



THE CITY OF NEW YORK
OFFICE OF THE MAYOR
NEW YORK, N.Y. 10007

EDWARD SKYLER
DEPUTY MAYOR FOR OPERATIONS

May 6, 2008

Honorable Eric R. Dinallo, Superintendent
New York State Insurance Department
25 Beaver Street
New York, New York 10004

Dear Mr. Dinallo:

On behalf of the Mayor, I am transmitting to you the Memorandum Of The City Of New York In Opposition To The Plan Of Conversion Of HIP/GHI, dated May 1, 2008. As you will recall, I testified before you at the January 29, 2008 public hearing. Now that the City has had an opportunity to study many reports and a great deal of data, including the compensation to the CEO of HIP (and the stock options it is reported he will receive which raise independent legal concerns), as well as the substantial records compiled by the insurance superintendents in the four other states – all described in the Memorandum – the City has concluded that the only acceptable outcome of the HIP/GHI pending request is for you to reject the conversion.

We appreciate your consideration of the analysis in the Memorandum as you review the proposed conversion. Please feel free to contact me with any questions or concerns at (212) 788-3191 or eskyler@cityhall.nyc.gov.

Sincerely,

Edward Skyler

NEW YORK STATE INSURANCE DEPARTMENT

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In re

PLAN OF CONVERSION OF HIP/GHI

Pursuant To New York Insurance Law, Article 73

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**MEMORANDUM OF THE CITY OF NEW YORK IN OPPOSITION TO THE
PLAN OF CONVERSION OF HIP/GHI**

Dated: New York, New York
May 6, 2008

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NEW YORK STATE INSURANCE DEPARTMENT

In re

PLAN OF CONVERSION OF HIP/GHI

Pursuant To New York Insurance Law, Article 73

**MEMORANDUM OF THE CITY OF NEW YORK IN OPPOSITION TO THE PLAN OF
CONVERSION OF HIP/GHI**

EXECUTIVE SUMMARY

The conversion to for-profit status of two longstanding, financially stable not-for-profits, Health Insurance Plan of Greater New York (“HIP”) and Group Health Incorporated (“GHI”) (together, “HIP/GHI”), both currently affiliates of EmblemHealth, Inc., will result in a new for-profit insurance corporation, also to be called EmblemHealth, Inc. (“EmblemHealth”), that will have only one goal: to make the largest possible return for its shareholders. *See* Point I.

The HIP/GHI conversion will adversely affect HIP/GHI policyholders and subscribers and will negatively impact on the delivery of health care benefits and services to all New Yorkers. The conversion should be rejected because it will result in lower quality of health care and service, diminished access to care and to insurance coverage at increased cost, a decline in the health of the population, and the weakened financial health of medical providers. *See* Point II.

The adverse effects of nonprofit health insurer conversions have been carefully documented by the insurance commissioners of four states that have considered conversion applications over the past six years. Relying on evidence of those effects, and applying statutes

that, like New York's, required an analysis of how the conversions would affect current plan subscribers and the state as a whole, the insurance departments and courts of Kansas, Maryland, Washington, and North Carolina have all rejected the conversions. In New York, the Insurance Superintendent approved the conversion of Empire Blue Cross-Blue Shield in February 2002, but Empire was a failing company, unlike HIP and GHI, and the Superintendent did not conduct the kind of extensive analysis done by each of the four states that have examined conversion applications since then. *See* Point III.

HIP and GHI argue that to remain financially viable they must become for-profit, and that conversion will be beneficial for their subscribers and for the state's residents, as did the nonprofit insurers that sought conversion in those four other states. On the contrary, HIP/GHI is a highly profitable company, and there is no credible evidence that it will go out of business if it does not convert. Further, the only benefits that are likely to ensue from the conversion will go to HIP/GHI's current officers and directors, not the policyholders or subscribers, and not New York's residents. *See* Point IV.

I. BACKGROUND

HIP and GHI, both not-for-profit corporations licensed under New York Insurance Law Article 43, seek to convert to for-profit status pursuant to New York Insurance Law § 7317. Such a conversion is permitted subject to the approval of a proposed "plan of conversion" by the New York State Superintendent of Insurance. Approval is not automatic, however. The Plan cannot be approved unless the Superintendent is assured that the conversion process will not "adversely affect [HIP and/or GHI's] contractholders or members" or "negatively impact on the delivery of health care benefits and services to the people of the State

of New York.”¹ Accordingly, before a plan can be approved, the conversion’s impact on current policyholders and enrollees of HIP and GHI programs, and the conversion’s effect on all New Yorkers, must be examined.

The conversion will result in a Delaware for-profit corporation.² The Plan includes the transfer, in two or more sales of stock, of 100% of the entire fair market value of HIP and GHI, 90% to the New York Public Asset Fund and 10% to the New York State Health Foundation. However, nothing in the Plan prohibits the new for-profit from issuing additional shares of stock and thereby diluting the value of the shares that New York may continue to hold.

The conversion will fundamentally shift GHI and HIP’s legal obligations from doing what is best for their members and the public generally, to pursuing the largest profit possible. GHI currently has a “single overriding mission,” namely “to provide affordable, quality health care to all New Yorkers.”³ HIP’s mission is to “provide quality health care to persons of moderate income.”⁴ These mission statements flow from the obligation of directors of New York nonprofit corporations to engage in a charitable enterprise.⁵ In contrast, the directors of a Delaware for-profit corporation are required by law to “maximize the long-run interests of the corporation’s stockholders,”⁶ even if the profits must come “at the expense of others.”⁷

¹ N.Y. Insurance Law §7317(b); *see also Consumers Union of U.S., Inc. v. State*, 5 N.Y. 3d 327, 359 (2005).

² *See* PLAN OF CONVERSION OF THE EMBLEMHEALTH COMPANIES TO FOR-PROFIT STATUS 23-24, *available at* <http://www.ghi.org/default.aspx?Page=607> (last visited Mar. 26, 2008) [“Plan of Conversion” or “Plan”].

³ HISTORY OF GHI, <http://www.ghi.com/default.aspx?Page=9> (last visited Mar. 26, 2008).

⁴ HISTORY OF HIP, <http://www.hipusa.com/visitors/history.asp> (last visited Mar. 20, 2008).

⁵ Charitable organizations in New York must “benefit the public.” *In re Application of Howard Beach Appeal Fund, Inc.*, 141 Misc. 2d 735, 737 (Sup. Ct., Queens Co. 1988).

⁶ *Katz v. Oak Industries*, 508 A.2d 873, 879 (Del. 1986). *See also Dodge v. Ford Motor Co.*, 170 N.W. 668, 684 (1919) (“A business corporation is organized and carried on primarily for the profit of stockholders. The Powers of the directors are to be employed for that end.”).

⁷ *Katz*, 508 A.2d at 879.

II. THIS CONVERSION WILL CAUSE MULTIPLE HARMS TO SUBSCRIBERS AND THE PUBLIC

The HIP/GHI conversion will adversely affect the policyholders and subscribers of HIP and GHI and will negatively impact on the delivery of health care benefits and services to all New Yorkers. The conversion should be rejected because it will result in lower quality of health care and service, diminished access to care and to insurance coverage at increased cost, a decline in the health of the population, and the weakened financial health of medical providers.

a. Conversion Results in Reduced Quality of Care and Service

A large body of evidence shows that the quality of care for plan subscribers markedly declines following a conversion to for-profit status. Several studies have compared the quality of care offered by for-profit and nonprofit health plans. In nearly every study, the nonprofits performed better, and in many cases the difference was significant.

One large study, published in *Health Affairs*, examined the consumer satisfaction ratings of 82,000 Medicare managed care enrollees and found that the strongest predictor of plan performance was for-profit status: “[F]or-profit health plans had significantly worse scores on ratings of care, [quality of] specialists, and the plan [as a whole].”⁸ The study also found that voluntary disenrollment rates in for-profit plans were twice what they were in their nonprofit counterparts (14.7 to 7.7 percent).⁹

A second study, published in the *New England Journal of Medicine*, found that patients in nonprofit HMOs were more likely than those in for-profit HMOs to be very satisfied

⁸ BRUCE LANDON ET AL., *Health Plan Characteristics and Consumer Assessments of Quality*, 20 *HEALTH AFFAIRS* 274, 281 (2001).

⁹ *Id.*

with their overall quality of care. The same study showed that sick enrollees in for-profit plans were more likely to report delayed care and unmet medical needs.¹⁰

A third study, published in the Journal of the American Medical Association, compared 329 plans and found that for-profit plans were “consistently associated with reduced quality of care.”¹¹ The authors concluded that the “drive for profit is compromising the quality of care, the number of uninsured persons is increasing, those with insurance are increasingly dissatisfied . . . and costs are again rapidly increasing.”¹² Remarkably, for-profits scored lower on all fourteen quality indicators that must be reported to the national Committee for Quality Assurance. These measures ranged from prenatal care and mammography to eye examinations to prevent blindness in diabetics.¹³

Other studies continue to find that nonprofit health plans surpass their for-profit competitors in numerous measures of quality. See, e.g., Mark Schlesinger, *et al.*, “Profit-Seeking, Corporate Control, and the Trustworthiness of Health Care Organizations: Assessments of Health Plan Performance by Their Affiliated Physicians,” *Health Serv. Res.* 2005 June; 40(3): 605–646.

The record from the two hearings conducted by the Superintendent corroborates and buttresses these studies. In New York State “not-for-profit health plans score consistently higher than the statewide average [on quality of care scores] and for-profit health plans, on average, score consistently lower.”¹⁴

¹⁰ HA T. TU & JAMES D. RESCHOVSKY, *Assessments of Medical Care by Enrollees in For-Profit and Nonprofit HMOs*, NEW ENGLAND JOURNAL OF MEDICINE 1288, 1288-93 (2002).

¹¹ DAVID U. HIMMELSTEIN ET AL., *Quality of Care in Investor-Owned and Not-for-Profit HMOs*, 282 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 159, 159-63 (1999).

¹² Id.

¹³ Id.

¹⁴ See Testimony of the Healthcare Association of New York State before the New York State Ins. Dep’t 1, 8, Jan. 29, 2008.

The HIP/GHI Plan does not attempt to rebut these studies or explain why they do not apply to their proposed conversion. Nor does the Plan address the effect on quality of the likely acquisition of a converted HIP/GHI by a national for-profit entity such as United or WellPoint. In the Medicare enrollee study cited above, the second strongest predictor of displeasure with the quality of care received – after for-profit status – is that the insurer is national rather than regional. National companies, and national for-profit companies in particular, were viewed as providing a poorer quality of care.

This finding is directly relevant to the proposed conversion: while the HIP/GHI nonprofit boards have expressed a future intention that the converted entity remain a New York company, conversion is in fact likely to be followed by acquisition.¹⁵ A recent study found that “[m]ost of the regional HMOs that had converted to for-profit status have been acquired” by national for-profits. In North Carolina, the insurance commissioner heard evidence that post-conversion, there was “little doubt” that such a buyout would occur.¹⁶ Similarly, the insurance commissioners of Washington and Maryland rested their opinions in part on the likelihood of a subsequent national acquisition and its attendant impact on the quality of care that enrollees would receive.

Indeed, New York State’s experience with the Empire conversion illustrates the point: the newly-converted Empire Blue Cross and Blue Shield was acquired by national insurer WellPoint in 2005, less than three years after its conversion. That outcome was directly contrary to the Superintendent’s expectation, in approving Empire’s conversion, that Empire would use its new power to obtain equity capital to itself acquire other insurance companies and become a

¹⁵ JAMES C. ROBINSON, *“The Commercial Health Insurance Industry In An Era Of Eroding Employer Coverage,”* 25 HEALTH AFFAIRS 1475, 1478 (November/December 2006).

¹⁶ MARK A. HALL & CHRISTOPHER J. CONOVER, FOR PROFIT CONVERSION OF BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA: ASSESSMENT OF THE POTENTIAL IMPACTS ON ACCESSIBILITY AND AFFORDABILITY OF HEALTH CARE. REPORT TO THE NORTH CAROLINA DEPARTMENT OF INSURANCE, IX-7, Apr. 2003.

stronger local carrier.¹⁷ The record also confirms that EmblemHealth is more prone to acquisition than Empire. This is because Emblem Health is smaller than Empire, and there are no limits on potential buyers related to retention of the Blue Cross trademark.¹⁸ Studies also have shown that the quality of customer service for existing subscribers declines markedly following a conversion to for-profit status. In the Medicare enrollee study noted above, for-profit plans had lower scores than nonprofits on various customer service surveys.¹⁹ For-profit subscribers were more likely to face significant administrative barriers in dealing with their insurer than nonprofit subscribers.²⁰ As was the case with respect to quality of care, HIP/GHI offer no contrary evidence, and no studies demonstrate that quality of service improves with the shift to for-profit status.

Thus in New York, as elsewhere, conversion would likely result in a decline in the quality of care and service for plan subscribers. Such a decline adversely impacts existing HIP/GHI enrollees.

b. Conversion Results in Withdrawal From Government Programs and From Insuring Underserved Segments of the Population

As a for-profit plan, HIP/GHI would frequently be forced to resolve tensions between maximizing value for shareholders and keeping its programs affordable to existing subscribers. The law requires that a for-profit entity choose the former. Such choices are bound to adversely affect current HIP/GHI enrollees and the public.

A common feature of nonprofit plans is cross-subsidization: using profit margins of commercial products to extend affordability to other products, such as the State Children's

¹⁷ In the Matter of the Amended Plan of Conversion Pursuant to Chapter One of the Laws of 2002 of Empire Healthchoice, Inc., d/b/a/ Empire Blue Cross and Blue Shield 41 (Oct. 8, 2002) (NY State Dep't of Ins.) (final order).

¹⁸ Testimony of New Yorkers for Accessible Health Coverage by Mark Scherzer, Legislative Counsel, before the New York State Dep't of Ins. 1, 2, Jan. 29, 2008 [hereinafter Scherzer Testimony].

¹⁹ LANDON, *supra* note 8, at 281.

²⁰ TU & RESCHOVSKY, *supra* note 10, at 1289.

Health Insurance Program (SCHIP), known in New York as Child Health Plus.²¹ In the for-profit health care world, cross-subsidization is simply not an option. The CEO of the nation's largest for-profit Blue Cross Plan has stated that cross-subsidization is not something that he believes for-profit companies are permitted to do as a matter of law.²² Thus, post-conversion, some plans have opted out of Medicaid HMOs, and Missouri's converted Blue Cross plan even discontinued maternity coverage.²³

Other states' insurance commissioners have placed great weight on the availability and use of cross-subsidization by nonprofits in their review of proposed conversions, as have the courts. For example, Kansas's Supreme Court upheld the decision of the State's Insurance Commissioner to reject the conversion of that state's nonprofit Blue Cross/Blue Shield, relying in part on the Commissioner's finding that the conversion would necessarily result in an end to cross-subsidization.²⁴

The record before the Superintendent supports the prior studies and predicts that EmblemHealth will also terminate its cross-subsidization practices: While "HIP may be able to sustain itself in the Medicaid program [as a nonprofit],...a private EmblemHealth may...lead to Medicaid beneficiaries losing a reliable source of coverage, [with] fewer choices of insurers and provider networks."²⁵

For-profits are also less likely to cooperate with state regulators in meeting state policy goals, including reducing the number of uninsured in a state. Researchers prepared a

²¹ STEVEN B. LARSEN, REPORT ON THE PROPOSED CONVERSION OF PREMIERA, PREMIERA CONVERSION PROJECT 7, available at http://www.insurance.wa.gov/special/premera/Premiera_Index.asp (citing Testimony of Robert Gray, CFO, Highmark, Inc., before the Penn. Ins. Dept, Sept. 2002).

²² Testimony of Leonard Schaefer, CEO, Wellpoint, Inc., before Md. Ins. Dept., Sept. 2002.

²³ MARK A. HALL & CHRISTOPHER J. CONOVER, *The Impact of Blue Cross Conversions on Accessibility, Affordability, and the Public Interest*, 81 MILLBANK QUARTERLY 509, 530 (2003).

²⁴ *Blue Cross and Blue Shield of Kansas, Inc. v. Praeger*, 75 P.3d 226, 239-40 (KS 2003).

²⁵ Testimony of Consumers Union of U.S. Inc., Before the New York State Ins. Dep't., 1, 7, Jan. 29, 2008 [hereinafter Consumers Union Testimony].

report for the State Insurance Department in North Carolina that concluded it was “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 groups.”²⁶

When New York or the nation moves towards universal health coverage, this could become even more important. Massachusetts’ universal health coverage program relies in large measure on that state’s non-profit insurers.²⁷ It would be ironic if this State approved the conversion of GHI and HIP, only to find its hands tied in achieving the hugely important policy goal of universal health care because the needed nonprofit insurers are no longer in existence.

Finally, HIP and GHI currently offer health insurance products that are available to subpopulations that for-profits do not insure.²⁸ The drive for profits, however, may well lead to changes in benefit designs that would make access to insurance a challenge in the small group market and for lower income families.²⁹

c. Conversion Produces Higher Premiums and Lower Spending on Care

Conversion will almost certainly lead to higher prices for policyholders and members, and reduced spending on medical care, as a result of the pressures on the company to maximize profits and the additional costs incurred by for-profit companies. Moreover, studies have repeatedly demonstrated that the existence of offsetting administrative or other cost savings, resulting from conversion, is a fiction.

EmblemHealth will unquestionably incur additional taxes and costs as a for-profit company, as HIP and GHI acknowledge.³⁰ It will be required to pay New York State income

²⁶ HALL & CONOVER, *supra* note 16, at IX-11.

²⁷ See <http://www.mahealthconnector.org>.

²⁸ NANCY DEAN BEAULIEU, *An Economic Analysis of Health Plan Conversions: Are They in the Public Interest?*, 7 FORUM FOR HEALTH ECONOMIC ANALYSIS & POLICY 129, 133-34 (2004)

²⁹ *Id.* at 138.

³⁰ PLAN OF CONVERSION, *supra* note 2, at 15-16.

tax, whereas currently both GHI and HIP are exempt from such taxes.³¹ It will also be required to pay State and MTA taxes on insurance premiums, approximately 2% of premiums. EmblemHealth also will incur new federal tax obligations, as HIP's revenues lose the benefit of its present federal income tax exemption under §501(c)(4).³² In evaluating the proposed insurer conversion in Washington, Price Waterhouse concluded that the loss of tax benefits that accompany becoming a for-profit "is significant and must be considered...in evaluating the potential negative financial impact to the company, policyholders, and public as a result of the Conversion Transaction."³³ As the reviewing court noted, these additional expenses would have to be "absorbed" and "could add to the pressure that would be exerted...to increase profits."³⁴

As a public company, EmblemHealth also will face new or higher costs for annual listings, auditing, and legal fees. It will have to comply with the Sarbanes-Oxley Act, which according to some estimates has by itself added more than \$16 million a year to the cost of being a publicly-traded company.³⁵

In the face of these higher costs and its need to show profits, a for-profit HIP/GHI will have to raise its prices and reduce its spending on medical costs by lowering its Medical Loss Ratio ("MLR") – the portion of premium revenues that is spent on paying medical claims. On average, post-conversion, the MLRs of for-profit companies are five to ten percentage points lower than those of nonprofit plans.³⁶ In California, of the ten health plans that spent the largest portion of premium revenue on health care, eight were nonprofits. In the Washington State

³¹ *Id.*

³² *Id.*

³³ *Premera v. Kreidler*, 131 P.3d 930, 954 (Wash.App.Div. 2006) citing, *inter alia*, Internal Revenue Code § 833. See also *Consumers Union of U.S., Inc. v. State*, 806 N.Y.S. 2d 99, 112 (2005).

³⁴ *Id.*

³⁵ BRICE DUNWOODIE, *The Cost of Compliance, Sarbanes-Oxley*, CMSWIRE, available at <http://www.cmswire.com/cms/enterprise-cms/the-cost-of-compliance-sarbanesoxley-000474.php> (last visited March 26, 2008).

³⁶ HALL & CONOVER, *supra* note 23, at 522.

conversion proceeding, evidence was presented that as much as 10% of the converted entity's revenues would be shifted from payment for actual health care to other purposes.³⁷ The State Commissioner concluded that a decrease in MLR was likely.³⁸ This finding was upheld by the State's courts on review.³⁹

Even in the limited record developed in this matter, there is evidence that conversion will result in HIP/GHI subscribers no longer receiving the same level of health benefits as when the companies were nonprofits. Specifically, the record demonstrates that “[a]s a for profit company, HIP-GHI would be permitted to spend less of each premium dollar on health expenses and more on marketing, administration and executive salaries and benefits.”⁴⁰

Lowering the MLR means that money now going to provide medical care would instead go to insurance administrative costs and to stockholders. That shift will be harmful to health care delivery throughout New York. Care previously paid for by insurance will go unreimbursed, harming hospital and other providers. Competitors of HIP/GHI may feel emboldened to lower their MLRs as well, knowing a strong competitor is likely to do the same.

Commissioners in Washington, Kansas, Maryland, and North Carolina all thought it likely, based on the available evidence, that the insurance companies at issue would raise their rates as a result of conversion.

HIP/GHI have offered only conclusory, unsupported statements that their premiums will not rise at a faster rate than they would have in the absence of conversion. GHI concedes that they “do not have a comparative premium study comparing products and premiums by line-of-business for periods before and after conversion,” suggesting that no weight

³⁷ HEALTH POLICY ANALYSIS PROGRAM, PREMERA BLUE CROSS'S PROPOSED CONVERSION TO FOR-PROFIT STATUS: KEY ISSUES AND FINDINGS OF EXPERT CONSULTANTS 4 (2005).

³⁸ *Id.*

³⁹ See *Premera v. Kreidler*, 131 P.3d 930, 947 (Wash.App.Div. 2006).

⁴⁰ Consumers Union Testimony, *supra* note 25, at 5.

should be given to their claims regarding premiums post-conversion.⁴¹ However, there is no dispute that all the pressures and expenses that are associated with being a publicly-traded company will be present. Moreover, HIP/GHI have cited as one of the potential benefits of its conversion the ability to expand their coverage area and make additional acquisitions.⁴² Such expansion will impose even more costs, such as the advertising and other costs incurred by entering into a new market. If the converted entity is to not only turn a profit, but turn a profit that grows by the quarter, either rates will have to rise significantly, or benefits must be cut. Either way, HIP/GHI's subscribers are likely to be harmed. Consumers Union, which has been monitoring conversions for more than ten years, testified at the hearing about these bad policy outcomes, and warned that if EmblemHealth's prices increase, prices of its competitors may increase as well.⁴³ If so, health care delivery for all New Yorkers will be adversely affected as well.

d. Conversion Has Negative Impacts on Hospitals and Other Providers

A merged, converted HIP/GHI will be able to exert greater negotiating pressure on health care providers. This tougher negotiating posture means increased costs for non-HIP/GHI customers and perhaps the loss of care for HIP/GHI enrollees. In addition, the lower rates of reimbursement given by converted for-profit insurers place the already perilous fiscal health of hospitals, particularly those serving low-income communities, in greater danger. Thus, both current plan members and New York State residents as a whole will be harmed from conversion.

⁴¹ See Scherzer Testimony, supra note 18, at 3.

⁴² PLAN OF CONVERSION, supra note 2, at 10.

⁴³ See Consumer Union Testimony, supra note 25, at 6; see generally <http://www.consumersunion.org/conv/>.

After nonprofit health plans convert, it is common for providers to begin to “feel the squeeze.”⁴⁴ This is because the merged converted entity has increased monopsony power in the market for the delivery of health care services. A frequent result of increased pressure on providers has been the termination of provider contracts. These terminations cause disruption in the care of plan enrollees, and can cause “critical gaps in the provider network that compromise optimal care or perhaps make insurance unavailable in some regions.”⁴⁵

The risk of provider termination is particularly acute in a state like New York, as such terminations have been far more common in large markets.⁴⁶ California, for example, after its Blue Cross plan converted, suffered several instances of contract terminations that disrupted patient care.⁴⁷ Disruptions were so severe that the California Medical Association filed a class-action lawsuit against the State’s converted Blue Cross Plan for civil RICO violations and various other state law violations.⁴⁸ Strikingly, a 2000 survey of Southern California physicians and hospitals found both groups ranked the former nonprofit far behind plans that retained their nonprofit status on several different indicia of performance. Forty-six percent of all hospital respondents rated the converted plan worst in the state.⁴⁹

The for-profit entity’s likely relationship with providers would be bad not only for HIP/GHI subscribers, but also for health care delivery throughout the State. The reduction in reimbursement rates resulting from conversions has placed a great deal of strain on hospitals,

⁴⁴MARYLAND HOSPITAL ASSOCIATION, CONVERSION IMPACT IN OTHER STATES, Jan. 29, 2002, *available at* http://www.nwfco.org/are_conversions_bad_med.pdf.

⁴⁵MARK A. HALL & CHRISTOPHER J. CONOVER, *For-Profit Conversion of Blue Cross Plans: Public Benefit or Public Harm*, 27 *Annu. Rev. Public. Health* 443, 450 (2006).

⁴⁶ *Id.*

⁴⁷ *Id.* See also, Troy May, *Blue Cross Drops Three Local Hospitals in Contract Impasse*, *San Jose Business Journal*, Oct. 4, 2002 (noting that an average of 45 patients per day would have to seek care elsewhere because of the dispute).

⁴⁸ LARSEN, *supra* note 21, at 38.

⁴⁹ DELMARVA FOUNDATION, *DELMARVA FOUNDATION IMPACT OPINION: THE POTENTIAL EFFECTS OF A CAREFIRST ACQUISITION BY WELLPOINT OF MARYLAND STAKEHOLDERS* 12 (Feb. 2003).

with one study finding that after conversion, hospitals were more likely to suffer financial trouble.⁵⁰ Moreover, the lower rates of reimbursement may reduce the availability of services statewide.

e. Conversion Reduces Funding for Public and Community Health Efforts

Health plans commonly devote some money for outreach aimed at improving the health of the community, regardless of plan enrollment. These important benefits can include safety net services, targeting programs to low-income neighborhoods, and providing charitable contributions.⁵¹ Nonprofits are substantially more likely than for-profits to provide these community benefits.⁵² In contrast, for-profits face legal limits on the amount of corporate revenue that can be donated to charitable causes.⁵³ Should HIP/GHI convert, the loss of the their ongoing contributions will not be sufficiently counterbalanced by the one-time infusion of funds to the New York State Health Foundation as provided in § 7317.

III. ALL FOUR STATES THAT HAVE CONSIDERED CONVERSIONS OF NON-PROFIT INSURERS IN THE PAST FIVE YEARS HAVE REJECTED THEM

Nonprofit health care conversions began in the 1980s. At first, regulators were either unable to stop the conversions or unaware of their deleterious effects.⁵⁴ Most states lacked any statutory authority to stop the conversions and even where such authority existed, there were no empirical data to suggest the conversions would be harmful.

Today, much more is known about what happens when non-profit health insurers convert, and the Superintendent has the obligation to act on that information. Since 2002,

⁵⁰ CHRISTOPHER J. CONOVER ET AL., *The Impact of Blue Cross Conversions on Health Spending and the Uninsured*, 24 HEALTH AFFAIRS 473, 480 (2005).

⁵¹ LARSEN *supra* note 21, at 2, 27.

⁵² M. SCHLESSINGER ET AL., *Measuring Community Benefits Provided by Nonprofit and For-Profit HMO's* 114, 114-132, INQUIRY, Summer 2003.

⁵³ *See Kahn v. Sullivan*, 594 A.2d 48, 61 (Del. 1991) (applying sections of Internal Revenue Code setting maximum deductibility of a charitable donation to determine whether a charitable gift amounted to corporate waste); *Theodora Holding Corp. v. Henderson*, 257 A.2d 398, 405 (Del. 1969) (same).

⁵⁴ CONSUMERS UNION, NONPROFIT HEALTH SECTOR: HISTORY AND TRENDS, (2008), *available at* http://www.consumersunion.org/conv/conversions_101/nonprofit_health_sector_history_and_trends/index.html.

proposals by insurers to convert to for-profit status have been made in four states, and rejected in every one of them. The four states relied heavily on objective studies that found conversions in other states to be harmful to the public interest. Each of the four states rejected the very same arguments advanced by HIP/GHI as to why they need to convert. Specifically, the nonprofits have all argued that a conversion was necessary to “increase risk-based capital,” to improve “products and services,” to support “subscriber growth,” and to operate on a “level playing field.” None of these arguments was found valid in the four states, and there is no evidence to suggest any of these rationales are valid here. Approving the HIP/GHI conversion would be the first such approval since the empirical evidence outlining the harmful impact of such conversions became available.

a. Kansas

In 2001, Blue Cross and Blue Shield of Kansas (BCBSKS) and Anthem Insurance Companies applied to the State’s Insurance Commissioner (now Governor) Kathleen Sebelius to approve a transaction that would have (1) converted nonprofit BCBSKS to a stock insurance company; and (2) sell all BCBSKS stock to Anthem. Under Kansas law, the Commissioner was required to approve such a transaction, known as a sponsored demutualization, unless she found the deal was “unfair and unreasonable to policyholders of the insurer and not in the public interest;” or “the acquisition [would likely be] hazardous or prejudicial to the insurance-buying public.”⁵⁵

After the presentation of more than 75 exhibits, the Commissioner rejected the proposed transaction, holding that the effects of the transaction would fail both tests: it would be

⁵⁵ KS ST § 40-3304.

bad for existing policyholders and hazardous and prejudicial to the insurance-buying public.⁵⁶ In particular, the Commissioner found that as a result of the conversion, premium rates “would rise in the small group and individual markets at a substantially greater pace than would occur otherwise.”⁵⁷ In addition, a study conducted by Price Waterhouse at the Commissioner’s request found that for BCBSKS to achieve its stated goal of reducing medical expenses, it would have to engage in more aggressive contracting with providers.⁵⁸ This practice could have the effect of disrupting ongoing care for plan subscribers, and could also harm the long-term health of the State’s hospitals.⁵⁹

Notably, the Kansas Commissioner also rejected BCBSKS’s arguments about the benefits of conversion, many of which are asserted in the present matter by HIP/GHI. BCBSKS focused heavily, as do HIP and GHI, on the increased access to capital and financial flexibility the conversion would ostensibly bring. The Commissioner, however, found any benefits would “largely inure to the benefit of...investors [in the new for-profit entity], not the policyholders and the insurance-buying public.”⁶⁰ BCBSKS also argued that conversion would allow it to achieve economies of scale and decreased administrative costs, but as the Commissioner noted in rejecting the argument, there was “little financial data” to support it.⁶¹

In a unanimous decision, the Supreme Court of Kansas upheld the decision, rejecting arguments by Anthem and BCBSKS that the Commissioner had misapplied the State’s conversion statute and that there was no support for her conclusion that premium rates would rise

⁵⁶ Executive Summary of the Final Order by the Commissioner of Insurance, In the Matter of the Conversion and Acquisition of Blue Cross and Blue Shield of Kansas, Inc. 1 (Feb. 11, 2002), *available at* http://www.ksinsurance.org/about/archive/bcbs/Executive_Summary_of_the_Final_Order.pdf

⁵⁷ *Id.*

⁵⁸ In the Matter of the Conversion and Acquisition of Blue Cross and Blue Shield of Kansas, Inc. 15 (Kan. Ins. Dep’t Feb. 2002) (final order) [hereinafter Kansas Opinion].

⁵⁹ See *supra* note 50 and accompanying text.

⁶⁰ Kansas Opinion, *supra* note 58, at 25.

⁶¹ *Id.* at 28.

as a result of the Conversion.⁶² The Court found the Commissioner's interpretation of the statute to be reasonable,⁶³ and her factual determinations to be justified. The Commissioner had done exactly what the statute required: "examine the proposed transaction from the perspective of policyholders, the insurance-buying public, and the public interest based on the statute's standards."⁶⁴

b. Maryland

In November 2001, CareFirst, a nonprofit insurer serving populations in Maryland, Delaware, and Washington, D.C., announced its plan to convert to for-profit status and be acquired by for-profit Wellpoint for \$1.3 billion. Maryland law required its insurance commissioner to approve the transaction unless the Commissioner determined that it was "contrary to the public interest."⁶⁵

The Maryland review process was extremely thorough. There were 15 days of evidentiary hearings spanning almost a year. Seven depositions were conducted. Hundreds of documents were obtained by subpoena and multiple document requests.

After this extended process, Commissioner Steven Larsen denied the proposed conversion in March 2003, finding that it was indeed contrary to the public interest.⁶⁶ The Commissioner concluded that Wellpoint had failed to provide sufficient evidence to allow for a full analysis of the conversion's effects on the availability and affordability of health care.⁶⁷

⁶² See *Blue Cross and Blue Shield of Kansas, Inc. v. Praeger*, 276 Kan. 232 (2003).

⁶³ *Id.* at 248.

⁶⁴ *Id.* at 250.

⁶⁵ MD Insurance § 14-133.

⁶⁶ In re The Consolidated Application Conversion of CareFirst, Inc. and CareFirst of Maryland, Inc. to For-Profit Status and the Acquisition of CareFirst, Inc. by Wellpoint Health Networks, Inc. 62-100 (Md. Ins. Administration, Mar. 2003) [hereinafter CareFirst Opinion].

⁶⁷ *Id.* at 210.

CareFirst had failed to take account of the conversion's effect on its mission to "provide coverage at minimum cost and expense."⁶⁸ In thousands of pages of documents related to the transaction, CareFirst's Board had barely referenced the nonprofit's mission.⁶⁹ Further, the purported benefits of the transactions were rejected as largely nonexistent. An independent study conducted for the Commission by Dr. Carl Schramm, a former for-profit health insurance executive, found that there were no economic or business reasons why CareFirst should be converted. Examining several past conversions, Schramm concluded that those transactions had not conferred the benefits that were promised.⁷⁰

The Maryland Commissioner also noted the conflicts of interest facing the CareFirst Board, given that conversion would result in a potential "windfall of cash made available to CareFirst executives."⁷¹ Not surprisingly, the Commissioner believed that such compensation potential was driving the Board's decision-making process.

CareFirst appealed the Commissioner's decision, but pending a decision it reached a settlement under which the conversion did not go forward.

c. Washington State

In Washington, Premera Blue Cross filed a petition to convert, under a statute granting the insurance commissioner authority to deny the petition if he found the applicant's post-conversion plans were "unfair and unreasonable to its subscribers and not in the public interest;" or if the conversion would be "hazardous or prejudicial to the insurance-buying public."⁷²

⁶⁸ *Id.* at 96-98. This mission parallels the missions of GHI and HIP quoted supra notes 3-4, and accompanying text.

⁶⁹ *Id.* at 96-98.

⁷⁰ DR. CARL J. SCHRAMM, BLUE CROSS CONVERSION: POLICY CONSIDERATIONS ARISING FROM A SALE OF THE MARYLAND PLAN 45, Nov. 2001, available at http://www.abell.org/pubsitems/hhs_bluecross_1101.pdf.

⁷¹ CareFirst Opinion, supra note 66, at 192.

⁷² RCW 48.31C.030(5)(a)(4) & (6).

In a detailed opinion, Commissioner Mike Kreidler rejected the proposed conversion, based on findings that have a particular resonance for this matter. First, he found that premiums in the individual and small group markets would increase in those counties where Premera was in a strong market position,⁷³ and that the increase would be unfair and unreasonable to subscribers and hazardous or prejudicial to the insurance-buying public as a whole.⁷⁴ He also found that Premera's medical loss ratio would necessarily decrease as a result of the conversion, which was also both unfair to subscribers and hazardous and prejudicial to the insurance-buying public.⁷⁵ Further, these effects were likely to be exacerbated should Premera be acquired by a national entity, the risk of which was great because the for-profit board "would have a fiduciary responsibility to its shareholders to maximize shareholder value. . . ."⁷⁶

The conclusion that premiums would rise while the medical loss ratio dropped was further buttressed by the likelihood that the for-profit entity would see its taxes rise.⁷⁷ In particular, Premera would lose its federal § 833(b) tax deduction and would face higher state taxes.⁷⁸ The Commissioner concluded that, in light of the higher tax burden and the increased costs of operating as a public company, either premiums would have to increase or reimbursements would have to decrease.⁷⁹

The asserted benefits of a conversion were rejected as "speculative."⁸⁰ As GHI and HIP now urge,⁸¹ Premera argued it should be allowed to convert to a for-profit in order to

⁷³ In the Matter of the Application regarding the Conversion and Acquisition of Control of Premera Blue Cross and its Affiliates 22 (Wash. Dep't of Insurance, July 15, 2004) (final order) [hereinafter Washington Opinion].

⁷⁴ *Id.* at 56.

⁷⁵ *Id.* at 56-57.

⁷⁶ *Id.* at 19.

⁷⁷ *Id.* at 57.

⁷⁸ *Id.*

⁷⁹ *Id.* at 22.

⁸⁰ *Id.* at 21.

⁸¹ PLAN OF CONVERSION, *supra* note 2, at 2 (arguing that because of their nonprofit status GHI and HIP are at a "significant competitive disadvantage").

operate on a “level playing field.”⁸² The Commissioner dismissed this argument, finding that Premera did in fact operate on a level playing field.⁸³ In part this holding was based on the determination that Premera could achieve its objectives, including increased access to capital, without converting to a for-profit.⁸⁴ A review of other nonprofit plans showed that they were able to increase their capital up to 75 percentage points in just one year.⁸⁵ The Commissioner’s ruling also pointed out that Premera could increase its capital via debt financing and investments — being a for-profit was simply not necessary.⁸⁶

Premera appealed the Commissioner’s decision to the State’s intermediate appellate court, which upheld the decision.⁸⁷ In response to Premera’s arguments, *inter alia*, that the Commissioner had “erred in concluding that the conversion will hurt subscribers and the insurance-buying public” and that the Commissioner had “improperly failed to consider the benefits of the proposed conversion,”⁸⁸ the Court stressed that the Commissioner need not “wait until likely future harm to the public appears” and held that his findings were justified as a “preventative.” The Court took particular note of the “considerable testimony to the effect that for-profit converted carriers tend to spend less on medical care as a percentage of their premiums.”⁸⁹ The Court further noted that as a for-profit, “Premera would face the tension of maximizing its stock value for its shareholders and containing premium rates and provider payments.”⁹⁰

⁸² Washington Opinion, *supra* note 73, at 19.

⁸³ *Id.* at 21.

⁸⁴ *Id.* at 20.

⁸⁵ *Id.* at 14.

⁸⁶ *Id.*

⁸⁷ See *Premera v. Kreidler*, 131 P.3d 930 (Wash.App.Div. 2006).

⁸⁸ *Id.* at 933.

⁸⁹ *Id.* at 953.

⁹⁰ *Id.* at 954.

As to the purported benefits, the Court explicitly relied on Hall & Conover's study that found increased access to capital and improved financial flexibility to not be dependent on conversion,⁹¹ and it found the conversion's potential efficiencies to be "general at best."⁹² Thus, the Commissioner had correctly rejected the conversion plan "on the grounds that the plan as a whole was unfair and unreasonable to subscribers, not in the public interest, and likely to be hazardous or prejudicial to the insurance-buying public."⁹³

d. North Carolina

Blue Cross and Blue Shield of North Carolina ("BCBSNC") also filed to convert from non-profit to for-profit status. The plan of conversion was withdrawn, however, on the day that state regulators released a report demonstrating that conversion would lead to a significant rise in premiums and in the number of uninsured in the state over a five-year period.⁹⁴ BCBSNC recognized that an order from the state in its favor would not be forthcoming.⁹⁵ While the North Carolina Department of Insurance did not issue a formal opinion, reports in the press indicate that the Department had the same concerns as those of other states: "[E]very time we'd say, 'Why do you need access to capital? Why do you need more technology? Give us specific examples.' That just didn't happen."⁹⁶

IV. THE REASONS ADDUCED BY GHI AND HIP IN SUPPORT OF CONVERSION COMPLETELY LACK EMPIRICAL SUPPORT

HIP/GHI argue that they must convert to remain financially viable. None of their arguments survives scrutiny.

⁹¹ *Id.* at 955.

⁹² *Id.*

⁹³ *Id.* at 957.

⁹⁴ See *Why Did Blue Cross Change Course?*, THE DURHAM, N.C. INDEPENDENT WEEKLY, July 16, 2003, at 13.

⁹⁵ *Id.* at 14.

⁹⁶ *Id.* at 14.

a. Financial Necessity

HIP/GHI's Plan attempts to make the case that the conversion is necessary to the company's financial health, and therefore that conversion will benefit the company's membership and the state's residents.⁹⁷ That effort utterly fails. To the contrary, facts contained in the Plan show that HIP is thriving financially and that GHI is stable. Absent such financial necessity, it is impossible for HIP and GHI to show that the conversion meets the dual statutory criteria of the conversion.

HIP. According to the Plan, HIP has exceeded its statutory reserve required by the State Insurance Department in every quarter from 2002 to the present. At the end of 2006, it had net assets of approximately \$924.5 million, 260.3% of the required statutory amount. A year later, according to the latest financial report HIP has filed with the State Insurance Department, its net assets have grown to \$993.7 million. Further, HIP's cash assets have increased even while HIP has engaged in a series of acquisitions. It acquired Vytra Health Plans Long Island in 2001, ConnectiCare Holding Company, Inc., in 2005, and The PerfectHealth Insurance Company in 2006. ConnectiCare in turn owns for-profit HMOs in Connecticut, Massachusetts and New York. PerfectHealth provides qualified high deductible health plans, providing HIP with entrée into the health savings account market.

HIP is nothing short of exuberant about its financial health. HIP regards its financial performance over the past three years as so stellar as to warrant a bonus of nearly \$3.75 million to its chief executive, on top of his \$1.25 million dollar salary. Three other top executives saw their compensation approximately double based on HIP's performance.⁹⁸

⁹⁷ PLAN OF CONVERSION, *supra* note 2, at 2-4.

⁹⁸ E.B. SOLOMONT, *HMO Chief's Pay Doubles Pre-Merger*, NEW YORK SUN, Apr. 18, 2008, available at <http://www2.nysun.com/article/74929>.

GHI. GHI is not as cash-rich as HIP but its Preferred Provider Organization (“PPO”) is an exceptionally stable business. Over 60% of the PPO business is retrospectively rated, which limits substantially its insurance risk. Its business with the City of New York, its largest customer, provides it with a virtually risk-free book of business of over 875,000 lives and an administrative fee of over \$134 million.

The Plan reports that GHI has been below its statutory reserves since December 2000.⁹⁹ But over the last few years, GHI has been making up this shortfall, and now, according to its 2007 financial statement, GHI's net assets of approximately \$311.7 million are about \$12 million higher than the required statutory amount of \$299.8 million. Moreover, GHI – like HIP – has been able to acquire other businesses. According to the Plan, it acquired Well Care Management Group, Inc. in 1999 and ABC Health Plans in 2005. Plan, at 11.

b. Preserving GHI and HIP’s Competitive Position

The Plan provides only generalities about the purported necessity for the conversion to preserve the companies’ competitive status. The Plan states:

HIP’s and GHI’s competitors have taken advantage of the restrictions under which HIP and GHI operate through pricing practices, extensive advertising and other competitive pressures, thereby attracting a significant amount of their business.

Plan, at 3. What is missing is virtually any detail. The Plan does not say which competitors attracted how much business from whom, or when any loss of business actually occurred. The Plan repeats similar vague assertions elsewhere. *See, e.g.*, Plan at 13.

The Plan notes that “[w]ell-positioned competitors in the upstate HMO market have limited the growth opportunities of GHI’s HMO subsidiary, GHI HMO,” *id.* at 12, but GHI’s HMO competitors upstate are largely nonprofits. The existence of viable and competitive

⁹⁹ PLAN OF CONVERSION, *supra* note 2, at 12.

nonprofit health insurers elsewhere in the State undermines GHI's claim that it must convert to survive.

c. Legal Restrictions on Non-Profit Insurers

The discussion about legal restrictions on non-profits is equally vague. The single most important change in the competitive environment that the Plan points to was the repeal of a favored payment rate to hospitals for non-profit insurers. *Id.* at 15. But that change occurred in 1997, more than a decade ago. Since then, GHI has been stable and HIP has flourished, hardly painting a picture of a dire necessity to convert to for-profit status in 2008.

The Plan complains repeatedly about HIP and GHI's lack of access to equity capital. *See, e.g.*, Plan 16. But this is a tautological argument. By definition, nonprofits do not have equity, *i.e.*, stock, capital. Absent from the Plan is an analysis of whether equity capital is indeed cheaper than debt. The Plan's argument that equity capital is necessary to acquire other insurers is refuted by the very facts it sets forth, showing that both GHI and HIP have been able to make strategic acquisitions. Moreover, the argument elides the essential question of whether additional consolidation, especially of for-profit entities, is in the public interest.

The Plan's expressed wish to relieve HIP and GHI of administrative expense limitations, Plan at 16, is another aspect that is counter to public policy, which favors monies going to medical providers rather than shareholders or for administrative costs. According to the most recent financial statements submitted by HIP and GHI to the State Insurance Department, their administrative costs are approximately 10.8% and 6.8% respectively. These administrative costs are far lower than their for-profit competitors. That relatively little of health insurance dollars is siphoned off for administrative purposes is a public good. HIP and GHI's wish to be relieved of this limitation is a reason by itself for why the Plan should be rejected.

Similarly, the Plan speaks of restrictions on executive compensation as an undesirable limitation. Plan at 17. Under the Plan, EmblemHealth officers and directors can receive stock options six months after the initial offering, which will enrich the very persons offering the Plan. Worse, stock options will be at the expense of the State because they may dilute the shares that the State will hold under the Plan.

HIP's claim that it faces damaging limitations on executive compensation is belied by the facts. HIP's chief executive received almost \$5 million in compensation last year; three other officers received over \$1.5 million annually.¹⁰⁰ Reasonable limitations on the compensation of officers of nonprofit insurers is a good thing, scarcely a reason to allow conversion.¹⁰¹

d. Spreading Fixed Administrative Costs

Of a piece with its argument that it needs to acquire other companies, the Plan posits that acquisitions of other health plans will allow it to spread administrative costs over more members. Plan at 16-17. But again the Plan is bereft of any specifics, and appears uncertain of its own position:

Spreading fixed administrative costs over a broader membership *may* allow HIP and GHI to achieve higher operating margins and improve their ability to withstand competitive price pressures.

¹⁰⁰ See *HMO Chief's Pay Doubles Pre-Merger*, supra note 98. See also GALE SCOTT & BARBARA BENSON, *HIP Prez Forced Out After Merger*, CRAIN'S NEW YORK BUSINESS, Mar. 24, 2008, available at <http://www.craigslist.com/apps/pbcs.dll/article?AID=/20080324/FREE/424710595/1049/information>.

¹⁰¹ It was recently reported that the current employment agreement of HIP's chief executive grants him an option to purchase 1.2% of the shares that are to be issued on the six-month anniversary of the conversion. See JACOB GERSHMAN, *HMO Chief's Pay Doubles Pre-Merger*, THE NEW YORK SUN, Apr. 24, 2008, available at <http://www.nysun.com/news/20-million-could-flow-hip-ceo>. This right, which is reportedly worth as much as \$20 million, likely violates Insurance Law § 7317, which provides that "The conversion transaction shall not result in inurement to any private person or entity." The applicant's bestowal of such stock options spotlights the question of whether this conversion is in the public interest. Maryland's Insurance Commissioner denied an application for conversion in part because it found that a "windfall of cash...made available to...executives only if [conversion] is consummated" was the very type of payment anti-inurement provisions were designed to outlaw. See CAREFIRST OPINION, supra note 66, at 183.

Plan, at 17 (emphasis added). Not only is there no calculation that expansion will lead to efficiencies, there is also no calculation that even if there were such efficiencies that they would exceed the costs incurred and to be incurred in the conversion, such as accounting requirements or higher taxes.

In fact, there is strong evidence that a converted HIP/GHI would not be able to achieve any benefits from scale. One study has concluded that “economic evidence indicates that economies of scale are not present” when managed care organizations merged.¹⁰² One other study found some efficiency benefits from conversion, but determined that the economies of scale run out when the enrollment of the combined entity would exceed 800,000.¹⁰³ Inasmuch as GHI alone has over 2.6 million subscribers,¹⁰⁴ HIP/GHI would not be likely to achieve efficiencies from a larger subscriber base.

What *is* likely, however, is that the combined entity would find its administrative costs to be significantly higher than expected.¹⁰⁵ In California, a converted health plan was unable to achieve profitability through lower administrative costs, instead seeing those costs increase nearly 15% after conversion.¹⁰⁶ In both Kansas and Washington, the State Insurance Commissioners explicitly rejected arguments proffered by the insurance companies that a conversion would allow the realization of administrative cost savings.¹⁰⁷ These cost increases do not include the higher costs attendant upon being a public company, previously discussed. Because HIP/GHI is likely to find itself needing to cover increased administrative costs, the pressure to derive profits from other areas will only be heightened.

¹⁰² ROBERT TOWN, *The welfare impact of HMO mergers*, 20 JOURNAL OF HEALTH ECONOMICS 967, 984 (2001).

¹⁰³ BEAULIEU, *supra* note 28, at 163.

¹⁰⁴ GHI PLANS, *available at* <http://www.ghi.com/default.aspx?Page=48> (last visited Mar. 20, 2008).

¹⁰⁵ See ALLIANCE FOR ADVANCING NONPROFIT HEALTH CARE, *THE NONPROFIT HEALTH PLAN ADVANTAGE* 1, 1 (Oct. 2004).

¹⁰⁶ HALL & CONOVER, *supra* note 23, at 522.

¹⁰⁷ See Kansas Opinion, at 28; Washington Opinion, at 15.

e. Added Membership

In one of the few specifics presented in the Plan, HIP states that its HMO commercial membership declined by approximately 96,000 during the last ten years, but in the same paragraph it acknowledges that this loss was offset by a gain in government-sponsored programs. Plan, at 3. In other words, HIP, as a nonprofit, is providing insurance to persons for whom the State seeks coverage as a matter of public policy, who otherwise might not be covered. Elsewhere the Plan notes, with appropriate self-congratulation, that HIP and GHI “are two of the few health plans that participate in all government sponsored programs including Medicare, Medicaid, Child Health Plus and Family Health Plus” The conversion endangers, rather than promotes, this participation.

f. Needed Investments

The Plan speaks repeatedly of the need for capital for needed investments in such things as electronic infrastructure. *See, e.g.*, Plan at 17. But again, the Plan is lacking in specifics: what information technology do GHI and HIP need that they do not currently have, or are unable to acquire with current assets and income, or with capital raised from debt if necessary?

In fact, a 2005 survey of national experts found that improved access to capital did not justify conversion where the not-for-profit entity was healthy financially.¹⁰⁸ Most for-profit insurers use major amounts of capital primarily for new acquisitions — not to improve or maintain the existing quality of care.¹⁰⁹ Moreover, much of the capital that is raised by for-profit companies is debt, not equity.¹¹⁰ Non-profits can access capital from debt offerings. Indeed,

¹⁰⁸ HALL & CONOVER, *supra* note 45, at 11.

¹⁰⁹ BLACKSTONE GROUP, ANALYSIS OF CAREFIRST, REP. TO MD. INSUR. ADM. (2002), *available at* <http://www.mdinsurance.state.md.us/sa/jsp/availPubInfo/Reports.jsp?divisionName=Reports&pageName=/sa/jsp/availPubInfo/Reports.jsp>.

¹¹⁰ *Id.*

501(c)(3) nonprofits issue tax-free bonds, and thus raise capital at significantly lower costs than for-profits.

CONCLUSION

If the petition to convert is approved, New Yorkers can expect a decline in the quality of health care provided through the state, the loss of important community benefits, and higher health care costs. HIP/GHI subscribers in particular will also suffer a lower quality of service, the loss of choice with respect to important health care products like SCHIP, possible disruption of medical treatment and significantly reduced spending on health care. Should HIP/GHI be acquired and become a national plan, the aforementioned effects would only be exacerbated.

A conversion to for-profit status would both “adversely affect” HIP/GHI subscribers and “negatively impact” the delivery of health care benefits and service to the people of New York State. The Superintendent should reject the proposed conversion.

Dated: New York, New York
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