

Wisconsin Blues' Conversion: The Privatization of a Health Insurer

Bruce Fetter, PhD

ABSTRACT

Wisconsin Blue Cross was chartered in 1939 as a “charitable and benevolent corporation” to cover hospitalization costs at a time when most Americans did not have health insurance. In order to promote the protection that insurance afforded, the Wisconsin legislature exempted the company from most state and local taxes. During World War II, the federal government created tax deductions for both employers and employees, which created new demand for health insurance. The company extended its coverage to physicians’ services and, as Blue Cross Blue Shield United of Wisconsin (BCBSUW), became the state’s largest health insurer. In 1965, when Medicare and Medicaid further extended health coverage to the elderly, disabled, and indigent, the company took on the additional activity of administering those benefits on behalf of the government. The surge in demand for health care led to inflation in health costs in the 1970s.

Many in the insurance industry and government felt this inflation could be controlled through the extension of market competition among insurers. They therefore proposed abandoning their tax exemptions in exchange for the right to operate as for-profit corporations. As a condition of this transformation, the state government required that BCBSUW create charitable foundations to benefit medical education and public health. After privatization, however, the for-profit successors of BCBSUW failed to control both medical costs and company administrative expenses. A substantial share of the profits went to their executives.

INTRODUCTION

Risk of sickness and death is unevenly distributed in all populations. Since the 1880s, the US healing pro-

fessions have helped lower morbidity and mortality in various segments of the population, but some individuals have remained more vulnerable than others.¹ Life insurers and then health insurers have enabled policyholders to cushion themselves and their families against the economic shocks of illness and early death.

Insurance companies have taken 2 general forms: for-profit organizations, which sell policies to individuals or groups at rates calculated to produce income sufficient to pay claims, compensate staff, and provide dividends to stockholders; and companies in which policy holders, not-for-profit corporations, or government agencies financed by taxation pay claims, business expenses, and administration costs. Until the late 1980s, many of the nation’s largest life insurers were mutual companies financed largely through their policyholders’ premiums, while many of the largest health insurers were not-for-profit corporations.

This article traces the history of Blue Cross Blue Shield United of Wisconsin (BCBSUW), the state’s largest health insurance company. It began in the 1930s as a not-for-profit insurer covering hospitalization costs, acquired the function of paying other medical expenses after World War II, and underwent privatization between 1991 and 2001. The paper concludes with an assessment of the company’s changing relationship to its policyholders.

NON-PROFIT HEALTH INSURANCE: ORIGINS OF WISCONSIN BLUE CROSS

The predecessor of BCBSUW was chartered as a not-for-profit organization by Wisconsin law 180.32 of 1939. A new organization called Associated Hospital Services, Inc. (Blue Cross) began operations at the beginning of 1940 as a “charitable and benevolent corporation,” which took the form of a non-stock, not-for-profit service insurance corporation. The Wisconsin legislature interpreted this section of the law to mean “the public policy of this state is declared to be: to ease the burden of payment for hospital services, particularly in the low income groups.” In return, Wisconsin

Author Affiliation: University of Wisconsin-Milwaukee.

Corresponding Author: Bruce Fetter, History Department, University of Wisconsin-Milwaukee, PO Box 413, Milwaukee, WI 53201; phone 414.229.5207; fax 414.229.2435; e-mail bruf@uwm.edu.

Blue Cross received exemption from most city, state, and federal taxes, the latter of which was partially rescinded in 1986.²⁻⁴

Like other mutual and not-for-profit insurers, Blue Cross included a commercial element in that it employed a sales staff to market its policies and a management to oversee sales, determine premiums, and invest its income. These functions grew in importance during the World War II when the federal government created tax exemptions for health insurance premiums that were available to both employers and employees. Like other insurers, Wisconsin Blue Cross and its successors reported its finances to the Wisconsin State Commissioner of Insurance. These reports constituted financial accounts intended for public scrutiny. Over time, company managers also compiled cost-accounts, private documents “to provide information useful for internal decision-making.”⁵

Although not-for-profit corporations such as Wisconsin Blue Cross did not pay dividends to shareholders, the insurance industry devised a metric based on financial accounts that applies equally to both for-profit and not-for-profit insurers. This is the SGA ratio, the total sum spent on sales, general, and administrative expenses, calculated as a percentage of premiums collected in any given year. In 1949, Wisconsin Blues’ SGA amounted to 8% of its premiums, which totaled \$6 million.

Competition with private insurers led Blue Cross to extend its coverage to physician care. In 1945, the Medical Society of Milwaukee County (MSMC) established Surgical Care (Blue Shield) to provide such coverage, and, a year later, Blue Cross began to sell its policies as supplements to its hospitalization coverage. This combined hospitalization and physician insurance was the forerunner of Blue Cross Blue Shield United of Wisconsin (BCBSUW), which took its final form in 1981.⁶

The State Medical Society of Wisconsin (SMS), today known as the Wisconsin Medical Society, initially objected to the linkage between insurance for hospitalization and that for physician fees and so established a competitor, the Wisconsin Plan, which covered medical services but initially did not cover hospitalization. The Wisconsin Plan became the not-for-profit Wisconsin Physicians Service (WPS) in 1946. The establishment of rival insurance companies precipitated an 18-year struggle from 1946 to 1964 between the SMS and the MSMC.² As a result, Wisconsin obtained 2 competing not-for-profit insurers. Of these, Blue Cross was the larger. Twenty-five years after its foundation, its pre-

miums had reached \$50 million per year, of which only 5.1% was spent on SGA.

Nonetheless, health costs were rising steadily. Hospitalization in particular took a substantial proportion of American health expenditures. In 1929, it had constituted 17.9% of total health dollars; by 1962, its share had grown to roughly one third.⁷ In absolute terms, hospital costs rose nationally from a little over \$1 billion in 1940 to nearly \$13 billion in 1964 (from 1% of GDP to nearly 2%), while SGA expenditures for health insurance nationally held constant at 0.2% of gross domestic product (GDP).⁸

THE CONSEQUENCES OF MEDICARE AND MEDICAID: EXTENDED COVERAGE, INFLATION, AND MARKET SOLUTIONS

Most of the health insurance payouts went to employees and their dependents. Americans outside the workforce did not benefit from this protection. Beginning in 1950, the federal government began to provide insurance coverage for the indigent and elderly. These policies culminated in the Medicare and Medicaid Acts of 1965, which paid for physician care and hospitalization for the poorest groups in US society: the elderly, the indigent, and the disabled. Medicare Part A hospitalization was funded through a compulsory payroll tax matched by employers, comparable to Social Security tax. Medicare Part B offered optional insurance coverage for physician charges for the elderly. Medicaid covered hospitalization for the disabled, the unemployed, and their dependents and was financed by a complicated system of state-federal cost-sharing. Private insurers, such as the Wisconsin Blues, could obtain lucrative contracts with the federal government to administer Medicare and Medicaid programs.

Unfortunately, these new federal programs lacked effective cost controls. Medicare Part A expenses, which were calculated on a cost-plus basis, proved particularly troublesome. Hospital costs nearly doubled between 1970 and 1975 and again between 1975 and 1980.⁹ National expenditures on hospitalization alone rose to \$135 billion in 1982, no less than 4.1% of the GDP. Little noticed at the time was a parallel increase in expenditures for the administrative and net costs of private health insurance to \$16.5 billion, 0.5% of GDP and 2.5 times the percentage of 1964. Health care costs as a whole rose from about 5% of GDP in 1965 to 10% in 1983.

According to James Robinson,¹⁰ health inflation stimulated a search for new ways of controlling costs. A policy trend had emerged in the late 1970s that stressed

controls determined by market forces rather than government regulations. Two new tools were devised to control costs: privately owned health management organizations (HMOs) and purchasing alliances. HMOs, which were Congressionally authorized in 1973, were private multi-specialty medical groups that provided both hospitalization and medical care in exchange for premiums. Costs were to be contained through competition between HMOs.

As far as hospital costs were concerned, a 1983 prospective payment system ultimately reduced relative costs. The proportion of health dollars taken by hospitals dropped from 42.1% in 1982 to 31.7% in 2000. Total health costs, however, continued to rise, accounting for about 13% of GDP in the 1990s and rising to 16% in 2003. The hospitals' share of GDP also continued to rise: to 4.8% in 1992 before subsiding to 4.2% in 2000. Administrative costs of health insurance, which included administration of Medicare and Medicaid, also rose disproportionately, to over \$80 billion in 2000, some 0.8% of GDP. Substantial SGA revenues tempted insurance company managers to seek to capture some of the overhead for themselves through privatization.

PUTTING THE WISCONSIN BLUES ON THE PRIVATIZATION TRACK

Indeed, privatization was in the air in other parts of the insurance industry as well. In the mutual life insurance sector, increases in revenue had previously been distributed to policyholders in the form of lower premiums rather than to shareholders as dividends. In the late 1980s, management of some of the largest mutual insurers proposed demutualization. This involved distributing stock to existing policyholders and managers, excluding future policyholders from ownership, and henceforth raising new capital through the sale of stock on the open market in the demutualized successor companies. Many mutual insurers followed this pattern. The proportion of life insurance sold through mutual companies fell from 55% in 1985 to 16% in 2005.¹¹

Among health insurers, the analogous process among not-for-profit Blue Cross Blue Shield companies was pioneered by The Indiana Blue Plan in 1989. It bought a Dallas-based for-profit company that operated as a wholly owned subsidiary that paid dividends to its stockholders and distributed stock options to the subsidiary's managers but left Indiana's Blue's not-for-profit operations intact. Its management was restrained from privatizing by the charitable function stipulated in its original state charter. The only way these companies could abandon their tax-exempt status was by

preserving charitable assets equal to those of the insurance companies before their privatization. This process, called conversion, was pioneered in 1996 by Blue Cross of California, which transferred more than \$4 billion worth of newly issued stock to 2 charitable foundations in exchange for the right to privatize its operations.^{12,13}

BCBSUW actually anticipated some of the processes leading up to privatization. In 1983, it created United Wisconsin Services, Inc. (UWSI) to operate its managed care and employee benefits divisions, and in 1991, it obtained state permission to issue stock in UWSI as a wholly-owned, for-profit subsidiary. Between 1991 and 1996, the mother company reduced its holdings of UWSI stock to 38%, the remainder going to private investors and as stock options for designated executives. UWSI acquired and created its own for-profit subsidiaries, which managed regional HMOs and wrote coverage for small groups. By this time, UWSI was collecting nearly \$1.1 billion per year in premiums.¹⁴

Following the precedent established by California Blue Cross, BCBSUW applied to convert the remainder of its enterprise from a non-profit insurer into a stock company, which became the Cobalt Corporation in 2001. Aside from stock options for the management, most of Cobalt stock was initially assigned to a new foundation benefiting Wisconsin's 2 medical schools. In its charter, the foundation was obliged to sell its stock on the open market within a few years.

Cobalt was then bought out in 2003 by WellPoint, the successor to California Blue Cross, which was in turn absorbed in 2005 by Anthem, the holding company originally derived from Indiana Blue, which now runs an amalgam of formerly not-for-profit Blues in 16 states. Anthem then adopted WellPoint as its corporate name.

PRIVATIZATION: JUSTIFICATION AND CONSEQUENCES

Despite the large volume of published financial accounts for BCBSUW, it is difficult to find a company explanation for its privatization. Nonetheless, some documents do give clues to the management's intentions. The 1997 UWSI form 10-K describes the aim of its products thusly: "to provide employers with cost effective solutions to their employee benefit needs." The 1999 UWSI 10-K account of its business strategy identifies "cost containment for the buyer" and geographic expansion through "acquisitions and...strategic alliances."¹⁴ Finally, the 2002 Cobalt form S-3A argues that the 1991 privatization of UWSI enabled the company "to gain increased access to capital markets."

The amalgamations with WellPoint and Anthem accomplished the 2 latter objectives, but what about cost containment? How did they cope with the increase in national health care costs from 10% of GDP in 1983 to 16% in 2003? And what was the effect of these increases on policyholders? Mark Hall and Christopher Conover¹⁵ compare the administrative costs of for-profit Blue Cross insurers with those of not-for-profit insurers and find that the former are of the order of 1 to 2 percentage points higher in cost than those of comparable not-for-profit insurers. Thus, privatization tends to raise the bill for policyholders.

Indeed, the privatization of BCBSUW, despite the claims of its management, did nothing to stem health cost inflation in Milwaukee. In 2003, per capita health costs paid by Milwaukee employers (\$8144) were 38% higher than the Midwest average (\$5880).¹⁶ Hospital operating costs alone were 14%-26% higher than in comparable cities.¹⁷ These costs were shared by employers who negotiated group health policies and their employee policy holders. Neither group can be said to have benefited from the privatization. Employees in particular have suffered from benefit caps and higher administrative costs.

And just how efficient are the privatized companies? Published financial accounts do not provide much information on internal company thinking, but the SGA ratios offer a common metric for judging the efficiency of health insurers.

As stated earlier, in 1964 BCBSUW succeeded in reducing its administrative costs to 5.1% of benefits. UWSI, in its 10-K reports for 1997 and 1999, claims very low SGA/benefit ratios for its HMO products: 8.9% in 1994, 7.9% in 1995, 8.4% (or 9.3%) in 1996, 9.3% in 1997, and 9.6% for 1998.¹⁴ By contrast, Cobalt's 10-K for 2001 reports BCBSUW SGA/benefits ratios for insured medical products of 14.3% in 1999, 12.0% in 2000, and 9.6% in 2001.¹⁸ Privatization further raised SGA ratios as reported by WellPoint in their 10-K forms from 19.6% in 2001, which then fell to 19.3% in 2002, 18.8% in 2003, 17.0% in 2004, and 16.3% in 2005. Anthem reported an SGA ratio of 19.2% in 2003,¹⁹ which fell, after the absorption of WellPoint, to 16.3% in 2005.

These ratios compare unfavorably with those for health care professionals, which remained not-for-profit. WPS,²⁰ for example, reported an SGA ratio of 8.9% in 2001. In Minnesota, where health insurers are required by law to operate as not-for-profits, BCBS Minnesota reported ratios of 8.1% in 2002, 11.4% in 2003, and 14.2% in 2004.²¹ Privatization appears to have substan-

tially raised the administrative costs of BCBSUW and its successor companies.

Some of these proceeds went to stockholders. Others, however, went to the company's management. This phenomenon first came to the public's attention in 1996, when 2 executives of a subsidiary of UWSI, American Medical Service Group (AMSG) received cash payouts of \$1.85 million each and stock options on 1 million shares of UWSI stock, which then had a market value of \$20 million.²² Each cohort of executives netted ever larger earnings—largely from stock options—when 1 company absorbed another. In fiscal year 2002, 6 of the 7 top officers of Cobalt each received compensation in excess of \$1 million.^{23,24} In that same year, each of the 5 top WellPoint executives received total compensation in excess of \$4 million.²⁵ The CEO received over \$19 million in 2002 and was estimated to be entitled to over \$45 million if he retired in 2004.²⁶ The chief executive of Anthem alone received \$55 million total in 2003²⁵ and comparable amounts over the next 3 years.²⁶

In sum, the 1991-2001 transformation of BCBSUW had consequences far different from the 1939 legislative intent "to ease the burden of payment for hospital services, particularly in the low income groups." American health care, of course, had substantially changed. Senior citizens, the poor, and the disabled had gained government-financed access to care. Companies had acquired taxation benefits when they provided health insurance for their workers, although they were under no legal obligation to do so. The new needy were the working poor: the young, the self-employed, Latinos, and those working for firms that did not offer health insurance. In addition, workers were underinsured. The executives of the privatized successors to BCBSUW received inordinately large compensations, but it is difficult to find any benefits for the policyholders or the indigent. The for-profit agency was no longer easing many burdens.

Funding/Support: None declared.

Financial Disclosures: None declared.

REFERENCES

1. Fetter B. Health care and social change in the United States: a mixed system, a mixed blessing. *Hygieia Internat.* 2004;4(1):277-298.
2. Sinclair F. *Blue Cross in Wisconsin*. Racine, Western Printing and Lithographing Company; 1965:vii-x, 18-30, 41-45, 51-61.
3. Consumer Union. *Amicus curiae* brief. August 11, 2000. Available at: <http://www.consumersunion.org/conv/docs/AmicusWisconsin.doc>. Accessed November 25, 2007.
4. Cobalt Corporation. Form 10-K, Annual Report for 2001, Filed March 27, 2002. Available at: http://oci.wi.gov/hmo_info/profiles/compbro.htm. Accessed November 25, 2007.

5. Giroux G. A short history of accounting and business. A book in progress. Available at: <http://acct.tamu.edu/Giroux/history.html>. Accessed November 25, 2007.
6. Commissioner of Insurance, State of Wisconsin. Information on the Conversion of Blue Cross & Blue Shield of United of Wisconsin, 1999. Available at: <http://oci.wi.gov/bcbsconv.htm>. Accessed November 25, 2007.
7. Reed LS, Rice DP. National Health Expenditures: object of expenditures and source of funds. *Soc Sec Bull.* 1964;27(8):11-21.
8. Department of Health and Human Services. Centers for Medicare and Medicaid Statistics. National Health Expenditure Accounts for 2000. Available at: http://www.cms.hhs.gov/MCBS/Downloads/HHC_2000_chapter2.pdf. Accessed November 25, 2007.
9. Mayes R. *Universal Coverage: The Elusive Quest for National Health Insurance*. Ann Arbor: University of Michigan Press; 2004.
10. Robinson J. The politics of managed competition: public abuse of the private interest. *J Health Politics, Policy Law.* 2003;28(2-3):341-353.
11. Rankin J. Winning moves for insurers. Resource; April 2005. Available at: <http://www.loma.org/res-04-05-winningmoves.asp> Accessed December 16, 2007.
12. Schramm C. The diseconomies of Blue Cross conversion; 2005. Available at: http://www.healthleadersmedia.com/print.cfm?content_id=63732. Accessed November 25, 2007.
13. Garigan M. Health conversion foundations. Georgetown University, Center for Public and Nonprofit Leadership. Working Paper 2. Washington DC; 2004. Available at: <http://foundationcenter.org/getstarted/topical/healthco.html>. Accessed November 25, 2007.
14. United Wisconsin Services, Inc. Form 10-K, 1997, 1999. Available at: <http://www.secinfo.com/dVut2.7Cgj.p.htm>. Accessed November 25, 2007.
15. Hall MA, Conover CJ. The impact of Blue Cross conversions on accessibility, affordability, and the public interest. *Milbank Memor Quart.* 2003;81(4).
16. *Business Journal of Milwaukee*. Milwaukee health care costs still higher than Midwest average. March 15, 2005.
17. *Business Journal of Milwaukee*. Report: Diverse forces drive Milwaukee's high health care costs. June 28, 2006.
18. Cobalt Corporation. Form 10-K, Annual Report for 2001, Filed March 27, 2002. Available at: http://oci.wi.gov/hmo_info/profiles/comppro.htm. Accessed November 25, 2007.
19. Robinson J. Consolidation and the transformation of competition in health insurance. *Health Aff.* 2004;23(6):11-24.
20. Wisconsin Physicians Service Insurance Corporation. Statement of Revenue and Expense for the year 2001. Available at: <http://oci.wi.gov/markcond/wps2001.pdf>. Accessed November 25, 2007.
21. State of Minnesota. Department of Commerce. Examination on report of BCBSM, Inc.dba Blue Cross and Blue Shield of Minnesota, Eagan, Minnesota as of December 31, 2004.
22. American Medical Services Group. Form 10-K, Annual Report for 1997 and 1999. Available at: <http://www.secinfo.com/dQQ9u.5d.htm> Accessed December 16, 2007.
23. Cobalt Corporation. Form DEF 14A. April 30, 2003. Available at: <http://sec.edgar-online.com/2003/04/30/0000950134-03-006752/Section15.asp>. Accessed November 25, 2007.
24. Salary.com. Cobalt Corporation. Available at: http://swz.salary.com/execcomp/layouthtmls/excl_companyreport_C1005592_summary.html. Accessed December 16, 2007.
25. Salary.com WellPoint Corporation. Available at: http://swz.salary.com/execcomp/layouthtmls/excl_companyreport_C1001890_summary.html. Accessed December 16, 2007.
26. Anthem Corporation. Form 4. Larry Glasscock. Available at: [http://www.secinfo.com/\\$/SEC/Registrant.asp?CIK=1156039](http://www.secinfo.com/$/SEC/Registrant.asp?CIK=1156039). Accessed December 16, 2007.

Wisconsin Medical Journal

The mission of the *Wisconsin Medical Journal* is to provide a vehicle for professional communication and continuing education of Wisconsin physicians.

The *Wisconsin Medical Journal* (ISSN 1098-1861) is the official publication of the Wisconsin Medical Society and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor is responsible for overseeing the production, business operation and contents of *Wisconsin Medical Journal*. The editorial board, chaired by the medical editor, solicits and peer reviews all scientific articles; it does not screen public health, socioeconomic or organizational articles. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *Wisconsin Medical Journal* nor the Society take responsibility. The *Wisconsin Medical Journal* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

For reprints of this article, contact the *Wisconsin Medical Journal* at 866.442.3800 or e-mail wmj@wismed.org.

© 2007 Wisconsin Medical Society