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D U K E

Center for Health Policy, Law and Management

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Peter A. Kolbe
General Counsel
Department of Insurance
State of North Carolina
Raleigh, NC 27611-6387

Dear Mr. Kolbe:

As requested, here are the calculations requested. Table C-7.3AA shows the potential impact of the assumed premium margins postulated assuming this were achieved purely through premium increases. The top third of the table shows without modification the projections reported in BCBSNC Business Plan. In the first alternative, we assume as a base case that BCBSNC retains throughout the projection period the same premium margin actually attained in 2001: 2.6%. Our figures assume that this lower assumed premium margin is attained through BCBSNC lowering its premiums; but our model takes into account the slight lowering of operating expenses that would accompany this change, due to lower commissions paid to brokers and to lower premium taxes (since both are paid as a percent of premiums).

In the second alternative, we assume that BCBSNC increases its premium margin to 6.0% in 2003, but that the margin does not increase after that. In 2002, we assume only a 4.3% margin, based on the actual premium margin BCBSNC reported that year. We again assume these differences from the business plan projections are achieved through increased premiums, but make the parallel slight adjustments to expenses needed to be consistent with the first base case. (In a separate analysis not shown, we found that, if we were to use BCBSNC's actual reported expenses and revenues for 2002 (unaudited) rather than those projected in its business plan, the premium difference reported below would be only $1.1 million lower, which is not substantially different).

In the final row of the table we show the gross premium difference between these alternative scenarios (6.0% margin rather than 2.6% margin). This amounts to $562 million over 5 years. The row immediately above shows how the assumed increases in the premium margin would affect the projections in Section IX of our main report of possible payouts by the Foundation during this same period, assuming the Foundation's value is based entirely on BCBSNC stock. (As stated in our main report, these projections are based entirely on BCBSNC's estimate of the company's stock value after conversion, and are not our own estimates.)[1]

[1] To calculate these payouts, we took into account the Foundation's maximum BCBSNC stock holdings permitted under conversion. Thus, in each year, the Foundation value consists of non-stock assets (i.e., based on stock already sold earlier) and stock assets based on their share of the total value of BCBSNC at that point. Consistent with our

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In Table C-7.3CC, we carry over these estimated premium impacts to ascertain how they might affect particular lines of business. We show the pro rata premium increase that might result in the individual, small group, and Med Supp. lines taking into account the observation of our key informants that BCBSNC is unlikely to be able to obtain an increase in premiums in the small group market that is more than 5% higher than would have occurred anyway due to medical inflation trends. We also assume that the premium increase (over and above what would happen anyway) would not exceed 10% in the individual market. The increase in the Med. Supp. market is the residual after following these two assumptions, and the postulated increases are consistent with the analysis in our main report that BCBSNC has less market power in the Med. Supp. market than in the under-65 individual market.

Based on these assumptions, we then calculate the decline in coverage in these markets and the corresponding increase in average daily uninsured that would result, based on the price-elasticity estimates discussed in our main report. (Even though elasticity of demand increases as prices increase, we use a single average price-elasticity estimate for each market segment, regardless of the premium margin, because there is no published empirical basis for varying the elasticity estimate according to the particular price level.) Using these assumptions, there would be 12,097 more uninsured people on any given day in 2003, which would grow to an average of 13,791 more during 2006. Many of the people who are uninsured in 2006 due to the postulated higher premiums will be different than those who are uninsured in earlier years, but some will be the same, since people tend to move in and out of the ranks of the uninsured.[2] We have not attempted to calculate the total number of individuals who would be affected over time, and it would very difficult to do so accurately. Therefore, we show only the total number of additional people who would be uninsured at each point in time if premiums were to increase by the amounts postulated.

Based on this estimated increase in uninsured, we calculate the added social burden that would be borne by NC citizens in the form of higher taxes and medical costs resulting from greater uncompensated care spending and Medicaid costs related to these individuals. This added spending amounts to $50.0 million over 5 years. An additional social cost (not shown on the spreadsheet) would be the increase in illness and death that results from an uninsured person's reduced access to care. We have not attempted to quantify the morbidity (illness) effects, only the mortality (death) effects. Several studies have documented that uninsured adults face a 25 percent higher risk of death relative to those with coverage. Based on this elevated risk, we would expect to see from 5 to 6 avoidable deaths each year from the postulated premium increases in 2003-2006 (and 2 avoidable deaths in 2002).[3] There is no universally accepted way

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report, we continue to assume the Foundation pays out the legally required minimum of 5 percent of the value of all assets.

[2] See Congressional Budget Office. *How Many People Lack Health Insurance and For How Long?* Washington DC: Congressional Budget Office, May 2003.

[3] This is based on an estimated 1 death each year per 2,323 average daily uninsured, which is calculated from the 18,314 excess deaths among the uninsured age 25-64 in 2000 reported in Institute of Medicine. *Care without Coverage: Too Little, Too Late*. Washington DC: National Academy Press 2002, divided by 42,554,000 average daily uninsured reported in the March 2000 Current Population Survey (see "Table A. People Without Health Insurance for the Entire Year: 1998 and 1999 http://www.census.gov/hhes/hlthins/hlthin99/hi99ta.html (accessed May 20, 2003). Although the CPS purports to measure the number without coverage the entire year, the evidence

to place a monetary value on these lost lives, but one method is based on society's willingness to pay to avoid premature mortality, in which case the value of these 5-6 lost lives would be $10-12 million annually (and $4 million in 2002).[4]

All of our sources and methods are fully explained in the footnotes and table notes. This analysis is based on the stated assumptions, some of which are simplifications of a more complex reality.

Mark Hall has reviewed our response and we jointly agree on its substance. Please advise if there is any further information you require.

Best wishes,

Christopher J. Conover
Assistant Research Professor

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suggests that people actually respond as if they are being queried about their coverage on the day they are surveyed (see CBO report in note 1), so the results from March 2000 survey represent a reasonable estimate of the average daily number of uninsured for that year.

[4] This is based on a recent meta-analysis of 203 estimates of the value of a statistical life and represents the current state of the art in terms of valuation of premature deaths. Janusz R. Mrozek and Laura O. Taylor. "What Determines the Value of Life? A Meta-Analysis." *Journal of Policy Analysis and Management* 21, No. 2 (Spring 2002): 253-270.