

The Curious Conversion Of Empire Blue Cross

In New York it's all politics, all the time.

by James C. Robinson

PROLOGUE: The movement toward conversion to for-profit ownership among Blue Cross and Blue Shield plans has provided a rich topic for study and debate since the Blues abandoned their traditional requirement that all licensees be non-profit. While the number of for-profit Blue plans remains small, it includes two of the fastest-growing, most profitable regional health plans in the nation: Anthem (the former Indiana plan) and the California-based WellPoint Health Networks. More than one-third of Blue Cross and Blue Shield enrollment nationally is now in for-profit Blue firms.

Many Blue plans traditionally performed a quasi-public function for which nonprofit ownership seemed fitting and proper. They sold community-rated products that made coverage more affordable for individuals and small groups. In many cases, they served as statutory insurers of last resort. Although they were generally slow to modernize their management and lost much of their market share in the 1980s and early 1990s, both nonprofit and for-profit plans have turned their businesses around and proved the value of their greatest assets—strong brand identity and long-term stability in customer and provider relationships—in the crucible of the marketplace.

In addition to scholarly and ideological debate, protracted litigation and political maneuvering have accompanied most of the Blues' conversion battles, with the disposition of hundreds of millions of dollars in nonprofit community assets hanging in the balance. Nowhere did the wrangling go on longer than in the state of New York, where Empire Blue Cross and Blue Shield took seven years to reach its goal. The most controversial element of the Empire saga turned out not to be whether to convert but, rather, who should receive the \$2 billion in social assets. Contrary to the practice in most other states, New York decided to appropriate the funds to the state treasury and spend them on health-related programs over three years, rather than endow an independent health-related foundation. The paper that follows traces the denouement to its sources.

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ABSTRACT: The for-profit conversion of Empire Blue Cross in New York challenges the case law and conventional policy wisdom that financial assets from formerly nonprofit organizations should be used to endow independent charitable foundations. The appropriation of Empire's assets by state government itself, and their subsequent deployment to subsidize health care institutions and repay political obligations, changes the conversion process from one that pits nonprofits against for-profits to one that pits private, nonprofit organizations against public-sector programs in the competition for new financial resources.

ON 7 NOVEMBER 2002 Empire Blue Cross Blue Shield (BCBS) culminated a seven-year effort to convert from nonprofit to for-profit ownership, selling 20 percent of its stock and obtaining \$417 million in one of the most successful initial public offerings (IPOs) in the history of the health insurance industry. The IPO proceeds and other corporate assets were not used to endow a charitable health care foundation, as is done in most other states, but were transferred to the New York State budget largely to finance wage increases for unionized hospital and nursing home workers. The quid pro quo was the endorsement of a conservative governor by a liberal labor union, contributing to a Republican electoral landslide in a Democratic state and to the governor's commitment to sustain health care programs in what otherwise was a disastrous budgetary context. The big losers were the community organizations that would have received the largess of a charitable foundation and who instead were left to gnash their teeth, denounce the predatory state, and invoke constitutional objections to one of the most brilliant and sordid chapters in the annals of health policy.

The Empire epic offers something for everyone involved in the contentious debates over ownership and accountability in health care, illustrating themes common to conversions in other states but injecting elements distinctive to the highly regulated New York context.¹ For critics of for-profit health care, the Empire conversion represents a tragic finale to an institutional structure that relied on cooperation rather than competition to balance private interests and further the public good. For critics of nonprofit health care, the conversion is a salutatory recuperation from a history of eleemosynary ineptitude that squandered \$800 million and an 80 percent market share through lack of shareholder oversight. For critics of the regulatory state, the conversion symbolizes the weakening of an iron triangle of governmental, insurance, and hospital interests that historically protected each other against the rigors of administrative transparency and fiscal responsibility. But the Empire conversion is best read not as a morality tale of public altruism versus private greed or of market efficiency versus governmental gridlock. While the process violated perhaps every civics lesson in how public policy should be made, the outcomes were far from the worst imaginable and, indeed, can be interpreted as evidence of the recuperative powers of both the public and private sectors. The conversion-oriented management of Empire did not abscond with the treasury but, on the contrary, saved the firm from bankruptcy, accumulated \$2 billion in

social assets, and created an innovative managed care organization. The state legislature and executive were able to remedy the worst of the burdens they had imposed on Empire and facilitate a transition from regulatory excess to market incentives for performance. The channeling of the charitable assets to the state's health care providers possibly avoided Medicaid cutbacks, partially alleviated the nursing shortage, and put dollars into the pockets of low-wage technicians and aides.

The Empire conversion raises again in poignant form the question of who really owns a nonprofit organization, which nominally belongs to everyone and really belongs to no one. Each of the many stakeholders in the Empire debate—including the firm itself, state government, the hospital industry, the labor union, and the dozens of community and patients' organizations—could argue that historical precedent and contemporary need gave it claims to whatever monies flowed from the sale of the new corporation's equity to Wall Street. The outcome of the Empire conversion suggests that ownership rights ultimately reside with the politicians who create the rules and, indirectly, with the organized political constituencies that elect (and can replace) those politicians. Left to themselves, state insurance departments and attorneys general will either prevent nonprofit conversions altogether or channel the conversion funds to a charitable foundation. If the state legislatures get involved, however, they can choose to permit (or even encourage) conversions and direct the assets to the state treasury rather than to an independent foundation. Heretofore, the struggle for control of nonprofit health care assets has pitted conversion-oriented executives who want to retain value for the new for-profit firm against community organizations who want to maximize the assets transferred to an independent foundation. Henceforth, the struggle may pit deficit-plagued state governments against those who would endow a foundation.

Fall Of An Icon

In 1989 Empire Blue Cross celebrated fifty-five years as the quintessence of a distinctively American approach to health policy: the pursuit of social ends through private, nonprofit means in a manner that forestalled pork-barrel politics and market-system profiteering.² Empire was the largest U.S. health insurer, with ten million enrollees and an 80 percent local market share; offered community rating and guaranteed issue in the individual and small-group markets; administered many of the corporate health benefit accounts headquartered in New York City; and kept health maintenance organizations (HMOs) at bay with a one-size-fits-all indemnity product design. It worked closely with state government to support Medicaid, certificate-of-need (CON), and hospital rate regulation; with the federal government as the largest Medicare intermediary; and with the hospital industry to assure liquidity and the channeling of complex cases from suburban facilities to the Manhattan academic medical centers.³ Cooperating with everyone and competing with no one, Empire in 1989 was the closest the United States ever got to single-payer health care.

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Barely was the celebration complete when the truth about Empire and the system of public-private coregulation was forced out for all to see. Decades of cooperation with New York’s voluntary hospitals had produced arcane payment mechanisms that favored treatment of patients in the most costly settings; foreclosed price competition; and undermined efforts to move toward a primary care, community-centered focus. Decades of cooperation with government had produced a dense web of special benefits and burdens for the insurer and myriad cross-subsidies among the insurer’s many enrollee groups. Empire had a staid, self-congratulatory culture focused on placating politicians, not pleasing customers. Its financial accounts were an enigma, as no one could ascertain where the firm was making a margin and where it was losing its shirt. The fall was brutal. Empire’s finances crashed in the early 1990s, with reserves plummeting to less than 1 percent of premium revenue, compared with a statutory minimum of 12.5 percent, implying by any normal standard of insurance accounting that the firm was bankrupt.⁴

Enrollment went into a tailspin as New Yorkers voted with their feet for for-profit HMOs such as Oxford and U.S. Healthcare. In 1992 Empire still had 8.1 million enrollees but by 1996 had only 4.5 million; it bottomed out at 4.1 million by the end of the decade. Empire ranked sixty-seventh out of sixty-eight BCBS plans in customer service, had the highest rate of upheld patient complaints to the state department of insurance, maintained seven incompatible and outdated computer systems, and had moved only 2 percent of its membership into managed care at a time when President Bill Clinton was proposing to restructure the U.S. health care system around vertically integrated HMOs.⁵

In a highly regulated state such as New York, economic woes inevitably have political implications, and it was politics that eventually brought down Empire’s management, culture, and operating principles. Empire was required to receive approval from New York’s insurance department for the premiums it charged in the individual and small-group markets, and repeated rounds of requested increases engendered vocal expressions of distress from consumers facing tight budgets and from politicians facing tight reelection campaigns. The media had a field day documenting the compensation and perquisites of the board and senior management, complete with corporate accounts at Tiffany’s and Cartier, backup luxury apartments and limousines, a preference for helicopters over the train when traveling to the state capital to request rate hikes, and a let-them-eat-cake response to questions about nonprofit mission.⁶ More serious were the sweetheart contracts with accounting and auditing firms, which repeatedly gave a clean bill of health to what subsequently were proved to be fraudulent accounting practices, and the granting of a massive computer contract to a dentist board member

with no computer background, which squandered millions of dollars and brought chaos to a firm whose business fundamentally is transactions processing.⁷ Massive computer problems prevented the insurer from distinguishing legitimate from fraudulent claims and subjected it to hundreds of millions of dollars in overpayments to physicians, clinical laboratories, and other providers for services that were not covered benefits, were not medically necessary, were upcoded to maximize reimbursement, or were not provided at all.⁸

From 1992 until the arrival of new management in late 1994 and the initiation of the conversion process in 1995, Empire struggled to change its culture and operations while remaining a nonprofit. It experimented with preferred provider organization (PPO) and HMO products and shifted 14 percent of its overall enrollment to these offerings by 1996. It began consolidating computer systems and upgrading customer service and by 1996 was only seventh rather than sixty-seventh among Blues plans nationally. It began earning profits on community-rated small-group and Medicare risk business.

But the overall financial losses continued. Between 1992 and 1996 Empire lost \$477 million in the individual “direct-pay” market even as it drove enrollment down from 177,000 to 63,000 and at the end of 1996 canceled all direct-pay indemnity products in favor of the state’s mandated HMO and point-of-service (POS) product designs. More disturbing were the continuing losses in the experience-rated and self-insured accounts. If Empire could not profitably retain the corporate customers willing to purchase the most generous benefits for the healthiest enrollees, it would be forced ever backward onto the public sector. Many large customers took their business elsewhere, loudly complaining of poor service and worse; AT&T, the insurer’s largest client, left in 1993 and filed suit alleging years of fraudulent overcharging.⁹ The federal government threatened to drop Empire from the administration of Medicare and the Federal Employees Health Benefits Program (FEHBP) because of gross inefficiency.¹⁰ The erosion continued, and by 1996 Empire was dependent for 38 percent of its membership on the highly politicized New York City and state employee accounts.¹¹

Regulation And Its Discontents

Theories of regulation often paint a picture of an agency or commission born in an initial upsurge of populist enthusiasm that slowly declines into servitude to powerful economic and political interests.¹² For Empire, as a quasi-private and quasi-public entity, the risk of capture came from both the hospital industry and the state government.

But the history of New York’s largest insurer is less a story of freedom followed by capture than one of capture followed by partial liberation. Empire was born in 1934 already captured by the New York City nonprofit hospitals, which organized and endowed the Associated Hospital Service to improve revenue collection and facilitate access to care during the Depression.¹³ For twenty-five years the insurer

supported the hospital industry financially and politically, raising premiums to cover costs and arguing to politicians and the public that premium increases were an unavoidable symptom of desirable improvements in the quality of care. In the face of ever greater resistance to premium increases, however, Empire gradually distanced itself from the hospital sector and sought an independent role as coordinator in a system of state, hospital, and insurance coregulation. Once freed from industry control, Empire slid under the oversight and authority of state government, providing the mechanisms and at times the financial means for New York to lead the nation down a regulatory trajectory from CON to Medicaid prospective payment, all-payer hospital rate setting, guaranteed issue, and community rating.¹⁴ In this process Empire was given many special favors, subjected to many special obligations, and driven to the brink of bankruptcy. The eventual conversion to for-profit ownership culminates a decade-long effort by the firm to escape this second Babylonian captivity.

■ **A spiral of adverse selection.** In the 1980s Empire was virtually the sole insurer of hospital services in downstate New York and, by extension, the sole provider of insurance products in the individual direct-pay market segment. Empire's unmanaged indemnity product design, New York's specialty-dominated medical profession, excess hospital capacity, and the community's AIDS epidemic combined to inflate costs and hence premiums at a rate that exceeded regulators' willingness to incur the ire of subscribers. Denial of rate requests and implicit mandates to subsidize politically visible constituencies is a common feature of price regulation in other industries and usually results in an extension of regulatory authority over an ever broader range of activities to enforce compliance.¹⁵ In New York, however, the regulatory state undermined its agent's ability to finance cross-subsidies by permitting competitors' entry into the insurance market in hopes of fostering consumer choice and provider competition. There resulted a spiral of adverse selection, as firms with healthy employees abandoned Empire for lower premiums and more-efficient HMO products, leaving the sicker individuals and firms clinging to Empire's indemnity offerings. In 1990, for example, the medical claims ratio (percentage of premium revenue paid out as medical expenses) was only 53 percent for the small firms that subsequently left Empire but 94 percent for all groups, implying that profitable customers were leaving while unprofitable ones stayed. A similar flight occurred among larger firms. In 1988, for example, Empire's community-rated accounts incurred costs 12 percent higher than those of its experience-rated accounts; by 1991 the difference had widened to 27 percent.¹⁶

■ **Poster child for corruption.** Empire's management always insisted that adverse selection was the cause of its financial problems and for several years was able to convince the state insurance department and legislature to support premium increases and impose regulatory mandates on its competitors. However, internal whistle-blowers and investigative journalists ultimately uncovered a dual set of accounts that documented how management was shifting losses from the large-group

accounts (which were not subject to premium regulation) to the individual and small-group accounts (which were). Empire had always argued that it pursued large profitable accounts to subsidize small unprofitable accounts but had been performing so inefficiently in the large-account sector that it was channeling the subsidies in the other direction.¹⁷ There followed a cascade of missing and destroyed documents, more whistle-blowing, obstruction of justice, executive dismissals, and criminal indictments.¹⁸ Empire became the poster child in the widely publicized 1993 Senate hearings, chaired by Sen. Sam Nunn (D-GA), on corruption, inefficiency, and perquisites in Blue Cross plans nationally. After dozens of hearings and reviews of endless documents, the Senate Permanent Subcommittee on Investigations issued a 200-page report dismissing the argument that adverse selection was the cause of Empire's woes, pointing instead at inefficiency, self-dealing, and the overly cozy relationship with the New York State Insurance Department.¹⁹

Back in Albany, the Republicans called for the head of the insurance commissioner and, by extension, of the Democratic governor who appointed him.²⁰ The insurance commissioner underwent a quasi-religious conversion and discovered a pattern of inefficiency and obfuscation at Empire (in lieu of victimization by for-profit insurers).²¹ The insurance department threatened to seize control of Empire but ultimately contented itself with pressuring the nonprofit insurer to replace its chairman and chief executive officer with people drawn from erstwhile for-profit nemeses such as Metropolitan and CIGNA.²²

■ **Impact on cost control.** The fickle favor of the state also was evident in the history of hospital cost-control initiatives. New York was an early enthusiast of regulatory solutions to health care woes, creating one of the nation's first CON statutes in 1964, shifting from cost-based to prospective payment for Medicaid and Empire in 1969, and extending rate regulation to other insurers in 1983. In compensation for its many special roles, Empire was favored with a regulated hospital payment rate 13 percent below that of the commercial health insurers, which protected the Blues' hegemonic market share but encouraged employers to purchase hospital coverage from Empire and physician coverage from a competing carrier. In 1996, for example, 60 percent of Empire's enrollees were covered by hospital-only indemnity products, despite the fact that the firm had absorbed United Medical Service, the local Blue Shield plan that covered physician services, in 1974.²³

Price control tends to freeze in place the structure of the industry to which it is applied, and the New York hospital industry proved to be no exception. Hospital rate regulation guaranteed the survival of New York's hospitals, kept admissions high and stays long, delayed the reduction of excess capacity, perpetuated a hospital-centered clinical culture, and set the stage for financial crisis when deregulation exposed the overbedded industry to a frenzy of discounting later in the 1990s.²⁴

The political scandal and financial near-demise of Empire in the early 1990s led to a distancing of relationships between the state and the insurer. One by one, the special benefits and special burdens once assigned to Empire were extended to all

carriers or abolished. In 1993 the entire small-group insurance market was subjected to community rating for a state-defined set of insurance benefits, and in 1996 all insurers active in the midsize and large-group segments were required to participate on a guaranteed-issue basis in the individual direct-pay segment (the data that convinced the legislature of the imperative for this statute were later discovered to have been fraudulently miscalculated by Empire).²⁵ In 1996 New York repealed its hospital rate regulation program, depriving Empire of its statutory discount but permitting it to leverage its not inconsiderable enrollment to drive down the rates it paid for inpatient services. By the time Empire proposed to convert from nonprofit to for-profit ownership, the firm could truthfully declare that it no longer enjoyed any special privileges, no longer endured any special penalties, no longer was insurer of last resort, and no longer served as almost an arm of state government.²⁶ After six decades of servitude, Empire considered itself free of the hospitals and free of the state. Neither the hospitals nor the state, however, was willing to relinquish control without compensation.

Who Owns A Nonprofit Organization?

From its inception in 1995 to its culmination in 2002, the debate over Empire's conversion to for-profit status operated on both philosophical and political levels. As a matter of logic, the philosophical question of whether to convert should have been answered prior to the posing of the political question of who would receive the organization's assets subsequent to conversion. As a practical matter, however, the changing responses to the second question exerted a decisive influence over the answers given to the first. Each of the key stakeholders began with a philosophical opposition to for-profit insurance and then switched in favor of conversion in anticipation of obtaining control of the assets. In the end, of course, only some of the financial hopes could be satisfied, but by then there remained no coherent philosophical opposition to the conversion.

■ **1995 proposal.** The original claimant to Empire's financial assets was Empire itself, as the firm badly needed capital in the early 1990s to finance state-mandated insurance reserves and market-mandated investments in information technology. The 1995 proposal would have restructured Empire as a nonprofit holding company with for-profit subsidiaries open to outside investors. The company's managed care products, which represented the growing and profitable future, would have been moved into the subsidiaries, leaving the shrinking and unprofitable indemnity products with the nonprofit parent firm. This restructuring, which would not have released any assets for social uses, was attacked by community organizations and patients' rights groups as an attempt to appropriate the value of decades of tax exemptions and other social benefits. Empire's board quickly abandoned the restructuring initiative and proposed a full conversion and consequent transfer of assets to a charitable foundation. To gain access to new capital, therefore, Empire would be obliged to give away its existing capital. Henceforth, the firm dropped off

the list of claimants and maintained a pragmatic willingness to cooperate with whichever contender seemed most likely to win the assets and hence support the conversion.²⁷

■ **Complications of full conversion.** Until recently, conventional policy wisdom and the relevant case law have asserted that the value of the assets held by non-profit organizations undergoing for-profit conversion should be transferred to an independent charitable foundation dedicated to improving health and health care.²⁸ The consensus derived from a series of hospital and HMO conversions in which investors and executives reaped a large share of the conversion proceeds.

Between 1996 and 2000 Empire worked with the New York political establishment and a coalition of fifty community and patients' rights organizations on proposals to endow a comparable foundation. Conversion was complicated, however, by the murky ownership structure of the firm. The creation of Associated Hospital Service in 1934 had been authorized by special legislation, and it was unclear sixty-five years later whether Empire could change its ownership without a commensurate change in the statutory framework. Between 1997 and 1999 the state held public hearings to discuss conversion, but garden-variety political gridlock and focused opposition from the hospital industry forestalled action. Empire pursued its efforts to convert without new legislative authority, encouraged by a supportive interpretation from New York Attorney General Dennis Vacco. Then, in December 1999, the newly elected and politically ambitious attorney general, Eliot Spitzer, reversed Vacco's interpretation and opined that conversion would be illegal absent new legislation. Empire prepared to go to court to defend its conversion proposal, but observers gave it little chance to cut the Gordian knot of regulation and litigation without political assistance. Empire ultimately realized that conversion required new legislation, that new legislation required support from the hospital industry, and that such support required a different allocation of the financial assets.

■ **Union antipathy.** The New York City health care system was dominated by academic medical centers and medical subspecialists who had nothing to gain and everything to lose from managed care's predilection for primary care, a shift of many treatments from inpatient to outpatient settings, and the exploitation of excess capacity to drive down provider payment rates. The hospitals watched with dismay as HMOs drew millions of enrollees from Empire through lower premiums that reflected lower payments to hospitals, and they dug in against what they interpreted as an attempt to change Empire from a hospital-friendly indemnity carrier to a hospital-unfriendly managed care organization. In this they were immeasurably aided by Service Employees International Union (SEIU) Local 1199, which represented 210,000 workers in hospitals, nursing homes, and other health care entities. Local 1199 was, and is, the most powerful political force in New York politics, able to mobilize thousands of activists and deliver tens of thousands of votes to politicians who agree that what is good for unionized health care facilities is good for America.

The antipathy between Empire and Local 1199 dates back at least as far as the disputes in the early 1990s over the insurer's management of the union's health benefits fund, which led to the dismissal of Empire and the effort by Local 1199 to launch a competing insurance firm focused on the business of New York's many union health trusts. This initiative faltered in its original form but reappeared in a novel guise in 1998 when the union and the Greater New York Hospital Association (GNYHA), which represents the hospital industry in the metropolitan region, proposed to invest union and hospital monies in Empire and thereby acquire control of the firm.²⁹

The legality of investor control of a nonprofit organization, even by nonprofit investors, was questionable from the first, and the union-hospital initiative faltered because of opposition from facilities that questioned the wisdom of a joint venture with one bargaining adversary (the union) to control another bargaining adversary (the insurer). Empire was viscerally opposed to the initiative, which the hospitals and union interpreted as evidence that investor ownership rather than access to capital per se was the true motive behind the conversion proposal.³⁰

■ **Role of the community coalition.** In proposing to endow a charitable foundation as part of its conversion process, Empire had cooperated with New Yorkers for Accessible Health Coverage, a coalition of community and patients' rights groups that had resolved its philosophical objections to for-profit ownership in anticipation of sizable representation on the new foundation's board. The alliance was spearheaded by AIDS advocacy organizations but included groups representing patients with breast cancer, multiple sclerosis, and other conditions that are targeted by underwriting practices in any unregulated insurance market. These organizations had been effective in pushing guaranteed-issue and community-rating legislation and had come to feel an ownership stake in New York's insurer of last resort, as they were the ones who needed that last resort. They were skeptical of the political agenda of the hospital industry (the feelings were mutual) and nurtured a vision according to which Empire's assets would be used to support community-based programs and advocacy efforts to garner additional governmental subsidies. Neither the hospital-union coalition nor Gov. George Pataki, however, was interested in using Empire's assets to fund what they viewed as a collection of ineffective do-gooders and overly effective agitators.

■ **Empire's 2001 proposal.** In April 2001 Empire sought to break the legislative logjam by arguing that a new foundation could subsidize public insurance and prescription drug programs, which otherwise would fall on the state budget.³¹ This reduced to an offer to give the organization's assets to the state and, not surprisingly, drew opposition from the community organizations without reducing opposition from the hospitals. Empire then negotiated behind the scenes with the hospitals and emerged in June of that year with a proposal to endow two foundations, one of which would have been controlled by the community organizations as before, albeit with only half the assets, while the other would have been dedicated to funding hos-

pital initiatives. This compromise placated the hospitals, which found themselves capable of relinquishing their philosophical opposition to conversion and felt justified in receiving the funds based on their historical role in establishing and (through the 13 percent rate discount) subsidizing Empire.³² However, the compromise alienated the community groups, unleashed a torrent of adverse media coverage alleging sleazy backroom deals, failed to solve a major financial problem facing the labor union, and so did not represent political equilibrium.³³

■ **The union's secret deal.** The last philosophical conversion in favor of for-profit conversion came from Local 1199, which had been engaged during 2001 in tense wage negotiations with its hospital allies. The eventual wage increase would require \$220 million of increased spending per year, a sum that the hospitals claimed they lacked any means to pay. In the waning days of 2001, Local 1199 and the hospital association negotiated in secret with Governor Pataki on legislation that would move Empire's assets to a fund within the state budget that was earmarked for health programs, including Medicaid payments to hospitals and other health care facilities.³⁴ Five percent of the proceedings from the eventual sale of the equity were allocated to a public foundation whose board was to be appointed by the governor and two legislative leaders (rather than by community-based organizations or other independent entities). Empire's assets were estimated at \$1 billion, sufficient to cover the wage increase over the three-year contract, and were to be supplemented by (speculative) increases in federal payments and other sources. A variety of health programs that previously were supported by general taxation were transferred to the special fund, implying an implicit appropriation by the state of whichever portion of the assets did not go to wage increases. The legislation was passed on the same day it was announced in January 2002 with strong support from both the Assembly Democrats, who dared not cross Local 1199, and the Senate Republicans, who dared not cross Governor Pataki.

■ **Media response.** The *New York Times* and other media commentators were contemptuous of the dissonance between the secretive Empire legislation and the governor's annual State of the State speech, delivered a week earlier with a righteous admonition to forswear fiscal gimmicks.³⁵ They also noted that Empire's assets would be exhausted after three years, while the higher wage rates would demand financing in perpetuity. The media also had a field day with the exclusion of home health agencies (some of which were battling unionization by Local 1199) and the legislative precedent for appropriating the assets of the state's second-largest non-profit insurer, HIP, which had already proposed conversion.³⁶ Henceforth, each new insurance conversion in New York would require special statutory authority, allowing the legislative and executive branches to determine the timing of each conversion to suit their budgetary and political needs. (In February 2003 Governor Pataki proposed a statute that would allow conversion of two more nonprofit insurers, with the assets being directed to the state treasury).³⁷ Criticism evolved to cynicism when Local 1199, traditionally on the left wing of the Democratic Party, endorsed the

“Empire’s prospects as a publicly traded company now depend on its ability to acquire or be acquired.”

reelection of the Republican governor while vociferously denying any quid pro quo resulting from the Empire agreement.³⁸

■ **Failed legal challenge.** New Yorkers for Accessible Health Coverage and Consumers Union filed suit to block diversion of the Empire assets to the state treasury (but not to block the Empire conversion itself) as an unconstitutional “taking” of private property by the state.³⁹ The use of libertarian language and fine legal distinctions between “charitable” and “public” assets by organizations more comfortable advocating single-payer health insurance highlighted the intellectual and political quandary faced by advocacy groups once they had been abandoned by their labor union allies. Their gloom only deepened in November 2002 when the reelection of Pataki confirmed the willingness of large numbers of Hispanic and union voters to embrace the Republican Party. The legal challenge was dismissed by the New York State Supreme Court in March 2003.⁴⁰

The Initial Public Offering

The IPO of WellChoice, the new for-profit parent of Empire Blue Cross, confirmed the liberation and rehabilitation of what was once a ward of the regulatory state. The institutional investors, including hedge funds, pension plans, and university endowments, oversubscribed the Empire equity offering by a factor of 10, permitting its investment bankers to price at the top of the proposed range and unload the maximum overallotment of shares. At the end of its first day as an investor-owned corporation, WellChoice had a 20 percent equity float of seventeen million shares trading at \$27 a share, implying a market capitalization of \$2.2 billion.⁴¹ This represented a vote of Wall Street confidence in a firm that was worth virtually nothing in 1992, had optimistically suggested a value of \$300 million in 1997, and was valued at \$1 billion during the 2001 political negotiations. The new valuation, all of which accrued to New York State as holder of the firm’s equity, reflected remarkable progress by Empire on every dimension of organizational and financial performance. From 1998, when the insurer gained its footing after years of chaos, enrollment had risen from 4.2 million to 4.6 million, revenues had climbed from \$3.3 billion to \$5.2 billion, and the firm had enjoyed sixteen consecutive quarters of operating profits.⁴² The bond markets had preceded their equity counterparts in endorsing the turnaround, with Standard and Poor’s upgrading Empire’s debt from B- (junk bond) status in 1997 to BB in 1999 and then to A- (investment grade) in 2002.⁴³ Internal operations had been streamlined, with the “first pass” rate of automated payment rising from 44 percent to 72 percent for hospital claims and from 71 percent to 87 percent for physician claims. The brand image had undergone a full makeover from its old, male, union image to a young,

female, and professional image for the new millennium. Despite the universally acknowledged value of the “Blue” brand, Empire had even sought to change its logo to a pink cross and shield until prevented by the national Blue Cross Blue Shield Association, settling on a blue butterfly image to signify metamorphosis.

Empire’s prospects as a publicly traded company now depend on its ability to acquire or be acquired in the national consolidation of Blues companies. The original arguments for conversion highlighted capital access to finance investments in information technology and to attract top-notch managerial talent, but these two goals had been achieved during the five years during which conversion languished in political purgatory.⁴⁴

The consequence of conversion for Empire itself is the firm’s ability to use equity capital to acquire Blues plans in other states and non-Blues plans in the New York region. Of course, once Empire is owned by investors interested in growth through industry consolidation, it will become a target for acquisition by other firms, especially by WellPoint and Anthem, the two investor-owned, multistate Blues plans.

Efforts by BCBS plans in Georgia, Missouri, and Virginia to convert and grow through acquisition all ended with the firms being acquired. Senior executives at Empire are barred from obtaining stock options in WellChoice for one year after the IPO, forcing them to increase the value of the firm and its stock after that date if they wish to benefit financially from the conversion. This alignment of incentives between the firm and its managers contrasts with cases where nonprofit executives received stock options, consulting contracts, and other emoluments as a direct consequence of their conversion strategy. However, the WellChoice executives do enjoy golden parachutes, with the chief executive officer, for example, eligible for more than \$5 million if he (or the WellChoice directors) negotiates a sale of the company to some other insurance corporation.⁴⁵ Empire Blue Cross will not be subject to outside tender offers until the State of New York completes the sale of WellChoice stock. Once the value of the erstwhile nonprofit’s assets has been successfully transformed into wages for Local 1199 members, however, the insurer will be for sale and will need continually to convince the shareholders that their investments earn a better return from Empire’s incumbent team than from whichever team would manage the company after a merger.

Implications For Politics In Other States

The process and outcome of the Empire conversion has implications for every state with both a budgetary crisis and a nonprofit insurer potentially amenable to conversion. The long-standing consensus that conversions of nonprofit insurers (and hospitals) to for-profit status should endow a charitable foundation has been brought into question. The advocacy organizations that traditionally supported the creation of these foundations have been so intent on fighting the private sector that they did not perceive their vulnerability to the public sector. Politicians lack

any inherent love for private foundations, especially ones that will support independent policy analyses, but acquiesce to the transfer of nonprofit assets to such entities when no better options are on the horizon. Modest precedents to the Empire outcome already existed: The Wisconsin Blue (Cobalt) conversion assets were used to subsidize the state's medical schools, and the Virginia Blue (Trigon) conversion funds were transferred to the state budget without being earmarked for health programs.

Not only does every state face a crisis in funding Medicaid and coverage expansions for the uninsured, but every one has numerous nonhealth projects that are highly valued by politically mobilized constituencies. At a minimum, advocacy organizations will need to argue that endowing an independent foundation, which holds the conversion assets in perpetuity and spends the interest on research and service projects, is socially more compelling than channeling the funds right away to Medicaid and other governmental priorities. This imperative may be a good rather than a bad thing, in that political competition will pressure foundations to be accountable in deed as well as in name to the community from which they obtained their funds.

■ **Deficits of Empire's conversion.** The Empire Blue Cross conversion does preclude a new center for applied policy research, demonstration projects, and support for community-based health care programs in the Empire State. The special governmental fund that will receive the conversion assets will function in some ways as a foundation, channeling Empire's assets and other revenues to a variety of health programs, but the legislature has control, which means that its actions are subject to all of the political pressures that legislators face. It will dispense both the principal and the interest on the Empire assets, in contrast to the usual foundation approach of dispensing only the investment earnings. The public programs that will draw on the assets (with the exception of the wage increases) would otherwise have been funded by tax revenues. As the advocacy organizations feared, the charitable assets from the nonprofit conversion will be used as substitutes for rather than supplements to existing public funds.

After his reelection, Governor Pataki proposed diverting non-Empire revenues away from the fund and diverting to the health fund financial responsibility for programs previously supported by general tax revenue.⁴⁶ The public appropriation of the Empire assets reflects the political culture of New York State, with its centralization of authority within government and its skepticism concerning independent centers of policy influence. This contrasts with political cultures in states that never centralized power to such an extent and hence felt comfortable allocating conversion assets to private foundations to pursue idiosyncratic visions of public policy.

It is yet unclear how much attention other states will pay to the New York experience. In Maryland, for example, the Blue Cross plan (CareFirst) suggested that the legislature could appropriate the nonprofit's assets to the state treasury

“The conversion to investor ownership will eliminate most vestiges of Empire’s dependence on New York politics.”

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instead of endowing a foundation, but the Maryland insurance commissioner rejected the conversion proposal outright.⁴⁷ In Washington State the hospital association opposed the Blue Cross (Premera) conversion proposal but argued that if conversion were to happen, the assets should be allocated to the hospitals rather than to a foundation (or to the state treasury).⁴⁸

■ **Unusual alliances.** The legislative appropriation of the Empire funds created an unusual political alliance between a labor union, a Republican governor, a Democratic assembly, and the hospital industry. It engendered an equally unusual (albeit transient) intellectual alliance among critics on the left and right. Some liberals oppose the solution because of their philosophical opposition to the use of charitable assets as alternatives for public tax funds to support Medicaid and other health programs, viewing charitable and public funds ultimately as complements to rather than substitutes for one another.⁴⁹ Some conservatives oppose the solution because of their philosophical opposition to the appropriation by an expansionistic state of a new source of private funds, seeing nonprofit organizations as mechanisms for ameliorating social problems without recourse to state authority. For conservatives, charitable and public funds are substitutes more than complements. Both sides support foundations as a locus of policy analysis and experimentation independent of politicians who are under pressure to supply pork to their constituents and of corporations that are under pressure to supply profits to their shareholders.

■ **A partial retreat of state authority.** If the denouement of the Empire conversion exemplifies the willingness of the public sector to appropriate private assets, the epic also represents a partial retreat by government from its regulatory trajectory of the 1980s. State authority in New York, and elsewhere, now is hemmed in by a thicket of opponents and obstacles to further expansion. Decades of tax-and-spend liberalism have created broad-based popular support for tax reductions; the appropriation of the Empire assets was driven in no small measure by the governor’s desire not to delay tax cuts despite being in a budgetary crisis.⁵⁰ In 2003 Local 1199 and GNYHA broke their tactical alliance with Governor Pataki after he recommended new cuts in Medicaid funding for health care institutions.⁵¹ This antitax legacy undermines state governments’ ability to finance insurance subsidies and Medicaid expansions for low-income citizens, driving them to questionable fiscal maneuvers of the sort witnessed in the Empire conversion. The evolution of the employment-based health insurance system and the insurance carriers’ strategic orientation create additional barriers to the pursuit of governmental objectives by traditional means. Large employers are ever more willing to shift fringe benefits from state-regulated insured products to federally regulated self-insured programs. Empire Blue Cross administers many self-insured corporate accounts, and its conver-

sion to a Delaware-chartered for-profit corporation from a New York-chartered nonprofit organization has been driven by the desire to participate more fully in a market segment where national networks and information technology investments are essential to achieving economies of scale.⁵²

The conversion to investor ownership will eliminate most vestiges of Empire's dependence on New York politics. Wall Street is only too cognizant of the financial risk posed by overzealous regulators and underfunded public programs in particular states and is willing to pay a sizable premium for the stock of insurers that are well diversified across geographic boundaries and across products and customer segments.⁵³ Empire now has the same obligations to New York State as do its competitors, paying approximately \$60 million in corporate income taxes, premium taxes, and sales taxes each year.⁵⁴ It must obey the myriad benefit mandates, guaranteed issue and community rating rules, and anti-managed care regulations listed in its IPO prospectus as business risks to investors.⁵⁵ That prospectus makes no mention, however, of any special rights or any special responsibilities to serve as the insurer of last resort, to restrain hospital cost inflation, to help enforce CON provisions, or otherwise to serve as an arm of state government.⁵⁶

If the Empire conversion has a tragic aspect, it lies in the inability of the New York political establishment to use the firm's assets to make headway against any of the state's serious health and health care problems. The \$300 million originally envisaged to flow from the conversion could have endowed a center for research and demonstration projects; the \$1 billion anticipated in the political compromise and the \$2 billion valuation in the IPO could have reached beyond studying problems to solving them. Bankrolling a union wage increase and reelecting an incumbent governor are worthy goals, at least from some perspectives, but they leave the state health policy problems exactly where they were when Empire still was a nonprofit organization owned by "the community."

THE LENGTHY CONVERSION PROCESS finally did clarify the ownership status and locus of accountability of Empire Blue Cross. Old, nonprofit Empire belonged to the state, the state is governed by its elected representatives, and its elected representatives are accountable to organized political constituencies. New, for-profit WellChoice belongs to its shareholders.⁵⁷ The special obligations and dispensations that once characterized the insurance company have been transferred, at least in part, to the hospital industry. Use of Empire's assets for wage increases represents only one among many financial and regulatory supports, which include special funding for graduate medical education, regulatory barriers to competition from freestanding ambulatory care centers, and impediments to entry by investor-owned hospital chains. Tripartite coregulation by the state, hospital industry, and Empire is gone and has been replaced by a new regulatory triangle of the state, hospital industry, and Local 1199. In health care and especially in New York State health care, it's all politics, all the time.

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NOTES

1. This analysis was developed through review of the relevant documents and discussions with numerous participants and observers. Of particular help were Daniel Fox (Milbank Memorial Fund), Michael Stocker (Empire Blue Cross Blue Shield), Kenneth Raske (Greater New York Hospital Association), James Tallon (United Hospital Fund), Mark Scherzer (New Yorkers for Accessible Health Coverage), and Pete Grannis and Peter Newell (Insurance Committee, New York State Assembly).
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