coverage, and used community rating to set uniform premiums without regard for individual enrollee health status or risk factors. Local accountability and community mission were indeed hallmarks of the early Plans."

Blue Cross and Blue Shield Plans received special regulatory advantages and tax-exempt status from the state in exchange for the community benefits which they provided. In the eight years since the Blue Cross and Blue Shield Association changed its rules to allow conversion, five (of 45) have become publicly traded -- Cobalt Corporation (Wisconsin), RightChoice Managed Care (Missouri), Trigon Healthcare (Virginia), WellPoint Health Networks, Inc. (California), and Anthem Insurance (Indiana). Blue Cross and Blue Shield Plans in at least ten other states (including Kansas) plan to convert.[15]

Much of the discussion of for-profit versus not-for-profit health service providers centers on two controversies. The first asks whether for-profit health providers have goals, values, and practices that are consonant with the provision of health care. Implicit in this formulation is the belief that health should not be subject to the profit motive. The second controversy concerns whether not-for-profit health care organizations provide sufficient community benefits to justify their tax exemption. If not-for-profit providers and insurers differ little from their for-profit counterparts in terms of charitable services rendered, the argument goes, they should not receive special benefits from the state.[16]

The following propositions bring these two issues into sharper policy focus:
"If nonprofits provide more community benefits than their for-profit counterparts do, then conversion could result in the loss of such benefits to communities. If, on the other hand, nonprofits provide fewer benefits than for-profits do, or if the benefits provided are less valuable than the tax exemptions conferred, then

the tax preference is subject to question, and conversions may result in a net benefit to communities." [17]

The controversy can be further distilled: Does a not-for-profit organization provide greater or lesser benefits to the public than the taxes paid by the for-profit organization that might take its place? Although some community benefits accrue to the entire community, others flow to specific classes of individuals within the community, the medically indigent, for example (see the list of community benefits below). Tax dollars paid by a for-profit, on the other hand, would go into a general fund to finance a variety of public services, from public safety and roads and bridges to public health. Although the monetary value of a not-for-profit's community benefits may equal the taxes paid by a for-profit, the benefits of the expenditures are differently allocated.

Blue Cross and Blue Shield Plans have changed over the last fifty years from their quasi-public beginnings. For example, in the 1950s Blue Cross Plans began to shift from community rating to experience rating when setting premiums. By the 1980s a number of Plans removed their insurer-of-last-resort requirements, which guaranteed issue of a policy to all who paid the premiums. In 1986, the Blue Cross and Blue Shield Plans lost their full exemption from federal taxation. Over time, the processes of market change and strategic adaptation have made the Blue Cross and Blue Shield Plans resemble more closely their for-profit competitors.[18]

The size of the organization that converts to for-profit status is important relative to its impact on the market and the alternative uses to which its tax-exempt assets are put. Obviously, larger organizations (some of which may have resulted from consolidations) have a larger effect than smaller organizations. If these larger organizations have a sizeable share of a market, they may feel free to increase prices above the levels that would occur in a highly competitive market. On the other hand, larger not-for-profits confer greater benefits on their communities when they cease their public purposes. When California Blue Cross converted to for-profit status and merged with WellPoint Health Networks, Inc. in 1996, the deal created two foundations: The California Health Endowment with assets of $3.5 billion (in February 2000) and the California HealthCare Foundation with assets of $900 million (in February 2001), both dedicated exclusively to improving the health of Californians.

A Comparison of Hospital Sale and Conversion Legislation, Selected States

State	*AZ*	*CO*	*NE*	*SD*	*WI*
State Notification Required	■	■	■	■	■
State/AG Approval Required			■		■
Transaction Documents on Public Record		■	■		■
Public Hearing	■	■	■		■
Referral to State Health Agency	■	■	■		■
Outside Expert Retained at Expense of Buyer and/or Seller		■	■		■
Compliance Provisions		■	■	■	
Nonprofit to Nonprofit Transactions Covered	■	■		■	
Community Assessment/ Access to Care Provision	■	■	■		
Remedies and Penalties		■	■		■

Source: Volunteer Trustees Foundation For Research and Education, 2002.[19]

The Public's Interest and Public Policy

Despite the controversy surrounding the actual provision of community benefits by not-for-profit health services providers, the list of benefits that should be conferred is more commonly accepted. Not-for-profit health organizations typically provide one or a combination of the following:

- Charity care
- Lower prices
- Provision of services to public program enrollees at cost or below cost
- Subsidization of community health services
- Research and education
- Community control and accountability.[19]

Unlike the case of consolidations, there is no federal regulatory agency that reviews and comments on the potential benefits and costs to the public of conversions from not-for-profit to for-profit status. Nevertheless, several states in the 1990s established laws for reviewing, approving, and monitoring not-for-profit conversions. Several organizations (e.g., the National Association of Attorneys General, the American Hospital Association, and the Volunteer Trustees Foundation for Research and Education) proposed

model acts or conversion guidelines for states to follow.

In a study conducted by the Volunteer Trustees Foundation for Research and Education,[20] common elements of fourteen state hospital conversion statutes include:

- State notification of intent to convert
- Transaction documents are on the public record
- Public hearing
- Referral to state agency (usually the attorney general and/or state health agency) for review, analysis, and approval.
  - Valuing the assets and structuring the transaction
  - Analyzing transaction for breach of duty and conflict of interest
  - Evaluating impact on access to care
- Use of sale proceeds stipulated
- Monitoring compliance with conditions of approval
- Remedies and penalties

The author is unaware of any studies that measure the impact of these statutes on the provision of health services in the states where they have been implemented.

Conversions of Blue Cross and Blue Shield Plans typically require the approval of the state Insurance Commissioner. To date, Kansas is the only state that has halted a Blue Cross and Blue Shield conversion, although other state governments, Maryland, for example, are gathering information about proposed Blue Cross and Blue Shield consolidations and conversions in their states and will soon make decisions to allow or deny the proposals.

The Role of Regulation in an Evolving Market

A prominent theory of government holds that when markets fail to operate effectively, it is justifiable for the public sector to intervene and regulate market activities and transactions. Monopolies and inefficient distribution of certain goods and services are examples of market failures. When it is proper to intervene is open to dispute. Do consolidation and conversion represent market failures or are they merely evidence of an evolving, yet functional, market? It may be too early to tell.

Although the potential dangers to the public of consolidation and conversion should remain on the policy radar screen into the future, consider this evidence from a recent study of Blue Cross and Blue Shield Plans.[21] The authors report that enrollment in Blue Cross Plans nationally had fallen from 87.8 million in 1980 to 65.2 million in 1994. Some market analysts were writing Blue Cross Plans off as a sad anachronism, too large and too slow to react to the rapidly changing market. Yet, by the end of 2000, Blue Cross enrollment had rebounded to 80.1 million and continues to grow. How can this be explained? According to Cunningham and Sherlock, "Some have converted to for-profit ownership; many have consolidated; all have developed managed care strategies to varying degrees." [22] They go on to say, however, "The larger plans tend to be superior performers, although size per se will not explain performance as well as strong management will explain both size and results." In other words, organizational form may have less to do with performance than the skills and values of management.

In discussing conversions, Claxton and his colleagues wrote, "The goal of public policy should not be to prevent conversions; such rigid policy could impede desirable change. Rather, the goal should be to preserve valued functions and resources in the context of a competitive marketplace." [23] The challenge for policymakers is to define the valued functions and resources they want to preserve and to design policies that will maintain them without hampering unnecessarily the natural evolution of the market.

Endnotes

[1] Both not-for-profit and for-profit organizations rely on retained earnings and debt for new capital expenditures. Under certain circumstances, equity capital can be less expensive than debt. Stocks with higher price/earnings ratios lower an organization's cost of capital relative to debt. Although the current economic performance of health maintenance organizations is not as good as their historical track record, in the 1990s several HMOs had P/E ratios in excess of 30 (Gray 1997).

[2] The definitions of these terms are far from fixed (see Wellever, A., "Rural Health Care Networks," in T. Ricketts (ed.) *Rural Health in the United States*, 119-133, New York: Oxford University Press, 1999). The range of organizational linkages and their characteristics, from the perspective of one study, are arranged in Figure 1 from the least binding to the most binding.

[3] Shortell, S., E. Morrison, and B. Friedman, *Strategic Choices for America's Hospitals: Managing Change in Turbulent Times*, San Francisco: Jossey-Bass Publishers, 1992.

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[5] Hoare, G., A Katz, H Baldwin, "Rural Linkages: Challenges for the 1990s," Health Policy Analysis Program, Department of Health services, School of Public Health and Community Medicine, University of Washington, Seattle, WA, 1991.

[6] O'Connor, K., *Health Care Glossary of Terms & Definitions*, The Understanding Business Press, 1996.

[7] California Institute for Rural Health Management, *Glossary of Healthcare Terms*, Oakland, CA, 1998.

[8] Grossman, J. and B. Strunk, "Blue Plans: Playing the Blues No More," in P. Ginsburg and C. Lesser (eds.) *Understanding Health System Change: Local Markets, National Trends*, Ann Arbor, MI: Health Administration Press, 2001.

[9] Cunningham, R. and D. Sherlock, "Bounceback: Blues Thrive as Markets Cool Toward HMOs," *Health Affairs*, 21(1):24-38, 2002.

[10] Gray, B. "Introduction: Overview of the Conversion Phenomenon, " *Bulletin of the New York Academy of Medicine*, 74(2): 175-179, 1997.

[11] Haas-Wilson, D. and M. Gaynor, "Increasing Consolidation in Healthcare Markets: What are the Antitrust Policy Implications?" *Health Services Research*, 33(5), Part II: 1403-1420, 1998.

[12] Liebenluft, R., "Informing Health Care Antitrust Enforcement: Issues for Health Services Research," presentation by Robert F. Liebenluft, Assistant Director, Health Care, Federal Trade Commission, Washington, D.C., at *Health Services Research Seminar Series*, University of Minnesota, Division of Health Services Research and Policy, Minneapolis, MN, October 22, 1997.

[13] Hellinger, F.J., "Antitrust Enforcement in the Healthcare Industry: The Expanding Scope of State Activity," *Health Services Research*, 33(5), Part II: 1477-1494, 1998.

[14] Grossman, J. and B. Strunk, 2001.

[15] Cunningham, R. and D. Sherlock, 2002.

[16] Gray, B., 1997.

[17] Claxton, G., J. Feder, D. Shactman, and S. Altman, "Public Policy Issues in Nonprofit Conversions: An Overview," *Health Affairs*, 16(2): 9-28, 1997.

[18] Grossman, J. and B. Strunk, 2001.

[19] Claxton, G., J. Feder, D. Shactman, and S. Altman, 1997.

[20] Volunteer Trustees Foundation for Research and Education, "Common Elements in Hospital Conversions Legislation: A Summary of Findings From Fourteen States," http://www.volunteertrustees.org/hospitals/pt1.html, accessed March 3, 2002.

[21] Cunningham, R. and D. Sherlock, 2002.

[22] Cunningham, R. and D. Sherlock, 2002.

[23] Claxton, G., J. Feder, D. Shactman, and S. Altman, 1997.