



On behalf of the NYS Association of Health Underwriters, I appreciate the opportunity to put forth the recommendations of our organization in achieving universal health care insurance in New York State.

Many of the solutions being discussed, including single payer, are not realistic and in their desire to be a simplistic one step solution, gloss over the real problems in the health care system. The health care system in the United States is one of the best in the world. The reason the health of the United States population is not the best can for the most part be attributed to poor lifestyles, not shortcomings of the health care system. We address this issue in our proposals.

Single Payer Approach is fundamentally flawed and unproven

Single payer solutions claim to be able to provide insurance to all residents by eliminating unnecessary administrative expenses in the current insurance carrier model and using that savings to purchase government provided insurance, such as Medicare, for all residents. The flaw in that logic is twofold: first it has never been shown that the savings is of the magnitude claimed by these proponents. The estimates are high level views of an unrealistic perception that the insurance companies could be closed in one day with the savings being immediate. It assumes that the government-run system would be capable of handling the additional volume without a significant increase in cost. The savings, if they were real, would be spread over several years as insurance company obligations are run off. In addition, there is no accounting for the public cost of several thousand unemployed insurance company employees. Assuming for the moment that the estimates are in fact accurate, the second flaw in the logic is more significant. The cost of health care still remains high and hasn't been addressed. The cost issue is temporarily masked by spreading the current claim costs over a larger base of insured residents but as time goes by and the rate of increase in health care costs continues unchecked, the issue of affordability will return, although this time as a tax issue for the government-run entity, not an employer issue.

We are proposing two approaches. The first is short-term measures that address the affordability of health insurance in the small group and individual markets. The second is a proposal to address the major driving force behind the high cost of health care.

Insurance as the financing mechanism:

As long as insurance is the vehicle chosen to finance health care, we need to understand and follow the dynamics of insurance and risk management. Regulatory and legislative mandates that hamper the fundamentals of insurance have led to higher insurance costs by creating adverse selection in the small group and individual pools. Insurance markets work best when there is the chance of substantial loss, when that loss is sufficiently rare and uncertain and when the presence of coverage will not alter behavior. Once those events become predictable and not random, it is no longer insurance but an inefficient financing tool. The pooling of risk is an essential component of insurance and requires an appropriate mix of risks in order to work properly. Adverse selection is when the risk pool becomes skewed due to people making decisions based on their individual and predictable situations. If their perceived medical costs are going to be less than the premium, they will probably not buy the insurance and will drop out of the pool. This causes premiums to rise and as they do, that threshold for dropping insurance

rises causing more people to drop out. The resulting spiral is what's currently happening in the individual market in New York State. That situation is exacerbated by flat community rating which can be explained by the utility of insurance in a decision making model. Currently, a high risk 55 year old pays the same rate as a low risk 25 year old. The 55 year old understands that the probability of medical care is high for someone his or her age and there is a great utility or value in purchasing insurance. The 25 year old knows that the frequency and probability of requiring significant medical care is very low for him so insurance has less of a utility for him and he will more than likely prefer a larger paycheck than buy insurance. Since they're paying the same premium, it's likely that the pool will consist more of the 55 year olds than the 25 year olds, classic adverse selection. Consider the situation of a sick individual versus a healthy individual regardless of age. One knows that the probability of medical care is extremely likely and the other knows it is extremely unlikely. Obviously, the decision to purchase insurance is easy for the sick individual and the healthy individual will, in many cases, decline insurance. Insurance is not meant to be purchased only by those who will use it. The concept is to pool everyone's cost to be spread over the entire population, not spread the cost over just the users of medical care. Although insurance in New York State is accessible, it is not affordable. The two terms, accessibility and affordability, while not mutually exclusive, are very close to that.

We are making three recommendations intended to increase the availability of insurance in New York State.

Small Group Market:

Our first proposal is for the small group market. We would propose that the current flat community rating structure be modified to recognize some of the difference in risk that is being underwritten. The current structure should be replaced by a modified community rating structure in which rates can vary within a 25% corridor above and below the established rate. While this will increase the cost for older employees, it will significantly reduce the cost for younger employees and lower the threshold at which they compare perceived cost with insurance cost. This will bring younger, less costly members into the current pool who will be subsidizing the cost of insurance for the older, more costly employees. From a practical perspective, it's more likely that older employees have higher incomes than younger employees and are in a better position to afford the higher premium. Each employer's rates will be determined by their census of employees.

A criticism on this methodology in the past has been that employers will be reluctant to hire older employees but this has not been shown to be the case in the other states (which are most of the remaining 49 states) that have modified community rating. Additionally the restrictive corridors minimize the rating impact of older employees.

Benefit design is a secondary consideration. Health care cost is the target and no manipulation of plan design, other than managed care, has been shown to ELIMINATE cost from the system. At best it shifts cost to the member who then may have some inclination to avoid an ED visit but these are nickel and dime efforts. A reasonably designed PPO plan that has incentives to use providers with lower cost is all that's needed to reduce health care costs.

Since purchasers of small group insurance generally are not sophisticated buyers, we would recommend some sort of standardization of language and policies. It should not be as rigid as in the Individual Market but allow a degree of creativity for carriers in this market to test alternative approaches.

Individual Market:

Our second proposal on the affordability of insurance is for the individual market. We are recommending the same rate corridors as proposed in the group market. However, this market is and will always be defined by adverse selection since each person makes the economic decision for himself or herself as to whether the cost of the insurance is greater than the perceived cost of their future medical care. This differs from the group market in which the decision to offer insurance is usually made by a third party, the employer, and is not related to a person's need for

medical care. In addition the employer in many cases subsidizes the cost of the insurance so the employee does not bear the entire cost of the insurance premium thereby resulting in a higher percentage of healthy individuals purchasing coverage. The adverse selection that occurs in the individual market causes a disproportionate number of high cost cases. The opportunity here is to establish an effective high risk pool for that limited section of the population responsible for the majority of the claims. By eliminating all or a portion of all high cost cases from the pool of covered individuals, premium rates should be lower. This approach is used in the Healthy New York pool where high cost claims between \$30,000 and \$100,000 are removed from the rate calculations. We realize that Regulation 146 is intended to help subsidize carriers for specified medical conditions but the inefficiencies and unpredictability of that system has negated its impact. That needs to be replaced with a real stop loss approach similar to that used in the self-funded marketplace. Funding is available from the Federal government to help states investigate high risk pools as well as ongoing funding for supporting those pools. The current system in New York redistributes cost among the carriers but Federal support could actually replace some of the existing dollars and result in lower cost. The benefits of the individual mandated policies need to be reduced. The plan is much too rich and is generally greater than most private sector policies. There is a lack of high deductible plans in the individual market, which could be a significant draw for the uninsured market. Although the statutes allow for this type of plan, no carrier wants to be the first to enter this market with such a plan. It would be better to replace the mandated POS option with a mandated high deductible option.

There is another option, put forth by Excellus Blue Cross Blue Shield and Empire Blue Cross Blue Shield to combine the Individual and Small Group markets together. As an alternative to our approach, we would support this approach.

Public Insurance Programs:

The eligibility for coverage provided by the State through its subsidized programs; Family Health Plus, Child Health Plus, Medicaid and Healthy New York; should be sufficient to cover those people who truly need the State's assistance. However we feel that there is such a low requirement of personal responsibility in these plans, that there is room for improvement. This, by the way, is the same criticism we have of many of the employer-based system. Insureds have no reason to maintain a healthy lifestyle since there is no penalty or difference in cost for doing so. This is addressed in the Disease and Lifestyle Management section of our testimony. In the public programs, incentives for annual physicals, childhood immunizations and checkups, mammograms, prostate screenings, etc are a better way to spend our funds than on constantly pouring money into a system that does not recognize efforts to stay healthy. Those incentives in the Medicare program have shown to be successful in recent trials and the same will work in the Medicaid program.

Disease and Lifestyle Management:

Our third proposal deals with the high cost of health care itself and is more of a longer term goal. It addresses the lifestyle related preventable conditions that are estimated, by the Center for Disease Control, to be up to 75% of the cost of all health insurance premiums. In the current system, there are no consequences for poor lifestyle behaviors; smoking, obesity, lack of exercise, poor eating habits, etc. We don't feel that members, who are trying to lead a healthy lifestyle, whether or not they have existing medical conditions, should be subsidizing the cost of those members who have no regard for the impact they are having on health insurance premium rates. Smokers pay a higher cost for life insurance because their mortality rates are higher and the same analogy should apply to health insurance when it concerns a habit that is under the control of the individual.

The body of evidence coming from recent research has shown that effective wellness and disease management programs can have a significant impact on health care costs. Unfortunately, it's also been proven that in order to get a significant portion of people to practice a healthy lifestyle, there needs to be an incentive, usually monetary.

There is no incentive for a small employer or individual to change or alter their behavior because there is no credit in their insurance premium for doing so. They will continue to pay the same rate if they stop smoking even though the evidence is clear that they will incur significantly lower health care costs in the future.

Right now, insurance companies are prohibited by Section 4224 of NYS Insurance Law from providing incentives for members who practice a healthy lifestyle, don't smoke, etc. These are considered illegal inducements to renew or purchase insurance. Our goal is to have legislation passed which would allow these incentives to occur. A similar bill was passed in Michigan last year (Enrolled Senate Bill No. 88) that allowed carriers to promote optimum health by offering a healthy lifestyle program including "goods, vouchers, or equipment that supports achieving optimum health goals". A subsequent bill was introduced and passed (Enrolled Senate Bill No. 848) which allows wellness incentives. An incentive is defined as, "...rebates or reductions in premiums, reduced copayments, coinsurance or deductibles, or a combination of these incentives for participation in any wellness or health maintenance program offered by an employer". Obviously Michigan has seen the benefit of incenting healthy behavior and has taken the appropriate steps.

Assembly Bill A03683 and Senate Bill S413 were introduced in the recent session that would allow carriers to provide actuarially appropriate reductions for participation in bona fide wellness programs. We would strongly urge this type of legislation should be adopted as a major step in addressing health care costs.

Mandating that coverage be purchased:

Our organization consists of health insurance agents and brokers. We make our living advising clients who buy insurance so on the surface; we would seem to be in favor of mandating insurance for employers. However, the market should decide who offers insurance, not the government. Recruiting and retaining employees is competitive now and the lack of health insurance is a detriment to those employers who don't offer it. We feel that's incentive enough. If the reforms in the individual market are achieved, that should provide reasonable cost health insurance.

Any mandate proposed should be on the individual. With the proper reforms in the Individual market, those programs can become affordable once again.

Our proposals are focused on marketplace reform, not a government takeover. While we do feel government should play a role, it should be eliminating the barriers that exist to true reform and subsidization for low-income and uninsured through the creation of the high risk pools. Since there are no mandates involved, there is no concern over ERISA pre-emption.

Health insurance costs in New York State, just like the rest of the country are high which contributes directly to the number of uninsured and the level of uncompensated care. Addressing the insurance portion of the issue is only addressing the symptom. The supply side management approach of limiting the amount paid to providers of care is about at its limit. We need to begin a program of demand management that addresses the unlimited and unnecessary demand we place on our health care system. While short term measures should be adopted, as we have suggested, any legislation, which doesn't include measures to deal with the long-term issue of health care costs, is shortsighted and will not fix New York's problem.

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