Why and Where There's Wills and Ways for Strategic Partnerships

Speakers:

- D. Mark Weinberg, Group President, Individual and Small Employer Division, WellPoint Health Networks
- Marilyn Park, Senior Policy Analyst, AFL-CIO, substituting for Gerald Shea, Assistant to the President for Government Affairs, AFL-CIO

(Additional information about the speakers appears at the end of this section.)

Transcript:

MR. CURTIS: As you heard from the previous panel, coordinating with employer coverage makes sense, but it can be an incredibly labor intensive effort, [for both states and employers,] depending on how your program is structured. I know a lot of states are worried about that. An option for states is to partner with, coordinate with, organizations whose job it is to deal with the employer market and who already have information on benefit plans, who can routinely obtain and convey information on employer contributions and so forth. In other words, one-stop-shopping mechanisms for states, for organizations whose interests are aligned with states on this issue. [In other words, "coordinating with employer coverage" need not involve coordination efforts by employer.] Obviously, major commercial insurers could provide such an option.

Now, to tell you the truth, some states, at our behest in part, talked to such carriers [in the context of children-only expansions], and the carriers basically said, well, wait a minute, you're talking about children from, say, 133 to 199 percent of poverty only, and only for the seven to 18 year olds. So we're going to do all this for what? We figure in the average group, size 15, we may get two kids, after going through all this. From our point of view, it's not worth it.

When you are adding parents, it immediately ups the ante [the number of people for whom premium assistance would be cost effective]. And as we have inquired around the country, trying to find carriers with long-term interest, the fellow sitting next to me is the one who got the big picture the first nationally. He is Mark Weinberg. He is a Group President at WellPoint, which I think, among other things, is the largest individual-market carrier in the country, but is also very big in the small employer market. Blue Cross of California is a subsidiary of theirs, and they are the biggest carrier in the small group and individual market in California with, it says here, five million members. Even by Medicaid standards in most states, that's big.

And Mark is very well known in the industry as an incredibly capable executive, and he also is known for thinking outside the box. For example, he has expressed concern, despite his status in the individual market, that individual tax credits, if they're not properly structured, could lead to some disintegration in the employer market, which he doesn't think would be necessarily a very good thing at all for people who have coverage.

So he's going to talk to you about this from his vantage point, and I hope you listen carefully. I also hope that his interest and United's experience and interest, from what happened in Rhode Island, can be parlayed elsewhere in the country.

And I will introduce Gerald Shea if he gets here. He's been called off for an emergency by the president of the AFL-CIO, but they are trying to get him now.

Mark.

MR. WEINBERG: Thanks very much for the introduction. It is in some ways "strange bedfellows" for a health insurance company to be talking about partnerships in the area of public assistance programs. But we've thought about this for a long time. I'm going to try to give you a sense from our company's perspective, and I'm going to try and represent as best I can the perspective of the industry.

As you all know, there's not a whole lot of consistency in how individual insurers deal with the market, but I think there are some evolving points of view about what's going to be necessary for our role to be a beneficial role in the future, and I think it does include figuring out ways to look at new partnerships and to be a part of the solution for people who seem to be stuck outside the system.

I may use some language that is the wrong jargon. In the last hour or two, I heard some jargon that I don't necessarily recognize either, but that's just sort of the beginning, I think, about how we figure out how to work together.

Our company does business in every state in the country, but we're very focused in the small-employer market and in the individual market in seven states, seven fairly large states, that represent about 85 to 90 million of population. We've chosen those states to do business because, in fact, those are states where there is the possibility of actually being successful in penetrating the individual and small-group market. That doesn't lend itself well, unfortunately, to states that, for some of you, we might view as being overregulated. Some of you might feel are absolutely appropriately regulated.

But again, it probably brings us to the second important consideration in trying to figure out how we work together. We probably have to better understand each other's points of view. We cover about two million individuals in small groups, members of small groups over the course of the country. It's about 100,000 businesses. An average size is about six. That's pretty consistent with the average size of employers in this country under 50, and that's what we regard as a small business.

As you all know, that's the core of the problem. What I wanted to talk about first was the question of why the industry would be so motivated to have an interest in this. And of course, because all I deal with is employers under 50, I look at what the market is, and I see as you do that only about 50 percent of small businesses in this country offer health benefits, and for many years that number had been declining. That number is actually increasing right now, and what

we all don't know is whether or not that increasing dynamic is going to continue, or whether that's going to change as a result of the obvious economic factors that are at play. I do know from my experience in dealing with employers that there's a great amount of inertia in almost everything that they do related to benefits for employees. And so there is a reasonable notion that, if you can move people in the right direction when the economy supports it, there's a good chance that the private market can help keeping it moving in the right direction even when the economy is not as robust as it is.

But we are keenly aware that, for employer's under ten lives, especially, this is a huge issue. Only about 30 percent of Americans that work for employers with less than ten employees will say that they get their health care from their own employer. They either get it from some other source, another family member, a public program, an individual company, or they don't get it at all, and they don't get it in pretty high numbers.

As that moves up to about 25 employees, that number drops dramatically, and above 50 employees, it's not much of an issue anymore. That's not a surprise to any of you. We're interested in solving this program, because we have identified approximately a million small employers and about two million individual purchasers that we think are candidates for purchasing private insurance. They don't buy it today, but we have a lot of reasons to believe that, if we do this right, they will buy it. One of the concerns we have about approaching government from a public direction to serve those people is, we may end up spending government money that's not necessary to be spent, and I think that's the crux of both the problem and the great opportunity.

The last thing I think any of us should be trying to do is compete with each other in such a way that would cause unnecessary public money to be spent in places where private money is available and there is a willingness to use it. And that would be a great outcome if we could find exactly how to make those two things coexist, and I believe that they can.

Let me tell you a little bit about these two million people that we cover who pay every month for their health insurance coverage. They pay on average about $120 a month, nationwide—that's over two million members. We pretty carefully designed what we sell so that we fit into what we have come to understand is their pricing threshold. We don't sell health insurance like we did ten years ago at all, and we don't sell health insurance in this market the same way we sell it to the large employer market.

[In] the large employer market, we go out to large employers and we say, what would you like? They tell us what they want. We go build it. We give them a price. They either choose us or they choose somebody else. [In] the individual [and] small group market, we study what people's motivation issues are, what their drivers are, what their concern is, and how willing they are to see money spent on health insurance for their employees, how important that is relative to other ways that they can spend their money. And oftentimes it's fairly low on the list, but it's a desirable thing to do. Where it lies in the list is incredibly related to what the price is. It's incredibly related to it. It doesn't matter whether this particular thing is covered, whether there's a certain level of out-of-pocket cost sharing. It is almost 100 percent, what's the price?

And that has changed a lot over the last ten years, as so much else has. It's probably changed so much because just the absolute prices we are talking about are so much more material today than they were ten years ago relative to almost anything else. But needless to say, that's where we are. Price drives it. So we've studied those prices, and we've attempted to have a portfolio that's available that we know will meet the price threshold of increasing numbers of small businesses. We work very hard to make that happen.

That means that, in spite of very high medical cost inflation, our prices are actually planned to be either level or go down over time, and you know what that means. That means that we have to make lots of tough decisions about how coverage structures work. Again, we're not trying to dictate to anyone what they ought to have. We're just trying to reflect what they're willing to spend their money on, and it says a lot about how you begin to penetrate the large numbers of small employers and even individuals who are not yet motivated to buy, and we believe we can bring a lot of them in, not all of them, but we can bring a lot of them in.

That's very motivating to us. We see a huge market opportunity. We do two things by pursuing it. We can build our business, and we do something important for the community. All the data that we look at, the Purex Royal data, says that the people who are out of the system are, in fact, getting a break at the expense of the people that are in the system. They are generally healthier. They are going to be generally more interested and more likely to stay healthy than the people who are covered, and so there's great reason to want to bring them [in], because that all by itself will bring the average price of health insurance down.

It doesn't mean there's not lots of people that are locked out that are sick and all of those things. That's a different subject that has to be solved in a slightly different way, but the lion's share of people we're talking about here will probably have a better health profile in an insurance pool than those who are currently in the insurance pool. So it's very, very desirable for insurers to want to be part of this solution, so that they can share that good benefit with everyone else that is currently covered.

I liken this oftentimes to the problem that emerged in the late '80s with shoplifting. It was a new phenomena. Retailers had to deal with it in a new way. They had to create all kinds of security devices. They had to hire people. The cost of shoplifting was replaced by the cost of avoiding shoplifting, but nonetheless, everybody who shopped was paying for it.

We have the same issue in the insurance industry today. The problem of people outside the system [who] are simply costing all the rest of us more money than we ought to be paying.

That [price] range, [as] I was saying, was about $120 a month. The range of what people pay for individual and small-group insurance for our company is between about $50 a month and about $180 a month. So it's a very broad range. There's not a lot of different choices. We believe seven or eight choices is about the right number. They're of every form that you can imagine. They include MSAs. They include HMOs. They include open-access plans. They're dominantly open-access direct-referral kinds of plans and much less visible than the heavy-handed managed care that we saw ten years ago.

I'm bouncing around in my thinking, but now that I'm at this point, this will present another problem as we look at public programs for the future. Most of the programs out there are built around the existence of a thriving HMO-controlled system. Those kinds of control systems are going to be—well, they already are less and less popular than they were even five years ago. The percentage of Americans in HMO products has declined steadily for the last five years, and it will continue to decline for two good reasons.

One, Americans do not like being that overcontrolled. That's the impression they have. And I think this is true of people with means and true of people with lesser means. So it's an important consideration for both private and for public programs.

The second reason that fewer and fewer people have HMO products as opposed to open-access programs is because, relatively speaking, they are becoming more and more expensive. They are very, very rich benefits, and the people who are part of HMO programs, their health is normalizing. For many, many years, they were younger and they were healthier. Well, those younger and healthier people are now older and more normal people.

And what we're beginning to see in the late '90s is, for the first time, the true cost of managed care. The true cost of managed care is that, benefit by benefit, it's slightly less costly, not enormously less costly, but slightly less costly, but when you compare it to insurance-based products that have cost sharing, what you find is that those products are, in effect, for the same populations dramatically lower priced.

So Americans are moving to lower priced products, which means they're moving out of HMO plans. Now will we see a similar kind of demand for people who are paying a much smaller part of the cost, because it's being subsidized by government programs? I'm not sure, but, you know, what I've observed is that people to tend to pick up what's "in the air" in terms of public opinion across the means categories. And so I think it's very, very important that we are sure that the programs we have in the future provide for non-managed care alternatives for people who through their employers or who receive something on their own.

Lots of studies have indicated that employers that are not offering insurance would offer insurance with as much as a ten- or a 15-percent lower price. They are very, very interested. Sixty-three (63) percent in a recent study—63 percent of employers that did not offer health insurance today—said that they would be much more or somewhat more likely to offer it with some level of government subsidy. With a ten-percent decrease in premiums—when we studied just employers and what they're paying—a ten-percent decrease in premiums would bring 43 percent of those who do not offer would be more likely to offer health insurance.

So we're not talking about the need for huge subsidies. The interesting thing about this is—from the data that we've looked at and from our own experience watching people buy and people not buy and people's reaction to price when it goes up, when it goes down—very small amounts of difference, very small changes in price, will motivate a lot of people to come into the private market.

And so one of the things that I'm very cautious of—and I think it was mentioned when I was being introduced—is over-subsidizing employer-based premiums or over-subsidizing individual-based premiums. When you think about it, if over seven or eight states the average price people are paying is only $120 a month per family member on average, then a reasonable subsidy that will bring a lot of people in probably begins at $15 or $20 or $25 a month. That's a whole lot lower than what oftentimes comes into mind when we think about how to begin using subsidies in an effective way. Again, that doesn't necessarily fit for this program, but in general the use of subsidies for employers is a very, very powerful tool and we should be careful not to overuse it.

Let me tell you some things we've observed as we start thinking about how to build partnerships with the public system. What we recognize is that, in terms of advertising, these programs spend a lot of money on outreach. We spend a lot of money on advertising. As I look at what's involved in marketing private health plans, and I look at what it's turned out that is involved in outreach programs for people for public programs, they're not all that different. What we all find out is, this a lot harder than we thought it would be. There were several people up here earlier who said, we had expectations for all kinds of people, kids, to come into these programs. If you build it, they will come. And people were disappointed all around the country with the response. Well, it's exactly what happens when you're in the private market, too, and so we work very hard to create marketing mechanisms so that people will respond to these programs.

But the reality is there is as much money, if not more money, being spent on these public programs on marketing and outreach than there is in public companies on their entire marketing systems and advertising. I'm somewhat dumbfounded when I look at the dollars spent on media between these kinds of programs and the dollars that we spend on media for the populations that we serve. So I have to believe there's an opportunity there to spend that money smarter, if we could figure out how to do it together somehow. And what we do know is, if advertising is focused on price and on value, people respond. We do a lot of advertising to uninsured people. We get an incredible amount of people who are poor and that are going to buy our plans, believe it or not, and they do.

We also get an amazing number of people who are not going to qualify for our plans because they're simply not going to be able to afford it. So we know that the kind of outreach and advertising we do creates potential candidates for these programs. Do we have any way of dealing with [that] in today's world? No. It's kind of just wasted effort. But it's a shame. I suspect that oftentimes in the outreach programs that are done in these various states, there are great candidates to purchase health insurance, too, you know, without subsidies. We ought to find a way to be able to bridge that gap.

What we do find is that low-income people do buy coverage. It's surprising. Our average income—we do a lot of research on this—the average income of our group of individual and small-group members is only slightly higher than the average income of the country, and we look state by state. It's pretty much no different. We do have somewhat of a skewing, as you could expect, towards slightly higher education and towards slightly higher household income,

but not a lot. And when we look at what the deviations are around it, we clearly have people that all of us would characterize as poor or near poor who are purchasing health insurance coverage every single day or participating with high premium contributions through their employers. And maybe, as a matter of public policy, that choice that they made is not a fair choice, but it's a choice they made, and with limited resources we ought to be real careful that we don't necessarily lose that dynamic.

What We've Learned

- Poor and Non-Poor respond to advertising focused on price.
- People of low means often do buy private coverage.
- Increasingly, affordable price, credit card payments, etc., improve sales rates of all.
- Understanding that most hospitals and physicians will "extend" payments makes higher out-of-pocket cost sharing viable for many.

There are also other things that we have learned that will cause people to come in. Increasingly, as price becomes more affordable—and we've watched this—more and more people are coming into the insurance industry. The ability for people to use credit cards for their copayments, credit cards for their premium payments. All those things actually cause people to stay in the system longer. And these are small issues, but in our industry those things have not been done. People can't put their health insurance premium on their credit card like they can many of the other household things—that if they get into trouble, they can pay their electric bill on their credit card, et cetera. These things are only just coming out this year in the industry. And we know from tests that we've done that they have a dramatic effect on people's willingness to maintain their private small-group or individual coverage.

There is another thing that we've learned over time, and that is, when we talk about programs that have out-of-pocket cost sharing—you know, deductibles, coinsurance, dollars that people have to spend up to an out-of-pocket limit—you get into this very strange dialogue about, Is it fair? Can I afford it? And they have dramatic impacts on the price people can pay. Going from a no deductible to a $250 deductible probably reduces the price of a health insurance policy by 30 percent. And as you incrementally move that up, it's a declining effect, but it's a dramatic effect.

So, out-of-pocket cost sharing is an important way of getting the price down, but we also know from about 15 years of experience in this that, as these out-of-pocket cost-sharing mechanisms are [put] in place, people really do self-manage their care better. And I don't think this is about people's lack of ability to get access, but when we actually look at how people use and what they use and to what degree they use, our data would indicate that people will manage their care better than we can manage their care through all of the managed care mechanisms that we've attempted to create over the last 15 years.

So out-of-pocket cost sharing is an important issue. People raise the question, well, how will I deal with it? There are a lot of unknowns about the way the health care industry works, and one is [that] almost every hospital and every physician will negotiate a payment schedule with somebody who has got an out-of-pocket cost, and they'll negotiate those over fairly long periods of time. We don't talk about that, and as a matter of public service, there's a great opportunity not only to help people understand what the price of being insured is, but also that there are mechanisms to help them—working with their providers of care—help them stretch any sort of "lumpy" costs there might be over time.

I know this doesn't apply completely to the kinds of programs we're talking about here, but I know there's also great fear about any out-of-pocket cost sharing for these kinds of programs, and I guess I'm just trying to urge you to consider that those things are important mechanisms to keep the price down, whether the price is being paid by a consumer, by an employer, or by a combination of state and federal money—that these all matter in keeping dollars best spread to the largest number of people who can ultimately benefit.

Well, let's see. People have talked about crowd-out. Let me mention a couple of other crowd-out issues. These are things that we may only see from the private market. There is the obvious issue. Our greatest concern about crowd-out is really what happens to the remaining people in the system.

There is, of course, insurer concern about enrollees being lost to a public program. But that's not the real concern. The real concern is that somehow it destabilizes the risk pools and that what ends up happening is, a good that is done over here hurts people over here. The people that are hurt over here are also members of your community. They're also people who have done the right thing in maintaining their employer sponsored coverage.

What we have measured since late 1997, as these programs have begun to grow, is that the percentage of our enrollment in individual and small group that is made up of people under age 18—kids—has declined steadily. It's not a huge decline, but it has declined steadily. We estimate that the impact of that decline over those three years represents between 30,000 and 50,000 kids—not a killer when you're talking about a couple-of-million member book of business. But there was an adverse impact of those 30,000 to 50,000 kids that left this program to move into public programs. Chances are, they were making a positive contribution to the pool and probably making a positive contribution to their parents' coverage or whatever family they're part of. We're very, very concerned about an adverse impact that essentially takes lower risk people out of the insurance pool, leaving higher prices and higher costs for the remaining

people who really did nothing to deserve it. They just were responsible and maintained private coverage. You have to be very, very careful that, as we do this, we look very, very carefully not just at the calculations associated with crowd-out, but let's try and understand what's happening in the insurance pools in the various parts of the system.

Private Market and Crowd-Out

- Percentage of under-age-18 members declining with program expansion.
- Increased rates for remaining families and increased insurer risk due to declining multi-party contracts.
- Retention of privately covered parents of kids enrolling in public programs.
- Qualification, audit, consequences for abusing, selection gaming.

We also recognize that there is a great likelihood that, when kids move out of an employer-based program to a public program, that the parents, within the next six to 12 months, often leave that private insurance program as well. And, again, if they're leaving, our data would suggest they probably had relatively low health risk. They felt that was a pretty good risk for them to drop out of the program. And the thinking goes like this. The kids are taken care [of]. That's what I was really worried about to start with. I'm pretty healthy. I'm relatively young. I'm 36 years old or whatever. I think I can go bare now. And so that person, that adult, puts them self at risk, but they also, again, have adversely affected the insurance pool that they left. We're concerned about that.

The other thing from the private industry—and, of course, we hear all this anecdotally, this last item, but—of course, every insurance broker that is dealing in a state that has got an active SCHIP program believes in their heart of hearts that the eligibility and the qualifications are being gamed. And it's a tough issue to deal with, but if the worst thing that happens is somebody falsifies a self-declaration and that through some process they're ultimately found out and then they lose their coverage at the next effective date, if that's the worst thing that happens, then it's an opportunity for anti-selection as well against the program, because we know from all kinds of experience that people are the most interested in getting health care when they have a fairly high and fairly credible awareness of health needs in the next 30 to 60 days.

So it's a caution that everybody has to be very, very careful of. It's tough in this qualification process, but again, as we think about the business, the private insurance business, you know we're in the business of doing underwriting evaluations of people, what their health risk is for purposes of their qualification for health insurance in individual or small group. There's an awful lot of great information that can be used for that to help determine somewhere along the line the reasonable eligibility for these programs as well.

Well, let me go to where I see the opportunities. There are probably six or seven of them. We believe that we're all probably spending too much on marketing and outreach. I mentioned that earlier. I think there is a great impact. There's a great opportunity for us to find a way to build a single outreach and marketing capability as part of the private insurance market that has a defined and specified intention of identifying people who would qualify for these programs. We can bring in, I believe, a surprisingly large number of people that would qualify for these programs, just because they're part of the response we get in our normal marketing.

Opportunities

- Spending on "outreach"/marketing; competing messages—impact on crowd-out
- Media, response mechanisms, staff and support
- Common enrollment, underwriting and qualification processing
- Transition management through temporary eligibility spells
- Combined hospital and physician contracting
- Universal alternative purchase-credit or program-enrollment at time of enrollment

We deal with 45,000 independent agents and brokers in the seven states we do business in. There are between 100,000 and 150,000 such active brokers throughout the United States. They live in every community. They're part of every community. They are probably as good at knowing what's going on at a household level as anybody can be. What a great asset that would be if we could find a way to leverage those people, to help find people who would be eligible and qualified. And of course, if they're all under contract with the health insurance companies, we're all paying them, and if they receive a call from somebody who wants to buy health insurance and that person is not able to afford health insurance, they still had to go through all the motions.

They're bound by their own requirements and their own liability to see it all the way through. So nothing comes out of it for them if they don't have a way to place that child or that adult. So a great opportunity would be to take advantage of that and for us to set up a way for those people to place some of those.

Because we do a lot of marketing and advertising, we have enormous media response mechanisms in place, people on the phones that triage and take information. We have staff and automated support systems, everything from the internet to CD-ROMs to kiosks that we put out in communities. There are so many things that the private market has out there that have relevance even in poorer communities and in shopping centers and through health fairs and underwriting fairs, all of which we conduct for purposes of finding people that are going to purchase. That whole mechanism, as a triaging support system, I think, is quite interesting to think about.

We have an elaborate enrollment and underwriting and qualifying process of our own. This is the third one. I mention that. We do it for different purposes, but the fact is thousands and thousands and thousands of people every month go through our system, probably in excess of 35,000 or 40,000 a month. Some of them end up purchasing health insurance; some of them don't. That qualifying process could have other aspects to it that are not related to qualifying people to pay for health insurance. They could qualify people to be eligible for these kinds of programs. The people are all there. The activities are all set up. They're all automated. The data is all captured—a tremendous amount that's actually gathered on people that go through this process as well.

We're also aware, as I'm sure you are, that people move through spells in their life where they're more eligible for private insurance, maybe more eligible for public insurance. And since we know that there is an awful lot of transition there, finding a way to link these things so that we can be responsive to people whose eligibility changes would be of great interest, probably, to both sides. We think there are some things that could be done there and there are some great incentives on both sides, obviously, to make that happen. We shouldn't have anyone remain on public programs any longer than they need to, and we shouldn't have anybody feel compelled to have to remain in a system that they can no longer afford any longer than they need to.

The private health insurance industry, even though a lot is changing in this regard, has amazing contractual relationships with physicians and hospitals all over the country. Aren't there better opportunities to take advantage of those other than just purely outsourcing to single entities? There are some ways that these contracts could be done on [for the] mutual benefit of health insurance companies and a public program that has been constructed to work more in tandem with the private insurance system.

Those are just some examples. I think other folks have mentioned the fact that we are in the business of doing a lot of administration. We have computer and technical capabilities that are very interesting, both clinical and administrative. I think there are any number of ways we could leverage those kinds of things.

I guess my bottom line on this would be sort of where I started, that there is a huge opportunity to make a big change in the number of Americans without coverage, whether that be through public programs or private programs. I happen to believe that there are millions who will qualify and will spend money on programs that they will pay for, or their employers will pay for, with the right messages and the right outreach.

There are obviously also millions who will not be able to make that hurdle from time to time, or maybe for a long extended time. So we really have the same problem to solve, and I think there are ways we can approach it jointly and have a much bigger impact than what any of us are realizing today.

I want to leave you with five things to think about that have to do with concerns sort of at the fringe. And that is, we are in a changing market, and as some of these dynamics are changing, it may change all of our perspectives on how to think about these programs in the future.

The first one is that employer offer rates for health insurance are increasing. I mentioned that at the beginning. I believe they're going to continue increasing for awhile, and I think when the data on the year 2000 is available and complete, we're going to see that there has been another dramatic decline in the number of uninsured Americans. We all know that that's heavily related to the growth and prosperity of the economy and the success of the private market to take advantage of that when people become employed.

Insured and Uninsured Dynamics—ALL AGES

	1998 Percent Uninsured	1999 Percent Uninsured	1998/1999 Population Change (000s)	1998/1999 Insured Change (000s)
Poor	***32.3%***	***32.4%***	***- 2,218***	***- 1,503***
Non-Poor	***14.0%***	***13.3%***	***+ 4,562***	***+ 5,574***
TOTAL			***+ 2,344***	***+ 4,071***

Source: March 2000 Current Population Survey

There was between 1998 and 1999—just for example, if you do some extrapolating from the Current Population Survey—the population of the country increased by about 2.3 million. The increase in the number of insured people was 5.6 million. So there was a dramatic increase in the number of people that had insurance—excuse me—let me take that back. The increase in the insured was about 4.1 million, but of that 5.6 million were non-poor. The reason that happened is because there was a decline in the population of poor people by 2.2 million. They went from poor to non-poor. [When] people go from poor to non-poor, they become capable of buying health insurance or qualifying for private health insurance, and they did. 1999 was a great example of that.

I think we're going to see that again. But as employer offer rates go up, let's make sure that we think about programs that are going to be consistent with employers being more willing to play a larger and larger role in this. I think premium subsidies, done right, can really encourage that to continue even though there is some slowing.

But as I said, employer behaviors are not going to change overnight. I think there has been a dramatic shift. I think many employers have been shamed into offering health insurance benefits to employees and I think that's going to continue.

Keep in mind that the private market is going to be offering lower and lower priced products. I described to you how our range of products works. I think that [trend] will continue. That means that the question of what does it take to supplement that with public programs needs to be identified and thought about.

We're going to see a huge emergence of defined contribution, where employers will be paying a fixed contribution. We've launched this all over the country this year in our small employer market. And that's going to have some impact on some of these dynamics. More and more private insurers will be offering multiple options to employers, where every employee can pick any one of six, seven, eight different options, and those are going to be more than just straight managed care options. They're going to be all kinds of options.

As you think about that—a public program having a role in that and being one of the choices or one of the things that people can qualify for—that trend will continue.

Need to consider and better understand the impact of:

- Increasing employer offer rates
- Lower price private market offerings
- Defined employer contribution
- Multiple employee selection
- Private market trend away from restrictive managed care

And then as I mentioned, the final trend is this movement away from restrictive managed care. It's a real thing that really is—and it's a real part of what's changing. Do we want to end up with public programs that are dominantly stuck in a model that most of America is moving away from or is there a way to embrace that as part of the future? Thank you very much.

MR. CURTIS: We'll hold questions until the end of the panel. Unfortunately, Gerry Shea was called off to some kind of an emergency with the president of the AFL-CIO, but Marilyn Park has graciously agreed to make a few brief remarks that represent the key points that Gerry would have made. She's a senior policy analyst with the AFL-CIO, and she has actually contacted IHPS over the last several months on a number of occasions because of the increasing interest of the AFL-CIO in coordinating with states on some kind of premium assistance initiative.

AFL-CIO unions, obviously, represent workers and their families very actively. That's their key role in the world. And, for those of you who are used to looking at population-based data on the uninsured, you know that when you look at modest-income working families and whether or not they have coverage, one of the strongest determinants of whether they have coverage is the degree of unionization in a state, and that's because unions think health benefits are so important. On the other hand, as Marilyn will tell you, there are union members whose wages are so modest that they cannot afford to negotiate contributions big enough to cover a whole family, and therefore, unions are interested in coordinating with states to get people covered. Marilyn.

MS. PARK: Thank you, Rick. I was sitting here busily trying to shorten things, and I heard the word "defined contribution" and sort of panicked—you can't say that [word] around us without [us] getting a little nervous. Anyway, thank you very much. I will really try to be brief, and the fact that President Sweeney called Gerry Shea away at the last minute is not a reflection of our lack of commitment to this issue.

We are really very excited. We're relative newcomers to the world of public programs, but very interested. A number of the unions that we work with had initially come to us because they saw a tremendous opportunity for their low-wage workers, their part-timers, to get coverage by blending the public partnership with this private coverage that we offer.

So let me tell you a little bit about where we're coming from and why what I've heard today makes me think more than ever that we really are a very good fit in a lot of ways. Some of you have actually already been patient and talked to me on the phone and helped me understand the Massachusetts program, the Wisconsin program over the last year, and I hope to be talking to more of you about how the unions in your states that would be interested in participating in these programs could mesh their world with your world. I understand the complication of merging employer coverage and Taft-Hartley coverage and public coverage—they will have their own challenges—but I think they're very doable.

I just wanted to give you a little bit of a history. We, basically since World War II, have been negotiating health benefits, starting in the manufacturing industry, and most union members traditionally have had health coverage. At the same time, even though unions have done quite well with health coverage, the labor movement has advocated universal coverage throughout this period, and when we're not advocating for the national level, we are bargaining for it fairly successfully at the bargaining table.

But nonetheless, we see a great need for subsidizing coverage for some of our low-wage workers. As you can imagine, we're organizing a lot more among home-care workers, child-care workers, janitors, people who traditionally didn't have union representation. But the economy still doesn't support coverage for them, and we see this as a great opportunity.

You probably think typically of the coverage of, let's say, the auto workers, which really is top of the line—no deductible, they bear no more than 20 percent of the total cost of the premium. But, in fact, unions really do parallel a lot of what's going on in the rest of the country, and even in these prosperous times, it's very troublesome to us how many people are not able to get decent single coverage, and certainly not family coverage. And if we're talking about home-care workers who make $7 an hour, we're talking about people who certainly can't afford family coverage on their own.

We also have been experimenting … In addition to having part-time workers that work at supermarkets and part-year workers like Head Start and Child Care—all of them present challenges—others that have irregular work hours include hotel workers or construction workers in parts of the country where the work goes up and down and they're moving in and out of coverage quite a bit. So we see that this is an opportunity to provide more stable coverage for the worker themselves, as well as for their family members who, in these low-wage sectors, almost never have coverage.

For those of you who aren't familiar with what a Taft-Hartley is, we kind of operate in two worlds. About eight million union members and their families receive their health benefits through what's called a Taft-Hartley or multi-employer plan. And those are the plans that are jointly administered by management and labor, and the union is basically running the plan and delivering the benefits and has a tremendous opportunity to deliver quality and cost-effective care. Initially, it started in industries like construction, where people worked for many small employers and jumped around, so you needed to pool employer contributions. But now we have Taft-Hartleys in the service industry and the health care industry, retail, clothing. And what it is is basically a pool that allows people who would not [otherwise]—based on their wages and the fact that they have so many small employers—be able to afford the coverage.

But, in addition, we see the Taft-Hartleys as natural partners in a program like this, because legally we don't really see any impediments to them signing up for these SCHIP programs and receiving premium subsidies for the people in their plans. And in addition, though, we also see opportunities for the single-employer plans that we negotiate with at the bargaining table to coordinate with them because, from what we understand, a lot of employers are still being coaxed into these programs, and we feel that when we're negotiating for the first time or renegotiating health benefits, if we could put SCHIP premium assistance programs on the agenda, then we may be able to arrange contributions and other requirements being met, outreach money, so that the employee—and I'll tell you a bit of an actual example of that now—so employers can start participating more. I mean we feel we can do that role of pulling them in.

So both in our union run plans and in our state and employer plans we have collective bargaining agreements. We think that we can make a contribution here. I just wanted to tell

you… For example, there's a very big Taft-Hartley in New York which I think exemplifies some of the benefits just to workers of being in that kind of a health system. 1199 Health Benefit Fund, Service Employees of New York, Dennis Rivera, very big health workers plan. They have tremendous cost savings. They have overhead of only seven percent, and they've been able to provide full hospital outpatient and drug coverage for $4,000 an employee last year as compared to almost $1,000 more for the country as a whole, and people pay no coinsurance.

Other things that they do—because people stay in these Taft-Hartley plans for a long time and because the union is so institutionally committed to the health benefit, we get to see things like shop stewards doing health education on site, helping people with complex medical problems navigate the system, lots of preventive care, asthma and disease management programs, on-site disease management programs. Just to give you a sense of the kind of continuity you have in a union-run plan, in 1199, the average worker stays there 17 years as compared to 17 months in a commercial plan.

I wanted to just discuss some other union initiatives which illustrate that we are thinking creatively about coverage expansion for our low-wage workers, and where we think premium assistance could fit in here. In California, there are a lot of home-care workers who are independent contractors. And what we did out there was, we worked to help create a quasi-public authority which is their employer in name, and that created a purchasing pool. So now they all get health coverage for the first time, which is very rare for home-care workers, through this public authority, and that's 100,000 people who are in-home supportive-service workers getting health insurance for the first time.

In Chicago, we organized janitors as part of our Justice for Janitors Program. This is the service employees again. And this was the first time janitors ever got health insurance, and it was only because the Taft-Hartley was able to pool contributions, along with the employer contribution, that made it possible.

I want to mention one other union, AFSCME, which represents both public and private employees. Even though they historically represent public employees, they now represent lots of low-wage health care employees too. And they have had great success negotiating for part-timers coverage and also asking for health insurance as part of living-wage contracts with government contractors.

And right now they're also working in New Jersey to try and work with the Medicaid program and home-care workers who provide services at Medicare and Medicaid facilities to see what solutions they could come up with for providing these low-wage workers with coverage.

What I heard today just reminded me of why Taft-Hartleys are a natural fit for this program. You need constant communication with employers and coordination. You need to identify which workers have accessed the possibility of employer coverage. You need to know the scope of the coverage and the contribution levels. And while all this sounds very challenging, the Taft-Hartleys of the world, in particular, are already there with an entity having all this data and infrastructure to make this possible.

So I think that it would be very easy for us to jump in and participate with these programs. We started talking to HCFA. As I said, we've talked to some of you, and we've basically been looking at about seven sites around the country where union members could benefit from this and where there's a strong base of local union leaders coupled with government programs that we could either work with to expand to premium assistance or that are already in place. And so, hopefully, you will be hearing from some of us. Some of you out here we haven't already talked to we will be contacting you soon with our local union people.

So that's what I just wanted to say on behalf of the AFL-CIO, that we're really committed to this program. We're new to it. We want to work with you on making regulations in the statute work smoothly, and we also at the same time remain very supportive of public programs. We know that not everybody is going to fit into premium assistance. Some people are going to be moving in and out of the workforce too much for that to be their solution, and federal dollars need to stay in the public programs. And while we're looking at the tax-credit thing, we like all of you are sort of wondering what it will do to the employer-based system. So we're still at the exploration stage on that. And you probably will hear from us again, too, because we are stepping up our efforts to just do outreach to eligibles as part of organizing campaigns in the home-care industry and other industries where you have a lot of immigrant workers, in particular.

So that's it. Thank you very much, and we look forward to working with you.

MR. CURTIS: We're going to take a couple of questions. Time is short. Mark, I know several people in the audience would ask some variation on this question. You mentioned that, for non-HMOs, that self-regulation of care, with steep cost sharing, is as effective as managed care. Their concern would be that, for the near poor, substantial cost sharing can be a deterrent to appropriate and needed access to care. And that, therefore, for this population, there would need to be fill-ins, maybe not going quite as far as current regulations would require, but at least substantial fill-ins. What are your views on that in terms of whether you could live with what you might view as induced demand?

MR. WEINBERG: Well, I guess I'd have a couple thoughts. One is, in today's world, most companies are selling a variety of plans from things that have almost no cost sharing to things that have substantial cost sharing. And employees pick which one they would want. That's certainly how all of our programs work. It may very well be that matching up the right plan to subsidize is really the question, and it may be that the closest fit we would have in terms of minimal cost sharing would probably be one of the most expensive plans we sell, but that might be the mechanism that we would link to in terms of subsidy.

It doesn't take away from the argument, though, about the impact of cost sharing, and it doesn't have to be massive cost sharing. We know from all kinds of experiences—it's simply the question of brand versus generic drug, office visit or ER visit versus calling a nurse assistant's line, the effect on compliance with regimen. All those things are impacted by a patient having some stake in the game, and the issue seems to be that that stake has got to be material for that person. Now, for some people, "material" might be a fairly small amount of

money, but it's got to be enough for people to say, I've invested in the program. And that's at least what our experience is. That may not fit well with the models that we'll have to deal with.

Administratively, there's easy ways to build wrap-arounds. There's easy ways to pick, in that selection process, that the program that would be subsidized would be the one that would have the closest match in terms of out-of-pocket cost sharing.

AUDIENCE PARTICIPANT: I just had a couple of questions. You said that your average premium was $120 per month per person. Do you know what your average premium for family coverage is?

MR. WEINBERG: It would be about 1.8 times that. [$216]

AUDIENCE PARTICIPANT: Okay. And the second question is—With regard to state-level, small-employer market reforms, do you have any thoughts on—maybe even a wish list of—things you think might enable or encourage small employers to purchase insurance, things that haven't already been done?

MR. WEINBERG: The thing that I think could have the greatest impact, believe it or not, would be some joint, broadly funded—from the industry, from the states, potentially from some other foundations and other interested parties—a broad-based public-service communication program about how important it is to be covered, the pure issue of what the cost of not being covered is.

It is striking—I mean you talk to anyone, and I think this is probably true at almost any income level—people are shocked to know what a couple of days in the hospital costs. It happens so seldom to us that very few of us have that experience. It's not like most of the other goods and services that we buy as Americans. We're fairly good at guessing the price of things that we use all the time. We haven't the vaguest idea of what it costs to use—to be caught up in the need for—medical services and the number of places that those dollars come from. If people really saw that, if they could see it as a matter of good healthy communications, and how absolutely good a deal it is to become part of the system, either by paying all or by paying part of what it would take, or just going through the process of getting in, our data would say that that could have the biggest impact.

And I'd bet the insurance industry would be willing to participate, to use part of its marketing funds for a generic set of messages, you know, state by state, to try and cause people to be motivated to get covered.

AUDIENCE PARTICIPANT: Could you describe quickly the major features of the plan that the average premium is $120 a month? I mean in terms of deductible, coinsurance.

MR. WEINBERG: Okay. Question is about what would it be—well, they're generally about seven or eight plans that are in the range. They [cover a] very broad [range]. The richest plan would be a plan that has a $10 office visit copay, has 90-percent coverage in the hospital up to $2,000 or $3,000, then pays 100 percent up to five million. That would be the richest end of

it. It would have no deductibles, fixed copayments for drugs, probably higher for brand than for generic, but it would look like a pretty comprehensive plan. That would be probably at the richest end. That's probably even richer than an HMO that might be sold. It would be similar, but that would be the richest open access plan.

At the other end would be the cheapest plan. [That] would be a plan that has the same $5 million of lifetime coverage, but it would have a $1,000 or maybe $2,000 deductible, one of those two. I can't remember, but that deductible would not have to be satisfied for office visits. So office visits would be first dollar. Generic drugs would be first dollar. There would be an allowance for lab and X-ray annually, and you know, maybe $500 of drugs a year, something like that. That would be a plan that might cost $30 or $40 a month. And, you can imagine, in between is everything that would hit the price points in between. So that's the range. From about as rich as you can get to about as much of a balance of catastrophic with first-dollar coverage as possible.

AUDIENCE PARTICIPANT: Does it matter—I'm sure it does—which state it's located in? In other words, are you talking about prices in a state where there can be initial underwriting at issue in terms of health status?

MR. WEINBERG: Okay. That $120 is an average for all the states that we do business in. It doesn't vary a lot, probably plus or minus ten percent. So there are some variations from state to state. Those all include states where there is initial underwriting at the time a person purchases, but they're all guaranteed-renewability states. They all have small-group rate bands that are relatively narrow. So there is guarantee issue for the small employers, and they're all paying within a, you know, plus or minus 20-percent rate band.

MR. CURTIS: We are trying to keep on schedule, but I would like to ask Marilyn just one more question. In some states, virtually all of your members who are full-time employees have a 100-percent employer contribution to worker and to family coverage.

MS. PARK: Not by state but by union or by nearby industry.

MR. CURTIS: Right. Do you have any sense of how often the negotiated contribution is such that there really is a substantial worker's share to bring in families? In other words, how often could you really reach uninsured folks because they're part-time workers and dependents or whatever?

MS. PARK: Right. It is interesting. It's almost schizophrenic, because even in those low-wage industries where you wouldn't expect there to be family coverage and there is, then there isn't heavy cost share. And I think that is sort of tradition of the union not to have heavy cost sharing if you negotiate and you offer it.

So I think for us, what we see with premium assistance is bridging the gap more at the contracting stage where we take a group of workers who traditionally weren't offered it or it is offered for some reason and they're so far from affording it that we are trying to bridge the gap

between not paying it at all and having it for the first time. I don't know if that is responsive. There is very little heavy cost sharing from what I can tell.

MR. CURTIS: Well, I know that in some instances they will, for example, have 100 percent for the worker and zero negotiated for dependents.

MS. PARK: Right.

MR. CURTIS: And a state interested in single-source coverage for full families might want to coordinate [with] it. But I don't know if that's a typical thing in many states or if that's a real anomaly.

MS. PARK: And I think that we have talked about that with some unions and see that as a possibility.

About the Speakers

Mark Weinberg is Group President, Individual and Small Group Businesses, WellPoint Health Networks Inc. Mark Weinberg runs WellPoint's individual and small group businesses – the billion-dollar national division that includes the Blue Cross of California and UNICARE brands. Previously, Weinberg served as WellPoint's executive vice president of national business and specialty services. He has served in other senior officer positions since joining the Company in April 1987.

Weinberg was responsible for building Blue Cross of California's individual and small group businesses to the number one market share position in California. Today, Blue Cross of California has over 5 million members and a market share of approximately 30 percent of members who purchase health insurance products as individuals or through employers of less than 50 employees. He also helped launch the Company nationally under the UNICARE brand, whose territory has grown to include 19 U.S. states.

Prior to joining Blue Cross of California, Weinberg held a variety of business consulting positions with the accounting firm of Touche-Ross and Company in Chicago. Previously, he was general manager for the CTX Products Division of Pet, Inc., and I.C. Industries Company in St. Louis, a designer and manufacturer of commercial computerized processing equipment. Weinberg holds an electrical engineering degree with graduate work in operations management and computer design. He holds patents in the United States, Japan and Great Britain.

Gerald Shea is currently assistant to the president for Government Affairs at the AFL-CIO. Mr. Shea was appointed to this position by John J. Sweeney when Mr. Sweeney was elected president of the AFL-CIO in October 1995. Mr. Shea held various positions at the AFL-CIO from August 1993 through October 1995, serving first as the director of the policy office with responsibility for health care and pensions and then in several executive staff positions. Before joining the AFL-CIO, Mr. Shea spend 21 years with the Service Employees International Union as an organizer and local union official in Massachusetts and later on the national union's staff.

Mr. Shea was a member of the former (1994-1996) Advisory Council on Social Security and a member of the Social Security Advisory Board from 1996-1998. Shea serves as a public representative on the Joint Commission on the Accreditation of Health Care Organizations (JCAHO), is a founding board member of the Foundation for Accountability (FACCT), Chair of the RxHealth Value Project and is on the board of the Forum for Health Care Quality and Measurement. He recently completed service at the Medicare Prospective Payment Advisory Commission (MedPAC) and at the Institute of Medicine Quality in Health Care Committee's Subcommittee on the External Environment. Mr. Shea is a native of Massachusetts and a graduate of Boston College.