VI. Potential Impact of Conversion on Profitability

Sections VI-IX provide four analysis of the potential impact of BCBSNC’s\(^1\) conversion on accessibility, affordability, and the public interest, taking into account the profile of North Carolina developed in earlier sections. We begin with a general discussion of how conversion might affect profit incentives, along with a review of the levels and components of profitability. In subsequent sections, we then review the major elements that influence profitability, including premium rates (in Section VII), and (in Section VIII) product offerings, underwriting practices, utilization management, and provider payment rates. We conclude in Section IX with a discussion of other public policy issues, including BCBSNC’s role as a “public citizen” and the potential benefits of conversion – most particularly the Foundation and greater tax revenues – that should be weighed against some of the potential adverse effects we identify.

Framing the Issues

General Approach

We begin our analysis of accessibility, affordability and other public interest factors by focusing on the increased profit incentives that will result from conversion. For insurers, there are two types of profits: profits made from the insurance business, which we refer to as the operating margin, and overall profits, which include earnings from investments and account for taxes. We focus on operating profits since this is the profit measure that most directly relates to how BCBSNC conducts its health insurance business.\(^2\)

BCBSNC claims that its operations and its profit goals will not be affected by conversion.\(^3\) With or without conversion, it says that it will seek to achieve an operating margin of 4-6%\(^4\), comparable to other for-profit health insurers, up from the level of about 2% it achieved in 2000 and 2001. Indeed, in 2002, its operating margin increased to 4.1%, from 2.4% in 2001. BCBSNC also claims that conversion will not affect any of its key operational arenas, such as pricing, product offerings, provider contracting, managed care practices, underwriting criteria and the like. We evaluate these claims first by analyzing possible changes in overall incentives to generate profits, and then by looking at each of these components of profitability separately to

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\(^1\) A note on terminology: The abbreviation BCBSNC is used to refer to the Blue Cross & Blue Shield plan in North Carolina. Blue Cross (abbreviated BC) is used to refer to Blues plans generally or in other states.

\(^2\) Although we use these and other accounting concepts throughout our report, we do not intend to provide a precise accounting of BCBSNC’s financial condition, or that of other BC plans we discuss. Instead, we rely on information provided in BCBSNC’s Business Plan, financial statements, and other similar documents, as well as available published or public information about other converted BC plans. Because we rely on such a variety of sources, the accounting conventions and practices used to generate these numbers are not always consistent and, therefore, financial numbers from different sources are not always directly comparable. Accordingly, we have attempted to avoid comparing numbers unless we believe they reflect a consistent accounting approach.

\(^3\) For instance, BCBSNC CEO Bob Greczyn stated at the public hearings that “we have never promised that premiums will not go up – only that there will be no difference in the way we operate if we do or do not convert” (Greczyn October 9, 2002).

assess whether conversion is likely to change BCBSNC’s practices in ways that are either favorable or unfavorable for accessibility, affordability, and public interest generally.

It is not our role to question the sincerity and credibility of BCBSNC’s current management in their stated intentions. We look beyond these stated intentions to focus on the fundamental incentives that may be created by conversion, the market and regulatory structures in which these incentives would function, and the track record of BC conversions in other states. This broader view is appropriate because conversion is a one-way change that will affect BCBSNC for generations to come. BCBSNC and its predecessors have been nonprofit for almost three-quarters of a century, and once BCBSNC converts it is highly unlikely to ever return to this status. Business plans, business managers, and business owners are all temporary. Corporate organization is much more permanent.

We use a “mixed methods” approach to evaluating the impact of conversion, one that combines both quantitative and qualitative evidence. Qualitative evidence comes mainly from the expert interviews with key informants summarized in Appendices A and B, and from documents gathered through numerous literature and web site searches. For the most part, we do not use quantitative measures to attempt to “prove” the likely impact of conversion. Instead, quantitative measures provide objective evidence that sets the context for more qualitative assessments, or helps to illustrate or confirm points made through qualitative sources.

“Conversion” as Event or Process
We need to address one other preliminary point about how to conduct a before-and-after analysis of these issues. The core question is how conversion will affect the public interest. This requires us to define what constitutes “conversion.” One view is that conversion is the discrete set of corporate transactions contained in the Plan of Conversion that will occur only if the Plan is approved and executed. We call this “conversion as an event.” Another view is that conversion is a longer planning and strategic process that began several years ago and is currently ongoing. We call this “conversion as a process.” Under the first view (conversion as event), we would focus only on any differences in BCBSNC operations that might occur following execution of the Plan of Conversion, comparing future BCBSNC to current BCBSNC. Under the second view (conversion as process), we would compare current and future BCBSNC behavior with an earlier time, prior to when BCBSNC began to prepare itself for conversion. Rather than choose between these two views, we will conduct our analysis recognizing that both exist.

This complication in the analysis is necessary because it is likely that BCBSNC has already begun to change its operations in anticipation of conversion. This is indicated from multiple sources in the interviews we conducted and the literature we reviewed. National experts on insurance markets and BC conversions explain that the best strategy for any health plan intending to convert is to be in the strongest possible financial shape because this will enhance the value of the stock. A leading industry advisor, for instance, recommends that, prior to conversion, a Blue Cross plan should “develop a for-profit culture, . . . tighten its medical management, hit its earnings targets and shore up its operating surplus – or leave its conversion

5 Qualitative and mixed methods are often used in public policy research to investigate questions that cannot be clearly resolved through quantitative analyses alone (Sofaer 1999).
plans on the shelf” (Fluegel 2000). BCBSNC itself explained in written comments to the Department of Insurance that:

Successful conversion to for-profit status also requires receptivity of the market and investors to ensure that equity funds can be raised to meet the investment and other financing requirements of the company. . . . Generally, companies will have reduced or little success in a public offering if their most recent market or financial results are poor or declining. Conversely, the best opportunity for successful conversion and a positive reception by investors is when recent financial results . . . are positive and offer a strong outlook for the future.

The perception is also widely shared among very experienced market analysts and benefits consultants in North Carolina that BCBSNC has been managed for the past several years “with an eye on the equity markets.” Several knowledgeable interview subjects said that Mr. Greczyn’s “goal all along” has been to instill a “profit-driven culture” at BCBSNC and to “get its book of business in a favorable situation” for conversion, since conversion has been a “glimmer in his eye” from when he first came to BCBSNC in 1998. Indeed, discussions about the possibility of conversion appear (according to interview sources) to have begun in the early 1990s just prior to the departure of CEO Tom Rose.

Several of these knowledgeable subjects felt, however, that BCBSNC would become even more profit-focused following conversion, especially since the public, political, and regulatory scrutiny that exists during the conversion process will abate. One competitor explained that it would be a “political problem” for BCBSNC if it appeared to be too profit-driven prior to conversion, so “it’s a delicate balancing act” between improving profits enough to be “well positioned” for issuing stock by “sending the right signals” to investors, versus maintaining political and public support during the conversion process, but these latter constraints would not exist once conversion is accomplished.

In view of these observations, we believe the best way to do a before-and-after evaluation of a company that is already in the process of changing is to assume that it will continue to change in the fashion that it has been changing in recent years, but even more so. The overriding question, then, is whether this will be good, bad, or neutral for affordability, accessibility, and the public interest generally.

Levels and Components of Profitability

Profit Pressures
Conversion from nonprofit to for-profit status will increase pressures on BCBSNC to generate more profits. This point almost goes without saying, since the incentive to generate profits is the fundamental difference between these two forms of corporate organization. As one nonprofit proponent noted, for-profit insurers have a “legal, ethical, and fiduciary duty to maximize profits

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6 In June 1994, the BCBS Association changed its policy to permit for-profit plans to remain part of the Association (Goddeeris and Weisbrod 1998); these early discussions at BCBSNC appeared to coincide with the extensive deliberations that culminated in the Association’s change in national policy.
for shareholders.” An authoritative text on corporations law explains that the main objective of for-profit managers is to maximize shareholder wealth:

Shareholder wealth maximization is not only the law, it is also a basic feature of corporate ideology. . . . A 1995 National Association of Corporate Directors (NACD) report, for example, stated: “The primary objective of the corporation is to conduct business activities with a view to enhancing profit and shareholder gain.” . . . [Or] as Nobel laureate economist Milton Friedman once quipped, “the social responsibility of business is to increase its profits.”

Maximizing shareholder wealth is not necessarily a negative purpose, however. The incentive to increase profits can produce better customer service, more product innovation, and greater efficiency through lower overhead and better control of medical costs. Also, higher profits will likely increase the value of the stock held by the proposed Health Foundation for North Carolina. However, profit incentives could also have some negative consequences for the public interest, discussed below.

For-profit conversion intensifies profit incentives because managers of publicly held companies are highly sensitive to how their operations are perceived by the investor community. A national expert explained that for-profit insurers “will have to get their 15% growth and their return on equity to keep [stock] analysts happy.” An observer in Virginia said that BC there has to “dance the dance for financial analysts and investors; they have to perform.” The pressures this creates are explained by Leonard Schaeffer, the long-time CEO of WellPoint, which owns for-profit BC plans in California, Georgia and Missouri:

There is no question that the pressure for economic performance and thus accountability to investors is very real. . . . Stock analysts who follow companies want them to perform to their calculated profit estimates every quarter. Having said that, though, . . . there was almost no change in how we behaved [following conversion]. We were [already] one of the most profitable plans in the United States. However, when we became publicly held, and listed on the stock exchange, for the first time ever there were incredible pressures for achieving our goals for quarterly earnings (Iglehart 1995).

In our interviews, a market analyst noted that these pressures affect the entire management team across a wide range of activities, in part because managers directly benefit from stock incentives.

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7 Bainbridge (2002). This treatise further explains:

The law’s basic position on corporate social responsibility famously was articulated in Dodge v. Ford Motor Co., 170 N.W. 668, 684 (Mich. 1919); . . . "A business corporation is organized and carried on primarily for the profit of the stockholders. The powers of the directors are to be employed for that end. The discretion of directors is to be exercised in the choice of means to attain that end, and does not extend to a change in the end itself, to the reduction of profit . . . in order to devote them to other purposes.” Dodge’s theory of shareholder wealth maximization has been widely accepted by courts over an extended period of time. Almost three-quarters of a century after Dodge, the Delaware chancery court similarly opined: “It is the obligation of directors to attempt, within the law, to maximize the long-run interests of the corporation’s stockholders.” Katz v. Oak Indus., Inc., 508 A.2d 873, 879 (Del.Ch.1986).
He explained that these effects are not always very visible since “there are a zillion ways to target more profitable business segments” through incremental decisions about underwriting, marketing, claims payment, etc.

In recent discussions with the Department of Insurance (“DOI”) over requested rate increases, one BCBSNC senior manager expressed a great deal of concern that, when the DOI lowered the requested increase by about 5 percentage points, this could have a big impact on the value of the stock issued after conversion and the resulting value of the Foundation. Therefore, it appears that the company’s potential stock value is very much on the minds of BCBSNC’s senior management already.

Some industry analysts we interviewed observed that the investor community is not satisfied simply with achieving a profitable plateau because investors look for continual improvements in financial results. BCBSNC reflected this in written comments to the DOI that:

Both historical EPS [earnings per share] growth and projected EPS growth (which is clearly influenced by EPS growth potential) are extremely important. . . . Investors will look at EPS growth achieved historically to provide context for projected EPS growth, which will be critical to their investment decisions. . . . This can be seen throughout our industry and others as public companies’ market values are largely driven by revenue and earnings growth potential” (emphasis added).

Therefore, although for-profit managers may speak in terms of hitting certain targets, the targets tend to be reset to encourage continuing growth in profits. As one industry advisor put it, for-profit insurers basically just “try to make as much money as they can.”

National experts noted that nonprofit BC plans, in contrast, have an expectation or legal requirement of not accumulating too much surplus. Since they cannot pay out their earnings through dividends, at some point if they are successful they may reach a stage where it is not necessary to continue earning more profits. According to BCBSNC’s current projections, this would occur in roughly five years if it is able to achieve its profit targets of 4-6%; at that point, it would meet its surplus goal of roughly 25% of annual premiums (compared to 18% at the end of 2002). As a nonprofit, any additional surplus presumably would be unnecessary or excessive, so one would expect a nonprofit BCBSNC to reduce its profit levels at that point. Some BC plans have even paid back excess surplus to policyholders in the form of rebates or rate reductions, as occurred for instance in North Carolina in 1986 when BCBSNC created a $75 million rate stabilization program that reduced rates by 8-9% over four years, according to DOI records.

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8 See Aug. 15, 2002 Letter from Peter A. Kolbe to Daniel E. Glaser.
9 Note that maintaining zero profitability may not be optimal, even for a nonprofit, because there still is an ongoing need to add more to surplus and reserves each year to account for growth in claims expenses due to additional plan members and medical inflation. However, whether a plan needs to earn margins of 1% or 2% or 3% to keep surplus and reserves at a stable level in relation to annual claims depends on the rate at which its claims are growing due to membership and medical trends.
10 According to actuarial testimony provided on behalf of BCBSNC, a 4% profit margin for five years would increase the company’s surplus level to 22% in five years, and 6% profits for five years would produce surplus of 27%. Testimony for REDACTED G. Harris REDACTED October 7, 2002, p. 15.
The effect of profit incentives is borne out in the comparative financial performance of for-profit and nonprofit BC plans nationwide (Table 6.1). Over the most recent five years for which data are available (1997-2001), the underwriting gains of for-profit BC plans were roughly 1 to 2 percentage points higher than four nonprofit BC plans, and overall profits, including investment income, were 1.5 to 4.0 percentage points higher (before taxes).\(^\text{11}\)

This consistent pattern over five years indicates the potential that stock ownership appears to have for motivating management to improve financial performance. This potential is also seen in the profit trends of the four BC plans that underwent free-standing conversions several years ago. When BC of California first began conversion, it was in serious financial trouble, but since conversion, its overall profit margins have consistently been among the highest in the industry. In Georgia, BC steadily increased its operating margin 1-2 percentage points a year following conversion. In 2001, the first year under WellPoint, the operating margin at the Georgia BC plan

\(^{11}\) Note that the for-profit weighted average is distorted somewhat by the much-better-than average performance of WellPoint, which is by far the largest plan. If conversion is viewed as a “roll of the dice” following which there is an equal chance of ending up with the average performance of any of the five for-profit companies we examined, then the unweighted averages may be a better measure of what might be expected following conversion. Using unweighted averages (i.e., treating each company equally), underwriting profits overall are lower than when using weighted averages.
jumped four percentage points. Profitability has also improved steadily in the Missouri and Virginia BC plans following their conversions. In Missouri, BC’s net income increased almost 600% from 1998 to 2000, and in Virginia, the press reported in 2001 that the BC plan had exceeded Wall Street expectations every quarter since it went public.

These statistics do not prove, however, that for-profit status is a guarantee of profitability. In the national comparative data reported in Table 6.1, there was at least one for-profit plan that lost money on its insurance business in each of these five years. Also, profitability levels are relatively modest; even the most profitable plans had operating margins of only 3.7 to 4.5%, reflecting the competitive industry in which these plans operate. Even when investment income is added, profitability for the group is only 6.5% in the best year (2001). Finally, this track record does not prove whether these particular for-profit plans had higher profits than they would have had if they had remained nonprofit, since almost all BC plans nationally have improved their profitability in recent years (Cunningham and Sherlock 2002). Nevertheless, the consistency and level of profitability that for-profit plans have achieved suggests that conversion has made a difference, when compared with the performance of most nonprofit Blues plans over the same time period (Schramm 2001a).

**Comparing Nonprofits with For-Profits**

Acknowledging that conversion can be expected to increase profit incentives does not, however, resolve what impact these incentives will have on how BCBSNC does business. Many differences will probably be fairly subtle because nonprofit insurers are also under many of these same financial pressures already. Both national and local experts explained that all Blue Cross plans are much more market-oriented in the current environment than was the case 10-20 years ago, regardless of corporate form. The advent of managed care in the 1980s made health insurance markets much more competitive, forcing all BC plans, including North Carolina’s, to abandon ways of doing business that once made them markedly different from commercial insurers, in order to survive. BC plans were once run by providers, and they voluntarily used business practices such as community rating that were much more accommodating to people with medical problems. These notable features are now historical artifacts at BC plans around the country, including BCBSNC.

This reality is echoed in the refrain repeated numerous times by North Carolina interview subjects from all different perspectives (purchasers, agents, patient advocates, competitors, industry observers) that BCBSNC is already operating as if it were for-profit. The view is widespread that BCBSNC is nonprofit “in name only” and is essentially indistinguishable from its for-profit competitors in being “focused on the bottom line.” The prevailing attitude is captured by the comment of one representative of employers who said that, for the most part, ordinary people “have no idea” if BCBSNC is nonprofit or for-profit, and “don’t care about” its legal structure, since all they want is to get the best value for their health insurance dollar, and they don’t see any real difference now between how BCBSNC operates compared with for-profit insurers.

In North Carolina, most observers mark 1994 as the major break from the past, when BCBSNC severed its long history of close ties with the hospital industry and brought in a new management team headed by Ken Otis, who previously ran a for-profit managed care subsidiary of Blue Cross...
in Florida. According to press reports, the primary goal of this new management team was to improve BCBSNC’s managed care offerings, primarily its HMO products. To do this, BCBSNC said it needed to diminish the influence of doctors and hospitals on its board of directors, which it accomplished in 1996 by removing seven of its physician and hospital administrator board members. The Otis management team struggled, however, to keep BCBSNC profitable, running operating deficits each year from 1995 through 1998. (Overall, BCBSNC had significant profits these years, but only through its investment earnings.) Therefore, when Bob Greczyn became head of operations in 1998 as part of yet another new management team, a main objective was to restore BCBSNC to operating profitability, which was accomplished in 1999 and has improved since then.

Similar stories have unfolded in other states where BC plans have converted. In each of these states, interview subjects explained that financial problems had caused their BC plan to “change its stripes” in years prior to conversion by bringing in new management that had a much more market- and profit-oriented business approach. Conversion was seen as a continuation of this change toward behaving more like any other commercial insurer, but not the main catalyst of these changes. Therefore, when conversion occurred, most subjects thought it caused little or no noticeable change in how the BC plan was doing business, and that the BC plan would have continued to behave in largely the same way even if it had remained nonprofit, since it was under the same management team. One person commented that the BC plan in his state is no less socially oriented than it was before, only now perhaps it has fewer qualms. As several subjects put it, the conversions in these states were the effect of a change in corporate culture, rather than its cause, since the management team that did the conversion had already put a for-profit culture in place prior to the conversion.

We do not conclude from these sources, however, that conversion will make no difference in how BCBSNC operates. In our studies of other states, we did not compare converted BC plans to nonprofit plans in still other states that have no apparent intention of converting. Had we done so, the consensus among industry experts is that detectible differences could have been observed in corporate ethos and business strategies. For instance, we spoke with one highly knowledgeable industry advisor who has worked at and with both for-profit and nonprofit health plans, including both Blues and non-Blues plans. He said that there is a “subtle but important difference” between nonprofit and for-profit health insurers. “In a very fundamental way, they operate differently.” Other market-oriented analysts noted that nonprofits have “more flexibility to consider community needs.” In the view of one observer, for “nine out of 10 individual decisions” regarding pricing, underwriting, provider contracting, etc., “they’ll decide the same thing, but the issue is what is the impact of the 1-in-10 decision where they will differ? The difference can be significant.” In California especially, many people commented that BC stands out as being very profit-oriented and aggressive in its business strategies, even compared to its non-Blue competitors.

Potential differences between nonprofit and for-profit health plans are also explored by academic research comparing the performance of each type of health plan:
• On the question of patient quality and satisfaction, the evidence is mixed, but the weight of the evidence suggests that members of nonprofit HMOs are more satisfied and receive better service and somewhat higher quality of care than members of for-profit HMOs.\textsuperscript{12}

• On the question of profits, all the available empirical evidence also comes from HMOs, with the weight of the evidence showing no difference between for-profit and not-for-profit plans.\textsuperscript{13}

• On the question of premiums, all of the available evidence comes from comparisons of HMOs, with the weight of the evidence showing that for-profit plans have lower premiums.\textsuperscript{14}

We hasten to note, however, that these findings do not resolve the issue before us since they look only at HMOs, not at health insurers generally or Blue Cross plans in particular.\textsuperscript{15} More important, such studies typically do not account for important differences between patients enrolled in different types of plans: in Medicare HMOs, for example, people in for-profit plans are much poorer and less educated than their counterparts in not-for-profit plans.\textsuperscript{16} Of even greater importance, almost none of these studies compares before and after a conversion.\textsuperscript{17} Rather, they compare between HMOs that are nonprofit and others that are for-profit. Since many of the nonprofits are BC plans and most of the for-profits are not, these studies provide only limited insight into differences that result from the conversion of a BC plan. Also, evidence of financial performance from many years ago is of questionable relevance in today’s

\textsuperscript{12} For studies favoring nonprofit HMOs, see Tu and Reschovsky (2002); Landon, Zaslavsky, Beaulieu, Shaul and Cleary (2001); Himmelstein, Woolhandler, Hellander and Wolfe (1999); Kuttner (1998); Nudelman and Andrews (1996); (Feldman, Wholey and Town 2003). For studies finding little or no difference, see (Blustein and Hoy 2000); (Born and Simon 2001). Born and Simon (2001) found that, regardless of profit status, more profitable HMOs had higher quality ratings in subsequent years.

\textsuperscript{13} An analysis of 163 HMOs found no significant difference between nonprofit and for-profit HMOs in their return on assets, a measure of profitability (Bryce 1994). This is supported by a recent study of all HMOs in the U.S. during the period 1986-2001, which found no difference in profitability between nonprofit and for-profit HMOs. This study also found that HMO conversion to for-profit status did not produce any statistically significant change in profitability (Feldman, Wholey and Town 2003); however, we consider this finding to have questionable relevance here, for reasons discussed below.

\textsuperscript{14} A national study of HMOs from 1988-1991 found that, after controlling for many differences between the two ownership types, for-profit HMOs had premiums that were 3.5% lower than their nonprofit counterparts (Wholey, Feldman and Christianson 1995); a similar analysis for 1990-1995 found 6.2% lower premiums at for-profit HMOs (Feldman, Wholey and Christianson 1998). A similar analysis of all HMOs in the U.S. during the period 1986-2001 showed 4.3% lower premiums at for-profit HMOs; however, a companion analysis of premiums for the Federal Employees Health Benefits Plan (which had the advantage of controlling for differences in benefit levels), found no difference in premiums between for-profit and nonprofit HMOs (Feldman, Wholey and Town 2003).

\textsuperscript{15} There is also some question about how meaningful these differences are since, in practice, quality ratings appear to have little influence on which plans people prefer. A recent study found that only 22% of consumers had even seen information that rates health plans, only 3% considered changing their plan based on such ratings and less than 1% had actually made a change (Taylor and Leitman 2002).

\textsuperscript{16} Blustein and Hoy (2000).

\textsuperscript{17} This type of comparison has been done in academic studies only for hospital conversions and HMO conversions, not BC conversions. For hospitals, one study found that conversion does not reduce hospitals’ provision of charity care or unprofitable services (Young and Desai 1999). However, another study found that hospital conversions were followed by an increase in patient mortality (Picone, Chou and Sloan 2002).
marketplace. Therefore, we return to examining other evidence regarding the changes that are likely to result at BCBSNC from increased pressures to generate profits.

**Administrative Costs and Medical Loss Ratios**

Before going further, a brief bit of accounting terminology is needed. Operating margins of health insurers are calculated after subtracting two categories of expenses from premium revenues: medical claims expense, and administrative expenses. Each expense component can be stated as a ratio or percentage of total premiums (or operating revenue). These are known as the medical loss ratio (MLR) and the expense ratio. Note that overall profits include underwriting gains or losses as well as investment gains or losses. BCBSNC has given no indication that conversion would be expected to increase its investment gains;\(^{18}\) hence for purposes of this analysis, we focus on the possibilities of achieving its profit objectives through reductions in either the expense ratio or MLR.

If profit goals were met entirely through an improved expense ratio (lower administrative costs such as salaries and agent commissions), public interest issues would be greatly reduced. BCBSNC’s expense ratio has averaged about 20% in recent years, which is considerably higher than industry averages of about 13-15%.\(^{19}\) BCBSNC states that it intends to meet its profit objectives in part by lowering administrative costs (Oct. 23, [REDACTED] Hearing, p. 179), and it is notable that BCBSNC’s expense ratio has improved significantly in the past year, to 17.3% in 2002.

Historically, there is some evidence that BC plans dissipated through higher administrative costs much of their competitive advantage from not having to pay taxes.\(^{20}\) Indeed, this was one of the

\(^{18}\) As pointed out in one of the briefs in the proposed BC acquisition in Kansas, “it is worth making the logical observation that investors buy insurance company stock for the profit potential of the insurance operation, not for the insurer’s ability to generate investment income. Investors can generally invest directly in all the same instruments in which insurers do without exposing themselves to the insurance risk.” (Kansas Testimonial Team 2002: 20).

\(^{19}\) An analysis of data for 1997-2000 for many, though not all, BC plans nationally found the following administrative expense ratios (AERs): (a) independent not-for-profit plans (n=19)=13.0%; (b) consolidated not-for-profit plans (n=7)=13.4%; and (c) for-profit plans (n=4)=23.4%. As a comparison, the AER for 10 commercial plans also studied was 15.3% (Schramm 2001a: 64). An analysis of HMO data over 15 years found that administrative costs at for-profit HMOs are 1.57 percentage points higher than at nonprofit HMOs (Feldman, Wholey and Town 2003). However, caution is in order in comparing expense ratios since, without adjustment, plans with a high level of administrative services only business (ASO) will appear to have high expense ratios if the administrative costs for ASO activities are included without any counterbalancing premiums or revenues. As an illustration, Anthem’s AER for calendar 2000 was 21.2% without adjustment, but fell to 15.3% when compared to operating revenue and “premium equivalent” revenue for ASO accounts (Table 5-11 in PWC 2001). A recent compilation by Blackstone Group showed an adjusted AER for WellPoint of 10.8%; for Anthem 14.1%; and for Cobalt 9.4%. The sharp contrast between these figures and those reported by Schramm strongly suggest his are unadjusted. However, Schramm’s figures are similar to those cited by BCBSNC in its Business Plan.

\(^{20}\) This evidence is mixed: Feldman and Greenberg (1981) showed that hospital discounts were related to increased market share for BC plans, yet greater market share did not result in greater discounts; they suggested that market power was dissipated as administrative slack. Frech and Ginsburg (1978) showed that BC plans let their cost advantages be dissipated through a combination of administrative slack and more complete insurance coverage. Blair, Ginsburg and Vogel (1975) and Blair and Vogel (1975) were unable to detect any economies of scale among BC plans, suggesting whatever scale economies exist are dissipated as managerial slack. In contrast, however, Adamache and Sloan (1983) did find evidence of economies of scale and more limited support for plans letting their competitive advantage be eroded through managerial slack. Hays (1981) argues that the studies showing slack failed
stated reasons for taking away their federal tax exemption in 1986. Profit expectations from shareholders might make BCBSNC more focused on lowering administrative costs. Moreover, the ability to acquire or merge with other health insurers conceivably could lead to lower administrative costs since health insurance appears to have some economies of scale.21

However, conversion will also require BCBSNC to pay roughly $15 million more in net taxes each year, under current law.22 Noting that BCBSNC has recently reduced its administrative expense ratio, it appears unlikely it will be able to reduce administrative savings substantially more than its additional tax burden. Indeed, its confidential Business Plan projects.

Therefore, we cannot conclude that further improvements in BCBSNC’s expense ratio will fully alleviate the pressure to increase profits.

Moreover, conversion may increase BCBSNC’s overhead expense ratio if it enables BCBSNC to pursue acquisition or development of new ventures that do not prove to be as profitable as it hopes. (This is suggested by BCBSNC’s written testimony at the public hearing that rate increases will be driven, in part, by the “costs of building and maintaining a successful company” (our emphasis).) Also, as noted above, the pressure to improve profits is ongoing and eventually administrative expenses will bottom out. The lowest expense ratios among BC plans nationally are roughly 8-10%, and even the largest national companies such as United Healthcare and Aetna, each of whose memberships exceed 15 million (6 times the size of BCBSNC), achieve administrative costs only in the 10% range.23

As also noted above, there is no reason to believe that a profit-maximizing company will be content with only the profit gains available through administrative expense reduction. Instead, industry analysts said that for-profit insurers can be expected to look for profit improvements through every mechanism available. A good illustration of this point is the many ways that BCBSNC itself has increased its profits in recent years.

21 This is documented in confidential data developed by Accenture for CareFirst, as reported in Blackstone Group (2002). Also, a national study of BC plans using data from the 1980s found that administrative cost ratios decline with plan size (Foreman, Wilson and Scheffler 1996).

22 Other health insurers pay a premium tax of 1.9% for most lines of business. Previously, HMOs, including BCBSNC’s HMO business, paid no premium tax, and nonprofit health insurers, such as BCBSNC, paid only .5%. Recently, however, the rate for nonprofits and for HMOs has increased to 1.1%, still less than the 1.9% for commercial health insurers. NCGS 105-228.5. According to BCBSNC’s 2003 premium projections, conversion will increase its premium tax by $24 million. This increased state tax would reduce BC’s federal tax obligation, however, so the overall increased tax cost is estimated to be about $15.6 million.

23 These points are documented in confidential data developed by Accenture for CareFirst, as reported in Blackstone Group (2002).
The prediction that pressures to increase profits will not be alleviated by reduced administrative expenses is borne out in our case studies from other states with BC conversions. In California, BC’s expense ratio has been essentially level since 1997, and there is contradictory evidence for earlier years, with one source indicating BC’s expenses may have increased following its initial conversion. One analysis found that BC of California’s administrative costs are almost 4 percentage points higher than what would be predicted based on how its operations compare to other HMOs nationally (Feldman, Wholey and Town 2003). Key informants we interviewed reported that BC California’s enviable profit levels have been achieved mainly by lowering its medical loss ratio, which is 10 percentage points or more lower than those of other major competitors in the state.

In other states, converted Blues plans have been more successful in lowering their administrative expenses following conversion, but they have also lowered their medical loss ratios at the same time. For instance, in Georgia, BC reduced its MLR 3-4 percentage points following conversion. In Missouri, BC’s MLR dropped about five percentage points over three years. In both Missouri and Virginia, BC’s MLR is significantly lower than most other major insurers in the market. Similarly, in North Carolina, BCBSNC lowered its MLR eight percentage points between 1997

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24 Comparison with other insurers is more meaningful than simply viewing a trend over time at a single health plan because market-driven changes can affect most of the industry in similar ways, for both nonprofit and for-profit plans. Note, however, that comparisons between insurers can also be misleading due to the fact that MLRs are typically much lower for individual and small group business, due to higher overhead costs involved with selling to and servicing smaller units, and insurers sometimes cover widely different mixes of large groups versus small groups and individuals. Still, it is fair to observe changes in loss ratios after BC plans convert, compared to industry averages, or to compare loss ratios between similar plans, such as between different BC plans with similar mixes of group and non-group business.
and 2000. Over this same time, BCBSNC moved from a level similar to BC industry averages (89%), to a level similar to its leading (for-profit) competitors in the state (81%). In general, for-profit BC plans have loss ratios that are about 5-10 percentage points lower than those of nonprofit BC plans.

In summary, conversion inevitably will increase pressure on BCBSNC to improve its profitability, which in turn will translate into pressure to lower the medical loss ratios for its various products in addition to administrative costs. Although a lower MLR is not necessarily bad for consumers or the public interest, this is not unquestionably a positive development either. Therefore, we turn our attention to the variety of factors that can affect the medical loss ratio. In no particular order, they are: premium rates, product offerings, underwriting practices, utilization management, and provider payment rates. The following sections will explore each of these factors to determine how they will likely be affected by increased profit incentives and whether these effects raise concerns about accessibility, affordability and the public interest generally.

26 Its MLR has increased since then, due in part to its acquisition of Partners HMO whose MLR was higher. Although it might be expected that BCBSNC would bring the MLR for its Partners business in line with similar BCBSNC products as these Partners subscribers are migrated to BCBSNC, BCBSNC does not project any decrease in its 2002 MLR. However, its actual 2002 MLR of 83.0% was REDACTED lower than what it initially projected in its REDACTED Business Plan.

27 According to one source, for 1997-2000, MLRs for selected BC plans were as follows: (a) independent plans (n=19)=83.7%; (b) consolidated plans (n=7)=83.8%; and (c) for-profit plans (n=4)=73.5%. As a comparison, MLR for 10 commercial plans also studied was 80.1% (Schramm 2001a: 64).
VII. Potential Impact on Affordability

This section provides our analysis of the potential impact of conversion on health insurance premiums. We first consider the possibility that conversion would lower rates and then assess the potential post-conversion for premiums to increase faster than they would otherwise, focusing particular attention on the markets for individual, small group and Medicare Supplemental coverage. We conclude with an assessment of the potential impact of rate increases on the number who are uninsured or underinsured and on the gross increase in premiums paid by BCBSNC subscribers. Although it arguably might have been included in our discussion on affordability, we defer discussion of coverage for high risk individuals, the “medically uninsurable,” until the next section on accessibility.

Possible Decrease in Rates

An argument might be made that conversion could lower premium rates by creating access to more efficient sources of capital or a stronger incentive to reduce administrative costs or control medical claims costs. Historically, there was some evidence from the 1980s or earlier that nonprofit BC plans may have been less efficient than their commercial for-profit counterparts (Blair, Ginsburg and Vogel 1975; Frech and Ginsburg 1978), but this literature is very dated and other studies during this period found no difference in efficiency (U.S. General Accounting Office 1975; Pautler 1981). More recent evidence suggests instead that BC administrative cost ratios decline with increases in both plan size (number of plan members) and market share. A national study of BC plans has found that being 10% larger is associated with a 1.66% reduction in administrative cost ratios, while 10% greater market share is associated with 6.9% lower administrative cost ratios. Of equal importance – since cost savings would not necessarily be passed on to consumers – this same study found that a 10% increase in market share is associated with 6.2% lower premiums, while size per se is not significantly related to premiums (Foreman, Wilson and Scheffler 1996). Thus, if conversion improves the ability of BCBSNC to compete, this could have beneficial effects for subscribers.

In principle, a converted BCBSNC also could become more efficient through a merger or acquisition. However, the efficiency effects of recent consolidations among BC plans have not been studied. The evidence on mergers and acquisitions generally, both in health (i.e., hospitals) and in other industries, is mixed: following such events, sometimes prices go up and sometimes they go down (Pautler 2001). Hence, any projected beneficial effects on premiums of merger or acquisitions is necessarily speculative.

Another theory advanced by some health economists is that people have inherently less trust in for-profit health insurers and so the market forces these insurers to charge lower prices for equivalent products in order to overcome this reluctance to purchase (Wholey, Feldman and Christianson 1995). A recent report to the Maryland Insurance Administrator claims to find evidence consistent with this theory, from an analysis of HMO conversions over 15 years (Feldman, Wholey and Town 2003). These respected health economists concluded that “HMOs reduce their premiums by a small but significant and permanent amount [about 4%] when they
convert to for-profit ownership.” This analysis has a number of significant methodological limitations, however, that make its findings of questionable relevance to the proposed BCBSNC conversion. First, these economists analyzed HMO conversions, not PPO conversions, and PPO is BCBSNC’s dominant plan type. This difference is critical to the issues of trust and market competition that underlie the authors’ explanation of why premiums might decrease. Also, HMOs generally have not performed as well financially as have major, multi-line health insurers. Second, two-thirds of the conversions in this study occurred more than ten years ago, and most of these resulted from health plans that were in financial distress. Current market conditions are substantially different and BCBSNC is by no means in financial distress. Third, this database did not include actual premiums or rates. Instead, these analysts constructed premiums by dividing total annual premium revenue by member months of coverage. These constructed measures are not the same as actual insurance rates. At best they approximate company-wide pricing rather than pricing in discrete market segments; thus, for example, a shift in an HMO’s mix of coverage from large employers to small employers would register an apparent increase in premiums even if the literal premiums for the two groups remained identical. Unfortunately, the authors had no information on the average size of employer groups covered that might have controlled for this possibility. Finally, these analysts were unable to measure or control for changes in covered benefits. Therefore, the lower premiums they detected may reflect diminished benefits rather than lower prices or profits.

Despite the possibility that conversion might lower prices, we lack any hard evidence that would strongly support such a contention. Also, it should be kept in mind that, due to its higher tax liabilities, the company would have to generate roughly $15 million in efficiency savings before subscribers could possibly see any beneficial impact on the rates they otherwise would have paid. In other states, one expert on BC plans nationally said, “I haven’t seen one conversion where [BC] prices went down.”

National experts we interviewed also did not think that it is likely that improved access to equity capital would necessarily result in lower insurance prices at BCBSNC. One national expert thought that financially healthy nonprofits with a strong market share should have no trouble raising the capital they need for business innovations. Another expert noted that most for-profit health insurers in recent years have chosen to raise capital through debt rather than equity, and another expert noted that the primary reason that for-profit insurers needed major amounts of capital in recent years is to undertake new acquisitions, not to improve ongoing operations. This weakens the argument that capital costs will be lowered by conversion.

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28 In addition to the points noted in text, these analysts noted that their primary data source had fairly serious problems with data quality, such as missing data or nonsensical values, which resulted in their having to reject 30-40% of the data for some of their key measures.

29 The latter point comes from the Blackstone Group, which reported the following figures to the Maryland Insurance Administration: for the period 1/1/97-6/30/02, $5.7 billion was raised for acquisitions by WellPoint, Trigon, Cobalt, RightCHOICE and Anthem, of which $3.8 billion came from equity and the rest from debt. In contrast, these companies raised a net of $76 million for capital needed for operations, increasing their debt by $445 million and reducing equity by $368 million during the same period. The report does not indicate how much of the
Rate Increases Generally and in Other States

Generally

Regarding the potential for higher rates, based purely on economic theory, BCBSNC prices might either increase or remain the same following conversion. One branch of economic theory suggests that nonprofit and for-profit prices may be similar because nonprofit insurers try to maximize their surplus revenues to provide other community benefits such as subsidizing coverage for the medically uninsurable. Alternatively, some theorists have postulated that nonprofit insurers will seek to reduce their prices to average costs in order to maximize the number of patients served. Under the first theory, we would expect little or no change in prices following conversion, whereas under the second one would expect more significant changes.

The prevailing view among the experts and other key informants we interviewed is that the second theory is more accurate for BC plans generally. One expert thought that “all things being equal,” for-profit insurers will have somewhat higher rates than nonprofits, and a market dominated by for-profits will have higher overall rates than one with a strong nonprofit presence. However, the expert thought this difference is in the range of only 2-5%. This is consistent with BCBSNC’s recent statements that it intends to increase its overall operating margin to 4-6% from the level of about 2% that it has averaged in 2000 and 2001. This is also consistent with the discussion above that, in general, nonprofit BC plans aim for an operating profit of 1-3% lower than that achieved by for-profits.

Another reason that conversion might result in somewhat higher prices over time is that a converted BC plan would not be expected to restrain price increases simply because it felt it had enough surplus. One former BCBSNC board member we interviewed recalled that previous management at BCBSNC had not sought to maximize premiums as this was viewed as inconsistent with its mission. Several national subjects noted that nonprofit BC plans are more likely to restrain future rate increases a bit if they already have sufficient surplus, and they have sometimes given rebates or rate reductions to pay down excessive surplus. Indeed, this occurred with BCBSNC in 1986, when, according to Department of Insurance records, the company determined that it had excess surplus and so created a $75 million rate stabilization fund that reduced rates 8-9% across the board.

Finally conversion might alter pricing behavior if conversion led to acquisition of BCBSNC by a larger out-of-state company, a possibility that is discussed more in Section IX. One national expert on BC plans noted that multi-state insurers pursue a national pricing strategy that attempts to meet overall corporate profitability goals by seeking higher profits in some states to offset lower profits in others, depending on different market conditions.

latter reduction resulted from dividend payments vs. stock repurchases (confidential data reported in Blackstone Group 2002).

30 Marsteller, Bovbjerg and Nichols (1998) provide a good discussion of this point as it relates to hospitals, but their analysis is equally applicable to health plans.
However, these general theories and possibilities are only suggestive of what might happen following conversion. Another indication of what might happen comes from the following summary of experience in other states.

**Other States**

In the other states we studied with BC conversions, it does not appear that conversion has resulted in substantially higher rates overall. Most insurance agents, regulators, industry observers, and even patient advocates interviewed in other states thought that the converted BC plans were pricing their products in line with their competitors, that increases in medical costs have been the primary drivers of BC’s rate increases, or that conversion did not cause rates to increase. One keen observer of the California market, for instance, said that keeping rates affordable is key to BC’s business strategy there. It wants larger market share in order to have more bargaining power in negotiating with providers, so it seeks to increase its profit margin by lowering provider payments rather than by increasing premiums. The sole empirical analysis we have been able to locate compared BC of California’s average HMO premium revenues (total premiums divided by total member months) to the “expected” value of average HMO premiums based on a prediction equation derived from examining all HMOs in the U.S. from 1986-2001. The company had lower-than-predicted HMO premiums prior to conversion and in the two years following, but from 1996-2000 (with 1997 missing) HMO premiums were higher-than-expected and returned to lower-than-expected in 2001 (Feldman, Wholey and Town 2003). These analysts interpret this to mean that BC of California once was a low-priced HMO, became a high-priced HMO after conversion, and now may have returned to being low-priced (although the latter is based only on a single year of data). We have earlier cited some of the limitations of this study, so we do not give it more weight than the assessments of our interview subjects, but it is consistent with a view that BC of California initially built up its membership base with lower premiums, which then gave it additional market power that it was able to exploit several years after conversion, but more recently competition has forced it to restrain premium growth. Also, a separate analysis conducted for the Maryland Insurance Administration concluded that the previously converted BC of Georgia has, so far, not changed its general pricing strategy following its acquisition by WellPoint in 2001 (Wakely Group 2003).

However one chooses to interpret these somewhat conflicting indications from other states, we do not believe that the experience in other states resolves the issue in North Carolina, for several reasons. First, as several national experts stressed, each market is different and so it is difficult to draw conclusions about what will happen in North Carolina based on what has happened elsewhere. For instance, in two of the states we studied (California and Missouri), the converted BC is not the overall market leader, as it is in North Carolina.\(^{31}\) Also, our interviews in other

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\(^{31}\) For example, a recent study of BC plans in 11 communities characterized the overall market in Orange County, California as fragmented, and noted that most competition was from national rather than local plans, HMO penetration was high and BC of California was regarded as a “distant competitor” in the HMO market. In contrast, BC plans studied in seven other communities were characterized as “dominant” in the local markets studied, which tended to be more concentrated, more mixed in terms of local vs. national competition, with low HMO concentration and BC plans were more often either the market leader or a “close competitor” in the HMO market (Grossman and Strunk 2001). In general, North Carolina markets are far more typical of the latter than the former. This illustrates that any comparison of plans across states that does not account for differences in the markets in which BC plans operate is of only limited use in trying to extrapolate to the North Carolina experience. In theory,
states focused mainly on rates in the group market and did not separately examine each market segment, as we do in North Carolina, including the market for individual health insurance and Medicare Supplemental insurance.\textsuperscript{32} Therefore, conclusions from our study of other states shed little or no light on these particular market segments.

The second important caveat that national experts stressed is that it is “impossible to prove” in other states what factors have driven rate increases and to what extent, even after the fact, looking back in time, much less looking forward. Documenting exactly what has happened is especially difficult in the other states we studied insofar as regulators there do not track insurance rates, so the main source of information was the informed opinions of market participants and observers. Even then, highly informed and experienced subjects often had difficulty drawing conclusions. In the words of one North Carolina agent, “It’s very, very hard to project [what impact conversion would have]; there are too many variables.”

**Market Structure**

With these uncertainties in mind, we have chosen to focus on the potential to increase rates rather than on concrete projections of rate increases. The size of potential rate increases depends mainly on market structures and regulatory constraints. This structural perspective is appropriate because, absent any unusual factors, there is every reason to believe that a profit-driven company will attempt to maximize its profits.\textsuperscript{33} As discussed above, it is not likely that a converted BCBSNC will be satisfied with any particular target level of profits, or will achieve its profit targets only through reductions in administrative costs or other efficiency promoting measures. Statements to this effect may accurately reflect the current intentions of BCBSNC’s current management, but there is no guarantee, nor any reason to expect, that these intentions would not change if circumstances changed. For instance, efficiency gains might not be as great as hoped for, or management itself might change. In short, a converted BCBSNC, like other for-profit companies, will likely seek to increase profits any way it legitimately can, including by

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\textsuperscript{32} For instance, an in-depth study of the individual market in California, released by the California HealthCare Foundation after our interviews, reported that, in one county, BC of California’s rates are about 12\% higher than Blue Shield’s.

\textsuperscript{33} Note that if BCBSNC has already set its premiums at a profit-maximizing level given its market power, then it would not be able to raise its premiums even higher than this level since, by definition, to do so would result in larger losses (from people dropping or reducing coverage) than gains (from the additional profits on those who retained it). Therefore, we look for indications that BCBSNC has market power that it has not fully exercised.
increasing prices if it is able to do so without losing too much business. Indeed, this would become its primary responsibility to its shareholders.

The primary constraints on the ability to increase prices are market competition and regulation. Therefore, in the following sections, we examine indications of market power and regulatory restraints, for each of the key market segments in which BCBSNC does business. The relevance of market power is seen in a simple illustration from U.S. industries generally: in markets where a company has a market share eight times that of its closest competitor, the average return on investment (ROI) is 45%, more than double the 21% ROI obtained by companies whose closest competitor has the same market share. Conversely, for a company whose market share is only 1/8 the size of its nearest competitor, ROI plummets to 8%.  

However, the question is not whether conversion will increase BCBSNC’s market power or market share. (It could do so if, by becoming more efficient, the company were to expand market share.) Rather, our analysis of market power is based on current conditions, not some projected future. Thus, our focus is whether BCBSNC currently holds market power that it has not fully exercised in some market segments. Unfortunately, there is no feasible way of “proving” from rate filings or other quantitative sources of information whether BCBSNC’s current premiums are already at a profit-maximizing level. Therefore, we instead must rely heavily on the key informant interviews summarized in Appendix B, especially interviews with twelve independent insurance agents (also known as brokers) in different rural and urban areas of the state. Independent agents are well positioned to report objectively on market characteristics and behavior, and they have been found in other research studies to be credible sources of information of this type. To the extent feasible, we use objective measures of market structure to corroborate the qualitative impressions of agents and other market observers and participants.

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34 Accenture analysis, Profit Impact of Market Strategies, based on 5,000 strategic business units across a variety of industries, confidential data cited in The Blackstone Group (2002). In the proposed acquisition by Anthem of BCBS in Kansas, two health economists representing BC testified that the market for health insurance is “contestable,” meaning that other insurance companies, third party administrators or direct employer contractors have ready access to the same provider networks that BCBSKS relies upon; hence, this potential competition places an important constraint on the plan’s ability to raise prices above competitive levels. Their reasoning was that conversion would not increase BCBSKS’s market power: hence, one could not expect any increase in premiums above what would happen anyway. While health insurance markets in general are contestable both in Kansas (which covers two-thirds of the Kansas market) and in North Carolina, this does not mean that BCBSNC might not have some market power in selected segments of the market which are less contestable and where premiums might be “sticky downward” due to BCBSNC’s dominant position in the market. A perfectly contestable market assumes easy and costless entry and exit: a good example is airline markets where a competitor can move in relatively easily if monopoly profits arise and can also leave relatively costlessly if need be since planes can be used anywhere and are not a sunk cost that must be abandoned if the incumbent competitor elects to reduce its prices to below those of the new competitor (Baumol, Panzar and Willig 1982). In the health insurance market, the cost of developing provider networks is considerable and the prospect of losing that sunk cost could be an important deterrent to an outside firm simply swooping in if profits are high in the individual market. Admittedly, there are some existing competitors in North Carolina who already have incurred the sunk costs of developing provider networks, but they do not have the agent network or infrastructure needed to compete well in this market (and the cost to develop these would not be trivial). It is perhaps for this reason that none of the major competitors we interviewed expressed any interest in entering the individual market and why, therefore, we believe it is plausible to conclude that BCBSNC may have some market power it could exploit following conversion.

35 Hall (2000); Conwell (2002).
We also consider, where relevant, the reports done in connection with pending or recent BC conversions in other states.

**Individual Market**

**Market Share**

Through a number of qualitative and quantitative sources, we conclude that BCBSNC has considerable market power in the individual (nongroup) market for major medical insurance, perhaps approaching monopoly power.\(^{36}\) Therefore, conversion has the potential to increase rates in the individual market. BCBSNC has a large and rapidly growing share of the existing enrollment in the individual market.\(^{37}\) As discussed in Section V, it had almost 60% of existing enrollment statewide in 2001, and over 70% in some counties. More important, BCBSNC has six times the enrollment of its next largest competitor. Using standard economic measures (the Herfindahl-Hirschman Index or HHI\(^{38}\)), this market overall is highly concentrated, which means that competition is less likely to constrain price increases. Note that market share is a necessary but not sufficient condition for there to be market power because ease of entry by new competitors may prevent a plan with high market share from exercising market power (Pauly 1987). However, the combination of where BCBSNC premiums are relative to the rest of the market, coupled with the observations of our key informants, suggests this market power is not just hypothetical.

Because BCBSNC currently sells only PPO products in the individual market, it does not dominate the sub-markets for individual HMO or indemnity products. (It sells new indemnity coverage only through the Access Plan and Medicare Supplemental policies, but some indemnity coverage is renewed for policyholders of much older products.) However, PPOs are the predominant form of individual coverage in the state.\(^{39}\)

\(^{36}\) North Carolina is not unique in this regard. In 1997, the state ranked 33\(^{rd}\) in terms of the combined market share of the three largest insurers in the individual market (69%) and 30\(^{th}\) in terms of the market share for the largest insurer in this market (52%). (See Chollet, Kirk and Chow (2000).)

\(^{37}\) The annual growth in BCBSNC subscribers in the individual market has been in double-digits during 2001 and 2002, exceeding its planned growth and culminating in 30% more subscribers by December 31, 2002 than two years earlier.

\(^{38}\) The HHI measures the competitiveness of a market overall. The HHI is the sum of the squared market shares for each health plan in a given geographic area. In a market with one plan, HHI=10,000. The Department of Justice’s horizontal merger guidelines provide that markets with HHI less than 1000 are not concentrated; markets with an HHI greater than 1000 are concentrated; and markets with HHIs greater than 1800 are considered highly concentrated. See AMA (2001) for further discussion.

\(^{39}\) We show both comparisons because antitrust enforcement authorities have taken conflicting positions over the years about whether HMOs and PPOs constitute separate markets for purposes of assessing the extent or risks of monopolization. In Blue Cross and Blue Shield of Wisconsin v. Marshfield Clinic, the 7\(^{th}\) Circuit Court ruled in 1995 that markets should be broadly defined to include all health insurance rather than focusing on different products such as HMOs. Yet four years later, the Department of Justice concluded that, in Dallas and Houston, HMO markets were a separate product market from PPOs or indemnity coverage and challenged a proposed merger of Aetna and Prudential Healthcare on those grounds (see further discussion in AMA 2001).
virtually every country in the state, the individual market is concentrated and every MSA is highly concentrated with BCBSNC being in the best position to take advantage of this market power.

BCBSNC appears to have an even larger share of newly written business, which is the primary driver of market competition. REDACTED

Also, interviews with 12 experienced insurance agents in different parts of the state are highly revealing. All said that BCBSNC was by far their largest insurer for individual business, and some used colorful descriptions such as “the Blue Monster,” “2,000 lb. Gorilla,” and “King of the Hill.” 40  Half said that BCBSNC accounts for all or virtually all of their individual business, and they never or rarely quote other insurers. The rest said that BCBSNC accounts for 65-80% of this business. Accordingly, insurance agents thought that BCBSNC had the ability to increase its profits without losing business. In the words of one agent, “there is nothing to stop them,” and in the words of another, BCBSNC has “a lock on the market.” An expert who analyzes insurance markets nationally said that, with this market share, he expects BCBSNC would want to “make a ton of money.”
Representatives of employer groups also expressed this concern, both in interviews and at the public hearings. One, who represents mainly smaller businesses, said that business owners are “extremely concerned” about the ability of BCBSNC to raise rates, especially for individual products, since business owners often purchase their own insurance in the individual market when they don’t offer it to employees. Another said, “It’s impossible for me to conceive of any scenario in which prices will not rise [due to conversion]. I’ve tried to look at the bright side, give them the benefit of the doubt, but I can’t see what their incentive would be to lower prices [following conversion].”

Agents gave two sets of reasons for BCBSNC’s dominance of the individual market. The first relates to the quality and price of BCBSNC’s products. According the agents, BCBSNC has better PPO networks, especially in rural areas, and it has better coverage of prescription drugs. Also, it has a strong brand name appeal. The second reason given by many agents for preferring BCBSNC so strongly in the individual market is the large number of insurers that have exited this market in recent years and the difficulty this creates for policyholders who have developed health conditions after qualifying for insurance. Individual insurance in North Carolina is guaranteed renewable, but coverage is not “portable” to the same extent as it is in the group market. Therefore, agents explained, when an insurer exits the individual market, policyholders have to requalify for medical underwriting with another insurer or they will lose coverage entirely. As a result of these difficulties, which agents said cause them to “lose sleep,” many agents said that they have a very strong preference for BCBSNC in the individual market, even if another insurer offers a better deal. “Blue Cross will be here whether you like them or not.” They’ll “be the last one to turn out the lights.” As noted above, several agents do not bother to even quote other insurers, and the rest strongly recommend BCBSNC for this reason. Two agents went so far as to say they would refuse to sell any insurer but BCBSNC, even if this meant losing a commission, because their concern is so great about people being stranded without coverage later on.

This explanation points to a significant barrier to entry by new insurers, which further increases BCBSNC’s market power. In a well-functioning market, if BCBSNC were to make excess profits, at some point other insurers in the market should undercut them, or new insurers should enter. This potential is greatly lessened if agents who advise purchasers do not have enough confidence in other insurers to recommend them.

Another indication of barriers to entry comes from interviews with BCBSNC’s three leading competitors in the group market. None of these competitors sells in the individual market. Only one of the three said his company might potentially enter that market, if the business opportunities were sufficiently attractive. The other two said their companies have no interest in entering the individual market and would not do so, even if there were substantial profits being made. They are not in that market anywhere else in the country because they are not set up to sell in that market and lack the personnel, experience, and systems needed to compete effectively. They stressed that the individual market is fundamentally different from the employer group market for various structural, regulatory, and technical reasons. This point was confirmed by our interviews with independent experts who analyze markets nationally. Also, in recent years, no new insurers have entered the individual market recently and a dozen insurers have left this market since the end of 2000. Mutual of Omaha, BCBSNC’s number two
competitor in the individual market, also announced its intention recently to leave the market. Even so, at some price, new competitors would enter, so whatever market power BCBSNC has is limited to some extent.

One might reasonably ask whether consumer behavior would prevent BCBSNC from raising rates even though competition is weak. We only have very indirect evidence that relates specifically to BCBSNC customers. 41 If BCBSNC premiums were set at a profit-maximizing level in prior years and the company had “over-reached” by raising premiums by more than the market would bear, we would have expected to see a percentage decline in subscribers that would have exceeded the percentage increase in premiums. 42 That this did not happen is suggestive of some potential to raise premiums. However, we cannot draw an extremely strong inference since this pattern may also have arisen from lower-than-expected medical costs having nothing to do with the level of demand for individual coverage.

However, we do have general empirical evidence from national studies regarding consumers’ potential response to premium increases. This evidence suggests that, whether consumers will drop or keep their coverage depends heavily on family income, with poorer families showing a very high responsiveness to price increases relative to higher-income families. For example, the price elasticity of demand for families below poverty has been estimated at −1.64 meaning that for every 10% increase in premiums, 16.4% would drop their insurance coverage (Thomas 1992). If everyone were this price-sensitive, it would make no business sense to increase premiums since the company would lose more money from those who dropped coverage than it would gain in higher premiums from those who remained. However, price elasticity of demand for families above 500% of poverty has been calculated at only -.54 nationally, meaning that only 5.4% would drop if premiums rose 10%. According to these studies, 125% of poverty is the point at which the elasticity of demand reaches 1.0. Below this income level, increasing premiums would be self-defeating even if no competitors existed in the market. However, most people who purchase individual insurance are well above this income level.

The potential for BCBSNC to increase rates in the individual market is borne out by comparing current insurance rates and observing BCBSNC’s recent pricing decisions. 43 Products and products and those of three of its four largest competitors shows that only the products of the smallest competitors are substantially cheaper. Rates from two largest competitors are 50% to 150% higher. Although this could be due in part to greater benefits or more lenient underwriting, a gap this large appears to leave some room for potential increases. Consistent with this potential, in its 2002 rates, BCBSNC doubled the profit margins in its individual rates, from 3% to 6%. 42 BCBSNC officials explained in discussions with Department

41 It is worth noting that nonprofit CareFirst also achieves an underwriting margin slightly more than 5% on its individual business, compared to less than 4% for small group (1-50 lives), slightly more than 1% for groups 51-99 and less than 1% for groups with 200 or more members (confidential data in Blackstone Group 2002). It is also worth noting that, based on rate filings since May 1996, the requested MLR for BCBSNC’s Blue Advantage policies

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of Insurance officials that this increase is justified in part by the greater risk associated with individual business. However, the particular reason for increasing profit margins is less important in our analysis than the inclination and ability to do so.

The Regulatory Framework

A substantial increase in profits from the individual market is feasible within the applicable North Carolina regulatory framework. Although individual rates must be filed with and approved by the Department of Insurance (“DOI”) prior to being implemented, the examination is based largely on whether insurers use legitimate factors to calculate their rates, whether there is adequate actuarial justification for those factors, and whether the factors are being applied consistently. For instance, the DOI has in the past objected that an insurer projects a steeper increase in medical costs than is justified. However, rate review under the applicable law does not typically address the profit margin that a for-profit insurer explicitly builds into its rates. This has been done recently with BCBSNC, however, due to the pending conversion and because BCBSNC is still nonprofit.

In ordinary circumstances, the primary basis on which the DOI questions profit levels is the minimum loss ratios set by law. (The loss ratio is the percent of premiums that is paid out in medical claims.) For the individual market, the minimum loss ratio is 55%. This indicates that in theory BCBSNC might be able to add as much as 20% more to its profit margin in this market, implying a possible 36% increase in premiums. In interviews, DOI actuaries indicated that if loss ratios departed substantially from what an insurer has historically sought, they would likely invoke their statutory authority to require that benefits be “reasonable in relation to the premiums.” But, there is no bright line as to when this threshold has been crossed. If an insurer’s original rate filing for a new product targets the minimum loss ratio, it does not appear that the DOI would be likely to object within the current regulatory framework if the insurer is for-profit. Therefore, it appears that a converted BCBSNC

(its largest individual plan) has been very stable: for high option rates, the MLR fluctuated between 72.75% and 77.2% (in 2003 it is at 76%). In contrast, its target margin has been erratic, starting at 5% in 1996, dropping to 3% thereafter, and rising to 6% for 2002 and 2003. (All figures compiled by Ernst and Young from NCDOI rate filings.)

This is considerably lower than in some other states, such as New York, where the statutory MLR in the individual market is in the 75-80% range.

A loss ratio of 75% means that BCBSNC pays $75 in medical claims for every $100 in premiums. For the same level of claims payout, a 55% loss ratio would require premiums of $136.36. Note that this sizable potential increase is purely hypothetical and is based on several questionable assumptions. The first is that the loss ratio is lowered only through increased premiums, rather than through reduced claims costs, such as by negotiating lower provider rates. Second, this assumes that increases of this magnitude would increase overall profits rather than driving away more business than the increase in revenues. We are not able to judge to what extent BCBSNC premiums in the individual market currently are below the profit-maximizing levels. However, the recent decision to double margins suggests that BCBSNC previously, for whatever motivation, had not set its premiums at the profit-maximizing level (or else the effort to increase margins by raising premiums even higher would have been counterproductive). Rather than guess how far BCBSNC would move toward the 36% that hypothetically would be allowed under current MLR rules, we simply note that this is the “worst case scenario.” It should be further explained that any such increase is a one-time opportunity that could occur through either a single action (highly unlikely) or instead through a series of accumulated premium increases over a number of years.

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could, over time, greatly increase its profit level for individual insurance within the current framework.

Several national experts who were interviewed, including some who favor free enterprise, thought that North Carolina might benefit from tougher rate regulation law in the individual market, e.g., requiring higher minimum loss ratios or more explicit control over rate increases. One market analyst noted that, in states where Blue Cross plans dominate the market, stronger rate regulation laws are common, even when the Blue Cross plans are nonprofit, in order to keep them from “doing anything they want.”

One regulatory constraint on excess profits that currently exists (i.e., pre-conversion) is the possibility that government officials (including possibly the attorney general, who oversees nonprofit corporations generally) might exert pressure to prevent nonprofit health plans from accumulating excess surplus or reserves. Some form of government scrutiny appears to have played a role in the BCBSNC decision in 1986 to rebate excess surplus through reduced rates. If BCBSNC converted, the government would not have the same standing to require or put pressure on BCBSNC to do this in the future; moreover, such a course of conduct would obviously be contrary to BCBSNC’s obligations to its shareholders as a publicly traded for-profit.

**Group Insurance**

The indications are not nearly as great in the group market as in the individual market that BCBSNC has the ability to substantially increase rates. Although the regulatory framework is similar, there are significant market constraints. These market conditions differ somewhat, however, between smaller and larger groups.

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45 In other states, this has also been the subject of private lawsuits. For instance, all four BC plans in Pennsylvania currently are defendants in several class-action lawsuits on grounds that their collective surpluses exceed the state minimum requirement by nearly $3 billion (Ditzen 2002). A similar suit against BCBSNC was filed in 1997 but dismissed by the trial court in 1999 for failing to state a cause of action. In affirming this dismissal, however, the appellate court ruled that “if Blue Cross accumulates a reserve in excess of the statutory limits, the Commissioner is authorized under N.C. Gen.Stat. § 58-65-40 to modify the rates, thereby affecting the amount of the reserve.” Lupton v. Blue Cross and Blue Shield of North Carolina, 139 N.C.App. 421, 533 S.E.2d 270 (2000). It is noteworthy that the statutory limits the court referred to apply only to nonprofit health insurers. It is an open question, however, whether this ruling applies to all forms of surplus or reserves, or only to special reserve funds designated as “contingent reserves.”

46 Small groups are defined by law as those with 50 and fewer full-time employees. In 2001, BCBSNC’s market share of premiums in the small group market was 35.1% (NCDOI, 2002). Large groups are more loosely defined as those large enough to self-insure, although not all do so. Medium groups are those in between, typically in the 50-100 employee range.

One might also further subdivide the small group market into very small groups, under 10, including the self-employed. However, insurers are legally required to offer groups of two or more the same products and rates as for all groups up to 50, so market conditions are essentially the same. For instance, insurers must use exactly the same rating factors for very small groups as they do for other groups up to 50, including the ability to charge them 20% more than standard rates based on expected medical claims costs. Although insurers often are not eager to take on very small groups, they nonetheless may not increase their rates more than this 20% allowance. As a result, insurers reportedly engage in various practices that discourage enrollment in other ways, described in Section VIII. Thus, competition may operate differently for this sub-market segment than for other small groups. We address these problems as underwriting issues rather than rating issues, in Section VIII, which also discusses the special situation of the self-employed.
Small and Medium Groups

BCBSNC faces considerable competition in the group market. Precise statistics are available only in the small group market where, although BCBSNC is the largest insurer with one-third of the market, the next two insurers combined have about one-quarter of the market, and there are about a half dozen other companies actively competing for new business. Interviews with employers, agents, competitors, and expert industry observers all indicate that, in general, the group market is highly competitive, such that BCBSNC would lose business if it raised its rates too high. Among experienced insurance agents, those in larger cities thought raising prices would “backfire” since there are several strong competitors who appear committed to this market, and small employers are very price sensitive. Indeed, the empirical literature suggests that small employers are considerably more price sensitive than medium or large-size employers (Blumberg, Nichols and Liska 1999; Gruber and Lettau 2000). One agent said small

47 In contrast, in 2000 there were 21 states with market shares in the small group market larger than BCBSNC’s (26.6%) and 19 states with larger market shares for the five largest carriers (U.S. General Accounting Office 2002).
48 The research literature includes a range of estimates of the price elasticity of demand for health insurance among small firms, with several studies showing these elasticities to exceed 1 (Feldman et al. 1997; Blumberg, Nichols and Liska 1999). This means that for a given percent increase in health insurance premiums, say 10%, at least 10% (or more if the elasticity exceeds 1) of small employers would drop their health insurance coverage. Given the disparate estimates available, the Congressional Budget Office used a most likely estimate of 1.1 in a recent analysis of the projected impact of reduced premiums (Baumgardner and Hagen 2001).
employers will switch insurers for as little $25 per member per month. Another agent captured the general sentiment, saying that when he does comparison pricing, he is constantly “amazed” at how close the top four or five carriers are. “There’s not a dime’s worth of difference”; it “comes down to nickels and dimes.” Among BCBSNC competitors, the prevailing, although not uniform, view is that it is “very difficult to pass on unjustifiable rate increases” in the group market since employers are “rigorous in challenging renewal rates” and group purchasers are very price sensitive. According to some of its competitors, BCBSNC “has no room to give,” since they’re already priced “right at the edge” at the top of the market; therefore, “if they did that [raised rates], they would lose business.” National experts who analyze insurance markets across the country also tended to agree that the group market, including the small group market, is generally competitive enough to “take care of itself.” These expert opinions are consistent with data from the Health Insurance Plan of California, the nation’s largest state-run health insurance purchasing cooperative for small employers. An analysis of HIPC premiums for 1994-1997 found that WellPoint was a typical competitor, having neither the highest nor lowest premiums in this market.49

This does not mean, however, that BCBSNC lacks any ability to increase group rates. One insurance agent noted that, in some eastern counties, physicians will give discounts only to BCBSNC so only BCBSNC has a broad managed care network, which gives it a virtual “monopoly” on PPO or HMO products. While the claims of pure monopoly appear exaggerated, this view is supported by the data in Section V, showing that BCBSNC has at least half of the small group market in a number of counties and smaller cities, and over 80% in some. Another agent said that a number of clients only want to consider BCBSNC “pretty much regardless of price” because they and their parents have had BC all their lives. National experts also thought that BCBSNC’s brand name and customer loyalty, which are “remarkably resilient,” might allow it to maintain prices 2-5% higher than competitors. They also noted that brand name recognition will become even more important under “defined contribution” arrangements, since these shift health insurance marketing for group coverage to a more “retail” basis that allows employees rather than employers to choose which plan to enroll with.50 A national study of 12 Blues plans concluded that the trademarks were viewed as their most important asset, citing a BCBS Association marketing study showing the cross and shield symbols to be “two of the most widely recognized trademarks in the United States” (Grossman and Strunk 2001: 49), but this study also reported a general perception among Blues plans and their competitors that the value of these trademarks is diminishing over time.51 Nevertheless, in North Carolina, a

49 See Feldman, Wholey and Town (2003). The advantage of looking at this market is that coverage is standardized, as are the “rules of the game” with respect to medical underwriting: hence any observed premium differences cannot be attributable to WellPoint’s having a worse benefit package or “cherry-picking” the best risks. Unfortunately, the HIPC was not in operation when WellPoint converted in 1993, so there is no way of obtaining a comparison that would show whether WellPoint’s behavior changed following conversion.

50 As noted above, it is unknown whether current BCBSNC pricing already reflects this brand name advantage or whether this reflects some measure of untapped market power that could be exploited following conversion.

51 In light of this expert opinion, it is worth noting that the national HMO study we cited earlier found that affiliation with Blue Cross did not affect HMO premiums in the 1986-2001 period (Feldman, Wholey and Town 2003). Were the trademark of sizable value, one would have expected BC affiliation to be associated with higher premiums, all other things being equal. However, the HMO market is arguably the most price-sensitive and competitive component of the market; hence failure to observe any residual value of the mark in this market does not preclude its having some value in the PPO markets where BC plans, including BCBSNC, tend to dominate. Also, most of the data for this study comes from a period when there were few or no for-profit BC plans, so it has limited ability to

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Brand Strength Study REDACTED found that BCBSNC has “much higher” consumer awareness than its leading local competitors (United and CIGNA).

A BCBSNC competitor was very concerned that, with BCBSNC’s acquisition of Partners HMO, it would be hard to compete effectively with BCBSNC because of its size, and thought that BCBSNC could probably increase rates 2-3% without losing much business. Experts who analyze markets nationally also explained that pricing in the group market tends to be competitive within a band of 5-10%, such that, if BCBSNC were now in the low or middle of this range, it might have some room to move up a bit. Similarly, insurance agents from smaller North Carolina towns felt that BCBSNC has some ability to increase group rates (roughly in the range of 2-5%) without losing too much business, because of BCBSNC’s superior brand name and networks. Consistent with these estimates, BCBSNC increased its profit margin in its 2002 rates for small groups by two percentage points, from 3% to 5%. The company also has been able to reduce its loss ratio in the small group market. REDACTED For groups of 3-25, it has a loss ratio of 70%, compared to a statewide average of 83% across all its competitors for groups this size. 52 This sizable difference might be construed as some measure of “brand loyalty,” but there is no way of deducing from these figures whether the company has yet fully maximized its position in this market.

It is also important to note that competitive conditions that prevail for the group market generally may not extend down to the smallest end of this market: employers with fewer than 10 workers. The available data are insufficient for determining whether BCBSNC has any greater leverage in this submarket. 53 However, interviews revealed that insurers generally are less interested in this end of the market because they perceive it as having more adverse selection (greater tendency to buy insurance based on individual health needs), and regulatory rules prevent them from screening groups based on individual health status or from charging much higher rates (more than +/- 20%). Therefore, although all group insurers are required to serve this market, they do so with some reluctance, often cutting agent commissions and using other techniques to discourage enrollment by these very small groups. We address these issues in more detail in Section VIII, as an aspect of accessibility. However, we found no evidence that these factors give BCBSNC any additional pricing advantage for this submarket beyond whatever market power it has for small groups generally.

Large Employer Groups

Some potential for rate increases also exists in the large group market, including the self-insured. Although one might think the largest and most knowledgeable purchasers would be the most vigilant against rate increases, we heard a somewhat different account from agents and advisors

52 Redacted Calculations for 3-25 are based on data reported in NCDOI (2002).

53 In 2001, in the 3-25 group segment, BCBSNC ranks first, with 35.7% of covered lives (38.0% including Partners), compared to second-ranked United Healthcare, with 23.1%, nearly identical to the market shares for these firms in the 1-50 market overall. In the 1-person group market, BCBSNC with Partners ranked second with 28.8%, just behind Mega, with 29.7%; however, BCBSNC/Partners accounted for 53.2% of newly issued policies, suggesting this ranking could soon change if it has not already.
for large employers. They explained that it is more cumbersome for a larger employer to change insurers due to the number of people affected, so their existing insurers have somewhat more leeway to raise large group rates than with smaller employers. One subject felt that, even with large group business, there were sufficiently few competitors that BCBSNC “can do pretty much as it pleases” in its pricing. For new business, two BCBSNC competitors suggested that BCBSNC is more willing now than it would be as a for-profit to take on groups that will not produce as much or any profit, in order to build market share or to get or keep a favored employer. However, as with small groups, this “wiggle room” or “fudge factor” for large groups is self limiting. Beyond a fairly narrow band, interview subjects thought that if rate increases became large enough, BCBSNC would lose business to other insurers.

Groups Overall
The potential to increase rates for small and large groups is limited by several additional factors. First, these interview subjects spoke only in terms of modest one-time increases rather than sustained increases year after year that amount to large, double-digit price differentials. There was broad agreement that the major factor driving group rates is increasing medical costs, and that, in general, competition is effective in restraining rate increases that are significantly greater than medical cost trends. Second, the regulatory framework limits the ability to exploit differential market power in different parts of the state; therefore, as long as BCBSNC faces significant competition in the larger cities, it is limited in its ability to increase rates in more rural areas where it may have less competition and more market power. This results from the regulatory requirement that rating factors be fair and nondiscriminatory. Geographic adjustment factors can be based only on documented medical claims costs, not on a desire to derive more profits from one location than another. Although the data supporting geographic factors are not closely scrutinized at present, these factors must be certified by professional actuaries, and regulators could object, or request additional explanation, if they detected patterns that did not appear justified.

Medicare Supplemental Insurance
We also consider BCBSNC’s ability to raise rates for Medicare Supplemental (“Med. Supp.”) coverage, which is sold on both an individual and group basis. BCBSNC is the largest Med. Supp. insurer, but it faces somewhat more competition than in the regular individual market. It has almost half of the state’s enrollment (based on year 2000 data) and the next largest insurer, AARP/United Healthcare, has about 20% of the market. The next three largest insurers have about 12% combined, and there are a large number of insurers with very small market shares. AARP/United Healthcare is currently priced lower than BCBSNC for individual Med. Supp. coverage. While we do not have a breakdown by county, we have no reason to suppose that the picture would differ substantially from that discussed above for the individual health insurance market. However, the picture differs somewhat by type of standardized plan. Only five other carriers in North Carolina sell the H, I, or J plans, which are the only ones with prescription drug coverage.

An insurance agent and two advisors for the elderly indicated that the Med. Supp. purchasers are somewhat price sensitive and so will look at alternatives if price increases are too steep. In contrast to the individual market, the price competitiveness of Med. Supp. insurance is greatly enhanced by the fact that only standardized benefit plans can be sold to individuals, which
facilitates the comparison of prices among insurers. Despite standardization, however, a national provider of customized consumer shopping guides for Med. Supp. insurance policies has found that “annual premiums continue to vary dramatically for individuals purchasing identical plans in the same location.” (Weiss Ratings 2001). Empirical evidence suggests that the price elasticity of demand for Med. Supp. is only -.5 to -.6 (Marquis and Phelps 1985, p. 16). This means that for each 10% increase in premiums, 5 to 6% of those with such coverage might be expected to drop it or change to a different company.

The ability to change Med. Supp. insurers depends on whether people have developed health problems since they first purchased individual coverage, especially for coverage that includes prescription drugs. Individual Med. Supp. subscribers cannot automatically transfer to other insurers since insurers are not required to guarantee issue coverage beyond the open enrollment period when a person first signs up with Medicare, except in special circumstances.54 Thus, if BCBSNC prices went up, consumers would be free to price shop, but if they cannot pass underwriting standards, they would either have to stay with BCBSNC or abandon coverage altogether. We were told that underwriting is especially stringent for prescription drug coverage in that insurers will reject this coverage for applicants who regularly take a single prescription drug, even if they are not sick. Thus, those who are sick or who use prescription drugs potentially are locked into BCBSNC.

Based on BCBSNC’s medical loss ratios for its individual Med. Supp. business, if it had the market power to increase rates, it could do so by 15-20% before hitting the regulatory minimum loss ratio of 65%.55 BCBSNC has shown no inclination to do so in recent years. Based on rate filings over the past four years, the requested MLR for BCBSNC Med. Supp. policies has risen: for older “pre-standard” policies, the MLR rose from 77.7% in 2Q 1998 to 84.4% by 2Q 2002 whereas for newer “standard” policies, MLR rose from 73.2% to 77.9% during the same period. Likewise, its margin on pre-standard policies has remained consistently at 7.0% for these four years, while increasing only slightly for standard policies (1998=4.7%; 1999=3.4%; 2000=3.7%; 2001=3.7%; 2002=5.2%).56

Based on these several indications, BCBSNC appears to have some ability to increase Med. Supp. rates, subject to regulators’ authority to require that rates be “reasonable in relation to the premiums.” However, BCBSNC’s ability to increase its Med. Supp. rates does not appear as great as its ability to increase rates for regular individual major medical insurance.

**Potential Impact of Rate Increases**

Considering the size of BCBSNC, any increase in rates due to conversion would have a significant impact on what BCBSNC subscribers pay in gross premiums for health insurance.

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54 Specifically, coverage is guaranteed issue (GI) for six months after enrolling in Part B of Medicare. This extends to all plans for the elderly, but for the disabled, GI extends only to plans A, C and J. If a person is a member of a Medicare HMO that leaves the market, GI is for 63 days following termination: for elderly, GI extends to plans A, B, C & F, but for disabled, only plans A & C are GI.

55 As with the individual insurance market, this too is considerably lower than in some other states, such as New York, where the statutory MLR in the Med. Supp. market is 80% for nonprofit carriers and 75% for for-profit carriers (NYSID 2002).

56 All figures compiled by Ernst and Young from NCDOI rate filings.
However, based on key informant interviews and what happened in other states, we do not have a solid basis on which to project the size of any premium increases that might result from conversion. In the large group market, we feel reasonably confident that BCBSNC lacks sufficient market power to increase premiums significantly more over time than medical cost trends. But in some other market segments, BCBSNC appears to have some leverage to raise prices in order to increase its profit margins, if so inclined. Still, we are not able to quantify the likely size of such increases.

It appears that, at a minimum, BCBSNC would increase premiums at least by the added tax due to moving from a 1.1% tax rate to 1.9% in order to pay the additional premium taxes of a for-profit insurer. At the public hearings, Mr. Greczyn said that this additional tax burden would be “borne by our policyholders” (October 23, 2002 Hearing, p. 207), which we take to mean that BCBSNC would expect to increase premiums to cover this additional expense. However, it is not certain what product lines would or could bear the brunt of this increase, and in what proportion. If the entire amount of additional taxes were recovered through the individual market, this would require a premium increase of 4.9%; conversely, if the entire amount were sought through the small group market, the premium increase in that market would be 3.6%, and for Med. Supp. alone the premium increase would be 4.9%. Were BCBSNC to instead raise premiums pro rata across all three markets, the increase would be 1.4%. If it tried to recover its increased taxes from its entire book of insured business, including larger groups (but excluding federal employees and other self-insured groups), the increase would be .9%.

Following the same logic, if conversion hypothetically were to cause BCBSNC to target an additional 2 percentage point increase in pre-tax operating margins, and if this were done entirely through price increases, this would require $61.9 million more in premiums. This would translate to premium increases of 12.6%, 9.2%, and 12.5% in the individual, small group and Med. Supp. markets respectively, if concentrated in only one market segment, or an increase of 3.7% across

57 Using BCBSNC’s the added tax due to moving from a 1.1% tax rate to 1.9% would million based on premium for that year to return BCBSNC to the same net income position. However, because the premium tax would also have to be paid on higher premiums, the added tax due to moving from a 1.1% tax rate to 1.9% would have to be charged to return BCBSNC to the same net income position.

BCBSNC stated at the public hearings that it believes its premium tax will increase regardless of conversion because the legislature may take away its remaining tax break to help alleviate large budget deficits. Although legislation was recently introduced to this effect, it has not been enacted, so we proceed on the basis of current law.

58 It is also possible, however, that this additional expense could be absorbed by lower administrative costs or by lower profit margins. However, Mr. Greczyn specifically said that the second possibility will not happen (October 23, 2002 Hearing, p. 208). Concerning the first possibility, BCBSNC has not made a clear case that conversion will enable it to lower its administrative costs more than it would have done so as a nonprofit. Also, neither possibility is reflected in its confidential Business Plan, which projects that increased premium taxes will be accounted for entirely by an increase in operating revenues.

From the standpoint of the public interest, this rate increase might also be regarded as a public benefit rather than a cost. BCBSNC subscribers “lose” the million difference is subsidized by all federal taxpayers since it represents the amount of tax savings to BCBSNC from deducting the state premium taxes on the company’s federal income tax return.
all of them; if it tried to spread this increased profit across its entire book of business, including larger groups (but excluding federal employees and other self-insured groups), the increase would be 2.3%. 59

We cannot state with any certainty that increases of this magnitude would or could occur. Although the evidence above regarding profit pressures and BCBSNC’s market power is such that premium increases of some magnitude cannot be ruled out as a possibility, we have no basis for projecting a premium increase of any particular magnitude. We are able, however, to estimate how purchasers would likely respond to any such rate increases. Based on numerous empirical studies and the assumptions detailed in Appendix C:

- In the individual market, a 1% increase in BCBSNC premiums would likely result in roughly 700 to 4,400 people dropping their BCBSNC coverage (with 1,500 being the most likely estimate). The gross increase in annual premiums paid by BCBSNC subscribers in the individual market would be $4.9 million.
- In the small group market, a 1% increase in BCBSNC premiums would likely result in employers with roughly 1,500 to 4,400 covered workers dropping BCBSNC coverage (with 1,900 being the most likely estimate). The gross increase in annual premiums paid by BCBSNC subscribers in the small group market would be $6.7 million.
- For Med. Supp. insurance, a 1% increase in BCBSNC premiums would likely result in 800 to 900 people dropping BCBSNC coverage. The gross increase in annual premiums paid by BCBSNC subscribers across all Med. Supp. products would be $4.9 million.

The magnitude of these effects depends on how much rates might increase. In the small group market, our key informants indicated that competitive conditions might preclude any additional rate increases beyond medical cost trends, but that 2-5% is the most that could be expected, 60 so multiplying the above effects by 2 to 5 provides some indication of the possible results of premium increases in the small group market. For example, assuming 2,000 workers would drop BCBSNC coverage for every 1% increase in small group rates, a 2% rate increase would result in 4,000 workers dropping BCBSNC coverage, and a 5% rate increase would result in 10,000 workers doing so. Unfortunately, we do not have a similar rate increase figure on which to peg a plausible or possible effect in the individual market. Key informants were much more confident that rate increases are possible, but did not provide sufficient information for us to quantify the range of possibilities.

It is important to understand that dropping BCBSNC coverage is not the equivalent of becoming uninsured. The chances of becoming uninsured are much greater for those covered in the individual market. BCBSNC faces much less competition there, and it has very favorable pricing relative to competitors, so subscribers are much less able to find a better deal elsewhere. In fact, it is possible, as noted below, that other insurers would increase their prices to keep pace with, or shadow, any BCBSNC increases. If so, the impact would spill over to subscribers of

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59 The actual percentage premium increases would have to be higher than these hypotheticals once one takes into account the reduction in demand that would result from premium increases of this magnitude. See Table C-7.3 for calculation details.
60 Appendix B, pp. 5-6, 32.
other insurers who also drop coverage.\footnote{This assumes, however, that other insurers are not already at their profit-maximizing pricing levels, which we do not know to be the case.} Also, subscribers are not allowed to automatically qualify for coverage elsewhere without undergoing medical underwriting (no “portability” of coverage or guaranteed issue). Taking into account empirical evidence on how quickly those who lose private coverage are able to regain coverage elsewhere (either through Medicaid, group coverage from a spouse or other means), we estimate that, for every 1,000 people losing coverage in the individual market, the average number of uninsureds (on a given day) would increase by 500 individuals; in the small group market the number of uninsureds would increase by 450 for every 1,000 people losing coverage.\footnote{See Table C-7.4 for calculation details.}

An increase in the number of people without insurance obviously has a negative effect on the affordability and accessibility of health care, and on the general public interest in population health. Numerous studies show that people without insurance delay or avoid seeking needed care due to the increased costs and therefore have worse health, higher mortality, and a greater incidence of avoidable hospital use.\footnote{Calculations by authors based on figures from Hadley and Holahan 2003.} Moreover, because such a large fraction of care for the uninsured is subsidized through “cost-shifting” or taxpayer-financed care in public hospitals or clinics, the average uninsured person imposes a cost of roughly $729 annually on taxpayers and patients.\footnote{For instance, the uninsured face a risk of death that is 25% higher than equivalently situated individuals with private insurance. The voluminous evidence on delays in seeking needed care is found in Institute of Medicine (2002b), while the adverse effects of lack of coverage on health status and mortality risk is found in Institute of Medicine (2002a).} Some fraction of the uninsured also end up on Medicaid, resulting in an additional cost to taxpayers averaging roughly $147 per uninsured.\footnote{Calculated by authors based on an estimate of 6.6 percent of the uninsured eventually qualifying for Medicaid (Monheit and Schur 1988) and on average annual North Carolina Medicaid spending in 2001 of $2225 per AFDC adult.} Thus, for every 1000 people that might lose coverage due to rate increases, $876,000 in costs would be shifted to sources of uncompensated care and/or Medicaid.

The impact of dropping BCBSNC coverage in the small group market is much more uncertain, however. Because market conditions are more competitive and coverage is portable and guaranteed, some fraction of small employers who might drop BCBSNC coverage would switch to other insurers with more favorable pricing. Even among employers who might drop coverage altogether, some of their employees could enroll as dependents on another family member’s plan, or might find affordable individual coverage. On the other hand, to the extent that BCBSNC is a market leader, other insurers might also follow its price increases, causing other employers market-wide to drop coverage. We are not able to estimate these different possible market-wide “ripple” effects of BCBSNC price increases in the small group market.

Med. Supp. coverage differs from both of these situations. Like individual insurance, BCBSNC is the market leader and subscribers cannot automatically change insurers if their rates increase too much, but like in the small group market, Blue Cross faces significant competition for new enrollment. Moreover, dropping Med. Supp. coverage does not result in people becoming uninsured since subscribers are still covered by Medicare. Therefore, the impact depends on the
comprehensiveness of a person’s supplemental coverage. Losing Med. Supp. coverage would increase the deductibles and coinsurance that Medicare beneficiaries have to pay, which would predictably cause some people to avoid or delay seeking necessary medical care. For instance, those who rely exclusively on Medicare coverage are 40-50% more likely than those with Med. Supp. not to have obtained cancer screening in the past year (including mammograms, clinical breast examination and Pap smears) (Makuc et al. 1994); and are 84% less likely than those with employer-sponsored drug coverage to obtain effective cardiovascular drugs (Federman et al. 2001) thereby elevating their risk of premature death. In addition, because Medicare does not cover prescription drugs outside the hospital, roughly one-third of those with Med. Supp. policies have prescription drug coverage. Studies have found that those with prescription drug coverage receive roughly three times as many prescription drugs (unadjusted for health status) as those with Medicare-only coverage (Artz, Hadsall and Schondelmeyer 2002). Therefore, losing this coverage is likely to contribute to poorer health and/or high out-of-pocket burdens.
VIII. Potential Impact on Accessibility

This section provides our analysis of the potential impact of conversion on accessibility. We begin with a discussion about the medically uninsurable and the extent they are covered by the BCBSNC Access Plan. We then discuss conversion’s potential impact on other product offerings, underwriting practices, utilization management, and provider contracting, including payment rates and contracting practices. The latter are of relevance to the extent they may have adverse spillover effects on patient access to services in their local area.

Covering the Medically Uninsurable

The Access Plan for the Medically Uninsurable

The medically uninsurable are people who are denied insurance coverage or charged extraordinarily high premiums due to poor health, and are not eligible for a public insurance program such as Medicaid. This occurs predominantly in the individual insurance market or the small end of the small group market. Based on national averages, slightly less than 1% of the non-elderly population is medically uninsurable, i.e., have been denied private insurance coverage due to their health (Beauregard 1991). However, 43% of these have coverage through public programs such as Medicaid. Leaving aside this latter group, North Carolina currently has an estimated 29,000 medically uninsurables. Most states address this problem using either: (a) high risk pools (32); (b) laws that require insurers in the individual market to guarantee issue all products (11) or some products (5); or (c) having a Blue Cross plan that acts as “insurer of last resort” (4). There is some overlap between (a) and (b), leaving only two other states (DE, GA) that do not directly address this problem.

BCBSNC has been an insurer of last resort in some fashion since at least 1960, meaning that for most or all of its history, it has offered some type of coverage for people who are medically uninsurable and cannot find coverage elsewhere. (Unlike in some other states, BCBSNC is not required by statute to be insurer of last resort.) This proposed conversion is significant because North Carolina would be only the second state where a converting Blue Cross plan still had a unique last resort role at the time of conversion. (The other is Virginia.) In most other conversion states, legislative developments had relieved the Blue Cross plan of this role several years prior to conversion, by creating an industry-wide risk pooling mechanism.

Currently, BCBSNC’s last-resort product is known as the Access Plan. It was created in 1991 to replace a similar plan known as SNAP, and was modeled in part on coverage that was proposed in a bill (HB 985) that would have created a statewide high risk pool. In its Plan of Conversion, BCBSNC states that it will “continue to offer a subsidized guaranteed issue product in the

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66 This is based on U.S. data showing 2.5% of the uninsured are medically uninsurable (Beauregard 1991) applied to the 1,167,000 uninsured in North Carolina reported in the March 2002 Current Population Survey.

67 Achman and Chollet 2001 show which states are in each category as of 2001. Interestingly, North Carolina is listed as using none of these approaches – a reflection of how invisible BCBSNC’s “last resort” status is to the outside world, for reasons explained below.
Individual market for individuals who are otherwise uninsurable,” which is presently the Access product, and that it will “continue to offer this [i.e. the Access] product post-Conversion” with the same pricing arrangement it is currently using. In REDACTED BCBSNC states that “we would not foresee significant changes in the covered benefits that are provided as part of [the Access] product” and that “benefits would not be reduced.” One could question whether this is a permanent commitment that legally binds BCBSNC now or in the future. However, we have found no reason to question the sincerity and reliability of this commitment. As BCBSNC’s general counsel was quoted in a news article saying, “I can’t predict the future, forever and ever, amen. What I can say is that our current president and CEO and this management team have said it is part of the business plan that we will continue [the Access] commitment as we have done for the past 68 years” (Triad Business Journal, Feb. 15, 2002). A similar commitment has been honored by the BC plan in Virginia since its conversion in 1997. Also, for reasons noted below, this commitment imposes only a very small cost on BCBSNC (proportionate to its size), so it has little financial reason to back out of this commitment.

Even though BCBSNC has committed to continue offering the Access Plan under the current terms, there is reason to conclude that conversion could hamper access to coverage for the medically uninsurable. This is because BCBSNC is not currently honoring the spirit of the agreement or understanding that was originally reached in 1990-1991 about how the Access Plan should be priced. Without a conversion, if BCBSNC remained nonprofit and continued to receive a tax reduction, there would exist some leverage to have BCBSNC price the Access Plan in a manner that is more favorable to the medically uninsured and more consistent with the spirit of the original agreement. Conversion removes this leverage. The following additional history and information explain this point.

The Access Plan arose from legislative efforts in 1990 to create an industry-funded high risk pool similar to those that now exist in over half of other states. Historical documents and interviews with active participants at the time indicate the following: BCBSNC opposed the high risk pool on the grounds that it was unnecessary in view of BCBSNC’s role as insurer of last resort. Representatives from the Department of Insurance convinced BCBSNC of the need to revise its last resort policy, and BCBSNC publicly made the following commitment: to price the policy at no more than 175% of “normal rates,” that is, “175% of the rates charged for a standard risk nongroup individual [policy] with comparable benefits.” BCBSNC also committed to calculate future rates “using the [same] factors until such time that BCBSNC feels a restructuring of the program is necessary.” BCBSNC actuaries initially expected up to 3,000 subscribers, which they projected might produce up to $4 million a year in losses.

68 Minutes of a Feb. 7, 1991 meeting of BCBSNC’s Access Implementation Task Force state that “Access was developed in response to [the Department of Insurance] backed House Bill 985. This bill would establish a state high risk pool in order to provide coverage for the ‘uninsurable.” BCBSNC was concerned about its not-for-profit tax status, and decided that it was less expensive to subsidize this product than to lose its tax status. Once this product is approved, a representative of [the Department of Insurance] stated that it will no longer push the Bill for the high risk pool.”
70 Minutes of a Feb. 7, 1991 meeting of BCBSNC’s “Access Implementation Task Force.”
Following that commitment, BCBSNC initially set its rate for the Access Plan at 155% of the rate for its indemnity plan called CMM (for comprehensive major medical). (This is somewhat lower than the 175% agreement because the CMM plan had better benefits. In other words, the Access Plan cost 75% more, after adjusting for differences in benefits.) Access Plan prices increased at the same rate as CMM prices for the next five years. However, in 1992, BCBSNC introduced a new PPO product called Select, which it heavily marketed in the individual market. In short order, this policy began to attract most of BCBSNC’s individual policyholders. As this happened, the rate increases under the older CMM policy became increasingly steep because healthier people who could satisfy medical underwriting criteria were drawn into the new policy, leaving a higher percentage of sick people in the risk pool for the older CMM policy. This resulted in what is known as a “rate spiral,” since the more the CMM price went up, the more people switched to the newer policy, but only if they were healthy enough to do so, which forced the CMM rates even higher. Because Access premiums were still tied to CMM rather than to Select, the Access premiums rose steeply in tandem.

When this switch was made, BCBSNC did not rebase the Access rates to 175% of the Select plan. Thus, it switched the reference plan that is used to determine annual increases, but it did not use this reference plan to reset the overall price level for the Access Plan that was specified in the original understanding with the Department of Insurance. Therefore, the starting point for the new reference plan was substantially higher than the original 175%.

The same scenario repeated itself a few years later when BCBSNC introduced Blue Advantage to replace the Select Plan. Once again, this set off steep rate increases, this time in the Select Plan. In 1999, BCBSNC actuaries again switched the reference plan to its most popular product in the individual market (Blue Advantage), but again did so only for purposes of rate increases, without resetting the overall price of the Access Plan relative to the reference plan. These various rates and changes in the reference plans were filed over the years with the Department of Insurance.

As a consequence of this series of premium spirals for the reference plans, and of rebasing the Access Plan rates as the reference plans changed, the Access Plan is now (in 2003) priced at a level more than

For a 45 year old male in Durham in the preferred (non-discounted) rate tier, the $500 deductible Blue Advantage plan costs $2,697 whereas the corresponding Access Plan costs $20,690 per year, which is 767% higher. (The figures for the $1,000 deductible plans are $2,416 and $18,696, respectively.) Compared to the Blue Advantage “standard” rate tier for higher risks, Access rates are about six times as high. Interview subjects (principally insurance agents) commented that these prices are “outrageous,” “a nightmare,” and “prohibitively expensive,” even for people with very serious health problems who are “desperate for coverage.” Of 12 experienced insurance agents we interviewed, 10 had never sold a single Access policy, and the other two had not sold any in the past five years.
These views are confirmed by the steep decline in the number of people enrolled in the Access Plan. Historical records indicate that, originally, 1,037 people were covered by Access in 1991 and BCBSNC said that it expected enrollment to grow as high as 3,000. However, by 1996, enrollment had dropped to about 500, and it has dropped precipitously in the last few years, from 170 in early 1998 to 86 at the end of 2000, remaining in the 70s to 80s since then. Some of this drop is due to other options becoming available to the medically uninsured; for example, over this same time, federal and state laws were enacted that require BCBSNC and other insurers to accept anyone who applies for small group health insurance, including the self-employed, and to offer individual coverage to certain people who leave group coverage. Undoubtedly, a number of people who were, or who might have been, covered by Access are now covered by these options. However, this decline began prior to some of these laws, and has continued for years following these laws. Therefore, a good portion of this decline must also result from the spiral in price of the Access Plan.

One way to assess the extent of undercoverage of this population is to compare the levels of coverage in other states. If North Carolina had in place a high risk pool for uninsurables like the pools in 32 other states, it would cover 8,500 people based on national averages, or 3,900 if it mirrored the experience of the 10 states in the South with such pools. (This average masks a very large range. The enrollment in North Carolina could be anywhere from 400 to 43,500 people, depending on whether the comparison is the lowest state (Florida) or highest state (Minnesota) (Table 8.1).)

The very high price BCBSNC is charging for the Access Plan has resulted in the plan earning about as much in premiums as it pays out in claims. In 2001 (the last full year for which data was provided us), total claims exceeded premiums by only 1%. This means that BCBSNC is subsidizing mainly only the administrative costs of the Access Plan. Since no agent commissions are paid on this plan, and there are so few members, this subsidy is small, less than $100,000/year according to the calculations in BCBSNC’s rate filings for this product. This compares with the paying less tax than other insurers and the $4 million it originally expected to lose each year on Access.

72 These include Alabama, Arkansas, Florida, Kentucky, Louisiana, Mississippi, Oklahoma, South Carolina, Texas and West Virginia.
73 Using national data on the percent of individuals under 65 denied health insurance coverage, the estimated total number of “medically uninsurable” in North Carolina who don’t qualify for public programs such as Medicaid is approximately 29,000. Even with subsidized premiums, state high risk pools are beyond the financial reach of many of these individuals, however. Hence, the 8,505 figure represents only the number likely to enroll in a high risk pool were it funded in a fashion similar to those operating in other states.
74 This figure is less than the million additional state premium tax that BCBSNC would have if it were for-profit.
If BCBSNC remained nonprofit, and especially if it continued to receive some tax break, whatever leverage exists to have BCBSNC adjust its pricing for the Access Plan to be more consistent with the original understanding in 1991 would presumably continue to exist. However, if BCBSNC converts to for-profit status, North Carolina will have the worst of both worlds: no high risk pool, partly as a result of BCBSNC’s historical opposition to such a pool (which it has not yet reversed), and instead a “last resort” policy that is priced so high that fewer than 100 people in North Carolina can afford it, only about 1/340 of our rough estimate of the total number of medically uninsurable people in the state. As a matter of health policy, this puts North Carolina in poor standing compared with other states, almost all of which have either high risk pools or other viable options for covering substantial numbers of people who are medically uninsurable.

**Funding Requirements and Options for Covering the Medically Uninsurable**

To determine what “might have been” had BCBSNC either run the Access Plan as the equivalent of a statewide high risk pool, or had relinquished its last-resort role in favor of such a pool, we use the latest available data from all the states that now have high risk pools in place to examine the average cost per eligible, medical loss ratios and administrative loss ratios. We find that if North Carolina had a pool whose performance was average compared to pools nationwide, the pool would cover roughly 100 times as many people as are now covered by the Access Plan, resulting in an annual loss of $28 million; alternatively, if BCBSNC operated a pool typical of states in the South, the annual loss would be $9.9 million, less than the net value of the current BCBSNC tax subsidy. Even if it had merely matched the performance of the state with the smallest size pool in relative terms (FL), North Carolina would be covering nearly four times as many people and incurring losses roughly 20 times as large as those now borne by BCBSNC for its Access Plan. Conversely, if it operated a pool whose relative size is as large as Minnesota’s, this would cover more than 43,000 people – i.e., more than the entire population in North Carolina theoretically needing such a pool.
Of equal relevance, the average-sized pool would effectively absorb almost double the current net tax benefits still conferred on BCBSNC. A pool the size of Minnesota’s would dwarf those tax benefits even further. Thus, it would be unlikely that a nonprofit Blue Cross, with its current tax treatment, would be willing to bear the full burden of a statewide high risk pool that performs on par with most other states. On the other hand, if the state were to establish such a high risk pool and have BCBSNC contribute its proportionate share of losses (based on market share), then, for an average-sized pool, the company would have to contribute an annual amount somewhat less than its current tax savings, but over 150 times what it currently contributes to the Access Plan. This approach would provide a more level playing field than simply insisting that BCBSNC maintain a pool as a condition of conversion, since BCBSNC’s competitors would also contribute, in proportion to their market shares.

Marketing, Underwriting, and Managed Care

Product Offerings and Geographic Marketing

This section considers whether conversion is likely to have positive or negative impacts on BCBSNC’s product offerings and geographic marketing. We divide our discussion along several lines: between North Carolina evidence and evidence from other states; between major product markets, such as individual and small group, and secondary product markets such as Medicare Supplemental and association health plans; and between product markets generally and geographic markets, such as rural vs. urban areas.

The possibility that conversion will have negative effects on product offerings and geographic marketing is suggested by the fact that most of the for-profit insurers in North Carolina do not operate in all 100 counties. A former BCBSNC vice president was quoted in 1996 that “we serve all geographic markets, segments, and small groups, whereas for-profit carriers serve those markets that meet their corporate objectives” (Durham Herald-Sun 3/26/96). Indeed, in recent years, profit concerns have caused BCBSNC to withdraw its HMO products from the state employee plan and to not renew contracts to process claims for Medicare and for military health coverage. Also, BCBSNC did not bid for participation in Medicare’s new PPO demonstration project. However, these moves have not seriously affected accessibility because these large government programs are usually able to find alternative sources for service.

BCBSNC’s business plan discusses or mentions various plans for REDACTED reductions in the marketing or offering of some specialized products. REDACTED However, it appears these plans are consistent with those in place prior to the plan of conversion and likely are plans that BCBSNC would be pursuing regardless of conversion. Moreover, none of these stated plans appears to have a strong adverse impact on accessibility, and other plans may improve product offerings. For instance, profit incentives have already led BCBSNC to revamp all of its major health insurance lines in recent years and to introduce a new set of managed care products that increase access to specialists and reduce other managed care restrictions.
In other states where BC conversions occurred several years ago, the conversion has not resulted in BC’s pulling out of major product or geographic markets. In particular, these BC plans have remained committed to the individual and small group markets, and they have continued to cover their entire geographic regions.\textsuperscript{75} To the contrary, remaining strong statewide and in the individual and small group markets are principal business strategies of these BC plans.

We detected only minor or scattered concerns about geographic marketing and product offerings in other states where BC conversions occurred several years ago. In several states, we heard similar accounts of BC plans’ failure to maintain provider contracts for their HMO networks in some rural counties, but these BC plans have not pulled out of these counties entirely. In Missouri, there were concerns similar to those in North Carolina about BC’s closure of association groups leading to steep rate increases for some members, but regulators there said this resulted mainly from BC’s need to comply with new federal and state laws that prohibited the particular form of association groups that existed then. BC in Missouri was one of the first major plans to pull out of the Medicare HMO market, and it did so across the state rather than in selective counties, as other insurers did. In both Missouri and Virginia, it appears that the BC plans withdrew from the Medicaid HMO program following conversion, but details are sketchy. A leading investment analyst (Bear, Stearns) in a November 2001 report notes favorably for investors that Anthem planned to exit Medicare HMO markets and that Anthem has “minimal” participation in state Medicaid managed care. The report explains that investors “view the low exposure to Medicaid as important, given the deteriorating fiscal condition of many state budgets.”

In California, a few interview subjects criticized BC for refusing to participate in the small group purchasing cooperative and attributed this to a desire to avoid higher risks. However, others attributed this to BC’s view of the association as a threat to its strength in the small group market and the company’s desire to compete directly against the cooperative rather than join it. Many sources in California praised BC for being “about the best” of all private insurers, including nonprofit Kaiser, in its participation in low-income government programs. BC of California is by far the largest participant in the state’s Medicaid managed care program, it also administers the state’s high risk pool, and it is a large participant in the CHIP program for low income children. These sources noted that BC was making a profit from these government programs; otherwise it would not be participating. But they also noted that BC seemed eager to have this business even though the profit margins were slim, in part because this gives it more leverage with providers in negotiating lower payment rates for their commercial products. BC of California has withdrawn its Medicare HMO products from a number of counties, but it did not have a large enrollment and the impact was much greater when other insurers also withdrew. BC of California no longer serves as a Medicare contractor for claims processing.

\textsuperscript{75} Although BCBSNC executives have said repeatedly that they cannot state unequivocally that the company would never leave a major product market, given all the evidence, we believe that the likelihood seems low; moreover, this could occur regardless of conversion. Regence Blue Shield, a nonprofit, recently elected to cease new enrollments in the individual market because regulations restricting premium increases in the State of Washington made this market unprofitable (Grossman and Strunk 2001). Likewise, seven national insurers left the individual market in Kansas, reportedly due in part to what they said was “a difficult regulatory environment” (Arnold 2002). To date, BCBSNC has been able to make profits in this market rather consistently, so, absent a change in this situation, the company would have little motivation to leave the market unless it saw an opportunity to achieve even higher profits by doing so. But these examples also illustrate the sensitivity of these markets to changes in conditions.
In the private market, interview subjects said BC of California is known for being a continuing innovator in product design, a “visionary” that is “always five steps ahead” of the competition. As noted below, however, some skeptics believe that frequent changes in product design may result in greater risk segmentation. Also, concerns were expressed that the company’s bare bones policies may not offer adequate protection or may be misunderstood by less sophisticated purchasers. A growing number of the largest insurers in the U.S. (Aetna, UnitedHealth Group and CIGNA, all of whom are BCBSNC competitors) are testing predictive modeling programs to generate individualized health forecasts that identify more accurately who will become sick (Anderson and Minnich 2001; Ash 2001; Advisory Board 2002). Such technology is expensive and has the positive potential to encourage greater use of preventive care, but the downside is that the same technology could be used for very aggressive medical underwriting.

Interviews in North Carolina were largely consistent with the experience from other states. Regarding product markets, none of the major interest groups (agents, purchasers, providers, patient advocates, and industry analysts) in North Carolina thought that conversion would cause BCBSNC to withdraw from major product markets, such as the individual or small group market. Market analysts noted that much of BCBSNC’s current financial strength comes from the individual and small group markets. As discussed above in Section VII, these are its most profitable lines of business and where it has the largest market shares.

Concerns were expressed only regarding secondary or peripheral product markets. For instance, an employer representative said that it’s “in the nature of things” that “anything that gets in the way of trying to make a profit” will be scrutinized and therefore conversion may lead to closing more association plans or other specialized pools. One competitor said that profit pressures might cause BCBSNC to “cull” some of its products that aren’t generating profits in order to focus on those that do, but gave no specifics about what this might entail.

The primary example cited in other interviews and at the public hearings is BCBSNC’s closure of almost all of its large association groups, composed of individuals or small businesses in a particular trade, industry, or profession. In a series of terminations beginning about 1999, BCBSNC decided not to renew long-standing arrangements with associations in which BCBSNC offered specially-designed coverage at rates that were specific to the group. Instead, members were offered replacement coverage through either a normal individual or normal small-group policy, as appropriate. Organizers or administrators of the association groups we spoke to were not at all pleased with these developments, and some were quite upset. One commented that members of his association are “confused and upset, it’s been a very rude awakening to what’s going on in health care right now.” Two subjects thought that terminating association groups was driven by a desire to make BCBSNC more profitable leading up to conversion. One had the following to say: “One of the things [BCBSNC has] said time and again is that [conversion] won’t affect coverage or prices. It certainly has affected our coverage.”

However, it appears that BCBSNC has had plans in place for about four years to transfer association groups to its regular platform of individual and small group products. According to our interviews with BCBSNC officials, this is being done to reduce administrative costs, and because most of these groups had experienced steeply increasing rates that caused BCBSNC to
conclude that the association model was no longer a viable financial model. Also, BCBSNC has handled these transitions responsibly by offering replacement coverage in each instance. For some, the new coverage comes at a much higher price since each policyholder is subject to re-underwriting and is placed in a rate tier according to the individual’s or group’s claims history, rather than using an average rate for the entire association group as had been done before. However, the worst rate tier is only about twice what other healthy small groups and individuals pay, rather than rates for Blue Assurance (the plan for policyholders who leave group coverage and purchase guaranteed issue individual coverage under HIPAA), whose rates can be four times as high.

As long as BCBSNC continues to follow these practices (offering appropriate replacement coverage on a guaranteed issue basis that is rated using rate tiers that are no more than twice the rates paid by healthy subscribers), the public interest impacts from closing less profitable lines of business will be minimized. There is some basis for concern in this regard, however, since BCBSNC recently requested a 25% increase in the rating factor for its highest rating tier, which is used mainly for these situations. Therefore, a binding commitment to continue past practices would lessen concerns about potential negative impacts from closing future association groups and other lines of business.

We also inquired about the role that BCBSNC has played in the past in assisting subscribers who might be stranded when other insurers exit the individual market. BCBSNC has sometimes offered its standard coverage to these subscribers, regardless of health status. Regulators recalled that this sometimes happened a number of years ago after they “leaned hard” on BCBSNC’s public spirit. In recent years, however, this has happened only once (when Conseco exited), and in several other instances BCBSNC has declined to take on stranded subscribers. BCBSNC’s willingness to do this, although not legally required, is an important protection for those who have developed serious health problems since they first purchased individual insurance because, otherwise, they would probably not have been able to obtain replacement coverage elsewhere. North Carolina law, like in most states, does not guarantee that individual subscribers can switch to other insurers, only that they can renew with their current insurer. Two agents were concerned that, following conversion, BCBSNC might no longer be “willing to come to the rescue” of policyholders who are stranded when other insurers exit the state. Senior BCBSNC officials said that, regardless of conversion, they will continue to decide how to handle such requests on a case-by-case basis, as they do now, depending on what they view to be in the company’s financial interest.

Regarding geographic coverage, several interviewees and speakers at the public hearings had concerns about whether BCBSNC would continue to serve less profitable rural areas. One observer noted that BCBSNC recently has been shedding unprofitable business such as association health plans, and so speculated that conversion would result in up to 20 rural counties losing coverage because small business coverage in those areas simply was not profitable. Others were not so specific, but thought that, as a not-for-profit company, BCBSNC now feels some obligation or is under pressure from the public and regulators to operate statewide. As a

76 Strictly speaking, BCBSNC does not have a legal obligation to operate in all 100 counties, but this does not preclude the possibility of pressuring the company to do so based on its historical mission, nonprofit status, and reduced taxes.
for-profit, they thought that this social conscience may dissipate and BCBSNC would decide on geographic coverage based more on market conditions than on a sense of obligation to the community, resulting in gaps in rural markets. Other observers, however, thought that BCBSNC has strong incentives to continue marketing its major products statewide, since statewide coverage is key to its business strategy to be more competitive for larger employers, including those with multi-state or multi-county workforces or out-of-state headquarters. Covering only a portion of the state would be a significant handicap in competing for or retaining this business.

The primary respect in which we detected concrete concerns regarding geographic coverage relates to provider contracting for managed care products, discussed in depth below. In brief, if BCBSNC is not able to obtain sufficient provider contracts in a particular county, it may be forced to stop offering one or more products in that county, such as its HMO or POS products. However, it is not likely that BCBSNC will stop offering all products in a county, especially its main PPO products, and it offers those products now in a few counties where it lacks contracts with the main hospital or a key physician group. BCBSNC is able to do this because it can pay these providers their usual rates, as in an indemnity plan, and pass these higher costs on to subscribers by reflecting them in its geographic rating factors for those counties. Indeed, to facilitate this, BCBSNC has, in the past few years, begun to use county-specific area rating factors, which it updates once a year, and it may begin to update them more frequently (for newly issued policies) or divide some counties into smaller rating areas. Provider contracting may cause BCBSNC’s products to be noncompetitive in these counties, which could diminish its willingness to invest in advertising and field agents in those counties, but there is no strong economic reason to pull out of difficult counties altogether.

On balance, there is no strong evidence that conversion will have a substantial negative impact on product or geographic availability for BCBSNC’s major products. Culling specialized products and focusing marketing efforts geographically are practices that already occur and are likely to continue, and the same can be said about provider negotiations. Although provider negotiations may intensify following conversion, BCBSNC will also have profit-driven incentives to continue offering and to improve its major products, and to maintain at least some presence statewide. The one significant basis for concern we detected would be if BCBSNC were to increase the higher-risk rating tier for the products it offers as replacement coverage for subscribers who are displaced when BCBSNC closes out older or secondary products.

**Underwriting and Other Risk Selection Practices**

*Generally*

Another way BCBSNC might seek to increase its profits is by more aggressively or selectively distinguishing between people who are lower versus those who are higher risks for medical costs. There are several ways to engage in risk selection, including product development and marketing, but the most direct method is through underwriting. Being able to identify and accurately price each individual or group according to its particular health risks gives an insurer a competitive advantage. This explains the historical move by all BC plans from community rating to experience or risk rating. Many people see this movement as contrary to the public interest because it undermines the pooling of risk that keeps insurance affordable for less healthy people who need it the most. On the other hand, more accurate risk selection makes health insurance more affordable for lower risk people, which might encourage more people overall to
purchase insurance. Both views of the public interest are credible, and we do not here endorse one or the other. However, we will report our findings on the potential for conversion to change underwriting and other risk selection practices so that these findings can be evaluated from either perspective.

According to interviews and other sources, the time has passed when BC plans, both in North Carolina and elsewhere, were much more lenient underwriters than other insurers, willing to accept anyone who (in the words of one analyst) can “fog a mirror.” For at least a decade BCBSNC’s underwriting practices and policies have been broadly consistent with those of for-profit insurers (excepting the Access Plan discussed above which has extremely limited enrollment). Underwriting and other practices are now largely the same across the industry, due predominantly to legislation that sets uniform standards. For instance, federal law requires all insurers to guarantee issue small group insurance, and state law requires them to use consistent rating practices that limit how much more insurers can charge the highest risks relative to the lowest.

Accordingly, several agents said that BCBSNC has become stricter or less lenient, or has become more detailed or “tightened up” in its underwriting practices and criteria in recent years. For instance, BCBSNC now uses weight tables “like everyone else” to assess health risk for otherwise healthy people, whereas it did not do this REDACTED years ago, and BCBSNC’s age groupings and county ratings are more specific than they used to be, but again consistent with other insurers. On balance, most North Carolina agents said that BCBSNC is “fair” and “middle of the road” in its underwriting practices, that is, neither stricter nor more liberal than other insurers.

Some noted differences, however. For group products, several agents said that BCBSNC is quicker to charge higher rates for health problems than other insurers, or less willing to give discounts for good health. For individual insurance, several agents thought BCBSNC was more lenient, sometimes willing to take cases that other insurers decline, but others said that BCBSNC is quick to decline individuals and complained that BCBSNC aggressively advertises rates for people with “squeaky clean” medical records that few people actually have.

Despite the broad similarities between BCBSNC and its competitors, there are still areas in which subtle differences can have significant effects and so where conversion might have an impact. Speaking generally, one proponent and scholar of nonprofit Blues plans nationally argued forcefully that nonprofits will maintain a number of underwriting and coverage practices that assist the sick and uninsured. However, “once the market exercises discipline, these services become losers” because for-profits have no obligation to spend money “doing good works” or being “Mr. Nice Guy.” As a for-profit, they’re “not supposed to act like Mother Teresa.” According to this view, “the market is driven by avoiding having to insure sick people. That’s how you succeed.”

Instructive publications include Grossman and Strunk (2001); Friedman (1998); Cunningham and Cunningham (1997); and Blackstone and Fuhr (1998).
In other states in which BC conversions occurred several years ago, we heard some, but not a great deal of, concern about conversion leading to more aggressive underwriting or risk selection practices. In most states, interview subjects thought that the converted BC plans were “in the middle of the pack” in their underwriting, or even somewhat lenient. For instance, in two states subjects noted that the converted BC does not increase rates for higher risk small groups as aggressively as other insurers do.

The most criticism came from California (the state with the longest history with a converted BC), where BC has a reputation as an aggressive but fair underwriter. Several subjects felt that BC was more “sophisticated” at selecting good risks and segmenting risks than most other insurers, and that its acumen in this regard is one of the keys to its success, something that other insurers are “envious of.” Two subjects thought that BC “crassly” manipulates benefit coverage and product design to enhance favorable risk selection and risk segmentation. Similarly, in Missouri, some subjects noted that BC no longer includes maternity coverage in its individual policies unless purchased as a rider at an extra cost, unlike United which spreads the cost of this coverage across all its policies. In California, it is also notable that, in 1998, BC changed its rating for Medicare Supplemental policies to a method that increases the rates as the member ages.

On balance, there is some basis for concern about conversion resulting in further tightening of various underwriting practices, which could lead to fewer people qualifying for affordable coverage. However, many of these underwriting practices are subtle and complex and not readily subject to regulatory oversight. Therefore, for the most part, further evolution of various underwriting practices in response to increased profit pressures is one of the difficult-to-quantify tradeoffs that must be weighed against the potential benefits of conversion.

**Very Small Groups**

One area of more particular concern that we investigated is very small employer groups, those with five or fewer employees, many of which are self-employed workers or family firms (“Mom and Pop shops”). Insurers generally find that these groups tend to have substantially higher claims costs because they are more likely to delay the purchase of insurance until they know someone in the group is expecting to have high medical costs. Therefore, insurers have adopted various tactics to avoid these groups or defray these costs. One is to automatically charge the highest allowable rate, even when there is no indication of actual health problems. Another is to pay insurance agents extremely low commissions for these groups, which discourages agents from selling to them or encourages them to send these groups to other insurers. Finally, for self-employed workers (who are called “groups of one”), insurers are required to offer only a standardized benefit package and not their full range of products. Because each benefit package
is rated separately, this allows insurers some leeway, subject to regulatory approval, to set prices for one-person groups much higher than similar coverage for groups of two or more.

In our North Carolina interviews, several subjects thought that BCBSNC was somewhat more lenient or less aggressive in its treatment of very small groups in these various ways than other insurers. This is supported by data showing that, in 2001, BCBSNC/Partners accounted for 53.2% of newly issued policies to one-person “groups,” indicating that its underwriting and pricing policies for this segment may be more generous than most insurers. This raises the possibility that BCBSNC could change its marketing and underwriting practices to the disadvantage of these groups. Agents noted that BCBSNC pays about a 3% commission for groups of five and under, compared with its usual rate of about 7%. Another insurer pays no commission since it requires very small groups to contact it directly, and another insurer pays a flat rate of about $4-7 per person for the first three people (compared with $21/person for larger groups). Two employer representatives and one agent were “fretful” that BCBSNC will find more ways to send a “loud and clear message” to brokers and employers that it doesn’t want this business. The agent explained that BCBSNC is “usually the last one” to adopt such tactics since it prefers to wait and see what happens to others who are pushing the boundaries, but once it is clearly defined what is permissible and what the market will bear, BCBSNC eventually follows along with the rest of the market.

In our review of historical records, we found that BCBSNC previously was the only insurer in the state that voluntarily offered its normal group products to one-person groups outside of the Caroliance purchasing cooperative, but two or three years ago it stopped doing so. Now, its price for the standardized coverage that must be offered to one-person groups is more than twice as much as the price for its regular policies that have similar coverage – a pattern that we believe is true for most other insurers.

In summary, there are good reasons to conclude that very small groups face significant problems market-wide in finding affordable insurance. To the extent that BCBSNC might contribute less to these problems now than do other insurers, there is some justification for concern that this could change in the future. And, to the extent that BCBSNC has become more like other insurers recently in how it deals with very small groups, this also might be held against BCBSNC as an indication of its profit-driven inclinations. We believe it would be sound public policy to address these issues uniformly for all insurers. However, a temporary moratorium on any changes in these policies and practices by BCBSNC might be justified as a transition measure while potential remedies are studied and implemented market-wide.

**Managed Care and Customer Service**

Conversion is not likely to have an adverse effect on managed care practices and customer service, and could improve BCBSNC’s performance in these areas. In recent years, BCBSNC has noticeably scaled back the intrusiveness of its managed care practices and improved its customer service, as part of its efforts to increase enrollment. In its managed care products, BCBSNC has moved away from gatekeeping models and the use of capitation payments for

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79 The legality under federal law of some of these practices has been questioned under interpretations issued by the U.S. Department of Health and Human Services (Conwell 2002).
providers. Instead, it is promoting an open access HMO model that allows patients to go directly to specialists in the network without first getting permission. BCBSNC was also a strong supporter of a managed care patient bill of rights (S.B. 199), enacted in 2001, which embodies some of these same principles.

BCBSNC has also improved its customer satisfaction ratings, and now ranks higher than the national and state averages in key performance measures. In recent years, BCBSNC has consistently maintained the highest accreditation level with the National Committee on Quality Assurance for its HMO products. Likewise, in 2001 (the latest available data), the grievance rate per 10,000 BCBSNC members was less than half the statewide median both for HMO and PPO plans (NCDOI November 2002).

In our interviews, most agents had no complaints about BCBSNC’s utilization management practices. A few agents reported difficulties, some serious, with enrollment and other administrative issues, but not with disputes over whether treatment is medically appropriate or how other claims issues are resolved. Some agents were highly positive about BCBSNC’s customer service generally (“impeccable,” “absolutely no problems”). A benefits consultant for larger employers likewise said that BCBSNC has “improved tremendously” in recent years in its operating systems and customer service. These improvements appear to be driven by a profit-oriented goal to increase enrollment. Therefore, conversion is not likely to reverse these gains, and could foster them.

Concerns were raised by advocates for patients with physical or mental disabilities, who felt that BCBSNC is currently not sufficiently sensitive to various needs of the disabled community. They were highly critical of BCBSNC’s past opposition to mental health parity laws, and they had a general, nonspecific “nervousness” that things could only get worse from conversion since “putting profits before people” could result in covered benefits “dwindling” or being “whittled down.” Some agents also expressed concern that BCBSNC has been paring back benefits too much, for instance, capping prescription drug coverage at only $1000/year and not applying out-of-pocket maximums to this portion of the coverage.

In other states, we detected no strong indication that conversion has caused BC plans to drop their service levels or intensify their managed care restrictions. An analysis of HMOs that serve federal employees found that conversion resulted in no significant change in customer satisfaction scores for three HMOs (Feldman, Wholey and Town 2003). In California (where there is the most history post-conversion), BC has improved its customer satisfaction noticeably in recent years and now has one of the best ratings among the state’s major plans. In other states, converted BC plans are seen as being more “in the middle of the pack.” However, problems were noted in Missouri, where BC’s complaint rate is higher than most other major insurers and several times higher than the nonprofit BC plan in Kansas City. ⁸⁰

⁸⁰ For a somewhat different analysis, one that is focused on WellPoint, see Delmarva (2003) (prepared in connection with WellPoint’s proposed acquisition of CareFirst), which concludes that the complaint record of the converted BC plan in California is worse than the state average, but the plan in Missouri (also now owned by WellPoint) receives an average number of complaints.
One issue of concern that was raised several times in our interviews and at the public hearings relates to the possibility that conversion might facilitate BCBSNC being acquired by a larger out-of-state company. If this were to happen, some market observers and participants felt that this would be bad for policyholders since it might divert capital and attention away from improved products and customer service in North Carolina. On the other hand, merger or acquisition might, in theory, improve service through economies of scale and superior technology. Although none of our case studies allowed us to pursue this issue in depth, two sources in Georgia thought that BC’s customer service had worsened following WellPoint’s acquisition of that plan.

Provider Contracting

Overview

A final area of concern we explored in our key informant interviews is whether conversion would cause BCBSNC to change how it contracts with physicians and hospitals, for instance by demanding lower payment rates or limiting who it will contract with. In Maryland, consultants who reported on this issue to the Maryland Insurance Administrator (in connection with the proposed conversion of CareFirst and its acquisition by WellPoint) concluded that “the Maryland provider community would probably experience the brunt of the negative changes that might ensue contingent upon the conversion” there. Before evaluating this issue in North Carolina, we need to clarify the extent to which this is a matter of broader public interest, in contrast with being a concern only for providers. In any market, suppliers generally seek to obtain the highest feasible price for their services and buyers seek to pay the lowest. Often, there is no public policy concern leaving this inevitable jostling to the give and take of market forces. In an ideal world, BCBSNC serves as a purchasing agent for its subscribers, who simultaneously desire freedom of choice and convenience but also do not wish to pay too much for health care. To the degree that BCBSNC is able to use its market power to lower payments to providers, the public will benefit even though hospitals and physicians will be paid less than they might prefer, assuming some of these savings are passed on to consumers. There is no compelling public interest in paying providers more than the amount needed to supply the “right” amount of medical care to consumers. This implies that it is not necessarily contrary to the public interest for BCBSNC to be tough in its bargaining with providers or even to fail to reach an agreement with some providers.

In actual health care markets, however, there is a risk that a dominant insurer will behave as a “monopsonist” (that is, a monopolistic buyer) with respect to providers of health care (Dranove and Satterthwaite 2000). Monopsonists generally pay lower prices than would prevail under perfect competition, which can result in fewer services being supplied than is optimal for social welfare. This might be seen, for instance, in provider contract terminations that cause

81 The Delmarva Foundation for Medical Care (2003). The study found that WellPoint had in the past been ranked by hospitals as the worst plan, and regulators further reported that WellPoint’s negotiations with hospitals had caused more disruption compared to other HMOs. A companion analysis conducted for the Maryland Insurance Administrator found that in general there was no significant difference between for-profit and nonprofit HMOs in terms of payment rates to physicians or hospitals; but a separate analysis of BC of California found that it paid less than the expected price for hospital services in 1993-1995 but more than the expected price from 1996-2001, with 1997 data missing (Feldman, Wholey and Town 2003). An earlier study for the period 1985-1997 also showed no difference in hospital payment rates by for-profit HMOs compared to nonprofit HMOs, but it also showed that HMOs pay lower prices when they purchase a larger share of hospital days in a market (Feldman and Wholey (2001).
disruptions in patient service or critical gaps in the provider network that compromise optimal care, or perhaps make insurance unavailable in some regions. Moreover, even if perfect competition prevails, driving down provider payments might be contrary to the public interest if this made it impossible for hospitals to serve members of the community without insurance or to continue offering essential services that are not fully compensated and so need to be cross-subsidized through “excess” payments through private insurance. Economists call these unprofitable but essential medical services “public goods,” and competitive markets tend to under-produce public goods. We review the available evidence to determine whether concerns about changes in provider contracting raise any of these public policy issues.

**Stance Toward Providers Generally**

As a general matter, the impression from a variety of sources, including key informant interviews and a confidential physician survey commissioned by BCBSNC, is that BCBSNC has improved its relationship with providers in recent years and enjoys a somewhat better reputation among physicians than its competitors. On four different measures of satisfaction and loyalty among physicians and practice managers, the company consistently ranked higher in 2002 compared to 2000. Historically, BCBSNC was founded by hospitals, governed by hospital administrators and physicians, and maintained a very positive relationship with the provider community through most of its history. Because BCBSNC has staff throughout the state, including rural areas, it is considered more “high touch” and generally easier to work with than some other insurers. Providers’ attitudes changed, however, in the early 1990s. Relationships with providers soured quickly when, shortly after arriving at BCBSNC, former CEO Ken Otis moved aggressively toward managed care, which requires arms-length negotiating with providers. This new era was reflected in the 1996 termination of contracts with the state’s largest hospital and culminated in an “unprecedented legal battle” in late 1997 between the company and two hospitals owned by Novant (Associated Press 1997). However, Bob Greczyn, who replaced Ken Otis, appears to have halted or partially reversed this deteriorating relationship at the same time that BCBSNC remains committed to managed care.

Nevertheless, in our key informant interviews in North Carolina, there was a general consensus that BCBSNC is a very tough negotiator, and it is viewed as being “tremendously powerful,” although this power is very market specific. Even in areas where it has a relatively small market share, BCBSNC has leverage since in these communities hospitals often have high uninsured and Medicaid loads that make them very reliant on private insurance payments to remain financially viable. However, several individuals reported that facilities had begun to “push back” in negotiations in recent years; some also have found they can survive without the BCBSNC HMO or PPO. In addition, there were reports that BCBSNC is less able to deliver volume in return for discounts since it now uses a point-of-service model for its HMO product.

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82 For instance, national data show declining operating margins for academic health centers between 1994-2000, along with rising levels of uncompensated care (Dobson et al. 2002). In North Carolina, the Triangle’s three main hospitals saw a 20% increase in indigent care losses just in the past year (Fisher, 10/28/02), which for these hospitals alone translates to nearly $120 million in charity care during 2001 alone.

83 Bob Greczyn joined the company in August 1998 as chief operating officer and in April 2000 became CEO.
Views were split on whether conversion would give BCBSNC more leverage or change how it negotiates with providers. Several people thought that the company already is driving such hard bargains that conversion would not change what it could negotiate with providers since BCBSNC could not get any tougher than it already is. Also, there was general recognition that, sooner or later, providers will reach an outer limit on what they tolerate: at a certain point, they will refuse to contract rather than absorb losses. However, many providers and other observers expressed concerns, both in interviews and at the public hearings, that the company could become even tougher. The general feeling was that BCBSNC still “leaves some bargaining power on the table” in its negotiations and so it could drive payments even lower. One hospital executive expressed the fear that conversion would give BCBSNC bargaining power that he characterized as “a license to steal.” Others worried that further ratcheting down of hospital rates could put in a vulnerable position the rural hospitals that rely very heavily on limited private insurance revenues to provide the surpluses needed to pay for care for many uninsured people. Many providers and observers thought BCBSNC would become more willing to walk away from recalcitrant hospitals, especially small rural facilities. The general perception appears to be that BCBSNC would become more driven by profits rather than by what remains of its historical mission to serve as many people as possible. Although over time this mission has eroded in any case, some speculated the erosion would accelerate under conversion. These issues are explored in more detail below by examining particular aspects of BCBSNC’s negotiating practices and strategies.

**Payment Rates and Negotiating Style**

According to key informants, BCBSNC generally starts provider negotiations with a take-it-or-leave-it posture, but rates are often negotiable for hospitals or larger physician groups if the provider objects strongly enough. Nevertheless, for hospitals, our key informants stated that many institutions entered into bad contracts in the early to mid-1990s; hospitals subsequently have tried to improve these, but BCBSNC generally has been very tough, denying rate increases for years at a time according to some hospitals. Despite this, BCBSNC’s negotiators were said to maintain a respectful attitude, trying to look at the merits of a hospital’s request based on “needs” such as higher-than-average uncompensated care loads or a teaching mission. In contrast, other insurers were said by some to have poor people skills and to have a tendency to issue ultimatums and to be more prone to justify payment rates in terms of profit expectations or “bottom line” considerations.

Despite this apparent difference, most of our key informants said that, in contrast to the past, BCBSNC today does not really recognize public goods such as uncompensated care and teaching in its payment rates to hospitals. Instead, hospital administrators reported that BCBSNC compares them to peer hospitals but does not take into account each hospital’s unique circumstances, beyond a willingness to pay higher rates based on having a more severe case mix. Thus, it appears that BCBSNC’s attitude towards public goods is not much different than its competitors, all of whom tend to discount such pleas since, as we were told, they “hear the same story from nearly every hospital.”

For physicians, BCBSNC ties its payment rates to a percentage of the Medicare fee schedule. There was general agreement that its rates have tightened over the past few years, but disagreement about whether they have fallen below Medicare levels. The company reports
comprehensive major medical plans (which are paid through discounted charges) and a handful of Personal Care Plan contracts for which capitation is used for primary care physicians. The company is viewed as paying less than most other payors, but most subjects acknowledged that some other carriers pay physicians even less. Primary care physicians generally have higher overhead than specialists, so they are thought to be more vulnerable to being squeezed.

Several key informants noted that this resulted in much higher payment rates for SEHP compared to the company’s own products. However, during the past year, the SEHP has begun directly negotiating its own rates with selected providers (Fisher, April 20, 2002), culminating in an average physician fee reduction of 7% for the fee schedule that will take effect in April 2003 (Fisher, February 8, 2003). However, the state also has indicated that it may seek bids to award the SEHP contract to another carrier once the current contract expires in 2005, with the expectation of saving up to 20% on physician fees and 10% on hospital outpatient charges (Fisher, December 12, 2002). Whatever impact this might have on BCBSNC’s negotiating ability clearly will occur even without conversion, so we did not explore it further.

Some of those we interviewed felt that the company’s current negotiating approach would not change following conversion. But others thought that BCBSNC negotiators would have personal economic incentives (such as stock options) that would make them less likely to “give” and would induce them to be more aggressive in seeking the lowest rates possible, so the focus would be less on maintaining access and more on the bottom line.

**Contract Terminations and Geographic Coverage**

Some informants felt that, if negotiations became even more strident than they are now, this could lead to increased contract terminations. For physicians, there have been several recent instances of contract terminations for specialties such as orthopedics and anesthesia (at least seven anesthesia groups canceled their BCBSNC contracts in 2002 alone) (Fisher April 16, 2002; Vollmer April 26, 2002). However, similar events have occurred with all the major health plans, not just BCBSNC, and we got no sense that the company sharply deviates from the competition (for better or worse) in this regard. Our interviews indicated that BCBSNC appears to seek a target number of physicians in an area to obtain a marketing advantage with employers and we see no good reason to suppose that this general strategy would be abandoned following conversion.

With respect to hospitals, BCBSNC currently contracts with nearly every hospital in the state. Following conversion, one person felt certain BCBSNC would move in the direction of more selective contracting, pointing to what happened in Virginia following the Trigon conversion.
This was echoed by another person who thought that conversion would lead the company to want to position itself to sell to another entity. Therefore, it would be more interested in strategic relationships with selected hospitals rather than contracting with as many as possible. However, two other individuals thought that BCBSNC will maintain broad provider networks by forming tiered networks that continue to include most or all providers but simply charge patients more or less according to how deep of a discount providers agree to accept. (CIGNA is already planning to introduce something like this in North Carolina and nonprofit Blue Shield of California has already done so, suggesting BCBSNC could move in this direction regardless of conversion.)

Nationally, there has been a trend toward more contract terminations as hospitals have been increasingly assertive about exercising their market power. These are more common in large markets than in medium and small markets, which implies that even if they increase in frequency, this will not usually result in geographic access barriers. Moreover, most of these showdowns were initiated by hospitals rather than health plans. In North Carolina, most respondents reported that they were unaware of any contracts being fully terminated between BCBSNC and hospitals. One major termination occurred in Charlotte in 1998, but that has since been resolved. Others cited several different instances of hospitals giving termination notices, followed by adverse publicity and subsequent resolution of the impasse before patient services were disrupted.

Most North Carolina hospital executives thought it likely that conversion would result in more of these hardball or protracted negotiating sessions. In some other states where Blue Cross plans have converted, especially California, we heard a number of instances of hospital contract terminations that resulted in disrupting patient care. In fact, WellPoint has been sued by the California Medical Association alleging that it has jeopardized the quality of patient care in pursuit of profit. However, we heard different accounts of which side was at fault, and whether this was due to conversion or was the result of market turmoil that would have occurred in any event. Also, complaints of this nature were not registered very strongly in Georgia and Missouri.

Regarding geographic coverage, several interview subjects suggested that as a nonprofit company, BCBSNC now gets pressure to operate statewide, but as a for-profit, the company may become immune to such pressure, resulting in gaps in rural markets. It is true that, as a not-for-profit, the company has some flexibility to consider a service mission when making its contracting decisions, whereas as a for-profit it would have to behave in such a way as to maximize profits. Moreover, what happens following conversion will depend on the company’s strategic orientation, which in turn may depend on whether it is acquired and the orientation of the acquirer. For example, national studies show that managed care plans generally contract with fewer than half of all hospitals in their markets (Feldman et al., 1990; Zwanziger and Meirowitz 1998). But such a change in orientation could occur (as it did for BCBSNC for a period in the 1990s) regardless of conversion. More likely, however, the available evidence suggests that BCBSNC is not likely to change its basic orientation toward statewide coverage, and there is little or no evidence that this has occurred in other states following BC conversions. In Georgia, for example, physician and hospital contracts for both PPO and HMO products roughly doubled

87 For a more thorough account consistent with our research, see Delmarva Foundation 2003.

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following the company’s conversion in 1996; BC of California also has seen a general rise in its physician and hospital contracts for PPO and HMO products between 1994 and 2000. At worst, converted Blues plans in some other states have withdrawn their HMO products from rural counties, but have not completely exited these counties. Also, there are differing accounts as to whether this was initiated by the Blues or the result of dominant providers refusing to enter into HMO contracts with any insurer. In counties with more than one hospital, tougher negotiations may result in contract termination for one hospital, but there still would be alternatives for patients. Thus, the likelihood of serious holes developing in BCBSNC’s basic network seems remote, even if it were to base contracting decisions entirely on business considerations rather than also considering its historical service mission.

Constraints on BCBSNC’s Bargaining Power

Our interviews revealed several important constraints that would limit BCBSNC’s negotiating behavior if BCBSNC were inclined to change. First, it does not appear to be in BCBSNC’s general interest for it to push so hard that it has to leave a geographic area entirely. Stranding BCBSNC customers without adequate access to local providers would give people a strong motivation to switch to a competing insurer. As a general proposition, BCBSNC has achieved some of its market dominance precisely because of its broad provider networks. Therefore, it seems unlikely the company would readily forego an advantage that permits it to differentiate itself from the competition simply as a result of conversion. Indeed, BCBSNC’s growing national account business makes it increasingly important to maintain a presence statewide. In an instance where hospital survival might be at stake, BCBSNC would be better off, generally speaking, to just allow higher reimbursement rates and pass on this cost to customers. Within reason, most patients would rather pay somewhat higher premiums than to have to travel longer distances for hospital care. However, a key informant noted that an alternative to having providers under contract in every county would be to simply rent a PPO network in the counties where there are no contracting physicians.

BCBSNC’s ability to pass provider costs through to subscribers is enhanced by its use of county-specific geographic rating factors. This allows it to increase rates in one county if needed without making its products less competitive in other counties. A similar strategy mentioned above would be to form “tiered” networks that pass on higher provider rates in the form of increased copayments or deductibles. Thus, given the stark choice between accepting a higher-than-desirable increase in reimbursement rates or not contracting at all – thereby giving customers a much stronger motivation to switch – BCBSNC may be more likely to “blink” in contract negotiations than to accept a hole in its network. So while it is conceivable that a

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89 The empirical literature shows that the single most important predictor of which PPO a person picks, among individuals permitted to choose, is whether the PPO includes in its network that person’s previous source of care (Hosek and Marquis 1990).
90 We heard several different accounts of providers resorting to “hardball” tactics, such as informing their patients that they might have to switch plans if an agreement is not reached, which triggered protests to BCBSNC that ultimately culminated in its backing down.
more aggressively profit-oriented Blue might result in more providers refusing to contract, it is not likely this would lead to entire areas without coverage.91

BCBSNC’s bargaining power is also constrained by providers’ own market power and their ability to rely on other sources of payment. National studies show that an insurer’s leverage is directly proportional to its share of hospital bed days (Melnick et al. 1992).92 We showed in Section III that BCBSNC’s share of hospital revenues in absolute terms is relatively small, amounting to only 8% of charges on average and only occasionally straying into double-digit levels. However, as a share of private third party revenues, BCBSNC’s leverage appears more substantial, averaging more than one-quarter statewide and approaching one-third in hospitals that are not part of hospital systems and therefore presumably more vulnerable to BCBSNC market power (recall that less than one-third of total beds fall within such non-system hospitals). However, national data also show that in areas where a large share of an insurer’s patients rely on a single hospital, the plan generally pays higher prices. Moreover, prices are even higher in instances where the hospital market is more concentrated, such as a rural county with only one hospital. A national study has shown that, in areas with a single hospital, hospital costs grew 8.5% a year in markets with high HMO penetration and 15.5% in markets with high PPO concentration; in contrast, areas with two competing hospitals saw costs decline by 3.4% in high HMO markets while increasing only 3.9% in high PPO markets (Morrissey 2001). In Section III, we showed that nearly two-thirds of the beds in non-system hospitals were in counties with only one hospital. According to the national evidence, these facilities are most able to resist BCBSNC market pressure.93

National trends also suggest that hospitals’ negotiating leverage has increased significantly due in part to an increase in consolidation in recent years (Devers et al. 2003). As illustrated by the consolidation that has occurred in the North Carolina hospital industry, documented in Section III, we have no reason to suppose the story is any different here. For physicians, although we do not document the extent of integration among physician groups in North Carolina, nationally the formation of larger physician groups, especially among specialists, and vertical integration between hospitals and physicians, has been another important factor that has increased physicians’ market power vis-à-vis health plans elsewhere in the country. Anecdotally, there is evidence that this is occurring to some extent in metropolitan areas of North Carolina as well.

Another factor that gives providers an advantage in metropolitan areas is that large employers often side with providers since they don’t want their employees to experience a disruption in service, thereby undercutting a plan’s ability to maintain a tough posture (Devers 2003). As one example cited in our interviews, High Point Regional Hospital was said to have gone “eyeball to

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91 In discussions with BCBSNC managers, they noted that their decision to market in a given area is driven by the availability of a reasonably-priced provider network. If provider payments are too high, coverage may cost so much that it may not be worth marketing.

92 However, an earlier study found no relationship between hospital discounts obtained by BCBSNC plans and their share of a hospital’s total business (Staten, Umbeck and Dunkelberg 1988).

93 We did not calculate hospital market power using the traditional Herfindahl-Hirschman Index (HHI) because there is controversy about the extent to which this is a meaningful measure of concentration in the hospital market (Schramm and Renn 1984).
eyeball” with BCBSNC, which “ultimately blinked.” The hospital was thought to have gotten the upper hand by garnering the support of the community and employers. Similar recent examples were given in other parts of the state.

Finally, the regulatory framework in North Carolina with respect to network adequacy gives providers with large market share a strong countervailing lever since, if there are not sufficient providers of a particular type under contract in an area, subscribers may not be required to bear any additional expense for services rendered by non-contracting providers. This has played out most vividly in the case of anesthesiology groups which, in several areas of the state, represent the only locally available providers (Fisher 8/23/02). Because of this rule, providers with a large local market share have strong bargaining power to limit how much of a discount, if any, they need to give to any insurer.

**Particular Contracting and Payment Practices**

*Most-Favored Nations (MFN) Clauses*

We also inquired into a variety of more specific contracting and payment practices. One of these is the use of most-favored nations (MFN) clauses, which require providers to give an insurer their best price or deepest discount. When used by a dominant insurer, these clauses are controversial, and may be susceptible to legal challenge, since they make it more difficult for a smaller insurer to gain a foothold in the market. Providers may sometimes be willing to give a lower rate to a smaller insurer if this doesn’t affect a lot of their business, but not if an MFN clause requires them to extend the same discount to their largest payors. Insurers, for their part, claim they are simply trying to ensure they get the best available price and are on equal footing with competitors.

It appears that MFN clauses currently are not used in most of BCBSNC’s contracts with physicians. BCBSNC states that it asks for this clause only when a physician wants a large payment increase and the company wants to make sure the same rate increase is being applied to its competitors. These clauses do exist, however, in many hospital contracts with BCBSNC. However, many hospital executives reported that they are able to negotiate this clause out of their contracts. Regardless of whether these clauses exist, some observers noted that, as the market leader, BCBSNC is usually able to obtain the best available discount, since most hospitals won’t give competitors any greater concession than they give to BCBSNC. Where MFN clauses exist, they are seldom or never enforced aggressively. BCBSNC has informed us that, at least in recent years, it has not resorted to an outside auditor to enforce this provision; instead it relies on a pledge by the CFO that the hospital is in compliance.

Nevertheless, we saw some evidence these clauses may be inhibiting competition, to some degree. Although no hospital administrator reported having heard of MFN provisions being enforced, they said these give the impression that BCBSNC has the upper hand. One rural hospital reported that an MFN clause with BCBSNC prevented it from having the flexibility to contract directly with a large self-insured business, but it did not have the leverage to negotiate

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94 Historically, many BC plans across the country have had MFN requirements, but the terms generally are enforced only sporadically (Grossman and Strunk 2001).
this clause out of its contract. Also, if enforced, these clauses are thought to force hospitals to reveal their rates for other plans, rates that otherwise would be regarded as trade secrets. Opinions were equally divided about whether this situation would remain unchanged following conversion or whether BCBSNC would become more aggressive about insisting on MFN clauses. If so, and if competitive harms were to result, antitrust authorities presumably would have jurisdiction to take corrective action.

**All-Products Clauses**

In our key informant interviews, there were also mixed opinions about all-products clauses that would prohibit providers from signing up only for the most lucrative of BCBSNC’s products and avoiding those with lower fees (typically the HMO products). All-products clauses generally may be viewed as beneficial to consumers to the extent that they expand choice, but they might also be viewed as unjustified use of market power, especially by providers. All-products clauses do not appear to be written into most or any provider contracts with BCBSNC. However, we heard repeated accounts that BCBSNC evidently tries to achieve this same objective through oral negotiations, although with mixed success. Thus, BCBSNC negotiators might ask a provider to sign contracts for all its products and refuse to do any business with the provider unless they can reach agreement on all of BCBSNC’s products. However, BCBSNC apparently does not require providers to sign a written commitment to continue doing this in the future. In some markets, hospitals evidently are able to participate only in selected products such as PPOs and not sign HMO contracts. However, physicians complained that BCBSNC has been able to very effectively leverage the relatively generous payments provided by the State Employees Health Plan, which it administers, to obtain much deeper discounts for its own Blue products. In other words, physicians say they are not permitted to sign up exclusively for the more generous state employees plan, but must also participate in BCBSNC’s PPO network.

According to other accounts, there are not serious problems of this nature. Some observers thought that payment rates are essentially the same for all lines of business, so there would be no great advantage or disadvantage to being in some versus all of BCBSNC’s networks. Even if there is a disadvantage for providers, others noted that other major health plans use the clauses even more aggressively, and questioned whether this was anticompetitive. Many experts view all-products requirements as beneficial to the public interest in terms of maximizing choice and maintaining geographic coverage. In any event, there was no consensus about whether conversion would tend to increase or decrease the use of all-products clauses or contracting strategies.

**Hospital-Based Physician Provisions**

BCBSNC’s managed care contracts include a provision to encourage hospitals to convince their hospital-based providers such as anesthesiologists to sign BCBSNC contracts. If hospitals fail to do so, BCBSNC is permitted to deduct from its hospital payments any excess costs resulting from failing to have contracts with these physicians. According to BCBSNC, only 15-20 hospital contracts now contain this provision, and hospitals say they are often able to negotiate out of including these provisions. But in light of the growing number of anesthesia practices

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95 This applies to anesthesiology, radiology, pathology, emergency medicine, neonatology, and other specialties.
refusing to contract with BCBSNC, the company may become more insistent on including these provisions. If BCBSNC were to pass some of the savings along to patients in the form of reduced premiums or out-of-pocket expense, the public interest would be served by allowing BCBSNC to try to secure the participation of hospital-based physicians.

**Contracting Hospital Agreement**

One issue we heard about repeatedly in interviews with hospitals is the negotiating advantage BCBSNC has by virtue of the detailed hospital financial data it has access to that no other competitor does. This stems from a Contracting Hospital Agreement (CHA) that has been in place since the 1970s between BCBSNC and all of its contracting hospitals. This agreement, negotiated at a time when BCBSNC’s board was still controlled by providers, calls for BCBSNC to serve a quasi-regulatory function of ensuring that hospital charges are reasonable. This arrangement arose at a time when indemnity insurance that paid actual hospital charges prevailed, as contrasted with the current situation where hospital payments are negotiated. Each time a hospital requested an increase in its charges, BCBSNC essentially audited its financial records to see if the increase was justified by its costs. Now that indemnity insurance has all but disappeared and hospital rates are negotiated at arms length under managed care contracts, hospitals complain bitterly that this antiquated agreement gives BCBSNC unfair access to their confidential business and financial records. BCBSNC for its part claims that it separates its managed care contracting division from its hospital auditing division so that the information is not used inappropriately.

To defuse this controversy, BCBSNC began phasing out the CHA in July 2002 and replacing it with a new Hospital Participation Agreement (HPA). As existing managed care contracts expire, they are replaced by HPAs. The new hospital agreement does not require submission of detailed cost data, but instead only abbreviated charge data (similar to that obtained by other carriers). BCBSNC has made two important commitments in writing:

- to allow hospitals wishing to do so to move to the new agreement prior to their regularly scheduled renewal dates (subject to reasonable limits on the capacity of BCBSNC’s hospital contracting team to conduct these negotiations, and assuming that both parties can reach agreement on all contract terms, including payment terms).
- prior to execution of a new hospital agreement, hospitals with BCBSNC contracts under both CHA and managed care agreements have the option, as they have had for some time, to submit to BCBSNC abbreviated financial information (similar to the abbreviated charge data required by the new agreement but slightly more detailed) if these hospitals agree to include in the managed care contracts terms that allow BCBSNC to reconcile the impact of any hospital charge increases on BCBSNC payments for its managed care subscribers.

**Unfair Payment Practices**

Finally, no concerns were voiced about payment delays following conversion, but it should be noted that the empirical analysis done for the CareFirst conversion found that, following conversion, BC of California paid claims somewhat more slowly than before conversion (.85

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96 The following is only a summary of the exact commitment contained in a letter of October 8, 2002 from Maureen Kelley O’Connor to Mark Hall, which is reprinted in Appendix D.
In the latest year for which data were available (Feldman, Wholey and Town 2003), consistent with their general finding that for-profit conversion among HMOs results in a slight slow-down in payments. Some of these historical problems may be mitigated, however, by more recent state legislation regarding payment practices by all health insurers.

Complaints were voiced in North Carolina interviews about a variety of miscellaneous payment practices that providers claim are unfair. In general, we do not consider these to be major public interest issues relating to conversion since: (a) they have arisen while BCBSNC was not-for-profit; and (b) they are not unique to BCBSNC or to for-profit insurers. Also, the Department of Insurance and other authorities have mechanisms to consider such complaints as they arise. Nevertheless, for sake of completeness, we will summarize these issues:

- Some hospitals view it as unnecessarily complicated and unfair for BCBSNC to use the All-Patient DRG system rather than Medicare DRGs for hospitals, and feel that the All-Patient DRG system is a “black box” that allows BCBSNC to arbitrarily change weights at any time without notice. Moreover, even though Medicare coding has been the de facto standard, hospitals can find themselves denied payment or having to accept a lower payment because Medicare codes were mistakenly used instead of All-Patient DRG codes etc. One hospital hired a firm to examine its claims so that it could understand exactly why payments were so often lower than expected.

- Some providers alleged that BCBSNC uses its “Claim Check” software to deny or delay legitimate claims and that it demands retrospective refunds for services rendered up to three years earlier.  

- Some providers dislike that BCBSNC eliminated or scaled back its predetermination program, which provided prospective advice about coverage for services, since this results in greater uncertainty about whether a service is covered and consequently, more coverage denials.

- Some providers also alleged that BCBSNC refuses to accept valid assignments of benefits and that it requires patients to give written authorization for appealing payment denials even when patients have no financial stake in the outcome. (The first problem was partially addressed in June 2002 with a Department of Insurance ruling that prohibits insurers from refusing to honor assignments of benefits to non-network providers, in situations of inadequate network coverage).

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It should be noted that two-thirds of all health plans across the U.S. use either ClaimCheck or similar software to detect claims errors (Martinez 2002).
IX. Other Potential Impacts

This section concludes our analysis of the potential impact of BCBSNC’s conversion by addressing other more intangible potential effects on the company’s political and social orientation, assessing the public benefits arising from higher tax revenues and Foundation funding, noting the possible effects of future acquisitions made possible by conversion, and concluding with some broad evidence from other states.

Political and Social Orientation

In addition to the particular areas of concern addressed so far, we inquired more broadly into whether conversion might affect positively or negatively the role that BCBSNC plays in the political, community and public policy arenas generally. BCBSNC is the single most influential private institution in the state’s health care delivery system and it is the only full-service nonprofit health insurer in the state. According to many of our interviews, BCBSNC also wields considerable political power within state government. If conversion were to produce a major change in its orientation toward health care public policy issues, this could have a significant, and perhaps profound, effect on the future course of public policy in the state.

Similar issues arise in the regulatory arena. Several national experts expressed the view that it is “easier to regulate” nonprofits and to “get them to work for the public good,” since you can “ask more of nonprofits” regarding pricing and access for vulnerable risk groups. One pair of experts, who have researched health insurance markets nationally, reported that BC plans “find themselves balancing the demands of being a good corporate citizen against the pressures to enhance margins. . . . Plan respondents felt that the public and regulators still have an expectation that the Blues serve the community in ways other plans are not expected to, albeit in more informal and ad hoc ways than in the past. . . . For example, several plans noted regulators’ expectations that the Blues accept the enrollees from plans that have gone bankrupt. While thesePlans have generally complied, one of them said that they now only do so when it is in their financial interest”(Grossman and Strunk 2001). The question, then, is whether a converted BCBSNC will continue to be as amenable to this kind of pressure or persuasion.

In Missouri several interview subjects noted that, following conversion, the BC plan there became much less socially oriented in its legislative and public policy positions. Missouri regulators said that BC began to oppose them more often and actively on various regulatory and legislative issues. Consumer advocates agreed, noting that at one time BC was the only major insurer to “come to the table” to discuss systemic reform such as solutions to the uninsured or the problems created by risk segmentation; however, now it is like any other commercial insurer that just looks out for its own interests in the public policy arena and tries to protect its ability to make money. One seasoned advocate was especially forceful in his view that conversion was a very discouraging “watershed” event that ratified or cemented the flaws of the current system and “gave up the ghost” of any realistic hope for systemic or fundamental reform.
We heard a different account in Virginia (prior to the Anthem acquisition). There, one observer said that BC is very conscious about how it is viewed from a political standpoint by the public, the press, and regulators, which constrains its behavior to some extent. Several people thought that BC is still active in trying to craft workable solutions to public policy and regulatory issues in Virginia. However, one patient advocate expressed the view that BC in Virginia does not “really care what people think because they don’t have to” due to their size. Another said that BC projects an “arrogant” attitude in which it “like[s] to be perceived as caring about the community,” but the perception does not reflect reality.

In North Carolina, several people interviewed noted that, on occasion, BCBSNC has “broken ranks” with the rest of the industry to either support, or to agree not to oppose, patient-oriented legislation. An example mentioned more than once is BCBSNC’s support of the managed care patient bill of rights, even though it contained a managed care liability provision which most other insurers adamantly oppose. One prominent patient advocate thought that BCBSNC has always been willing to at least talk about public policy options for the uninsured, and that, generally, BCBSNC has held somewhat more progressive positions in these discussions than most other insurers.

Another example given in one North Carolina interview is the perception that BCBSNC has been somewhat more willing than other insurers to apply mandated benefit laws to large self-insured employers who are not subject to these laws. This person felt that, perhaps, this is because BCBSNC is subject to some degree of governmental or societal pressure due to its unique corporate or regulatory status. He “wondered” whether this same “leverage” would exist after conversion.

However, some North Carolina subjects had strongly worded views about the “very negative force” and “detrimental role” that BCBSNC has played in leading opposition to legislative initiatives such as a mental health parity law. Others were not so harsh in their criticism but still agreed that BCBSNC usually is “not on the side of angels” and that it formulates its legislative positions for strategic business reasons, not “out of the goodness of its heart” or with any sense of a social mission. In 1998, the Department of Insurance fined BCBSNC $300,000, one of the largest fines in history against a North Carolina health insurer, for failing to cooperate with regulators. Another example, cited several times in interviews, is BCBSNC’s consistent opposition to the creation of an industry-funded high risk pool. One advocate for such a pool suggested that conversion might be good because if BCBSNC no longer had a reduced tax rate for serving a “last resort” role, then it would have less standing to oppose the creation of a high risk pool, which he believes is very much needed due to the extremely high cost of BCBSNC’s Access Plan. However, BCBSNC has not yet offered or endorsed a high risk pool proposal.

Considering these differing views, there is some basis for concern that conversion may affect BCBSNC’s role in political, regulatory, and public policy affairs. It is impossible, however, to gauge the extent of this concern, even in qualitative terms or to determine the extent to which the same concerns would exist if BCBSNC did not convert. Perhaps the best prediction is the view expressed by one local expert, who thought whatever political constraints and social orientation existed prior to conversion would remain in a lesser form, but still to some extent, considering the size, history, and ties BCBSNC has with the community. Therefore, he thought BCBSNC is
not likely to completely abandon its good citizen role and it will probably continue to try to work out acceptable compromises on public policy issues. However, this observer thought that BCBSNC will not “lose money over the long haul to serve corporate citizenship,” and he noted that, if BCBSNC is acquired (which he thought would be likely), the residual political constraints will be less and BCBSNC may be less cooperative or involved in public policy issues. For example, Community Catalyst, a national opponent of BC conversions, has criticized Anthem because, following its out-of-state acquisition of BC in Maine, Anthem began to press the state to loosen its community rating requirement, lengthen the pre-existing exclusion period, and lift the cap on the size of deductibles.

**Increased Taxes and Foundation Benefits**

It has been noted that “health ownership conversions hold out the possibility for unlocking community assets and making them available to finance new socially beneficial initiatives” (Robinson 2000). In weighing the balance of public interest considerations flowing from conversion, it is very important to consider the benefits that will come from the sizeable endowment that would be given to a new Health Foundation for North Carolina, as well as the public benefits that can derive from the additional taxes that a for-profit BCBSNC would pay under current law. The Foundation will receive all of the initial stock of the new BCBSNC; in other words, its endowment would be worth the entire market value of BCBSNC. We have no firm basis for projecting what this value will become following conversion, REDACTED

Under federal tax rules that require private foundations to spend at least 5% of their net worth each year, this could produce roughly REDACTED million in funding each year for the statutorily specified purpose of “addressing the various issues and needs relating to or affecting the health of the people of North Carolina, including, but not limited to, the unmet health needs of underserved North Carolinians.” In addition, under current law BCBSNC would pay roughly REDACTED million more each year in state taxes. However, this amount is not earmarked for any particular state purpose; moreover, the current premium tax differential has steadily eroded over the past 15 years, and BCBSNC itself has expressed the view that the differential may well be eliminated regardless of conversion. If so, then increased taxes would not be a clear-cut benefit resulting from conversion. In contrast, the foundation would be established only if conversion were to occur.

This is obviously a lot of money, and a lot of good can be done with it. According to one leading patient advocate in North Carolina, “the Foundation can provide huge, huge benefits to address the problem of the uninsured,” and a prominent health policy researcher commented that “it is unthinkable that anyone would threaten the creation of a foundation – potentially worth billions dedicated to our most urgent health needs.” In California, where two foundations were created worth over $3 billion at the time, there was widespread enthusiasm in our interviews for the role
these foundations have played in health policy statewide: “absolutely wonderful,” “huge positive benefits,” “major impact.” Some observers noted that, when the foundation is funded by the health insurer’s own stock, this creates a “win-win” situation in which the better BC is at earning profits, the more good the foundation can do because the more its stock is worth. (However, this relationship lasts only as long as the Foundation owns the stock, and it is required by BCBS Association rules to divest itself over a period of 10 years or less.)

Despite the great potential for good by the Foundation, it is not clear that the Foundation’s revenue stream would definitely be enough to directly offset all of the possible affordability and accessibility consequences of the conversion if there were to be no conditions or constraints placed on BCBSNC as part of the conversion. BCBSNC is a very big company; [REDACTED] million per year equates to about [REDACTED] a year for each BCBSNC customer. At the prices BCBSNC currently charges for insurance, this amount could purchase coverage for roughly 11,000 people, depending on what benefit level and risk tier one assumes. This is equivalent to about 0.5% of BCBSNC’s total membership, or less than 3% of its new sales in 2002. In short, the conversion would generate a large amount of money potentially available for offsetting the accessibility and affordability impacts of conversion, but this amount needs to be viewed in proportion to the very large size of BCBSNC and therefore in terms of the relative magnitude of these potential impacts.

A second consideration is whether Foundation funds will in fact go toward improving accessibility and affordability, or instead will be used to promote the health of North Carolinians in other ways that do not directly counteract potential impacts of conversion. The statutory purposes of the Foundation are broad, allowing it to “address[] the various issues and needs relating to or affecting the health of the people of North Carolina, including, but not limited to, the unmet health needs of underserved North Carolinians.” If the Foundation were, hypothetically, to pay the $28 million estimated costs of subsidizing an average-sized high risk pool, this would consume more than half of its estimated funding, far more than any other BC conversion foundation spends on such purposes. In some other states with foundations created by BC conversions, subjects we interviewed commented that the foundations’ missions include improving access for the underserved, but none said this is the primary purpose. That is confirmed by an extensive independent analysis and report, done by the consulting firm LECG for the Maryland Insurance Administrator, which studied all BC conversion foundations in depth (LECG 2003). LECG reported that only a “relatively negligible portion” (1.8%) of BC foundation funding goes “toward programs that provide subsidies for health insurance,” and only one-third of funding directly supports the delivery of care through grants to clinics and hospitals. Most notable is the California Endowment, which has devoted more than $100 million over the past four years to support low income clinics and to help subsidize the state’s high risk insurance pool.

However, these foundations in other states are not viewed as permanent sources of ongoing support for significant numbers of people who cannot afford or obtain health insurance or health care. LECG (2003) found that the bulk of BC conversion foundation funding (roughly two thirds) goes to purposes such as research, public policy advocacy, and education. Likewise, most people we interviewed thought that the primary role of these large foundations is to heighten community awareness of health policy issues, mobilize support for legislative action, fund
research that will generate information and ideas for the public policy arena, and fund pilot demonstration projects. Although these are worthy purposes, their impact is uncertain for alleviating the plight of those who might be displaced by increased premiums or tougher underwriting policies.\textsuperscript{100} LECG (2003) attempted to conduct an efficiency and impact analysis of BC conversion foundation funding, but found that sufficient performance measures were not available to do so. Therefore, it was “unable to . . . demonstrat[e] causative relationships between the activities of foundations (making grants) and improvements in underlying mission objectives (lowering uninsured or improving health statutes),” and it was “not able to conclude that foundations are the optimal models for delivering their actual activities.”

Moreover, other BC conversion foundations have pursued many objectives other than accessibility and affordability. “For example, [these] foundations have moved into areas such as violence prevention, environmental health, youth smoking and substance abuse prevention, and basic research, analysis, and healthcare database development of healthcare information” (LECG 2003). The same is true for hospital conversion foundations, which, according to one national expert, have “redefined themselves to have broader public health purposes than providing direct patient care . . . [or] subsidizing health insurance for uninsured workers and their families” (Kane 1997). In California, some people we interviewed felt that the BC conversion foundations have not made full use of their resources and had little to show for all the money they had spent. One national expert thought that even the “most progressive” or “activist” foundations, by nature, are very conservative about how they spend money because they’re “sitting on a pot of money, and they don’t want to get rid of it.”

In North Carolina, the Foundation’s initial board members are highly qualified, which is reassuring. However, their collective view of the public interest and the Foundation’s mandate may differ from what would be necessary to directly offset possible negative effects of conversion. Some North Carolina subjects were optimistic that the Foundation would provide direct subsidies for health care or insurance coverage for the uninsured, but others were skeptical, saying they had “some lack of trust” that the Foundation will “really do what people say it will do.” One thought the Foundation could get bogged down in bureaucracy, personality conflicts, and “power plays” among board members, or could “spend years” setting up its structure, rules and guidelines, without really doing anything tangible. Another thought a “lot of people” will “question whether it is appropriate” for the Foundation to simply “chip in for health insurance or Medicaid.”

One example close to home of the range of activities funded by health foundations is BCBSNC’s own foundation, which it created about two years ago with an endowment of $15 million and recently supplemented with an additional $20 million. Its largest single grant ($1 million) has been for a “patient-focused assistance program, which will . . . [fund] case management, financial counseling, data management and pharmacy services” at a low-income clinic for the uninsured. However, its other grant activities have pursued broader social, educational, and health promotion goals beyond the delivery of health care. These include assistance for victims

\textsuperscript{100} One observer in North Carolina commented about the California Health Care Foundation that, “in a profound bit of irony, [it] used funds flowing from the conversion in a recent research effort which found that an increasing number of non-poor people in California have dropped or been dropped from health insurance. The money to finance the research was previously available for community rating of insurance premiums.”
of Hurricane Floyd; a domestic violence crisis line; health and safety education for children (including environmental issues, bicycle safety, and nutrition and physical activity education); promoting physical activity through support of high school athletics, YMCA memberships for underprivileged youth, and treadmills for senior citizen centers; support for medical research by sponsoring public fundraising events such as “Race for the Cure” and the “Celebrity Golf Classic”; and support for various community groups and events such as an African-American Male Summit and recognition for outstanding community volunteers and leaders in medicine. Naturally, the much larger Health Foundation for North Carolina could do much more than this, but this is an indication of the range of activities that could conceivably fall within its broad set of purposes.

To the extent the Health Foundation for North Carolina funds “various issues and needs relating to or affecting the health of the people of North Carolina” other than by directly subsidizing the accessibility and affordability of health care, it is difficult to weigh the Foundation’s potential benefits against the potential accessibility and affordability detriments of conversion. This is not meant to detract from the very real public benefits of pursuing other health-related purposes; it is meant only to observe that these broader purposes prevent a comparable “apples-to-apples” weighing of the pros and cons involved in the conversion. Therefore, a reasonable strategy would be to minimize to the extent feasible the conversion’s direct and predictable negative impacts on affordability and accessibility, and then to look to the Foundation’s broad range of potential benefits to offset the less observable, more dispersed, and less preventable impacts of conversion.

**Future Changes**

Another factor in assessing public interest is whether conversion is likely to facilitate a change in ownership and control of BCBSNC, in particular, whether the company is likely to be purchased by a larger out-of-state company. The two leading candidates to pursue acquisition would be WellPoint, which is based in California, and Anthem, which is based in Indiana. WellPoint has acquired the converted BC plans in Georgia and Missouri and had attempted to acquire the plans in Maryland, the District of Columbia and Delaware until the March 2003 decision of the Maryland Insurance Administrator to deny this conversion. Anthem has recently acquired the converted BC plan in Virginia and it owns BC plans in eight other states, mostly in the midwest and northeast. An acquisition by one of these two companies, or a merger with one or more other BC plans, could significantly alter the conversion’s impact on issues relating to accessibility and affordability. This is because the ownership and control of BCBSNC will affect who its managers are and how management and operations policies are determined. If BCBSNC were controlled by an out-of-state firm, it is possible that commitments made by the current management could be altered and that pricing, product, and marketing policies would change. Also, other public policy considerations would enter the picture, such as the possible loss of jobs to other states and the degree of community orientation and focus of BCBSNC. On the other hand, merger or acquisition in theory might improve the company’s performance through economies of scale or access to superior technology.

The possibility of BCBSNC’s sale to an out-of-state company is not idle speculation or paranoia.
Blue Cross scholars note that “the Blues have a number of incentives to expand geographically” (Grossman and Strunk 2001). These incentives will persist over the long term regardless of either the aspirations or stated intentions of current management. Moreover, national experts noted that this is the pattern that has unfolded within a fairly short time in most of the other states where BC plans have converted, including in Georgia and Virginia. Therefore, knowledgeable observers expressed the view that “there is little doubt” BCBSNC would be acquired by, or merge with, a larger out-of-state insurer. One national expert said that it would be “naive” to think otherwise, and that an out-of-state acquisition of BCBSNC could happen fairly quickly following conversion.

This strong possibility led to concerns by a number of people we interviewed that the purchase of BCBSNC could lead to bigger changes than those that flow simply from profit orientation. For instance, two market analysts thought that outside ownership “tends to change” how “community oriented” management is, making them less likely to be “swayed” by local concerns. They felt this can result in a “different perspective” under which management is less amenable to making concessions regarding pricing, underwriting, and maintaining certain risk pools. They said that a locally-owned BC may have more restraint in exploiting market power for pure self-interest, and an out-of-state owner is more likely to exit a market that isn’t performing well. In the view of one market analyst, this local/outside difference is a bigger factor than nonprofit vs. for-profit corporate form in shaping corporate attitudes and policies.

Georgia is the only state where we conducted interviews following an outside acquisition. There, several subjects said that the original conversion had no major impact on BC’s corporate culture and market behavior. However, many felt that the sale to WellPoint has had a discernible effect; for instance, one person said BC became more difficult to deal with and less responsive to working out problems. However, some subjects felt that operations and attitudes are essentially the same under WellPoint as before.

We did not attempt to project the changes that might occur from any acquisition of BCBSNC or merger with a larger company. Therefore, because of the legitimate concerns and uncertainties about how out-of-state control might affect BCBSNC’s operational and management policies, public policy issues, including accessibility and affordability, should receive additional attention in connection with any major transaction in which BCBSNC would relinquish operational autonomy.¹⁰¹

Net Effects of Conversions and Foundations

¹⁰¹ In North Carolina, any acquisition would be subject to approval by the DOI pursuant to the Insurance Holding Company System Regulatory Act, which mandates consideration of the following factors: the competence and integrity of the new managers, the impact on competition, the interest of policyholders, and the public interest. NCGS 58-19-15. In other conversions where the proposed acquirer was known (e.g., Kansas, Carefirst), information about the financial and market performance of that entity were considered in the regulatory review process, including not only standard financial benchmarks, but also the results of market conduct surveys, evidence about consumer satisfaction and past/pending litigation. See PriceWaterhouseCoopers (2002), Kansas Medical Society and Kansas Hospital Association (2002) and Kneedler, Marston and McNally (2002) as examples of this sort of analysis.
One possible way to assess the net effects of all these many factors that bear on the accessibility and affordability of health care is to observe market-wide changes in states before and after BC conversions, controlling for other relevant factors. It is difficult to do this rigorously, however, because BC conversions are so recent and because so many different factors are changing at once. However, data are available for a crude, unadjusted, comparison. Table 9.1 shows per capita health expenditures and uninsured rates statewide, relative to the national average, before and after BC conversions. Unfortunately, the latest state-level spending data end in 1998, precluding an examination of the most recent conversions. Additional complications are created by different definitions of what constitutes a conversion and by the fact that each conversion is somewhat unique. At best, these figures are only broadly suggestive of the possible market-wide effect of conversion, especially since this analysis fails to take account of many other factors that might also account for these trends.
This rough cut of the raw data shows mixed results: the overall situation in some states improved following conversion but worsened in others. Taking California as an example, the state’s per capita health spending was 98.2% of the national average in the five years prior to its 1996 conversion, but this dropped to an average of 90.4% of the U.S. average in the few years for which we have data following that conversion. The ratio of these two figures, 0.92, says that health costs went down by 8% relative to the national average between the two periods. Consistent with that general picture, California also was able to improve about 2 percentage points on the nation in terms of its relative uninsured rate following the BC conversion there. These changes are similar if we date the California BC conversion from 1993, when it created a major for-profit subsidiary, rather than 1996, when the entire company converted.

Clearly one cannot attribute all of these changes to BC conversions, since there are many relevant factors that are not controlled for, such as changes in per capita income and in government programs. However, statewide spending levels decreased about as often as they increased, and more often than not, the uninsured rate improved, following BC conversions in other states. Thus, as best as we can infer from these admittedly crude comparisons, affordability and accessibility do not inexorably deteriorate following a BC conversion.\(^{102}\)

To better isolate the potential effects of conversion from yet another perspective, we conducted a multivariate analysis that statistically controls for differences between states and controls for other factors (such as general economic trends) that are known to influence both health expenditure trends and uninsured rates.\(^{103}\) Using the first conversion definition (became a stock company), we found no significant change in either uninsured rates or in overall inflation-adjusted health expenditures following conversion. However, hospital spending was lower by 1.4% to 2.0% in the first three years following conversion, a statistically significant amount. Hospital spending was no longer significantly lower for year 4 and beyond, however, and hospital profits were not statistically different in any time period. Also, physician spending was 2.1% higher in the year 4-and-beyond period (but not in the prior years).

Our data provide no way of demonstrating whether the temporary reduction in hospital spending results from lower hospital utilization or lower payments to hospitals, but these findings are consistent with our key informant findings that conversion may result in more aggressive bargaining behavior with providers. If this is the case, however, this finding does not provide a basis for determining whether lower provider payments are captured by BC plans as increased

\(^{102}\) This is supported by a systematic survey of the foundations created by BC conversions in other states, in which foundation officials “indicated little evidence that [the conversions in their states] resulted in any major adverse impacts on the relevant populations.” The study’s authors concluded that, “at a macro level, previous BCBS Plan conversions do not appear to have caused massive disruptions in their respective state’s healthcare . . . delivery systems.” LECG 2003.

\(^{103}\) Specifically, our analysis controls for different types of regulation that vary widely across states, including certificate of need and hospital rate-setting, for differences in sources of payment for hospital care (including Medicaid and Medicare), differences in insurance coverage (Medicare, Medicaid and uninsured), differences in HMO penetration and other area characteristics that influence the demand for medical services (per capita income, physician supply, population density, service wages). We also include what are called state fixed effects, that is dummy variables representing each state and each year. As a result, we have controlled for the possibility that states whose BC plans converted were somehow different than those that didn’t. In essence, each state serves as its own control and the net impacts we are measuring can be interpreted as what happened to spending in those states relative to what might have happened absent conversion. Full results are reported in Tables C-9.2 and C-9.3.
profits or instead are passed on to subscribers in the form of lower insurance rates, since this measure of health care expenditures focuses only on providers and not on insurance premiums.

These findings do not necessarily mean that the same results can be expected in any state where conversion occurs since they may be unique to the particular states that converted or the particular time when conversion occurred. We cannot rule out these possibilities since we can control for only a limited number of variables for which objective data readily exist. Another important caveat is that the findings about spending are somewhat sensitive to how we define conversion. When we broaden the definition to include acquisitions by mutual insurers (such as Anthem prior to 2001) and the creation by nonprofit parent companies of large for-profit subsidiaries that issue stock, we see a statistically significant decline in total spending as well as hospital spending, but each occur only in the second year following conversion, not in other years. It is difficult to interpret this mixture of partial effects and non-effects, in some but not all years, that differ by how conversion is defined.

The absence of definitive proof of net harms to macro level indicators of affordability and accessibility statewide does not mean, however, that conversions are necessarily neutral or beneficial. As we have stressed throughout this report, there is a great deal of uncertainty about the actual effects of previous conversions in other states due to the complexity of the issues and limitations in available data. Also, each state is unique, so even if the historical record were clear elsewhere, it is difficult to predict with great certainty what the actual effects will be in another state. Despite these uncertainties, this report presents considerable evidence to help determine which issues are potentially of greatest concern, and which may not be, in North Carolina.