



## **The Nelson A. Rockefeller Institute of Government**

### **Choices and Challenges in New York's Health Insurance Market**

#### **A Public Policy Forum**

*September 18, 2007*

*Richard Nathan:*

Good morning. My name is Dick Nathan and I am honored to be the co-director of the Rockefeller Institute of Government and we welcome you. On behalf of the Institute, I want to say how pleased we are to be partnering with United Hospital Fund and Jim Tallon, Peter Newell, and Danielle Holahan. We also are very grateful, all of us who are involved, to the New York State Health Foundation, which is supporting the Coverage Consortium. We have a wonderful program and set of panels. We are going to learn a lot at an exciting time, a very exciting time.

Peter Newell of the United Hospital Fund and Courtney Burke, director of the Institute's Health Policy Research Center, organized this program and gave it this title: Choices and Challenges in New York's Health Insurance Market. That's good. Views from health plans from business and labor leaders as universal coverage discussion begins. I said to Peter, we should have added "begins again." Yet this is indeed an exciting time and we have a lot to cover and a lot to learn. You have the agenda and there are also bios of the speakers, so we won't go into long introductions and we have asked the speakers to talk for 15 minutes so there will be time for discussion.

The first panel is Health Plan Leaders and Courtney Burke is going to be the moderator. And the second panel before we break for lunch is Business Leaders, which Jim Tallon will moderate. In chapter 12 of Bob Ward's book, *New York State Government*, is a good discussion of health policy that might be helpful to you, although most people in this audience already know an awful lot. Our panels today cover the geography, particularly upstate, in a really good way. A lot of territory. And we are going to hear different perspectives in a way that will be valuable to all of us. I am going to ask Jacqueline Martinez, who is the senior program director of the New York State Health Foundation, to say a word of welcome and then Jim Tallon is going to make some comments about what we want to cover and do here jointly today. Jacqueline has a really exciting background working where it counts, in the community at the front lines, and she brings that perspective to the Foundation. Jacqueline, we thank you for being with us.

*Jacqueline Martinez:*

Good morning everyone and on behalf of the New York State Health Foundation and Jim Knickman, who regrettably cannot be here today, I want to welcome you to this conference. I am delighted to be here to advance the agenda for New York State health reform and to expand coverage. I am joined by my colleagues Jamalia Brashears, our program associate and Meg Figley, our communications



associate, to join the discussion of the needs in New York's health insurance market. As many of you know, today's topic of discussion is critical to the mission of our foundation. We were established to receive the charitable funds resulting from the conversion of Empire BlueCross BlueShield from a nonprofit to a for-profit corporation. Part of our mandate included expanding coverage for New York's 2.2 million uninsured as well as the under-insured population of New York State. The other two parts of our mission areas include improving access to quality care and strengthening the public health system in building the capacity of communities to address their health concerns. The foundation's strategy to expand health coverage in New York State involves supporting projects and analyses to increase coverage options in both the public and private markets. The second part of our strategy is to address the system's cost inefficiencies, recognizing that close to \$3.5 billion of government funding reimburses uncompensated care for uninsured New Yorkers. The foundation is committed to supporting initiatives that will go to reduce cost in

our health care system. To date, the foundation has dedicated over \$20 million over the next five years to expand health coverage in New York State. Our current strategies include complementary activities. The foundation has allocated \$2 million to support community-based initiatives to be replicated throughout the state that will address (1) the persistent problem of enrolling uninsured New Yorkers and keeping them enrolled and (2) expanding coverage for individuals who are not eligible for public insurance. The foundation also has dedicated an additional \$2 million to support projects seeking to increase cost efficiency in our system.

The second part of our strategy involves a partnership with the State Department of Health and we are supporting their efforts to reduce costs associated with the Medicaid program in real time. An existing grant to the State Department of Health seeks to identify high-cost Medicaid patients for targeted care management interventions and design reimbursement and care-management strategies to reduce the cost and improve the care of these patients. And, also to collapse Medicaid categories to minimize the barriers to accessing health coverage and to reduce administrative burdens.

The third part of our strategy involves examining options for small group and individual markets and the staff have been exploring various options to increase efficiency in this market. We plan to identify a set of targets that will (a) help us to understand the impact of New York's regulatory environment, (b) expand options for small business and independent workers with a special focus on upstate markets, and (c) to replicate existing small business projects in other regions across the state.

Finally, as many of you are aware, an essential element of our strategy is to extend coverage to all New Yorkers, and part of this strategy involves funding a New York State coverage consortium dedicated to producing data and state analysis that will inform and guide state leaders and decision makers in their discussions to drive major health care reform in the state. The consortium consists of a diverse set of institutions that seek to identify the action steps and policy changes necessary to expand coverage. The participating institutions, some of which are here today, are: Columbia University, which will analyze the viability of several coverage expansion options and will result in a comprehensive menu of choices for lawmakers to choose from; Cornell University, which will partner with Columbia to identify the characteristics of New York's health-care market that can impact health care reform, and they will conduct an opinion poll of New Yorkers to evaluate perspectives on health care options; the Manhattan Institute, which will host two conferences on coverage

options that determine the market and regulatory changes that will allow the uninsured to purchase coverage; the Rockefeller Institute, which will conduct analyses of options to reform the small-group market, host conferences such as this one, to better guide policy discussions on this topic; and the United Hospital Fund, which will examine the small-group market in partnership with the Rockefeller Institute, and also will further the study analyses on public programs simplification, designing options of an insurance connector or purchaser entity, as well as the impact of coverage mandates on employment. They will also continue to convene stakeholders to guide coverage expansion efforts. What the Foundation hopes is that the consortium efforts result in a coherent balance made up of analytic data, public engagement, communication, and dissemination efforts. You can learn more about these activities in the brochure that is provided for you at the registration table.

Today's forum focuses on small business and sole proprietors that are vital to the New York State economy and represent more than 80 percent of all employees, including half of all private-sector employees. At the same time, more than half of the 2.2 million uninsured are employed in small businesses. The one factor that contributes to the obvious problem associated with this market is the alarming cost of premiums. During the period from 2000 to 2006, family insurance premiums for New York State workers rose 5.5 times more quickly than median earnings. On average, family health premiums rose nearly 72 percent while median earnings rose only by 13 percent. In 2006, the average monthly premium for small groups with single coverage in New York State was \$419, which is \$100 higher than the national average. But we're here to focus on solutions instead of the problems of this market. During the course of today's meeting, it is critical that we spend our time discussing real solutions that the coverage consortium members and other experts can examine, model, and replicate throughout New York. Today's conversation should focus on the population that keeps our economy moving; who provides critical services to all New Yorkers, and who could ultimately benefit from the potential market changes. The challenges we face within this segment of the insurance market may seem daunting, but they must be addressed. Any efforts to expand coverage without a strategy to expand options for small business will fail to achieve the mission of covering a large portion of the uninsured and, worse, it will fall short of the democratic principles that govern our state and our nation. We must find real workable solutions for small employers and individuals. We look forward to understanding what changes are needed to help small employers and individuals faced with purchasing insurance in New York State. We commend you for taking on this challenge today and our foundation looks forward to working with many of you to address this market. I would also invite you to contact our staff at NYS Health. Kelly Hunt, the senior program di-

rector who is overseeing and guiding this area of grantmaking in the foundation and her colleague, Jamalia Brashears, will be pleased to answer any questions regarding the consortium's work or any other of the initiatives focused on this market. So, thank you and I look forward to the discussion today.

*James Tallon:*

Let's see if we can get right to the program. First, I want to thank Senator Clinton for getting this subject into the headlines this morning. The good news is that our subject continues to be on the agenda in a very serious way. It's really good to be here. Dick Nathan is not just my good friend but when I was in government, Dick and I co-authored some articles and some chapters



together. We worked very closely. It's wonderful to again be associated personally with him and it's wonderful to have United Hospital Fund work now in this new partnership with The Rockefeller Institute of Government. We at the Fund, continually over the last four, five, six years maybe a little longer, have been moving our public policy work to a statewide basis, and are now working more overtly with the upstate community while still continuing our work downstate. We consider this a wonderful opportunity to work with the Rockefeller team and work with many of you across upstate, across the entire state.

The United Hospital Fund, for those who are not familiar with us, is an independent organization. We do not represent the hospitals. The Greater New York Hospital Association, Ken Raske I know is going to be here today, I saw him outside, The Health Care Association of New York and the other regional associations are the advocacy groups. We are basically a small philanthropic organization focused on improvement and service delivery in health care and we have evolved over time into focusing on health policy questions, working on insurance, the financial performance of the health system, on quality improvement, safety improvement, information technology, restructuring of care around chronic illness models and then cutting through all of that with what we call the Medicaid Institute at United Hospital Fund; where we have tried to dig with some depth into the Medicaid program in New York because it is such an extraordinary driver of policy choices. We look forward to working with all of you. I will be moderating the panel a little bit later and we will work through the day. Some of you are familiar, we have done this kind of roundtable discussion in the City

on a number of occasions over the past several years and what I would say about this discussion today is that everybody is here to give some thoughts and give some ideas. For me, the most important thing we are going to do today is listen, because we're going to hear what some of the dynamics and what some of the choices are. I see our senior colleagues in state government are well-represented here today. Dennis Whalen and all of the team are with us. So, this is also a time for listening, listening where the opportunities may be and how we can think about them working with each other. So, I thank you very much on behalf of the United Hospital Fund. Dick, thanks for your hospitality here at Rockefeller and Courtney, it is yours.

*Courtney Burke:*

It is my job to keep everything running on time and I think we are already 10 minutes over. We have a fabulous panel of speakers. Their biographical sketches are in your folders and we are going to start with David Klein.



*David Klein:*



Good morning everybody. Jim and Peter and Courtney, thank you for having me here today. This is a matter of incredible importance for the country and for upstate New York, where I live. My bio is in the materials provided. Suffice to say that I run a not-for-profit BlueCross BlueShield plan in upstate New York. We also are involved directly in health care delivery, running a primary-care medical group, a home-care agency and other businesses, a long-term care insurance company, consulting firms and so forth. We are inextricably tied to the success of the upstate economy and when we look at what is going on in the upstate economy, we are worried. We're worried in general and when we look at health care we are worried even more. We see a physician shortage. We see hospitals that are aging and in need of repair, renovation, and modernization. We see the need for investment in health information technology (HIT). We see an affordability crisis. If we add to this set of problems a growing number of uninsured, the notion of an economic turnaround of upstate simply will not

occur. We began thinking about what could be done to deal with the question of the uninsured about a year ago when candidate Romney was still Governor Romney and he signed into law the universal health insurance program in Massachusetts. We said, what can we learn from that experience? We had such questions as who are our uninsured, what success have we had in this state in designing solutions to deal with these uninsured populations, what can we do? We came up with some ideas. We have tested them with some other companies, notably Empire BlueCross BlueShield in the City, and we are here today to share them with you.

In your materials is a prepared text. I am going to highpoint it over the next 10 minutes or so, Courtney, to try to get us through all the ideas. Then we will leave conversation to the dialogue that will follow. We start with the notion that any solution should be based in pluralistic financing, that you have to have the public-private-sector partnership. Government is there as a safety net for those who can't finance coverage themselves and funding for government programs should come from the broadest base of tax revenues. Secondly, government has an accountability to encourage employers and workers to voluntarily purchase private health coverage. Encouragement could become a mandate downstream; but at least at the outset what we are targeting is the notion of incremental change. We have seen a tremendous success over the past decade or so in looking at government programs. State and federal government actions have materially reduced the number of uninsured in the state through Medicaid, Child Health Plus, and Family Health Plus offerings. We have gone from about 2.9 million in 2001 uninsured down to about 2.6 million currently. If you look at who is covering this incremental 300,000 people it is government programs and that is a good thing because these people otherwise could not afford coverage. But there have been some costs associated with these programs. The expanding Medicaid program, safety net program, is paid for by taxes. These are broad-based taxes, property taxes, sales taxes, state income tax, franchise taxes. We additionally have some very targeted taxes that create more than \$2 billion in funding that adds, frankly, to the cost of health insurance. These taxes are used not only to pay for these types of offerings but also to pay for important services that hospitals and medical schools provide. If we can get the private sector working then the tax burden is not as great. Everybody knows that New York State has a huge tax burden, which is an impediment to maintenance of the economy and so we are very sensitive to the unnecessary growth of government programs and how they are being financed.



### Some costs for those expansions

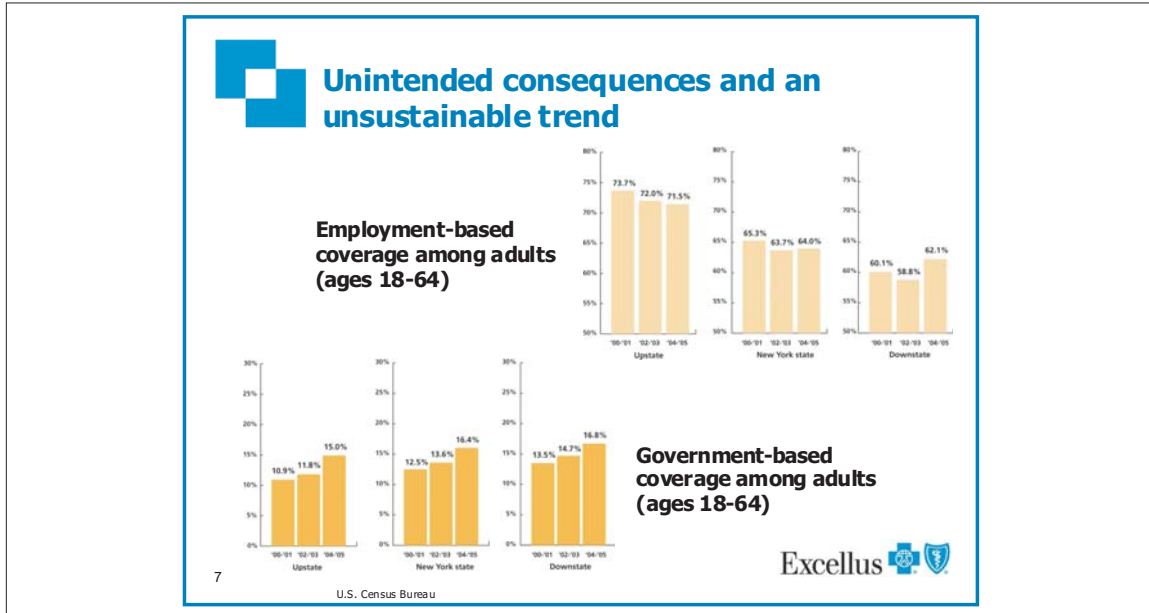
- **Expanding Medicaid increases the overall tax burden paid by businesses and individuals.**
- **Taxing the privately insured by more than \$2 billion to fund broad-based government programs makes coverage more expensive. These taxes are the second highest business tax in the state and fourth highest overall tax.**

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The second point on the slide here, and I am not sure that this is something that everybody knows... The second set of taxes, the \$2 billion taxes are basically the two HCRA taxes; the surcharge that covers large assessment. We looked at what those costs are by region and I am not sure everybody knows this but in Rochester, where I live, it adds close to 5 percent to the cost of premiums and every time we increase premiums, half the margin we are knocking out is somebody who can afford to buy care. We also note that we have, as a state, an inability to moderate what we tell people to buy and we have a proclivity for creating mandated benefits. Again, if I were to look at a typical statewide policy, we are adding about a \$1,000 a year in family coverage and that was before Timothy's Law was passed. I'm not saying these benefits aren't important benefits or that the services they made access to aren't good ones, but if you begin to think about the tax burden that people have in general and then the taxes that are on health insurance at a time we want people to buy more health insurance, it begins not to make sense.

When we look at the trend lines, and this is a little bit of a busy chart (see next page) and I apologize for it but I think all of you have copies before you, you can see that what this has led to, and again we are looking at the 2000-04 time table, is a decline in employment-based coverage. Upstate went from 73 percent down to 71 percent and statewide from 65.3 to 64 percent, at the same time you have seen a growth in government coverage. The problems associated with this go beyond the tax burden. Also, more and more government coverage is having a stifling effect on innovation and in some cases government under-funding the cost of care. The maintenance of a strong private sector provides a different type of safety net for providers. Just to digress for a moment, we have in upstate New York problems in retention



of a doctor workforce and if we were paying simply what Medicare and Medicaid pay these doctors, if we weren't paying a premium over those compensation levels, we would have trouble maintaining the workforce that we do. In some cases in highly competitive segments, like neurosurgery, we have to go much, much higher than what we automatically have gone to maintain access to these particular specialties. If we had only government funding, we would have problems in maintaining the viability of the delivery systems in these communities.

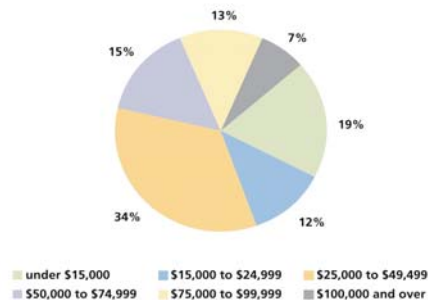
What we are suggesting is that we have a change in public policy to provide a proper balance between private and government coverage expansions and to have a proposal which is targeted to the three uninsured population segments. Let me start with the individual segment. Right now in New York State, you have only two options that the individual direct-pay market can buy. These are two standard products, which are legislatively defined to have comprehensive benefits. The average monthly cost for these products is about \$2,000, which is almost twice what you're looking for for comparable small-group coverage. The individuals that have signed up for this coverage are typically either very sick, knowing that they are going to spend more than \$12,000 or \$24,000 a year or they're very wealthy. When these programs came into existence about a dozen years ago, we had 110,000 people in them. We are down to about 55,000 now. This market is failing. If you look at who are the uninsured, and this would include not just individuals but those in groups as well, over a third earn more than \$50,000 a year. That would be represented by, on this box, the gray, the orange, and the blue. It would be the side of that pie chart that is facing



## A partnership goal: entice some of the uninsured to buy affordable 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)



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U.S. Census Bureau

Excensus

me as opposed to facing the ceiling. That is a lot of people and we believe that many, if there was product available for them to buy at a reasonable price, would buy. Our small group policies are among the most expensive in the country. That leads to 50 percent of New York's small businesses not providing coverage and if you look at who the uninsured are most of them, 54 percent of them work for firms of fewer than 25 employees. So what do we do to solve this problem? We have a series of ideas that we want to lay out.

It starts with merging small group and individual markets. The individual market has been mightily selected against. We are very cyclic here in that market. Small group has not suffered in the same way. Drive these two markets together and then community rate each product on its own basis to further remedy the problems we have had with adverse selection. Create a limited number of standard benefit plans; we're saying eight to ten but there is nothing magic in that number, which would range from consumer-directed health saving account (HSA)-style plans to the current comprehensive designs. By having standard plans, you are going to facilitate individuals being able to make comparisons between and among plans. Include wellness incentives. An example would be preventative and screening services, smoking cessation, weight loss, etc., so that we begin to mitigate problems downstream. Allow for innovation in plan design and if carriers could not be tied to the eight to 10 or whatever number there is, by petitioning to the insurance department and perhaps the health department; we would allow for an additional design to come into place with a demonstration period of a few years beforehand. But, you would find less adverse selection taking place predicated on which products are being offered. To get everybody to have skin in the game and to really focus on getting dollars to pay for care as opposed to for administra-



### To help assure affordability...

- **Impose minimum medical loss ratio of 80-85% on all standard products combined among all health plans**
- **Limit insurer/HMO administrative expenses and profits to 15-20% of premium**
- **Cut in half the 8.95% surcharge imposed on hospital services**
- **Establish stop-loss pool for claims in excess of \$20,000**
- **Funding from existing direct pay stop loss (\$40 million), Healthy New York (\$124 million), excess BDCC funds (up to \$500 million) and perhaps new cigarette taxes**

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tion, impose new loss ratios of 80 to 85 percent on all the standard products, on a combined basis among all the health plans. If you look at what is out there today, this will cover the vast majority of the plans. I think in the last year only a few plans were less than the 80 percent threshold that had been laid out. The converse of that is to limit health maintenance organization (HMO) administrative expenses and profits to 15 to 20 percent of premiums.

We go back to one of my early charts to show that the taxes on health insurance begin to impair the affordability of a product. Cut the 8.95 percent surcharge in half for this population to provide a direct subsidy, and in the new individual/small-group market, where 50 percent of the employers are not providing coverage and create a stop-loss pool. We are saying just for argument's sake at a specific attachment point of about \$20,000, that could be raised to a higher level if we are hitting program affordability issues and fund this from a variety of places; including: unused direct-pay stop-loss re-insurance funds, unused Healthy New York monies that are out there today, excess bad debt and charity care funds you are going to have, if this program works, hospitals with less bad debt and charity care write-offs, and perhaps new cigarette taxes. We model what this would do to premiums. This is using information from our Reg. 146 pool and also Empire's pool and if you add this up and this is a little bit of a busy chart, but if you go to the estimated net impact, which is a cumulative number, this will take the direct-pay premium down by about 30 percent and small group down by 20 percent. Again, we think that more people will stay with coverage or buy coverage with this type of reduction. These savings need to be further worked on. We need to look at all of the 146 experience that's out there to refine them, but we are pretty confident in them. We also believe that the savings may be low because today, and you can



## Estimated Premium Rate Impact of Proposals\*

Change	Individual Direct Pay	Small Group
#1 Merge Markets	-29%	+9%
#2 Community Rate By Product (Net of #1+2)	0-10%	0% to +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%
<b>Estimated Net Impact</b>	<b>-31%</b>	<b>-20%</b>

These savings are likely to be on the low side because...

\*Based on data under review by the Department of Insurance

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all think of your favorite example, there are people in the direct pay market like attorneys or accountants or consultants, like this audience in some cases, that would want to buy high-deductible health plans, HSA plans. In other markets, we have seen these products priced as low as \$200 and we would think that there would be some that would come in to buy them and that would help as well. The savings would make the private insurance market work. If we wanted to reduce some of our mandates as we did in Healthy New York, then we could reduce the premiums further. We are not recommending that.

On to the other segments. I gave you the individual small group, on to the working poor. We are not going to say much about this today but suffice it to say that you have a lot of people out there who are eligible for the safety-net programs that are not enrolled in them. Sixty-two percent of the uninsured are below the 200 percent of federal poverty line, 17 percent are between 200-300 percent. Of the 2.6 million, about 1.2 million are eligible but unenrolled; 70 percent of uninsured kids are eligible for SCHIP, but not enrolled. We think that there are streamlining opportunities available here. We could simplify forms, simplify certifications, extend periods of certification to get more people covered. If you add together this set of actions, we believe that you can get to about two-thirds of the current uninsured insured. As we begin to think about moving toward universal coverage in a four-year timetable, this represents a very good first step. And, again, it protects everybody, the state, the providers, by having it be a collaborative effort and maintenance containing pluralistic financing. Courtney, I will stop there.

*Courtney Burke:*

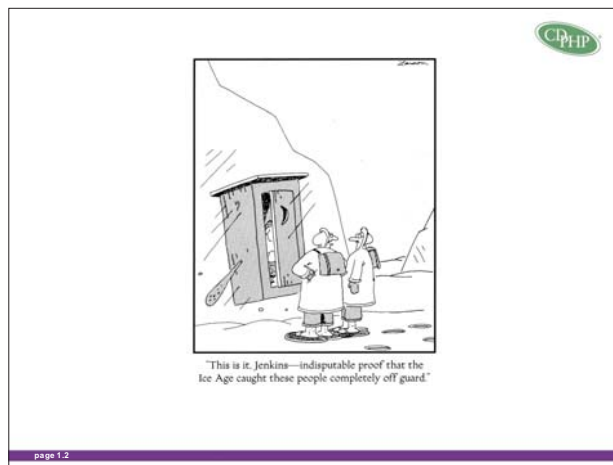
Thank you. It was great to see those numbers. I am sure some folks will have questions. At this point, I will turn it over to Bill Cromie.

*William Cromie:*

I am Bill Cromie with Capital District Physicians' Health Plan (CDPHP). We are a physician-directed plan that, through a combination of commercial and government programs, insure in excess of 400,000 people. This foundation impacts the character and interactions of our plan with our patients. I'd like to thank the New York State Health Foundation, United Hospital Fund, and the Rockefeller Institute for inviting me to speak. I am very privileged to talk to you today. David reflected on the cumulative wisdom of 25 years in this business, and he has the ability to deal with critical issues with high granularity and a great deal of thought. His thoughts reflect a lot of the ways that those of us who are in not-for-profit health care in upstate New York are looking at the challenges we face. It is a totally different conversation than downstate, where there is a whole different model, as you all well know. What I have chosen to do is talk a little bit about technology, because that's another piece that's very important in the equation to provide high-quality health care at a reasonable cost. The employers are looking for value and value is cost over quality. We have to manage that equation and I believe that will be accomplished with the use of technology.



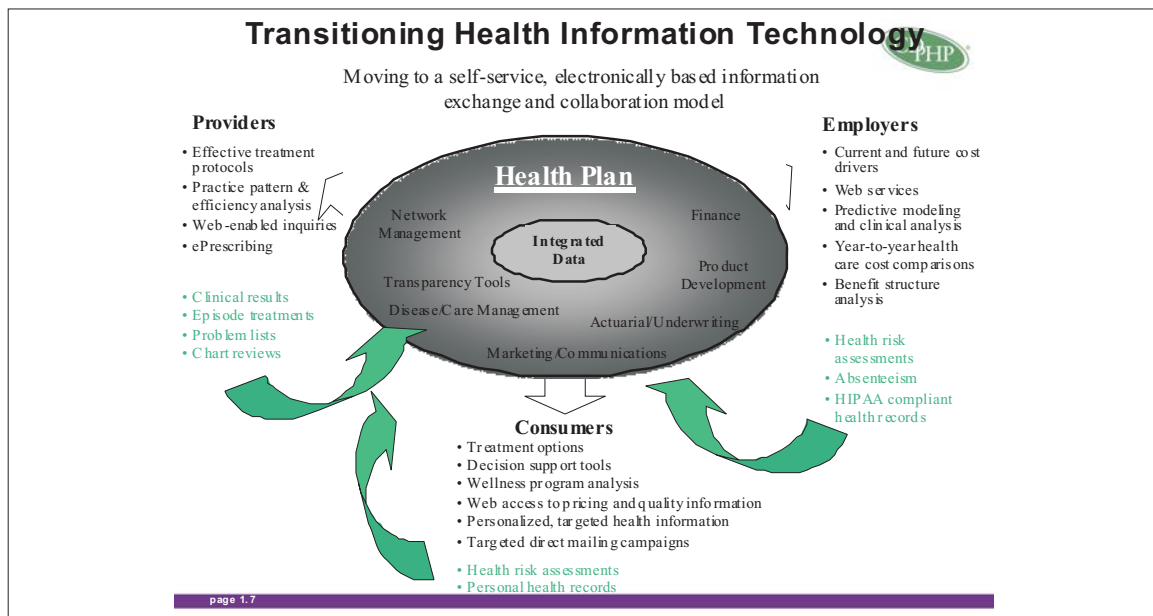
In keeping with my standard *modus operandi* — a little levity. Gary Larson, my favorite cartoonist: “This is it, Jenkins. Indisputable proof that the Ice Age caught these people completely off guard.” You're not laughing, but I'm thinking about what happens to providers in health care and technology. It really has caught the physician and provider community off guard because



the rest of the world has been totally transformed by technology and we have to drag, frankly as a physician, the physicians kicking and screaming into the 21st century because this is going to transform our lives and their lives. I don't want to leap ahead to talk about what Hillary Clinton was talking about this morning but, basically, the future insurance and health care market, if it's going to be anything like the kind of universal coverage proposals that we've been hearing about, needs to be a proper balance between private and government coverage expansions. And I think David talked about that clearly. We should target the uninsured populations. And, again, David did a nice job of showing you that Medicaid isn't exactly what you think it is, if there are 30 percent of the people who are truly able to buy health insurance but don't. We need individual small businesses and the working poor. There should be a direction on wellness and quality incentives in some or all of the plans that allow for innovation and flexibility. We should allow for a wide range of benefit plan designs from consumer-directed health plans to comprehensive plans. And we know that of all of those, the consumer-directed plans, particularly, are totally technologically driven. And, finally, emerging small-group and individual markets and establishing community rates for each product with separate product pools for each product, I believe, would be a very good start. And all of this mirrors a lot of the things that David has already presented.

The future health insurance market should be transparent. Technologically transparent. This is sensitive for many of the very large private health plans. For plans like ours, it's not sensitive. We've been rated and evaluated — whether it's the New York State Health Accountability Foundation (NYSHAF) or quality assurance report requirements (QUARR), you name it, we're used to that kind of lower spending evaluation. However, it needs to be interconnected and interoperable. Interoperability is a term you hear, and everyone talks about doing it, but it is not as easy as it appears. There is always the solution in the middle that will fit in between these pieces, but even that is a challenge. That is an issue we will have to deal with. The consumer needs real-time, personal health information. That will be transformational. And it's fairly generational. In the Capital Region, the average age of a physician is 52 years of age. Two percent use technology. They use e-mail, which their secretaries type. So you can see what the challenge is here. On the other hand, the consumers are moving to it. You see it in the younger generation; they couldn't live without it. The thing that we talked about is rewarding quality practice to provide value. It's that equation. Value equals quality over cost will drive the efficiency and all of the changes that we're seeking, because if you do that, you reduce costs. There is no question. There are an enormous number of studies done from Harvard or Dartmouth by Weinberg showing that the

best doctors have the best outcomes at the lowest cost. So, the cure in some ways, not the total cure, is technology.



Now, this is a busy slide but quickly, what we're looking for is to get efficiency in the quality of health care and at the same time, decrease costs. This will occur by the rapid growth of the electronic medical record (EMR), which means personal health records and opportunities for e-prescribing, remote patient monitoring, home monitoring, decision-support tools, and computerized physician order entry. A lot of hospitals are already using EMRs to great extent in reducing errors. But the challenge of these tools is interoperability, which we previously mentioned, the ability to exchange real-time data and transparency. Health data needs to be visible real time for all the people that need it but the challenge in that is privacy. So you run up against transparency and privacy and that's a substantial collision and one that has been worked on very hard by many entities.

The next slide (see next page) reflects the way we see it. In the middle is a health plan and we have three constituents that we deal with. Let's talk about the providers first. There are data, tools, disease management models, financial models, underwriting, products — all those pieces to integrate and electronically share with providers. They need evidence-based medicine, good treatment tools, practice patterns, efficiency analysis, web-enabled inquiries, and e-prescribing. In return from them, we need clinical results. We need episode treatments, problem lists, and chart reviews. We need to know what they have found. They have to share it with us.



### Constituent Benefits


	Member	Provider	Health Plan	Employer
<i>Point of contact information</i>	x	x	x	x
<i>Transparency</i>	x		x	x
<i>Efficiency and quality reports</i>	x		x	x
<i>Lower costs secondary to reduction in tests</i>	x		x	x
<i>Web-based solutions</i>	x	x	x	x
<i>Predictive modeling</i>	x	x	x	x
<i>More efficient resource utilization</i>		x	x	
<i>Consumer education</i>	x	x	x	
<i>Enhanced payment models</i>		x	x	

The employers need current and future cost drivers, web services, predictive modeling, clinical analysis, year-to-year health care cost comparisons, benefit structure analysis. But in return, we need the health risk assessment of their employees so we can help understand how to best provide their care. We need issues on absenteeism. And we need Health Insurance Portability and Accountability Act (HIPAA)-compliant health records. They have to be as responsible as we have to be compliant with the policy issues around HIPAA.

At the end, who is the winner in this? The winner is the consumer because they will have treatment options, decision-support tools, wellness programs, access to the web for quality information on providers and hospitals and pricing. They will have personalized, targeted health information. But what they have to share back with us is their health risk assessment and their personal health records.

So, this is a conversation between four groups of people that is exquisitely sensitive and all of those people are very concerned about this intermediation, that somebody will take something from them that they have traditionally done, and reduce their efficacy and ability. For example, take a hospital that has extremely complex patients. They're not thrilled about having that private health record in the patient's hands so they can go to another high-specialized hospital. That's almost their annuity. So the conversation that takes place between these people, the analogy would be the way porcupines make love —very carefully.

These are the benefits: point-of-contact information, transparency, efficiency and quality reports, lower costs secondary to reduction in testing. This is a big one, duplication of testing: predictive modeling, efficient resource utilization, consumer education. As you can see, the health plan is benefitted from this in that all the members, the employers, and the providers do help benefit from this exchange.



**What is an EMR?**

- Electronic Medical Record (EMR) is consolidated health record that is an isolated repository of practice and hospital encounters of a patient.
- The information generally included in and EMR is:
  - Patient demographics
  - Medical history, examination and progress reports of health and illness
  - SOAP notes
  - Medicine and allergy lists, immunization status
  - Lab test results
  - Radiology images
  - Clinical photographs
  - Medication information including side-Evidence-based recommendations for specific medical conditions effects and interactions
  - A record of appointments and other reminders

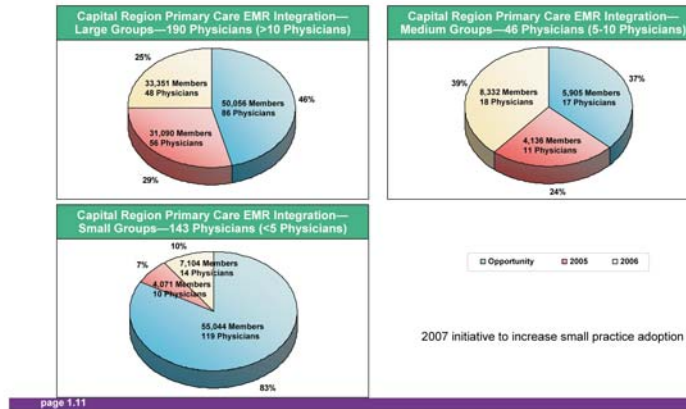
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What's an electronic medical record? It's a consolidated health record that is an isolated repository of practice and hospital encounters for a patient. So it's demographics, medical history, SOAP (subjective, objective, assessment, and plan) that the physician has provided, allergy lists, immunizations, lab status, radiology, clinical information, record of appointments, etc. The electronic medical record is the story of the patient. That's different from the personal health record. The personal health record is the comprehensive record containing all medical information related to the patient and accessible by the individual. They can own and keep this. And there is a huge debate about where this will reside. Will it reside in the hospitals? Will it reside in the health plans? On the web at Google? With the state? This discussion is substantial and there is no industry standard yet to define this.

This is just local information. This is information on our practices. We have felt that contributing to getting to the electronic medical record for practices is not a competitive advantage. It's a free good. It's something that we give to society because it's openly going to attract and help our physicians practice the kind of medicine that they need to. So what we did was created a physician incentive pool and over the past two and a half years we have pumped about \$4 million into our physician practices to help them get electronically con-

## EHR Adoption Among Primary Care Physicians: Small Practices are Lagging

### Primary Care Physicians

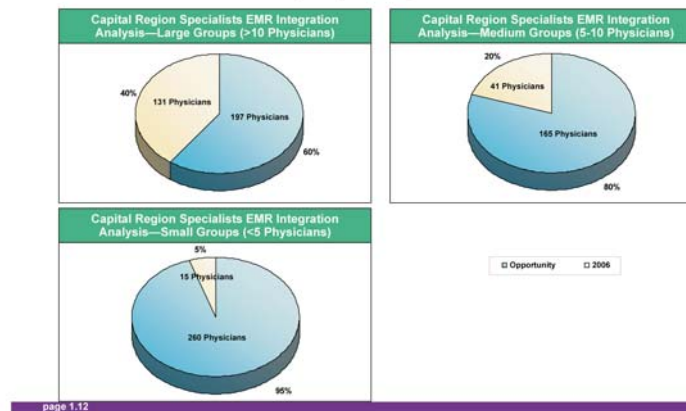


nected. And you can see that in the large-group practices, which is 190 physicians or above, of which 10 or more is a large-group practice, that's close to 60 percent on board. The blue is the opportunity. This is what we're looking for 2007. 2005 and 2006 are in yellow and pink. And close to 60 percent of the midsize groups and small groups, almost 83 percent have not adapted. So this year, our total focus as a plan is to focus on that small group of individuals, five or fewer physicians, to get them as comparable as their colleagues.

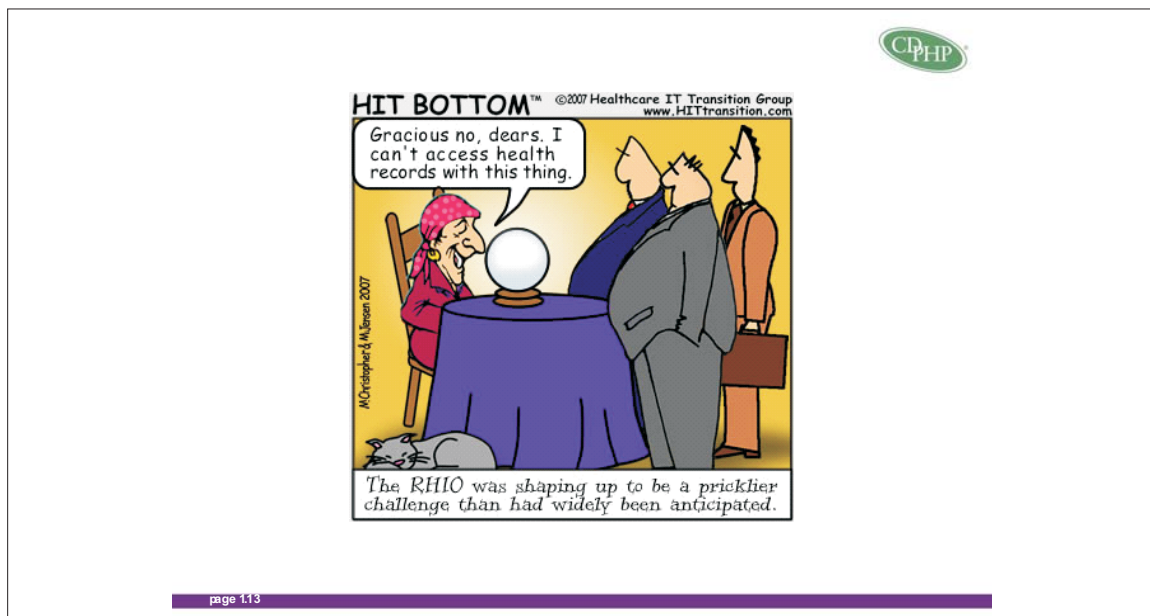
The next is specialty practices. As you can see, because they handle data but in a different way, they have been later adapters than the primary care practices and you can see that

## EHR Adoption Among Specialty Care Physicians: Specialty Practices are Behind Primary Care

### Specialty Care Physicians



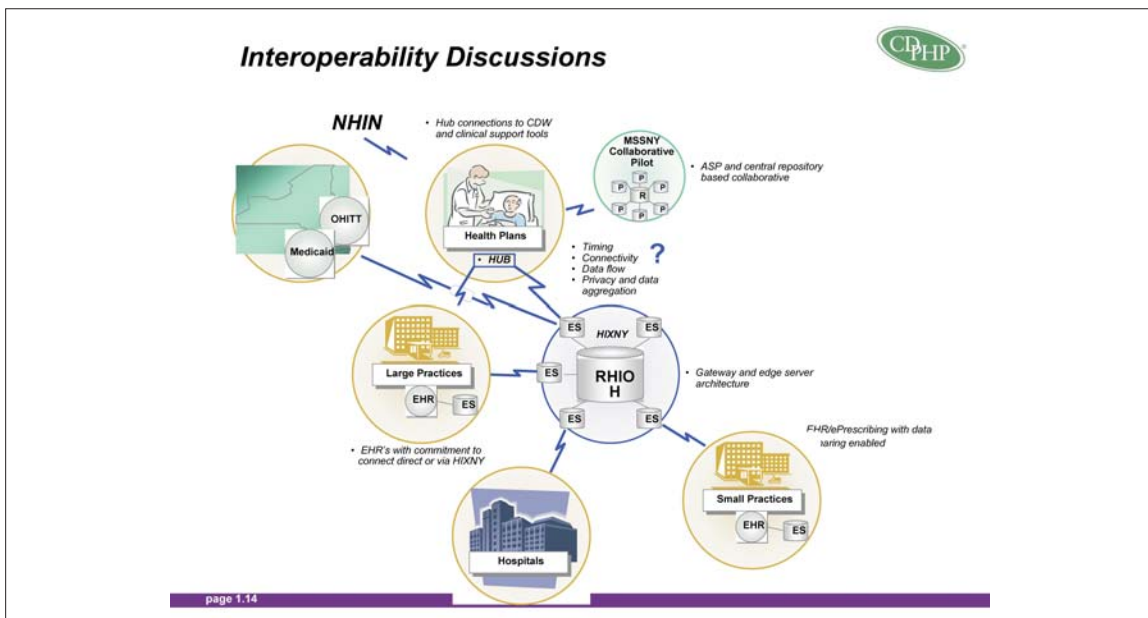
we have a 60 percent opportunity in the large group, which is 10 physicians and above, and 80 percent opportunity in the midsize group and close to 95 percent in the small specialty groups. Now, those are part, usually, of large practices, but the ones that are individual present a real challenge. They have a need to do this but they don't have the same drivers that the primary care people do because they are evaluated on a whole host of deliverables around case and care management that the specialists are not. So this is another challenge for us. But this gives you an idea that we are making some substantial headway in the Capital Region, getting momentum around us. We have an e-forum where we have brought in substantial vendors and good speakers to talk about how important the electronic medical record is. As Newt Gingrich told them, "Paper kills." It's important to have this data. And I think that the events in Katrina were dramatic in making it clear how important it is to have electronic medical records in the event of catastrophes.



So the Regional Health Information Organization (RHIO) has shaped up to be a pricklier challenge than we had widely anticipated. And there are the providers, the employers, and the hospitals. "Gracious, no. I can't access health records with this crystal ball." Everyone is looking for an easy fix. Everybody is looking for something that will solve all the problems. Everyone, the physician community particularly, is worried not only about being disintermediated but they're worried about the cost. And they're worried about the fact that technology will leapfrog them and that they won't be able to participate. Mike Cropp can talk about what happened to his place — about \$75,000 for a primary care physician. I think you saw in the *Albany Times Union* just a couple of days ago that there are micropractices where a doctor just decided that he was going to put in electronic medical records, he's go-

ing to have no secretary, he's going to have no nurse. He was going to practice using purely electronic records to practice medicine. So there are extremes on all accounts.

Here is what's going on in the Capital Region. I will try to get through this quickly. You have the state driving this and the feds, the National Health Information Network, and the Office of Health Information Technology Transfer intimately involved. I think Lori Evans is leading that initiative. And all of the members of the state and this organization along with health plans who are extremely interested in this process, and the Medical Society of the State of New York (MSSNY) have tried to work together to initiate the process that I have talked about, the use of technology, electronic medical and personal health records. So you've got MSSNY, the collaborations there and these are a variety of plans that are using ASP, which is an application service provider. This is a software program that allows information to be shared in a shared data center that is accessible by broadband. You don't have to have these files in your office. And ASP is likely to be the most effective and cost effective for primary practicing physicians. That's why the Medical Society of the State of New York is modeling this.



Health plans. They have clinical data warehouses. We are currently rebuilding our clinical data warehouse to provide the kind of privacy and HIPAA compliance that is necessary to hold and store the private health information in the electronic medical record and to share it in an appropriate way. The hub of this is hopefully going to be the RHIO, which is the Regional Health Information Organization and the edge servers, termed ES, will intersect with this. They will come from large practices; they'll come from hospitals and small practices

and share the electronic health records and allow us, in real time, to exchange information that will be clinically critical and will allow us to practice the kind of care that we want to.

I'd like to end with an anecdote: One of our employees was on a trip in South Africa and his partner became extraordinarily ill there. He had a history of pulmonary fibrosis and was in the emergency room there and people didn't know what was going on. So we called and we transferred information from his physician, from the hospital and from our health plan to South Africa and within 30 minutes he was in the intensive care unit (ICU), they had his diagnosis, they knew how to treat him, they knew all of his previous medications and probably saved his life. So the fact is it can happen. We can do it but this is going to be an incredible challenge because of the cost, because of some of the psychological resistance of disintermediation for some of the people involved in this diagram that I have presented to you but it is a huge opportunity to execute on the things that David has already talked about. Thank you very much.

*Courtney Burke:*

Thank you, Bill. I think your remarks are very important. As we discuss the issues of coverage and access, one of the things we often forget about is affordability and quality and I think that information technology is certainly key to making that happen. Next we're going to turn to David Uba, who is the vice president for strategic planning for HealthNow New York.

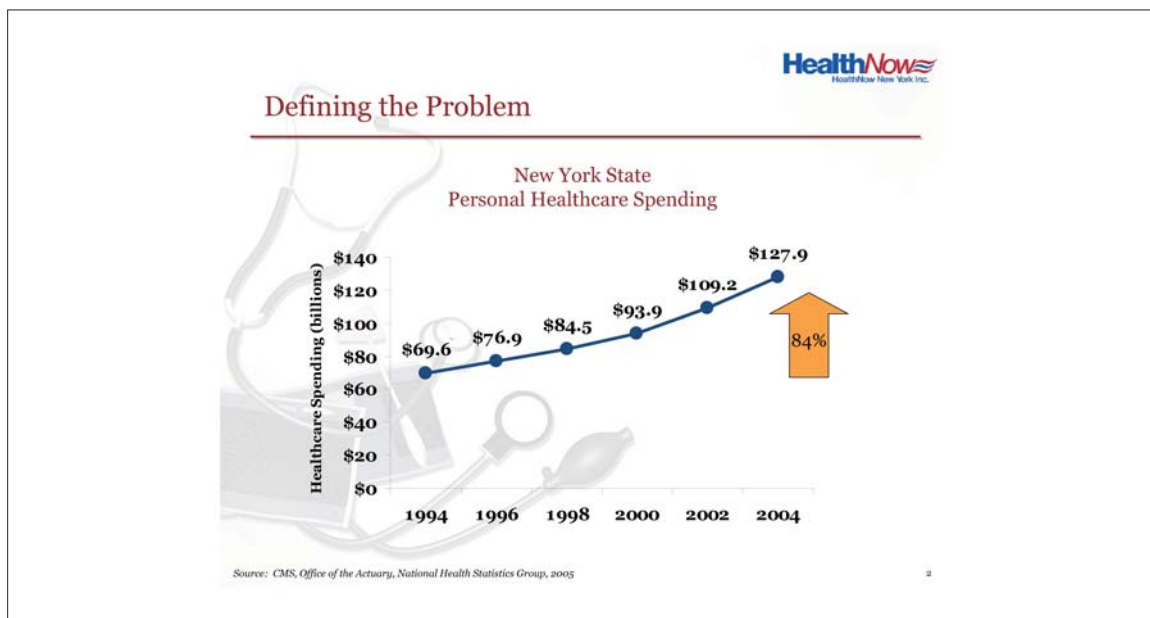
*David Uba:*

I'm glad I get to go while there are still some unique ideas out there. It's a pleasure to be here. My name is Dave Uba. I am vice president for strategic planning for HealthNow. We're the parent company of BlueCross BlueShield of Western New York and BlueShield of Albany. We cover about 700,000 individuals in western New York and northeastern New York. I want to



do both of what Bill and David did, talk a little bit about some granular issues and a little bit about some global issues. I won't spend a lot of time defining the problem because we all know what it is. I want to take the discussion from a different perspective and look at the

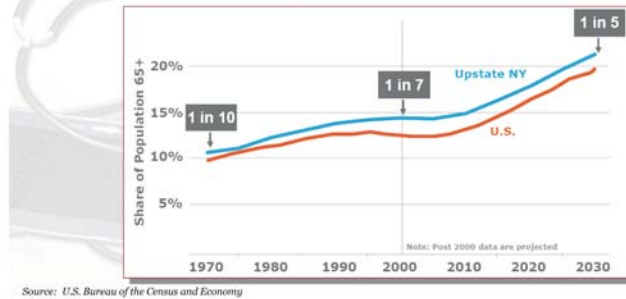
emergence of a retail market in New York State and how the flood of individuals being more and more involved in making health care decisions and paying for their own health care has created the need for us to create a market. We talk about products; we talk about affordability but the fact of the matter is, an actual market structure does not exist for universal coverage or for direct-pay reform or for small group reform and creating that market is going to be centrally important to achieving universal coverage. So I want to talk about the emergence of a retail market, what the components of a successful retail market would be, whether the environment in New York State is favorable or not favorable to that kind of market, and I will touch on a couple of other issues as they relate to universal coverage.



So this is the problem, health care spending in New York State and throughout the country has gone up 84 percent in the last decade. Similar national statistics can be thrown around. The increase in the gross domestic product as a percentage of spending is going up. What's causing medical inflation? While we're getting older, the problem is exacerbated in upstate New York. In 1970, one in 10 individuals was over the age of 65 and by the year 2030 one in five individuals will be over 65. We're getting older. We're getting sicker. It is estimated that by 2015, 149 million Americans will be treated for some type of chronic illness, representing 47.7 percent of the population. The aging of the population is exacerbated by other drivers of medical inflation whether it's expensive medical technology, effective yes, but still nevertheless expensive. It is improving care, fraud and abuse, variability in practice patterns, increases in utilization and medical errors. Low price sensitivity has also caused medical inflation. And I think we're probably all aware of this but it bears

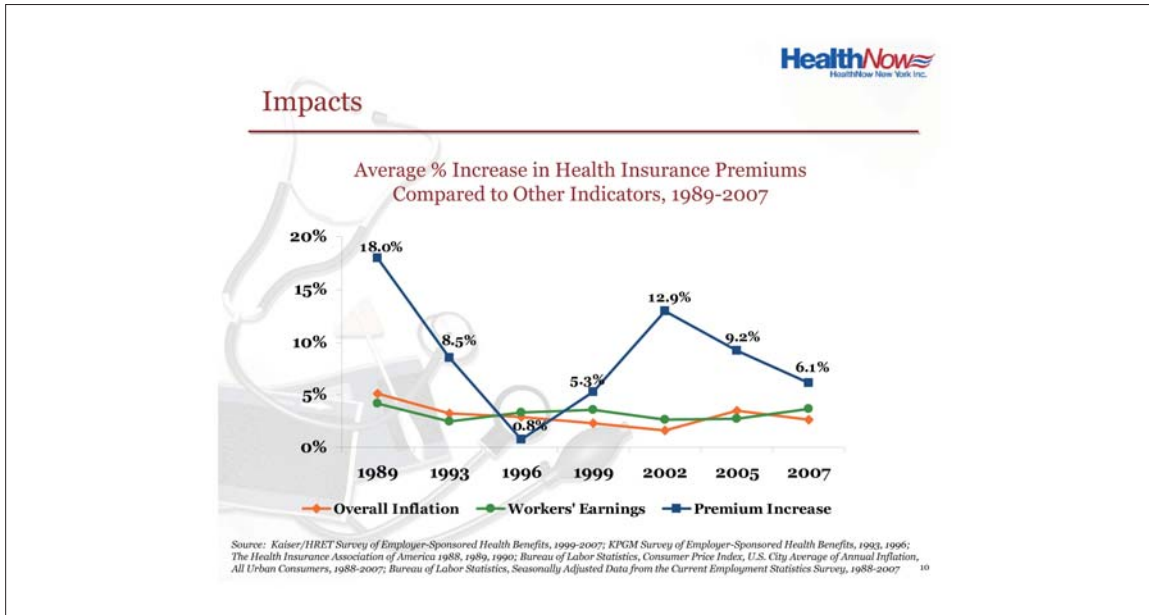
## Key Causes

- A key cause of medical inflation is the aging of the American population. This factor is magnified in upstate New York, as it is among the oldest metro areas in the nation.
- In 1970, 10% of the people in upstate NY were 65 years of age or older. By 2030, it is expected to increase to 20%.



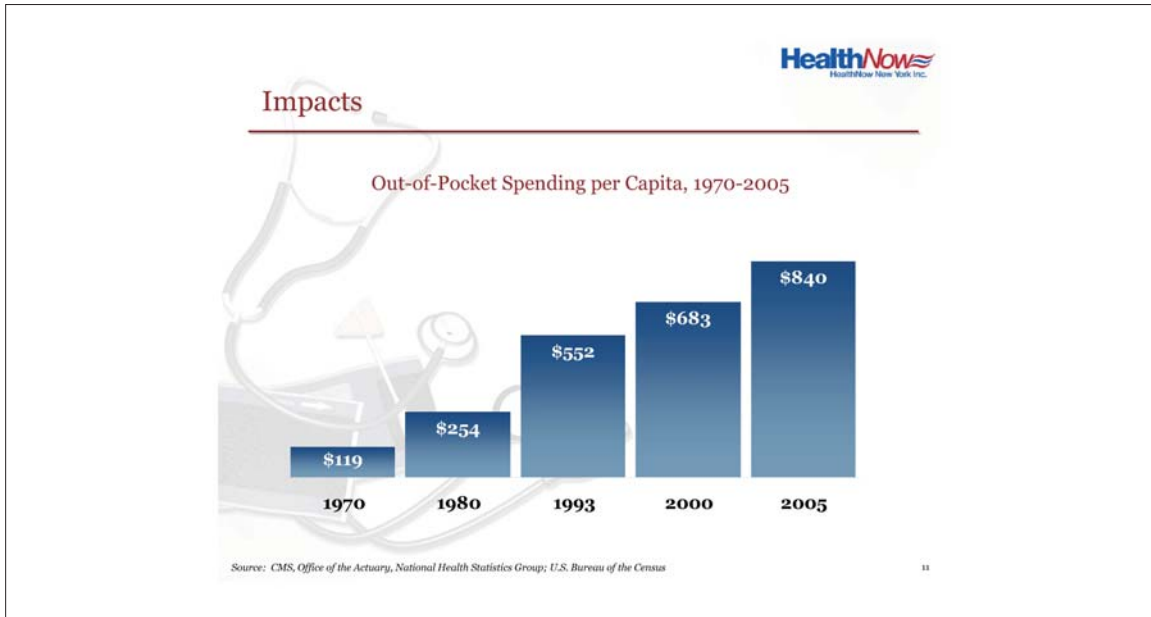
repeating. If you walked into a Target store and the salesman said, “Well, you need a new gazebo. You need a brand new grill for the backyard, a pool for the kids, a fire pit, and we’re not going to tell you how much it costs. You’ll have no idea how much it costs and we’re going to send the bulk of the bill to somebody else.” Imagine what other stuff you’d buy if this were the scenario, which exists in the health insurance and the health care industry as opposed to the actual retail market, which we’re all familiar with, where you actually have to bear the cost of the product that you’re purchasing.

So, what are the impacts? We touched on some of this before. Health insurance premiums are increasing at a faster rate than workers’ earnings and overall inflation. As a result, out-of-pocket spending per capita has increased from \$119 per person in 1970 to \$840 in 2005. David showed these statistics around the number of employers offering employer-based coverage. It’s shrinking in New York State. It’s shrinking in upstate New York. They’re not only stopping providing coverage for active employees but the number of firms providing retiree coverage is dramatically decreasing over the last several years; 66 percent of all firms with 200 or more workers in 1988 offered retiree health insurance and only 35 percent of those firms offer it now. So what’s happening is these trends are creating a growth in the individual market. More and more individuals are out there trying to find coverage for themselves. And the individual market is already, depending on how you look at it, in New York State about 9.4 million people. If you add the uninsured, those on public programs, Medicaid, Family Health Plus, Child Health Plus and the direct-pay market, that individual market is already huge. And it will continue to grow as these trends continue. So



what we see is a retail revolution. I guess the revolution is actually already here. But the size and the expected growth of the individual market cries out for a retail market where a market driven environment, where access to price, quality, service information is readily available and that is not what we have today. So whether it's through employer coverage, whether it's through more individuals looking for their own coverage, the individuals themselves will be much more responsible for the cost of health care and their own health. So we need to create this market. We need to enable the emergence of a retail market to control health care inflation and achieve universal coverage. I want to talk about the direct-pay market reform a little bit as a key ingredient in achieving universal coverage. Before I do that, I want to touch on some of the components that will be necessary to have a successful retail market to give us some idea of what major areas that are going to need some focus as discussions around reform and universal coverage continue.

I will give you this disclaimer, I am not an economist and this was not a scientific study. We simply designated these based on where we thought we were in New York State. So in an actual retail market, in any successful retail market you have product, variety, and choice. Abundant choice is in features driven by individual needs or lifestyle or life-stage factors. David touched on this. The limitation of two products in the individual market is not sufficient. There is not enough choice. There is not enough flexibility. We have a one-size or two-size fits all mentality out there at this point. The reason the direct-pay market is small is because the products are not affordable. We need more market-driven pricing. We need a much greater variety of price points. David mentioned those products can cost \$2,000,



\$2,500 per family per month, much, much more than the cost of even the small-group products. And so the market is unfavorable for that. We need transparency. We need information on price, quality, and service out there as consumers are asked to bear more of the burden of choosing and selecting health plans and managing their own health. They need the information to do so. If you had to buy a car without price, quality, and service information, it would be extremely difficult. We are starting down this track and I think we have a good head start. We have the New York State HMO report cards. We have pushes for standardization of quality metrics across providers. So we have the beginnings of that type of market in New York. Accessibility and simplicity are required, effective distribution channels, reaching

**Retail Revolution**

Components of a Successful Retail/Individual Market

Features	Current Environment
<ul style="list-style-type: none"> <li>➤ <b>Product Variety</b> <ul style="list-style-type: none"> <li>Abundant choices and features driven by individual needs, lifestyle, and life-stage factors</li> <li>Flexibility for innovation</li> </ul> </li> </ul>	Unfavorable (Red)
<ul style="list-style-type: none"> <li>➤ <b>Affordability</b> <ul style="list-style-type: none"> <li>Market-driven pricing</li> <li>Variety of price-points</li> </ul> </li> </ul>	Unfavorable (Red)
<ul style="list-style-type: none"> <li>➤ <b>Transparency</b> <ul style="list-style-type: none"> <li>Information about price, quality, and service               <ul style="list-style-type: none"> <li>Decision support tools</li> <li>Advocacy services</li> </ul> </li> </ul> </li> </ul>	Workable with some modification (Yellow)
<ul style="list-style-type: none"> <li>➤ <b>Accessibility / Simplicity</b> <ul style="list-style-type: none"> <li>Effective distribution channels</li> <li>Reaching consumers "where they are"</li> <li>Outreach, communication and awareness</li> </ul> </li> </ul>	Favorable (Green)
<ul style="list-style-type: none"> <li>➤ <b>Consumer Protection</b> <ul style="list-style-type: none"> <li>Appropriate regulations and controls of products and pricing</li> </ul> </li> </ul>	Workable with some modification (Yellow)


Favorable    Workable with some modification    Unfavorable

consumers where they are. I actually think this is okay. I don't think it's hard for an individual to look and see what their options are. New York State has great web sites, great tools that individuals can access and see what their options are but the fact of the matter is they're just not affordable. So it's not a matter of they can't find the products or anybody to offer them. They just can't afford them. So I think conditions are somewhat favorable. And there is some need for consumer protection, appropriate regulations, and controls of product pricing. So those are the major components that we will need to focus on to create this retail market and accommodate the flood of individuals shopping.



Additional requirements for universal coverage. The addition of new products is going to cause adverse selection. So some effective management of adverse selection and risk pooling is necessary but what could help that tremendously is an invigoration of these risk pools with much better risk. Covering healthier individuals will help spread out that risk among all the plans. Although we really would prefer to see an incremental approach to getting more and more New Yorkers covered, I think at the end of the day after all those private-sector reforms are done, hopefully, we see how those go, some coverage mandates will probably be necessary to get those last few remaining people covered. But I think we would like to see how some of these incremental changes and reforms can be effective first. We have to build on some of the progressive public policy programs that we have in New York State. David mentioned that they have been very effective in increasing the number of people who have gotten coverage over the last several years. Funding ought to be available, whether it's a redirection of existing funds as a result of some of these reforms, but it ought

to be available if we make some smart decisions and some changes. And it's going to require cooperation and coordination among all stakeholders in order to make this work.




### Direct Pay Market Reform

- Direct Pay products typically cost 2.5 times more than small group products.
- Claims expense PMPM for HealthNow's Direct Pay products runs from \$1,100 to \$1,400, 3.6 to 4.6 times the expense of a typical small group product.
- 4% of the membership in HealthNow's Direct Pay products drive nearly 2/3 of the claims expenses.
  - Mix of bad risk and those who can afford coverage
- The NYS Direct Pay market is small because the products are not affordable
  - Lack of product choice and flexibility

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I just want to touch on direct-pay market reform a little bit as a key enabler to achieving universal coverage. We talked about the medical expense. Our data matches what Excellus and Empire found, that contrary to popular belief, not everybody in direct-pay products is sick. Only 4 percent of the membership drives two-thirds of the expenses in our direct-pay products. So it is a mix of some bad risk, but it is also some wealthy people who can actually afford \$2,500 a month for a policy. So the bottom line on the direct-pay market is that it's small because it's simply unaffordable and what's driving some of that unaffordability are limitations on a plan design, creativity, and innovation. So what should the goals be? You know, simply if we take anything away from this discussion, it's more product choice and lower premiums for customers. We are not advocating individual underwriting. We do not want to see a retraction in New York's leadership role in open enrollment and community rating. Try not to disrupt the other markets, small group market, and try to achieve broad consensus among all stakeholders. A lot of this I think complements what David and Bill have said pretty well and is very consistent. More product choice beyond the two mandated offerings. I'm not sure that they necessarily should be standard products. I think they should be very market driven. I don't think they should be mandated. Companies, providers who wish to be in this market can be innovative and creative and offer these types of products. Allowing for varying levels of co-pays, deductibles, and co-insurance will help make those products much more affordable. Allowing flexibility in plan design. Potentially reconsidering the applicability of all the benefit mandates on all the products is probably something

that needs to be reexamined at this time. Enabling some market driven, innovative products. We needed to benchmark products like Wellpoint's *Tonic* product, Rocky Mountain Health Plan's *Solo* product, and Humana's *One* product as creative, market-driven segment-specific approaches to the direct-pay market and it's increasing the number of people who can access coverage.



### Proposed Direct Pay Market Reform

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#### Conclusions

- Products need to be more affordable for direct pay consumers
  - Current costs are out of reach
  - Current subsidies need to be more meaningful
  - Adverse selection needs to be addressed
- Product variety and choice are the keys to solving the affordability crisis
  - Not all Direct Pay customers are chronically ill
  - Product design should be more market driven
- Premium subsidies should be income-based
- Participation and consensus are important to achieve legislative action

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From an affordability standpoint, I think many of these themes can help make the products more affordable. New benefit and cost-sharing options will lower the cost especially if they are rated in separate risk pools. Now, again, we will have to deal with the adverse selection issues and balancing the risks among the participating plans but at least people can have access to a low-cost product. I think we would rather people had something than nothing because they can't afford the limited options that are out there. Potential solutions to the affordability issue. Perhaps apply Reg. 146; it's a direct pay in Healthy New York products only. Take it off from the small-group products. I think we, as an industry, would say that Reg. 146, the application, the mechanics of it need to be reworked so it works a little bit better but we can explore that. Additional subsidies could be reallocated from other areas either from the Health Care Reform Act (HCRA) or possibly new taxes to further stabilize the pools and subsidize premiums for low-income customers. David touched on this too, expanded coverage options and enrollment will invigorate these pools with better risk. As this risk goes into the pools, the cost should be more affordable and as more and more people get coverage, the amount of bad debt and charity care that hospitals have to endure should decrease and, therefore, we should have extra funds available to provide subsidization. I think the HCRA bad debt and charity care pool is about \$765 million. If we could move closer and

## Controlling Healthcare Costs & Achieving Universal Coverage

### Additional Considerations

- Evolve and standardize provider quality incentive programs and incent providers and payers to adopt emerging health information technology initiatives to further reduce costs
  - Physician and hospital quality incentive initiatives are effective
  - WNY HealtheNet and HealtheLink are models to emulate
- Continue to establish standards to measure, collect and disseminate information about price, quality, and service for consumers

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closer to universal coverage, that's money that could be used to stabilize the pools and provide subsidizations. Potentially exempting the direct pay products from HCRA hospital claim surcharges and the covered-lives assessment might free up some of that money and would have very little impact on HCRA revenue but hopefully go to decrease product price. I think, as David said, everyone has to have skin in the game. We would certainly advocate for a minimum loss ratio in products but I would say that all direct-pay products are well above that at this point, given the mechanics and dynamics of the market.

So from a direct-pay market reform perspective, products need to be more affordable. For the direct-pay consumers current costs are out of reach. The current subsidies that are out there need to be a little bit more meaningful and we need to address the adverse selection. To get to the affordability issue, product, variety, and choice are the major keys to that, innovative product design targeted at certain market segments. And consideration should be given to making some premium subsidies, not specifically stop-loss for the smaller market but premium subsidies ought to be income based. Participation and consensus among everybody in this room will certainly be helpful in driving legislative action.

Bill went over a couple of these (see next page) but I will just briefly touch on them. We talked about direct-pay market reform but to achieve universal coverage and to create that retail market that I had mentioned before, certainly evolving and standardizing provider incentive and quality, payments and Dr. Cropp will touch on this, I think. Driving adoption of emerging health care technology initiatives certainly will be helpful. We've had some good

## Controlling Healthcare Costs & Achieving Universal Coverage

### Additional Considerations (cont'd)

- Additional distribution channels need to be explored and developed, including on-line shopping and enrollment options for consumers, and various affinity programs
- Health plans need to evolve their service models to assume additional advocacy and advisory roles
- Maximize enrollment in Child Health Plus, Family Health Plus, and Healthy NY among eligible individuals, expand eligibility to higher income levels

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## Controlling Healthcare Costs & Achieving Universal Coverage

### Conclusions

- All stakeholders must prepare for the rapidly emerging retail healthcare market
- Creating a more robust direct pay market will help attain universal coverage
- Since the federal government will find it difficult to expand its role as a payer, experimentation and reform at the state level is necessary
- A combination of market-driven solutions, regulatory reform, creativity, and intense cooperation among all stakeholders can achieve universal coverage, more controllable healthcare costs, and improved quality

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success in the western New York market, wonderful collaboration between payers, providers, and health plans in Western New York HealtheNet and Western New York HealtheLink, which is our emerging RHIO in complying with the HCRA requirements in a community on a community basis.

We need make sure that information on price, quality, and service are out in the market, continue to establish standards for measuring, collecting, and disseminating that information. Make sure that distribution channels for these markets are available. Whether it is on-line shopping, enrollment options for consumers, I think a health care connector might be an

interesting idea but I think innovation among those offering the plans should be explored initially because I think that will breed more creativity. Health plans also need to recognize that they play a larger role other than claims payer. They are now providers of information. They also are advocates for consumers, as consumers need to find their way through this maze of new requirements being thrown at them. We need to maximize enrollment among the working poor and expand eligibility if we can do so, if we can get the appropriate waivers in place so that money can get reallocated.

So the retail revolution is here. The individual market is here. We need to make sure that the market conditions are right for it and we need to create a more robust direct-pay market to move toward universal coverage. And the reform I think is going to happen at the state level, not at the federal level. It's going to be very difficult for the federal government to expand its role as a payer given the budget issues. So reform at the state level and collaboration at the state level is not only necessary but it's appropriate. So some combination of these solutions should create a much more robust retail health care market and make products more affordable as we get toward universal coverage.

*Courtney Burke:*

Thank you, David, I certainly agree with your remarks that reform is happening at the state level at this point and it's a very interesting idea. It's about targeted, market driven products. So thank you. We would like to move on to Michael Cropp who is president and CEO of Independent Health and, importantly, also an M.D.

*Michael Cropp:*

Good morning and thank you to our hosts for convening this dialogue. I'll start by telling you, I'm even more technologically challenged than David so I don't even try to do this. I will just speak from my notes and we can make them available to you electronically afterwards. We've heard some really important information and some good insights and I thought it would be



helpful to me to give a slightly different perspective on the challenge that we face because we all understand the compelling need to have universal coverage, to have people in the

system so that we can work on improving the system, but we really need to focus on the issue of affordability if we want it to be sustainable because the one thing that we don't want to do is just to bring everybody into the system and, perhaps move it onto a slightly lower curve for a short period of time but have the same trend lines behind it. We know that that's not sustainable. We saw something similar to this when we had the first retail incursion into health care with pharmacy. Many plans implemented three tiered pharmacies and you're able to see a one-time savings initially. It just dropped down to a lower curve but the trend rates started going up pretty much at the same. Now, as that has begun to take root and we see real consumerism in pharmacy, we're seeing different trend lines altogether. And that comes about from information, plan design, proper regulation. It takes true market forces to work on that. Now, is dealing with the rest of health care as simple as dealing with pharmacy? Absolutely not. But there are some lessons there that we need to be able to take forward as we deal with the challenges of universal coverage.

Just by way of background, clearly you've heard that upstate New York is different from downstate. Most of you know that in terms of just the whole demographics, the economies, etc. There is a lot of diversity across upstate as well. Albany is a very different community than Buffalo. I think many of you saw reports recently that showed that Buffalo is the second poorest large city in the country. And, in fact, with all due respect to the two plans that are represented here today that we compete with, what keeps me awake more at night is people losing their coverage altogether and seeing the uninsured roles grow in Buffalo. So we have a challenge in Buffalo that may be somewhat different than the rest of upstate. Additionally, as a physician, I come to the dialogue with certain beliefs. Having practiced as a primary care physician, I believe, as Bill has stated and reinforced from literature examples, that better quality costs less. No question about it. But I also believe that more care does not equate to better quality. And those are basic premises that have driven me in my practice and my profession in the health insurance industry as well. As we look out to the universal coverage and the potential solutions, we know that we have to make some tradeoffs. Some choices are going to have to be made. If we want to go from covering a portion of the population to covering everyone, I don't believe it's sustainable to continue to cover everything that we cover. We need to recognize that all interventions are not created equally and we need to put an emphasis on those that have been proven to make a difference. Those are some of the kind of tradeoffs that we're going to have to face as we go forward.

I really don't need to touch upon some of the things that were covered earlier in terms of the benefits and why we're doing this and I really don't want to talk about the funding mechanisms because I think that those issues have been adequately addressed. I think Bill did a very nice job of talking about technology as a strong basis for what needs to happen in order to be able to affect the kind of changes to the system, to be able to make health care for all sustainable and affordable. But I want to talk about some other elements that are out there that are challenges that need to be addressed as you consider different proposals. I myself have not brought forward a specific proposal today. I just wanted to put some of these challenges out there for consideration.

A challenge that David raised: mandates. That's back to the issue of we can't afford to cover everything that we've covered to date for everyone. And we need to follow the lead that has been established by the mandate commission and take a careful look at that going forward.

Community rating represents some interesting challenges in and of itself. While community rating is probably a very good thing, what does community rating do to establish incentives for individual employers to work with their employees to do the right thing? It often gets in the way of that. So we need to consider the unintended consequences of things like community rating as we design our solutions going forward.

Reinsurance. I think that when Reg. 146 and other reinsurance mechanisms were put into place, they were well intended. But, you know what? The world has changed substantially since then. I believe that we were the first plan in the country that had an individual case that cost \$6 million a year. In spite of everyone's best efforts at the plan, in spite of all the great work of the providers all around the world, in spite of the patient and the family's interventions, \$6 million for one year. Now, I don't think our reinsurance pools considered the advance of technology to that level and we need to consider that as a reality today. So we need to look at the proper levels of reinsurance and whether truly extraordinary events that can basically wipe out a plan's margins for one year ought to be considered in a different way in a reinsurance pool mechanism.

There are some restrictive regulations that need to be addressed. There is a lot of bureaucracy that can be streamlined. And what has already been addressed are some of the significant taxes that are out there that can be channeled in different ways or reduced to be able to ease some of the burden in individual and small group markets.

Now, I want to touch upon some principles that I think are important to embed in the solution or solutions that come forward. First is the concept of individual responsibility. I believe that ultimately we need to have everybody in the system and, like David, that we're going to need to have a mandate at the end of the game to have everybody in. How that gets applied I will leave open to discussion. Everybody needs to be in, but if everybody's in, we need to understand that everyone has a responsibility. And on the other side of that, we have a responsibility too as insurers and providers to be able to be sure that they can access the system appropriately. So I think individual mandate has another side to that coin and that's individual responsibility and we need to recognize our responsibility as well.

And that leads to the second principle that I think we need to consider and that is access to care. Timely access to care. We've seen what's going on in Massachusetts now, where their plan might be scuttled by the lack of availability of access to primary care physicians. David has spoken about the egress of physicians in upstate New York and it's felt in Buffalo as much as anyplace else in New York State. But there are opportunities to address that problem short of increasing the compensation on a per unit basis for physicians. And I want to talk a little bit about that.

The third principle that I alluded to before that we need to keep in mind is we need to cover what works. All interventions, all services are not created equally. When the HMO Act was envisioned in the late 1970's, interestingly enough put forth as a proposal by one of our members from western New York, they envisioned comprehensive coverage in an era where the costs of care were significantly different than they are now and the technology available was significantly different than is available now. So we need to understand how things have evolved and move away from this concept of that comprehensive coverage that really gave birth to the HMOs through the HMO Act.

With respect to the individual responsibility, I think that we need to make sure that people have some vested interest in participating in the right way as individuals. And whether we do that through incentives, whether we do that through punitive actions on a tax basis, I think all that can be discussed. I think, in principle, my experience has been that if we can do it on a positive incentive side that works much better. It is much more sustainable to be offering more to people who are fully compliant if they have chronic diseases or are doing all of their preventive care work. It makes a whole lot of sense to reward that behavior and keep them in the game. Other approaches have been more punitive in terms of taxation or similar things to that. But if we're going to expect individual responsibility, I want to go

back to the other side of the coin and that is our responsibility to make sure that they do have access to care and that they have access to information and services in a way that they can use it. Whether it's electronic, whether it's voice, whether it's in person, if we're going to expect people to take personal responsibility, we have to provide them the information in ways that are understandable, in ways that are accessible, in ways that they can act on it. And as an industry, Bill has touched upon many of these things that we can do to assure that they have that information in a timely fashion but we also need to make sure that they have access to services.

With all due respect to Bill and the technology that he's proposing, those are great investments, those are strategic investments that we need to be making but what has always been at the heart of health care and what will remain at the heart of health care is the physician-patient relationship. It's the trust that occurs in that relationship that's key. And so we need to pay attention to these solutions that we bring forward to assure that we're building trust and we're supporting the information on both sides of that relationship in the right way.

Access to primary care, to preventive services, to those types of things is really a very important consideration. At Independent Health, we have done some exciting work over the past eight years now in helping physician practices redesign their processes to be able to provide same-day access; access when the patients need the care. Access that enhances the trust that exists between the physician and the patient. Access that, ultimately, by providing the timely care that's needed is able to reduce the cost of care considerably with demonstrable reductions in emergency room utilization, in imaging services, in specialty care, and in pharmacy care. That type of redesign to the processes of care is going to be important if we're going to deal with the primary care physician shortage and the issues of sustainability to the coverage solutions that we're talking about.

So, in summary, I think that what we have heard earlier today are important considerations in terms of how to create the right pools, how to get everybody into the system because only by having everyone in the system can we work on the system, but we must remember that in order to create a sustainable solution we have to be able to deal with the cost trends. And in dealing with the cost trends, if we don't deal with the issues of individual responsibility and with the issues of providing access to care in the right time frames, in the right way, we will never get at that trend line and all we'll be doing is a one-time solution to drive us to a lower trend line. Let me stop. Thank you very much.

*Courtney Burke:*

Thank you, Michael. Those were some interesting remarks on individual responsibility and giving people the tools they need to access the services that they need. Finally, we have Denise Gonick, who is vice president for legal affairs for MVP (Mohawk Valley Physicians) Health.

*Denise Gonick:*

I am MVP's chief legal officer. Dave Oliker, our CEO regretted that he couldn't be here today but I would like to thank you for having us here. It's been enlightening for me to listen to these comments by the CEOs and plans represented here. When Dave asked me to come and participate in this discussion I found myself going back and thinking about why we are here; why the



health plans are here. To me the promise of managed care was really to promote access to quality care that was affordable. It's the same thing that it was back in 1983 when MVP started as a physician created HMO. And when I think about the task that's before us, that's still it, isn't it? We're here. It's all about access. It's about affordability and it's about quality. You can't leave any one of those three out of the discussion. If we do so, it's at our own peril. They're intertwined.

MVP is now a diverse health benefits company. It's no longer just the HMO that it was in 1983 and that's instructive as to how the markets that we do business in have changed. We began in Schenectady, New York and now provide health insurance or administrative services to more than 660,000 people in upstate New York, Vermont, and New Hampshire. We offer a wide variety of products and services, as do my colleagues here, because we have to. Any notion that one size fits all or that there might be one solution just doesn't work. The customers are demanding a wide variety of choices. Certainly HMOs alone are no longer enough. The U.S. system of health care is incredibly complex and we're ever mindful of this at MVP. We've actually articulated our mission to provide peace of mind for our members that their health care needs are going to be met. And that's quite a challenge. The things that interfere with health care peace of mind are varied and by definition highly personal. The challenge for MVP and I daresay for my colleagues represented on the panel,

is to anticipate what those things are that might interfere with someone's peace of mind; to be vigilant when interference actually occurs; to seek out what the root causes are and to create and implement solutions for addressing them. So we think about this as our promise, that we will have a positive impact on the health and wellness of those that we insure. Certainly wellness and prevention, these are tenets that go back to the beginnings of HMOs and that need to be a part of any product designs that we talk about going forward. The health plans are more than claims payers. We're offering personalized tools and services to support wellness programs, work well/live well concepts, to empower and motivate individual members to take charge of their health. Healthy people understand that the value of prevention is important. To help people understand that health insurance is not something that you just need when you're sick is important to the solution. We also offer internally-developed clinical integrated solutions that help people manage their actual care.

Another part of our promise is to simplify access to quality, affordable health care. We have to offer multiple plan designs, different funding mechanisms to address the needs of customers. And we're all judged by external bodies, whether it's our customers, regulators, accreditation agencies, you name it. There is any variety of outside reviewers that will look on the work that we do and look to judge the value of it.

One thing that I wanted to mention. On the way in here this morning, I did hear a report on the radio, National Public Radio (NPR), about Senator Clinton's health plan proposal and they had a speaker reacting to it. He represented some type of a consumer organization; I didn't catch the name, and he was very resistant to what he had heard about the senator's plan. He didn't like the mandate. He didn't like it. He didn't think people should be forced to pay for something that was too expensive. That's what he didn't like about it. And that's got to be part of the discussion, how we're going to address that. Part of our obligation, I think, as health plans is to do everything in our power to keep costs down. It's right for government to push us to keep costs down. It's right for us to push our provider partners to keep costs down. But we also have to talk about what we're making available and address some of the realities that go along with that and what it takes to pay for it.

Another part of our promise is to strengthen the relationships between our members and the local health community. It really is about people in the end. Our employees and, I daresay, probably the employees of all the plans you see represented here today live and work in the communities that we serve and we think that local connection can make a difference in how we do our jobs. We maintain extensive, positive, and collaborative relation-

ships with providers and, like any other relationship of substance, that takes work, effort, and continual attention.

So part of our message to you would be one size doesn't fit all, and we need to try to achieve balance as difficult as that can be, and that we view the state of health insurance through the lens of the markets in which we do business. Certainly, the upstate market might be different than the downstate market and — even among upstate there are differences from place to place. But we can't have any discussion about what's wrong with health care without giving due consideration to what is right. We think that we have made progress in some areas. New York State's commitment to community rating is the right building block for expansion of coverage even if that means that we have to consider pools or certain risk areas in order for it to be evenly spread. And we also think that Healthy New York, as a product, is an example of something that can demonstrate flexibility in benefit design and can work for a population. So when I think about what we might do to make greater strides toward reducing the number of uninsured, there were five points that came to mind:

The first was leverage what was already available. I think you've heard that from a number of people today. We need to strive and commit to enroll all people who are uninsured who are currently eligible for an existing program into that program. Part of that is education, part of that is, again, this notion that health insurance is not just for when you're sick. Health insurance, if it's going to really work, if community rating is really going to hold true to its promise, we all have to be in it — educating the already-insured population on the value of their own role in health care. The coverage is really just the beginning of the discussion. Wellness and prevention are critical parts of the solution. And we've played an important role in the development of different tools and services to support individuals in their endeavors to live healthier lifestyles. That's not something that we do and check off the list; it's something you have to continue to do all the time — educate, make people aware of how their daily choices can affect them long-term.

Second, we have to create the right incentives. Any new universal coverage product shouldn't provide an incentive for employers currently offering health insurance to opt out of it. Any benefit design would need to be carefully considered and obviously the affordability and quality components to it can't be ignored. I also would agree with Dr. Cropp's comments that incentives or penalties for specific failures or omissions have to be considered. We've got to get to that mandate somehow where everybody's in.

Third would be to allow flexibility. We've heard that before, too. One size doesn't fit all. Our already insured populations, not just the large groups, are demanding customization, innovation, value, and speed. More of it and now. I think that the health plans that you see before you do have a role in any discussion and promotion about best practices, as well as sharing what some of those concepts are.

Fourth would be technology. Dr. Cromie spoke to this so well already but I would just add this — whether we're paying a claim, answering a question about a claim, or answering a general question, we, of course, have to do it accurately but it's got to be faster, easy, and look great, too. We are definitely a consumer oriented society right now. Consumers are savvy. They want it and they want it now. And health care, health information technology, I'm sure we all struggle with the costs associated with it, with investing in it. It's not going away. It's only getting more and more challenging. And yet medical errors are still a problem. Waste is still a problem. Continued investment in electronic medical records could help reduce these. And there is no question that the grassroots efforts that are needed to promote doctors accepting electronic medical records can only be fostered with participation from the health plans, as well as with support from the government. On a personal level, I would note that there has been a lot of discussion lately even with MVP about the impact of people's personal physicians beginning to adopt the electronic medical record, who go into a paperless office environment. Some of us have had the experience of going to see our doctor and actually have them sit there with the laptop, you know, typing as they talk to you. So it's a change. It's an investment in time and that's what we're going to need to do in order to move forward.

And, finally, any solution, I think, is going to involve continued dialogue between the private and public sector. I think we all want improvement in the status quo, but clearly we're not going to get there at the exclusion of any key stakeholder. The private sector has an important role to play in the administration of health care. We've been entrusted with information. We can use it to drive best practices and have a connection to our customers who hold us to an ever-higher standard. So we look forward to continued discussion of these issues with you. Thank you.

*Courtney Burke:*

Thank you to all of our panelists. There are a lot of good points that came out in the discussion today. We don't have a lot of time. We are running a little bit behind and we do

have time for discussion and questions this afternoon but I did want to allow for a just a few moments if that's okay, for some questions. If I could have the liberty of asking the first question — since we're in the day and age when sound bites are so popular in presidential debates, I was wondering if each of the panelists could give us a one- or two-word answer on the solution that they think would have the biggest change to the market. There were a lot of different things that were discussed like health information technology, individual responsibility for finding incentives, flexibility and benefit design, building on Healthy New York, enrolling the eligible, etc. We'll start with David and go this way.

*David Uba:*

Affordability driven by innovative products design and development.

*Denise Gonick:*

Benefit design and flexibility along with an individual mandate.

*Michael Cropp:*

Benefit design.

*William Cromie:*

I think it's a combination of choice, freedom for the consumer with responsibility to give them value, and to see that health care is provided. It's the right care at the right place for the right reason at the right time for the right cost. And that's all about benefits.

*David Klein:*

Choice and targeted subsidies.

*Courtney Burke:*

All right. And I did see a hand go up in the audience. If folks could just tell us who you are and where you're from, that would be great.

*Jeff Gold:*

Jeff Gold from the Health Care Association of New York State (HANYC). Thank you first of all. All of you reflect an intimate familiarity with the upstate economic market. You all represent not-for-profit health care plans, you are all part of the fabric of your community and you have all had long-term regional relationships where you function and I think are probably critical. If you were to put yourselves into the mindset of the CEO of a for-profit plan entering the same discussion, could you possibly come out at the same place that you've all just come out?

*David Uba:*

I think so. I don't think there is anything inherently wrong with for-profit health care. Hopefully, if they're running their businesses the right way then their business is driven by customer requirements and delivering value to the customer rather than being distracted and only trying to deliver that value to the stakeholder. So I don't think there's anything inherently bad about conversion per se or for-profit plans if they're running their business the right way. I don't think the business model determines that but it could. But I think a focus on the customer and customer requirements in delivering value ought to trump that and supersede it.

*David Klein:*

I would like to look at what David said. I don't think that there is anything inherently toxic in having shareholders and being accountable to them for creating margin and wealth. I think the difference between the upstate not-for-profit plans is that they are, as you said, Jeff, focused on the fabric of their communities and you've heard many of us talk about access to care. When you're beholden to Wall Street as opposed to Main Street, you don't care as much. Your focal point is not quite the same. And we've touched on conversations you've heard about technology and HIT, physician workforce; I would be surprised if a CEO of one of our for-profit competitors would lead to those types of comments. If our communities end up with bad health care, they become economic dinosaurs. High taxes. You would have image issues related to weather on occasion. We have pretty good educational systems across upstate. If we were suddenly to have not-available health care from hospitals or doctors that weren't good, they were bad, I just can't imagine very many businesses continuing to be able to recruit and retain employees in these markets. And, if

you had fill-in-the-blank publicly-traded health care company, they're not going to be concerned about the same... I've had direct conversations with some of those groups and they largely stay out of our markets because they don't see them as economic growth engines.

*Michael Cropp:*

Can I just add something to that? I think that looking at for-profit health plans is looking at the tip of the iceberg. There are huge drivers of the costs of health care. It's one thing to have choice at the top of the food chain in terms of for-profit or not-for-profit health plans but to have people have all of those machinations that are cost drivers invisible to them is a huge problem, and that's part of why my one-word answer was benefit design. Because we can't allow them to be hidden from market forces.

*William Cromie:*

I think those points are excellent. Another plus is, if you look at programs like SCHIP, Healthy New York, and Family Health Plus, the for-profits do not participate in those in general. This is another caveat of why we not-for-profits basically look at ourselves as community resources, part of the regional economy, and part of the solution for the state. If you look at quality rankings objectively, the plans around this table rank highest nationally, regionally, and statewide. It's not a priority of the for-profits.

*Courtney Burke:*

One more question.

*Rima Cohen:*

*(Too far away to hear part of the question).* How does segregating people into plans that have fewer benefits actually address the issue that there are always going to be a certain percentage of people who need care and need those benefits? For instance, because I'm healthy, if I take a plan that doesn't have prescription drug coverage or something else, if I end up needing those benefits, I'm going to have to get them somehow. Or the people who need them anyway, if they segregated themselves into the richer benefit packages, would be using that care. So overall, I don't see how that reduces health care costs.

*Courtney Burke:*

And just for this side of the room, if you could not hear the gist of the question, how does benefit design really help in high cost contributions?

*David Klein:*

I think your point is well made. Clearly, there are selection effects that take place and the antidote to them is pooling. What we see in particular in the direct pay market is that pooling has failed. And so the question is, how do you bring people back in at any level? Even the population that is not absolutely sick but just near-sick and the answer is, if you add some more choices and at least have a core of services, hospital and physician services, you get more pooling. In the model that we laid out, we had talked about small group and individual being pooled together, which is a stronger antidote to the poison you describe. In a perfect world, you would have one community-rated pool, but we are so far away from that. That horse left the barn years ago. You can't get back there. We had some discussions earlier about the value of incremental benefits. A lot of times benefits get added but not because they've gone through a rigorous economic analysis and actuarial studies and cost/benefit to the population. A mandate review commission should help to make it more of a fact-based debate. We don't have the opportunity to look backwards politically; that's not going to happen, but I'm sure something different than what we have in place. In both cases, you know, what we're trying to do is drop down costs so that the core benefits are available to more. It's a very tough call and your point is well made. Thank you.

*Michael Cropp:*

I think there's another side to this, too. When we say benefit design it doesn't necessarily mean take away benefits, although there are certain services that are covered under comprehensive coverage now that really don't stand up to the science and people can still access them. But you bring up an important point in terms of chronic disease as the major driver of cost. And when we think of benefit design, we think of the rough sort of premise that in order to improve compliance for people with chronic disease about a third of it can be achieved through working with the primary care provider, about a third of it can be provided through care coordination and a third of it is the individual's responsibility. And if you don't have benefit design flexibility to have them have skin in the game, you're going to be missing a full third of the opportunity. So some flexibility on benefit design to get people

engaged, I think, is an important dimension. We're committed to taking care of those people with chronic disease and making the investments that Bill talked about in order to help our care coordinators, our physician partners, and the members know what they need to do to do a better job on that front, too. But sometimes in the current environment we can't offer the right kind of incentives in order to get the engagement that we want. So some flexibility on that front is helpful.

*David Uba:*

I think you make a great point. I hope we weren't too narrow in our definition of all the things that were necessary for reform. Plan design is not the only answer. We have to approach affordability and accessibility comprehensively so it's plan design, but it's also the appropriate subsidizations, a focus on quality, and also the use of the information technology that we mentioned, effective disease and case management programs, sharing of information among all stakeholders. Plan design is not the silver bullet, one key component in a comprehensive set of issues that need to be addressed.

*Courtney Burke:*

We're out of time but before we move on to our business leaders, please join me in thanking our panel.

*James Tallon:*

Ladies and gentlemen, thank you, and thanks very much to our health plan panel. We have a very busy agenda. We are going to move through this panel, providing a point of view from the business community. We will then move to a quick lunch break and come back in and take a look at an interesting sector that we don't pay a lot of attention to, or haven't in similar discussion, the Taft-Hartley Plans. Then some of our colleagues from state government will give us an update of what's going on both in the health and the insurance departments and beyond. And then we're going to have some time to look into the agenda at the end. An hour is built in for a discussion, a broadly-based discussion. So everybody's going to get a chance to chat. Thanks to our colleagues on this panel and, as we said earlier, the bios are in the packet. John D'Ambrosio is president of the Orange County Chamber of Commerce. Steve McCormick is the plant manager at Anheuser-Busch in Onondaga County and has taken a leadership role with the Business Council. Ted Potrikus is the VP

and director of governmental relations at the Retail Council of New York. So, here are some good perspectives from the business community on the subject that we're dealing with and I will start with John D'Ambrosio.

*John D'Ambrosio:*

Thank you very much to the sponsors. We, the business community, appreciate being asked to be part of this discussion. I'm going to briefly tell you a little bit about myself because that sets the perspective for what I'm going to talk about. My professional background started in higher education administration and in 1982, after working as a volunteer for the Chamber, I



accepted a position, which at the time was called Executive Director. I've been there for 25 years now. The Orange County Chamber of Commerce this year will celebrate both its 10th and 125th anniversaries. You ask how that can be done. We consolidated two chambers in Orange County 10 years ago, and one of those chambers has a 125-year history. It's a 2,400 member chamber, which makes it one of the 10 largest in New York State. Our members include businesses of all sizes, both profit and nonprofit. Since 1984, we've offered health insurance to our members. We were one of the first in the state to do that. Currently, approximately 37 percent of our membership is enrolled in one or more of our health programs. However, that number has in the past been as high as 62 percent and that's a scary number if something goes bad. We believe that one of the causes of this downward trend is that more and more employers are dropping insurance coverage. People are picking it up through their spouses where that's appropriate. When that happens, what's really left in terms of the employees of the business, if, let's say, the owners go with their spouse's insurance because, basically, they can't afford it?

Now, who makes up the businesses that we serve? I think if you look at chambers across this state, you'll find these statistics are pretty consistent, and that is that 89 percent of all employers with employees (those that are not sole proprietors) have anywhere from one to 19 employees. We'll use that to define a small business at this point and, again, that's 89 percent from one to 19 employees. That's the breakdown in Orange County and it's close everywhere else except, perhaps, Westchester County where that number is 90 percent – pretty close. We think of Westchester as a big corporate kind of community and it closely

mirrors everyone else. While we haven't investigated the numbers on the national level, I believe they're probably similar. It's been said this morning that this nation's economy runs on small businesses, companies that are in existence and thriving with fewer than 20 employees, and this fact needs to be recognized when we talk about this issue.

Let's talk about the real world of health insurance options for small businesses. Historically, affordable group-rated health insurance has been provided by employers. The group was formed by the employer and included the employees and their families. And premiums were paid by the employer, sometimes, with employee contributions. Now, with insurance premiums continuing to rise, the number of employees being asked to contribute to the coverage has also risen. And for these businesses and their employees, this is going to be a hardship. But at least they still have an option. It's an expensive option, but they have it. Now, the reality for increasing numbers of employers, at least among our membership, goes like this: they contact our insurance coordinator to get the information that they need. (Please bear in mind that those who have 20 or fewer employees are doing this themselves.) The CEO is also the personnel manager and a lot of other things, including benefits administrator and more. So chances are, it's the owner who is contacting us and they are struggling to keep pace with what's been happening in an industry that is rapidly changing. We've gotten to the point now where if anybody calls regarding health insurance, they can only talk to our health insurance administrator because the rules and regulations, the costs of premiums, and all of that is changing very quickly. So, the business owner calls us and he or she is provided the information on the products and services we offer with regard to health insurance, and the primary issue is always, how much does it cost? They're not even asking about the benefits. They care about the cost. Now, I know that it's hard for you to believe, but every once in a while even I have to go to the barber and he is a small businessperson who, as soon as I sit in his chair, the only thing he'll want to talk to me about is health insurance. And this is a man who has been on probably eight of the nine plans we offer because it's all cost-driven for him. Our plans range from \$300 to \$400 for individual coverage and up to \$1,200 a month for families. Even health savings account options still have a cost of \$200 or more per month for the individual. So, in addition to trying to understand the complexity of the various plans and the options, the small business owner concludes, "I can't afford any of this." And industry specialists are going to confirm that too many of these people, like the barber, are jumping from plan to plan. If he feels he can save \$20 a month, to him that translates into a big number at the end of the year, and he keeps jumping.

What about the other 11 percent of the business owners? They're small businesses. The incoming chairman of our board is named Jimmy Smith. He owns a company called Advance Testing and he's a great example. We bring him with us whenever we go to Albany to talk to the Legislature because he brings the passion that comes from owning his own company. He started the business 20 years ago with one employee — himself — in the back of a station wagon. Now he has close to 100 employees. He tests construction materials. His corporate location is in Orange County, but he does train folks for the departments of transportation (DOT) in Massachusetts and Florida and other places like that. That requires him to look for an insurance plan that goes across the country and across the states where he works. In engineering, it's very competitive as it is in many fields, and if he doesn't offer a really good benefits package, the people aren't going to come to him. Up until recently, Jimmy used to provide full family coverage for all his employees. Now the new people coming in have to pay part of that cost because he can't afford to do it anymore. He's paying between \$50,000 and \$100,000 a month for health insurance for his employees and that's a tough nut for him. He acknowledged at a business forum that we had recently with Congressman John Hall, that in order for his company to grow, they had to include employee contributions. And as much as he wanted to, because it's like a family business, he just couldn't do it. He would like more incentives. He'd like tax credits that encourage businesses to provide more and more health insurance.

This is significant, this whole topic. It's going to force folks to shut down their businesses or go naked in terms of health insurance coverage. It's the number one question our staff get asked. No matter where we are and when we're there, it's about health insurance. So, for that small business owner who calls our office and in spite of what we tell that person, they take the coverage, by and large, because they need it no matter the cost. There are times when they can't afford it and we give them the options of Healthy New York, Family Health Plus, Child Health Plus, and all the other choices out there, but I don't know how many of these individuals are able to go with those companies. Too often it seems that those are the only options that we can offer to them. Now I've heard similar comments. We need to figure out how to make all of this work. We really do. During the early days of my tenure at the chamber, I frequently said that many business owners were forced to choose between two things — and it's more and more true today — the choice of paying their mortgages or paying for health insurance. And, sadly, it's too often the case. The current market priced products are too costly. Affordable health insurance is all they really want, and universal health options are not going to be viable if they're forced on the business community and have high costs associated with them. The consumer-driven health plans, if offered, have to

be affordable. It's not enough to be accessible; they've got to be affordable. And I don't have any specific recommendations. This is not my area of expertise. Debbie Bogdanski, who's our vice president for government, sitting in the back, knows a lot more about this than I do. But, please, don't place the burden of this on the business community because ultimately it's the small businesses that will bear that burden. We need to find a solution that includes the business community in policymaking. I appreciate being able to speak on behalf of the business community. Thank you very much.

*James Tallon:*

Steve McCormick.

*Steve McCormick:*

Thank you very much. Let me start with the end point. Imagine, and I'm going to speculate right now, I don't think we would be at this meeting today if health care inflation had been at the rate of CPR for the last 20 years. I don't think we would need to have this meeting. I've been in the beer industry for 29 years, so I'm not an insurance or health care expert. I'll give you a little bit more



about my background in a minute. But I would like to let you know about the beer industry. The producer price index for the beer industry in the last 20 plus years has gone up at half the rate of inflation. And I'm still paid okay. Our workers are paid okay. So that's a success story and fortunately we don't have to have our workers go to rally in Albany to try to get some more benefits or seek support from local member items to get our technology investments in our operations. And I understand the beer industry is far different from the health care industry. But I do want to let you know, if we were able to hold inflation in the health care industry providers, not on the paying side, but on the provider side, to half the rate of inflation, we wouldn't be having this meeting. And I'm not sure that's feasible, but I have some information that says we ought to have been able to do better than we have in terms of providing this.

For the last several years, I have been part of some state and regional efforts with the Business Council, in trying to look at what we, the business community, can do to make an

impact. Part of that really has been a learning experience on my part. And I've been standing back, not being a health care expert, watching. I've been looking and saying, "What's missing here?" What's missing here is the experience that I have had over 29 years of trying to make our operations competitive, more efficient. And we reap the benefits better. I've been at meetings with physicians and they're crying the blues. They have not seen Medicaid reimbursements or health insurance payment increases going to them. So I've been listening for three years and what I don't see is the same type of mechanism in place to focus on improvement in productivity. Two years ago, I was at a panel at the Business Council's annual meeting with Kemp Hannon from the Senate and Richard Gottfried from the Assembly and I thought we were going to be talking about affordability, and I was surprised by their focus. Not one conversation, not one interest on their part was in cost effectiveness. Market forces drive beer prices to be half the rate of inflation for the producers. That is not happening in the health care industry. There is not a mechanism. I do not see it. I believe the bottom line is that we need to do something different to make us focus on slowing down the rate of increase in health care costs. Forget about the paying side, what I can see missing is an effort, a focus, on driving down the rate of cost of delivering health care services and goods. That's what I have done for 29 years and I see it missing in this industry. I'm not an expert, but I can clearly see it's missing.



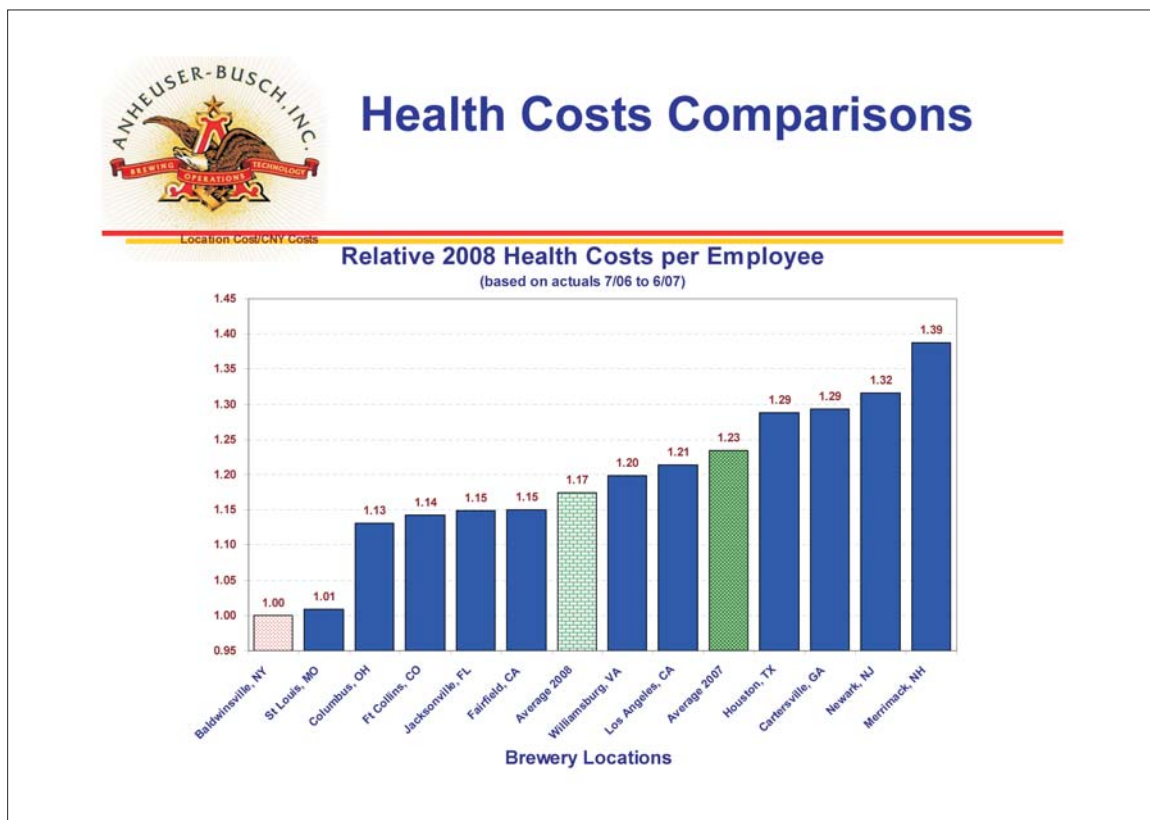
## **Anheuser-Busch Inc. Baldwinsville Brewery**

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- CNY employer: approximately 650 employees with health coverage
- Self insured with typically two health networks available to employees plus PPO
- 12 US brewery locations with essentially identical work conditions, pay rates and health coverage agreements (~80% IBT Union)

Let me go through some facts. We have one of our breweries in the Syracuse area, 650 employees with health care coverage. They have two choices, so we use MVP Health Care and United Health Care as choices for HMOs and then our employees have preferred provider (PPO) options if they prefer that. I'm going to give you a comparison. What you have

is a bar graph. showing you locational cost differences. And this is very recent information. We're self insured. So while we rent some networks, we're completely self-insured. And the cost, as it shows here, says our Syracuse operation among 12 locations in the United States has the lowest cost actual health care costs. I used to be the plant manager in our Newark, New Jersey plant and this shows metro New York City costs. You can see that's over the second bar from the right. That's pretty high; that's 32 percent higher cost than our Central New York (CNY) plant's actual cost. While the chart legend says 2008, it actually reflects our actual cost at each location for 12 months, and it's got an inflation factor of 4.6 percent. That's what we believe will happen to us next year as an organization. We can do better than the national average, but that's what we expect for inflation in 2008.



The two green bars show what our average is. And these are all similar. These are all Teamster workers in all of our locations. We're organized in all locations, and about the same average age (48) at all locations. We have wellness initiatives: smoking cessation, weight reduction, and a physical therapist who comes in three days a week. We have a plant nurse. We do a lot of things to try to help employees stay healthy...free fitness 24-hours a day. No premium payments are required of our employees. There are minimal co-pays for drugs and office visits. No drug formularies. They can get whatever prescription brand

names they want. Now, we have whole plant health communication for our employees, showing what the health costs are. Our employees have the option and a lot of them choose to be part owners of the company in terms of their 401K, separate from their pension. So they're interested and they do respond to some of these things.

So that's just our background. I'm the president of the Health Advancement Collaborative of Central New York. It's a central New York, Onondaga County-based organization. I'm also head of the Business Council of New York's Health Care Committee. So I have two roles. I have been thrust into these roles because I'm not in the health care business. When we first formed this organization in the Syracuse area, there was a lot of hostility to the insurance companies from the hospitals and the physicians that were at the table. There was a lot of local CNY concern about what the insurance premiums increases were, and the insurance profits and executive salaries.... Annually, they publish what the salaries of some of the executives are and that irritates a lot of people. But I was able to say, "Docs, we're self-insured. We're seeing pretty much the same thing and speaking up at that point got me to be in charge of the group. I regret that ever since.

So what we have is a very unusual organization. First, we recognize that we are far behind a lot of the other regions in New York State in the health information technology effort. We formed this group to say, "What can we do to make it more attractive?" I heard some of that. "We want to make our community more attractive to attract the talent not only to our business, but to some of the other engineering firms and businesses in our community. We want health care to be very effective." And then we want it to be low cost. I know what every consumer wants for any product. They want it now, they want it perfect, and they want it for free. Okay? So, we're working on those things here for our health care.

Here's just a snapshot of who we have (see next page) and we have one executive director for our organization. Here are some of the things we've done. We've prioritized two activities. The doctors, when we first met, wanted to work on medical malpractice. We brainstormed over what we would work on, that we could have an impact on. You see the two things we've prioritized. We want to work on capacity review, almost like a planning agency for outpatient services. We've chosen to work on magnetic resonance imaging (MRI). Here's why. In Rochester they have half the number of MRI facilities per capita as Syracuse. And, guess what, we use twice as many MRIs per capita as Rochester and Syracuse. So, this is not regulated by any certificate of need (CON) process. This is not regulated by any agency. And what we want to is to review these things. It's taken a long time, to get



## Health Advancement Collaborative of CNY

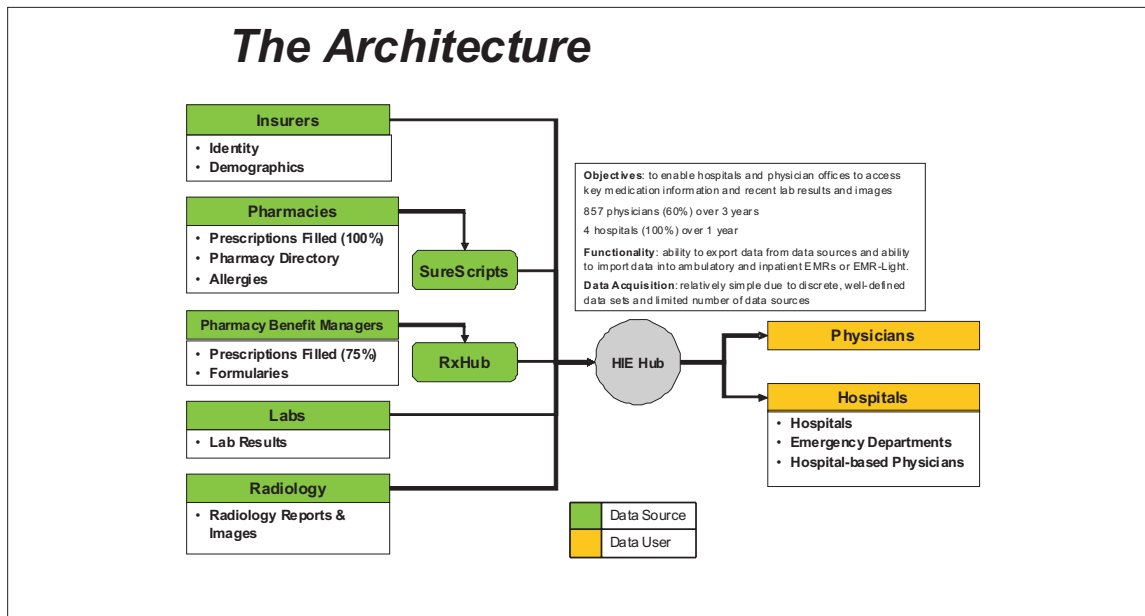
- Six member organizations nominating 26 directors:
  - Medical Society: 5 Physicians
  - Hospital Executive Council: 4 CEO's & staff
  - Health Insurers: Excellus Regional President, MVP CEO & staff
  - Chamber: 3 executives
  - MACNY: 3 executives
  - Metropolitan Development Authority: 3 executives
- At Large directors: Kinney Drugs CEO, Oswego Hospital CEO
- An Executive Director of HACCN

the doctors and everybody on board for this because the doctors are reluctant to recognize or acknowledge or say, "Hey, what's the solution," because obviously somebody's prescribing those MRIs. So we've agreed as a collective group, we're going to work on that. We've already started a lot of the framework for taking that on.

And then health information technology. I've got some other slides that will cover that. We have monthly meetings. By the way, we have great attendance. There's a lot of interest because what we're working on is important. There's passion from people who are participating. We think we can make a difference in our community. We're working on important things that represent the highest priority of these health care providers who think we can do something about it. We've been an organized not-for-profit for about three years.

Here's one thing that we did from a business perspective. We started benchmarking. We didn't want to benchmark California or Georgia. We benchmarked other parts of up-state New York. So, for the opportunity of medication management, that's the savings in Onondaga County alone. Could we achieve the same generic substitution rate as Buffalo? We didn't go far afield. That's \$169 million that we could save if we had the same generic substitution rate in Onondaga County as in Buffalo. And in the growth of radiology, obviously we picked Rochester because they are a lot better in terms of MRI. And we looked at labs. I can't remember which one. We used Jeff Rhodes & Associates from California. He did a lot of benchmarking for us and that's what he said. Two hundred twenty-seven million dollars is the size of the pie if we managed better (by the way, health care is not managed as

effectively as it could be) and we said, “Hey, we think we can get, realistically, by our efforts and health information technology just 8 percent of those savings and save \$19 million a year.” That gives you a snapshot of the business side. And then as a takeaway, I’m going to repeat it again. I think there is a lot of potential for managing the efficiency, the productivity of delivering health care services.



This is the standard of what we want to try to achieve. One key part of the technology architecture is the legal framework, it is a huge barrier. Huge. You know, we want to do things. If you came to our brewery, you would see fork trucks that drive themselves around the plant. They load trucks. If somebody changes the order, it’s dynamic, there is no paper. We do all this stuff. We don’t need any subsidies, we don’t need to get any grants from Congress or anything like that. And we do it. We make the investment and we get the savings. Here, if we want to do this and get the \$19 million in savings we think it might take about \$3 million a year in ongoing expenditures to save \$19 million. I’ve got to tell you, that’s a great return on investment (ROI). Invest \$3 million a year and get \$19 million a year back. Great plan. Gosh, we would jump at it. And a lot of the businesspeople think that is something we ought to do. We should jump at that. I’d drop every other project in my plant if I had a ROI like this. By the way, we invest about \$30 million a year in our plant. I’d drop them all and do this one. There are problems. There are the legal framework problems. We’ve designed ours differently than Binghamton. Binghamton is pretty far advanced, but they’re going to try the whole battle. Their effort is going to try holding the data. And we’re saying, “Oh, we don’t want to have any HIPPA responsibility liability.” So we’re always concerned legal is-

sues. So, to make progress, there are a lot of legal barriers. That's as much as I'm going to go into it. It's a complicated chart.



## CNY HIT = eCentral

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- Applied for HEAL grant for NY DOH
- Raising capital funds, exploring sustaining business models and soliciting technical partners.
- Avoided legal issues of holding patient information.
- Hosting a Sept 26 New York RHIO meeting at the Brewery in Baldwinsville.

Here's what we've done. We call ourselves eCentral. We're raising capital funds, we're getting grants, I have to go to all these meetings and ask for monies from different large organizations in our community. We are going to host, if anybody's interested, a regional health information organization of New York. All the major RHIOs are going to come to the brewery. And we're going to try to identify some key items. A big key item identified in Binghamton already is opt-in/opt-out. At first, I didn't know what that meant, but now I've learned. It is a big issue. I've met with Lori Evans, along with Mark Amodeo, Business Council's Health care Policy Expert. We understand that she is interested in the opt-in alternative (affirmative consent). And that's a barrier. That's another slowdown. And there's good reason for it but that decision is going to slow down our efforts and may render them almost ineffective for several years. And we question whether or not we should go forward. So these legal policy decisions have big impact on HIT efforts.

Here are some of the things we're doing to roll it out. (See next page.) By the way, we have identified those primary care physicians that would be the first practices to connect to our proposed network, and then later go to some specialists. We've really done a lot of study, a lot of work. In between our monthly meetings there is a committee of our organization that meets and works on these issues and they bring in a lot of experts.



## CNY HIT = eCentral Network Rollout

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- Build & test core software system as platform for expansion, piloting with all 4 local hospital emergency rooms, 4 large primary care practices, and 1 large lab. Build ability to track utilization for savings capture and support public health surveillance.
- MSSNY grant (if awarded) would allow Onondaga County Medical Society to convert 39 additional small medical practices to EMRs over 2 years.
- Expand over 5 years to include 797 additional medical practices (based on specialty, size and readiness), labs and imaging centers.
- Expand over time to regional hospitals, practices, labs, imaging centers, and pharmacies.

The problem is that there is no business model. Let's go back. If I invested that \$3 million a year to save, I wouldn't get that \$19 million. Half of those potential savings goes to Medicare. We can't capture it. Medicare is not going to pay in to any of this \$3 million a year but they're going to reap the savings. Then you're going to say, to the private payers, are you going to get all the private payers to pay in? It's a fragmented market. So, you start working and say, gosh, if I get a lot of free riders, if I only get 25 percent of the people using it paying in, do I get a return on that investment? It starts dropping pretty fast. So that's one of the problems. We're looking for a sustainable business model. There is one in Indiana. We've been doing a lot of benchmarking. They've made a proposal to us. And their funding comes exclusively from the hospitals. The hospitals alone pay for it. So there are different ways of doing it but it's hard to go forward when you think there are going to be huge changes. I know from the federal level people are talking about changes so... do we want to sink our money in and not be certain that we're going to be able to be returned all the money we invested because there may be other substantial changes? Do we want to invest in that Betamax when VHS is coming down the road? That's a really big concern for a lot of local physicians and for our organization.

We want to create a review process similar to what exists in Rochester. Now, we couldn't get all the physicians on board in CNY, so we decided to do it one bite at a time, just investigate MRIs first. We'll probably work on that for a year and then expand it to a lot of other things that are not currently regulated but are growing and adding to our total costs in that community. Now, I'm part of the business health care community and we're working



## Health Business

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- The health business is not a classical business and it is unlikely to be unregulated and subjected to market forces.
- Doctors and providers respond very well to financial incentives and reimbursements.
- The CON process was unable to prevent a “Berger Commission”.

on two issues primarily, affordable health insurance for small businesses. There’s an excellent proposal from Excellus to address that. And then there is our health information technology efforts to try to slow the rate of inflation for health care costs.

Here is my bottom line. This (health care) is not a classical business. I am not saying that this is at all like the beer industry. Doctors in our group at Health Advancement Collaborative have stated very clearly, including the hospitals, said they have responded to motivation. Hospital bed turnover responded to financial reimbursements to the hospitals. Financial incentives work well. That’s one key takeaway and I’m very glad to know the



## Health Business

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- The efforts to offer universal coverage, and to make health coverage fair should be matched with a similar vigor and organization.
- **Imagine** a separate legislature committee focused on health care costs and making legislative proposals and having review over all proposals from the current health committees of the legislature.
- **Our health care system is perfectly designed to give us the results we are getting. We need an organizational change.**

health care system responds well to financial incentives. There just aren't that many incentives out there. The CON process was unable to prevent a Berger Commission, which says that where there is a large investment and it is reviewed by the state CON process then one would think that we're okay. Our capacity doesn't need to be reevaluated. But the Berger Commission obviously splashed water on that. Even with the CON process we wound up with a lot of extra facilities that we've had to retire. Some may dispute if the reductions are needed.

Our health care system in New York State is perfectly designed to give us the results we're getting. If you don't like the results, you've got to change the system. My recommendation is there ought to be a separate legislative committee, with legislators who can make a difference, separate from those that Richard Gottfried and Kemp Hannon lead, one focused on the enablers to make productivity happen in the State of New York. That's my point.

*Ted Potrikus:*

Well, coming between the beer guy and lunch, I'll cut my remarks in half. I'm with the Retail Council of New York State and we're the statewide trade association representing retailers. We've got about 5,000 members. We've got everybody from the stores that you've all heard of to about 2,500 mom and pop stores that join us. And out of all the health policy experts that you



will hear today, I'd like to put myself at the top of the list of the people who should not be held out as health care policy experts because we at the Retail Council and I think in the retail industry got backed into this conversation somewhat involuntarily when the conversation shifted a few years ago to whether or not employers should be obligated to provide health insurance for their employees. When that intersection came, obviously they were going to look at the retail industry first. In New York State, we provide jobs for some 800,000 people and by dint of the modern retail marketplace and consumer demand, a lot of those jobs are part-time and seasonal. Retail is well known for being the place to go to get your first job, entry-level jobs that welcome young people or those without work backgrounds. Part-time jobs provide additional income for students, families, and retirees looking for flexible work schedules. And for those who want more, there is always opportunity to grow into full-time employment. But as that gradual but persistent trend is

seen, public officials and interest groups pegging health insurance to employment, you give someone a job, you're obligated to give them health insurance. It's a function of history from the World War II days when that started up. That puts us in the aforementioned intersection as we start talking about how employers who provide certain benefits certainly will have to look at one of the state's biggest employers, the retail industry, to find out how it measures up. For some, not just in New York, the solution has been a legislative one, a requirement that all employers of a certain number of workers either provide health insurance to their employees or face an assessment, payroll tax or some other compensation to the public. The Retail Council and the retail industry continue to strongly oppose that effort in New York State, to mandate health insurance coverage by employers or foist an assessment on those same employers. When we spoke to this issue at public hearings before the state legislature in May 2006 here in New York, we were busy opposing a bill that would have required certain employers to either provide insurance or pay the assessment that was a product of an hourly rate multiplied by the number of hours worked by full-time, part-time, and seasonal employees. Nothing in that bill or others like it took into consideration the fact that many of those employees had coverage through sources other than their retail employer such as through a parent, a spouse, or a primary place of employment. Nor did it acknowledge that some employees, particularly the younger ones, declined health insurance altogether. We had quite a coalition of groups opposing the bills with us, those representing manufacturers, the hotel and hospitality industry, food merchants and convenience stores, independent businesses, and others. And what the primary concern was, even though those bills said 100 or more employees, 50 or more employees, what everybody was worried about was that that threshold would ultimately come down to two or more and that every employer would be required to provide some sort of health insurance. We spoke then to the fact that these bills violated the Employee Retirement Income Security Act (ERISA). The preemptive authority had been upheld repeatedly by the Supreme Court and in June of this year, a federal court used ERISA to invalidate a law in Suffolk County that would have required certain large retailers selling groceries to make health care expenditures for most non-managerial positions. A year earlier, a United States District Court in Baltimore struck down Maryland's statute that would have required certain Maryland employers with 10,000 or more employees who did not spend 8 percent of wages on health care either to increase spending to threshold or pay the difference to the state. That was upheld in January. The lawsuits challenging both the Suffolk County and the Maryland laws were initiated by the Retail Industry Leaders Association, a national trade group representing a number of major retail companies. These lawsuits certainly found their merit in the fact that they were fighting unfair laws written to segregate and punish one industry.

But here's where the Retail Council shifts a little bit and, before it gets to sounding totally negative on the retail industry's part, the way that the Retail Council responded at the hearing in May 2006 and what we've done since then, what we're trying to do is get beyond the opposition to the detrimental proposals and come up with a way to address the issue in a more constructive manner. One thought that we offered in our 2006 testimony was to partner business with state government to improve access to affordable health insurance programs available for certain businesses and individuals, but deserving of a wider audience. We don't claim authorship of that idea but we know enough to latch onto a good one when we hear it and as we talked with lawmakers during that debate, the access idea made a lot of sense. So just a couple of months ago, we were very pleased to join with Governor Spitzer in supporting his expansion of access to the state's Family Health Plus plan with private employers and others given the option of participating under certain conditions. For those opting into the program, the state pays a portion of the premium for eligible employees and makes it easier for employers to offer health care coverage without making these businesses uncompetitive. There are small and independent retailers throughout the state who still want to provide health care but they have been priced out of the market, and creating and expanding these partnerships responds directly to that concern and looks for ways to help those employers attract and retain the employees they need. I think it's a great start. It's a big step forward and we're working today to get the word out to our membership.

Thanks to the wise counsel of many of our members, the Retail Council also found it important to reach out to the groups that some may have viewed as a natural foe, including our friends at the Working Families Party, which was the leading force behind the bills that we so strongly oppose. We may be on opposite sides of the issue, but together we have been able to open a dialogue on these bills and the matter of health insurance availability. And where we as a whole head from this point relative to health insurance probably will be determined in large part on maintaining the same sort of defensive strategy that we have had to maintain; we need to be able to judge the proposals as they come to us. I don't think it's our business to be out there setting health insurance policy. It's our business to be selling widgets and electronics and the holiday season is coming up and all that stuff. So that's really where the focus is. But so many people in our industry have taken on this new role of trying to figure out what it is that the retail industry can do to stay competitive, to fight the idea of these mandates but to work within that sort of giant universe to listen to what everybody has to say, to comment on the ideas as best we can, and to really work within some pretty non-traditional dialogues with our friends and with our natural foes who we don't think are foes; they just have a different opinion than us. We will continue to do that. We are looking for-

ward to all the things we've heard today and what we'll hear this afternoon and going forward. I'll be happy to answer any questions that you may have.

*James Tallon:*

Ted, thanks very much. We're about 25 minutes off schedule and I know you want to get to lunch and I want to get on with the program but, as we did before, a question or two before we break? For our panelists? Okay, I'm going to hold the discussion at lunch. We're going to come back in straight up at 1:00. Mike Fishman will talk about the Taft-Hartley plans. Our state friends will give us an update and then we've got about an hour program. It'll be cut down to about 45 minutes but we'll have a good discussion. I just want to especially thank John and Steve and Ted for putting a personal face, a very engaged face, on behalf of the business community in this discussion. Thanks for being with us.

## Afternoon Session

*James Tallon:*

We indicated we will go into this afternoon session first with a presentation by Mike Fishman and then we will turn to Kathy Shure and Troy Oechsner. Again, thank you to our morning panelists. Thanks to all of you. We'll have some time for questions.

This discussion is something I personally thought was very important to add to our conversation today because we frequently talk about employers and about government's role, and about the plans, as we have done this morning and I don't, despite the rich traditions of organized labor in New York, often focus in on the way in which organized labor participates. For those of you following the discussions in Detroit, unless something happened this morning that I haven't heard about, labor may even be in a bigger position in terms of the future of health insurance coverage as the auto industry tries to work its way through to a new settlement. As I said, I haven't heard the news this morning so I don't know where they are. Mike Fishman is the president of the Service Employee International Union, building service local 32BJ. He is a well known and well-respected labor leader. On this subject on health insurance benefits, he has been in the forefront of many conversations and so we

asked him to come in and give us some background on Taft-Hartley Plans and the labor perspective of what are also some real issues of working people in the state. Mike Fishman, good to have you here.

*Mike Fishman:*

Thank you very much for having me here. Let me give you a little background on 32BJ. We are a union with 85,000 members. About 60,000 are in New York City and our members take care of the apartments. They are the doormen. They take care of the commercial buildings; they're cleaners, janitors, and they also do security. They are security officers. We also represent workers,



another 25,000, from Washington, DC to Maryland to Pennsylvania, New Jersey, and Connecticut. So, for all of those workers, we bargain with our employers for health care.

### Origins of Taft-Hartley Funds

- Organized according to law sponsored by Senator Robert Taft and Representative Rep. Fred A Hartley, Jr. and passed over President Truman's veto on June 23, 1947.
- Passed by a Republican-controlled Congress in the wake of significant number of post WWII strikes and job actions.
- Truman described the act as a "slave-labor bill", adding that it would "conflict with important principles of our democratic society".
- Today, **26 million** workers, families and retirees in 2,200 Taft-Hartley health funds.



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I thought I would start with a little bit about Taft-Hartley. Some of the stuff I didn't know until I put this presentation together but... So what is Taft-Hartley fund? Taft-Hartley is two different people — Robert Taft and Fred Hartley, who proposed a law to govern health care funds in all kinds of industries. Until the point that they proposed that law in 1947, there were health funds that were union funds and those that were employer funds. But, in 1947, this law, which was passed by the Republican Congress, said that all money

that was bargained to provide health care or pensions or any other kind of benefit would be a trust fund that was managed by trustees from both management and labor. Truman described it as a “slave-labor bill.” He vetoed it because he felt that unions were doing fine with their funds and employers would do fine with theirs and they didn’t need to have this mechanism to constrain it. But, it did pass over his veto and today there are 26 million workers, families, and retirees in 2,200 Taft-Hartley health funds. That’s an enormous amount of people who are governed and helped by these funds.

They’re multi-employer funds. What does that mean? Our Taft-Hartley fund, the 32BJ Health Fund, has over 1,000 employers who participate. We bargained with an association and all those employers are part of that association, a few are independent, but we bargained this health fund together, and we manage it together. So when you’re talking about small businesses, a lot of the people we deal with are small businesses and in effect we bundle their money together with other small businesses and we’re able to provide a health benefit together. We collectively bargain with each employer all within an association. The funds and the assets are managed by a joint board of trustees, as I said, equal representatives of management and labor. I am the president of the union but I am also the chair of the fund, the president of the employer’s association is the secretary of the fund and we each have a number of trustees on either side. The assets are placed in a trust fund. It’s different than the union; it’s different than the employer. It is governed by ERISA. We have various stringent requirements and it is a completely separate entity that has as its sole purpose to provide a benefit for the employees and their families. It’s portable. And that is one of the great things

## Characteristics of a Taft-Hartley Fund

- Multi-employer.
- Collectively bargained with each employer.
- Fund & assets are managed by a **joint board of trustees** equally representative of management and labor.
- Assets placed in a trust fund
  - Legally distinct from the union and the employers, for the sole, and exclusive benefit of the employees and their families.
- Portable.
  - Mobile employees can change employers without losing coverage provided the new job is with an employer who participates in the same Taft-Hartley fund.



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about a Taft-Hartley fund. If you work for one employer and then you go to work for another employer, you can still continue to be in the same fund as long as you are in the same industry. So, it has a great benefit for our members.

How do we make decisions? First, there are only two sources of money: collectively bargained contributions and investment income. Highly regulated, as I said, by ERISA. We have to file a report every year. It specifies among other things, patient rights, permissible financial transactions, accounting standards, transparency requirements. Every year, we get a new set of ERISA regulations; we are audited by ERISA. They keep on top of us all the time and we as trustees have a responsibility to make sure that everything is followed. Operationally, we make all the decisions. We have to make decisions every day. Recently, we had to have a discussion about the fact that there are new drugs coming out that cost nearly a million dollars a year, the new bioengineered hormone drugs and growth hormone drugs. We don't think we can afford that so we have to make a decision to either pay for that or cut it out from our coverage. All of those decisions are handled by the trustees. We have to have all the interests of the participants in mind and we are bound by these laws to make sure that we do everything right for our participants. If we don't, they have the right to sue us under the law. We are fiduciaries and have to make decisions in accordance with the laws and their interests. I can assure you that when I walk down the street in New York City or when I sit in a restaurant and one of our members sees me on the street... This happened just the other day. I was sitting with my wife out in a restaurant having a cup of coffee, and one of our

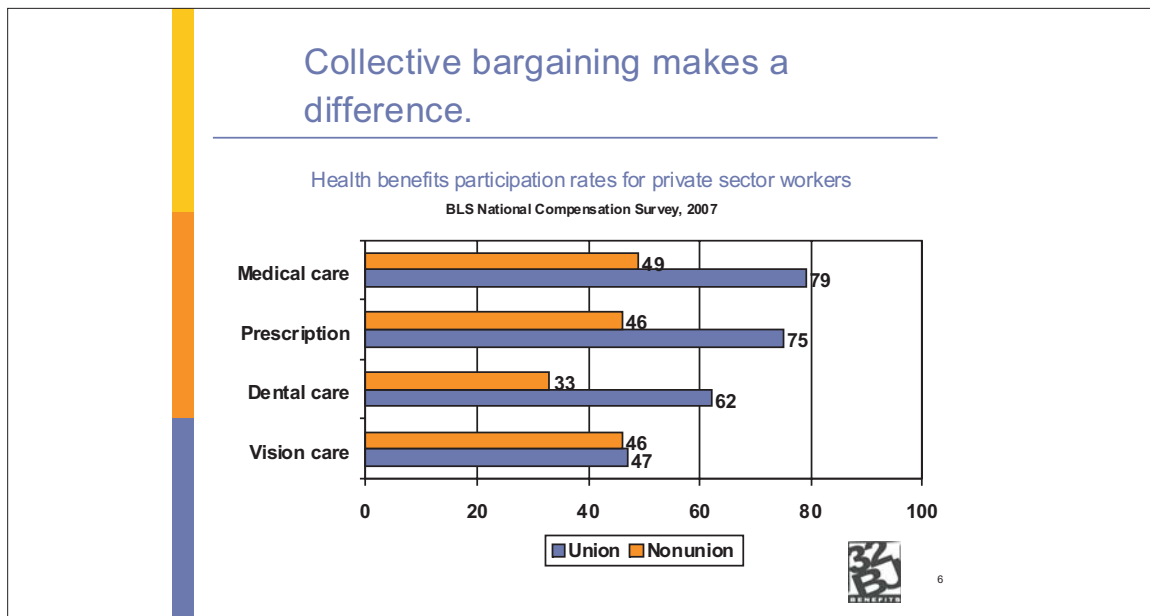
## Fund Decision-Making & Operations

- Only two sources of funding allowed – collectively bargained employer contributions and income from investments.
- **Highly regulated by the Federal government** :ERISA, Taft-Hartley and a myriad of subsequent laws and regs. All Funds make annual reports to the Department of Labor and the IRS. Among the regulated issues are:
  - Patient rights
  - Permissible financial transactions
  - Accounting standards
  - Transparency requirements
- Operational responsibility for a fund rests solely with the Trustees. They are charged with
  - making all major decisions unanimously
  - selecting professional experts, such as actuarial consultants, attorneys administrator, benefits vendors, financial managers, accountants, etc.,
  - ensuring that moneys are handled properly,
  - ensuring that participants eligibility is properly determined, and
  - ensuring that participants are receiving benefits fairly and properly
- Failure to insure any of the above is a breach of fiduciary responsibility



members walked by and said, “Mr. Fishman, how are you? I have a little problem with my health care.” So, I got out a piece of paper. I get direct feedback every day.

So, collective bargaining makes a difference if you look at the country and you look at medical care — 79 percent who are in unions have health care, 49 percent who are not in unions. Prescription drugs, you see the numbers. Basically, if you have a union it is more likely that you are going to have health care. The interesting thing about New York State and this is what started the conversation that I had with Jim when we were talking about Healthy New York is that New York is very different than any other state in the country. We still have 27 percent of New York’s working people in unions. Now, the density around the country is 11 percent and some states have zero or close to zero. But New York still has 27 percent of workers in unions, 2.2 million people. We collectively bargain with employers an estimated \$8 billion in health benefits. That is \$4,667 per person. That is a dramatic difference. I can’t stress how different that is. I worked in almost every state in the country at different times in my time with the union and in most cases unions are irrelevant to the discussion of health benefits. But in New York that is not the case. In New York, there is an enormous amount of money there because there’s a collective bargaining agreement and because unions have been advocates for health care for the union workers. Union employers account for 38 percent of all money spent by New York wage and salary employers.



So, what are the benefits at 32BJ? Let me tell you a little bit about our fund. For comprehensive medical and hospital benefits, we use Empire point of service (POS) network. In fact, the network that we bargained for with Empire was set up partially for us

because we were looking for a cheaper way to provide health care. We had the PPO network. We discussed with them how to get a smaller network, fewer doctors but better care, and we worked with them over a period of six months to change the network. So not only did we get what we think is a quality network but it actually reduced our costs by about 10 percent. Home and office visits \$15; inpatient 365 days, no co-pay; sub-acute and home care, no co-pay; emergency room (ER) \$50 co-pay; behavioral benefit, 30 days inpatient, 40 outpatient visits with a \$15 co-pay; drugs, \$7 generic, \$22 brand. Dental benefits, we have our own dental clinic that we run in our building in the city. We have 14 dentists, 2 orthodontists; they do all the work there. They handle about 17,000 patients a year. We have life insurance, vision, and long-term disability.

What's important about all of this is that we actually have to think about this every day. This plan design is relatively new. We didn't have any co-pay on drugs but, like all of you, we realized that there was no incentive or dis-incentive for our members to pay attention to the kind of drugs they were getting, whether they are using generic or brand. So we began to redesign our whole system, change to a different formulary, put in different co-pays, and we actually reduced our drug costs significantly — by about \$38 million a year. All of this adds up to about \$550 million a year in health costs. \$511 to be exact for all the health care for our members. We cover workers in New York, New Jersey, Connecticut, Pennsylvania, and DC. We have 140,000 covered lives with about 60,000 members and 80,000 dependents. The rate for our metro plan, which is our best plan, is \$899 a month for full family coverage, no employee contribution. It's something we feel very strongly about. The truth of the mat-

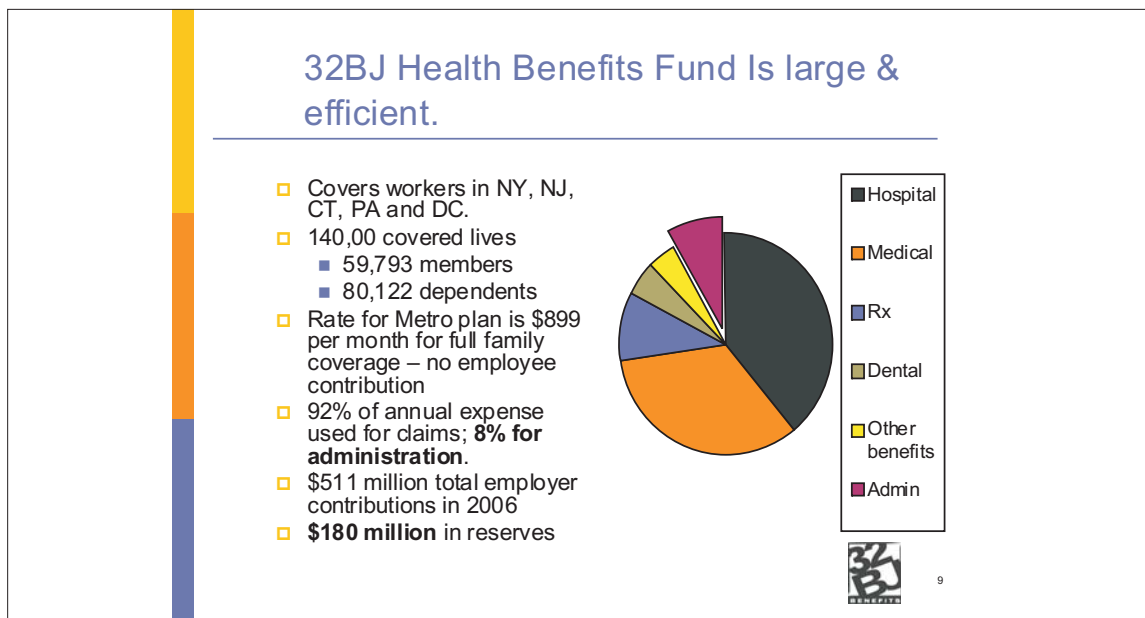
### 32BJ health benefits are comparable to any employment-based plan.

- Comprehensive medical and hospital benefits through Empire POS network
  - Home and office visits – unlimited with \$15 co-pay
  - Inpatient – 365 days, no co-pay
  - Sub-acute and home care – no co-pay
  - ER - \$50 co-pay
- EAP/behavioral health – 30 days inpatient + 40 outpatients visits with \$15 co-pay
- Rx benefits with \$7 generic/\$22 brand co-pays + chronic care Rx through mail
- Dental benefits - \$0 network co-pay + out-of-network schedule
- Life insurance
- Vision - \$0 co-pay every 24 months
- Long-term disability




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ter is many of our members, if you move outside of Manhattan itself where our members make about \$19 an hour, a decent wage, it goes down to as low as \$7 an hour. When you are at \$7 an hour you can't afford a co-pay, that is a premium sharing of any amount of money. If you have a \$50 premium sharing the people would rather take the \$50 and put it in their pocket for food or rent instead of getting health care and they will end up either on publicly financed health care or with no health care at all. Ninety-two percent of our annual expense is used for claims, 8 percent for administration. This was not always the case. We have worked hard to reduce our administration costs and we've taken a significant amount of work in-house. For instance, we have a call center in our building, 80 people on the phones. We do 450,000 calls a year. We don't handle the claims; we handle the discussion of the claims. Blue Cross handles the claim. A copy goes back to the member at home. If they get it and they think it's wrong, they call our center and our center takes care of the issues right there on the phone. That reduced the cost of BlueCross BlueShield by an enormous amount. So, we are only at 8 percent for administration and we intend to get that down further. We are in a building where the rent is fairly significant, or it used to be; now it's kind of the average in Manhattan. But we are going to find a way to move some place cheaper and think we can get that down to 6 or 7 percent.




We have \$180 million in reserves. That has not always been the case. We had to work hard to bring that back up. We have made a decision as trustees that we want four months' reserve and that will be about \$200 million, and then we are going to keep that going up a little bit each year to keep up with the overall cost of the fund. We expect that we will be spending about three-quarters of a billion dollars within the next three years on health bene-

fits as we add more members into our pool. We face all the problems that everybody else does in our expenditures. We have a very old population with chronic and acute diseases, so 1 percent of our members are accounting for 35 percent of our costs. Fifty-seven percent of our members average less than \$500 a year in benefit costs. Chronically ill members account for two-thirds of the total plan expense. Not only do we have an older population but many of our members are immigrants. We have, as you know, recent immigrants from Eastern Europe, Albania, Russia, a huge population of Russians coming in. Many of our members also came from South America at various times where care is very bad, so they have come to this country. They had little or no health care before coming here. They get into our system — we have a heavy incidence of diabetes, hypertension — and we have found that if we are going to be able to succeed as a fund we have to address that in some global way, not just by letting people go and choose what they want to do.



### Having good coverage does not always translate to good health.

- Caring for 1% of members accounts for 35% of Fund costs.
- 57% of members average less than \$500/year in benefit costs.
- Chronically ill members account for 2/3rds of total plan expenses.
  - Taking care of diabetics (6% of participants), uses 20% of total Fund expenditures



So, we have begun to redesign our plan so that we manage these diseases. We have drug discounts if you get into a management program for diabetes and hypertension. We have begun to talk about what I call centers of excellence — having people go to a central location for management of chronic illnesses where we can give them excellent care and they will get some reduction in their co-pays or some incentive for being part of the program. As well as working on the management of illness, we have to manage the costs because our employers that are paying \$889 a month are competing and looking at other service workers in New York who are getting no health care. And, at some point, they ask us how we can continue to give \$10,000 a year for health care when others are getting nothing or our competitor is not paying anything; and we hear that all the time. And so we have to

manage our care. Even with managing our care and managing our costs, we run in to this problem. But, we did a dramatic redesign of our benefits. We restructured the benefits, because our fund was going up 10 to 15 percent a year. We restructured our care; we restructured our call center; we changed the way we do business; we put incentives into the fund, and we actually dropped our costs and have kept them. We kept our costs flat for two years by restructuring our benefits and getting our members involved in a discussion about health care and while the trend line for the industry kept going up, our costs stayed flat. We have been able to now get to a point where we actually don't need any increase in contributions for the next two years because of the work we did two years ago.

## The Fund is very concerned with chronically ill members getting care.

- Instituted an aggressive disease management program for diabetics to assist members with getting appropriate care and learning self-care.

Disease	N of members	Percent of total	Total cost	Percent of cost	PMPY
Diabetes	9,530	6.1%	\$63,839,286	19.7%	\$6,312
Hypertension	7,910	5.1%	\$21,206,314	6.6%	\$2,767
CAD	3,570	2.3%	\$29,337,861	9.1%	\$8,220
CHF	1,136	0.7%	\$14,452,208	4.5%	\$12,720
Asthma	6,694	4.3%	\$17,489,104	5.4%	\$2,616
ESRD	442	0.3%	\$15,678,091	4.8%	\$35,472
COPD	1,755	1.1%	\$11,539,866	3.6%	\$6,576
Depression	881	0.6%	\$1,553,869	0.5%	\$1,764
Breast cancer	360	0.2%	\$5,490,820	1.7%	\$14,448
CVA	568	0.4%	\$6,898,631	2.1%	\$12,144
HIV	360	0.2%	\$4,871,466	1.5%	\$13,536
Obesity	2,257	1.5%	\$14,962,889	4.6%	\$6,600
		22.9%	\$207,320,405	64.1%	

Diabetes Data - based on adults eligible for DM program

	Participants eligible	Participants not compliant	Percent not compliant
Diabetes testing & exams			
Hemoglobin HbA1c	7,896	1,993	25.2%
Annual retina exam	7,896	5,301	67.1%
Micr o-albu mi nur ia	7,896	5,191	65.7%
LDL (lipid)	7,896	1,661	21.0%
Influenza vaccine	7,896	6,520	82.6%



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The third issue I want to raise with you is providing coverage for low-wage workers. Eight hundred eighty-thousand New York state workers are employed in establishments where the average wage is less than the state median of \$15. The least costly plan in 32BJ is \$544 a month. That is \$3.16 an hour. Now, I don't know if that seems cheap or expensive to you but when we go to the bargaining table and somebody is making \$11 an hour and we say we want \$3 more for health care, that's a lot, right? And the employers say we can't do that.

### Our 3<sup>rd</sup> issue is providing coverage to low-wage workers

- 880,000 NYS workers who have no employer-sponsored coverage, are employed in establishments where the average wage is less than the state median (\$15.09/hour).
- The least costly 32BJ family plan costs \$544 a month.
- Buying this benefit would add \$3.16 an hour for a 40-hour worker.



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So we have to deal with this issue. We have to find a way to get health care for people, and good health care, with some subsidy from somewhere and we will talk about that in a minute. But, you know, I had the opportunity to be on the mayor's poverty commission last year and what was interesting when we started talking about this, is that in New York City there are 2 million people who are living in poverty — that means below the federal poverty guideline of \$21,000 a year. But of the workers in New York City, one out of four are directly or indirectly tied into the city economy or financed by the city economy or by city dollars or tax dollars. Yet many of those workers who are in poverty who don't have health care, the city is financing those jobs. We could start with the idea that the city and the state should not be financing poverty jobs and having jobs that don't have health care, and that would begin to address the cost of \$3.16 an hour.

So where do we think we can go and what are some of our observations? The governor says he wants to move towards a universal system and the way he has been talking about it may mean that we lose some of the private dollars. We don't think that is appropriate in a state like New York. Twenty-seven percent of workers are already in unions with some kind of collectively bargained health care. We should use that as a base to begin a discussion about health care in New York. We bring experience with providing benefits to working people. We bring efficient cost structures and we have an institution where our members listen to us. We put out a monthly newsletter, telling our members how to get health care, and how to navigate the system. We try to have a limited choice of plans. We can't have unlimited consumer choices. We have to have some stability so that we can administer it easier.

## Participating in NY's coverage expansion discussion

Some observations from the recent Family Health Plus-Healthy NY discussions.

### □ What we bring

- Collective bargaining agreements that commit employers to make substantial contributions
- Experience with providing benefits to working people
- An efficient infrastructure – 8% admin costs
- An institution trusted by 70,000 members and their families

### □ What we cannot do

- Act as an agent of the state certifying family income or immigration status
- Provide different benefits to different workers covered by the same collective bargaining agreement



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That's what keeps our costs down. So, where should we go? Our view as a step forward would have been with Healthy New York, a system where we ask the legislature to authorize that we would be able to get a subsidy into our fund from Healthy New York. That would pay a base level of cost for each worker who doesn't have health care. We would bargain for other dollars from the employers and we would match them together to be able to provide a very good level, a decent level of benefits at a very reasonable cost. I guess we are not supposed to be too political here but without being too political I would say that it passed the legislature, the governor vetoed it because he has a new plan that he thinks is going to be better next year. I think we have to continue the dialogue about private dollars, labor unions, collective bargaining, and how we can help in this whole debate. Thank you.

*James Tallon:*

Mike, thank you very much. If it works for Mike, rather than stopping and giving specific questions here why don't we conclude with our other two presentations. Mike, can you stay with us?

*Mike Fishman:*

Yes.

*James Tallon:*

And then we will open it up to a broader question discussion including everything that we have heard here today. We'd like to wrap up today by getting some comments both from the Department of Insurance and the Department of Health. We are very pleased to be joined by Troy Oechsner, the deputy superintendent for health of the New York State Insurance Department, and Kathy Shure, the director of the division of managed care program evaluation in the Department of Health. Both departments are working together and maybe Troy and Kathy will mention a little bit about the process. Let me turn to Kathy Shure and ask her for some perspectives from the Health Department side and then we will go to Troy Oechsner, and then we will open up the conversation to your questions and comments. Kathy.

*Kathleen Shure:*

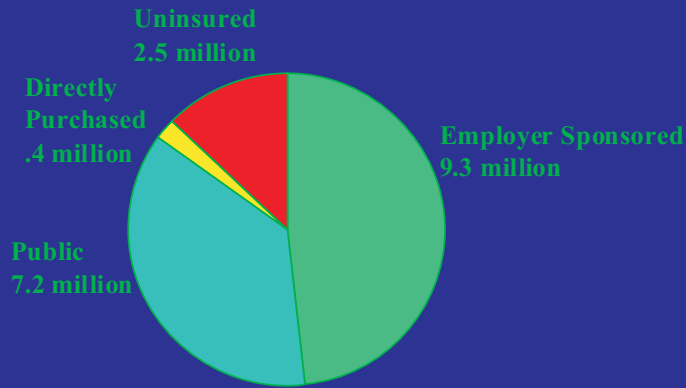
Thanks, Jim and Courtney. I appreciate you arranging this. It's a pleasure for us to be here. We have been asked to provide, Troy and I, an update on the activities of the administration to date and to give you some perspective on what we're thinking about going forward. Universal coverage is something Troy and I both talk about all the time and we are thrilled to be able to work on it.



For me, having been in health care for 25 years, working both in the private sector and the public sector it really is very exciting to be working on this topic. We will talk a little bit about what we think has been achieved in the last nine months or so, what the charge to the commissioner and the superintendent has been in terms of developing an approach to universal coverage and the process we are going through to get to that approach. We have spent a lot of time trying to figure out the best process to develop a comprehensive plan, and we have talked to a number of other states. Then we'll talk a little bit about what's going on, what will be beginning shortly, which is modeling different proposals, and then finally what we see as the next steps in terms of some incremental changes.

We all know we have 2-1/2 million uninsured in New York. There are a couple of things that I did want to point out, though. A number of speakers talked earlier about the fact that the reduction in the number of insured that has occurred has really come from increases

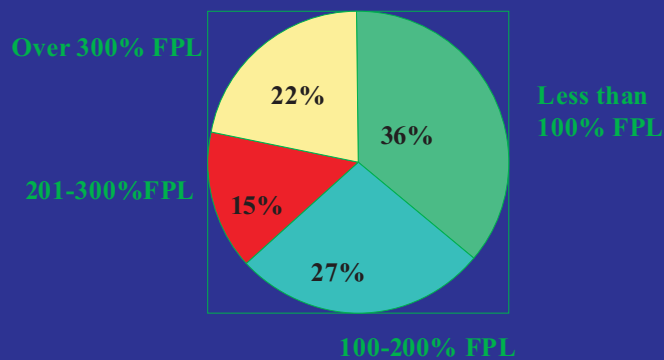
## Distribution of Insurance Coverage New York 2005



19 Million New Yorkers

in public coverage, and that is where everything is between the public and the private sector, \$7.2 million in the public sector, that includes Medicare. I thought that was interesting because with some of you, after you've listened to the debate in Washington on the SCHIP expansion there's been a lot of rhetoric about how the public sector doesn't belong in health insurance. That horse has left the barn a long time ago, but it is equally important to ensure that we have a private sector that is vibrant, that provides affordable products, because we do need to keep those dollars in the game. Somebody indicated earlier, I think it was David, that of the uninsured, about a third of them have incomes to up above \$50,000 a year. Well, there is an inverse to that and that is that about 78 percent actually have incomes below 300

## Percent Uninsured by Family Income



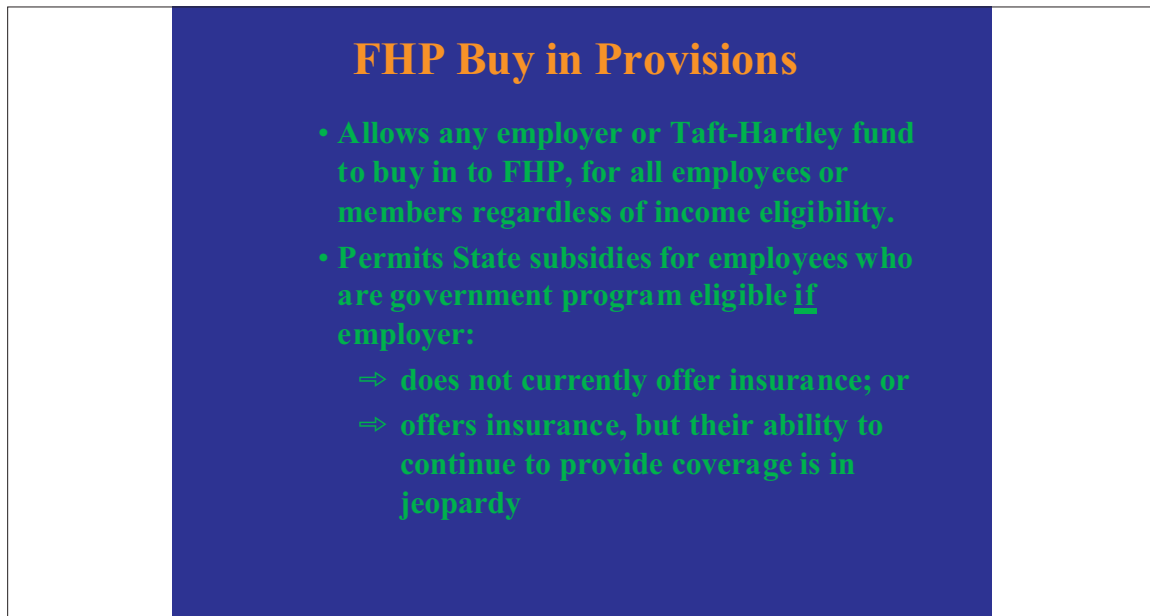
2.5 Million Uninsured

percent of the poverty level and there is a big gap between people at 100-150 percent of the poverty level where they qualify for a government program and that 300 percent, and where options on affordable coverage are very limited. These are people who often work for employers that don't offer health insurance or if they do offer health insurance, there is a premium contribution that they just can't afford. So we know that there are gaps there that we have to try and address.

So what has happened so far? I think the governor made it very clear that one of his priorities was addressing the problem of the uninsured and trying to reduce the number of the uninsured. During the first month of the administration when we were very rapidly trying to get a budget out, we took some initial steps that we thought from our perspective were no-brainers. Let's get all the kids covered and let's try and get at the individuals who are eligible for coverage but aren't enrolled. So those were the two focuses. What you saw in the budget that was passed was an expansion of Child Health Plus to 400 percent of the poverty level. We thought that was a no-brainer. Clearly, the federal government is not in agreement with us on that and I don't think the issue really was so much the 400 percent. There definitely is a perspective there that we should be trying to keep as many of these people in private coverage as opposed to public coverage and are we going to lose that private sector coverage by continuing to increase income levels. And so what they did was impose some new restrictions that came to us at about 8:00 on Friday night, new guidelines on what would have to be in place if we were to expand above 250 percent. And those were conditions that we just could not live with. So at this point we're reviewing all of our options. The feds have disapproved our proposal and we need to figure out what we are going to do going forward. State law right now does not permit us to do the expansion without federal participation. So again, we are reviewing our options. You are likely to see something on this in the next budget but we don't have a decision yet on where we are going to go on that.

Another thing we looked at was streamlining and simplification, and we made some progress there. In the budget was a provision that allows 12 months of continuous eligibility, which is very important to try and reduce the churning, people coming on and off coverage, and, also elimination of certain documentation requirements upon renewal. Again, what we want to do is reduce some of the barriers for people in obtaining access to coverage that they're eligible for. Also in the budget was an appropriation for a consultant to assist us with modeling universal coverage and I will talk a little bit more about that later. But some money was put in the budget, some additional money that we think we have access to from

the Insurance Department. We think we will be able to have a very vigorous analysis of various options out there.

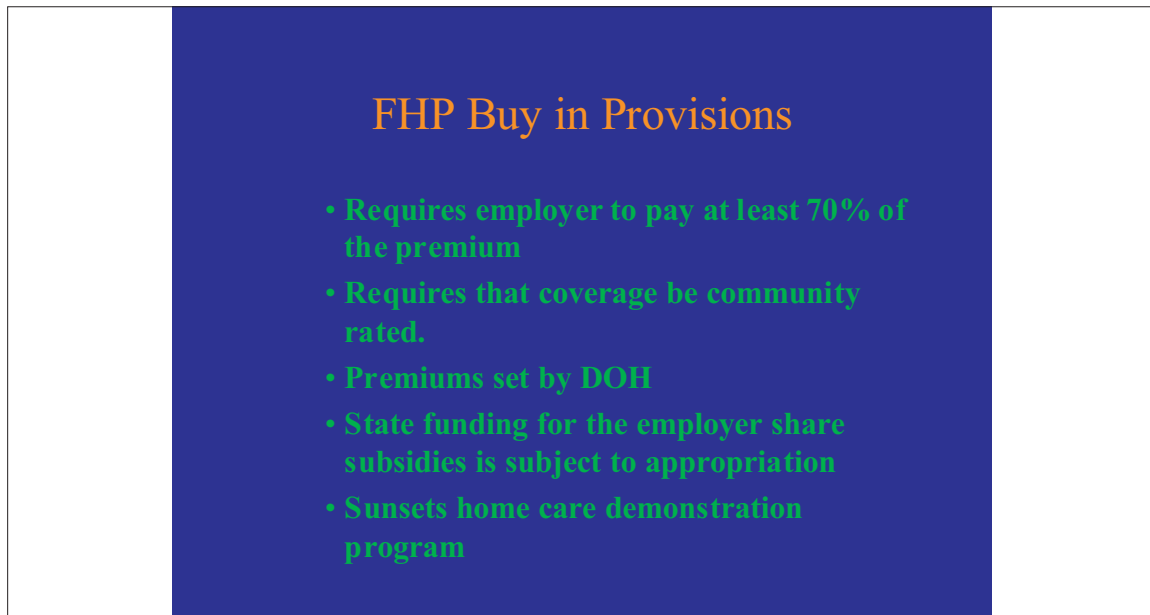


**FHP Buy in Provisions**

- Allows any employer or Taft-Hartley fund to buy in to FHP, for all employees or members regardless of income eligibility.
- Permits State subsidies for employees who are government program eligible if employer:
  - ⇒ does not currently offer insurance; or
  - ⇒ offers insurance, but their ability to continue to provide coverage is in jeopardy

The two last things I want to talk about, and these were not part of the budget but were part of the legislative session, are the Family Health Plus (FHP) buy in and managed care reform. People talked about this a little bit earlier. The FHP buy in allows employers and Taft-Hartley funds to essentially buy into Family Health Plus, to purchase Family Health Plus coverage. The basic concept here was that we have these public programs with large numbers of people in them. They offer very comprehensive benefits and fairly competitive premiums. Most of the people who are enrolled in these programs are actually covered through private health plans. Many of the plans that spoke earlier today all participate in these programs. So, the concept was can we provide a more affordable option for coverage out there in the market by inviting employers and unions to purchase coverage from the state through one of these programs. What this does is allow employers and Taft-Hartley funds to buy FHP. Let me step back a minute, because this builds on a program that was approved in the budget called premium assistance. Under that program, that was designed specifically to allow people who are eligible for a government program but working for an employer that offers insurance, to get that insurance from the employer. And the way it works is that the employer pays whatever the normal employer contribution would be toward the coverage, and the state picks up the individual's share. This was to address people's concerns about crowd-out and make it easier for private sector insurance to remain an important part of health coverage of New York. The buy in builds on that, and essentially what it does is if an employer is interested in buying this product for their employees who

are eligible for the government program, the government will pick up the employer's share of the contribution and the employers pays their own share. For those who are not government-program eligible, the employer pays the employer's share and the individual pays the individual contribution.



**FHP Buy in Provisions**

- Requires employer to pay at least 70% of the premium
- Requires that coverage be community rated.
- Premiums set by DOH
- State funding for the employer share subsidies is subject to appropriation
- Sunsets home care demonstration program

It also does a couple of other things. It permits state subsidies for employees who are government program eligible, and not just of the employee's share, but of the employer's share of the premium, if the employer does not currently offer health insurance or if he offers health insurance, but his ability to continue to provide that coverage is in jeopardy. And I will talk a little bit more about that in a second. The buy in has a couple of specific requirements. One is that employers must pay up to 70 percent of the premium. Also, that coverage be community rated and we are still working on how we will actually define that. The premiums are set by the Health Department. State funding for the employer's share of the subsidy is subject to appropriation. So we won't know exactly what that total subsidy amount will be until we have a budget. This is effective April 2008 so it will be part of the next budget. It also sunsets a demonstration program and this is something that kicked this program over the edge. We had a home care demonstration program in place in which the state was subsidizing home care workers, about 80,000 of them, who for the most part were eligible for a government program. We wanted to find a way to continue to make sure these people had health care coverage but to move toward broader based reform, not just target a specific group. And so we thought that FHP buy in was a way that we could provide both an additional option and address the situation with the home care workers, where that program's financial liability was in question.

The other thing we have been talking a lot about is universal coverage, but we also need to address some of the problems in our existing health care system. And as regulators of providers and insurers and as a purchaser of insurance, the Health Department and the Insurance Department find ourselves in the middle of disputes between providers and insurers. And so we began working on some proposals about a year ago that we thought might help reduce the points of contention between providers and insurers, and we put together ideas from the Health Department. When Troy came on board, he was working on some similar things. We worked together, came up with sort of a reconciled program bill that we thought would be effective, and then Troy convened everybody in the world, it seemed at the time, the Medical Society, the hospital associations, plan associations, and we sat in rooms for hours upon hours trying to knock out a deal. I'll let Troy take it from here.

*James Tallon:*

Let's set the stage. They're sitting in a room and they're having conversations and we're waiting to get the deal. But Troy could also talk about a lot of other things, too. Troy Oechsner.

*Troy Oechsner:*

All right. The stage is set, the die is cast. I'm Troy and when I came here it was a little bit birth by fire. There are a number of you in the room I see who were in that room when we were trying to negotiate the deal. And many of the ideas came from what we experienced when I was over at the attorney general's office. We had received complaints from consumers, providers, health



plans even, and what we tried to do was come up with a balanced, reasonable, fair set of proposals that dealt with everybody's concerns, and we got everybody at the table and hashed it out. Why this fits into the universal coverage piece is: (a) because a number of these are reforms, I am only going to touch on them very briefly; they are things that help to make our current system work better, the system that we are going to be building off of. And (b), having a dialogue and negotiations among stakeholders was a good run on a much larger discussion and process that we are going to be talking about in a moment.

## Managed Care Reform

- Payment for pre-authorized services
- External review
- PPO quality
- Cooling off period
- Claims submission deadlines

What we came up with was five basic pieces: (1) payment for already pre-authorized services — a complaint we had often received from consumers and providers was that a plan would pre-authorize a service, and then un-preauthorize and ultimately deny the claim. And so we negotiated a whole set of rules for when they can deny a service that they have already pre-authorized, and I think it was a big leap for many of the plans, but a good victory all in all; (2) external review — we obtained the right to go to an independent third party for denials of out-of-network services if you wanted to go see an out-of-network specialist. And we set up rules around that, which I think are fair and reasonable; (3) to require PPOs, preferred provider organizations, to capture the same kind of data that health maintenance organizations (HMOs) do and report it to the Department of Health, so that we can start to measure and have accurate assessments of that kind of quality health data; (4) a cooling off period regarding contentious negotiations between providers and health plans, often hospitals, that go down to the last minute. The current law often required notification to consumers when the contract was about to terminate and at the end of the day something usually was agreed upon that created a lot of confusion and concern among consumers who would often call us. This provides for a cooling off period of two months and notification 15 days after the termination of the contract. We saw it as a pro-consumer piece that was an important addition to the program; and (5) claim submission deadlines for certain Medicaid, Child Health Plus, and Family Health Plus claims. There is now a 15 month deadline for which out-of-network providers must submit those claims so that they are not languishing for a long period of time. That is something the plans wanted and there was a lot of give and

take with the hospitals on that, and again, I think we came up with a reasonable fair, balanced proposal in the end.

Okay, fast forward to a few weeks after we got that legislation passed to early summer and we are charged by the governor, and the departments of health and insurance to come up with a set of proposals for the governor for getting us to universal coverage. That charge included a number of elements. We want to use a building block approach, where we are build on what we have, making reforms to the system to ultimately get to universal and more affordable, high quality medical care for New Yorkers. We want to try to restructure the delivery system and there has been a lot of discussion today about health information technology, benefit design, quality, etc, and those are all the things we're going to be taking a look at to try and restructure our delivery system to reduce costs.

We are also charged with trying to learn from the problems that other states have or are currently experiencing. We spent a fair amount of time with folks from Massachusetts, both the people who work as the architects for putting their plan together, as well as having ongoing dialogues with some of the folks in their insurance department about current problems that they're having, Maine, Vermont, other states, what's going on there and what can we learn from them. We have seven public hearings scheduled. Jim Tallon, among others, is on the panel that has been hearing testimony from people around the state. We just had one in Glens Falls. You can see where they all are. We added one in Rochester. We also added a conference call on October 10th. In addition to the public hearings, we are doing a series of stakeholder meetings. With the public hearings we've posted a series of questions and the notice that went out with the press release. It's also on our web site, which is [www.partnership4coverage.ny.gov](http://www.partnership4coverage.ny.gov) and the point of the hearings is to solicit input. We really don't have any set ideas about what should or shouldn't be in the proposal. We're keeping an open mind and everything is on the table at this point. Just to mention in the Glens Falls experience — we were there from 10:00 a.m. until 6:00 p.m. almost without interruption. We heard from some 33 speakers and it was really informative. If anyone was there, the guy from the Rock Hill Bake House stole the show. We are having a series, it's some 60 organizations that Kathy and I will be meeting with throughout the next couple months many of them several times, to try to solicit input. It's consumers, business, labor, providers, and health plans. And then modeling of the proposals.

*Kathleen Shure:*

As I mentioned before the budget did contain an appropriation for a consultant to help us with this process, particularly on plan modeling. The request for proposal (RFP) that the consultant went out in July. The responses were due on Friday. We've received eight proposals. I can't really say anything more about it than that. But we are hoping to have a consultant selected in the next 30 to 45 days and under contract by the end of the year. If you know the contracting process in state government, that's very ambitious. But we would like to have that done so we can begin working on modeling in the first quarter of 2008 and have recommendations for the governor, which he has requested, in May.

*Troy Oechsner:*

And for the current executive budget coming up for this year there are a number of things that we're considering that are in the mix, including some potential additional building blocks in addition to the ones that Kathy outlined. We're looking at government programs, potential expansions, streamlining simplifications and consolidations in the insurance area. We're looking at various kinds of reforms to the market. Everything from what Sean Doolan and David Klein and Mark Wager and those folks have put out there to a number of other proposals as incremental steps toward making health coverage more available and more affordable.

**2008/2009 Executive Budget**

- **Potential additional building blocks**
- **Government programs**
  - expansions?
  - streamlining/simplification?
  - consolidations?
- **Insurance Reforms**
  - Markets?
  - Surpluses, Medical loss ratios, Equalization?
  - Medical malpractice?

Also in the mix is something we're taking a look at but have made no decisions on are surpluses, medical loss ratios, and tax equalization issues for health plans. In the interest of time, I'm not going to go into all the statistics. The good news is our health plans for the most part are healthy and that's a good thing.

*James Tallon:*

Thanks to Mike, Kathy and Troy. I have a couple of friendly but direct questions. Mike, you indicated the governor vetoed the bill on Healthy New York that you advocated. He signed the bill on the buy in on Family Health Plus, so do you just want to put the exclamation point about why that bill didn't work so well for 32BJ?

*Mike Fishman:*

There were a couple of elements that were difficult for us. One is that we work very hard to manage our plan and our benefits. We have to keep that plan of benefits standard and the Healthy New York bill would have allowed us to get a subsidy for the current plan we have. The bill as it is means that we have to use the Family Health Plus plan and that for us creates a problem, having different people on the same jobs with different plans. Secondly, there was a requirement that we would have to check immigration status and we don't do that. Seventy percent of our members are immigrants. The person who is on the job may be a citizen and other people covered may not be, but we don't want to be in the business of checking it out and putting our members through that when they are getting health benefits. The third issue is we have two sets of people. We are dealing with a very low-income level and a very high-income level. Family income could actually take them out of coverage under the bill when you have somebody who's working two jobs and their spouse is working a job and their family income may exceed the level of coverage. Therefore, they would be out of the plan and then we would have to get another plan. And so it becomes a difficult administrative issue for us and an internal issue when we have to have several different plans and options and ways of administration. So, we didn't think that worked for us.

*James Tallon:*

But let me actually stay on it for just a moment. You have very low-wage workers and you have some other folks for whom you have bargained moderately better wages, very

competitive wages. Among low-income workers, as we're talking about solutions and we've put a lot of New York into expanding health care programs to get there by building on Medicaid, putting Family Health Plus on top of it, and using that and even thinking of going a little bit higher there, do we really have a fundamental conflict in this discussion between the interests of organized labor, who wants to organize workers and health insurance benefits are critical to doing that, and the public programs, which is another solution? I mean, are we on a track where there's a fundamental difference between the interests of organized labor and of the strategy that turns the public programs for low-wage workers?

*Mike Fishman:*

I don't think so. We actually have the same interests. We believe that all workers should be covered by health insurance. We don't really care how they get it. We put a lot of money into the system by bargaining for money. We'd like to be able to use that money to the best advantage that we can to do it most efficiently. And there have to be some steps between the health coverage that we bargained for and getting everyone health care. But as far as I'm concerned, if we had a universal system and everybody was covered, that would be the best thing for organized labor. Everybody would have health care and we'd be able to take that away from the bargaining table as an issue and we'd be going to business for more wages.

*James Tallon:*

Thank you. Very good answer.

*Kathleen Shure:*

I agree we have the same interests on this and we spent a lot of time working with 32BJ both at the Insurance Department and the Health Department trying to see if we could figure out a way to make the buy in work. This issue of actually having to file an application for eligibility and complete all the requirements that exist in making a determination as to whether somebody's eligible for a government program is a barrier. We know it's part of the barrier in trying to get everybody that's eligible but not enrolled out there some of those requirements. We're working right now with 1199 on the homecare workers' demonstration. And they are in the process and hoping that as a union asking for some of this information from their employees will be easier than the government asking for it. But we'll see. They're going to be administering an eligibility screen to their employers and

trying to see how many are eligible for government programs. So we'll know whether or not this works. But it definitely is a barrier. We don't know yet how much information we'll get back and how much of a barrier it will be to making this work.

*Mike Fishman:*

The one piece I would add to that, which is complicated and this has happened since the discussion with 1199, is that the federal government is now criminalizing the behavior of both unions and employers. If you have knowledge that somebody does not have appropriate papers, then the union president could be arrested, the human relations person from the company could be arrested, so it's really going to create an enormous barrier for getting people health care.

*James Tallon:*

Any questions that apply to these presentations or any questions or comments that you want to make about earlier things? Dick Nathan.

*Richard Nathan:*

It's really a good day. Jim and Peter and Courtney have had a great set of presentations to learn from. Troy, in your presentation and, Kathleen, in yours as well, you talked about the state covering everyone, which other states are doing. Massachusetts is trying to do it, California has talked about it, Maine is working on it, Maryland, Vermont, and other states. At the same time, candidates are talking about national policy. So I have, not surprisingly, a federalism question. How does what you're doing fit with what everybody's talking about?

*Kathleen Shure:*

I'll start and then, Troy, you can chime in. I think, ideally, we would all like a federal approach to solving this problem. There are federal rules that make state reforms very difficult and they are largely in ERISA. I frequently say, we could solve this problem with money and getting rid of ERISA but both of them are difficult to achieve. But I think what we've all decided is we can't really wait for the federal government to solve the problem. So to the extent that we can't do that, we need to try to do what we can here to solve the problem in New York.

*Troy Oechsner:*

My predicting skills are pretty limited. Given that we have no idea what's going to happen in the future, if anything, on the federal level, my charge from the governor is to get working on it now. And I think we see ourselves as one of several states adding to the chorus that are going to be trying different things. Some of it will work, some of it probably won't work. But we're going to try a lot of different things and see what sticks. And, hopefully, if nothing else, it's going to create a momentum toward dealing with this for other states and on the federal level. But we're not waiting.

*James Tallon:*

We're at this point at the end of an administration that is obviously not supportive of a comprehensive insurance expansion and it has its arguments about why. I think the question is assuming that there could be a federal administration in 2009 that wanted to move forward on this conversation, would you move forward with a national strategy or would you move forward with federal support of the state strategy? And I think the one thing, the one little piece, with all due respect to my friends who would argue for a singular national strategy, is that in New York we are, I personally think, exposed to leveling down. My question is, what is the deal you could do nationally, in terms of a national program, how does that match up against utilization, expenditure, coverage patterns here in New York that have been traditionally on the higher side? I'm concerned about that conversation although I think that in final analysis if you gave me a universal proposal, you know, if it was really universal, you could go a long way toward making it happen. I think the other side of it, though, is what could the feds do to advance a state-based strategy? In all the years that we've worked this, what's the one single flaw in state-based strategies? We can't survive recessions. Cyclical support out of Washington to take states through recessions is absolutely critical in terms of any state initiative strategy.

*Richard Nathan:*

I'd like to hear you say just a little more about "leveling down." What do you mean by that?

*James Tallon:*

What I mean by that is in terms of benefit packages, eligibility levels and things like that, I'm going to take Medicaid as the principal example. There are still a lot of states out there that are not at a minimum 100 percent of poverty in coverage on Medicaid and, we're having a debate in which we're in the 150 percent range, 150 percent for some adults, they could go to everybody for 150 percent. We just put a SCHIP debate on the table that, albeit with subsidies and cost-sharing, takes us up to 400 percent on the kids and you hear the national outcry that, somehow there is something in the Constitution that says that 250 percent is the magic number. I'm very concerned that as you start to trim the benefit packages, that we get to a much narrower benefit. The national consensus that might be able to pass might not nearly be as comprehensive in terms of the underlying coverage that we have here in New York.

Other questions and other comments on the day. Kathryn Haslanger.

*Kathryn Haslanger:*

I'm going to try to figure out how to make this a question. It's sort of a observation from this morning. The question at the end was what is the single most powerful thing that you could do and the answer was pretty much was establish a benefit design. I'm trying to figure out what that meant in the context of a lot of remarks that were about the cost and the extensive number of mandates. And then the next two panels were talking more about appropriate care, about focusing on the influential quality settings, and on prime care management. I'm trying to put those two things together and feeling like this language about the benefit package and what was covered is really problematic. I guess my question is, going forward into the statewide discussions is there some way to re-conceptualize what's covered in a way that really puts the focus on what's appropriate and are we delivering the best quality kind of care?

*James Tallon:*

I think that most of you were able to hear that and it's essentially this issue between benefit design as a strategy and what does that mean versus system improvement as a strategy? Anybody want to take a crack at it, I would certainly say that the panelists can take a crack at

that one but any of our friends either from the plans or from the business community, please step in. I'll take answers from any direction. Anybody up here want to try it? Yeah, Mike.

*Mike Fishman:*

You said what I would say. I don't think plan design is the governing factor. There needs to be affordability, there needs to be active management, and there needs to be a mandate of some kind in order to make coverage work. Otherwise, with all due respect to the employers I deal with, money is not going to come into this system and it's got to come into the system from both the private sector and from the public sector. There needs to be an incentive for a partnership and then there needs to be active management by all the participants who are in it, not just labor but the business community, the participants in the fund, the health consumers themselves, and with government.

*Michael Cropp:*

Your question is an important one that points out some of the complexity that a lot of what each of us talked about are necessary components, but none of them are sufficient if we're going to get to where we need to be. If we want to have as a goal, everybody in the system so that we've got people who are currently outside who are healthier but could contribute to the pool, to help lower the average cost, to those that are currently in by adverse selection. We've got to have more affordable benefit programs. And we heard from David Klein, the cost of mandated benefits is considerable and it's a deterrent to having affordable product offerings, and not all mandates are created equal. Clearly, there are mandates that are out there that don't enjoy the benefit of scientific evidence to show their worth and there are other mandates that do. So I wouldn't take a chainsaw to mandates necessarily, but some prudence is needed if we're going to get to an affordable benefit.

But on the other side, we need to be able to get the right kind of engagement. I think Mike's slide was important in terms of the ability to engage people in a different way. You saw the savings on pharmacy. You know, I love the story about the head of our pharmacy and therapeutics committee. When we were talking about putting the three tier benefit in, he said, "This will never work. I have too many patients who are allergic to generic drugs." And then the next year we met, he said, "Hey, I have no idea where all those allergies went. It's amazing." But, you know, benefit design can affect the right kind of engagement for many decisions at multiple points along the way. Not the least of which is in helping people

with a chronic disease burden that we all believe is a significant component of the cost escalation that's going forward. But there's a piece, too, that we didn't talk about and that is that not all interventions are created equal and of real benefit. And there are actually some interventions being covered and come through the external review process that are actually harmful and problematic. One of our jobs that we view this, we've got to provide at a bare minimum, safety for our members. So that needs to be considered as a component as well. So I think that there's no question that benefit design is an important leverage item. For me, the most important leverage is true engagement of the people, whether it's the consumer of the health care, the patient, or even the provider. Because we have seen just incredible changes in provider practices with the right kind of incentives around doing the right work that brings about substantial improvements in quality and through better quality, lower cost trends.

*Richard Kirsch:*

I just wanted to follow up with Kathryn. I think one thing we have to be careful about is language. I was struck by a slide of David's presentation that says that cost sharing will lower costs. Cost sharing will lower the price of a product. It simply shifts costs to the consumer directly in terms of out-of-pocket cost. It doesn't lower costs. And, in fact, there is a lot of evidence that if consumers make decisions based on price sensitivity, they make the wrong decisions, they won't get in the system early enough and they'll be sicker later. So, we're not talking about lowering costs to the system, we're lowering prices of the product. And the same thing, Rima pointed this out nicely in asking questions, when you don't cover prescription drugs, you're not lowering the cost to the system, in fact you're raising the cost to the system because there is evidence, again, you don't take prescription drugs, you're going to end up having more expensive care. We have to be very careful if we take health care as a system, we need to see, how do we lower the cost to the system while improving quality? And some of the questions on improving technology and the kind of things you're talking about the right kind of intervention in terms of the questions to ask. But asking questions that shift costs usually leads to higher costs, and doesn't help us.

*James Tallon:*

Yes.

*Stephens Mundy:*

My name is Stephens Mundy and I'm the president of CVPH (Champlain Valley Physicians Hospital) Medical Center. I guess the comment that I would make is on the system as I see it in upstate New York (and I'm from Plattsburgh so I don't think of this as upstate, I have to tell you. Ticonderoga is downstate for me.) But we are losing physicians so fast, there will be nobody left. This summer I lost two out of three psychiatrists. I was on the phone with the Department of Health this morning talking about shutting down the only child and adolescent unit north of Albany. And it's not about hospitals, and I'm not asking for myself. I am asking for the physicians. I have to employ two out of my three pulmonologists because they can't make it. They're in a 10th percentile and they've got offers from interviews at the 75th percentile. This is a crisis. There was a meeting about three weeks ago in Glens Falls. This is the level that it's gotten to, the Association of Counties called a summit to ask for solutions to physician reimbursement as an economic development issue. And we're sitting here thinking about five years, 10 years from now, the next presidency. I've got to go back and shut down a unit and I don't know what to do. I just ask you to think about that and put as much effort into fixing some of that as we are into this today. Thank you.

*James Tallon:*

Thank you for the comment. Anyone have a comment with respect to this because obviously it's one example of a series of comments that have been made about changing the nature of service delivery and in this area, and certainly in the last 12 months we have heard this crescendo of workforce issues, professional workforce availability across upstate with concentrations in the North Country. Any comments on that, and I specifically say to the plan folks, is this your problem? Or whose problem is it? Yes.

*Alan Lubin:*

My name is Alan Lubin. I'm representing the Business and Labor Coalition of New York but for full disclosure, I'm also vice president of the statewide teachers' union. So, I think it's everybody's problem. It's not the problem of the hospitals, it's not the problem of the consumers; it's everyone's problem. There's no question about it. I think the solution to this and some of the other pieces that were mentioned, is education. And when I speak of education I'm speaking of education and retention of physicians and other specialists in

many different areas becoming part of the role of the state government if the government has to move forward in that direction. The amendments to the Berger Commission that protected the teaching hospital in Syracuse is a good step in the right direction and has Governor Spitzer's full support. That type of activity, and going further, a saved part of our health care costs should be in the education of the future doctors with incentives for them to stay here. So when we educate, it doesn't help us tomorrow, I know, but when we educate a doctor and we provide state support for that education, it comes with a commitment from the student that they will spend a certain amount of time working in parts of New York, more incentive to go to areas underrepresented by medical professionals. I think that's a big part of the solution. It has to be ongoing and it has to be cost-related, which means there is an added cost and the added cost cannot be added to the hospital, because then it's passed on to the consumer, passed on to the insurance company and we have exactly where we are today. When Mike Fishman talks about cutting back on costs, cutting back on the administration, it means somebody else has to take part of the responsibility and New York State has to take a much bigger part of the responsibility for group purchasing of medical supplies, equipment, drugs, and things like that to take the pressure off the individual medical plan, the individual consumer. The answer is not to shift the cost, but to absorb the cost and socialize it among everyone. I know there are people in this room who do not like to hear that, but that's really the solution to many of our situations in New York.

*James Tallon:*

Alan, I agree, it's everybody's problem, but let me go back to what the assertion was. The assertion was that in recruiting the next generation of physicians into the North Country, we are failing on price. Right now, you're getting outbid in the market. And so I understand about giving incentives for graduates to stay in the state and all this kind of stuff. We're just getting outbid in the market on this and how do you deal with that?

*Stephens Mundy:*

I just lost an anesthesiologist who was recruited to Phoenix on the first basis of Medicaid reimbursement.

*James Tallon:*

Well, can we do a deal? The obvious issue is how much leverage you can get just on the Medicaid reimbursement issue and what kind of leverage you get. That was a very good question and I appreciate the comment and Alan Lubin's comment also. Other questions or comments? In the back.

*Robert Ward:*

I'm Bob Ward with the Rockefeller Institute. Let's go back if we could to this question of plan design. We were watching with great interest what's happening in Massachusetts as the Connector Board has tried to put together a plan design, if you will. And if we have universal coverage we are either going to have no plan design and everybody can do what they want or else we are going to have some sort of plan design. I would be interested in hearing Mr. Fishman's thoughts since you deal with a plan design every day. Do you think that if people generally understand the idea that if there is a plan design it includes many things that are in, but it also includes some things that are not in? How often do you have to tell a member, "I'm sorry, we simply can't do that" and what kind of ramifications does that have?

*Mike Fishman:*

I do think that they understand as they go through it. But I was talking about our call center, 450,000 calls a year are really about plan design. If somebody calls up and says, "I went to the doctor and they didn't pay for this" or "They said they couldn't do that," we have those conversations every single day and it does make a difference. I would say the way we're managing our drugs, we're talking about makes a difference in change of behavior. Our emergency care co-pay and the specialists we have over at emergency room services have a lot to do with the fact that our members who, many of them don't speak English, were using the emergency room as their doctor and we had to drive them to primary physicians in order to be able to get them to bring our costs down. Each emergency room visit was costing us \$1,500 and a lot of times that was for, you know, "My child's sick and I don't know what's wrong with them." Whereas if they would go to a physician, it was only costing us \$75 and we had to drive them there using a co-pay as a disincentive and then add incentives for physicians.

*Barbara Cohen:*

One of the things we did to drive people out of the ER was added a nurse call line that speaks multiple languages.

*Mike Fishman:*

Right. We have 12 nurses 24 hours a day who take calls on issues. So I think plan design makes a difference in controlling costs. My point on plan design is that it won't make the difference whether people get health insurance. It's affordability and mandating either that the individual purchases or the employer provides health care. But yes, I think it's incredibly important.

*James Tallon:*

John, you're going to get the last question.

*John Rodat:*

I'd just like to follow up on that last question. To what degree does plan governance make a difference? As we listened to today's presentations and particularly the Q and A over the last 15 minutes, what struck me is the fundamental difference in the nature of the relationship between the plan members and different organizations. In Mr. Fishman's case, they are not only members of the plan, they are members of the union, a very different relationship than one involved with a health insurance plan whether commercial or not-for-profit. It is essentially a commercial transaction versus an employer self-funded plan, where the relationship between the individual and the organization is an employment relationship versus a public sector plan, where the relationship between the plan participant and the plan operator/manager is perhaps more distant but the nature of the relationship plays out in the electoral system. To what degree do those different governance and relationship models make a difference?

*James Tallon:*

Mike, you want to take a shot?

*Mike Fishman:*

Well, my experience is limited so I would say I think it does make a difference. I wouldn't substitute having the relationship we have for getting universal coverage. You know, I think that's more important. One of the things about Healthy New York was that you need a way to incentivize people to be engaged in the discussion. And I think there's one way to do it. Unfortunately, in most states, unions are not that strong and there aren't that many participants in the plans but in this state I think it actually would make a difference. I don't know how you would do that in a public plan or in an employer sponsored plan. You would have to create some mechanism for people to be involved, but I think it does make a difference.

*James Tallon:*

Well, we've come up to the appointed hour. Today for me was a lot about listening and I thank everyone who has come and done the presentations and I thank those who have commented or asked questions because I found it very helpful. We're now a dozen years later from the most recent update of the way in which we're regulating the individual, the direct-pay, and the small-group markets and there is obviously a lot of pressure coming from the problems that exist in those markets.

I was struck also by Steve McCormick's comments about Onondaga County and there certainly would be examples in Rochester and some other places about this, of sort of broadly-based coalitions, patterns of change in service delivery. We are now from 1996 forward 11 or 12 years into the Health Care Reform Act and remembering that while HCRA has become known for all of its subsidy pools, the underlying issue of HCRA is that we move from a regulated to a deregulated system at least with respect to payer-provider negotiations on the hospital side, and one starts to think about as you go forward that maybe one of the bigger questions here is how do we build back into this system the ability to put the direct pressure and ideas out for a service delivery change in addition to looking at the way in which you can influence this on the insurance side. So, I heard a lot of interesting conversations. Obviously, Troy and Kathy are talking now about the governor's real interest in moving into an ongoing discussion in which New York is going to continue to play a leadership role. I'm enormously encouraged by all the discussions about universal coverage.

*Richard Nathan:*

I just had a thought. It goes to what Troy and Kathleen were talking about and what we do here. Is there an intermediary stage? Is there something that would help what you're trying to do and shine more of a spotlight on what a lot of states are trying to do? That's a comment to think about. Thank you all very much and particularly to Jim and Peter and Courtney and Michael Cooper and Michele Charbonneau and other people who helped us. This was a complicated event; I think it was terrific.