# Cases in Strategic-Systems Auditing

## Trigon Healthcare, Inc.

*Growth through Acquisition in the Hypercompetitive Managed Health Care Environment*

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# Case Time Period—Late 1990s

The case is set in the late 1990s. Unless an instructor indicates otherwise, analyses and responses to discussion questions for this case should be based on the facts presented in this document and pertain to the time period presented.

*Case Development Team*

Norwood Davis, Chairman and CEO, spoke to shareholders during the April 29, 1998 annual meeting about Trigon's three goals. Trigon is focused on:

*… maintaining its "customer-driven" focus, sustaining 15 percent EPS growth, remaining the leading managed care company in the Southeast and mid-Atlantic.*

# Introduction

Senior vice presidents Tom Byrd and Tim Nolan pushed back from the conference table. They had been reviewing their most recent bid to acquire Cerulean, formerly Georgia Blue Cross Blue Shield. After months of due diligence and what Trigon's acquisition team felt was a sound and attractive offer, they had learned over the weekend that Cerulean was really "hot" with another party. Having poured over the numbers, Byrd and Nolan were comfortable that the value from their current bid could be achieved within the 6-8 quarter window established by management and expected by the market. However, it now appeared that unless Trigon was willing to "bump" its bid, Cerulean's management was poised to sell to WellPoint, the much larger California "Blue." Byrd and Nolan focused their attention once again on the importance of this acquisition to Trigon's overall regional growth strategy.

Trigon, as the leading health care company in Virginia with 38 percent market share, had begun to look outside of the state. (*Greensboro News Record*, April 17, 1997.) The fastest way to expand was through acquisition. Acquiring other "Blues" made sense due to Trigon's ability to leverage the Blue Cross Blue Shield brand name and its common systems and shared networks (http://www.trigon.com). Cerulean, the Georgia "Blue," was one of the first and most attractive "Blues" to put itself into play. According to industry experts, a successful acquisition like Cerulean would send a strong signal to analysts and shareholders that Trigon was serious about attaining regional leadership. In addition, common wisdom within the investment banking community suggested that acquisitions were necessary for long-term strategic viability in the hypercompetitive and consolidating **managed care**[1] environment. (*Life Association News*, July 1999, Kosnett.)

[1] See Appendix 1 for a glossary of commonly used terms in the managed health care industry. Glossary terms will appear bold in text.

# Company Background

Trigon began operations more than 60 years ago as Blue Cross of Virginia. In 1935, people throughout the country were reeling from the effects of the Great Depression with many unable to afford medical care of any type. From this crisis, a new way to pool health care needs emerged and a network of Blue Cross insurance companies was created throughout the United States. The concept was expanded during World War II when health care was added to the fringe benefits many workers received in lieu of pay raises. The '60s and '70s ushered in an era of automatic claims processing, expanded services, and dramatic growth in membership. By the 1980s, concerns for rising health care costs caused many of the "Blues," including Virginia, to begin offering **health maintenance organizations** (HMOs) and **preferred provider organizations** (PPOs) as an alternative to traditional **fee-for-service** plans. As one of the first companies to offer managed care plans in Virginia, Trigon became the largest health care **provider** in the state having 31 percent of overall market share in its licensed service area and a substantial presence in all major metropolitan areas.

Trigon Blue Cross Blue Shield is headquartered in Richmond, Virginia where it employs nearly 4,000 people. Most of Trigon's approximately 1.8 million customers reside in the Commonwealth of Virginia and 80 percent are affiliated with corporate clients. In 1998, Trigon's home page suggested a market strategy centered on offering customers a wide variety of choices in health plans. See Box 1 for Trigon's mission statement. However, like all companies in this dynamic environment, Trigon is constantly reevaluating its strategy in response to changes taking place in the industry.

**Trigon's 1998 Mission Statement**

Across the country, the Blue Cross Blue Shield symbols are the hallmark of health care coverage people know they can depend on. And in Virginia, Trigon Blue Cross Blue Shield brings that dependability to over 1.8 million people who rely on us for the health care coverage they need. With Trigon, you'll find a full spectrum of CHOICE in health plans designed to meet the concerns of your employees and the needs of your company. Each of our plans combines provider networks with various levels of benefits to create an array of managed care options. All are backed by the STRENGTH of our long-term leadership in the field, our commitment to QUALITY and SERVICE and the extra VALUE of programs and features that deliver important tools for an emphasis on prevention and cost management.

**Box 1**
Source: Trigon's 1998 Home Page

# Impact of Demutualization[2]

The 1990s were a time of transition, with Trigon first converting from a not-for-profit Blue Cross Blue Shield to a **mutual company**. In 1994, Trigon began the process of **demutualization** to become a publicly traded company. The goals of Trigon's demutualization were to obtain capital to fund acquisitions and to improve its information systems. Trigon successfully completed the demutualization process on February 4, 1997 with the issuance of 17.8 million shares that raised $215 million.

An outcome of demutualization was a name change to Trigon Insurance Company, doing business as Trigon Blue Cross Blue Shield, and becoming a wholly owned subsidiary of Trigon Healthcare, Inc., the new parent. The Blue Cross Blue Shield licensing agreement granted Trigon the right to use the franchise trade name within Virginia;[3] any out-of-state ventures would have to be undertaken as Trigon, rather than as Blue Cross Blue Shield. In connection with the demutualization, the company was required to make a payment of $175 million to the Commonwealth of Virginia.

The demutualization process brought about significant changes in Trigon's top management team, as well. New managers with significant experience in the managed care side of the business were added. These new managers included a new VP of marketing (Paul Nezi, with experience at Choice Care, a leading Mid-West managed care company), a new chief medical officer (William Bracciodieta, M.D., with background at Humana and FHP International), and a new senior VP of business integration (Tim Nolan, a Harvard MBA, with experience in venture capital, investment banking, and consulting at McKinsey).

As a result of Trigon's public status, senior VP and CFO Tom Byrd began traveling to investor conferences, making presentations, and answering analysts' and fund managers' questions about the company's strategy and stock performance. According to Todd Richter, an analyst at Dean Witter in New York, Trigon was at that time, "an extremely strong and well-positioned **network**-based company…one of the strongest and best-positioned Blue Cross plans in the country." (*National Underwriter*, September 9, 1996.)[4]

[2] All historical information regarding the demutualization process presented in this section was obtained from Trigon's 1997 10-K or http://www.trigon.com/.
[3] The rights did not extend to the northern suburbs of Maryland adjacent to Washington, D.C.
[4] See Exhibit 1 at the end of the case for excerpts from Trigon's 1993-1997 financial statements.

Regional analysts were rating the stock a "strong buy" (see Figure 1 for a summary of Trigon's stock performance and analysts' recommendations), indicating confidence in Trigon's ability to grow even within this increasingly competitive industry.

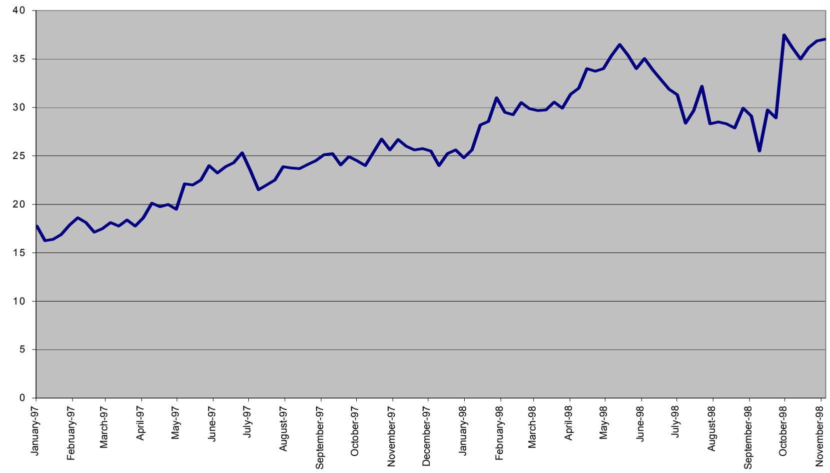


**Figure 1**
Trigon's Stock Performance January 1997 to November 1998
and Analysts Recommendations

| Brokerage Firm | Date of Recommendations | Recommendation |
|---|---|---|
| Major Broker | 11/23/98 | Strong Buy |
| Major Broker | 11/20/98 | Outperform |
| Scott & Stringfel | 11/16/98 | Buy |
| Warburg Dillon | 11/13/98 | Strong Buy |
| Ing Baring Furm | 11/13/98 | Hold |
| Davenport & Co. | 11/12/98 | Hold |
| ABN-Amro | 11/12/98 | Buy |
| Wheat First | 10/15/98 | Buy |

# Managed Health Care Environment[5]

The health care industry is a key sector of the domestic economy, accounting for about 13.6 percent of the U.S. economy in 1995, for a total of $989 billion. Based on current spending trends, it is estimated to grow to $2 trillion, or roughly 16 percent of the economy, by 2007. *(Trends in Health Care Spending by the Private Sector*, Congressional Budget Office, January 1998.) Originally created in the 1980s, HMOs have grown rapidly in the United States over the past 20 years largely as a result of the federal government and private employers seeking to curb the dramatic rise in health care costs. Managed care companies, which range from **managed indemnity plans** to **closed panel HMOs**, differ from fee-for-service insurers by actively managing health care cost and quality. During the 1980s, leading companies generated strong enrollment gains by focusing marketing efforts on the population's healthier segments.

[5] Unless otherwise noted, the primary source for the information on industry trends presented in this section is Standard and Poor's *1998 Industry Surveys/ Health Care: Managed Care Industry*.

By the late 1990s, managed care was the largest and most rapidly growing sector in the health care industry due to its undisputed success in reducing the overall cost of health care. However, the industry also was experiencing serious challenges and growing pains, including populations that were older and less healthy and increased competition from a fragmented group of rivals, which ranged from large, national, publicly held conglomerates to small, local, not-for-profit providers. Additional pressures on profitability came from underpriced commercial contracts, shrinking **Medicare** rate increases, and persistent medical cost inflation. Spending on pharmaceuticals had been a primary contributor to rising **medical loss ratios** (MLRs) a key measure of a managed care company's effectiveness in controlling health care costs. This measure is calculated as the ratio of the company's expenses that relate to customers' medical claims to total premium revenues for a given period of time (see Table 1 for a breakdown of Trigon and its competitors' MLRs). Cost efficiencies were only half of the profitability equation. Brand recognition, dependability, staying power, and quality of care all affected customers' and suppliers' choice of affiliation with HMOs and thus, revenue growth.[6] Taken

| Medical Loss Ratio Comparisons | |
|---|---|
| **National Competitors** | |
| WellPoint | 80% |
| Right Choice | 83% |
| Humana | 83% |
| **Trigon** | **83%** |
| Aetna | 85% |
| PacifiCare | 85% |
| Coventry | 85% |
| Foundation | 86% |
| United Healthcare | 88% |
| MAMSI | 89% |
| **Competitors in Virginia** | |
| **Trigon** | **83%** |
| Coventry | 85% |
| Optima (Sentara) | 85% |
| United Healthcare of VA | 93% |
| Optimum Choice (MAMSI) | 94% |
| QualChoice | 95% |
| Aetna US Healthcare | 96% |
| Kaiser | 97% |

**Table 1**
Source: Excerpt from Trigon's fall 1998 presentation to analysts

[6] See Exhibit 2 for a breakdown of Trigon's and its competitors' quality accreditation and customer satisfaction ratings.

together, pressures to manage costs and increase revenues resulted in fierce competition, modest operating earnings growth, and falling stock valuations for the entire industry.

The late 1990s also ushered in a flurry of acquisitions and mergers, particularly among large national providers, including Aetna, Cigna, U.S. Health Care, and Kaiser.[7] Motives behind the merger frenzy included increased bargaining power, convenience for geographically dispersed corporate customers, and, primarily, economies of scale. To achieve economies of scale and improve operating efficiencies, companies frequently attempted to eliminate system redundancies through integration. Systems integration, however, proved to be challenging for two reasons. First, systems were not always compatible and in such cases, companies had to choose whether to favor one system, merge the two systems, or create an entirely new system. Factors influencing system choice included the degree of centralization, the amount of risk sharing, and the degree of automation desired by management. A second challenge was related to human capital retention. While replacing people with technology can achieve needed cost efficiencies, technology by itself cannot provide certain customer services such as handling exceptions and troubleshooting problems, etc., which are directly related to operating effectiveness and overall customer and supplier satisfaction. "[I]ntegrating the 'back office' turned out to be harder than expected." (*The Economist*, October 4, 1997, p. 69.) In the past year, "…every major combined HMO failed to integrate its operations and live up to Wall Street's post-merger earnings expectations…as HMO's consolidate…they are forced to devote more energy to simple execution: the collection of premiums and payment of claims." (*Wall Street Journal*, August 17, 1998, Kleinke.)

Wall Street's negative response was a surprise and widely publicized and illustrated the pitfalls of neglecting execution in the face of rapid growth. "It was Aetna's merger last year with U.S. Healthcare…that landed the company in its current mess." (*New York Times*, April 11, 1998, Frudenheim.) Additionally, PacifiCare Health Systems lowered 1997 and 1998 earnings projections to account for unfavorable doctor and hospital contracts negotiated by its 1997 acquisition of FHP International, a former managed care rival. Cigna/Healthsource and PhyCor/MedPartners stumbled as well as a result of unexpected costs and difficulties in implementing new managed health care plans and integrating related acquisitions. Finally, the dramatic loss of more than 60 percent of market value of Oxford Health Plans in October 1997 followed its announcement that third quarter earnings would be hurt by higher-than-expected medical costs, continued delays in payments to providers, and overestimation of collectible

[7] See Exhibit 3 for a summary of recent acquisitions in the industry.

accounts. (*National Underwriter Life and Health*, November 3, 1997.) These issues were largely attributable to Oxford's failure to realize the importance of ensuring that any new system must be able to handle dramatic enrollment growth. This oversight resulted in management's inability to accurately gauge actual medical cost trends and process supplier and **member** bills. Taken together, these systems-related issues were unsettling for analysts and investors and hurt the overall HMO group outlook, although there seemed to be little alternative to growth for firms hoping to survive.

By 1998, however, analysts were expecting a turnaround in the industry due to projected continued growth in enrollment and an anticipated round of commercial rate hikes. They were optimistic that the industry would soon realize the long-awaited operating efficiencies and market power promised from the recent mergers.

# Trigon's Competitive Strategy [8]

Trigon chose to pursue growth in two specific ways. First, they sought to protect and extend existing markets within Virginia. The second, and arguably more critical growth-path, involved expansion into out-of-state markets. While most competitors were choosing either a national or local focus, Trigon elected to pursue regional growth to remain "the dominant player in the Southeast." (*First Call*, quoting Norwood Davis' remarks at the April 29, 1998 annual meeting.) This strategy was based on establishing a balance of "market presence, volume leverage and economies of scale" (http://www.trigon.com/investor).

Trigon was able to protect its dominant market position within Virginia by leveraging its more than 50 years of history and the Blue Cross Blue Shield brand name. Its 38 percent market share (*Greensboro News Record*, April 17, 1997) allowed Trigon to wield considerable power over both supplier and customer networks. (*American Medical News*, May 17, 1999.) Consequently, Trigon not only checked expansion by its next closest competitor, Sentara, which had captured only 6 percent of the market, it also deterred new entrants. For example, recent entrants such as Prudential and Kaiser were unable to make significant inroads into the Virginia market. The downside of Trigon's existing market share, however, was that significant new growth within Virginia could be difficult to sustain over the long term. Thus, Trigon's management considered growth beyond Virginia critical to achieving its strategic objectives. (*Trigon's 10-K,* 1997.)

[8] Unless otherwise attributed to a specific source, information regarding Trigon's competitive strategy was obtained from Trigon's 1997 10-K or http://www.trigon.com/.

One point favoring a regional growth strategy is Trigon's close geographical and cultural proximity to other Southeastern states. Trigon could better understand the needs of these regional customers and had more of a local presence and visibility than nationally focused companies. In addition, the HMO penetration rates in these states were significantly lower than the rest of the country. (See Figure 2 for a summary of HMO penetration rates by state.) Another factor favoring a regional approach was Trigon's understanding of the risk factors associated with these states' large rural populations. Specifically, Trigon could use existing databases from Virginia to estimate potential claims liability for neighboring populations better than companies from less similar states. Finally, no other company had expressed a goal of being the managed health care leader in the Southeast. As such, this region represented a unique niche opportunity for Trigon.

To achieve its growth objectives, Trigon adopted a marketing strategy very similar to Treacy and Wiersema's notion of "operational excellence." (*The Discipline of Market Leaders*, 1995, p. 33.) "Operational excellence" requires companies to deliver value to customers by providing high levels of reliability at a low cost. Sophisticated information processing technology and a highly motivated work force support this strategy of creating and maintaining a standard product that is simple and easy to use. The ability to carry out such a strategy effectively is predicated on excellent process control and near-perfect execution. This strategy was a change of direction from Trigon's past focus on tailoring products to meet individual customer needs. The shift was undertaken to "[position itself] for continued success in an industry environment characterized by continued consolidation, rising medical costs, and consumer concerns." (*First Call*, quoting Norwood Davis' remarks at the April 29, 1998 annual meeting.)

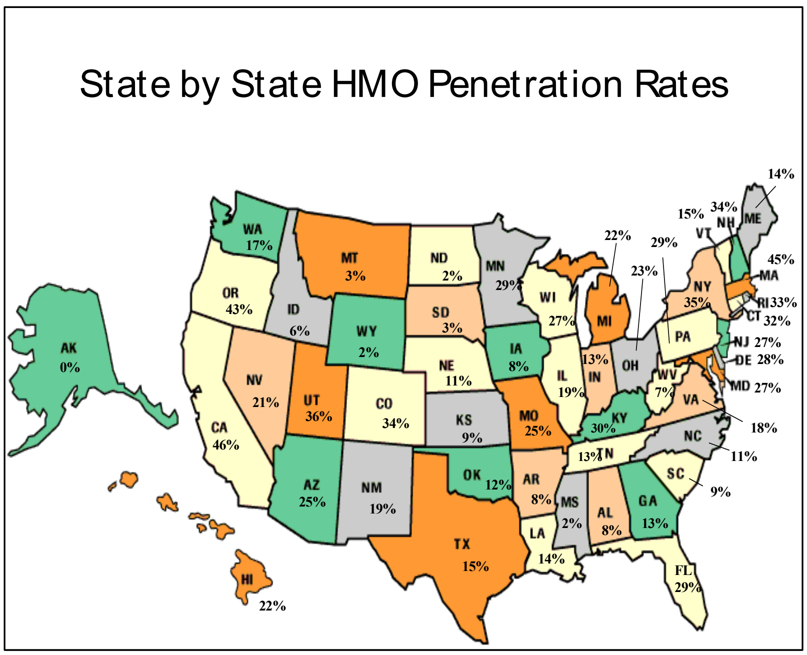


**Figure 2**

Source: http://www.medicaldata.com

# Implementing the Regional Growth Strategy

Market and industry pressures for rapid growth suggested that Trigon's goals would be more achievable via acquisition than by entering markets *de novo.* (*Trigon's 10-K*, 1997.) As a result, Trigon's management adopted a growth strategy consistent with the approach of many of its competitors, "go forth and acquire."

The quickest way for Trigon to leverage its strengths within the region and to gain access to supplier networks and customer bases was to acquire companies with strong positions in existing markets. Of such companies, clearly other "Blues" were among the most attractive targets for several reasons. First, and as previously noted, "Blues" had the advantage of decades of positive goodwill in their communities. Second, focus groups had shown that the "Blue" brand recognition was second only to Coca-Cola. (*Wall Street Journal*, July 10, 1998, Rundle.) Third, systems of other "Blues" tended to be relatively compatible, making integration less difficult and cost efficiencies more attainable. Finally, legal impediments existed for "non-Blues" trying to acquire a "Blue." According to Adam Bergman, a health care analyst with Scott & Stringfellow in Richmond, Va., "[o]nly a Blue Cross member can [operate under] a Blue Cross name in a given territory." (*Triangle Business Journal*, July 18, 1997.) For example, Andy Bressler (health care industry analyst for Bank of America) has stated that in Ohio, Columbia HCA was challenged successfully in court by the Blue Cross Blue Shield Association with respect to its attempt to purchase the Ohio "Blue."

Obvious choices to implement Trigon's regional acquisition strategy included the North Carolina and Georgia franchises. In addition to being part of the "Blues" franchise, these companies held large and growing market shares in states in which penetration rates were still relatively low. However, North Carolina had yet to transition from a not-for-profit to a public status, and thus was not a readily available opportunity. Thus, to gain a beachhead in the state, Trigon turned to Mid-South, a relatively small health care indemnity insurance company operating in the Fayetteville area. Among other benefits, Trigon's management felt that Mid-South would provide increased expertise in small and rural business contracts. (*News and Observer*, August 8, 1995, Marshall.) In return, Trigon would offer Mid-South "…expertise in developing and running a health maintenance organization."[9] (*Observer Times*, August 8, 1995, Pritchard.)

[9] See Exhibit 4 for Mid-South's 1996-1997 financial statements.

The initial valuation of Mid-South was derived by Trigon using projected cash flows based on assumptions of Trigon's ability to lower the target's MLRs, among other things. Trigon's valuation process notwithstanding, the competitive bidding environment left little room for price negotiation. Durham-based Coastal Physicians' bid of approximately $80 million (*News and* O*bserver*, August 8, 1995), as well as others' bids, forced Trigon's management to decide whether "playing in the weeds" in North Carolina was worth the acquisition premium. Trigon's management ultimately determined "at the end of the day to bump the bid." Thus, in February of 1996, Trigon purchased all the outstanding shares of Mid-South for $85.6 million, representing a premium of $56.7 million.

Initially, Trigon left Mid-South's existing management intact. According to Byrd, when Trigon did begin transferring its "operational discipline … and best practices," the smaller company had difficulty handling the transition. During this initial period, however, Trigon felt that acquiring Mid-South ultimately would reap the expected benefits. Additionally, the situation would provide Trigon with acquisition experience that could prove invaluable in the many significant acquisitions planned for the future.

Tim Nolan, a seasoned acquisition specialist, was hired after the Mid-South acquisition as VP of business integration to direct Trigon's future efforts. Nolan emphasized that Trigon's experiences with Mid-South were typical of the issues that companies often face during acquisitions and stated, "Acquisition bids are often made using optimistic assumptions… and the people who have to run the business aren't involved in the due diligence process. [Once finalized, the acquisition tends to be] "thrown over the wall" [and the operating teams are told to] "go off and create all the value …that's a recipe for potential trouble."

In looking toward future acquisitions, Nolan introduced new processes for due diligence, offer generation, and post-merger integration. While it appeared that many in the industry were still following a "go forth and acquire" strategy, Nolan ascribed to the market tenet of "never, never, never overpaying…if you can't make it work, know when to walk away." As a result, Trigon was in a stronger position to evaluate future acquisition targets and to create value from them.

# Cerulean Opportunity

While the recent acquisition of Mid-South furthered Trigon's regional growth objective, the chance to bid for Cerulean represented a uniquely attractive opportunity. The acquisition of the much larger Cerulean, due to its association with the "Blue" franchise and its location in the Southeast, would demonstrate that Trigon could maintain and enhance its regional leadership. Cerulean put itself in play in late 1997, although only to other "Blues."[10] Led by Nolan, Trigon's management began collecting information on the Georgia company, performing two due diligence exercises over the next six months (the first during the 1997 Christmas holidays and a second during the following Easter holidays).

Cerulean's position as a "Blue" made it possible to use Trigon's own operations as a close proxy for simulating potential cost savings and revenue enhancements. Over the course of months of studying Cerulean, Trigon's management became increasingly convinced that it could achieve significant operating efficiencies from the combination, which was a key condition for the acquisition to be successful.

Nolan made sure that Trigon "kicked the tires" by examining a host of productivity and operating details. These details included efficiency measures such as sales group close rates and calls per week, Y2K plans, system choice and integration, and disposition of pending lawsuits. "We must know what the deal is worth to us. We must understand how the game is played here, not just assume how the game is played. We have to determine whether we are the best managers of these assets," said Nolan. Byrd continued, "Tim led our efforts in terms of getting the play book together. We did our homework…we looked at how much redundancy we could take out and how fast. We knew the issues and questions and could put a value on Cerulean. We had looked at the acquisition from a financial perspective. We were clear on how far we were willing to go."

However, like the Mid-South bidding process, Trigon wasn't Cerulean's only suitor. Initially, several "Blues" were involved, including Florida, South Carolina, North Carolina, Alabama, and WellPoint (the largest "Blue" in the country). After a series of initial rounds, the field had been narrowed to just two competitors: Trigon and WellPoint. (See Table 2 for a timeline of selected Trigon events.)

[10] See Exhibit 5 for Cerulean's 1995-1997 financial statements.

As a regional bidder, Trigon appeared to have a clear advantage due to better knowledge of Cerulean's customers and operating style and thus a better chance to achieve operating efficiencies compared to a west coast company with no regional knowledge. WellPoint, larger than Trigon, had offered a competitive bid consisting of a stock swap valued at roughly $500 million. (*Los Angeles Times*, July 10, 1998) (See Table 3 for a comparison of relative company size.) In addition, the politics of the deal appeared to favor WellPoint, which reportedly offered Cerulean more autonomy (*Business Wire, Inc.,* July 9, 1998; *National Underwriter*, July 20, 1998, Bell) and a slower transition in terms of acquisition integration. A key remaining question was whether Cerulean's management would choose job longevity and the chance to remain a more independent company rather than the operating efficiencies and synergies that Trigon offered.

**1991: Converted from not-for-profit BCBS to a mutual company**

**1994: Began conversion to a for-profit organization**

**1995 (May): Acquired 80 percent of stock of Priority Health Care, Inc**

**1996 (February): Purchased Mid-South Insurance Co. for $85.6 M**

**1997 (February): Demutualization—17.8 M shares at $13/share. $215.2 M proceeds Trigon Health Care, Inc. formed, which owns Trigon Insurance Co. (formerly BCBS)**

**1997 (April): Adopted "operational excellence"**

**1997 (December): Trigon begins due diligence for the Cerulean bid (parent of BCBS of Georgia)**

**1998 (April): Trigon and WellPoint are the final bidders for Cerulean**

**Table 2**
**Timeline of Selected Trigon Blue Cross Blue Shield's Events**

Convinced that Trigon's bid was solid from a financial perspective, Byrd and Nolan turned to the more difficult task of attempting to assess the opportunity costs and the intangibles of the deal. It was important to avoid "falling in love with the deal" and overpaying by not taking into consideration the potential costs associated with completing a deal for which the value could not be achieved within the six to eight quarter time frame established by management and expected by analysts. Also, there were different opportunity costs associated with losing an attractive neighboring "Blue." Not only would losing allow WellPoint a beachhead in a region that Trigon had staked out for itself, but the loss could possibly lead the market to conclude that Trigon was having difficulty executing its regional growth strategy.

**Table 3**
**Selected Financial and Operating Data Comparisons for Trigon, Cerulean, and WellPoint**

| | Trigon | Cerulean | WellPoint |
|---|---|---|---|
| 1997 Sales (in thousands) | $2,063,620 | $1,542,635 | $5,826,444 |
| 1997 Assets (in thousands) | $1,928,820 | $553,363 | $4,533,415 |
| 1997 Medical Members* | 1,840,370 | 1,677,000 | 6,728,000 |
| 1997 Employees* | 3,583 | 2,400 | 10,600 |

*Information for Cerulean and WellPoint as of March 1998.

# Exhibit 1: Excerpts from Trigon's 1993-1997 Financial Statements

**Income Statement** (amounts in thousands)

| | 1997 | 1996 | 1995 | 1994 | 1993 |
|---|---|---|---|---|---|
| Premium and fee revenues | | | | | |
| Commercial | $1,431,114 | $1,320,596 | $1,157,899 | $1,081,820 | $1,050,157 |
| Federal Employee Program | 377,722 | 356,741 | 329,243 | 303,250 | 279,058 |
| Amounts attributable to self-funded arrangements | 1,062,101 | 1,077,478 | 981,741 | 908,234 | 905,529 |
| Less: amounts attributable to self-funded arrangements | (961,588) | (988,353) | (897,954) | (827,869) | (815,488) |
| | 1,909,349 | 1,766,462 | 1,570,929 | 1,465,435 | 1,419,256 |
| Investment income | 74,684 | 47,312 | 45,861 | 39,962 | 34,279 |
| Net realized gains | 54,063 | 59,410 | 52,976 | 12,793 | 26,199 |
| Other revenues | 25,524 | 49,356 | 55,176 | 45,467 | 30,555 |
| Total revenues | 2,063,620 | 1,922,540 | 1,724,942 | 1,563,657 | 1,510,289 |
| Expenses | | | | | |
| Medical and other benefit costs: | | | | | |
| Commercial | 1,194,641 | 1,086,388 | 959,328 | 802,666 | 795,921 |
| Federal Employee Program | 359,915 | 339,143 | 312,222 | 283,645 | 262,295 |
| | 1,554,556 | 1,425,531 | 1,271,550 | 1,086,311 | 1,058,216 |
| Selling, general and administrative expenses | 359,792 | 376,374 | 346,353 | 322,391 | 308,412 |
| Interest expense | 4,602 | --- | --- | --- | --- |
| Copayment refund program | --- | --- | 47,073 | 36,432 | --- |
| Total expenses | 1,918,950 | 1,801,905 | 1,664,976 | 1,445,134 | 1,366,628 |
| Income before gain on sale of subsidiary, income taxes, cumulative effects of changes in accounting principles and extraordinary items | 144,670 | 120,635 | 59,966 | 118,523 | 143,661 |
| Gain on sale of subsidiary | --- | 62,253 | --- | --- | --- |
| Income before income taxes, cumulative effects of changes in accounting principles and extraordinary items | 144,670 | 182,888 | 59,966 | 118,523 | 143,661 |
| Income tax expense (benefit) | 49,617 | (13,626) | 8,264 | 24,564 | 35,803 |
| Income before cumulative effects of changes in accounting principles and extraordinary items | 95,053 | 196,514 | 51,702 | 93,959 | 107,858 |
| Cumulative effects of changes in accounting principles, net of income taxes | --- | --- | --- | --- | 8,126 |
| Extraordinary items, net of income tax | --- | (190,820) | (4,707) | (644) | --- |
| Net income | $95,053 | $5,694 | $46,995 | $93,315 | $115,984 |

# Exhibit 1 (Continued):
# Excerpts from Trigon's 1993-1997 Financial Statements

**Balance Sheet Data** (amounts in thousands)

| | 1997 | 1996 | 1995 | 1994 | 1993 |
|---|---|---|---|---|---|
| Cash and investments | $1,370,868 | $1,213,902 | $1,119,652 | $1,001,571 | $940,914 |
| Total assets | 1,928,820 | 1,833,148 | 1,565,331 | 1,403,104 | 1,266,952 |
| Obligation for Commonwealth Pymt | --- | 175,000 | --- | --- | --- |
| Long-term debt | 90,147 | 4,880 | 4,145 | --- | --- |
| Total surplus | --- | 739,780 | 740,071 | 655,875 | 606,146 |
| Total shareholders' equity | 958,737 | --- | --- | --- | --- |

# Exhibit 2: 1998 Quality Rankings of HMOs*

(from *Newsweek*—reprinted with permission)

| Rank | Plan (State) | Plan Ranking | Satisfaction | Accreditation |
|---|---|---|---|---|
| 1 | Harvard Pilgrim Health Care (MA) | A | B | Yes |
| 2 | Tufts Health Plan (MA) | A | A | Yes |
| 3 | HMO Blue (MA) | A | B | Yes |
| 4 | Blue Choice (NY) | A | B | Yes |
| 5 | Group Health Care Cooperative of Puget Sound | A | B | Yes |
| 6 | United Health Care of New England (RI) | A | B | Yes |
| 7 | Kaiser Foundation Health Plan of Hawaii (HI) | A | A | Yes |
| 8 | Healthsource Massachusetts (MA) | A | B | Yes |
| 9 | Anthem BCBS of Connecticut (CT) | A | B | Yes |
| 10 | United Health of Wisconsin (WI) | A | B | Yes |
| 28 | Kaiser Foundation Health Plan-Mid-Atlantic | B | B | Yes |
| 32 | Kaiser Foundation Health Plan-Georgia (GA) | B | B | Yes |
| 34 | MD IPA & Optimum Choice (MD) | B | C | Yes |
| 38 | Optima Health Plan (VA) | B | B | Yes |
| 54 | Free State Health Plan (MD) | B | B | Yes |
| 66 | United Health Care of North Carolina HMO | B | B | Yes |
| 67 | Trigon HMO (VA) | B | C | -- |
| 68 | Partners National Health Plans of No. Carolina | B | B | Yes |
| 76 | United Health Care of North Carolina (NC) | B | B | Yes |
| 79 | United Health Care of Georgia (GA) | C | B | Yes |



These selected entries are from rankings of managed care plans from a survey of over 200 plans; however, a sizable number of plans declined to provide information for the ranking. Plan ranking represents each plan's standing in relation to the others, examining care for adults and children. The Satisfaction score is a ranking determined by subtracting the number of members who said they were highly dissatisfied from the number who said they were highly satisfied. Accreditation indicates whether the plan has met the standards of the National Committee for Quality Assurance in Washington. We present those companies ranked in the top-10 as well as those operating in Trigon's targeted Southeast region. Companies in the targeted region that declined to provide information included Aetna, Cigna, Foundation Health, Humana, NYL Care, PacifiCare, and Prudential. Not ranked or listed in those declining to provide information were Cerulean and WellPoint.

# Exhibit 3: Merger and Acquisition Trends in the Managed Health Care Industry

| Purchasing Company | Purchased Company | Year |
|---|---|---|
| Aetna | U.S. Healthcare | 1996 |
| | Virginia Mason | 1997 |
| Anthem | Southeastern Mutual Insurance | 1993 |
| | Community Mutual | 1995 |
| | BCBS New Jersey | 1997 |
| | BCBS Delaware | 1997 |
| | BCBS Connecticut | 1997 |
| BCBS Illinois | BCBS Texas | 1996 |
| BCBS of Michigan | PPOM | 1997 |
| Capital BC | BC of NE Pennsylvania | 1996 |
| Cigna | Healthsource | 1997 |
| FHP | TakeCare | 1994 |
| Foundation Health | Century Medicorp | 1992 |
| | CareFlorida | 1994 |
| | Intergroup | 1994 |
| | Health Systems | 1997 |
| | Physicians Health Services | 1997 |
| Harvard Community/Pilgrim Health Care | Formed Harvard Pilgrim | 1995 |
| | Mathew Thorton | 1997 |
| Healthsource | CYN Patients Choice | 1994 |
| | Provident | 1995 |
| | CentraMass Health Care | 1996 |
| Health Systems | MD Enterprises | 1995 |
| | Atlantic Health Service | 1995 |
| Humana | Group Health | 1994 |
| | Care Network | 1994 |
| | Emphesys Financial | 1995 |
| | Physicians Corp. of America | 1997 |
| | Choice Care | 1997 |
| Kaiser | Group Health | 1996 |
| | Humana Group Health | 1997 |
| | Community Health | 1997 |
| Oxford | Oak Tree | 1995 |
| PacifiCare | Freedom Plan | 1993 |
| | Advantage Health | 1994 |
| | Pastier Health | 1994 |
| | Value Care | 1995 |
| | Pacific Health Plans | 1995 |
| | FHP | 1997 |
| Pennsylvania Blue Shield | BC of Western Pennsylvania | 1997 |
| Qual-Med Inc./HealthNet | Formed Health Systems | 1994 |
| TakeCare | Lincoln National | 1992 |
| | CompreCare | 1993 |
| United Healthcare | Western Ohio HMO America | 1993 |
| | Complete Health Services | 1994 |
| | Ramsay-HMO Gencare | 1995 |
| | MetraHealth | 1995 |
| | PHP | 1996 |
| | HealthWise | 1996 |
| WellPoint | Mass Mutual | 1996 |
| | John Hancock | 1997 |

Source: Chan-A-Shing, 1998 unpublished honors thesis, UNC.

# Exhibit 4: Excerpts from Mid-South's 1996-1997 Financial Statements

**Balance Sheet Data** (amounts in thousands)

| | 1997 | 1996 |
|---|---|---|
| Assets | | |
| Current assets | | |
| Cash | $1,592 | $1,095 |
| Investment securities, at estimated fair value | 56,910 | 52,923 |
| Premiums and other receivables | 6,136 | 4,427 |
| Other assets | -- | 326 |
| Total current assets | 64,638 | 58,771 |
| Property and equipment, net | 6,641 | 6,844 |
| Deferred income taxes | -- | 81,204 |
| Goodwill and other intangibles, net | 50,173 | 53,673 |
| Restricted investments, at estimated fair value | 3,027 | 3,645 |
| Other assets | 3,829 | 1,523 |
| Total assets | $128,307 | $124,536 |
| | | |
| Liabilities and Shareholders' Equity | | |
| Current liabilities | | |
| Medical and other benefits payable | $15,191 | $20,024 |
| Unearned premiums | 1,282 | 235 |
| Accounts payable and accrued expenses | 2,685 | 1,647 |
| Other liabilities | 2,107 | 1,047 |
| Total current liabilities | 21,265 | 22,953 |
| Deferred income taxes, noncurrent | 1,161 | -- |
| Medical and other benefits payable, noncurrent | 20,832 | 16,203 |
| Total liabilities | $43,257 | $39,156 |
| Shareholders' Equity | | |
| Common stock | 5,447 | 5,447 |
| Capital in excess of par | 80,173 | 80,170 |
| Retained earnings | (1,597) | (297) |
| Net unrealized gain on investment securities, net of deferred income taxes of $553,332 in 1997 and $33,187 in 1996 | 1,028 | 61 |
| Total shareholders' equity | 85,050 | 85,380 |
| Total liabilities and shareholders' equity | $128,308 | $124,537 |

# Exhibit 4 (Continued): Excerpts from Mid-South's 1996-1997 Financial Statements

**Income Statement** (amounts in thousands)

| | 1997 | Feb. – Dec. 1996 |
|---|---|---|
| Premium and fee revenues: | | |
| Commercial | $74,711 | $52,920 |
| Investment income | 3,521 | 3,277 |
| Net realized gains | 231 | (1,165) |
| Other revenues | 336 | 247 |
| Total revenues | 78,799 | 55,279 |
| Expenses | | |
| Medical and other benefit costs: | | |
| Commercial | 60,670 | 40,314 |
| Selling, general and administrative expenses | 19,661 | 14,592 |
| Total expenses | 80,331 | 54,906 |
| Income before income taxes | (1,532) | 373 |
| Income tax expense (benefit) | (232) | 670 |
| Net income (Loss) | ($1,300) | ($297) |

### Excerpts from Trigon's 1997 Notes to Consolidated Financial Statements

Note 18: Acquisition and Disposition Activity

In February 1996, the Company purchased all of the outstanding shares of Mid-South Insurance Company (Mid-South) for approximately $85.6 million. Mid-South is a Fayetteville, North Carolina based life and health insurance company. The acquisition was accounted for as a purchase and, accordingly, the results of operations of Mid-South are included in the consolidated financial statements since the date of acquisition. Goodwill and other intangible assets arising from the transaction amounted to $56.7 million and are being amortized over periods not exceeding 25 years. No pro forma information has been provided since Mid-South's results of operations prior to the Company's acquisition were not material to the Company.

# Exhibit 5: Excerpts from Cerulean's 1995-1997 Financial Statements

**Income Statement** (amounts in thousands)

| | 1997 | 1996 | 1995 |
|---|---|---|---|
| Revenues: | | | |
| Premiums | $1,514,076 | $1,323,663 | $1,159,476 |
| Investment and other income | 17,259 | 14,358 | 11,980 |
| Realized gains | 11,300 | 4,113 | 15,265 |
| Total revenues | 1,542,635 | 1,342,134 | 1,186,721 |
| Benefits expenses | 1,370,962 | 1,175,740 | 1,039,095 |
| Operating expenses | 172,060 | 146,616 | 126,077 |
| Total expenses | 1,543,022 | 1,322,356 | 1,165,172 |
| Operating income (loss) | (387) | 19,778 | 21,549 |
| Non-operating income (loss) | 1,275 | 1,275 | --- |
| Income before taxes, minority interests, and cumulative effect of a change in accounting principle | 888 | 21,053 | 21,549 |
| Income tax expense (benefit) | (2,050) | 3,159 | 3,857 |
| Minority interests in (earnings) losses of joint venture investments | 1,460 | (421) | (282) |
| Net income | $4,398 | $17,473 | $17,410 |

**Balance Sheet Data** (amounts in thousands)

| | 1997 | 1996 | 1995 |
|---|---|---|---|
| Cash and investments | $315,323 | $307,190 | $223,994 |
| Total assets | 553,363 | 521,338 | 418,940 |
| Total est. benefit liabilities | 206,412 | 181,718 | 175,846 |
| Total liabilities | 311,681 | 287,123 | 245,901 |
| Shareholders' equity | 195,037 | 187,570 | 173,039 |

# Appendix 1: Glossary of Managed Health Care Terms

**Acute Care:** hospital care focused on a patient whose physical or mental condition requires immediate intervention and constant medical attention, equipment, and personnel.

**Ambulatory Care:** non-emergency health care services given to patients who don't require overnight hospitalization.

**Capitation:** a fixed amount per individual that is paid periodically (usually monthly) to a provider as compensation for providing comprehensive health care service during the period, regardless of the actual level of service usage. The fee is set by contract between a prepaid health care plan and the provider.

**Closed Panel HMO:** a managed care plan that contracts with physicians on an exclusive basis for services and does not allow those physicians to see patients from another organization.

**Coinsurance:** payment by a member of a fixed percent of liability for care up to a fixed maximum limit.

**Community Rating:** the practice of pooling the medical claims costs of similar classes of insured groups, such as small businesses or individuals, as a way of developing premium rates for a specific individual or business within each pooled category.

**Co-payment:** a member's fixed payment for each service.

**Deductible:** payment by a member of a specified initial portion of annual medical costs incurred by the member.

**Demutualization:** the process by which a mutual insurance company may reorganize as an insurance company to be owned by stockholders.

**Diagnostic Related Groups (DRG):** a classification method that categorizes services with respect to primary and secondary diagnosis, age, and complications.

**Discounted Fee-for-Service:** a payment program in which providers agree to receive less than their standard fee for providing medical services to members.

**Eligible Member:** an individual or entity holding a membership interest in Virginia Blue Cross Blue Shield as of December 31, 1995.

**Fee-for-Service:** method of payment in which providers are compensated for each service they perform.

**Fee Schedule Payment Program:** a payment program in which providers receive no more than a specified fixed payment for any given covered service.

**Gatekeeper:** a term typically used to refer to an HMO's primary care physicians or nurse practitioners, who are responsible for referring members to specialists or other services.

# Appendix 1 (Continued): Glossary of Managed Health Care Terms

**Health Maintenance Organization (HMO):** an organization that arranges the delivery of comprehensive health care services for its members at a fixed-periodic payment.

**Independent Practice Association (IPA) Model HMO**: an HMO that contracts directly with physicians in independent practices.

**Inpatient Services:** rendered hospital services to a member who has been admitted and occupies a hospital bed for the purpose of receiving medical services.

**Managed Care:** health care financing and delivery arrangement designed to provide health care through organized relationships with health care providers.

**Managed Indemnity Plan**: form of managed health care that requires simple pre-certification of elective admissions and large case management of catastrophic cases superimposed on a traditional indemnity plan.

**Medicaid:** health benefit program for low-income U.S. residents who are aged, blind, disabled, or are members of families with dependent children. The program also pays nursing home costs for indigent elderly patients. While Medicaid is jointly funded by state and federal governments, each state sets eligibility standards.

**Medical Loss Ratio:** the ratio of medical claim expenses to total premium revenues. Considered a key measure of a managed care company's effectiveness in controlling health care costs.

**Medicare:** federally funded U.S. national health insurance program for persons aged 65 and older, and for all disabled persons regardless of income or age.

**Member:** an individual or group covered by any of the Company's products.

**Mutual company:** corporation whose ownership and profits are distributed among members in proportion to the amount of business they do with the Company.

**Network:** the doctors, clinics, health centers, medical group practices, hospitals, and other providers that a managed care plan employs or contracts with to provide care to its members.

**Outcomes Management**: evaluation of the relative success and cost-efficiency of various medical products and services.

**Outcomes Research:** studying the results of various treatment protocols as a way of determining the most effective ways to treat specific health problems.

**Participating Provider (PAR):** provider who has signed an agreement with the Company to provide health care services to members, usually at a discount.

# Appendix 1 (Continued):
# Glossary of Managed Health Care Terms

**Physician Practice Management (PPM):** an organization that manages all of the back-office or administrative functions of a physician group practice, so that doctors can focus on treating patients. By banding together in an organized fashion, physicians are attempting to regain some of the power they have lost to HMOs.

**Point of Service (POS) Program:** an option available on PPO network products in which each member chooses a primary care physician who is responsible for coordinating all health care services for the member.

**Preferred Provider Organization (PPO):** a network system in which selected providers furnish health care services to enrolled members. Medical services in the PPO network are typically provided at a greater discount than the PAR network.

**Primary Care Physician:** under managed care programs, a designated general practice provider who is responsible for coordinating the total health care services of patients assigned to the provider by the managed care company.

**Provider:** a physician or other medical professional who provides health care to patients. Medical facilities, such as hospitals or clinics, also are referred to as providers.

**Provider Profiling:** the collection and analysis of claims and benefits management data for the identification of cost, utilization, and quality of care characteristics of physicians, health care facilities and allied health providers.

**Stop-loss Coverage:** insurance that limits a company's liability to pay health care costs above a designated amount.

**Traditional Indemnity Insurance**: a method for providing health care services that does not generally attempt to control health care costs through such techniques as contracted provider networks and utilization management.

**Utilization Management:** activities, including admission review, second surgical opinion, and provider profiling that are intended to manage the use of medical services by members to promote the efficient use of medical care.