Testimony of the
Healthcare Association of New York State

before the
New York State Insurance Department

Eric R. Dinallo, Superintendent

on
Group Health Incorporated (GHI) and
Health Insurance Plan of Greater New York
(HIP) Conversion to a For-profit Entity

January 29, 2008
Thank you, Superintendent Dinallo, for providing the Healthcare Association of New York State (HANYS) with the opportunity to testify before the New York State Insurance Department (SID) regarding the proposal by Group Health Incorporated (GHI) and Health Insurance Plan of Greater New York (HIP), together known as EmblemHealth, to convert from not-for-profit to for-profit status. I am Jeffrey Gold, Vice President of Managed Care and Special Counsel. HANYS represents more than 550 not-for-profit and public hospitals, health systems, nursing homes, and home care agencies throughout New York State.

HANYS, in fulfillment of its mission, continues its strong support for the many important health care initiatives that are currently funded through Health Care Reform Act (HCRA) pools. In light of the significant financial challenges facing New Yorkers, particularly in funding quality health care services and new health care reform initiatives, HANYS is led to the inevitable conclusion that directing the vast bulk of the proceeds of the proposed GHI/HIP conversion into the HCRA pools is of such paramount importance to the continuation of these programs, that, in this case, it must override our significant concerns about this merger and for-profit conversion.

HANYS is nevertheless compelled to point out that the entities seeking to convert have below-average performance (as measured by your own agency and the Department of Health). This evidence, when coupled with the fact that for-profit plans perform poorly when compared to not-for-profit insurers in New York, reinforces our concerns about the direction of this future entity and the industry as a whole. Therefore, HANYS believes it is critical that the state should seek, as a condition of conversion, a commitment for performance improvement from GHI and HIP, with tangible consequences should they fail to meet specific goals.
HANYS also believes that the public discussion of the conversion proposal is a prime opportunity to highlight the need for broader reform in the current managed care system and ensure more accountability from payers, particularly for-profits.

“CLEAN HANDS”

Thus, we first note that public discussion of a conversion proposal is an ideal forum to challenge health insurance plans that hope to benefit financially from their proposed conversion from not-for-profit status to for-profit businesses. We suggest, therefore, that entities that come before you seeking to leave their charitable missions in their past, must, at a minimum, have their houses fully in order as a predicate to doing so. In particular, business practices and policies of the parties should be carefully scrutinized to ensure all are coming to the process with “clean hands” and any identified shortcomings are fully addressed and remediated by such insurance plan as a mandatory condition of being permitted to convert.

In this regard, we believe that regulatory agencies can require, as a condition of approval, commitments for improved performance by the newly converted entity. Such commitments can take a number of forms; for example, it could be similar to a performance bond, i.e., GHI/HIP would post a bond that would be payable to HCRA pools should the entity fail to meet state-designed performance measurements. Alternatively, SID could establish a series of performance goals and reporting requirements with penalties for failure to meet performance thresholds, analogous to the recent multi-state settlement with UnitedHealthcare to which New York State was a signatory. HANYS suggests that such approaches are appropriate conditions for approval of a conversion.
Not-for-profit managed care organizations (MCOs) that seek to become a for-profit business should not be rewarded with governmental support when they have been at or near the bottom of their class in consumer satisfaction and in addressing complaints from consumers and providers over the years. There is already strong evidence that for-profit plans are ranked notably worse than not-for-profit plans in terms of consumer satisfaction and quality of care. Therefore, it is disconcerting to the provider community that an already poorly performing not-for-profit might only worsen as it converts to for-profit and becomes more motivated by quarterly earnings expectations.

We suggest that factors to be considered when not-for-profit health plans seek to convert are whether the plan:

- has a reputation for providing access to quality health care and quality customer service;
- makes prompt and appropriate payment of provider claims;
- has an evolved and effective communication plan with providers; and
- has fair and reasonable utilization review practices.

Both empirical and anecdotal facts demonstrate that neither GHI nor HIP have met this burden. Both have poor track records relative to their peers. In 2007, the New York Consumer Guide to Health Insurers published an overall ranking of 47 MCOs based on the number of complaints received and upheld by SID. Out of 47 plans, GHI ranked 38th, HIP ranked 40th, and GHI HMO ranked 41st. Out of the 15 New York HMOs listed in the HMO category, HIP ranked 9th and GHI HMO ranked 10th. Of the three not-for-profit indemnity insurers ranked in that category, GHI ranked last.¹

The same report took data from the New York State Department of Health (DOH) consumer survey to determine consumer satisfaction with timely access to needed care and customer service. Members who were asked to provide an overall rating of their HMO on a scale from one (worst possible) to ten (best possible) provided ratings that resulted in GHI HMO being significantly worse than the average in the state. Similarly, members who were asked about how quickly they received services provided ratings that resulted in HIP being significantly worse than the New York average. When asked about problems getting needed care, members rated GHI HMO and HIP significantly worse than the statewide average.²

Figure 1.

Overall Consumer Satisfaction Ratings of Health Plans
GHI HMO and HIP vs. State Average
Source: Annual New York State Managed Care Plan Performance Reports

² Id. at 34-35.
In Figure 1, data from the annual New York State Managed Care Plan Performance report clearly show consumers consistently rated their overall satisfaction with GHI HMO and HIP below the statewide average and, as seen in Figure 2, well below their not-for-profit colleagues that are consistently ranked above the statewide average.

The 2007 Interactive New York Consumer Guide to HMOs published three-year complaint history rankings for New York HMOs (2004-2006). Once again, GHI HMO and HIP were at the bottom of the pack; GHI HMO fluctuating between 10th through 12th out of 15 New York HMOs and HIP ranking between 8th through 10th out of 15.³

In yet another consumer-focused study, GHI and HIP were found to be seriously lacking. In 2004, the New York State Office of the Attorney General conducted an investigation into health plan compliance with the state’s Managed Care Consumer Bill of Rights.

Specifically, plans were asked, by then-Attorney General Spitzer staff posing as prospective enrollees, about the clinical review criteria the health plan used to make medical necessity and coverage determinations for certain treatments. The subsequent report revealed statewide failures of HMOs to disclose the required information to consumers and issued grades (A-F) to the 15 plans investigated. HIP received an “F” because it failed to provide a single satisfactory response to any of the requests for disclosure. GHI HMO received a C, having provided satisfactory clinical review criteria in only two of the five inquiries.⁴


This collection of comparative information related to GHI’s and HIP’s respective performance as not-for-profit MCOs in New York State is a cause for concern. While statistics are not collected as to provider satisfaction with health plan performance, it is HANYS’ view that GHI and HIP would be similarly ranked well below the statewide average. GHI and HIP are not well regarded health plans by the provider community and are some of the worst offenders in terms of timely claims processing and payment, communication, and service. HANYS is concerned that these negative rankings may worsen if the entities become for-profit and there are no conditions for performance set as a condition of this conversion.

**VALUE ADDED: NOT-FOR-PROFIT VS. FOR-PROFIT**

In terms of the direction of this industry, we will talk bluntly about the growing wealth of evidence that not-for-profit plans in this state routinely outperform for-profit plans in myriad critical categories and we will ask why, despite the negative impact on consumers and providers, we find ourselves seeing mergers and conversions as a growing trend. We believe that there should be far more debate about whether there is true value added to the delivery of health care services by increasing the number of for-profit health plans in the New York State health insurance market.

While not-for-profit plans can be less than perfect and are sometimes the object of HANYS’ criticism, we readily acknowledge that for-profit plans have notably higher administrative costs, spend less of their premium on care, have lower consumer satisfaction, and lower quality of care.
Quality of Care

In the 2005 Commonwealth Fund study, conducted by the Harvard School of Public Health and Harvard Medical School, researchers concluded that not-for-profit health plans provided significantly higher quality of care to enrollees than for-profit plans.5

In addition, a 1999 study published in the *Journal of the American Medical Association* concluded that investor-owned HMOs deliver lower quality of care than not-for-profit plans. Using 14 different Health Plan Employer Data and Information Set (HEDIS) quality of care indicators, investor-owned plans had lower ratings for every measure than not-for-profit HMOs.6

Consumer Satisfaction

In overall satisfaction, New York not-for-profit plans score higher by consumers enrolled in their plans. A comparison of survey ratings from the New York State’s Managed Care Plan Performance report from 2003-2007 shows that, on average, not-for-profit health plans score consistently higher than the statewide average and for-profit health plans, on average, score consistently lower. It is noteworthy that GHI and HIP, despite their not-for-profit status, already score like their for-profit counterparts—that is, below the statewide average (see Figure 1).

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5 Schneider, Eric, et al., *Quality of Care in For-profit and Not-for-profit Health Plans Enrolling Medicare Beneficiaries*, American Journal of Medicine, Vol. 118 no.12, December 2005.

In addition, a 2002 study conducted by the Center for Studying Health Systems Change concluded that patients who have self-reported fair or poor health rated not-for-profit HMOs more favorably than for-profit HMOs. For-profit enrollees reported higher rates of unmet need or delayed care, and higher out-of-pocket spending than those in not-for-profit plans.\(^7\)

In Consumer Reports’ national ranking of 76 managed care plans based on patient satisfaction, three of the top four are in New York, including Capital District Physicians’ Health Plan (CDPHP), Independent Health, and Excellus Blue Cross Blue Shield—all are not-for-profit plans.  

In addition to quality and consumer satisfaction, there are other decided differences between the two when it comes to mission, values, and accountability. The Alliance for Advancing Nonprofit Health Care’s recent report comparing not-for-profit and for-profit health plans’ economic value and commitment to the under-served in New York State demonstrates that for-profit health plans act differently than not-for-profit plans in terms of performance, efficiency, and contribution to safety net programs. It is axiomatic that for-profit plans are primarily accountable to their shareholders and the revenue focus is placed on commercial product development and profitability. Moreover, for-profit plans appear to be less invested in regional health planning and in absorbing or sharing bad risk.

“ ‘Once you become a for-profit entity and take on public equity capital, especially in a high-growth industry, you cannot decide to reject the “grow or go” imperative because your investors fully expect earnings of 15 percent or better, year after year.’ ”

As charitable organizations, not-for-profits are accountable to more state regulatory oversight as well as to the communities they serve. At least in the upstate New York market, not-for-profit plans have demonstrated an increased ability to be economically viable while remaining invested in safety

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8 Consumer Reports September 2005
10Id. at p.12, citing Jack Needleman, Nonprofit to For-profit Conversions by Hospitals and Health Plans: A Review, Pioneer Institute for Public Policy Research.
net programs and working at being part of the long-term fabric of their communities. Regional health care planning and delivery is most successful when all stakeholders have a vested interest in the success of the community in which they serve. For-profit plans do not typically exhibit the same levels of involvement or interest for a simple reason—they answer to shareholders, not to the community where they render services.

Other important conclusions found in the Alliance’s study include:

- Not-for-profit HMOs both upstate and downstate participate in state-sponsored safety net programs to a far greater degree than the downstate for-profit MCOs. Within the plan group selected for this study, not-for-profit plans supported 88% of the enrollment in New York State sponsored programs, compared with for-profit plans that support only 12% of safety net membership.

- Not-for-profit plans have also demonstrated a higher level of dedication to the Medicare Advantage product line than for-profit insurers downstate.

- Insurers in the upstate not-for-profit market are more administratively efficient than insurers in the downstate region.

- Not-for-profit insurers offer more cost-effective (i.e., lower) premium options for consumers.

Significantly, the study concluded that:

“The emergence in New York of health care insurance markets that are predominantly for-profit raises significant public policy issues, especially with reference to community benefits and services. Should the upstate health insurance environment change with the entrance of for-profit plans, or conversion of existing plans to for-profit status, the upstate market is likely to look very similar to the downstate in that:
- There will be diminished access to care for the at-risk population.
- Premium costs will be higher.
- Administrative costs will be higher.

The health care insurance market upstate would become less attentive to the provision of public goods as insurers strive to maximize their economic advantages.”

Obviously, HANYS believes that health care consumers and providers are better served by health plans that are more administratively efficient and spend less of their operating revenue on administrative expenses. Consumers and providers deserve to have more of the health plans’ dollars spent on medical care. Obviously, HANYS prefers health plans that have higher levels of investment in medical care and spend less energy on maximizing underwriting gains. Can HIP and GHI, acting in a for-profit mode, meet the standards that the remaining not-for-profit plans are setting in these areas? It is unlikely, unless commitments are extracted that address these predictable shortfalls.

HANYS is mindful that—to some extent—the train may be well down the track with respect to the HIP/GHI conversion. Nevertheless, the data and the trends cannot and should not be ignored and we hope that regulators will require, as conditions for approval, that HIP and GHI upgrade their rankings among plans and commit to administrative efficiency and to paying appropriate percentages of incurred revenue for care and reinvestment in medical care, technology, and infrastructure.

**PAYER ACCOUNTABILITY**

Market conduct reform is necessary to ensure health care consumers are provided the benefits they deserve and providers receive timely and adequate reimbursement for the medical services they
provide. MCOs, whose motivation is to pay as little as possible and maximize profits or reserves (in the case of not-for-profit plans acting as if they were for-profit plans), must be held accountable for their market conduct.

There are three areas of concern. The first is a set of problematic market practices by plans that frustrate efficient delivery of health care and providers’ attempts to focus on providing medical care. The second is a group of managed care practices designed to discourage consumers from using the benefits they have purchased and providers from exercising their right to walk away from inadequate reimbursement rates and contract terms. The third area is the need to ensure all stakeholders are contributing to the health care investments in their communities by spending a reasonable proportion of premium income on medical care for enrollees or, alternatively, contributing to a community reinvestment fund.

The following proposals are among HANYS’ highest advocacy priorities for 2008 and reflect substantial effort in this area by the allied associations, in particular Northern Metropolitan Hospital Association and Nassau-Suffolk Hospital Council.

**Market Conduct Reform**

Current market conditions require stronger enforcement and reform to bring fairness and balanced leverage to the marketplace, reduce administrative and costly inefficiencies in health care, ensure providers are able to provide access to quality care and that patients are provided the health care insurance benefits they deserve.
Administrative Denials

A plan should not be able to deny claims for medically necessary, covered services based on a provider’s technical error or failure to overcome an administrative hurdle, in the absence of demonstrable detriment to the plan’s ability to manage the care provided to an insured. MCOs should not be able to circumvent their responsibility to pay claims by instituting rules and procedures that cause providers more administrative burden and to expend more resources to be paid for medically necessary, covered services they have delivered. This is particularly true when there is no actual prejudice to the payer. Only in health care does the failure to observe an obscure technical rule result in the complete denial of payment for services rendered without an opportunity to correct the defect or comply with the rule.

HANYS supports legislation introduced by Senator Charles Fuschillo (R-Freeport) and Assemblymember Adam Bradley (D-White Plains) (S.5540/A.8114) that would prohibit MCOs from denying payment for claims for administrative reasons. Development of new administrative reasons for denials that are not relevant to a plan’s actual case management of specific episodes of care must also be discouraged.

Providers’ Rights Under External Appeal Law

In 2007, HANYS supported the enactment of an expansion in the External Appeal program, allowing appeal of denials for out-of-network care. This is consistent with the principle that providers are in the strongest position to advocate for necessary medical care on behalf of their patients. However, providers have frequently been unable to appeal adverse determinations regarding medical necessity because of perceived and actual obstacles to the External Appeal
program. Providers continue to perceive that SID, in the last several years, has routinely refused to honor designations, seeking confirmations and reaffirmations of a designation, which was not contemplated by the statute (and thereby discouraged), or deeming retrospective determinations to be concurrent, and therefore barring some cases from external review under the statute. However, HANYS is optimistic that SID’s senior staff are now interested and willing to revisit SID’s internal practices and are interested in looking at the processes employed by health plans in relation to external appeals.

The shortcomings of the External Appeal Law must be corrected so that its use can be maximized. Providers must have a clear right to appeal adverse determinations, particularly since providers are currently prohibited from balance billing patients for covered but denied services. To that end, HANYS is working directly with SID to improve the appeal process so that it is expeditious and streamlined, allowing providers and consumers access to this important appeal right. HANYS also supports legislative changes as delineated in S.5459/A.8231, which has been introduced by Senator Hannon and Assemblymember Gottfried.
**Refund Demand Limitations**

Currently, there are no statutory limits, requirements, or prohibitions on the timing or scope of refund demands, or “take-backs,” issued by health plans to hospitals. Health plans should have no more than two years from the payment of a claim to demand a refund. In addition, health plans should limit the circumstances under which take-backs can occur to billing/coding errors or fraud. Under no circumstances should plans be permitted to take a “second bite” at the utilization review “apple” in the absence of an additional appeal right for providers.

Limitations should be placed on the timeframe and circumstances under which insurers can seek a refund of claims paid or an adjustment of subsequent payments. Omnibus prompt-payment legislation introduced by Senator Fuscillo and Assemblymember Bradley includes this provision (S.5540/A.8114).

**Prompt-Payment Law**

Under New York’s current Prompt-Payment Law, insurers are required to adhere to certain deadlines and make timely payment of claims. In the interest of supporting and encouraging provider investment in technology, plans should be compelled, as they are in other states, to pay electronic claims within a shortened timeframe. Moreover, plans that repeatedly violate prompt-payment laws should receive penalties that are effective in deterring recidivism.

The time within which an electronic claim must be paid should be reduced from 45 days to 15 days, and penalties for prompt-payment violations need to be increased to deter plans from repeatedly...
violating the law. Legislation has been introduced by Senator Fuschillo and Assemblymember Bradley to accomplish this objective (S.5540/A.8114).

**Coordination of Benefits**

HANYS helped draft and continues to support a SID regulation that would address coordination of benefits issues. While not yet promulgated, the regulation outlines a process to resolve the disagreement over which payer is primarily responsible to pay a claim, without detriment to the provider. However, additional coordination of benefits issues need similar resolution. While the pending regulation requires MCOs to honor each other’s pre-authorization requirements, it does not make a similar requirement for medical necessity determinations. This disagreement over medical necessity can leave providers unable to receive payment for a medical service already rendered. In addition, some MCOs send post-treatment questionnaires to enrollees to determine whether other insurance exists to cover a claim for medical services that have been provided. While on its face this would appear to be a prudent business practice, it becomes less so when the MCO had an opportunity prior to the medical service to pre-authorize or check an enrollee’s coverage and eligibility. When the patient fails to return the questionnaire, the claim is denied or payment is indefinitely delayed. The provider, who has already delivered the medical care and is not in a position to get this information from the patient who has left the hospital, is then left without payment, or must expend limited resources to chase it down.

The regulation should be promulgated as currently negotiated between members of the SID Health Care Roundtable. Additionally, payers should be required to coordinate benefits among other payers without taking back paid claims or denying claims based upon a plan’s refusal to accept the medical necessity determination of another plan. Finally, plans should be prohibited from using
coordination of benefits questionnaires as a subterfuge to delay and deny care for which they are fully responsible.

**Utilization Review Law**

Currently, New York law establishes timeframes within which utilization review agents must make adverse determinations. However, the law should be enhanced to protect consumers and providers. The failure to make a utilization review decision within the stated time should be deemed an approved claim and not an adverse determination. This provision is included in S.5459/A.8231, introduced by Senator Hannon and Assemblymember Gottfried.

**Administrative Burden for Emergency Department (ED) Visits**

To avoid the burden and cost associated with supplying medical records for all ED visits, commercial health plans should be required to consider certain common sense factors in applying the prudent layperson standard when determining whether the medical care provided was for emergency medical services. When reviewing a claim for coverage of emergency services to treat an emergency medical condition, a utilization review agent should be required to consider the time of day and the day of the week the patient presented to the ED, and the presenting symptoms. This provision is also included in S.5459/A.8231, introduced by Senator Hannon and Assemblymember Gottfried.
Fair Contracting

As insurers in New York merge, providers have less bargaining power and little recourse to dispute unfair contract provisions. Some health plan contracts include provisions that allow the insurer to make changes to its policies, manuals, and contracts with little or no notice and no ability for the provider to opt out. These changes can have a significant impact on financial arrangements, quality improvement efforts, and utilization management procedures. HANYS supports efforts to restore the balance of bargaining power between contracting health care providers and MCOs and recommends a requirement of notice and mutual agreement to material changes to an insurer’s policies and contracts.

CONSUMERS’ HEALTH CARE BENEFITS

HANYS has uncovered a number of health insurance practices that appear on the surface to have a legitimate rationale but, when more closely scrutinized, are revealed to serve no purpose except to discourage providers from exercising the right to contract, or to prevent consumers from using a broader or more expensive benefit that the plans must offer.

As shown by the public discussion of Oxford Health Plans’ out-of-network coverage practices, some health plans treat hospitalizations at a facility with which a plan has a contract as out-of-network, merely because the treating doctor is an out-of-network physician. This practice, especially when obliquely disclosed, results in patients abruptly discovering they are responsible for an unexpected and costly portion of the hospital bill that they believed was covered at an in-network hospital. This results in an unearned benefit to the plan because the plan only pays a percentage of a discounted in-network rate it negotiated in its contract with the hospital and then requires the
member to pay the remainder of the amount owed. The practice results in an undeserved windfall for the plan by punishing the consumer and the provider for using the very hospital where the plan has a contracted and discounted relationship. HANYS supports legislation that has been introduced by Senator Hannon and Assemblymember Gottfried (S.5119/A.8322) to prohibit payers from changing in-network hospital coverage to out-of-network based on the treating physician status.

Another managed care practice is emerging in which health insurers prohibit consumers from authorizing direct reimbursement from their insurer to their out-of-network provider. The reason, the plans say, is the need to educate consumers about the true cost of their health care.

The clear and objectionable result, however, will be an enormous and entirely predictable collection and administrative burden for providers who are already feeling the strain of limited resources. Moreover, this policy pressures providers into staying in a plan’s network regardless of the inadequacy of compensation. Legislation, which HANYS supports, has been introduced by Senator Hannon and Assemblymember Gottfried to allow patients to assign payment to an out-of-network provider (S.5231/A.8335).
The ongoing need to provide better health care to all New Yorkers is a shared responsibility among providers, businesses, health insurers, and MCOs. However, many health insurers and MCOs incur substantial profits and have excess reserves, while health care providers in general struggle financially. There needs to be a balance. At the same time, additional funding is needed to improve the provision of health services in communities, including improvements in quality, workforce, infrastructure, and efficiency. Requiring payers to reinvest in health care will benefit communities across the state. Currently, government and providers are playing their part in the financing of health care operations and infrastructure improvements. HANYS helped develop legislation that has been introduced in both the Assembly and Senate that would create a community reinvestment fund. Introduced by Assemblymember Bradley and Senator Hannon, A.8704/S.6056 would help
ensure that health care reinvestment becomes an equitably shared responsibility across all major payers.

Specifically, this legislation would enhance statutorily imposed medical loss ratios—a measure of the percent of a premium dollar spent on actual patient care services versus administrative costs or profits. Payers that truly fail to meet the new higher ratio would pay the difference between the current ratio and the new threshold into a community reinvestment fund. The funds collected from these payments would be used to improve health care in communities across the state. Regional committees would decide how these health care dollars are spent to meet the priorities and needs of local communities.

HANYS strongly supports enactment of A.8704/S.6056. This community reinvestment fund would provide the necessary mechanism to guarantee third-party payer accountability and ensure that communities continue to have access to the highest quality care.

These reform proposals are intended to improve the current system and prohibit inappropriate health insurance practices or payment methods. Strengthening and improving existing laws regulating the health insurance industry will restore balance between providers and payers, ensure that providers are paid for the medical services they render, and, most important, ensure all New Yorkers benefit from enhanced access to quality health care.

**CONVERSION PROCEEDS**

HANYS recognizes the public interest that is served by continuation of the many worthwhile health care access and public health initiatives supported by HCRA pools that the proceeds of this
conversion can help fund. We also acknowledge GHI/HIP must compete (including for capital) in the downstate market, which as currently configured consists of virtually all for-profit, publicly-traded corporations. Thus, while we have serious misgivings about the for-profit trend, we do not object, at this point, to this conversion, if the new entity is required to perform better in terms of consumer and provider satisfaction, and if the bulk (90%-95%) of conversion proceeds, which is estimated to be around $564 million, are directed to the HCRA pools. HCRA pools support numerous important programs including Child Health Plus, Family Health Plus, pharmacy services for low-income elderly, expansion of mental health services, school based health clinics and other public health initiatives (breast and cervical cancer, HIV/AIDS).

Important health care reform efforts underway in New York such as expansion of SCHIP, prevention and primary care initiatives, physician and nurse shortage solutions, chronic care management programs, and others all require significant financial investment. It is therefore essential that the money generated from the sale of EmblemHealth stock, be earmarked for these important health care initiatives.

CONCLUSION
HANYS applauds SID’s efforts to perform the due diligence necessary to protect consumers and providers from adverse impacts from this proposed conversion. Notwithstanding the financial windfall to the state and company shareholders because of a completed and successful conversion, there is little evidence that the resulting health insurance plan is a better company and public citizen for it. We hope that the aforementioned issues will be used in this and future conversion debates to ensure that all New Yorkers continue to have access to quality health care.