

Nonprofit Health Care and Insurance: Protecting the Public Interest

A public forum, “The Role of Nonprofit Health Insurance in New Jersey: Protecting the Public Interest in an Era of Health Restructuring,” was held in Trenton, N.J., on June 20, 2006. Co-sponsored by Consumers Union¹ and the New Jersey Appleseed Public Interest Law Center,² the conference clearly emphasized nonprofit health insurance and the state of New Jersey. However, the various presentations provided, in many instances, a much broader context---the role and performance of nonprofit health care and the nonprofit sector across the United States, and ensuring their public accountability.

Panelists at the forum were:

- **Howard Berman**, chairman of the board of the Alliance for Advancing Nonprofit Healthcare, which was established in 2003 to preserve, and at the same time improve the performance of, nonprofit health care organizations. Berman is also vice chairman, and former president and CEO, of the nonprofit Lifetime Healthcare Companies, which serve most of upstate New York.
- **William J. Marino**, president and CEO of Horizon Blue Cross Blue Shield,

Joel Cantor, director of the Center for State Health Policy at Rutgers University, served as moderator for the forum.³

What follows are edited comments by these experts from the June forum.

Howard Berman

The question of nonprofit versus for-profit ownership in health insurance is drawing significant attention across the country. Importantly, or perhaps confusingly, individual communities have been answering this question differently.

The question is not new. It draws so much interest today because of the number of zeros involved after the dollar sign. Also, like iron filings to a magnet, some legislatures see health insurance reserves and conversion proceeds as irresistible pools of money that they should take--or at least take control of. This is clearest in New York where the state claimed much of the conversion proceeds, not the local community.

The Real Issue

The real question, however, is larger than nonprofit versus for-profit health insurance. The larger question is the role of nonprofit enterprises in our society, and how we assure that they serve the public interest of their communities.⁴

We live in a three-sector economy. Two of the sectors are nongovernmental; the third is government. The two nongovernmental sectors in turn can be divided into a privately owned element and a community-owned component.

The Nonprofit Sector

The community-owned component is more commonly called the “voluntary” sector, or the independent sector, or the nonprofit sector. In our capitalistic economy it is unavoidable that we would be structured into at least three sectors. There are simply things that the private sector --- business --- just won’t do because the profit potential is

inadequate. Similarly, there are things that as a society we do not want government to do. Yet there are some things that still must be done. It is for these needs that we have created a third sector.

Just as society has made this pragmatic and strategic decision, this third sector has made its own critical strategic decision: to be nonprofit. Not that there will be “no profit,” because no profit is a route to extinction. Rather, that it will be nonprofit in the sense that it will not provide a financial return to those who provide its capital.

Being nonprofit is a business policy and operating decision, borne out of an understanding that the profit motive will both distort the organization’s decision making and reduce its ability to maximize its service impact. You may think that being nonprofit is a quaint historical artifact, reflecting the values or even the pressures of an earlier time. If this is your view, how then do you explain that most Blue Cross and Blue Shield plans, despite having to pay federal income taxes, have still elected to remain nonprofit, have been able to generate the capital needed to grow---without converting?

We should also recognize that these three sectors operate along a continuum. Interestingly, it is a circular—not linear—continuum. Along this continuum the sectors also overlap. Sometimes nonprofit enterprises get involved in for-profit ventures. For instance, my health insurer organization, the Lifetime Healthcare Companies, decided in the late 1980s to get into the long-term care insurance business. Long-term care looked like what hospital care must have looked like in the 1930s. The state of New York required that a separate long-term care insurance company be created in the form of a for-profit stock company. As a consequence, Lifetime Healthcare treats it as an investment, with 100% of the investment returns going to support the mission of the nonprofit health plan. Where a nonprofit health care organization gets into a for-profit venture, it should be a social entrepreneurship, where the organization only does things that are close to its knitting and with the understanding that the profits will be dedicated to mission.

Tax Status and Ownership Status

Tax exemption is a red herring that confuses the issue. It is because of tax exemption that government says, “I can claim your resources in light of all the tax benefits the organization has received.” Note, however, that the tax is on profits. If the organization makes no money, it pays no taxes. There are many for-profits that pay very little taxes. The fact that many Blue plans have elected to stay nonprofit despite taxation demonstrates that taxation is not really the critical factor. For nonprofit hospitals, nursing homes, and others having a 501(c)(3) federal tax exemption, exemption from federal income taxes is far less important than the tax deductibility privileges associated with donations and bond financing. Nonprofit health plans do not have, and never did have, the benefit of those privileges.

Any nonprofit health care organization subject to income taxation will want to consider reducing its income level by either providing more community benefits or lowering its premiums.

Nonprofit Health Care Performance

Today, we can see this vividly in the health insurance arena where for-profit and nonprofit health plans compete head-to-head. It is for this reason that we wonder if health insurers should be for-profit or nonprofit, and we ask the appropriate question about which form best serves the public interest.

From my perspective the answer is clear: all things being equal, nonprofit ownership in health care delivery and finance is best for the community. “All things being equal” is obviously a difficult thing to find. However, we have data from New York that shows, at least in a common regulatory environment, that nonprofit health plans perform better than for-profits in terms of having lower administrative costs, a higher percentage of revenues going to pay for medical benefits, and a greater level of participation in safety-net programs.

Others can comment in more detail on nonprofit/for-profit research. The general

conclusion, however, is that while specific exceptions can be found, as a group, nonprofit health plans generally out-perform their for-profit counterparts in terms of clinical quality, member satisfaction, medical benefit payouts, and other benefits to the community.

Can you imagine what our world would look like if our health care system were entirely for-profit, requiring a market rate of return on investment? Would there be greater gaps in coverage, access, and care? Of course there would be. We would see all of our current problems with the uninsured and the underinsured worsening. If we don't believe that it would happen, just look at the reality of Medicare HMO coverage where for-profit carriers have walked away from counties whose payment rates aren't high enough for them. Similarly, look at how for-profits have avoided unprofitable services and communities—both urban and rural.

If we put all our eggs in the for-profit basket, and it failed, would government come to the rescue? I will leave the answer to that question to your own pondering. Similarly, could it come to the rescue? More to the point, would we want it to? The answer here has consistently been “No.” Instead, we would undoubtedly seek to recreate the nonprofit health sector. What we want and what history shows we need is a pluralistic health care financing and delivery system.

Protecting the Public Interest

However, given where we are, for a pluralistic system to work, two things are critical. First, we must avoid using the force of “legislative right of way” to meddle in operational intricacies. Health insurer reserves look to everyone but the bond rating agencies to be huge numbers. In absolute terms they are; in relative terms they are not. When annual premium increases are announced, it looks tempting to attack reserve levels; it makes for a popular headline and attractive political fodder. However, if you attack reserves, you undermine stability. The real headline you create down the road is, “Thousands Lose Health Care.” Who wants to take credit for that headline? If reserves grow too fast, a pluralistic market will correct it - - just as it will correct over-pricing. Someone will

always take advantage of the arbitrage opportunity and price lower.

Secondly, for the nonprofit sector to work, we must make it more accountable for its overall actions and results. It is with some humility that I must admit that the nonprofit sector must do better. It must not simply do better than its for-profit competition because, frankly, that is too low a standard. It must do better for its community, particularly those in its community who cannot advocate for themselves.

This is easier said than done. And because it is so hard to do, it is here where the public interest can and must be protected. The need isn't to cap premiums, as they are currently talking about in California, or to subvert reserves to politically popular causes, or even to create a health care foundation to fulfill a mission that the converting company is willing to abandon. The need is to fulfill the original mission.

You can't expect a conversion foundation to accomplish what its parent was created to do. You can expect the parent to do it. In fact, to demand anything less is to invite failure. So the question should really be: How do we assure that our nonprofit health care system does better? The answer is straightforward, but not necessarily intuitive.

The Role of Governance

Organizations, like fish, rot from the head down. The head of any organization is not its CEO, but rather its board. If we want better performance from our nonprofit health care system, we must demand better governance.

Board members must come to understand that their role is not honorific, that being on a nonprofit board is work, and that this work is doing everything necessary to maintain and enhance the public's trust in the enterprise.

Assuring the public's trust is a stubborn problem. Evidence of this is clear in the public sector, where incumbents nearly always win re-election in spite of the regular calls to "vote the rascals out." It is also evident in the for-profit sector, where regardless of proxy

voting and annual meetings, rejection of board and management initiatives is so unusual that it is newsworthy. The nonprofit sector lacks these “gross” performance safeguards, as well as the additional government and stock exchange regulatory requirements of the publicly traded corporation.

There is no mathematical formula for selecting the right board. What is needed is a good process. A board should have an active governance committee. The governance committee should meet year round as both a nominating committee and an assessment committee. The governance committee should be looking at which board members will be leaving the board and what the needs are, in order to have a planned “harvesting” of board members. It must not be like a federal judgeship---a lifetime appointment. The committee cannot depend on what comes in over the transom. It must actively seek out people, one at a time, to meet the needs of the enterprise.

In structuring the board, diversity of opinion is critical. Not cosmetic diversity, but real, honest diversity of opinion. People are needed who can disagree, without disagreement being viewed as disloyalty. Also, no one can be a representative; effective boards do not have representatives. Boards only have members, whose only obligation is to that enterprise and its mission, and nothing else. When the governor appoints people, a tough problem is created for the rest of the board. To whom are those appointees beholden? Lastly, there must be no built-in conflicts of interest.

Transparency and Public Disclosure

Ultimately, effective nonprofit sector performance can be assured only if board members realize that ineffective performance will be found out.

Visibility is very important, and that is where newspapers, editorial boards, and public forums become involved. The most powerful motivator for nonprofit board members is their enterprise being seen as doing a good job. The worst thing they want is the question, “Aren’t you on the board of the place that just had to declare bankruptcy? What happened?” Nor do they want to have to respond, “I don’t know.” Sunlight is what keeps

everyone honest. If you can't simply explain a situation to an editorial board, and with a straight face, you're not going to want to do it. Real accountability requires a series of checks and balances that help ensure that the organization is doing the right thing. That requires the community to put a spotlight on selected performance measures. The community can't just demand accountability; it must monitor performance.

If chief executives know that boards will be demanding full disclosure and then using that information to carry out their governance duties, the stage will be set for responsive and responsible public action. But boards will only demand and use the performance information if they know that they must share it with the community through the timely public reporting of understandable performance data---and then, most importantly, requiring the personal signing of such mission-based reports by directors, who attest to their validity and reliability. In this way, boards can be held publicly accountable for the performance of their enterprises.

Let me give a few examples of performance measures that would be useful for public disclosure. For a nonprofit hospital you would be interested in what kind of margin was being made and what kind of community benefits were being provided. By community benefits, I don't mean health fairs that are marketing-oriented, but charity care, subsidized care for vulnerable population groups, and targeted health promotion or illness prevention efforts---but not necessarily just medical services, because fundamentally nonprofit health care organizations are community resources, and health status is affected by many variables. Some of the great hospitals around the country get involved in such programs as urban renewal, job training, and after-school programs for high school kids as ways to reduce illness, injuries and deaths.

For a nonprofit health plan, how much of the premium is going toward medical benefits? What is its participation in safety-net programs? For instance, if the health plan has a 50% overall market share, does it also have 50% or more of the Medicaid managed care market? How and how much is the plan involved in health promotion and illness prevention? Some initiatives will work, some won't. The focus needs to be on the

direction rather than the details, with continuous pursuit of that direction. Workable ideas and programs will emerge; unworkable ones will fall off the table.

Transparency and disclosure can be accomplished either voluntarily or by legislation. Frankly, initial reactions to these kinds of accountability initiatives tend to be negative. Leadership efforts, particularly those involving the risks inherent in accountability, are not easily embraced. They will be embraced, however, if it is understood that the alternative is legislative mandate and regulatory enforcement.

If we think we need to legislate, let's first use the bully pulpit of the legislature to demand public accountability and make clear the consequences of inaction. Some will step up to their responsibility. Unfortunately, others will not. Those who do will provide the empirical experience of what works and what falls short. From this experience, meaningful legislation, if needed, can be crafted.

When you try to legislate behaviors like good management or good governance, you make as good a judgment as you can at the moment about how to do so, but you essentially freeze things. And what happens is that organizations then turn their attention to how they can beat the rules, rather than how they can accomplish the intent. If you concretize things, you create a cottage industry that focuses on beating the rules. If you want accountability, the public must demand it. If the public lets managers ignore their boards, then some managers will ignore their boards. Increasingly though, CEOs are beginning to understand that career insurance lies in an informed board. But again, the public has to advocate for and demand accountability and disclosure. .

Public Scrutiny of Conversion Proposals

As a first step, regardless of what else we do through either legislation or regulation, we must have in place rigorous governmental processes for review and approval of conversion applications. Particularly, we should not allow the assets of the applicant firm to be used to finance the costs of preparing and defending the conversion application. Let those who think they will benefit from it pay for it. And, let the burden of proof---that

the public will be better served---fall on the applicant.

Conclusion

The nonprofit sector is where we go for solving our most troubling social problems. It is where we go to protect our values and culture. We expect much of the nonprofit sector because we give it our insoluble dilemmas. In doing this, we must understand that there will be fits and starts---but there must always be public accountability.

The nonprofit sector is society's safety net. Health care is too high a wire to walk without a safety net. Our choice is not to abandon the nonprofit system for a monolithic, for-profit or even governmental alternative. Rather, it is to make the nonprofit system continue to improve.

William J. Marino

Horizon Blue Cross Blue Shield of New Jersey is a nonprofit health plan. Last June, we made a decision that the company would no longer consider a conversion to become a for-profit company, even in view of the 2001 legislation that enabled conversions. That decision was not made because the management or the board at Horizon believed conversion would be bad for the company or bad for our subscribers. In fact, many believe that the failure of conversion was a missed opportunity for the state of New Jersey to obtain more than \$3 billion for improvements to the health care system. That would have been the market value of the stock that a foundation would have gotten had we converted.

Our decision to permanently pull conversion off the table was a business decision to eliminate the issue as a distraction which was eating up much time and too many of our resources. Our continued focus now is the execution of our strategy to fulfill our mission, to make health care work by improving the health care experience for our members and the communities we serve.

So as far as we're concerned at Horizon, the role of nonprofit health insurance in New Jersey is here to stay. But I am not sure there is agreement about what the phrase, "role of nonprofit health insurance," in New Jersey means. If all it means is that the largest health insurer will not be investor-owned, we are in agreement. If it means something more---which I suspect it does to some---then there may not be agreement. So I will discuss who we are, what we do, clear up some misperceptions, and hopefully better define what we believe the role of our company is moving forward.

History of Horizon

Horizon is the state's oldest and largest health insurer; we trace our history back to 1932 when Associated Hospitals of Essex County began as the first multi-hospital prepayment system in the nation. This company became known as Blue Cross. Prepaid coverage for surgical and medical services soon followed with the incorporation of Blue Shield in New Jersey in 1942. The two companies merged in 1986 and became known as Blue Cross and Blue Shield of New Jersey. In 1998, we adopted our current name, Horizon

Blue Cross Blue Shield of New Jersey.

Horizon does not have shareholders and is governed by a 15-member board of directors on behalf of our more than 3.2 million members. We're an independent company and a licensee of the Blue Cross Blue Shield Association.

As all other New Jersey companies, we are organized under state law. We are organized under the Health Service Corporation Act, and operate as a nonprofit health service corporation. The company, however, is not a state agency. More importantly, and a point of contention to some, is that Horizon Blue Cross Blue Shield of New Jersey is not a charity. Our company is not a tax-exempt 501(c)(3) organization. Horizon does not provide free services. The company is not supported in whole, or in part, by the state, by gifts, or by charitable donations, and does not enjoy charitable immunity under state law. In other words, we don't have the attributes of being a charity.

The crux of the contention around this issue is based upon four words in the enabling legislation---the Healthcare Service Corporation Act---which states that a health care service corporation is "a charitable and benevolent institution." The act, however, is silent as to what those words mean in terms of our operation. There are no requirements imposed by the act that define charitable and benevolent activities. Rather, the express statutory purpose of a health service corporation is to operate "for the benefit of its subscribers." The act does not provide explicitly, or implicitly, that the assets of the company belong to the state government or to the people of the state.

Mission

We operate Horizon Blue Cross Blue Shield of New Jersey for the benefit of our members as required by the law and, as our mission states, we also operate to improve the health care experience for all of the communities we serve. In addition to our subscribers, those communities include the health care professionals in our networks and employers and unions across the state.

Horizon Blue Cross Blue Shield is also very involved in communities in other ways. We have a 75-year tradition of charitable giving that has been strengthened by the creation of a \$25 million foundation created in 2004, which has already donated \$2.5 million to over 90 charitable organizations across the state. We have also been rated No. 1 on the New Jersey HMO report card for the last four years with regard to clinical outcomes. This is because we have tremendous outreach to the physician and hospital communities as well as to our individual members and customers, through a variety of disease management and care management programs. We are on the cutting edge nationally in some of these fields, such as e-prescribing.

We believe our community involvement is important because we are the hometown health plan; our 4,600 employees both work and live here. We're dealing with sick people who are frequently in distress, and it requires a certain humanism in the functioning of an operation. I think that is true--should be true---of all health plans, for-profit health plans or not-for-profit plans. As we strive to improve the quality of life and the health care experience for our subscribers, we fulfill our statutory purpose to work for the benefit of those subscribers. I believe that the 14 Blue Cross plans around the country that have converted to for-profit status from nonprofit status have not modified, and probably have increased, the level of their involvement in their communities with respect to both philanthropy and community outreach. That was certainly our intent during the five-year period when we were evaluating the possibility of converting to a for-profit company. It's the right thing to do, and it also makes business sense.

Misconceptions Regarding Charitable Obligations and Tax Exemptions

Yet, some still argue that the company has additional charitable obligations. First, they point to the four words of the Healthcare Service Corporation Act of 1938 stating that we are a "charitable and benevolent institution," and they add a so-called historic charitable mission, which is not defined. Secondly, they argue that Horizon has a further charitable obligation due to its benefits from tax exemptions.

The act does not expressly provide any additional operational requirements as a result of

the words “charitable and benevolent institution.” Moreover, it does not impose any additional charitable obligations on a health service corporation other than to “operate for the benefit of its subscribers.” Rather, the act notes specifically that we are in the business of providing and selling health insurance.

The argument that our company has additional charitable obligations fails to take into account the market forces and the legislative changes in health care. Those changes in the health care system, over time, have made this historic charitable mission argument a bit of a relic of a bygone era. And this is probably one of the areas where Howard Berman and I disagree. These concepts are not based upon a marketplace reality nor can they work in a competitive environment, as our not-too-distant past demonstrates.

The probable basis of this misconception of a historic charitable mission is the fact that Blue Cross and Blue Shield of New Jersey, as it was then known, operated as the state’s insurer of last resort. The legislature, however, made major reforms to the state’s health care system in 1992. One of those reforms eliminated an insurer of last resort. Now, all insurers who sell individual health policies are required to sell to any individual regardless of their health condition. If they don’t enroll their fair share, they must help offset the financial losses if any of those insurers who do.

The 1992 legislative reforms recognized the changing market forces in play and the need for not-for-profit health plans to be able to compete effectively in the marketplace with commercial competitors. In the late 1980s and early 1990s, Blue Cross and Blue Shield of New Jersey, mainly as a result of its status as the insurer of last resort and because it was used as a health policy arm of the state, was essentially bankrupt. Year-end 1988, the company had a deficit in reserves, a negative surplus, of \$278 million. If that were to happen today our company would cease to exist. Here I agree with Howard Berman’s concerns about the level of state government involvement in operations. That was part of the reason that the company was bankrupt. With the reforms of ’92, our three million plus customers today are a lot better off with regard to the quality of the products and service they receive than the four million that this company covered in 1985.

In 1988, the year of that big deficit, the Department of Insurance---as it was then known--hired Ernst and Whinney to conduct a management audit of the company. Many of the recommendations are instructive to this debate today. Ernst and Whinney concluded that the state needed to redefine and reduce the public policy role of the company in order for it to survive. The final report made the following two statements:

- “While the goal should be to reduce regulation of the plan to the level of other insurance companies, a plan and process should be developed by the Department of Insurance to monitor the plan’s financial condition until solvency is achieved.”
- And secondly, “The plan needs to make a clear break with its not-for-profit culture.”

The fact that the legislature in 1992 chose to end the company’s public policy role as the insurer of last resort is instructive. It is instructive with respect to its intent to maintain the company’s role as a charitable and benevolent institution. Those legislative reforms further eroded the distinction between Horizon Blue Cross and Blue Shield of New Jersey and other commercial health insurers. The U.S. Congress came to a similar conclusion around the same time.

The Ernst and Whinney report comments on the not-for-profit culture and mode of operation. Those comments are also instructive. They indicate a realization of the changing health care market forces in play, but something more as our research points out. It’s important to know what the public understands about the nonprofit sector and how it operates in the health care system. Most people in New Jersey do not know whether Horizon Blue Cross Blue Shield of New Jersey is a not-for-profit company---and our research seems to indicate that they don’t care. Furthermore, we have never had any potential customers ask or, as far as we know, base their insurance purchasing decisions on our not-for-profit status.

Our internal research also indicates that many people believe that not-for-profit

companies are generally less competent than for-profit companies. Our research seems to confirm what Mark Schlesinger and his co-author wrote in a 2004 report about the non-profit sector: “On the one hand, the public seems to have a reasonably well-defined sense of nonprofits as being less competent, but somewhat more humane and considerably more trustworthy. On the other hand, the majority of Americans do not see nonprofits as superior to for-profits in terms of fair or humane treatment of patients.” Also, I think these authors were drawing a distinction between the general perspective and the perspective of patients.

Given this research and the fact that not-for-profit health plans must be able to operate on equal footing with commercial health plans to survive and succeed, the question becomes: “What are we trying to achieve by keeping not-for-profit health plans not-for-profit?” If it is simply a desire to keep them from being investor-owned, there may be merit to that argument. If the goal, however, is to place upon not-for-profit health plans additional charitable and public policy obligations, that goal is largely unworkable.

This leads me to the second point in our debate---that we have additional obligations due to our tax exemptions. There are many misperceptions about this issue even among people knowledgeable about health care issues. Horizon Blue Cross Blue Shield of New Jersey pays federal and state taxes. The federal government noted the similarity between how we operate and how for-profit health plans operate and began taxing Blue Cross Blue Shield plans in 1986. Congress stated “...that it was concerned that exempt and charitable and social welfare organizations that engage in insurance activities are engaged in activity whose nature and scope is so inherently commercial that tax-exempt status is inappropriate.” In essence, the so-called charitable role of not-for-profit health plans has become a legal fiction.

In 2005, we incurred \$141 million in federal and state taxes. Currently the only state tax for which we have an exemption is the state sales tax. However, after last year’s state budget we now pay a significantly higher effective tax rate on our premiums than all other insurers that do a significant amount of business in this state, including for-profit

insurers and non-health insurers. Our company alone was singled out for this discriminatory tax treatment, which we are currently fighting in the courts. As a result of last year's tax increase, we are currently paying more in taxes as a nonprofit health service corporation than we would be paying if we were a for-profit health insurer.

So the argument for additional charitable obligations based upon our tax status seems to lose much of its strength when we look at those facts. Viewing history in its proper context, the subsidies paid and the losses the company sustained while serving as the state's insurer of last resort prior to '92 were in excess of any benefits it received from the tax exemptions prior to '86. Simply stated, the company did not reap any financial gains due to those exemptions. In fact, the exemptions did not cover the cost of being an insurer of last resort.

Today, Horizon pays significant taxes to the state and federal government. And as stated, we pay the highest premium tax rate in the state. Any contention that the company has a

having transparency with respect to our board. We have a very active, engaged board and a very high degree of transparency in how the company is run. We hold ourselves accountable, making our results publicly available in our annual report and elsewhere.

Capital Reserve Levels

Our level of reserves has even been used as a justification for raising taxes on our company. At the end of 2005, Horizon had \$1.25 billion in reserves. This amount cannot be viewed in a vacuum, but in its proper context. In 2005, we paid \$9.3 billion to hospitals, physicians, pharmacies and other health care professionals for both our fully insured and our self-insured members' medical costs. Our reserve level represents less than 50 days, or 14%, of our yearly medical claims.

Horizon Blue Cross Blue Shield of New Jersey consults independent benchmarks and experts to determine a prudent level of reserves based upon its risks. In addition to the requirements of state law, of the Blue Cross Blue Shield Association, and of financial experts such as Standard & Poor's, we engage independent actuarial experts to provide guidance on proper reserve levels. Two well-respected independent actuarial firms reviewed our reserve levels based upon our risk profile. These experts used risk-based capital (RBC) levels as the benchmark to determine appropriate reserve levels. Risk-based capital is an actuarial calculation taking into consideration all the health plan's risks---business risks, business cycle risks, competition, investment risks, underwriting, crisis events, and so on. The calculation is a percentage based upon a health plan's capital position.

Milliman, one of those firms, found that an appropriate risk-based capital range for our company would be between 545% and 1,045% of risk-based capital. The Lewin Group, which also was hired by the Pennsylvania legislature to review its state's four Blue Cross plans, came to a similar conclusion, with an appropriate range of between 650% and 950% of risk-based capital.

At year-end 2005, Horizon's risk-based capital was 780%, the lower end of the

appropriate ranges outlined by those two independent firms. Due to our prudent management of reserves, Standard & Poor's has given us an A rating, a financial rating some of our clients require in order to do business with us. We believe the people of New Jersey want the largest health insurer in the state to be an A-rated, financially secure company. They think our reserve levels are necessary and appropriate. We do not have excess reserves, and any such contention is not supported by the facts. Furthermore, it should be noted that because not-for-profit health plans do not have access to equity capital markets, they generally need higher reserves than for-profits. Even so, our products must be, and they are, as demonstrated by our leading market share, priced to be competitive in the market.

An essential question is: Who should determine the appropriate level of reserves for health plans? Should it be independent experts? Should it be special interest groups that might wish to tap those reserves? Or should it be politicians? Our public opinion research shows that the public overwhelmingly believes that the independent experts should decide.

Reserves are an important safety net needed to pay hospitals and physicians for our members' medical claims in a crisis, such as an epidemic, a natural disaster, or even a terrorist attack. At a time when federal and state governments are encouraging companies to prepare for such events, it would be unwise to weaken the financial strength of the state's largest health insurer, thereby weakening the financial strength of the entire health care system in the state.

Conclusion

Horizon looks forward to continuing its mission of making health care work by improving the health care experience of our members and the communities we serve. We intend to do that in our current corporate form as a not-for-profit health service corporation.

We also intend to work diligently to promote public policies that allow us to both

compete effectively in the current markets and increase access to health insurance, which is a great need in our state. We must reduce the number of the uninsured and improve the quality of care received by the people of New Jersey. This is much of the same orientation that we had over the past five years as we prepared ourselves to convert. In either scenario, we would be pursuing these worthy goals.

While our not-for-profit status may be an interesting issue, we believe that more time and energy should be focused on reducing state mandates and making individual market reform a reality. Action in those two areas will do a lot more to lower health care costs and insure more people in this state than focusing on the singular issue of our ownership status.

Mark Schlesinger

An oxymoron is a self-contradictory phrase, like “jumbo shrimp” or “working vacation.” For much of the American public, “nonprofit health insurer” is equally oxymoronic. Their stereotypical view is that nonprofit organizations are community-oriented and charitable, operating on humane principles. Yet their stereotypical view of health insurers is that they are financial parasites, concerned only with the bottom line and viewing people only as numbers rather than as individuals. All stereotypes are to some extent misleading, and the stereotype of insurers is to some extent quite unfair. Nonetheless, for many Americans the basic concept of a nonprofit health insurer is almost inconceivable.

There is very good evidence, however, despite these perceptions, that nonprofit health insurers in fact behave in systematically different ways than their for-profit counterparts. Moreover, they could behave in ways that are even more distinctive if we would hold appropriate expectations for them and reward them in appropriate ways---rethinking the 1986 decision to eliminate all nonprofit insurers’ federal tax exemption.

Before World War II, the health insurance industry was composed almost entirely of Blue Cross plans, followed by the addition of Blue Shield plans, so that 90% to 95% of health

insurance was a nonprofit enterprise. The one and only mission was to pay medical bills, relieving people of financial risks associated with medical expenditures. The one community-oriented thing these plans could do was offer insurance at what was called a community-rated premium---that is, a premium applicable for all people, whatever their age and health status. That was the operating principle under which Blue Cross and Blue Shield operated in their initial years. It made insurance affordable for older, sicker, and more disabled populations.

Unfortunately, it was not a sustainable form of community benefit, as commercial insurers entering the market during and immediately after World War II began to offer insurance to groups on an experience-rated basis. They offered lower premiums to groups with younger, healthier employees. Naturally, employer-based groups and union groups defected away from community rating to experience rating. By about 1960, the Blue Cross Blue Shield plans had to virtually abandon community rating for their group markets, although some retained it for individual markets depending on state regulatory requirements. Consequently, the distinguishing nonprofit character of insurance had disappeared for the most part. Not surprising, Congress acted, albeit slowly, to remove the Blues plans' federal tax exemption in 1986. Only about half of the states had ever given a 501(c)(3) tax exemption to nonprofit insurers.

Arguably, however, federal policymakers made a mistake, missing a significant change that was occurring at that time. Our fundamental expectations for health insurers were beginning to change, from not just paying bills to: 1) offering health promotion and disease prevention benefits to keep people healthy; 2) controlling the cost of medical care by weeding out excessive and inappropriate medical care; and 3) improving the quality of care provided by their affiliated physicians. Thus, precisely at a time that the financial rationale for a distinct charitable mission for nonprofit insurers was disappearing, the potential for a very different, meaningful rationale and role for a nonprofit insurer was emerging. Yet, policymakers then and now think about health insurance solely as a financial instrument, missing this broader potential.

Research suggests that there are three ways nonprofit and for-profit insurers look a lot alike in their performance, but crucially important research also indicates five distinct areas of difference. In terms of similarities, first and foremost is the cost of medical care provided under their respective auspices. Study findings vary, but there are no consistent differences. (There are some consistent differences in premiums charged, however, with for-profits' mark-up premiums above costs at 8% to 10% more than their nonprofit competitors. Consequently, in terms of premium-setting, there is a distinct benefit in keeping insurers nonprofit.) Secondly, while a few Blue Cross Blue Shield plans and some other nonprofit HMOs still maintain some community-rating presence (i.e., they are three times more likely to offer individual policies on a community-rated basis than comparable for-profit plans), for-profits make up some of this in terms of what's called partial or age-adjusted community rating. When you net that all out, there is not much difference in terms of community rating. And thirdly, there is very little difference in subsidized insurance, the one area where Congress retained an opportunity for nonprofit Blues plans to remain tax exempt under 501(c)(3). Our research suggests that hardly any nonprofit insurers have taken advantage of that opportunity.

In terms of distinct differences in performance, the first relates to quality of care. About 20 sophisticated studies have found that the quality of care provided under nonprofit insurers is overwhelmingly better. Of 10 studies using measures of health promotion and quality of care from the Health Plan Employer and Data Information Set (HEDIS), eight found significant advantages for policyholders in nonprofit insurers. Two found no differences. Of four studies comparing consumer satisfaction, three favored the nonprofits and one found no difference. Of four studies comparing disenrollment between nonprofit and for profit plans, all showed lower disenrollment rates from nonprofit plans. Thus, inarguably the quality of care provided under nonprofit auspices turns out to be better.

A second important difference is trustworthiness, which one could view as a less measurable aspect of quality. Some colleagues and I conducted research on this issue a few years ago, interviewing physicians affiliated with nonprofit and for-profit health

insurers. Controlling for many other characteristics of the plans, and the markets in which they operated, we found that the physicians affiliated with for-profit plans were about 70% more likely to indicate that they had misrepresented coverage to beneficiaries and 69% more likely to say their for-profit plans confused beneficiaries about their actual coverage. In short, it's not just that people expect nonprofit insurers to be more trustworthy---they actually are.

Thirdly, research indicates significant differences in utilization review by nonprofit and for-profit health insurers. Depending on the specific question asked, physicians are about 60% to 120% more likely to respond that utilization review in a for-profit plan compromises what they consider to be appropriate standards of treatment or otherwise impair their ability to deliver good quality medical care. In their utilization management, nonprofit plans are more likely to take into account family condition and the presence or absence of other caregivers outside of the medical care system, the critically relevant factor in determining what kinds of medical care is necessary.

Fourthly, research suggests that nonprofit insurers are spending about 60% more of their budgets on community benefit activities. They spend about twice as much of their budgets than for-profit plans on donations to the community and about twice as much on medical research. They are also about 50% more likely to have their own affiliated physicians engaged in medical research, and to conduct health care needs assessments in the communities in which they operate.

Fifthly, and finally, nonprofit health plans exhibit more stability in medical markets. They are about 70% more likely to maintain stable long-term relationships in Medicaid managed care markets. They are about three times more likely to maintain stable long-term relationships in Medicare managed care markets. Clearly, the for-profit plans pursue profits in ways that their nonprofit counterparts do not. Market stability is crucial to the relationships that people have with their physicians. Every time a Medicare managed care plan withdraws from a given market, about a third of its beneficiaries who have chronic conditions lose the connection with their ongoing specialist, which threatens the quality

of care they will receive.

In sum, ownership matters right now, and it could matter a lot more if people expected more from nonprofit plans. The American public doesn't expect more because many are clueless about the ownership of their health insurer. Our research indicates that only about one-third of the people in nonprofit health plans know they are in a nonprofit plan. Those who know they are in nonprofit health plans often expect their quality of care to be lower, even though we know the evidence is exactly the opposite. So people are misinformed, people are uninformed, and that lack of information prevents them from taking advantage of what we know to be important ownership-related differences. We don't have to just accept that. While our research shows that about one-third of the public is probably going to be forever clueless about nonprofit health care because ownership is a complicated subject, that leaves two-thirds who can be educated. Their attitudes and expectations can be changed.

Similarly, we do not have to accept the failure of policymakers at the federal and state levels to establish reasonable expectations for charitably oriented nonprofit health plans. Blanket removal of the nonprofit Blues plans' tax exemption was a policy error that can be corrected. The magnitude of the five performance differences discussed earlier could arguably be greater if we accorded nonprofit health plans the tax-exempt status which I think they merit. Right now we have a paradox. We have expectations that are inconsistent with performance, and we have expectations that are inconsistent with what nonprofits could contribute. In the case of Horizon, the expectations appear to be unreasonably high in relation to its tax obligations.

The nonprofit health sector can be thought of as a kind of pioneer, in terms of figuring out what things can be done in different ways. We should hold these organizations to higher standards, but we need to give them greater resources to be pioneers---to innovate and test new ideas and approaches. As we begin to document what works, then we can bring up the regulatory floor, holding everyone to a higher standard. This has been happening to some extent voluntarily with HEDIS, where in the initial year the

participants were almost entirely nonprofit plans. Gradually over time, the for-profits became embarrassed for not reporting their results. They started reporting their results and then states began to require such reporting. That's the dynamic. I think you always want to hold nonprofits to a higher standard---to push them further and later bring everyone else up.

Only if we revise our expectations, our public expectations, our public understanding, and our policymaker understanding, can we truly tap into the potential of what nonprofit health plans can offer to the American health care system.

Deborah J. Chollet

In my mind, two key factors underlie all of the public's concern about the role of nonprofit health insurers in the community: 1) their size—as one of a few very large carriers in New Jersey and in other states; and 2) confusion about their community benefit obligation as charitable and benevolent organizations.

Because of the size of nonprofit carriers, there are substantial dollars involved. Insurer surpluses have been rising for both nonprofit and for-profit insurers. Historically, rising surplus was not as great a concern for two reasons. First, health insurance was not as expensive; now it is essentially unaffordable for anyone with an income below 300 % of the federal poverty level (FPL).

Second, insurance markets have concentrated and, in traditional terms, are not as competitive as they once were. In most states, just three or four insurers now account for 80% premium volume. Such concentration of insurance markets erodes the argument that underwriting cycles will draw down surplus over time. An underwriting cycle will start when one or more, usually smaller, insurers reduce premiums to gain market share; other insurers then drop their premiums to protect their market share, drawing down their surpluses. In more concentrated markets, this is less likely to occur. There is not competition in the standard economic sense; instead, there are price leaders and price followers. Large carriers (the price leaders) are reluctant to start a price war, and small

carriers (the price followers) are likely simply to shadow-price the large carriers. Nationwide, I see only one insurer that appears to be drawing down surplus to buy market share in states where it has a small presence, while other large companies continue to sit on high levels of surplus.

So, is the underwriting cycle dead? The argument for it rests on two observations. First, in concentrated markets, insurers are less likely to drop price to gain market share. And second, large for-profit carriers are intolerant of “cyclicality”; for-profit company managers are paid for profit stability and growth, not for cyclicality.

It follows that we have a problem: what to do about health insurance prices and asset levels that are so high, with no apparent market dynamic to bring them down. In states like New Jersey, we focus on the nonprofit Blues plan in particular, because: 1) it is the largest carrier in the state; and 2) and as a “charitable and benevolent” organization, it is accountable to the community, not to shareholders. This brings us to the second key factor I mentioned---the community obligation of a charitable and benevolent organization. Where does the allegiance of a nonprofit health insurer lie--- to the company, to its policyholders, and/or to its potential policyholders, that is, the community?

Recent developments in Pennsylvania illustrate one solution for simultaneously addressing the issues of large surpluses, the absence of competitive market dynamics, and the community obligations of nonprofit health insurers. The four large nonprofit Blues plans in the state, accounting for two-thirds of the market overall, recently struck a “community reinvestment” agreement with the state. The agreement calls these plans to contribute 1.6 % of total premium toward subsidizing the “adultBasic” program (an insurance plan for adults below 200 % of FPL), the state’s Children’s Health Insurance Program, or individual rates—especially for people who are “guaranteed issue” when they leave an employer-sponsored plan or have a “trade adjustment” tax credit. If any of the Blues plans wants to provide some other type of community benefit, it must negotiate that with the Pennsylvania Insurance Department. Thus, the agreement defines a

perimeter, but not a tight perimeter, around what community benefit means within the financial capacity of these organizations.

The agreement does not put these organizations at risk of bankruptcy. Each year, the Pennsylvania Insurance Department reviews the surplus levels of each of these carriers and, based on its risk-based capital ratio, determines whether its surplus is too high, about right, or approaching a danger point. RBC takes into account all the risks that the company faces in four broad categories of risk; in general, the larger and more diversified the carrier, the lower the ratio that the carrier needs. The Blue Cross Blue Shield Association sets a danger threshold level of RBC at 375 %. In a stable market like Pennsylvania, a comfortable level of RBC does not have to be two or three times the 375 % threshold. Of the four nonprofit Blues plans in the state, the larger ones have ratios in the 500 % to 700 % range, and the smaller ones are in the 600 % to 800 % range. If the department finds that a plan's surplus is too high, it is not permitted to build risk-loadings into the next year's premiums, effectively lowering its premiums. If the surplus is too low, the plan can build risk factors into the premiums, and the Department encourages it to do so.

What I find remarkable is that the two plans that regulators required bring down their surpluses have been able to maintain operations at the very top of the margin for an efficient carrier. In the past few years, this phenomenon also has occurred in other states where regulation has been relaxed: the largest companies' financial performance settles with remarkable precision at the regulatory minimum.

This phenomenon suggests that there is something about largeness that creates stability, but it also creates a chilling effect on competition. It speaks to the need for the state to communicate with its largest carriers—especially when they have a community link by virtue of their history and their legal status—and to work with them in creative ways to achieve a reasonable balance between financial health and community benefit.

Notes

¹ Chuck Bell, programs director, represented Consumers Union. Based in Yonkers, N.Y., Consumers Union publishes *Consumer Reports* magazine and ConsumerReports.org. It also has operated a national project on health care restructuring and conversions with Community Catalyst in Boston. The two have worked in more than 40 different states providing technical assistance and information to community groups that are concerned about how health care might be affected, and what will happen to charitable assets in conversion of nonprofit health care organizations to for-profit status.

² Renee Steinhagen, executive director, represented New Jersey Appleseed, a nonprofit advocacy center providing a legal voice to unorganized members of the public. In collaboration with Consumers Union, Community Catalyst, and others, the center secured passage of New Jersey's Community Healthcare Assets Protection Act, and has been active in protecting community health care assets during several hospital transactions.

³ The mission of the center, established in 1999 under a grant from the Robert Wood Johnson Foundation, is to inform, support, and stimulate sound and creative state health policy in New Jersey and around the nation. In February 2003, the center published an issue brief and discussion paper on the proposed conversion of Horizon Blue Cross Blue Shield to for-profit status. Under New Jersey's Community Health Assets Protection Act, the center recently served as health care access monitor and completed a study of the impact on access to care of acquisition of a nonprofit hospital by a national for-profit chain.

⁴ For a nonprofit health insurer, "community" can be defined at a minimum as the subscribing population. At a maximum, it is all of the market that it can potentially serve. The board and management have to define what their active community is along this continuum.