Premera Conversion Study

Report 1

Premera Involvement in Washington and Alaska Health Insurance Markets

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Produced for:

Premera Watch Coalition
Washington State Hospital Association
Washington State Medical Association
Alaska Blue Cross Conversion Task Force

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I. Introduction

In the May 2002, the Premera Blue Cross corporation announced its intention to convert from nonprofit to for-profit status. In February 2003, Washington State Insurance Commissioner Mike Kriedler granted intervener status in the conversion process to groups of provider, consumer, public interest, and health care advocacy organizations with an interest in the outcome of Premera's conversion.[1] These groups of interveners asked the Health Policy Analysis Program (HPAP) to examine available information and conduct additional research in order to produce two reports that evaluate the possible effects of a Premera conversion on consumers and providers in Washington and Alaska.

This first report examines the role and recent behavior of Premera in the Washington and Alaska health care markets in order to create a baseline from which to assess possible effects of conversion.

A second report examines likely post-conversion scenarios based on experiences in other states where Blue Cross and Blue Shield conversions were completed or proposed. It identifies the following as problems associated with some, if not all, conversions: reduced spending on medical care; higher administrative costs; lower quality of care; withdrawals from markets; and more aggressive medical underwriting. Report 2 also notes that, in some cases, negative trends that became apparent post-conversion were evident immediately before conversion as companies positioned themselves for for-profit status.

Methods

For Report 1, we examined a wide range of written materials and data in order to document Premera's role in the Washington and Alaska health care markets. We also conducted a number of interviews (19) with knowledgeable experts on local or state insurance markets in Washington and Alaska. People we spoke with include representatives of state and local medical societies, hospital associations, brokers, and a wide variety of providers who do business with Premera. The providers whose representatives were interviewed varied substantially in size, type, and location within the two states.

We obtained and analyzed reports and data derived from insurance company filings with the Washington State Office of the Insurance Commissioner and the Alaska Division of Insurance. For Washington, we also relied on historical data compiled by the Washington State Hospital Association from official insurance filings. We obtained Washington data on enrollment by health plan from the Medical Assistance Administration and Health Care Authority to measure changes in Premera's market participation in public programs and the public employees markets.

We used publicly available information to provide accounts of recent historical events that have a bearing on Premera's role and to analyze the variations in this role by local markets. We reviewed a number of publicly available Premera documents, such as annual reports and filings for its conversion proposal, as well as transcripts of meetings on the conversion sponsored by each state's insurance commissioner. We did not have access to many of the materials developed during the conversion proceedings, including non-public company documents and the various

reports on the conversion developed by consultants to the Washington State Office of the Insurance Commissioner.

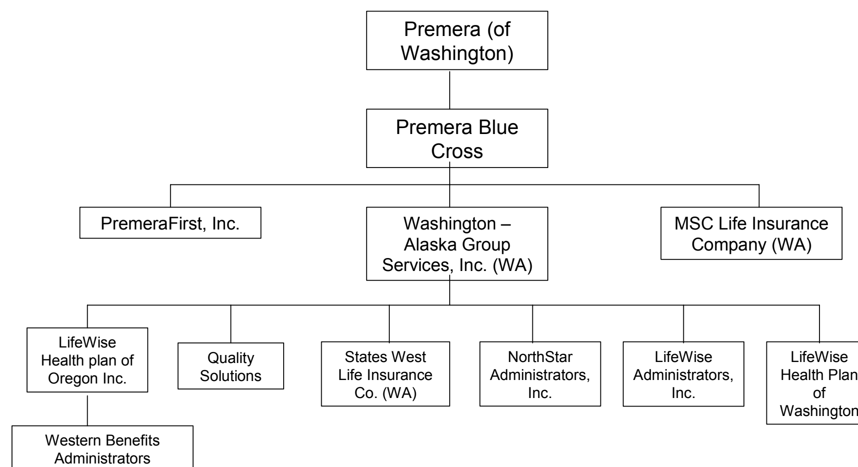
A Brief Review of Premera's History and Structure

Washington's Blue Cross plan, the predecessor of Premera, had its first incarnation as the Washington Hospital Service in May 1945. Washington Hospital Service was first authorized to accept payments for future health care services (that is, become an insurer) in July 1948.[2] Washington hospitals, which financed the formation of the company, retained voting rights on the Premera board of directors until relinquishing this control in 1984.[3]

The company began to operate in Alaska in 1957. In March 1969, the company changed its name to Blue Cross of Washington and Alaska.[4] In 1994, the company affiliated itself with the Medical Service Corporation (MSC), a Spokane-based Blue Shield plan—incorporated as a charitable organization in 1933—with extensive operations in eastern Washington. In 1998, the two companies merged to become Premera Blue Cross. The company's division in Alaska is called Premera Blue Cross Blue Shield of Alaska.[5] In November 1998, Premera created Premera Healthcare Inc. as a for-profit subsidiary of WA-Alaska Group Services, which is itself a for-profit subsidiary of Premera.[6,7] Premera also controls a life insurer and third-party administrator called NorthStar Administrators Inc. that manages employer self-funded health plans in Washington and Alaska. For a graphic presentation of Premera's structure, see Figure 1.

Premera also has affiliates in Oregon and Arizona. Lifewise of Oregon is a for-profit company operating under the Premera umbrella.[8] LifeWise Health Plan of Arizona, a subsidiary of for-profit MSC Life Insurance Company,[9] will begin enrollment in 2004.[10] Since the inception of Medicare in 1966, Premera has been a Medicare "fiscal intermediary" that processes claims and reviews provider billings for accuracy in Washington and Alaska. Later, the company became the intermediary for providers in Texas, Mississippi, Missouri, and Wyoming.[11]

FIGURE 1. Premera Blue Cross Organization Chart, 2002



Source: Premera Blue Cross, *Annual Statement for the Year 2002 of the LifeWise Health Plan of Washington*, p.55.

II. The Washington and Alaska Health Care Systems

Premera's role in the health care markets of Washington and Alaska can be best understood in the context of the social, economic, and health care system characteristics of the two states. Alaska is the nation's largest state geographically, but it has one of the smallest populations, meaning that much of the population is thinly dispersed, along with substantial concentrations in a few urban areas. By contrast, Washington has a concentrated urban population in the Puget Sound region, as well as a number of medium size cities and large towns dispersed across various regions of the state. But Washington also has thinly populated areas, and both Washington and Alaska have health care access problems, especially in rural areas.

Access issues in Alaska are of a different magnitude than in Washington. About 25 percent of the Alaska population lives in towns and villages that are only reachable by boat or aircraft. Almost 75 percent of communities are not connected by road to another community that has a hospital. Air travel is expensive, which adds a further barrier to accessing care.[12]

In Alaska, health care facilities and provider capacity are highly concentrated in certain areas, with other areas underserved or without facilities or particular practitioners. Every hospital in the state outside of Anchorage is a sole community provider. Because of its low population density, Alaska does not have county or district hospitals that can act as a central point for local health care networks—in contrast to Washington.[13]

In 1998, Alaska was ranked 48th among the states in its ratio of doctors to residents.[14] There are physician shortages in internal medicine, psychiatry, and obstetrics. Some specialties are highly concentrated in certain parts of the state, particularly in Anchorage. For example, the state has only one cardiology practice and one radiation therapy group, both in Anchorage. Fairbanks has few ophthalmologists, and no interventional cardiology services. Most tertiary services are available only in Anchorage. Some tertiary and quaternary services (e.g., a children's hospital) are not available in Alaska and residents sometimes must travel to the Lower Forty-Eight for care.[15]

Although Washington has a number of district or county hospitals, some types of specialty care and some providers tend to be concentrated in the heavily populated Puget Sound region, especially Seattle. Many counties are dependent on a few very small hospitals, and Washington has been very active in getting many of these into the federal Critical Access Hospital (CAH) program, which provides for enhanced reimbursement rates and reduced staffing requirements.[16] Many of these hospitals are sole community providers. Alaska also has a number of small hospitals qualified for the CAH program, although the state's reliance on many small clinics, rather than small hospitals, has hampered the effort to expand the state's number of CAHs, since a facility has to first be classified as a hospital to qualify for CAH status.[17]

In Washington, many areas are "over-doctored," as measured by accepted provider-to-population ratios. However, this is not the case in many rural areas, some of which fall substantially below accepted ratios. The Washington access picture is quite variegated, with some mostly rural counties having good access because of extensive safety net institutions, especially rural health clinics. On the other hand, the outlying rural areas of more urbanized counties often have poor

access because the safety net is not well-developed and many doctors practice mostly in the urban centers.[18]

Geographical barriers, provider shortages, and low levels of insurance, make access to health services a problem in Alaska in many respects. For example, in 2002, almost 19 percent of Alaskan adults said they did not have health coverage, in contrast to estimates for Washington adults, which range around 13 to 14 percent, depending on the source. Almost 20 percent of Alaska adults did not have a usual source of care in 2000.[19] By contrast, about 13 percent of adult Washingtonians said they did not have a usual source of care.[20]

Both states have a large military presence, although the role of the military in insuring Alaskans is larger at almost 13 percent, compared to 5 percent in Washington.[21] (See Table 1.) When military retirees and those eligible to use Veterans Administration services are included, almost 25 percent of the Alaska population is eligible for health care services through the Department of Defense or the Department of Veteran's Affairs.[22]

Alaska has 226 federally recognized tribes, and Washington has 29.[23,24] Native Americans make up less than two percent of the Washington population, and not all are actively affiliated with local tribes.[25] Alaska Natives and American Indians in Alaska made up 19 percent of Alaska's population in 2000, totaling 119,241.[26]

In Alaska, care within areas with large indigenous populations is often provided by Indian Health Service-funded (IHS) facilities. The IHS-supported system in Alaska comprises 7 tribally operated hospitals, 21 health centers, and 161 village clinics.[27] These facilities often serve everyone in an area, not just tribal members. For many residents of rural Alaska, initial access to health care occurs through a small, village-built clinic facility that is locally staffed with a community health aide/practitioner. In 1976, Congress allowed IHS facilities to begin billing third parties, and now Medicaid accounts for close to 50 percent of total revenues at some facilities.[28] Some Washington tribes also operate IHS clinics, but because most areas of the state have other providers nearby, IHS facilities tend to serve only tribal members.

All told, 200,000 Alaska residents are served through IHS, military, and veterans' health programs.[29] This heavy coverage from federal sources reduces the size of the private segments of the health care market.

As elsewhere, average health care costs per capita in Alaska have increased over the last quarter century. However, average total costs per person, which were 22 percent higher than the national average in 1980, are now slightly below the average national expenditure, at least according to the latest available federal expenditure data for 1998. Since Alaska has a relatively young population, however, this still represents higher than expected costs on an individual basis. By contrast, Washington expenditures per person were 90 percent of the national average, due to relatively low use of hospital services per capita (See Table 1.)

TABLE 1. Demographic, Economic, and Health Care System Characteristics, Alaska, Washington, and U.S.

		ALASKA	WASHINGTON	U.S.
	Data year			
Percent under 18	*2000/01*	33%	27%	27%
Percent over 65	*2000/01*	6%	12%	12%
Health spending per person	*1998*	$3,442	$3,382	$3,759
Uninsured	*2002*	18.7%	14.2%	15.2%
Employment-based insurance	*2002*	58.8%	61.5%	61.3%
Medicaid	*2002*	14.5%	13.0%	11.6%
Medicare	*2002*	8.3%	11.4%	13.4%
Military	*2002*	12.8%	5.0%	3.5%
Firms offering coverage	*2001*	45.7%	52.8%	58.3%
Medicaid or CHIP eligibility, children	*2003*	200% FPL	250% FPL	n/a
Poverty rate		12% (2000-01)	14% (2000-01)	16% (2001)
High risk pool?	*2002*	yes	yes	n/a
Annual average Unemployment	*2002*	7.7%	7.3%	5.8%

Source: All data from Kaiser State Health Facts, http://statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?, except uninsured and source of insurance, which is from the US CPS and unemployment, from the U.S. Bureau of Labor Statistics.

III. Premera's Involvement in the Washington and Alaska Markets

Premera Blue Cross has a prominent role in the health care markets of both Washington and Alaska. In both states, the company is the largest insurer when total enrollment across all insurance products is considered. Premera's role in the two states is similar in some markets but different in others. In both states, Premera has a large and even dominant role in the individual market. Premera has a relatively large role in employer-based markets in both states, including substantial roles in small group, large group, state and local governments, and self-funded portions of the markets. However, the company has decided to drop out of the public employees market in Washington for 2004.

Premera's role in publicly funded health insurance programs differs between the states. Premera has been a participant in Washington's Medicaid managed care program (Healthy Options) since the program's inception and also participates in the state's Basic Health program. By contrast, Alaska's Medicaid program does not involve any health insurance companies. Premera covers state employees in both markets, although it generally acts as administrator, not insurer, in Alaska. Federal employees enrolled in the Federal Employees Health Benefits Plan (FEHBP)

may be insured through Premera in both Alaska and Washington if they select a Blue Cross-Blue Shield plan as their insurer from among a wide menu of choices.

Premera has withdrawn from the Medicare+Choice market in Washington and does not participate in that market in Alaska. As a result of this and other withdrawals, most rural counties in Washington do not have any Medicare+Choice options. Alaska does not have any Medicare+Choice contractors who offer managed care plans, although one company, Sterling Life Insurance, does offer a fee-for-service plan.[30] Premera writes Medicare supplement (Medigap) policies in both states and provides long-term care insurance in Washington. Table 2 summarizes Premera's participation in various markets in both states. More detail regarding involvement in the markets of the two states follows.

TABLE 2: Premera Involvement by Insurance Market, Washington and Alaska, 2003

	Alaska	Washington
Medicaid/S-CHIP	No (all Medicaid is fee-for-service. S-CHIP program is integrated into Medicaid)	Yes
Basic Health	Not applicable	Yes
Medicare Plus Choice	No	No
Medicare Supplemental	Yes	Yes
Individual	Yes	Yes
Small Employer Group	Yes	Yes
Large Employer Group	Yes	Yes
Self-funded Employers	Yes	Yes
State and Local Employees	Yes (but often as administrator, not insurer)	Yes (ends in 2004)
Federal Employees	Yes	Yes
Long-Term Care	No	Yes

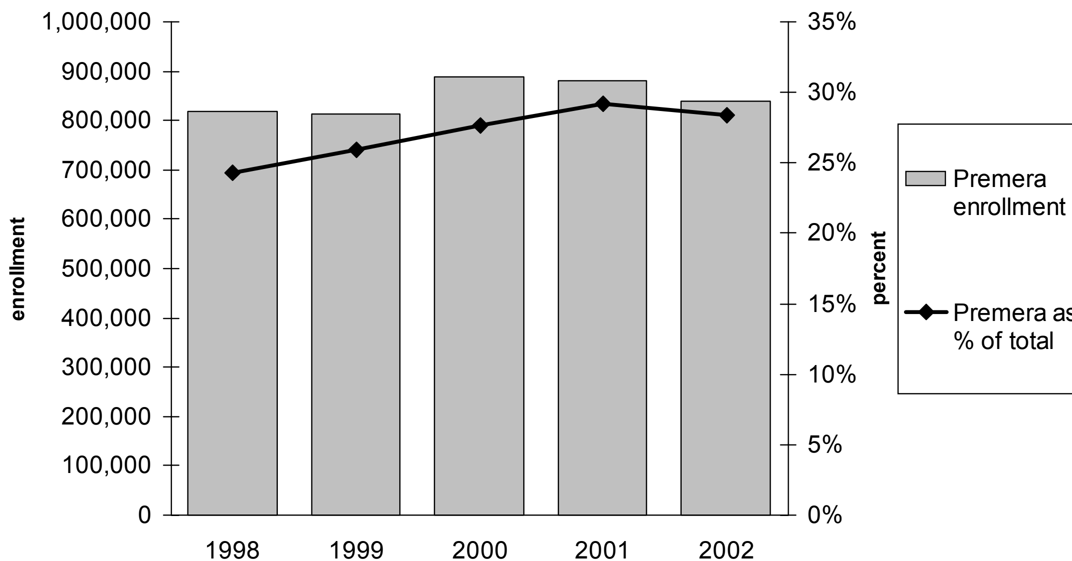
An Overview of Premera's Role in Washington

Premera has been one of Washington's largest insurers since the company's inception in the first half of the last century. Recently, the company increased its enrollment share, and Premera was the state's largest insurer in 2002 with 28.4 percent of the insurance market, just above that held by Regence, at 27.2 percent. The next largest was Group Health at 19.5 percent, followed by the 7 percent share of the Community Health Plan of Washington, which provides insurance in the Medicaid, Basic Health, and public employees markets exclusively. Premera's position as top insurer is a relatively recent phenomenon, with the top enrollment position held by Regence until 1999, when Regence had 29.9 percent of the market compared to Premera's 25.9 percent.[31]

Premera's share is up from 22 percent in 1996 (counting the enrollment of the Medical Services Corporation, which later merged with Premera).[32] Despite shifts in the relative size of carriers, the top three insurers together have steadily increased their market share. According to a report from the Washington State Office of the Insurance Commissioner, the proportion of all insured

premium revenues accounted for by the top three insurers increased from 48.5 percent in 1996 to 66.7 percent in December 2002.[33] This may actually underestimate concentration; for example, if we include the 2002 business of all subsidiaries or affiliates of Premera, Regence, and Group Health in this total, the concentration reaches 75 percent.

FIGURE 2. Premera Insured Enrollment, and Premera Percent of Total Enrollment



Source: Washington State Hospital Association compilation of Office of Insurance Commissioner data. Premera enrollment includes LifeWise, but does not include any employer self-funded enrollees, where companies provide administrative services only.

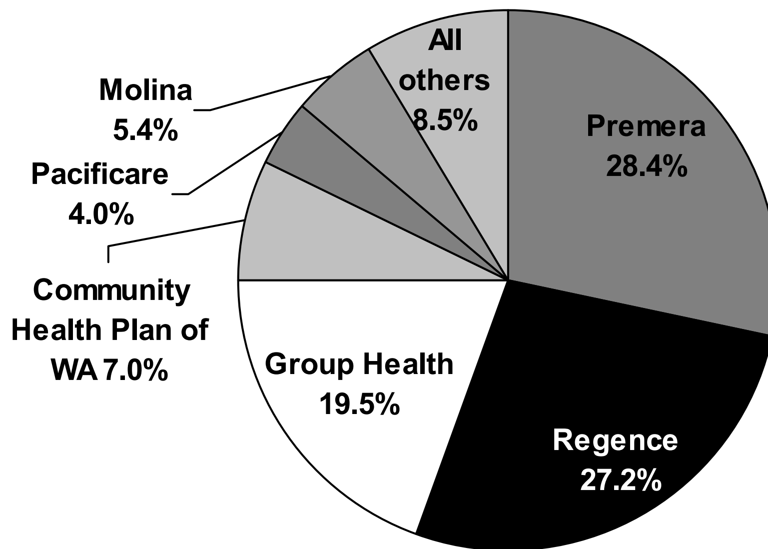
Although a relatively small number of insurers have accounted for most enrollment in most markets for quite some time, many small insurance companies that participated in the Washington market have withdrawn, gone out of business, or merged. As recently as 1997, the state had 30 full-service health plans, but this had dropped to 20 by 2002.[34]

Some of the last remaining large national companies in the Washington market, such as Aetna, have reduced their market participation or lost important contracts, thus diminishing their position. As a result, the state's market is seeing a reduction in the number of insurers and a bifurcation between the remaining largest participants; some companies are specializing in the publicly funded market, and others are shifting enrollment toward the employment-based and individual insurance markets.

Until recently, the largest companies tended to participate in most markets. In the past decade, however, the trend has been toward fewer companies participating in each market, and greater market dominance among the top insurers within specific markets. Currently, it appears that companies are pursuing a niche strategy regarding their participation in various markets. Premera, Regence, and Group Health have established themselves as the three dominant insurers in the private side of the market, with a strong presence in the small and large group employer

markets. Premera, Regence, and Aetna dominate the self-funded administrative services-only market. Premera, Regence, and Group Health also account for most of the individual market.

FIGURE 3. Washington Insurance Enrollment, Plans Grouped by Corporate Parent, 2002

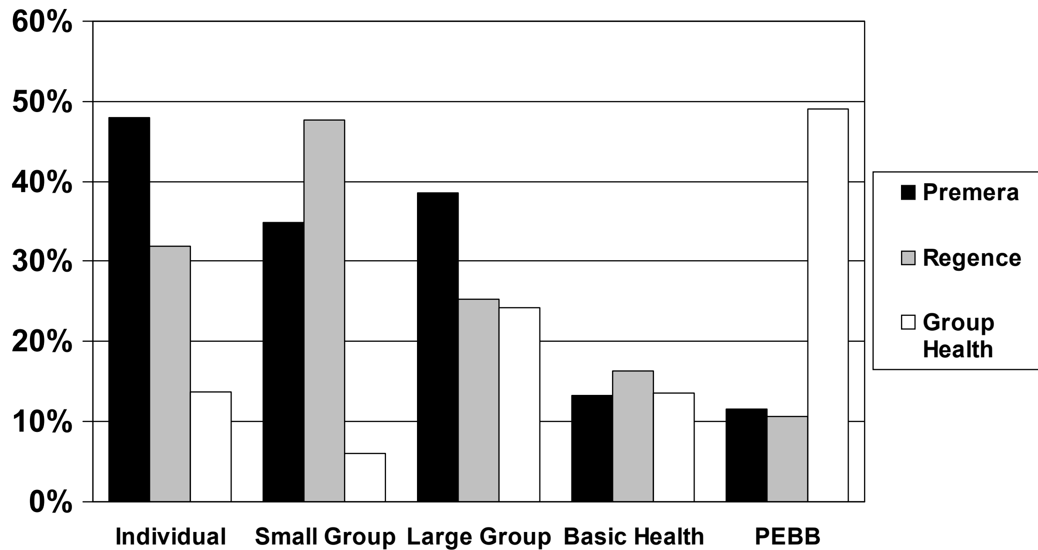


Source: Washington State Hospital Association compilation of Office of Insurance Commissioner data. Premera enrollment includes LifeWise, but does not include any employer self-funded enrollees, where companies provide administrative services only.

In contrast with their participation in the employer and individual markets, the Blues and many other commercial carriers have tended to pull back in many publicly funded markets. Premera, Regence, and Group Health greatly reduced their participation in Medicaid Healthy Options, and only a few in-state and out-of-state companies have simultaneously expanded their role in publicly funded markets. The Community Health Plan of Washington (CHPW), formed during the state's health care reform era by the state's community and migrant health centers, has established a prominent role in the Medicaid managed care portion of the market. More recently, Molina, a California for-profit insurer, has established a strong presence in the Medicaid market and is increasing its share of Basic Health. Together, these two companies accounted for 58.9 percent of the Medicaid Healthy Option/SCHIP enrollment in April 2003.[35] California-based for-profit Pacificare has also taken up a niche position, with substantial enrollment in the public employees market and the Medicare+Choice market.

Until recently, Premera has participated in the public employees market in Washington (Public Employees Benefit Board, or PEBB), although it is pulling out of that market in 2004. No doubt in part because of Premera's withdrawal from the market, the Community Health Plan of Washington will have a greatly expanded role in PEBB in 2004 and will be accepting new enrollees in 28 counties.[36] Group Health retains a substantial share of PEBB enrollment.

FIGURE 4. 2002 Share by Market, Top Three Washington Insurers



Source: Washington State Office of Insurance Commissioner. "Health Insurance Market Share for Private Carriers," undated. Enrollment includes LifeWise, but does not include any employer self-funded enrollees, where companies provide administrative services only.

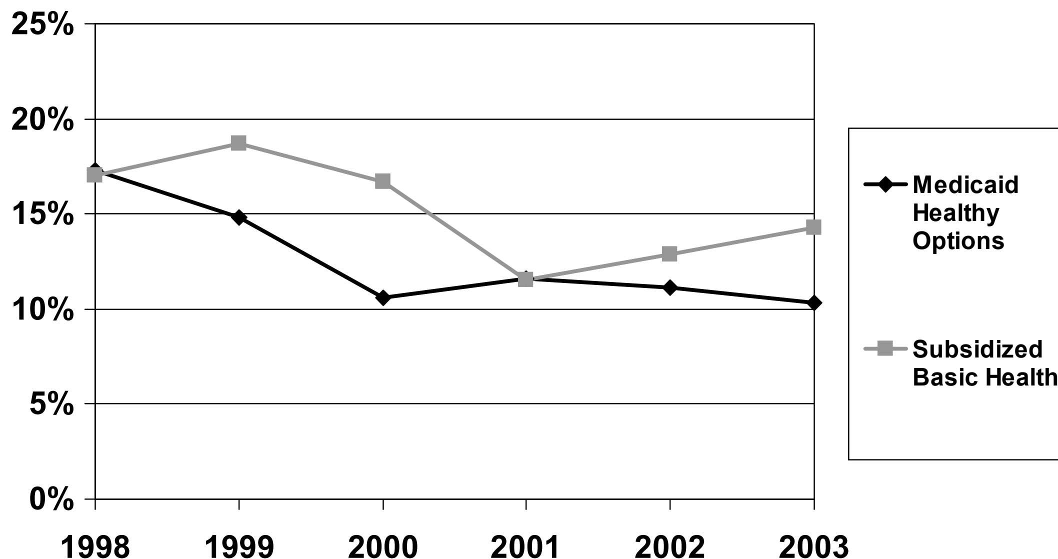
Premera's Involvement in Public Programs in Washington

Premera's involvement in state public programs for the low income (Medicaid Healthy Options and Basic Health) has declined over time, a pattern similar to that of other large commercial carriers. Medicaid is a state-federal program for low income people, mostly families and children. The Basic Health program is a state-funded plan for the "working poor," many of whom are not eligible for Medicaid. In late 1998, Premera participated in 30 Washington counties for both Basic Health and Medicaid Healthy Options, but by 2003 the company offered enrollment in only 10 Washington counties for Healthy Options and 11 for Basic Health.[37] Premera currently accounts for about 10 percent of Healthy Options enrollment. Other plans have also reduced participation in Healthy Options substantially. Group Health currently has open enrollment in five counties, and Regence in 10. Companies that specialize in public programs are picking up the slack. In 2003, CHPW participated in 31 counties and Molina in 30, and together these two insurers accounted for almost 60 percent of enrollment.[38]

Premera accounts for about 14 percent of Basic Health enrollment. Similar to Medicaid Healthy Options, the geographical contraction of the areas served by Premera in Basic Health has been abrupt in recent years. In 2000, the company dropped out of 11 counties—a reduction of more than 35 percent.[39] In the last two years, its share of Basic Health enrollment has increased slightly. Figure 5 documents recent enrollment trends.

Premera has limited its participation in markets focused on seniors and the elderly, having withdrawn from the western portion of the Medicare+Choice market in mid-2000 and from the remaining Eastern Washington portion in 2001, mirroring withdrawals by many other Washington health plans and national trends.[40,41] According to a bond rating company, Premera

FIGURE 5. 2002 Premera's Share of Washington Managed Care Public Insurance Enrollment



Source: Washington State Medical Assistance Administration, and Washington State Health Care Authority. Healthy Options enrollment share includes children in BHP+ and in S-CHIP. Data are for April of each year. Substantial public enrollment does not involve insurance carriers, e.g., Medicaid fee-for-service.

had been losing money in this market.[42] Premera remains in other portions of the senior health care market, however, offering a Medicare Supplement Plan (Medigap) in 38 counties in 2003 (excluding Clark). (Premera also offered a private long-term care plan in all counties in 2003.)

Other than the general decline of managed care organizations in rural counties where withdrawals by Premera mirrored withdrawals by other companies, Premera's involvement in public insurance programs does not follow a distinct urban-rural pattern. The counties for which Premera offers enrollment for public programs tend to be urban, but there are also a number of more urbanized counties in which Premera does not participate (for example, Skagit, Kitsap, Spokane, Snohomish, and Thurston). At the same time, Premera currently participates in some rural counties with small populations, such as Ferry, Pend Orielle, and Garfield.

Premera's commitment to the Medicaid market is unclear. According to a report prepared by the Lewin Group on Medicaid cost containment in Washington State, revenues derived by Premera from its Medicaid business are quite small. The Premera proportion of Medicaid Healthy Options enrollment was 11 percent in December 2002. However, the calendar year 2001 revenues that Premera derived from Medicaid represented only 3 percent of the company's total revenues. In this, Premera is similar to some other large Washington plans that have also reduced their exposure to Medicaid managed care. For example, Group Health held 7 percent of Medicaid

Healthy Options enrollment, and also derived 3 percent of its revenue from that line of business. Data from Regence were not available, but Lewin's report estimated that Regence's 8 percent share of Healthy Options enrollment made up less than 10 percent of that company's revenues. The remaining participating plans were much more dependent on Medicaid revenue, ranging from 52 percent for Community Health Plan to 98 percent for Molina Health Care.[43]

Recently, the operating margin on the Medicaid line of business was comparatively high for most plans involved in Healthy Options. Although 1999 was a losing year for many plans (only two of six participating plans analyzed by Lewin had Medicaid operating surpluses in that year), since then most plans have achieved substantial surpluses in their Medicaid lines of business. In 2000, Premera had the largest operating surplus at 11.4 percent. In 2001, Molina had the largest margin at 9.6 percent, and Premera achieved a 4.1 percent surplus. Early data for 2002 indicate continued surpluses for most plans, led by 14.5 percent for Molina (Premera data for 2002 were not listed in the report). According to Lewin, "The health plans have been generating an operating surplus of approximately 1 percent throughout the past several years across all lines of business; thus Medicaid has been a particularly profitable line of business in Washington in recent years."[44] The report goes on to recommend that Washington seek to lower Medicaid plan operating margins in coming years, but it did not recommend a method for doing this.

Although similar margin data are not available for Basic Health, we can surmise that the situation is relatively similar for companies with small proportions of their business in this program. Given state revenue trends and decisions, it is likely that the state will be under continued pressure to reduce health plan payments in both Medicaid and Basic Health. For plans with small proportions of revenue derived from Medicaid or Basic Health, this situation might present conflicting incentives. First, relatively small proportions of revenues would make it easier for a plan to withdraw from a market because the majority of company revenues are from other lines of business. Thus, such plans may be less willing to accede to efforts by the state to reduce premiums. This could be a growing problem for the Basic Health program given its shrinking enrollment, which might reduce health plan willingness to participate in any particular county. On the other hand, sustaining small losses or reduced surpluses may be easier to tolerate, at least for the short-term, for plans that generate most of their revenues from other areas of business. Regardless, it would appear that the small public program share of revenues in some of the major health plans (Premera, Regence, and Group Health) would reduce bargaining leverage held by the state over these companies, in comparison to companies having a higher Medicaid share. Should operating surpluses dwindle, additional pullouts are likely.

Premera Involvement in the Individual Market in Washington

Premera has a prominent role in the Washington individual market and enrolls new members in all 39 counties in either its Premera line of business or in its LifeWise subsidiary.[45] Regence is the next most active company in this market, operating in 21 counties in 2002, followed closely by Group Health in 19. In December 2002, Premera had the largest share of this market as measures by premium revenues at 47.9 percent, followed by Regence at 31.9 percent, and Group Health at 13.7 percent (See Figure 4).

Currently, eight health plans offer individual coverage in at least some counties. This market is not nearly as competitive as it may at first seem, however. Because some of these companies are affiliated with either Regence or Premera, only four separate *corporations* offer coverage. One of these, Kitsap United Providers, is active in only six counties. In nine counties in 2002, Premera and/or its Lifewise affiliate were the only companies offering individual insurance, and 17 counties had only one additional insurer. In ten counties, there were two other insurers, and in three counties three insurers participated in addition to Premera (see Figure 7, p. 20).

Participation by Premera and by other companies in this market has fluctuated considerably in recent years. The individual market was plagued by extensive withdrawals in the late 1990s by insurers, who complained of "adverse selection" in enrollment toward those needing expensive care, with resulting financial losses. It is worth reviewing this history briefly, as it illustrates how the actions of a few companies in a concentrated market can have substantial effects.

Companies participating in the individual market identified state requirements for guaranteed issue of policies (stipulated in a 1993 health reform law), along with continuing availability of maternity coverage, as factors leading to adverse selection.[46] In response, companies began raising premiums, with average premiums across all carriers increasing by 10.7 percent in 1997 and 15.9 percent in 1998.[47]

In an effort to reduce outlays in this market, Premera dropped maternity coverage in the late 1990s in its private individual plans. Other plans, including Regence, took similar actions. Regence also stopped selling plans with a low-deductible to stem losses due to high-cost individuals.[48] The combination of premium increases and coverage restrictions reduced enrollment still further. Premera still held 60 percent of the market in 1998, but the company's enrollment had already dropped by 30 percent from 1997 to 1998.[49] In November 1998, Premera closed this market to new enrollees.[50] Because Premera sold its policies statewide and was the only insurer in many Eastern Washington counties, its decision left 15 counties in Eastern Washington without individual insurance.[51] In September 1999, Regence and Group Health followed suit.[52] In response, the Insurance Commissioner opened enrollment in the state's previously moribund high risk pool to those who lived in counties where individual policies were not available.

With the strong urging of the major health plans, the Legislature enacted changes to state regulation of the individual market in 2000. The new law removed the Insurance Commissioner's authority to regulate rates and allowed insurers to screen from coverage the 8 percent of potential enrollees with the highest health risks. In response to these changes, Premera raised premiums 24 percent for existing subscribers in May of that year[53] and re-opened enrollment to new enrollees in the individual market in December 2000. Regence and Group Health also reentered the market.[54]

As a result of the 2000 legislation, potential enrollees in the individual market must now go through a rigorous health screen. If screened out by a carrier, an individual is then eligible for coverage in the state's high risk pool, the Washington State Health Insurance Pool, or WSHIP. The maximum premium that can be charged to enrollees for WSHIP coverage was set at 150 percent of the small group rate during the pre-2000 period, but the basis for comparison was

changed to the individual market in the 2000 law, which had the effect of substantially raising maximum premiums. Effective in October 2003, the score needed to screen someone out of the private individual market and into the state pool was lowered, increasing the number likely to be screened out of the individual market. This change was adopted because the first screening tool was rejecting less than the 8 percent target set by the legislature.[55]

As a result of previous instability in the market, the new screening tool, and high costs, the total enrollment in this market, which stood at about 190,000 at the end of 2002, has yet to recover from the pre-withdrawal era, when enrollment was between 250,000 and 300,000.[56,57] Enrollment in the high risk pool, which offers insurance to screened out individuals, remains quite low (2,554 in July 2003), most likely a result of the high costs of policies in the pool.

Premera appears to be committed to the individual market at present, creating a new subsidiary (LifeWise) in April 2001 to offer coverage to individuals.[58] This new division allowed the company to set coverage and prices for new enrollees without having to take into account existing subscribers, many of whom might be expected to be sicker than new enrollees, thus requiring higher rates. LifeWise was also created to offer rates that were more competitive with Regence, which were about 20 percent below those of Premera's.[59] Enrollment in LifeWise began in 2001 and increased to about 33,000 by 2002.[60] However, revenue share was still only about one-third that of Premera's regular individual enrollment at the end of 2002.[61]

In March 2003, LifeWise began selling a medical savings account targeted at the self-employed.[62] One characteristic of LifeWise that distinguishes it from the individual insurance policies of other companies is its very frequent price changes. LifeWise products are re-priced every three months for new enrollees, as opposed to annually. As a result, prices for the program reflect ongoing medical inflation and, other things being equal, would be likely to increase revenues and profits. Thus far, however, LifeWise has suffered from negative operating margins, possibly reflecting its nature as a start-up.

The importance of the individual market is underscored by recent reductions in the availability of alternatives. Other options to this market do exist, but they are either enrollment-limited or very expensive. In the turmoil of Washington's insurance reform and its repeal, one such alternative—the unsubsidized Basic Health Plan—disappeared entirely after premiums increased substantially (rising, for example, 61 percent in 1999). This set off an "adverse selection" death spiral that drove healthy individuals out of the plan. The state closed the unsubsidized Basic Health Plan at the end of 2002.[63] The subsidized Basic Health program still exists, however, but participants must be at or below 200 percent of the federal poverty level (FPL) to qualify. In addition, cost-sharing requirements for this plan are slated to go up substantially in January 2004, and a waiting list is currently being maintained to cap enrollment at 100,000 individuals.

Premera's Involvement in the Employment-Based Market in Washington

Premera participates in most facets of the employment-based market, with strong representation in the small, large, and self-funded markets. The company is the leading carrier in the large group portion of this market and has the second largest share in the small group market.

Premera held 38.5 percent of premium revenues in the large group employer market in Washington in 2002, whereas Regence and Group Health accounted for an additional one-quarter each (see Figure 4, above). This large group business in turn makes up almost 67 percent of Premera's total enrollment in the conventional insurance portion of the marketplace. Premera accounts for the second largest share of enrollment in the small group market at 34.9 percent. Regence has specialized in this segment of the market and had the largest market share in 2003 at 47.7 percent. Group Health was again the third largest, but had a relatively small share at 6 percent (See Figure 4). In an effort to consolidate its position in this market, Regence created a new health plan in fall 2002 called Four Front that requires payments for deductibles and coinsurance only after the fourth visit to the doctor.[64]

Premera also offers services to companies that self-fund their employee health benefits. These self-insurance activities are exempt from state insurance regulations and reporting requirements, and data on such activities are relatively scarce. According to 2002 data from the Association of Washington Health Plans, Premera had about 84,000 enrollees in the self-funded plans it administered at the beginning of 2002, or 11.4 percent of all enrollment held by the Association's members.[65] Aetna was at that time the dominant player in the market with just over half of all enrollment. More recent data, however, indicate that Premera gained market share to 362,000 enrollees by mid-2003.[66] Both Regence and CIGNA, a company which does not have any traditional risk-bearing insurance business in Washington, also have a relatively large share of this market.

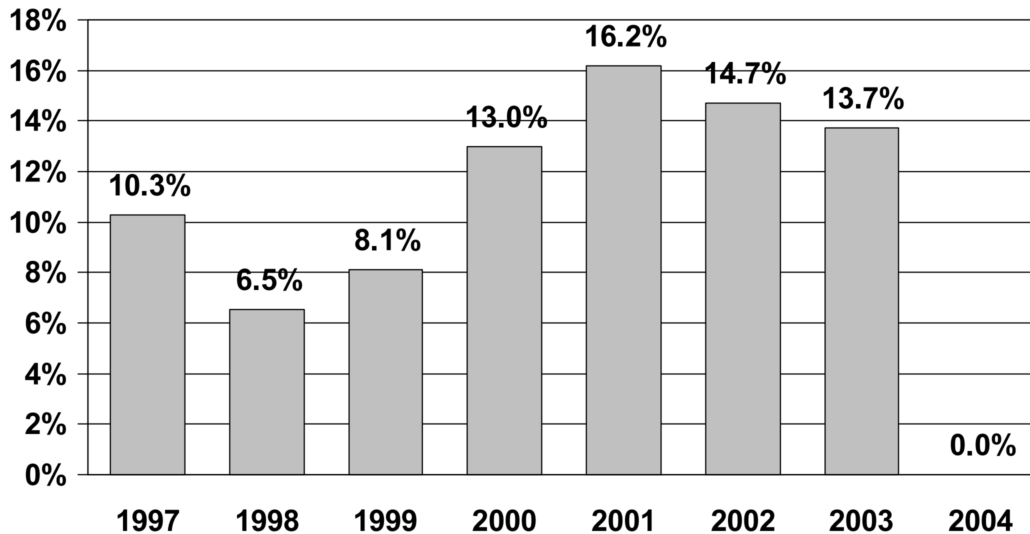
Premera was a participant in the public employees portion of the employer insurance market, offering enrollment in 38 of 39 counties in 2003. In April 2003, Premera was the third largest carrier in this market, accounting for about 13.7 percent of enrollment (see Figure 6). Premera will pull out of the PEBB market as of January 2004.[67] The Premera PEBB line of business has suffered from underwriting losses in recent years,[68] which suggests a likely motivation for exiting this market.

Employer markets often drive insurance company product innovation. For example, Premera created a network model HMO, called Premera HealthPlus, in 1981 in order to respond to employer calls to restrain health care cost growth. HealthPlus ended as a separate affiliate in 2000, a casualty of enrollee demand for less restrictive forms of managed care and losses in this product.[69] HealthPlus is still offered as a product line to some group applicants, however. About 15 percent of Premera enrollment was in HMO products in early 2002.[70]

According to one review of Premera's business strategy, Premera CEO Barlow is focusing on gaining business in the large, multistate employer market and joined an association of BlueCross plans involved in national accounts to facilitate this process. The company also built up a very large actuarial team to improve the accuracy of its underwriting decisions.[71] This strategy appears to be paying dividends, as Premera recently beat out Aetna to win the contract to provide insurance to Microsoft employees beginning in 2003, adding about 35,000 enrollees. Microsoft employees in other states will be covered by other Blue Cross Blue Shield plans but managed by Premera.[72]

Consistent with this focus on the employer market, Premera created a new product called Premera Dimensions in June 2002 that allows both employer-sponsors and enrollees a series of choices regarding physician networks, benefits, and care management/facilitation.[73] The product aids cost-containment efforts by charging higher rates for more coverage, wider networks, and looser care management procedures, and lower rates for more restricted coverage, networks, and

FIGURE 6. Premera's Share of Total Public Employees Benefit Board (PEBB) Enrollment



Washington State enrollment only. Data for 1997 through 2003 are for April of each year.
Source: Washington State Health Care Authority.

procedures. Premera spent $100 million developing the Dimensions product and its associated computer and management systems.[74] Enrollment in this plan was about 160,000 by spring 2003.[75] More recently, enrollment was stated as being more than 320,000.[76]

As part of the operations of its Dimensions products, Premera categorizes groups of doctors at large clinics and hospital networks according to cost efficiency after adjustments are made for case mix and illness severity. The most efficient practices are included in a tier called *Foundation*, which also includes smaller practices that have not been profiled and some more expensive larger groups that are dominant providers in some towns.[77] Patients who choose providers in the Foundation tier are charged lower rates. Premera is beginning to profile practices for quality and sends report cards to physicians who volunteer to be profiled.[78]

Although it examines activities of individual doctors, Premera assigns its rankings to the facility as a whole, not to particular practitioners. Premera's profiling system is designed to adjust scores according to severity of illness, in contrast to a system used by Regence (since abandoned) that did not adjust for severity of patient condition.[79] Some providers remain skeptical, however, that Premera's system will adequately adjust for quality differences.[80]

Geographic Variation in Participation in the Individual, Public Employees, and Public Insurance Markets in Washington

If we add the information we have regarding public programs with known market involvement in the individual market, several patterns emerge. Although Premera's statewide percentage of enrollment may not be particularly high for some public programs, this often translates into a powerful effect on particular area markets. And, in the individual market, Premera often faces no or few competitors. For example, although Premera ranks only third in PEBB enrollment at 14 percent, this low percentage obscures the company's importance within this market in particular counties. In 2003, Premera accounted for more than one-third of enrollment in 12 counties and more than 50 percent of total enrollment in 7 counties. Similarly, the Premera statewide Basic Health enrollment of 13.9 percent translates into one-third or more market share in six counties and virtually 100 percent in three others (Asotin, Garfield, and Kittitas). For Healthy Options and Basic Health Plus, Premera has more than a 33 percent share in five counties, despite a 9 percent statewide share for September 2003 (See Figure 8).

FIGURE 7: Premera Public Enrollment Percent by Washington County, and Market Participation in Individual Market

	PEBB	Basic Health	Healthy Options/ BH Plus	Individual Market: Number of Participating Plans (other than Premera)
Adams	62.4%	0.1%	0.0%	0
Asotin	6.7%	99.6%	27.8%	1
Benton	28.6%	0.0%	0.0%	1
Chelan	56.9%	0.0%	0.0%	0
Clallam	52.9%	0.0%	0.0%	2
Clark	0.1%	0.0%	0.0%	1
Columbia	17.1%	0.0%	0.0%	2
Cowlitz	14.8%	0.0%	0.0%	1
Douglas	60.2%	0.0%	0.1%	0
Ferry	46.0%	0.0%	35.3%	0
Franklin	28.1%	0.0%	0.0%	1
Garfield	17.9%	100.0%	14.0%	1
Grant	70.3%	0.0%	0.0%	0
Grays Harbor	31.9%	0.0%	0.0%	2
Island	13.7%	33.3%	21.1%	1
Jefferson	17.6%	0.0%	16.6%	2
King	6.8%	30.7%	21.3%	2
Kitsap	12.8%	0.1%	0.1%	3
Kittitas	7.5%	99.5%	73.4%	1
Klickitat	22.8%	0.4%	0.0%	1
Lewis	20.7%	0.1%	0.0%	2
Lincoln	41.6%	0.0%	0.0%	0
Mason	10.6%	0.0%	0.0%	3
Okanogan	58.2%	0.0%	0.2%	0
Pacific	39.3%	87.3%	54.3%	1
Pend Oreille	51.1%	0.0%	35.0%	0
Pierce	7.5%	32.9%	15.0%	2
San Juan	2.7%	0.0%	0.0%	1
Skagit	10.7%	0.0%	0.0%	1
Skamania	17.5%	0.0%	0.0%	1
Snohomish	11.5%	0.1%	0.0%	2
Spokane	22.8%	0.0%	0.0%	1
Stevens	35.5%	19.2%	14.7%	0
Thurston	10.1%	0.1%	0.0%	3
Wahkiakum	46.0%	0.0%	0.0%	1
Walla Walla	28.1%	0.0%	2.3%	2
Whatcom	5.3%	31.2%	34.7%	1
Whitman	12.3%	66.3%	11.9%	1
Yakima	5.9%	7.1%	5.8%	2
Washington	13.8%	13.9%	9.1%	4

Premera has few or no competitors in the individual market in certain counties, and if we look at this in conjunction with public program involvement, we can identify certain areas with a particularly high Premera market leverage. For example, in Pacific County, Premera accounts for more than one-third of the enrollment in PEBB, Basic Health, and Healthy Options/Basic Health Plus, and only one other insurer offers individual policies in that area. In Kittitas, Premera had well over two-thirds of the Basic Health and Healthy Options markets. High market concentration is not consistent across

product area in many counties, however. For example, in Pend Orielle County, Premera had more than one-third of the Healthy Option market and more than half of the PEBB market in 2003, but no Basic Health enrollment at all. Premera was the county's only provider of individual insurance in 2002. Because of this county-by-county variation, withdrawals from various programs (such as PEBB, planned for 2004) have a disparate effect.

Market Leverage and Provider Relations in Washington

The review, above, of Premera's activities in specific markets and the activities of other insurers demonstrate variations in participation and potential bargaining leverage by market type. Taken as a whole, decisions by a company about whether to participate in a particular market and where to participate create distinct geographical variations in its role. For example, in many parts of Western Washington, the three largest insurers as well as a number of minor players contend for enrollees, providers, and employers. By contrast, in parts of Eastern Washington, Premera is by far the dominant payer, often having one-third or more of the local insurance market share. Premera's predominant role in Eastern Washington is primarily a legacy of consolidation of county-based Blue Shield plans under the umbrella of the Medical Service Corporation (MSC), which was later absorbed into Premera.[81] Later, as other plans withdrew from the market, many enrollees shifted to MSC. (Premera continues to use the MSC name in parts of Eastern Washington.)

Insurers do not make public their market share for employment-based or individual products by county, nor does the Office of the Insurance Commissioner compile such data. Also, unlike in some states, Washington hospital discharge data are not available by specific payer. Nevertheless, we can begin to paint a picture of the wide variation in market share and potential effect or leverage in a market by assembling known data and supplementing it with information provided by local market participants.

Premera has a substantial role in Eastern Washington and in many cases is the dominant insurer. According to a Premera spokesperson quoted in the Spokane daily newspaper *Spokesman-Review,* Premera holds 34 percent of the under-65 market in that part of the state. The same article indicates that at least 20 percent of Premera's total enrollment is in Eastern Washington.[82]

In portions of Eastern Washington, the proportion is even higher. In Spokane County, for example, Premera, through MSC, holds almost 70 percent of the market. This concentration appears to be steadily increasing. For example, according to the *Spokane Business Journal,* Premera/MSC held 16 percent of the local market share in 1989, but that increased to 61 percent by 1998 as MSC absorbed enrollees from other companies that withdrew from the area. By 1998, only three carriers other than Premera had appreciable market share.[83]

Some providers recently offered some specifics on Premera's position in their facility or local market during a public meeting held in Spokane. For example, in a small hospital in Odessa, Premera accounts for 55 percent the commercial insurance business. According to another administrator in the area, "We have 45 percent Medicare patients… approximately 60 percent of those have a Premera Blue Cross Supplement."[84]

According to some observers, market share affects Premera's bargaining stances. For example, according to Dr. Elizabeth Peterson, Spokane County Medical Society, "Premera holds a 50 percent share of the health insurance market in Eastern Washington. This is their considerable leverage in our marketplace…. This is considerable pressure to sign under terms that are not acceptable."[85] According to an article in the *Spokesman-Review*, Leo Greenawalt, CEO of the Washington State Hospital Association, recently stated that "Take-it-or-leave-it contracts between Premera and rural hospitals are the norm."[86]

These statements regarding bargaining stance were echoed by a number of people interviewed for this study. According to one Eastern Washington hospital administrator, contracts often appear in the mail with little or no opportunity for discussion. "I'd never really felt like there was a negotiation," he said. "It was 'Take it or leave it' – you'd get a contract in the mail with 'do not alter this' and 'sign only where indicated'." By contrast, one eastern Washington physician thought that Premera has actually become easier to work with in recent years. "I think they're far less aggressive than they were four or five years ago," he said. "They've conquered the market and they have no reason to be anything but nice to us now."

Premera's dominance in some markets is tempered to some extent by its withdrawal from certain areas of insurance. According to one Eastern Washington hospital administrator, "It's been interesting over time how things have panned out. Premera's dominance has really waned in some respects because they continue to move out of marketplaces. Our business is primarily Medicare and Medicaid. It used to be that Premera was the dominant payer, but they've dropped several service lines over time."[87]

Another interviewee, the contracting director for a major health system in the western part of the state, noted that carving out a niche is key to survival. "We think we have a fighting chance against somebody as large as Premera because we do some things that nobody else does," he said. "A hospital like Northwest or Stevens, Premera could probably weather the storm if it left one of those two hospitals out."[88]

Several interviewees suggested that Premera responds well to strong providers who can demonstrate their value to the company and its members. "We are real proponents of adding value in the market, which we define in three ways: service, quality outcomes, and cost-effectiveness," said one practice manager. "We've invested pretty significantly into showing how we add value, and I think Premera responds to that. I think they respect a strong business partner."[89]

Many in Eastern Washington felt that the company was not always sensitive to local conditions and concerns. Some of these we interviewed claimed that relations between the company and its providers and customers worsened after Premera merged with MSC. According to one Eastern Washington resident, "It was only when MSC merged with Premera Blue Cross that I ever had to make phone calls or I ever had to go in and visit to explain something."[90] Most Eastern Washington interviewees commented on their frustration dealing with Mountlake Terrace-based staff after years of working with MSC staff in Spokane—requests that used to be handled locally now go back to Mountlake Terrace, where they disappear or come back unrecognizable. "The Westside folks are not particularly responsive and also are not very flexible," said one hospital

administrator. "They choose not to or can't understand the geographic differences, whereas the people in Spokane that we're dealing with have a better grasp of some of the issues that affect Eastern Washington."[91]

Another administrator said the Spokane office seems to have been stripped of any real authority. "There's still a Spokane office, but it seemed like they had some authority and some connection with Eastern Washington when it was still MSC," he said. "They don't seem that way now. It seems like Spokane doesn't do much but claims processing—they're a business extension but not a decision-making extension."[92]

Some observers noted recent improvements in Premera's operations. For example, according to Dr. Bill Gotthold of the Wenatchee Valley Clinic, "Premera was a difficult company to work with. Responsiveness to complaints was poor, and when we ended our managed care contract with them, it was with a sense of relief. In the last two or three years, we have witnessed a complete turnaround in the attitude and approach of the company."[93] According to another observer, "One only needs to look at Premera's support to the diabetes education and many other health programs and community programs for but a few examples which clearly show their integrity and commitment to the health and well-being of their insureds and our patients."[94]

The opinions of interviewees on the adequacy of Premera's payment levels varied tremendously. One hospital administrator reported that Premera refuses to honor his facility's critical access designation and insists on using a proprietary fee schedule that makes the company "one of the worst payers that we have." Other respondents also claimed that Premera's payments were among the lowest. Others thought Premera's payments were fair. One said, "They're pretty reasonable. They're in the pack. We just finished negotiations and got what we believed was a pretty fair arrangement."[95]

In general, relations between insurers and providers have become more contentious in recent years, but seem to involve Premera neither more nor less than other health plans. These issues came to a head in 1999 and 2000, when a number of medical groups pulled out of health plan networks temporarily or permanently during disputes over reimbursement. The disputes involved Regence and Premera, as well as Aetna and Qual-Med (which has since left the state). For example, in late 1999 in Spokane, about three-quarters of orthopedic surgeons refused to accept contracts with Premera, citing low reimbursements, with some complaining of 25 percent cuts, as well as increases in barriers to care, such as increased preauthorization requirements.[96] Later in that year, a number of orthopedic surgeons, general surgeons, and neurosurgeons—mostly located in the Puget Sound region—cancelled contracts with Regence. Some cancelled with Aetna, as well. A general physician group in Everett also canceled with Premera.[97]

Underlying these disputes was the insurers' adoption, following national trends, of fee schedules based on Medicare relative payments for various services. Because the Medicare schedules generally reduced payments for specialty services and surgeries and raised them for some primary care services, disputes with surgeons were most common. In mid-2000, Premera announced a 4 percent increase in reimbursement, claiming it was designed to reduce the danger of losses of doctors from its network. Because this too was based on Medicare-relative payments, however, some surgical specialties still received cuts.[98] The struggle over rates flares up

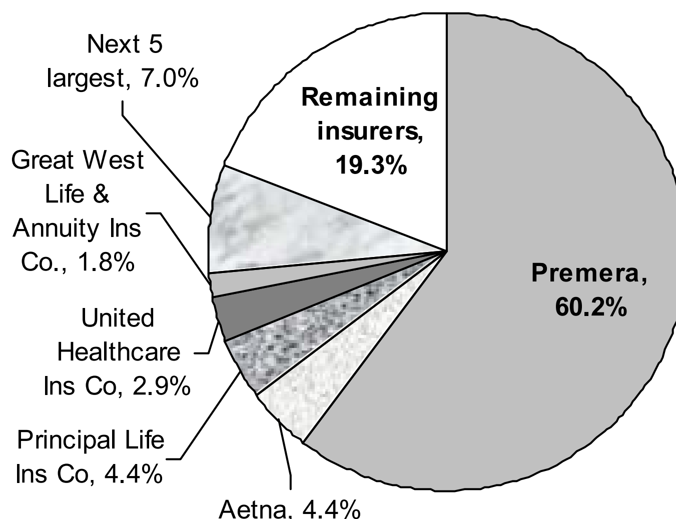
occasionally. For example, in mid-2001 Swedish Hospital in Seattle informed Aetna that it would no longer accept its payments for physician services. After negotiation, Swedish Hospital agreed to participate.[99]

An Overview of Premera's Role in Alaska

Alaska's health care market is marked by substantial involvement by public sponsors such as the federal government, the military, and Medicaid, which is administered by the state. Many Alaska residents receive services at the clinics funded by the Indian Health Service. With the exception of the Federal Employees plan, where participants can choose to be insured through a Blue Cross/Blue Shield plan (and therefore Premera), and the Medicare Supplement market (which is indirectly tied to the Medicare market and its benefit decisions), most of these public programs do not involve private insurers in Alaska.

Premera holds the majority of enrollment in the health insurance private market. Because the Alaska private commercial market is heavily fee-for-service, a number of small indemnity-type insurers have remained in the insurance market, in stark contrast to Washington. For example, in 2001, the state Division of Insurance reported 225 companies selling health insurance in Alaska. Despite the large number of companies, however, the Alaska market has tended toward one or two very dominant insurers even more strongly than has Washington. As late as 1996, Aetna had a slight edge over Premera in terms of health insurance premium market share, and together these two companies accounted for more than 70 percent of premium revenue.

FIGURE 8. Shares of Total Alaska Insurance Premiums by Company, 2001



Source: Alaska Division of Insurance, *64th Annual Report, 2002*. Does not include any employer self-funded enrollees, where companies provide administrative services only.

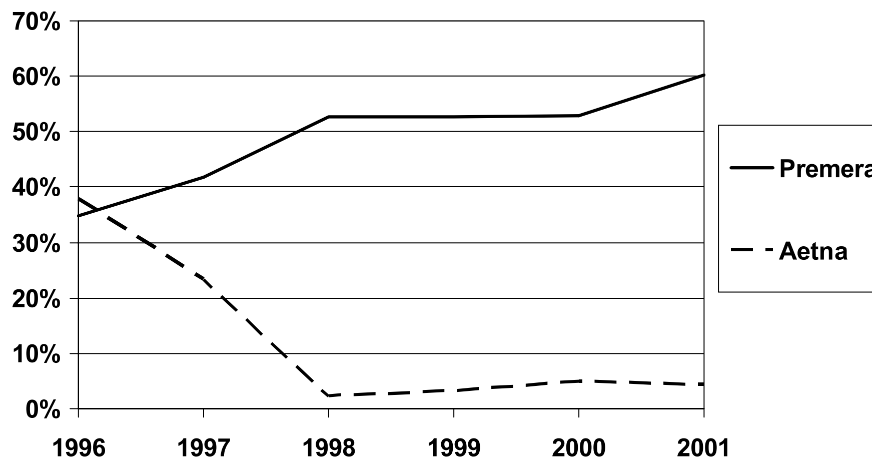
Since then, Aetna's business has shrunk precipitously, mirroring the company's contraction in a number of markets around the country. Aetna had a reputation for underpricing policies in a quest for market share, and its aggressive managed care tactics and rocky relations with

providers made it a lightning rod for complaints about managed care.[100] Premiums written by Aetna dropped from just under 40 percent of the market in 1996 to 2.3 percent in 1998. Its share has edged up slightly since then. At the same time, Premera's share of premiums increased rapidly, from just over one-third to more than half of all premium revenues by 1998, and stood at 60 percent in 2001. (See Figure 9.) Aetna was tied with Principal Life as second largest insurer in 2001, but held only 4.4 percent of the market. All remaining insurers each had less than 3 percent share.

This picture, however, may substantially obscure Aetna's role in the overall health care market in Alaska. Conventional health insurance revenues represent only a portion of insured lives, excluding individuals where Aetna is a third party administrator for self-funded plans. Aetna's current market strategy emphasizes business in the self-funded market.[101] A survey filled out by the company and submitted to the Alaska Division of Insurance for 2002 indicates that Aetna had substantial enrollment (66,777) in this market. However, this part of the market represents a very different effect on the health care system because the conditions and manner of coverage are influenced by employers as much or more than by the administering company.

Unlike Washington, within the private market many of Alaska's insurers are for-profit, with Premera currently being the only large nonprofit. Similar to Washington, more than three-quarters of Premera's insured business in Alaska is in the private market, with less than a quarter in publicly funded enrollment. As in Washington, Premera concentrates on the employer market in Alaska, with two-thirds (67.4 percent) of its enrollment in small or large groups in 2002. When federal employees are included (22.4 percent of Premera enrollees), insurance of people through a workplace comprises almost 90 percent of Premera's enrollment in Alaska. If the administrative services-only population is added, the number increases still further.

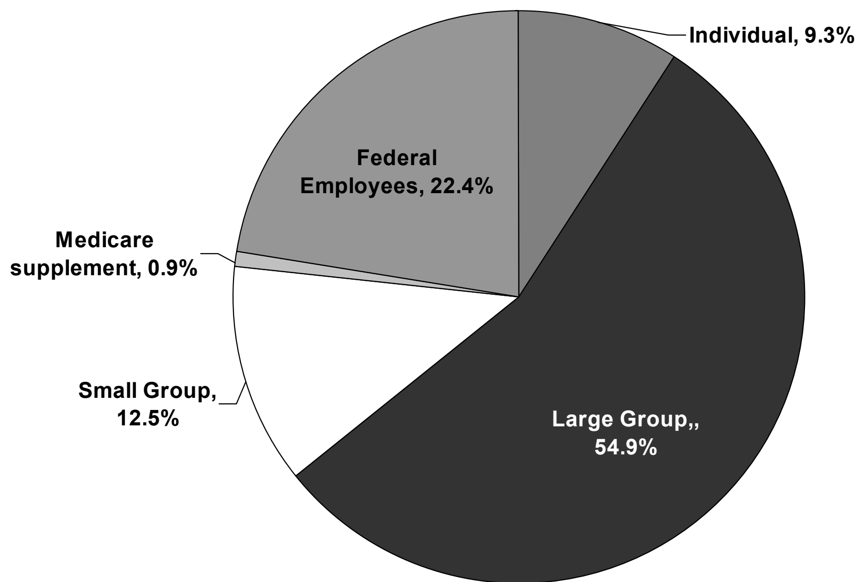
FIGURE 9. Shares of Total Alaska Health Insurance Premiums Written by Aetna and Premera



Source: Alaska Division of Insurance. Annual Reports, various years. Does not include any employer self-funded enrollees, where companies provide administrative services only.

Premiums from the individual market were less than 10 percent (9.3 percent) of Premera's total insurance business in 2002, and the Medicare supplemental market comprised less than 1 percent (See Figure 10).

FIGURE 10. Premera Enrollment by Market, Alaska 2002



Source: Alaska Division of Insurance. *Annual Statement for the Year 2002 of Premera Blue Cross*; and, Annual Alaska Health Insurance Surveys – Part 1. Does not include any employer self-funded enrollees, where companies provide administrative services only.

Like Washington, Premera participates in public employee insurance markets in Alaska. Alaska's state system is much more fragmented than Washington's, with many entities (such as the University of Alaska) individually self-funding rather than being part of a larger insurance network. Premera tends to act as administrator in the state and local public sector markets, rather than as an insurer.

We will now review activities within specific Alaska markets. Because Premera does not participate in publicly funded general insurance (Medicaid and Medicare), except in a very small, indirect way through the Medicare supplement market, we do not review that market here.

Premera's Involvement in the Employment-Based Market in Alaska

On average, fewer Alaskans are insured through their employers than is the case nationally. National firms operating in Alaska and offering health insurance to Alaska residents reduce the potential size of the local market.[102] The large size of publicly financed services (military, Medicaid, Indian Health Service-funded facilities) further limits the size of the private market even further.

Within the employer-based market, Premera has a very large role, operating in the small group, large group, and self-funded portions of the market. Premera has the majority of enrollment in the small group insurance market (50 or fewer employees). According to a recent survey by the

U.S. General Accounting Office, in December 2002 nine insurance companies sold small group coverage in Alaska. Premera, with year-end 2002 enrollment of 13,244,[103] held 51.9 percent of the small group market. The top five insurers together held 81.5 percent of the market.[104]
The small group market in Alaska is primarily local, in contrast with large group insurance market, where companies may group Alaska residents with out-of-state employees. Given high costs in the Alaska health care market, this translates into very high average costs for small group policies. Difficulties for employers in finding affordable health insurance have prompted a recent proposal to form a state-organized, but privately administered, small employer pool. This proposal was opposed by Premera, which argued that the pool would skim off low-risk enrollees, leaving the high-cost patients in the remaining portions of the small group market. [105]

Public employees make up another large segment of the Alaska insurance market. Aetna and Premera are the primary insurers or administrators in this market. More than one in five Premera enrollees in Alaska is a member of the Federal Employees Health Benefits Plan. Premera and Aetna are the primary administrators in the self-funded market for public employees. Aetna administers a "Select Benefits" plan that is funded by the state for non-unionized state employees. Other public employees are covered by union health trusts.[106] Premera administers the University of Alaska health plans and also administers the plan of the Anchorage School District.[107,108] Retirees of the Public Employees Retirement System and the Teacher Retirement System are insured by Aetna.[109] Premera's Northstar Administrators division administers plans for police and state troopers who are member of the Public Safety Employees Association.[110]

The Alaska Individual Market

Premera enrolled 10,783 in its individual market products at the end of 2002, just under 10 percent of its entire enrollment. Using a broad definition of the individual market derived from company surveys by the Alaska Division of Insurance, Premera had 29 percent of the total individual market in 2001.[111]

Similar to Washington, Alaska maintains a high-risk pool called the Alaska Comprehensive Health Insurance Association (ACHIA) for those unable to get coverage in other ways. In contrast with Washington, carriers do not screen high-risk patients directly into this pool. The pool is funded through premiums and assessments on insurers. At the end of 2001, enrollment in this pool was 457 individuals. ACHIA covers both high-risk individuals (sick or at risk of major illnesses) and those who have exhausted Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage after leaving a job. To gain access under the high-risk category, an individual must be uninsured and not be eligible to be covered through a small employer (2-50 employees) plan or through veterans health benefits, Indian Health Services, Medicaid, or a group health plan. The applicant must also have been rejected by an insurer within the last six months, or have insurance but be enrolled a policy with restrictive riders that reduce coverage, or have one or more of a number of qualifying high-cost conditions.

Market Leverage and Provider Relations in Alaska

Information gathered from interviews and other sources indicate a mixed picture regarding Premera's operations and provider relations in Alaska. The company is seen as more

knowledgeable about local conditions and more willing to work with local providers in improving the delivery of care than are some other out-of-state carriers. This is tempered by concern over the company's high and growing leverage in the Alaska market.
Because of its substantial and long-standing business presence in Alaska, Premera is seen by some observers as more knowledgeable of local realities than other national companies that operate in Alaska. According to one observer, "They seem to understand Alaska fairly well, as opposed to other payers who come in and have an 800 number down in Tennessee or have no clue that there is 350 miles and a mountain range between Fairbanks and Anchorage," he said.[112]

One interviewee commented on market bargaining power, or the lack thereof, of the state's provider community. "The largest group practice in the state includes 12 physicians," he said. "When you're dealing with a large insurance company, there's quite a disparity in power."[113] Most observers, however, did not characterize Premera's bargaining stance in Alaska as especially harsh.

Premera's managed-care procedures with contracted providers were seen positively by some. For example, Dr. Jean Bonner, the president of the Alaska Medical Association, recently observed, "I can't think of any request they have not honored. After requesting a pre-approval for various services—and I deal with a specialized form of medicine, endocrinology, and I treat a lot of diabetics who get very ill, and I use a lot of instruments and insulin pumps and things like that—they have [been] very helpful, much more so than the other insurance companies or other agencies."[114]

One Alaska observer criticized the company's practice of sending in visiting specialists to an area rather than contracting with local specialists. "There were circumstances when there was an itinerant group of physicians that were brought here and they were here two or three days of the year to see patients, and then they were adios, and there were non-network physicians left to see then for the rest of the year. Patients were the ones who were ultimately penalized up here—their claims were paid less because the assertion was that there were specialists available to see them, even if they were only here a couple of days a year."[115]

One interviewee who had a role as a health insurance purchaser also echoed many Eastern Washington administrators' comments about local staff trying hard but being hamstrung by the home office. "The relationship with local management is pretty good," he said. "That said, I can tell you that there is a distinction between how people feel about the people who are local versus decisions that are made out of Seattle that affect Alaska. The local office has been very helpful, but when we put [our business] out to bid and it went to Washington, the bid that Premera made was so outrageous, so out of touch with reality, that they are out of the running."[116]

One Alaska observer questioned whether a for-profit Premera would be able to avoid or resist the temptation of acquisition: "As soon as you are a stock company, a for-profit entity, when offers of purchase are made the board of directors has a fiduciary duty to seriously and objectively consider those offers," he said. "It may very well be your intent to keep things the same, but the stockholders may have a different idea, and that concerns me." One practice manager noted that "A lot of big businesses up here, Providence and BP, places that have a lot of staff, they can

afford to go self-insured and they're not all that bothered by this. But it's me and the little-sized companies that I think are going to see the impact."[117]

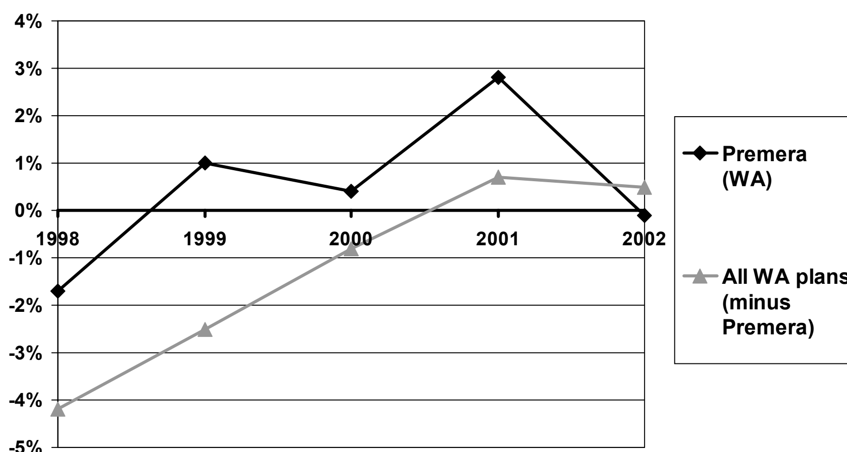
III. Premera Business Performance and Behavior in Washington and Alaska

This section reviews information regarding Premera's overall business performance as it relates to its insurance operations. (A thorough analysis of Premera's business performance and strategy, particularly of those entities not delivering health care-related services—e.g., its life insurance business—is beyond the scope of this report.) We review areas that shed light on the company's role as an insurer and that may have a direct or indirect bearing on things such as participation in specific markets, premiums, provider relations, and quality of care. Many of these measures are commonly used to assess the relative performance of health insurance companies. They include, for example, percent of premiums spent on health care; gains or losses on insurance operations; and amount of money spent on administering a plan. We also briefly describe trends in executive compensation and examine the available data on company performance on quality measures. Because data for many of these measures are limited for Alaska, this section emphasizes findings from Washington data.

Current Premera Insurance Business Performance Measures

If we look at operations across all lines of the traditional insurance business, Premera tends to have higher annual administrative expenses and lower payments for medical care as a percent of premiums than other carriers. In general, the company has maintained a revenue balance on current operations that is stronger than other full-service insurance carriers in Washington. Because we do not delve into the details of the company's business operation in this paper (and because we do not have access to Premera's internal documents that would shed light on this issue), interpretations of this information can be considered only suggestive rather than definitive.

FIGURE 11. Underwriting Margin (Annual Net Operating Income Divided by Annual Premiums), Premera and All Other WA Plans Average

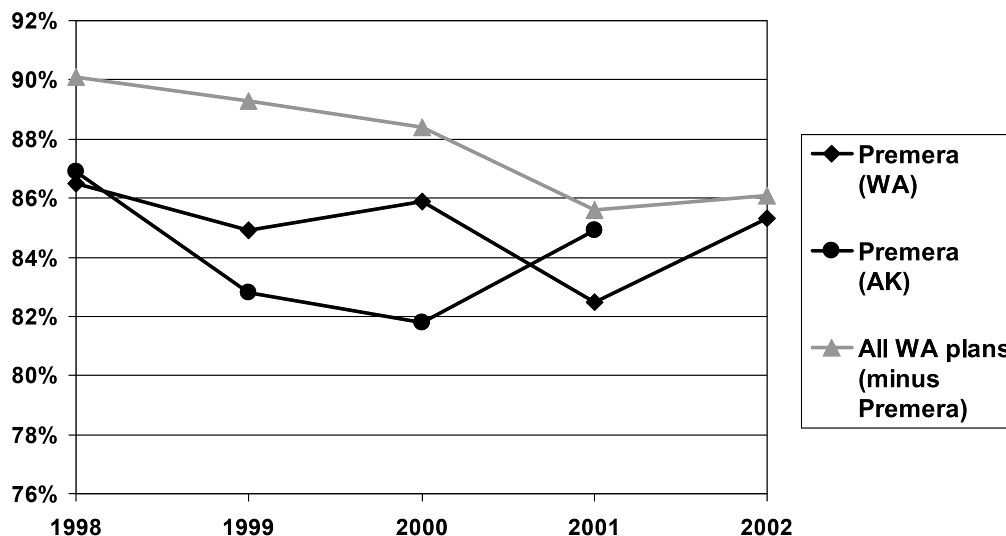


Source: Washington State Hospital Association compilation of Office of Insurance Commissioner data.

The **underwriting margin** is derived by totaling all premium revenues in a particular year, subtracting expenses for the year (such as administrative expenses, salaries, and payments to providers) and dividing that by total premiums. Margins in the negative range indicate likely premium increases in the near future. Figure 11 shows a recent deterioration in underwriting margin for Premera and other carriers, although on balance Washington insurers were still barely within the positive range for 2002 (by less than 1 percent). Deterioration in the underwriting balance likely presages continued upward pressure on premiums charged to groups and individuals. In the case of Premera, negative current operations for 2002 were driven by continuing losses in its LifeWise individual market subsidiary. Without the losses in LifeWise, Premera had a small positive operating margin for 2002.

Actuarial experience is a technical term for the percentage of total premium dollars per year that are paid out to health care providers. A very high actuarial experience could indicate either a very efficient operation or possible losses on current insurance operations. Very low numbers could indicate inefficient operations or perhaps excessive profits. According to one observer of the insurance industry, "Loss ratios (actuarial experience) lower than 85 percent indicate higher than normal administrative expense ratios, excessive premium levels when compared to risk assumed, or health plan objectives that call for higher than normal margins of profit. On the other hand, loss ratios above this level can be successfully maintained if administrative expense levels are correspondingly lower (provided premiums stay competitive in the marketplace)."[118] Figure 12 shows that Premera's actuarial experience in Washington has fluctuated around the 82 to 86 percent range over the 1998 to 2002 period. Other plans on average spent between 84 and 90 percent during the same period. In Alaska, the company has maintained spending on care ratios that are in line with its Washington experience. (Premera's Alaska actuarial percentages for the years 1996-1997 were higher, averaging 85 to 90 percent.)

FIGURE 12. Actuarial Experience (Percent of Premiums Paid for Health Care), Premera (WA and AK) and All Other WA Plan Average



Source: Washington State Hospital Association compilation of Office of Insurance Commissioner data; Alaska Division of Insurance, Annual Reports, various years.

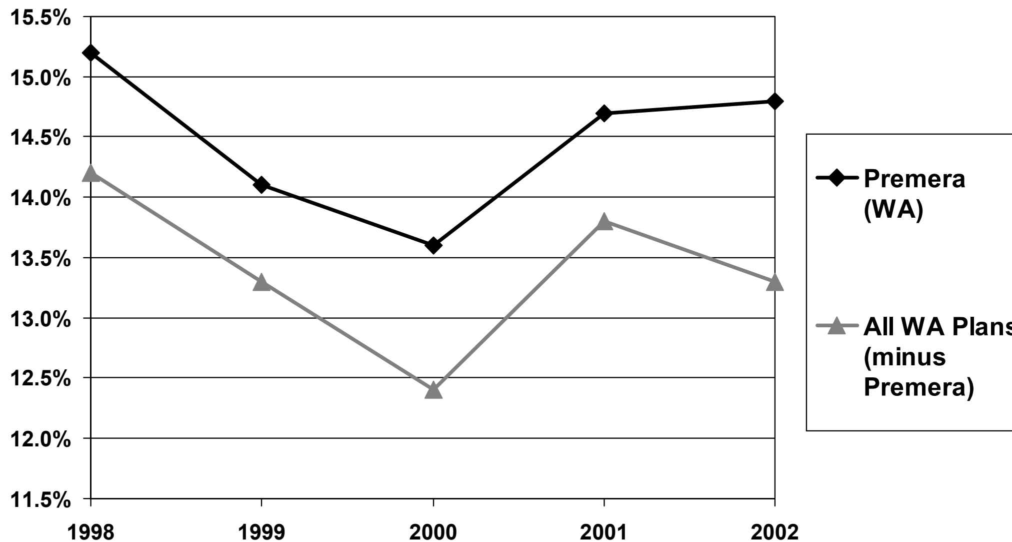
According to a statement by Premera, as reported in the *Puget Sound Business Journal*, the

company plans to keep its aggregate payments to health care providers at 84 percent of total premium income, with operating margins at 2 to 3 percent.[119]

Administrative expense may include a wide range of spending such as investments in technology, payments to employees, and executive salaries. In the short run, higher administrative investments could indicate investments in productivity-enhancing technology, or expenses surrounding a business expansion into different markets. Longer-run tendencies toward high administrative expenses could indicate high profit margins or high expenses, such as for executive salaries.

As Figure 13 shows, Premera's administrative expenses as a percent of premiums have been consistently higher than the average for all health plans. These expenses dropped during the years 1999 and 2000 for Premera as well as other carriers. More recently, Premera's administrative percent has increased, and remain higher than average.

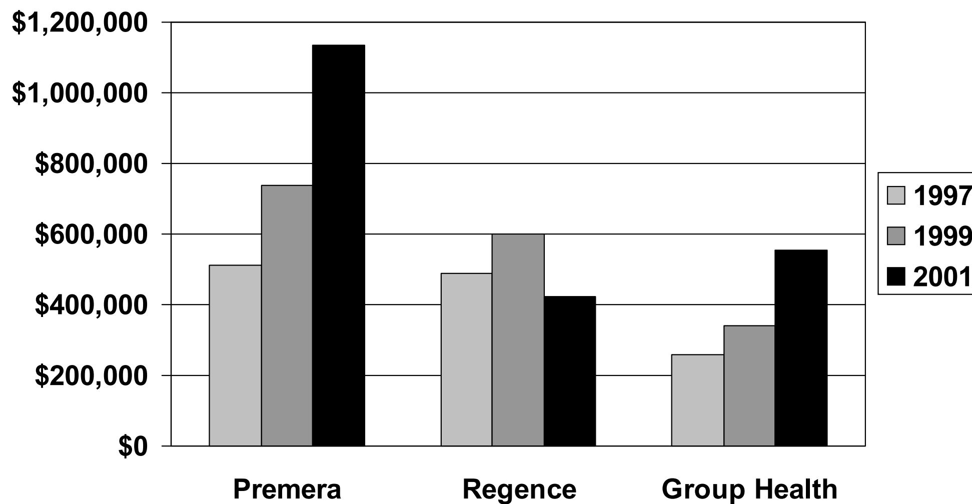
FIGURE 13. Administrative Expenses as Percent of Premiums, Premera and All WA Plans Average



Source: Washington State Hospital Association compilation of Office of Insurance Commissioner data.

Average compensation packages for Premera's executives tend to be substantially larger than those of other major carriers. Average compensation for the top nine executives for each insurer in 1999 was $411,000 at Premera, compared to $269,000 for Regence and $229,000 for Group Health. Looking only at the compensation for the chief executive officer in 1997, salaries were $511,000 at Premera, $489,000 at Regence, and $270,000 at Group Health. Over the 1997-2001 period, CEO salary increased by 122 percent at Premera in current dollar terms and by 113 percent at Group Health, while actually declining at Regence over this period. By 2001, CEO compensation at Premera topped $1 million a year ($1,136,000).[120] (See Figure 14) Whether Premera's higher salaries resulted from a strategy to attract executives accustomed to for-profit-level salaries as a prelude to conversion or for some other reason is not apparent from the data.

FIGURE 14. Top Executive Compensation, Three Largest Insurers, Washington State, 1997-2001



Source: Washington State Office of the Insurance Commissioner. *Executive Salary Report for Washington State's Top Three Health Insurers.* April 2000; O'Connor K. Where health-care dollars go. *Seattle Times*. July 11, 2002.

Measures of Preventive Care or Consumer Satisfaction

Survey and chart review data provide limited measures of how plan operations affect the appropriateness of care delivery, and patient satisfaction. These measures, although limited in scope, do show substantial variation between health plans, likely indicating substantive differences in care management or company-patient interactions. For example, Report 2 of this project presents evidence that the average for-profit plan tends to have lower ratings on some measures of consumer satisfaction and other quality-of-care indicators.

Many quality-related measures compare plans involved in public programs, and comparative private plan performance measures for Washington and Alaska were not available. Existing measures indicate possible health plan commitment or ability to achieve specified targets for preventive care. For example, a review of rates for meeting Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program standards for well-child visits in Healthy Options, BHP, and CHIP in Washington showed that Premera was a median performer at 32 percent of expected completed health screening visits for infants, half that achieved by Kaiser but twice that achieved by Aetna. Premera's performance was relatively high (first or tied for first among eight health plans) for visits for children and adolescents.[121]

Looking at public plan enrollees using the Health Plan and Employer Data and Information Set (HEDIS) measures show, for example, that Premera is about average on HEDIS immunization measures for its PEBB, Basic Health, and Medicaid populations in Washington. Kaiser is the best performer, and Aetna is, again, the worst.[122]

Premera scored at the state average for most measures of parent satisfaction with a child's care in the Consumer Assessment of Health Plans Survey (CAHPS). Premera scored below average for

the percent of children with a problem getting needed care. Conversely, for special needs children, the plan scored above average for a number of measures.[123]

IV. Summary

In both Washington and Alaska, insurance enrollment and revenues are heavily concentrated in a few insurers. Premera's insurance market share has been expanding in recent years in both states. Premera has recently surpassed Aetna in Alaska to become the largest insurer and has steadily gained insurance market share in Washington. In the insured market in Washington, Premera is the largest insurer by a small margin and appears to be gaining market share in the administrative services-only (self-funded) market. Premera is dominant in the insured market in Alaska, with more than 60 percent of total revenues, and also has a substantial administrative services-only share.

More than three-quarters of Premera's enrollment in each state is in the employment-based insurance portion of the market. In both Washington and Alaska, Premera's enrollment is weighted toward the large group rather than the small group market.

Premera has reduced its role in managed care insurance programs for low-income populations in Washington. Despite withdrawals and a statewide enrollment ranging from about 10 to 15 percent, however, Premera remains the largest insurer within these programs in a number of counties. As such, further reduction in participation by the company could disrupt coverage in a number of areas, especially rural counties. In Alaska, such programs do not involve private insurers. Available quality measures for treatment of enrollees within public programs, and patient satisfaction with care, show Premera to be an average performer.

Less than 10 percent of Premera's enrollment is in the individual market in each state. However, since this market tends to be small, the health plan's enrollment accounts for a large percentage of each state's individual market. Washington's individual market has not fully recovered from withdrawals by Premera, Regence, and Group Health in the late 1990s. Coverage in the WSHIP high-risk pool remains very small, likely due to expensive premiums. In this constricted market, any actions by Premera to reduce participation or increase rates would have a substantial impact. In Alaska, the small group market appears to be the most fragile, and Premera's preponderant role in this market gives its actions substantial weight.

Geographically, Premera has very substantial market leverage in many Washington counties and throughout the private insurance market in Alaska. In Washington, Premera's market share tends to be higher in Eastern than in Western Washington.

Providers have had difficult relations recently with various health plans, including Premera. Premera has a reputation as a hard bargainer among some, but not all, of the observers interviewed for this project. Some indications of improved business operations within the company are tempered by concern that Premera is not sufficiently sensitive to local markets in Alaska and Eastern Washington.

Premera appears to be somewhat more focused on bottom-line standards than the average Washington insurer. The company has created a number of for-profit subsidiaries in recent years. On average, Premera has lower total payments for medical care and has had somewhat better operating margins in recent years, despite having consistently higher administrative costs. The salaries paid to Premera executives are substantially higher than for other large insurers in the Washington market. Premera's recent pullout from the public employees insurance market and its previous withdrawal from participation in the Medicare+Choice program in Washington suggests a clear expectation that each market segment contribute to—or at least not detract from—net income. This bottom-line orientation is also found increasingly among a number of health plans, many of whom have also recently withdrawn from markets seen as insufficiently profitable.

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