



TESTIMONY

OF

**MARJORIE A. CADOGAN
EXECUTIVE DEPUTY COMMISSIONER**

**HUMAN RESOURCES ADMINISTRATION/
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF CITYWIDE HEALTH INSURANCE ACCESS**

**BEFORE THE NEW YORK STATE DEPARTMENT OF HEALTH
AND DEPARTMENT OF INSURANCE**

ON

**INCREASING ACCESS TO HEALTH INSURANCE COVERAGE
AND MOVING TOWARD UNIVERSAL COVERAGE:
DEFINING THE GOALS AND IDENTIFYING THE STEPS**

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Good morning. I am Marjorie Cadogan, Executive Deputy Commissioner of the Human Resources Administration's Office of Citywide Health Insurance Access (HRA/OCHIA). First, let me thank you for the opportunity to join you in this important discussion on an issue of great concern to individuals, families, businesses, and policy makers alike – increasing access to affordable health insurance with a goal of reaching universal coverage. Achieving universal coverage will improve the health of New Yorkers, the quality of our healthcare institutions, and the strength of our businesses.

New York's successes in expanding access to health insurance coverage have relied on forging multi-sector partnerships, maximizing participation, and paying close attention to cost and affordability. As new initiatives are shaped to reduce the number of New Yorkers without health insurance, we must continue to build upon this tradition of strategic collaboration finding not only consensus on a worthy goal, but also the means to achieve it.

Expanding health insurance access is a priority for Mayor Bloomberg and, under his leadership, New York City has seen significant increases in the number of individuals who have coverage. This is the result of New York State's new health insurance programs and investments made by the City's Human Resources Administration, its Department of Health and Mental Hygiene, and the Health and Hospital Corporation. Together we have maximized health insurance enrollment by shaping and coordinating private and public health insurance initiatives with public and private sector partners.

Since Mayor Bloomberg took office, enrollment in public health insurance has increased by 35 percent.¹ Moreover, for the public health insurance programs administered by HRA, enrollment has increased by 51 percent. As of September 2007, approximately 2.6 million New York City residents were enrolled in HRA administered public health insurance programs² and approximately 160,000 of the City's children were insured through the State administered Child Health Plus B (CHP-B) program.³

The City has also made a great effort to increase enrollments in private health insurance by small businesses and working individuals through the promotion of five unique options: HealthPass, Healthy NY, Brooklyn HealthWorks, LIA Health Alliance and Freelancers Union. Total enrollment in these programs has more than quadrupled during the Bloomberg Administration. Particularly significant investments have also been made by the State and the City to increase participation in Healthy NY, the most affordable resource for individual workers, sole proprietors and qualifying small businesses. In New York City, the average monthly Healthy NY premium for an individual is approximately \$200 compared to an average monthly HMO premium in the direct-purchase market of approximately \$800.⁴ In 2007, my office worked with the New York State Department of Insurance to increase visibility of Healthy NY for health insurance brokers by adding it to HealthConnect, the online quoting tool used by most brokers in New York City. City-sponsored continuing education seminars for insurance brokers and ongoing outreach to small businesses and business organizations have also been conducted to ensure that the program's great potential for increasing enrollment is fulfilled. As a result of these

efforts, in June 2007, there were over 34,000 Healthy NY enrollees in New York City, a 23 percent increase over last year's enrollment level.

The City has also worked to make domestic partner coverage available for purchase by New York City's small businesses. Over the past two years, direct negotiation with insurance companies has resulted in the offering of domestic partner coverage by all major insurance companies in New York City's small group insurance market.

While the effective partnership between the City and the State as well as New York City's independent efforts have resulted in increases in health insurance, far too many New Yorkers remain without coverage. Of particular concern to us are those New York City residents who face the most significant barriers to coverage. These individuals include low-income children and adults, young adults, and non-standard and undocumented workers. Without addressing the health insurance needs of these individuals, universal coverage efforts will inevitably fall short.

First, I would like to address efforts to cover low-income uninsured children. For the City as well as the State, low-income children who are eligible for public health insurance but are not enrolled (EPHINEs) are the primary focus of existing coverage initiatives. The majority of the uninsured children in New York City are already eligible for public health insurance but not enrolled. My Office estimates that the number of children EPHINEs ranges between 193,000 and 123,000,⁵ which is from 89 to 57 percent of the estimated 217,000 uninsured children in New York City.⁶ Given the high coverage

rates for children in New York City (only 11 percent are uninsured),⁷ reaching these EPHINE children involves overcoming three challenges. First, children without health insurance must be identified. Second, outreach must be targeted to those children. And, third, once coverage is achieved, it must be maintained.

There is widespread recognition that enrollment opportunities and efficiencies could be achieved by sharing electronic data among agencies that provide public benefits. The City's ACCESS NYC initiative, a single access point to multiple public benefit programs, was created with that understanding.

In proposed legislation,⁸ Congress has included provisions that would facilitate the sharing of financial eligibility information across means tested government programs in order to enroll and recertify children and adults in public health insurance programs. In addition to any federal data sharing initiatives, we believe agreements among public programs should be put in place at the State level to not only maximize auto-enrollment and auto-recertification opportunities, but also permit the ready identification of truly uninsured children.

Through partnerships between facilitated enrollers and City agencies created through the Mayor's HealthStat Initiative, we have created enrollment opportunities in every New York City neighborhood. Nevertheless, we have not reached the entire eligible population. Today, we call for a new approach to conducting outreach, one that puts data sharing agreements in place between public health insurance programs and relevant

public and private social services and educational programs. With them, we will be able to identify children who already have coverage and, therefore, focus our attention on those who still need help accessing it.

In addition to enrolling uninsured children and adults who are eligible for public health insurance but have never enrolled, there is a need to focus on retention of coverage for children and adults who have public health insurance but lose it. For example, an estimated 17 percent of children enrolled in Medicaid and 33 percent of CHP-B enrollees in New York City's public schools experience churning – that is, they have unstable public health insurance coverage.⁹ Improving continuity of coverage for children and adults is important for a number of reasons. Continuous health coverage promotes better health outcomes, strengthens patient-provider relationships and permits a more cost-effective use of resources.

We recognize that New York State's current effort to simplify recertification will improve coverage retention. The next step is to enable eligible children and adults to maintain continuous coverage for at least 2 years. The City is committed to work with the State to achieve this goal.

Next, I would like to address opportunities to cover uninsured young adults. According to the New York City Department of Health's 2005 Community Health Survey, young adults are the single most likely age group to be uninsured in the City.¹⁰ Twenty-seven

percent of New York City's young adults age 18 to 24 are uninsured – twice the rate of uninsurance of other non-elderly adults.¹¹

Private health insurance could be more accessible for young adults if insurers made it standard practice to offer dependent coverage up to age 25. Accessing dependent coverage through a family plan is often cheaper than enrolling as an individual in the direct-purchase market. The average premium for individual coverage is over \$800 a month for an HMO plan and approximately \$1,100 a month for a POS plan in New York City's individual market.¹² For young adults just above the upper levels of the income criteria for public coverage, 100 and 150 percent of the FPL, the HMO premium would consume 96 and 64 percent of their respective monthly incomes; the POS premium would take up 137 and 91 percent of their respective incomes.¹³

Although some insurers in New York City offer dependent coverage for young adults, workers and part-time students typically are not offered coverage under their parent's plan beyond age 19. Current insurance law gives insurers the *option* to offer dependent coverage to young adults up to age 25 regardless of student status. Encouraging all insurers to take advantage of this new coverage option could help make coverage more affordable for families with young adult dependents, many of whom earn too much for public coverage but cannot afford private coverage on their own. Making a dependent coverage rider available at the employee or parent's expense would not only be valued by many families, but would add young, healthy adults to the insurance pool to reduce health insurance costs overall.

Next, I want to address approaches for increasing coverage for low-income adults of any age. Adults without children (“childless adults”) who have incomes above 100 percent of the federal poverty level (FPL) and adults with children above 150 percent of the FPL cannot access public coverage. To give you an idea of how little these income cut off levels are for adults in New York City, adults living alone without children and earning just \$851 per month, the median cost of a rent-stabilized apartment in New York City¹⁴, are not eligible for Medicaid or Family Health Plus (FHP).¹⁵ Additionally, a single parent with a child who earns more than \$1,700 per month cannot qualify for FHP.

To begin, Family Health Plus’s income eligibility for childless adults should be raised to 150 percent of the FPL – the same income levels permitted for parents. Providing a public coverage option for low-income uninsured adults is important since many of these individuals are not offered private health insurance by their employers and cannot afford to purchase coverage in the individual, direct-purchase market.

In addition, other low-wage workers and small businesses often are unable to afford the cost of health insurance, particularly in New York City where the costs of living, doing business, and health insurance premiums are higher than elsewhere in the State. Small businesses with fewer than 50 employees, low-wage workers, non-standard workers and undocumented workers are particularly likely to being uninsured. Of the approximately 1 million uninsured adults in New York City,¹⁶ an estimated 600,000 to 800,000 fall into overlapping groups of low-wage, non-standard and undocumented workers.¹⁷ It is

important to note that these population groupings are not fixed or mutually exclusive; individuals may move from one group to another or belong to more than one group.

- Across all types of uninsured workers in New York City, the majority are employed by small businesses.¹⁸ More than 97 percent of the approximately 365,000 businesses in New York City are small, meaning they have fewer than 50 employees. Of those, 86 percent have fewer than 10 employees.¹⁹ Failure to include very small businesses in the State's coverage initiatives will not address the City's needs.
- Low-wage workers, who often work in small businesses, are yet another group that is likely to lack health insurance. In New York City, there are approximately 400,000 full-time, full-year low-wage workers (earning \$11 per hour or less) who are uninsured. Over 50 percent of those uninsured low-wage workers are employed by small businesses.²⁰
- Non-standard workers are also likely to lack health insurance since they typically do not have access to employer-sponsored health insurance. Non-standard workers include part-time workers, independent contractors and on-call workers. There are approximately 244,000 uninsured non-standard workers in New York City.²¹
- Undocumented adults have limited access to health insurance since they are not eligible for public health insurance and many have limited or no access to employer-sponsored coverage. There are approximately 200,000 uninsured undocumented adults in NYC.²²

Making changes to the Healthy NY program would enable greater coverage for these uninsured working adults and their families by building upon this already established low-cost, private health insurance option for small business employees, working individuals, and sole proprietors.

The first change that should be made is to help equalize access to Healthy NY for New York City's businesses by adjusting the income eligibility levels to reflect regional variations in the cost of living and doing business. Currently, small business employees, working individuals, and sole proprietors in New York City are less likely to enroll in Healthy NY compared with those in the rest of the State. Forty two percent of the State's population lives in New York City²³, but only 24 percent (less than 35,000 individuals) of Healthy NY enrollees live in New York City. One obstacle to expanding enrollment is that the current income eligibility standard, which is set at the same level throughout the State, does not take into account the City's higher cost of living and the downstate area's higher insurance premiums. For example, Healthy NY premiums are 17 percent higher in downstate counties, including New York City, than the rest of the State.²⁴

To address the cost disparities between the downstate and upstate areas, Healthy NY's income eligibility in the downstate region should be expanded by approximately 20 percent, raising the income eligibility to 300 percent of the FPL for individuals and sole proprietors (approximately \$31,000 for an individual and \$62,000 for a family of four). This 20 percent income eligibility expansion also would permit small businesses in the

downstate region to participate in Healthy NY if at least 30 percent of employees earn approximately \$44,000 or less per year.

Secondly, changes should be made to the Healthy NY application process to make it easier for non-standard workers, especially those who are part-time, on-call, or work for multiple employers and are paid in cash, to enroll. Approximately 26 percent of New York City's workforce is comprised of non-standard workers, and approximately 29 percent of these workers are uninsured.²⁵ Additionally, 18 percent of non-standard workers in the City are in families with incomes below \$20,000,²⁶ meaning that these workers would meet Healthy NY's income eligibility requirement of making less than approximately \$25,000 per year.

Non-standard workers contribute vastly to the City and the State's economy and should be able to access and contribute to the cost of coverage. Currently, the Healthy NY application for working individuals asks for proof of income. Non-standard workers paid in cash may not be able to meet these requirements. These workers who cannot provide income documentation from their employers should be allowed to provide a written self-attestation of income and employment status.

Along with expanding coverage through Healthy NY, one way to improve the health of New York City residents is to increase the provision of mental health benefits. The Healthy NY benefit package should be modified to include the same minimum benefit package as Timothy's Law, which stipulates that private insurers are required to offer

most medium-size businesses in the commercial market at least 20 outpatient visits and 30 inpatient days per calendar year.²⁷ In addition, the \$100 million available under Timothy's Law for small businesses electing these mental health benefits should be used to finance any increases in premium costs that may occur as a result of adding them to the Healthy NY benefit package. Although earlier studies found increases in costs of approximately one percent for mental health parity, recent studies suggest that mental health benefits combined with managed care can improve access to mental health services without increasing total costs for health insurers.²⁸

Adding these benefits to Healthy NY would be a step toward increasing mental health coverage for lower income New Yorkers. Mental health problems can be as serious as physical health problems. Yet, many people go without treatment because they do not have coverage for mental health services. Untreated mental health disorders cost employers billions of dollars each year in lost productivity²⁹, and mental illness often contributes to increased costs for physical illness, especially chronic disease.³⁰

Finally, another option for improving the affordability of health insurance would be to provide the New York State Department of Insurance (DOI) with greater authority in reviewing health insurance rate increases. Over time, premiums for private health insurance have increased rapidly. In the past decade (1996 to 2006), average health insurance premiums have increased by 296 percent for large group plans, 298 percent for small group plans and 378 percent in the individual, direct-pay market. From 1996 to 1999, when a maximum rate increase of 10 percent was in effect, premium rates

increased an average of 5 percent per year for large and small groups and an average of 8 percent per year for direct pay plans. During 2000 to 2006, when the maximum rate increase was lifted, premium rates increased an average of 14 percent per year for large and small groups and 16 percent for direct-pay plans.³¹

Currently, insurers can implement a premium rate increase of any magnitude without the DOI's prior approval, so long as they meet statutory minimum loss ratios and actuarial certification requirements. Medical loss ratios, which are a measure of the portion of the premium insurers spend on healthcare costs for enrollees rather than administrative costs or profit, are often used as an indication of whether enrollees are receiving adequate value and access to needed care for their dollar. In New York, minimum medical loss ratios for insurers using the file and use rate submission process are 80 percent for the individual direct market and 75 percent for the group market.³² Insurers only need to obtain DOI's approval before raising rates if they fall below these medical loss ratio thresholds. By giving DOI greater authority in reviewing rate increases before they are implemented, there is an opportunity to reduce the extent to which premiums increase in all insurance markets, given other factors such as increases in healthcare costs and potential adverse selection issues in the direct-purchase market.

I want to take a moment to emphasize that, in addition to considering these proposals designed to expand coverage, reduce enrollment and re-enrollment costs, and address affordability, equal attention must be paid to ensuring that health insurance dollars improve health outcomes.

Having health insurance does not automatically lead to improvements in health status.

The current healthcare system creates barriers to accessing primary care, and low reimbursement rates often force primary care providers to compromise quality of care by increasing patient volume and focusing only on acute care needs. As a result, healthcare providers often fail to discuss recommended preventive services and chronic disease management with patients.

If we are going to successfully provide healthcare coverage to all New Yorkers and make a difference in overall health status, we need to move toward a ‘pay-for-prevention’ system of health care. Such a system rewards doctors for providing primary care, helps patients manage existing chronic conditions, and delivers the health outcomes we want.

A key step in improving health outcomes is the utilization of prevention oriented electronic health records (EHRs). EHRs are an important tool for providing effective and efficient primary care. Replacing paper charts with EHRs brings each person’s health record directly to the point of care, at the moment it is needed and where it can do the most good. EHRs allow providers to more accurately monitor outcomes for both individuals and communities, and provide a system of accountability by monitoring the delivery of care and rewarding those providers who keep their patients healthy.

Mayor Bloomberg committed \$27 million to bring health information technology and improved quality of care to underserved neighborhoods in New York City. Combined with \$3 million in State HEAL grant funds, this funding will help more than 1,300

providers adopt EHRs in their offices. However, more support is needed to ensure that all primary care providers, especially those who serve individuals with public health insurance and the uninsured, adopt EHRs.

The health insurance expansion as well as the cost and quality improvement options I have described will benefit many people throughout New York State. They will have a particularly powerful impact on New York City residents, where there is a concentration of uninsured individuals with barriers to attaining health insurance coverage. The overlapping groups of small business, low-wage, and non-standard workers warrant special consideration in State health insurance expansion plans.

Thank you for the opportunity to testify before you today. New York City looks forward to working in partnership with the State on expanding access to health insurance and moving toward universal coverage.

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² Human Resources Administration's Office of Data Reporting and Analysis: HRA Facts Report. August 2007.

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⁵ Reducing New York City's Uninsured: Identifying Communities with The Greatest Numbers of Uninsured Children and Adults Eligible for Public Coverage. OCHIA, report forthcoming 2007.

⁶ Unpublished data from Profile of New York State Uninsured in 2006. The New York State Department of Health. (2007).

⁷ Unpublished data from Profile of New York State Uninsured in 2006. The New York State Department of Health. (2007).

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- ¹⁹ Reference USA as of 3/2/2007.
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- ²² OCHIA analysis of Campbell, Hoefler and Rytina. Estimates of the *Unauthorized Immigrant Population Residing in the United States: January 2006*. Department of Homeland Security Office of Immigration Statistics, August 2007. Analysis includes adjustments for private coverage based on Goldman DP, Smith JP and Sood N. *Legal Status and Health Insurance Among Immigrants*. Health Affairs. 2005; 24(6).
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- ²⁴ OCHIA analysis of monthly Healthy NY premiums, including high deductible plans.
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- ²⁶ OCHIA analysis of Current Population Survey Contingent Work Supplement, February 2005.
- ²⁷ In addition to mental healthcare, benefits not covered by Healthy NY include home healthcare, chiropractic care, substance abuse treatments, physical therapy, and hospice care.
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