



Promoting Private Coverage Solutions to Address the Uninsured

Prepared remarks by David Klein, Chief Executive Officer of Excellus BlueCross BlueShield, before the NYS Departments of Health and Insurance

September 5, 2007

Good morning.

My name is David Klein. I'm the chief executive officer of Excellus BlueCross BlueShield and its parent corporation. Our collective 7,000-employee company provides health coverage to about 2 million New Yorkers in many parts of upstate New York.

With 30 locations across upstate, we also provide physician care, home care and nursing agency services to more than 120,000 patients each year. Our long-term care insurance business provides coverage to more than 100,000 people throughout the United States.

Thank you for inviting me to provide testimony on what is not only one of the most important social issues we face, but an issue that is also fundamental to our mission as an organization as well our very survival as an upstate employer. It is no exaggeration to say that the economy of upstate New York is our destiny because jobs mean health care benefits. As both an employer and stakeholder, we face a myriad of challenges in the upstate New York health care marketplace, whether it is the age of our hospitals, physician shortages, adequacy of health information technology, or affordability of coverage. Any solution to the uninsured must address each of these critical issues.

My remarks today will seek to make the case that solutions leading toward universal health coverage should place greater emphasis on removing barriers to and creating incentives for more private health care coverage because government should not and really cannot take on the entire burden. And, the approach toward affordable access and other health care issues need to be addressed in a collaborative partnership arrangement.

Please permit me to begin my testimony with what I believe are two common principles we share for public and private health coverage.

Common principles for public/private health coverage

First, government has historically assumed the role of financing health coverage for people who truly cannot afford it. Intelligent public policies enacted over recent years have placed a greater emphasis on the importance of the poor getting more primary care needs addressed before their health conditions worsen and become both life threatening and more expensive. We also believe that the ideal method of funding health coverage for the poor is through the broadest base of taxes as we do for such things as education or public safety.

The second principle is that government should seek ways that encourage employers and workers to voluntarily purchase private health coverage. Every individual with private health care coverage is one less individual with a potential need for taxpayer-financed coverage or catastrophic care. Historically, the concept of health insurance was an invention of the private sector with collaboration among the providers of care, employers and government. Pluralistic financing benefits the health care delivery system by protecting it from the ebbs and flows of the election cycle and competing demands for government spending. Today, millions of Americans have private health care coverage. Our collective challenge is to make it more affordable without sacrificing the quality of care provided.

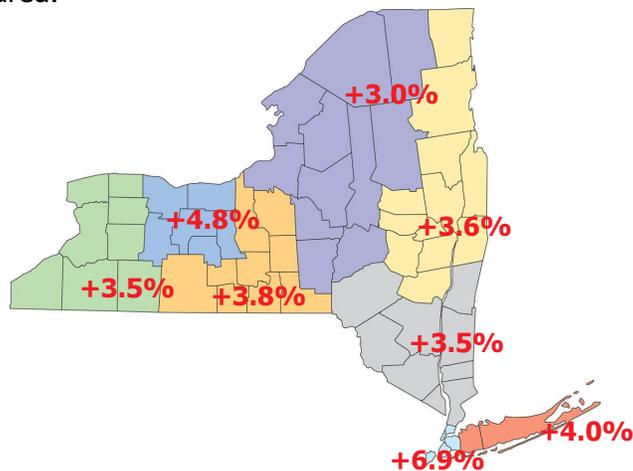
Government programs are expanding

New York State has experienced success in decreasing – or at least stabilizing – the number of uninsured by increasing enrollments in government programs such as Medicaid, Child Health Plus and Family Health Plus. With every expansion of government insurance programs, there are costs associated that are born by taxpayers. Our economy is less diversified and less competitive relative to taxes, so expanding entitlements is challenging to our common goal of seeking job growth.

Government actions have added costs to and decreased numbers of the privately insured

On top of what are already considered to be uncompetitive broad-based tax rates in New York are \$2 billion in additional taxes collected from those who voluntarily purchase private health care coverage. These “HCRA” taxes created by the Health Care Reform Act are relied upon to pay for bad debt and charity care rendered by hospitals, graduate medical education, Medicaid and a host of other items. Together, taxes paid by the privately insured represent the second highest business tax in the state and the fourth highest overall tax.

We would estimate that for a standard type of group benefit design, the two HCRA taxes – the 8.95 percent surcharge and the covered lives assessment – may represent as much as 3 percent in some regions of the state and nearly 7 percent in New York City, as reflected in this map. Survey after survey demonstrates that cost is the reason why the uninsured don’t have coverage, so imposing taxes on those who do have coverage poses the risk of losing them to the ranks of the uninsured.



Other government actions that increase costs for the privately insured are mandated benefits imposed on employers who are voluntarily providing health coverage. A study by NovaRest

Consulting for the Employer Alliance for Affordable Healthcare in May 2003 estimated that mandated benefits increased health insurance premiums by a net amount of 12.2 percent a year. And, that was before the enactment of Timothy's Law.

Splitting the issues of spending versus tax policy

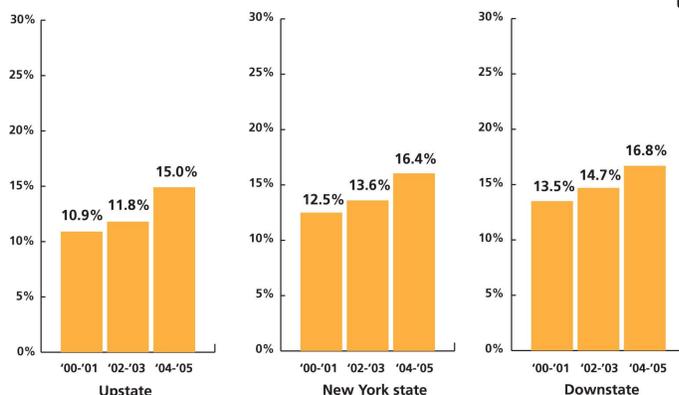
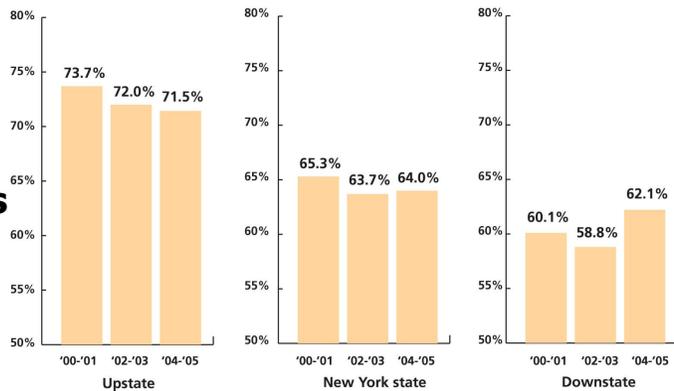
Let me be clear. I am not challenging the fact that HCRA finances critical programs. Hospitals need support for addressing charity patients. Graduate medical education needs to be supported so we have future generations of well qualified physicians to care for us. The issue is whether the funding for those critical programs should be from broader-based tax revenue sources. We also have no issue on the value of the benefits that the state government has chosen to mandate on group insurance policies. For those having a health policy that now provides additional coverage for mental health care, it is unquestionably a great benefit.

The larger observation I'm attempting to make is the merit of taking a step back to see if the "solutions" at one end of the quest for universal coverage and expanded access to care may also be an impediment to achieving that very same goal. By that, I mean that if we implement public policies that make coverage more expensive for those who voluntarily purchase it, we are making it less likely to expand coverage in the private sector. In fact, the added costs are creating a deterrent.

Troubling trends in health coverage

As shown in the following charts, looking at employment-based coverage statistics from the U.S. Census Bureau, we are seeing a decline in coverage trends in upstate areas; while in the downstate market, with a robust economy, there is a slight reversal. What we see in government-based coverage trends is significant growth regardless of regions. This growth of government health coverage is the reason for New York seeing relatively stable overall uninsured rates.

Employment-based coverage among adults (ages 18-64)



Government-based coverage among adults (ages 18-64)

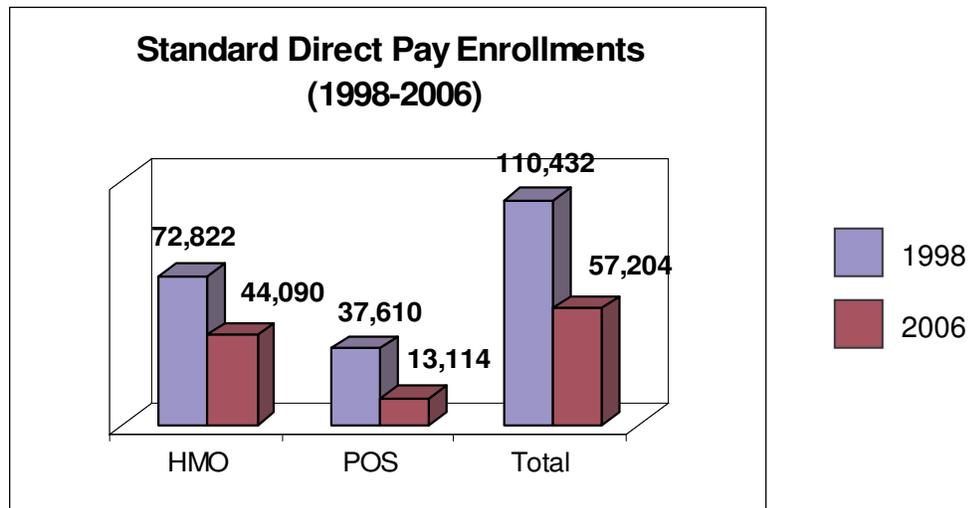
When we look at those movements together, I believe we are seeing signs of an unsustainable trend, particularly for upstate: continued erosion of employment-based coverage and continued growth in government-based coverage. Other Labor Department statistics add further to these findings. We witnessed the loss of about 60,000 employees from 2000 to 2003 in the major regions of our insurance offerings – Rochester, Buffalo, Binghamton, Syracuse and Utica. These opposite trend lines are undesirable statements about our economy and our prospects to expand health coverage.

Balancing private and government coverage

We need to properly balance private and government coverage expansions. And, as we try to figure out global solutions to universal coverage, it makes sense to identify the makeup of the uninsured population. In other words, who are the uninsured? In looking at Census data, it's clear that, generally, the uninsured are individuals who can't – or don't – purchase coverage on their own, small businesses and the working poor.

The individual direct pay market

Today's individual direct pay market is rapidly deteriorating. We've seen statewide enrollment in the two standard – but very comprehensive – benefit designs nearly cut in half over the past eight years. When viewing prices of the two products, this is not a surprising result. The statewide average monthly premiums for family coverage are now more than \$2,000. These standard benefit packages are the only ones, by law, that can be offered to individuals who directly purchase health coverage.



Those kinds of premium prices are not profiting anyone either. Over the past five years, on average, our health plan has paid out \$1.20 in medical benefits for our direct pay members for every dollar we collected in premiums and that is **after** the state subsidy is added. If the state hadn't paid any subsidy, we would have paid out \$1.32 in medical benefits for every dollar we collected in premium. Sustaining such losses in all lines of business would be a recipe to no longer be in business. These results support the unfortunate conclusion that the individual market is only being used by those who are very sick or very wealthy.

The small group market

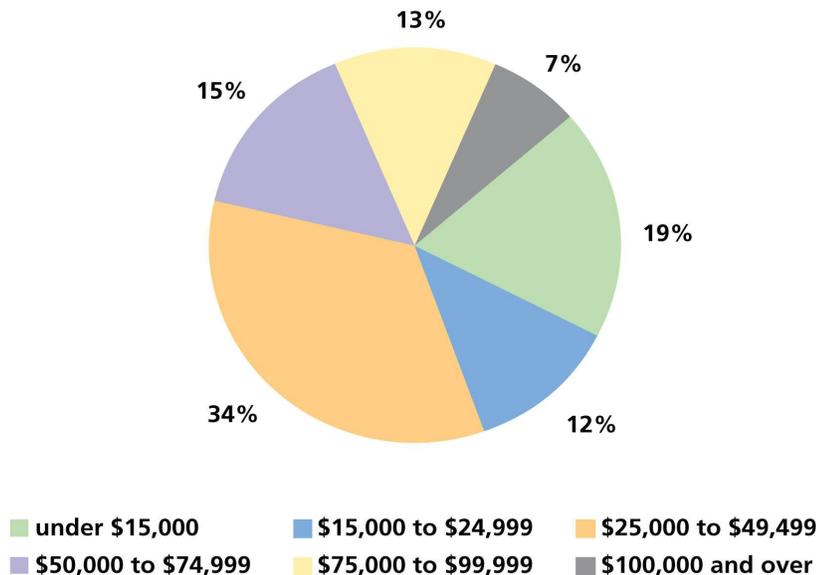
A somewhat stronger – yet vulnerable – market is small groups. In many areas of the state, small group policies are among the most expensive in the United States. For that reason, about half of small groups don't provide coverage to their workers. About 50 percent of those who are employed – but also uninsured – work for firms with less than 25 employees.

The potential to entice more of the uninsured to get coverage

There is much potential that exists to reduce the ranks of the uninsured among not only the poor through greater enrollment and eligibility changes but also among those who may be able to purchase private health coverage.

More than a third of upstate's uninsured adults earn \$50K+

Distribution According to Household Income: Upstate Uninsured NYS Adults, Ages 18-64, 2003-2005 (three-year average)



When looking at Census data related to upstate's uninsured adults, more than a third earn \$50,000 or more. In fact, 20 percent of upstate's uninsured adults make \$75,000 or more. Seven percent of uninsured adults make \$100,000 or more. For some of these uninsured adults, the two expensive direct pay standard products may be outside their reach. But products available in the small group market that offer value but less comprehensive coverage than the direct pay standard designs would likely fall within a price point of affordability for many.

Concepts for a new approach

The fact that we can identify potential new customers for the private insurance market is at the essence of a series of concepts of what the state could foster to achieve our common goal.

If the following ideas were implemented collectively, the state could help achieve significant reductions in private coverage premiums and attract and retain more New Yorkers in private health coverage.

- **Merge markets**

First, we would recommend that the state merge the small group and individual markets. This step alone would dramatically reduce premium rates for individuals, but it would also increase rates for small groups. Therefore, I will re-emphasize that the ideas offered are to be considered collectively rather than individually. Other changes being advocated would more than make up for the impact to small groups.

- **Standard designs with more options**

Second, we would advocate the notion of creating more standard benefit plans that range from lower priced consumer-directed health plans to more expensive comprehensive designs to particularly improve the options available in the individual market. Each product would be offered on an open enrollment basis and be community rated separately. The concept here is similar to the Medicare Supplemental products that provide the ability for consumers to comparison shop and have a wider array of benefit choices. Wellness incentives should be built into most, if not all, those designs. And innovation should be promoted. This could be done by permitting the Superintendent of Insurance to encourage demonstration products.

- **Adding skin in the game for insurers**

Third, health plans need to put something on the table – or skin in the game – in our collective quest for more affordable health coverage. Instead of imposing price controls by artificially suppressing rates by re-implementing the prior approval process, we would recommend imposing a minimum medical loss ratio of 80 to 85 percent on all standard products combined among all health plans. Our personal preference is 85 percent among all insurers. By doing this, it will ensure that the lion's share of the premium dollar collected is paying for medical benefits and limit insurers and HMOs to a level of 15 percent of the premium dollar for the combination of business expenses and profits or net income.

- **Stop loss pool**

A critical piece to enhance affordability of coverage among the newly combined direct pay and small group market is a redeployment of some existing subsidies used for hospital bad debt and charity care and the Healthy New York program, along with perhaps additional sources of revenue into a new stop-loss pool for claims in excess of \$20,000. This change would offset the impact of high cost medical claims and therefore result in major premium savings. Equally important is the fact that more New Yorkers who enter hospital emergency rooms currently as bad debt or charity care patients will more likely to be privately insured patients.

- **Tax cut**

Because one of the benefits of expanded health coverage would mean more people will have coverage who need urgent care, the surcharge of 8.95 percent now paid by the privately insured on hospitals bills to help finance hospital charity care should also be cut in half for this vulnerable population in the 1-50 market. The overall impact of about 2 percent on premiums from this change would outweigh what we believe would mean a nominal loss of subsidy revenue to hospitals.

Collective impact

Taken together, we believe these concepts would collectively reduce premiums in the individual market by about 30 percent and in the small group market by 20 percent. The data behind all this is currently under review by the Department of Insurance, so they should be considered preliminary estimates.

<u>Change</u>	<u>Individual Direct Pay</u>	<u>Small Group</u>
#1 Merge Markets	- 29%	+9%
#2 Community Rate by Product (Net of #1 +2)	0% - 10%	0% - 4%
#3 Stop Loss (Net of #1 + 2 + 3)	- 29%	- 18%
#4 Discount Half of 8.95% Tax (Net of #1 + 2 + 3 + 4)	- 31%	- 20%
Estimated Net Impact	- 31%	- 20%

If anything, we believe the impact may be on the low side. Let me explain why. In the small group market right now, some individuals are purchasing health savings account products at prices in the \$200 per month range. Individuals who may be employed but are not offered coverage through their employer lack the ability to buy HSA-type products. Their only choices are the two expensive standard benefit designs that are several hundreds of dollars in price. For those individuals, having additional options such as health savings accounts (HSAs) may address their needs and meet their personal budgets.

If we can, in fact, entice significant numbers of healthy New Yorkers into private health coverage by making more affordable options available, their very addition to the ranks of the insured would actually further reduce premiums by having a healthier pool of members.

The proposals advocated here do not include elimination of any mandated benefits. That would be a role for state policy makers to determine, and there is precedent for creating exemptions. When Healthy New York products were established by the state, some mandated benefits were deliberately excluded to create lower prices. My only point here is that if state government chose to make some products without some mandated benefits, such a choice would further reduce premiums.

The working poor

State government has an important ongoing role to review what should be done and what taxpayers can afford to do for the working poor. This includes potential expansions of eligibility rules, maximizing use of available federal funds and promoting enrollment in safety net products. Private insurers have a responsibility to participate as partners with adequate payments to cover the costs. We believe that taking an incremental versus a dramatic approach would be wise. If New York were to attempt to move quickly and materially ahead of other states toward universal coverage without a lot of new dollars identified to support it, the effort would likely outstrip our state economy's ability to sustain it.

More collaboration

In conclusion, expanding access to affordable health coverage should be a collaborative venture between public and private sectors, and that approach should extend to other opportunities of improving care and reducing costs. Our recommendations are an important first step toward improving our health care system and attaining universal coverage. Other initiatives – such as an upstate physician recruitment and retention plan, medical malpractice reform, a cohesive statewide policy for health information technology, and coordinated hospital modernization and health care planning – should be undertaken simultaneously to adequately address the challenges in our health care system.

Thank you again for inviting me to offer a perspective on our common goals and ideas for achieving them.