Report of the Joint Legislative Committee on Health Insurance Plans 1956.

Legislative Document (1956) No. 64

STATE OF NEW YORK

REPORT

OF THE

JOINT LEGISLATIVE COMMITTEE

ON

HEALTH INSURANCE PLANS

1956

ALBANY
WILLIAMS PRESS, INC.
1956

Legislative Document (1956) No. 64

STATE OF NEW YORK

REPORT

OF THE

JOINT LEGISLATIVE COMMITTEE

ON

HEALTH INSURANCE PLANS

1956

LETTER OF TRANSMITTAL

To the Legislature of the State of New York:

Pursuant to concurrent resolution adopted April 2, 1955, the Joint Legislative Committee on Health Insurance Plans respectfully submits this report, covering the work of its investigation to and including the present date.

Senator George R. Metcalf, *Chairman*
Assemblywoman Genesta M. Strong, *Vice Chairman*
Senator Samuel L. Greenberg, *Secretary*
Senator Walter G. McGahan
Assemblyman Lucio F. Russo
Assemblyman Allan P. Sill
Assemblyman Max M. Turshen

March 31, 1956.

PERSONNEL OF THE COMMITTEE

The Committee:

SENATOR GEORGE R. METCALF, *Chairman*
ASSEMBLYWOMAN GENESTA M. STRONG, *Vice Chairman*
SENATOR SAMUEL L. GREENBERG, *Secretary*
SENATOR WALTER G. MCGAHAN
ASSEMBLYMAN LUCIO F. RUSSO
ASSEMBLYMAN ALLAN P. SILL
ASSEMBLYMAN MAX M. TURSHEN

SENATOR WALTER J. MAHONEY, *President Pro Tem*, The Senate
ASSEMBLYMAN OSWALD D. HECK, *Speaker*, The Assembly
ASSEMBLYMAN JOSEPH F. CARLINO, *Majority Leader*, The Assembly
SENATOR FANCIS J. MAHONEY, *Minority Leader*, The Assembly
SENATOR AUSTIN W. ERWIN, *Chairman, Finance Committee*, The Senate
ASSEMBLYMAN WILLIAM MACKENZIE, *Chairman, Ways and Means Committee*, The Assembly

---

Counsel:

MR. CHARLES K. MCWHORTER
MR. SAMUEL FEIGENBAUM

The Staff:

RAY E. TRUSSELL, M.D., *Project Director*
E. DWIGHT BARNETT, M.D., *Project Director*
FRANK VAN DYKE, *Project Administrator*
MISS LISBETH BAMBERGER, *Staff Member*
HAROLD J. BAUMGARTEN, JR., *Staff Member*

PRELIMINARY STATEMENT

The Joint Legislative Committee on Health Insurance Plans has initiated a broad study of gaps in health insurance coverage of the people of New York State. The research activities of the Committee have been and continue to be carried out through contractual agreement with the School of Public Health and Administrative Medicine of Columbia University. The progress of the study has been directed and reviewed at monthly meetings of the Joint Committee. The work of the Committee began on October 1, 1955. The activities of the Committee have been concentrated since then on the following general projects or areas of study.

I. Review of contracts, benefits, and scope of coverage under all types of health insurance plans available in the State.

   A. Blue Cross-Blue Shield plans.
   B. Commercial insurance company plans.
   C. Other, or "independent" plans.

II. Review of existing sources of information on health coverage in the State.

III. Pilot study of methods of payment for medical care in one community in the State.

   A. Household survey.
   B. Survey of public health facilities and services.
   C. Survey of hospital discharges.

IV. A review of State and local methods of providing direct health service to people of the State.

V. Study of prepayment for dental services.

VI. Study and report on health insurance for State employees.

Activities of the Committee

The staff is composed of two full-time persons and one half-time person. The equivalent of two full-time secretarial staff has been utilized since November. The two co-directors of the study have guided staff activities on an as-needed basis. A part-time statistical consultant has been employed. Data for the pilot community survey was gathered by persons employed on a part-time basis under the supervision of a staff member and the National Opinion Research Center. In addition to this, members of the University faculty, administrative and technical employees of the State and officers and officials of the prepayment plans and insurance industry have been generous with their time.

I. Review of contract benefits and scope of coverage under all types of health insurance plans available in the State.

A. Blue Cross-Blue Shield Plans.

1. A questionnaire was prepared which was sent to the Blue Cross, Blue Shield and independent plans.
2. A meeting was held with representatives of the eight Blue Cross and seven Blue Shield Plans in Syracuse on November 14.
3. The State Medical Society was informed of this and other aspects of the study through a series of meetings.
4. As the reports came in, a preliminary analysis of the data was prepared.

B. Commercial Insurance Company Plans.

1. A conference was held with a Deputy Commissioner of Insurance in New York on November 17 to get information on insurance company rates and benefits. A similar meeting took place in Albany on December 3 and 4 with the Deputy Commisioner of Insurance, the Chief Actuary and other officials. The Insurance Department made available whatever information was requested. On several occasions discussions were held with two officials of the Life Insurance Association of America to discuss insurance company practices in provision of health insurance. Data was secured from these and other insurance groups.

C. Other, or "Independent" Plans.

1. Data on the "independent" plans operating in New York State was obtained from the Social Security Administration, Department of Health, Education and Welfare, Washington, D. C., and analyzed.
2. Detailed information was obtained regarding the Health Insurance Plan of Greater New York, Group Health Insurance and several other large independent plans from officials of these plans. Research persons in the New York City Health Department and other official agencies were consulted in this connection.

II. Review of existing sources of information on health coverage in the State.

1. The National Family Survey data and questionnaire of the Health Information Foundation's 1953 study was reviewed.
2. With permission of the Health Information Foundation, the National Opinion Research Center prepared a special report of the Northeast and New York State family survey data available as a part of the national study, based upon information requested by the staff.

3. Both these reports were analyzed and were discussed by the Joint Committee and the staff.
4. The two most recent New York State studies on medical and hospital services available in the State and provided to people of the State were briefly reviewed.
5. Various discussions were held with State and local health officials on data now available.
6. Other pertinent data were secured from:
   a. New York State Department of Labor, Bureau of Research and Statistics.
   b. U. S. Department of Labor, Bureau of Labor Statistics.
   c. AFL-CIO, Department of Social Security.
   d. American Public Health Association, Sub-committee on Medical Care.
   e. New York State Federation of Labor.
   f. New York State CIO Council.

III. Pilot study of methods of payment for medical care in one community of the State.

Genesee County was selected as the locale for a study after discussion and meetings with medical societies, the Hospital Association, the State Department of Health and the Joint Hospital Survey and Planning Commission.
A number of trips to Batavia were made to discuss and plan with local public health, medical and hospital personnel.

A. Household survey.

Consultations were held with representatives of the National Opinion Research Center in setting up the family survey in Batavia. The staff is now engaged in working through the data obtained through these family interviews for relevant case study material.

B. Study of hospital discharges.

1. A questionnaire was prepared.
2. Local hospital personnel gathered data.
3. The staff and a statistical consultant, through a series of meetings, planned statistical evaluation of data.
4. The data received from Batavia was coded and tabulated by I.B.M. process.

IV. A review of State and local methods of providing direct health services to the people of the State.

Meetings were held with the State Commissioner of Welfare and officials of the Welfare Department, the Director of the State Hospital Planning Commission and officials of the State Department of Health to discuss State services.

V. Study of prepayment for dental services.

A. A number of persons in the dental care field, including a member of the faculty of the School of Dentistry at Columbia University, and research persons in the Division of Dental Resources, United States Public Health Service were consulted to obtain background material for the study of prepaid dental care.

B. Information on prepaid dental plans now in operation was obtained from officials of the following plans:

1. Group Health Dental Insurance, Inc., New York City.
2. Labor Health Institute, St. Louis, Missouri.
3. Hotel, Restaurant Employer-Union Welfare Fund, Los Angeles, California.
4. International Longshoremen's, Warehousemen's Union —Pacific Maritime Association Welfare Fund, California, Oregon, Washington.
5. Group Health Association, Washington, D. C.

VI. Health insurance for State employees.

Early in December the Committee requested the research staff to make recommendations concerning hospitalization insurance for State employees. The other tasks of the Committee and staff were postponed, and a memorandum was prepared dealing with basic issues and desirable criteria. Public Hearings were held on February 22 by the Committee on Health Insurance for State employees.

The testimony on the following pages, while pertaining to a health insurance plan for a limited group, demonstrates many of the viewpoints and issues in the field of health insurance today.

VII. The work of the Committee is proceeding in accordance with the responsibilities defined by the concurrent resolution adopted April 2, 1955, and renewed by the Legislature in the 1956 session.

INDEX

MINUTES OF THE PROCEEDINGS OF THE JOINT LEGISLATIVE COMMITTEE ON HEALTH, ACCIDENT AND HOSPITAL INSURANCE PLAN, HELD IN THE SENATE CHAMBER, THE CAPITOL, ALBANY, NEW YORK, ON FEBRUARY 22, 1956, 2 P.M.

Present:

SENATOR GEORGE R. METCALF, *Chairman;*
ASSEMBLYWOMAN GENESTA M. STRONG, *Vice-Chairman;*
SENATOR SAMUEL L. GREENBERG, *Secretary;*
ASSEMBLYMAN MAX M. TURSHEN, Member of the Committee;
ASSEMBLYMAN ALLAN P. SILL, Member of the Committee;
DR. RAY E. TRUSSELL and DR. E. DWIGHT BARNETT, Project Directors;
FRANK VAN DYKE, Project Administrator;
CHARLES MCWHORTER and SAMUEL FEIGENBAUM, Counsel to to the Committee.

THE CHAIRMAN: The hour of 2 o'clock having arrived, I would like to start the hearing of the Joint Legislative Committee on Public Health Insurance Plans.

It gives me a great deal of personal satisfaction to see so many people in the chamber and to see so many people who are interested in what we are trying to do on health insurance programs in the State of New York.

I think we might start today by introducing the members of the Joint Legislative Committee to you. Our Vice-Chairman, Mrs. Strong, will be here in a very few moments, I am sure. Our Secretary is Senator Samuel L. Greenberg, who is seated on my left, and Assemblyman Max Turshen next to him, and on my right is Charles McWhorter, who is our Republican counsel, and Samuel Feigenbaum, who is our Democratic counsel. That gives you some idea of the members of this committee.

We are here today to go over legislation which has already been submitted, dealing with health insurance programs for state employees. Many of you, I am sure, when you came in here, picked up three bills on the outside. The first bill was the one which Mrs. Strong and I introduced. That is a measure which deals largely with prepaid hospital insurance care. You will notice—those of you who have read that bill—that it sticks very closely to the service benefit idea of health insurance. There is also a bill that has been introduced by Senator Milmoe. That includes hospital, medical and surgical care, with particular reference to the cash indemnity program of private insurance carriers. Then, on my left, Senator Greenberg is the sponsor of

what we call the Harriman bill or program, and that also sets forth different ideas.

Now, the purpose of this meeting is to hear from as many people in the state as possible who are interested in this program who have come here to give us their ideas of what these bills should incorporate or any final bill which is passed by the legislature. As you can see by looking around the room, there are a great many people who are interested and who would like to testify, and unless you and I want to sit down for breakfast tomorrow morning, we are going to have to limit ourselves just a bit; so I am asking that each person limit himself to ten minutes. Of course, if you would like to take less time than that, it is all right, but, anyway, if you would confine yourselves to ten minutes, it would help.

That rather noticeable chair in front of me is the place where we would like you to sit when you testify or stand in front of it, and I say that for this reason: It would be much easier for the people who are here to hear what you have to say if you do take your place in the chair or standing in front of it.

All of you men who came in here and wanted to speak I am sure filled out one of these cards, and the first gentleman that I am going to call on is a representative of the New York State Medical Society.

Incidentally, Mrs. Strong has come in. She is Vice-Chairman of our committee. I am very glad to have you here, Mrs. Strong.

Dr. McClintock, as I said, is representing the State Medical Society, and he will be our first speaker.

DR. JOHN C. MCCLINTOCK: Thank you very much, Mr. Chairman and members of the committee.

The Medical Society of the State of New York is the major medical organization of this state, consisting of 61 county medical societies and approximately 23,500 members.

The society has recommended to its membership the service-indemnity type contract, with a $6,000 service benefit ceiling. This means that medical care provided for in the contract and rendered by a participating physician to a member is fully paid for by the plan, provided that the member's income is not in excess of $6,000. A member whose income is in excess of $6,000 may be charged an additional amount by a participating physician above the amount of indemnity allowed in the contract. If a member receives medical care from a non-participating physician, he is indemnified according to the schedule of allowances in his contract.

A participating physician, as the term is used in connection with Blue Shield plans, is any duly licensed physician of the state who agrees with a plan to provide medical care to its subscriber within the terms of the subscriber's contract, and further agrees that, in the event of the plan's financial inability to pay 100 percent of the schedule of allowances, he will accept a pro-rata portion of the scheduled allowance and in no instance will the subscriber sustain a loss of benefits.

The reason that plans in this state of the type recommended by the Medical Society have been successful is that over 90 per cent

of privately practicing physicians voluntarily assume the obligations of a participating physician. If they did not assume such obligations, such plans would not be possible.

SENATOR GREENBERG: You have been talking about medical care and surgical care, have you not, sir?

DR. MCCLINTOCK: I have been talking about medical care.

SENATOR GREENBERG: You have not been talking about hospitalization?

DR. MCCLINTOCK: Not per se; the overall medical care.

THE CHAIRMAN: The next speaker is a very distinguished doctor, who has come here today from Philadelphia. He is Dr. Madison B. Brown, Executive Vice-President and Medical Director of Hahnemann Medical College and Hospital, Philadelphia. From 1952 to 1955 Dr. Brown was Chairman of the Council on Prepayment Plans and Hospital Reimbursement of the American Hospital Association. Prior to his appointment at Hahnemann, Dr. Brown held the position of Executive Vice-President and Medical Director of the Roosevelt Hospital in New York City.

DR. MADISON B. BROWN: Thank you, Senator Metcalf and members of the Joint Legislative Committee.

On behalf of the American Hospital Association, and speaking for myself, I wish to thank you for this opportunity to appear before you.

The American Hospital Association is pleased to have this opportunity to tell you to the policies and principles which we believe in and which our members subscribe to. When we received the invitation to testify from Senator Metcalf, we considered it our duty to place before you our philosophy with regard to the coverage which should be available, not only to the employees of the State of New York but to all of the people who utilize the facilities of the voluntary hospital systems which are so effectively serving the people of the United States.

In the United States and in Canada the voluntary hospitals have as a counterpart, as an adjunct, and as a vital link to the public utilizing hospitals, an efficient, well-run and widely-accepted system of voluntary insurance and voluntary prepayment for hospital care. This system is not complete, it has not reached certain segments of the population, and in some instances the coverage offered to its beneficiaries is inadequate. It is not without its "bad apples," but, in general, the coverage does much to stabilize the financial condition of the hospital patients and the hospitals. The American Hospital Association has had a great and long-term interest in the field of hospital prepayment and insurance and through the years has done much to foster and encourage the expansion in these fields. As early as February, 1933, the American Hospital Association was giving active leadership to the formation of non-profit prepayment plans. At this time the Board of Trustees of the Association ". . . approved the principle of insurance as a practical

solution of the distribution of the cost of hospital care, which would relieve from financial embarrassment and even from disaster in the emergency of sickness those who are in receipt of limited incomes. . . . ''

Why do we consider this hearing an important opportunity? It offers an opportunity to present some basic principles in this area which we firmly believe are of great importance to the hospitals of America and to the communities served by those hospitals. These principles are (1) benefits should be provided on the basis of the patients' needs and in the amounts necessary to provide adequate recovery—known as service benefits; (2) coverage should be offered to all of the community at a community rate and with the same benefits for the entire community; and (3) the benefits should be comprehensive, a vital link between the health of the community and the community hospital.

Speaking to point (1), service benefits, may I make the following observations:

Hospital services involve all the professional and technical personnel of the hospital, supplemented by mechanical aids which have been coordinated into a working unit to complement the physician's knowledge and practice in the treatment of his patient. Service benefits should extend through the whole of the hospital organization, including the most complex and the simplest types of procedures.

Under this broad definition the service benefit covers all degrees of illness. It provides care in occordance with need. Its elasticity covers the requirements of all patients. It is not designed for only the average patient. The extreme catastrophic illness obtains full coverage just as the minor, less devastating condition.

Service benefits, therefore, make the entire hospital organization available for the needs of the individual patient, as determined by his personal physician. No dollar limitation stands as a deterrent factor in the provision of necessary treatment. No necessary service is omitted because of cost to the patient.

In the ''Approval Program of the American Hospital Association for Hospital Service Plans,'' the following is found, in paragraph 5 of the General Principles:

> ''5. Plans should arrange for service benefits to members, rather than provide cash allowances for the purchase of hospital care.''

In elaboration of our second point of philosophy, that coverage should be offered to all of the community at a community rate and with the same benefits for the entire community, may be comment:

The community which the state legislature is concerned with is the entire State of New York and we feel that the coverage for persons living in New York City, Buffalo, Malone or Plattsburgh should be the same. While these communities just mentioned vary greatly in size and the hospital facilities vary accordingly, a person hospitalized in these hospitals can anticipate the highest quality of hospital care through standardization brought about through the efforts of the Joint Commission on Hospital Accreditation. Hence,

beneficiaries under a system of service benefits and equal coverage are afforded good and complete hospital care throughout your community, regardless of location.

Thinking in terms of health care needs of this community, consideration should be given to all members of the community—the old and the young, the preferred and the less-preferred risk—which, of course, leads to a consideration of those presently employed as well as those retired.

Universal acceptance of voluntary prepayment is an objective of the American Hospital Association's sponsorship of voluntary prepayment. The history of this development records continuous reduction in membership restrictions to a point where opportunity for participation has been made available not only to small employed groups but also to large segments of other classes in the population formerly barred from coverage. Only without discriminatory selection of participants plus full cooperation of hospitals can prepayment accomplish optimum public service. To repeat: Only without discriminatory selection of participants plus full cooperation of hospitals can prepayment accomplish optimum public service.

The third principle and point of philosophy deals with comprehensive benefits.

We believe you have the responsibility not only as members of the legislature but also as citizens to extend health care coverage as broadly and in as comprehensive a manner as is possible, yet consistent with sound administration, acceptable medical standards and acceptable hospital practice.

In a free economy encouragement should be given to the integrity of the individual; therefore, voluntary prepayment offers the greatest opportunity to accomplish this task.

Comprehensive benefits are the backbone of good prepayment or insurance for hospital service. The development of broadened benefits in the hospital sponsored prepayment plans stemmed from hospital leadership and reflect the same motivations which combine to effect the development of hospital service. Comprehensive benefits make available all of the hospital on a prepaid basis; no member of the hospital team is left on the bench because of a financial problem.

In considering the matter of comprehensive coverage the Council on Prepayment Plans and Hospital Reimbursement of the American Hospital Association in 1948 made the following observation about deductibles:

> "The theory of deductible coverage assumes an elective loss and a control of elective use. It is applied in commercial insurance programs to escape small claims. But the insured loss in hospital coverage is relatively small and factors other than choice act as deterrents to the use of hospital services.
>
> "This additional restraint on the use of hospital care would probably bar from service a number of patients who should have and badly need the benefits. It appears, therefore, that the deductible feature does not contribute to the effectiveness of hospital plans."

We feel that this can create an unnecessary rigid control of the use of service and thus deductible features cannot be considered compatible with the objectives of complete health care.

The above is cited as an example of our feelings regarding the philosophy which should prevail when considering prepayment or insurance for a community.

Again, thank you for inviting the American Hospital Association to appear before you today. It is my sincere hope that through this effort on our part a contribution has been made to a worthwhile and effective program of hospitalization benefits for the employees of the State of New York.

THE CHAIRMAN: Thank you very much, Dr. Brown.

Our next speaker is Dr. Thomas Hale, Jr., President of the Hospital Association of New York State.

DR. THOMAS HALE, JR.: Mr. Chairman and members of the committee: I am Dr. Thomas Hale, Jr. I am the director of a large medical center hospital and this year I am serving as President of the Hospital Association of New York State. This association represents 305 voluntary and public non-profit hospitals, which provide 95 per cent of all general and allied special hospital beds in the State of New York. At the outset I should like to make it clear that I am not an expert on insurance, hospital or otherwise. I desire to address myself solely to the matter of hospital coverage from both the hospital's and patient's viewpoints.

The cost of being sick has increased like everything else. It is not difficult to understand why this should be so. Hospitals have had to meet the competition of private industry and government and as a consequence their payrolls have more than tripled during the past 15 years. The 40-hour week for nurses and other hospital employees is an important factor in these increased costs.

The so-called miracle drugs and the modern medical and surgical techniques, frequently involving the use of expensive equipment and machinery operated by highly skilled technicians, add to the costs. Likewise, the more than 44,000 items of supply which a modern hospital must stock have greatly increased in price. While modern methods have substantially cut the average number of days a patient stays in the hospital, this fact in itself has added to the cost of care. The percentage of patients leisurely recuperating and requiring a minimum of attention has been sharply cut, if not eliminated altogether. So that today the population of a hospital is made up almost entirely of acutely ill people requiring the closest attention and utilizing to the fullest all of the hospital's facilities, thus requiring more nurses and technicians.

The hospital administrator, therefore, is in a good position to see at first hand the hardships that occur when patients have heavy bills to pay. This is not only distressing in cases where the patient has no hospital coverage, but equally disturbing when the patient's hospital benefits do not fully cover his expenses. Indeed, it frequently happens that the patient has failed to read the fine print in his hospital insurance and finds out that he is not covered for the type of hospitalization and service he has received.

The hospital does not like to be put in the middle in situations of this kind. It does not like to have to explain to the patient that certain charges are not covered by his hospital plan. Patients are naturally resentful of exclusions and more often than not take it out on the hospital. The fuller the service benefits allowed in a hospital coverage plan the better it is both for the patient and the hospital. I should like to emphasize for the record that it is the physician who orders the patient to the hospital and who prescribes his treatment and care and not the hospital. The hospital provides the facilities and acts under the doctor's orders.

With their great background of experience in the economics of hospital care, the voluntary non-profit hospitals of the Nation established the Blue Cross plan, which I should like to emphasize is the hospitals' own answer to this serious problem of financing hospital care. It is the most liberal plan as far as benefits for the patient are concerned. Furthermore, it is non-cancellable; the employee may continue as a member after leaving the employer under whom the coverage was secured, and it continues on after retirement, so that aged people have full coverage which otherwise would be unobtainable for them.

Full coverage is, of course, expensive, but that is the field of the actuary and the insurance expert. I would urge this committee to make the coverage for the state employees as complete as it is possible to do so, with all benefits carefully spelled out in detail.

Thank you very much for allowing me to appear before you.

THE CHAIRMAN: Thank you very much, Doctor.

Our next speaker is Dr. Wilson Smillie, who is Executive Director of the State Charities Aid Association. I have a little background material on Dr. Smillie here. He was formerly Professor of Public Health and Preventive Medicine, Cornell Medical College; staff member of the International Health Division of the Rockefeller Foundation. He was awarded the Sedgwick Memorial Medal by the American Public Health Association for distinguished service in the field of public health. He is the author of several books on public health.

DR. WILSON G. SMILLIE: Mr. Chairman and members of the committee: This statement relates to a bill to amend the Civil Service Law in relation to providing hospital service benefits for state and retired state employees.

For many years I have been distressed because of the inability of American families who are in the lower income brackets ($5,000 a year and under) to secure adequate comprehensive medical care. The most disastrous medical emergency that can come to the family is illness requiring hospitalization. The major incident that breaks the back of the family structure is prolonged hospitalization of the breadwinner.

Unfortunately, hospitalization costs have increased faster in recent years than family income. Thus, the peril of hospitalization becomes an increasing hazard to family integrity.

We have worked out a most successful buffer against these family hazards by a device called the Blue Cross. This and other service benefit plans have failed, however, to provide benefits for those who need them most pressingly, at a period of life when the family income is diminishing. I refer, of course, to the individual who is over 65 and who is on a modest pension.

I am in favor of this bill which will provide hospital service benefits for state and retired state employees and their dependents for many reasons, some of which may be briefly stated:

1. I am in favor of the bill because it makes provision for hospitalization to the individual who has been retired from state service due to old age or to disability.

2. Because the bill provides for such a full hospitalization coverage. The deductible features of the bill are minimum and I believe are properly conceived and planned.

3. I am in favor of the bill because the employee, if he accepts the plan, is required to pay 50 per cent of the premium, the remainder of the premium to be paid by the state.

4. I am in favor of the bill because the coverage shall be available to the dependents of employees. Particularly valuable is the clause which provides for dependents of subscribers who are retired.

5. I am in favor of the bill because the bill makes it possible for the employee to utilize hospital facilities when required, without delay that might arise because of added costs.

I am aware that this bill provides for employment benefits that have long been assumed by industry and by other states and by many municipalities. If this bill becomes a law, New York State will assume its rightful place among other states through provision of those benefits to its faithful employees.

THE CHAIRMAN: Our next speaker is Mr. J. Henry Smith, Vice-President and Associate Actuary of The Equitable Life Assurance Society, American Life Convention and Life Insurance Association of America.

MR. J. HENRY SMITH: Senator Metcalf and members of the committee: I am appearing today on behalf of the American Life Convention and the Life Insurance Association of America, two trade associations whose combined membership represents 253 companies, writing approximately 85 per cent of the group accident and health insurance written by the insurance companies in the United States today.

Our two associations are quite in sympathy with the purpose of your committee to make state employment an attractive lifetime career, and we applaud your efforts to provide health insurance benefits like those provided in private employment. We would like to aid in making your program a reality. We stand ready to provide the necessary insurance service and also we are glad to offer suggestions and advice drawn from our extensive experience.

Our associations would like me to extend our gratitude for being invited here today. I have a printed statement which I will not

read in full at this time. Our testimony is in two parts. The second part will be given by the succeeding speaker, with your permission, Mr. Donald Cody, but in turning in this testimony I would like to make one or two points orally, if I may.

It seems to us that one of the most important considerations in designing a health insurance program is to realize that health costs, under modern medical conditions, cover a broad range. It is true that hospitalized illnesses frequently are very expensive. It is not true, however, that the costs of hospitalization as such make up the bulk of the medical bill; nor is it true that all financially difficult illnesses are treated in the hospital by any means. This fact is well corroborated by a recent study which, like others, indicates that of the medical bill which the average family suffers in America today, less than 25 per cent represents charges by hospitals; physicians' charges are a larger part of the medical bill, as much as 31 per cent; drugs and medicines outside of hospitals as much as 17 percent, and other costs, such as special nursing, laboratories, and so forth, today under modern methods run as high as 10 per cent of the total bill. We believe, therefore, that health insurance should cover a wide range of health costs. It is true that hospitalization was the first type of health insurance in this country, but it rapidly was expanded into surgical coverage and into medical coverage of a more general nature, and today we have a strong movement in the direction of a comprehensive plan, with extended benefits designed particularly to cover catastrophic medical situations of a type which the insurance companies call major medical expense insurance.

We believe it rather obvious that modern planning for health insurance provides breadth of coverage to avoid gaps in the family protection, to avoid inconsistencies of those who suffer different types of medical catastrophes. We believe it unwise to pick up one area of benefits and to spend practically all of the available money providing what might be called extraordinarily liberal benefits to that particular area, to the exclusion of other important areas.

We should also like to point out that a health insurance program today should be designed in anticipation of substantial changes in the pattern of medical care and that methods of providing insurance likewise are going to be subject to considerable evolution. We don't yet know the best ways of providing insurance, since it is still in its formative stages. We are sure of one thing—that there are going to be changes, important changes, to be taken into account in any one health insurance program. We therefore recommend that the plan be so designed as to permit flexibility of benefits in the future, so designed so as to permit the plan to be altered to keep it up to date.

I feel constrained to point out one other thing having to do more with the report which the staff of your committee turned in, as to what type of insurer is best equipped to handle the benefits for state employees. I think it must be clear that any bill which the legislature might pass would certainly not exclude any type of carrier from having an opportunity to furnish benefits under this

bill and I would think that any bill should not in its intent, whether or not in so many words, exclude the opportunity for any type of carrier to participate in this kind of insurance if it is credited and worthy. I bring up this point, because the staff's report seems to us to imply that the insurance companies do not have the facilities and the methods of providing the type of insurance needed for state employees. I cannot strongly enough make the point that that is not true; that we are capable of doing so; that Blue Cross and Blue Shield are not the only types of carriers that can handle this type of insurance, and I make some emphasis on it just to straighten out the record, because I am sure that when our propositions are examined that will be wonderfully clear. We can write the kind of insurance spelled out in your program, Senator Metcalf, and we can write the kind of insurance spelled out in any of the other bills.

We are not sure that we would advise the type of structure that would be proposed for your type of bill for reasons other than the question of whether we can carry them and handle them properly, but we can do it if that is the kind of insurance you want and you want to pay for it.

With respect to this matter of cost, health insurance is a little bit treacherous. It has almost built-in increasing cost potential. That arises from the fact that medical care itself is necessarily increasing in cost, and I say this without any criticism of doctors or hospitals, for we are all well aware of what they are up against, but it is nonetheless a fact, and in considering a bill which, in effect, will have substantial import with respect to the state's budget in the future, we would recommend that the form of insurance be so arranged that it will not almost automatically carry with it increases in cost that are not controlled from time to time through the state's budget.

In this respect I might point out that the Federal Government is currently looking into the same problem that is before you; namely, provision of health insurance benefits for public employees. As we understand it, the bill which probably will emerge in the federal legislature soon will have definite cost controls and it will have one other interesting feature which we commend to your consideration, because a large state like New York has many aspects similar to the Federal Government. That feature is that the bill will probably be so arranged as to permit all types of insurers to function and to provide a variety of kinds of insurance. In this fashion the bill will be advantageous in that it will not restrict the kinds and forms of insurance that will be used and it will permit great flexibility.

I will summarize this quickly, if I may, by reading from the testimony at the end. It is our recommendation that the legislature approach this subject with the following principles in mind:

1. The insurance should cover a broad range of health costs, not merely one phase of costs. This principle should hold even though it may not be possible, in view of budget limitations, to make the insurance as adequate as is desirable in every cost area. Not too large a proportion of the available funds should be spent in one

area of health cost, because to do so would produce inconsistencies in coverage that are not justifiable.

2. The provisions of the insurance plan should contain reasonable yet effective controls on claim payments in order that costs will not be unduly increased in the future with out budgetary controls.

3. The bill should assure that all recognized types of insurers will have a fair opportunity to assist in providing the insurance.

4. The bill should not so crystallize the structure or details of the insurance coverage as to make it difficult to adapt to changing conditions, to advances in medical care and to new developments in health insurance as commonly utilized in industry and commerce.

With your permission, I should like to introduce Mr. Donald Cody, who will now offer some comments more specifically applying to the bill before this committee.

ASSEMBLYMAN TURSHEN: Before you do that, I would like to ask you one or two things. When you speak of the fact that you cover about 85 per cent of the group accident insurance . . .

MR. SMITH: Written by insurance companies in the country.

ASSEMBLYMAN TURSHEN: I assumed that is what you meant. Can you tell us, or do you have today or is it at all possible for you to get actuarial figures, so as to give us an idea as to whether you can write the form of insurance that we are talking about at approximately the same rate, or do you think that our rate would be more?

No. 2. Would the coverage that you now give in your 85 per cent group—would it be a similar coverage? Would it be less inclusive or more inclusive, and (3) can you tell us whether we have in our particular problem anything entirely different than you now have or areas that would be entirely different than the groups you now cover?

MR. SMITH: May I speak to part of it now or bring it in later by letter?

ASSEMBLYMAN TURSHEN: If you can give us the answers right now, we would appreciate it.

MR. SMITH: I wasn't quite sure of the nature of your first question. You asked whether the cost we now charge would be approximately the same as . . .

ASSEMBLYMAN TURSHEN: As you are now charging for your 85 per cent group.

MR. SMITH: The cost would be actuarily tailored to the particular group of employees that we are to cover for the state. In that sense they would be based on the same general statistics but would recognize the peculiar and particular characteristics, if they are peculiar or particular, of the group of state employees that you might cover under the policy issued to the state. So I would say the answer to the question is basically the costs are of the same nature but would be specifically tailored actuarily.

As to the second question, if that one is adequate, among the many, many groups that we cover there are all varieties of insurance plans. There are some that I would almost have to apologize for, because they do not provide enough benefits. There are some which are quite liberal, indeed. The degree of benefits provided, the amount of benefits, the scope and nature of them are dictated to us by our policyholders. We write plans to match what they feel they need and what they are prepared to pay for. Many of these plans come out of collective bargaining agreements and provide the type benefits which, through bargaining agreements, have been decided upon. There are plans which provide only hospitalization benefits. Some provide that and no other coverage. Those today are becoming less and less numerous and less and less popular, for the reasons I have indicated in the earlier part of my talk. I feel sure that most of the new plans being written today cover a fairly wide spectrum of health insurance costs, not just hospitalization costs alone.

In covering hospitalization costs, we have some plans which provide benefits as generous as those spelled out in Senator Metcalf's bill. They are relatively few, I would say, because more often we get a wider range of cost covered under a health insurance plan with whatever money is available, spread more broadly rather than concentrated in one narrow area of health insurance coverage.

I may have covered your third question in that.

ASSEMBLYMAN TURSHEN: I think you have in your second answer.

Statement of J. Henry Smith before the Joint Legislative Committee on Health Insurance Plans, State of New York, on the Subject of Health Insurance for New York State Employees

One of the important considerations in designing health insurance is that the range of important health costs is broad. Modern developments in medical care have emphasized the costs of a wide variety of services beyond those provided by physicians and hospitals. The increasing utilization of the many services, skills and equipment supporting the medical profession and the development of expensive drugs and techniques have made the average family bill for medical care a rather diverse one. This fact was corroborated in a recent study in Boston, carried out under the auspices of the Health Information Foundation, as reported in a recent paper by Oden W. Anderson of that organization. He quoted the following statistics:

Type of Service	Charges by Type of Service Per Family as a Percentage of Total Cost
Physician's Services	31%
Hospital Charges	23%
Drugs and Medicines	17%
Dental Costs	19%
Other	10%

Health insurance attempts to cope with this variety of charges through several different mechanisms. We began first by covering hospital expenses, but soon moved into coverage of surgical benefits and other medical charges, and now we are extending into a still broader range of costs. Because of the historical pattern, hospital and surgical expense insurance has come to be regarded as rather basic. However, the protection thereby provided was not adequate to meet the needs of those suffering extended and severe illness requiring a great deal of medical care, frequently outside the hospital, nor did it defray expenses arising out of special nursing care, expensive drugs or other specialties. For that reason, there have been developed extended forms of insurance, which the insurance companies often call Major Medical Expense coverage, designed to offer important assistance in financially catastrophic situations. The modern tendency in industry is to provide substantial protection in most of the areas of medical costs, in recognition of the wide distribution of average medical costs.

As yet health insurance is in a formative stage. It is unrealistic to be dogmatic as to the form which health insurance should take or as to its extent or depth of coverage. We are continuously learning new and important methods of dealing with the problem and through a multiplicity of approaches we can expect substantial improvements in the pattern of health insurance in the next few years. At the same time we must be prepared to adapt the insurance device to continuation of rapid change in the whole field of health care which future medical advances are sure to bring.

These two factors of the need for breadth in health insurance protection and the necessity for retaining flexibility, suggest that in designing a health insurance plan for employees one should employ a scope of benefits as broad and flexible as experience justifies and as comprehensive as can be financed, and that leeway be permitted for future changes. In general, insurance buyers proceed accordingly in modern health insurance planning. It is no longer the pattern to pick up one area of health costs, such as those arising from hospital care, and to attempt to deal with it to the exclusion of other important areas. Rather, different combinations of health insurance benefits, or some sort of comprehensive plan, is adopted to cover a wide variety of contingencies with which the average family is faced. In this planning it is not often provided that all of the expense with respect to any particular area of health cost will be met by the insurance plan, but rather the effort is to provide a breadth of coverage that will not permit a family to get hit too hard in an uncovered area.

Turning to the problem of writing a bill to provide insurance for the employees of the state, my general argument runs in the direction of a bill which would not spell out in any particular detail the provisions of the health insurance to be furnished, but rather would specify broadly the desired protection and authorize and direct some agency or special committee of the state to work out an attractive program, subject to appropriate budgetary limitations. In this structure the agency deciding upon the

program initially would be required to keep abreast of developments in health insurance, to keep a check on the operation of the state plan and to recommend changes in the plan when desirable. In this way the state would be able to keep its health insurance operations up to date and to keep employment with the state attractive in this respect.

The special conditions surrounding public employment and the purchase of health insurance by a governmental agency introduce some problems not found in industry generally. For example, it seems unreasonable for a legislative bill to be written in such a form as to prejudice the opportunity for one accredited type of insurer to participate in the insurance program. It is, therefore, respectfully suggested that whatever bill is approved by this committee be completely open not only in its explicit terms but in its underlying intent, as to the use of any type of insurer found worthy.

In this respect again there is far from unanimity of view that a certain type of insurer or type of plan is superior and there is little reason to assume that any particular type will retain permanently any advantage it may have at present. In this respect, we would like to challenge the implication in the report of the staff of this committee to the effect that insurance companies are not in a position to render health insurance service as satisfactory as other carriers. We emphasize this to straighten out the record as to the ability of the insurance companies to handle the insurance proposed in the bills before you. We are confident that we will be able to provide the insurance you require quite satisfactorily and at reasonable costs. Our mechanisms are extraordinarily adaptable and flexible. For example, your staff report to the contrary notwithstanding, we are quite prepared to handle hospitalization insurance in amounts which will reimburse the patient in full for any conceivable duration of confinement and for all charges, regardless of their amount, if the policyholder is satisfied to provide that kind of insurance and to pay its cost. We would not recommend such a plan but we could handle it.

This reference to cost introduces another important consideration in connection with insurance for public employment. In view of the expanding nature of health insurance and of a persistent tendency for the cost to rise over the years, we believe that the legislature will want to exert some care as to the cost potential which a health insurance bill entails. A plan which would provide service or reimbursement to the individual in full for a substantial category of expense may, as history suggests, have a continuously increasing cost factor that could produce a total charge well beyond that contemplated at the time the bill was passed. In private employment it may be in order to undertake an "open-end" cost type of contract, but other considerations come into play for a legislative bill dealing with the public budget.

This brings to mind the study being given to this same topic by the Federal Government with respect to health insurance for its employees. It is our understanding that if Congress passes a

bill it will probably contain controls as to the amounts which the Government will spend for the insurance to be provided. We understand further that an insurance structure is emerging from the considerations being given to this subject by the Federal Civil Service Commission, which may be useful for a large state like New York. It appears that under the plan contemplated an opportunity will be provided for a wide variety of insurers to offer a number of different kinds of health insurance to federal employees, with a limited cost participation by the Government. The advantage of participation by diverse types of insurers and the advantages of flexibility are thus preserved.

THE CHAIRMAN: Before we call on the next speaker, I would like to say, in passing, in answer to one thing that Mr. Smith brought up, and that is as far as our Joint Legislative Committee was concerned the fact that we only took up hospital care has nothing to do with our feeling that medical and surgical benefits are certainly necessary under any comprehensive plan. The fact is that we felt in the time that we have been able to study this question that that was as far as we wished to go at this time and if we could construct a secure and fine foundation under that particular portion of the program, we could go on from there. I am glad to have you bring up these ideas, but I think that should be made clear, and that it is not the opinion of this legislative committee that we should just go half the way and not any farther.

Our next speaker is Donald D. Cody, Second Vice-President and Group Actuary of the New York Life Insurance Company.

MR. DONALD D. CODY: Like Mr. Smith, I represent the Life Insurance Association of America and the American Life Convention. I have a prepared statement which I would like to leave with you, but I would like to hit some of the high spots of it.

Mr. Smith has suggested that in any program that the premium dollars available should provide the best protection at the optimum efficiency. That is our criteria for designing programs.

Now, the best protection is obviously a comprehensive protection, in the sense that it provides, as you have pointed out, sir, both hospital and non-hospitalized costs. We feel also it should provide for what we call catastrophe costs, even at the expense of minor expenses, all being governed by the amount of money that is available. In the area of catastrophe medical expenses the scope of coverage should cover all sorts of things that aren't covered by normal hospital and surgical programs, like drugs, for instance, or prosthetic devices or transportation by airplane to the Mayo Clinic or many other things that you can think of that you hear about every day.

Now, in addition to having this very comprehensive pattern, we feel that in an effort to spend the dollars of premium wisely that programs have to have certain controls, and these controls arise out of a realistic attitude toward human nature. It is natural for a patient who is sharing a bit of the cost to be more concerned about doctor's calls to his home or the extent of laboratory tests that are

taken, the number of days that he stays in the hospital. I am not suggesting that necessary treatment be neglected, but there is always an area where one can properly leave off with medical treatment where if the patient has no objection it can be continued.

Now, these controls take the form of amount limitations, schedules, limitations on days in the major medical field arises out of the idea of co-insurance, the payment, say, of 80 cents on a dollar instead of 100 cents on a dollar, or it can arise in the form of deductibles, which cut out the minor payments. There are always deductibles, by the way, in every medical program. Anything short of a completely socialized medical scheme, the patient is always going to have to pay for some things. It doesn't cover everything.

So these things are a matter of degree.

SENATOR GREENBERG: It doesn't pay in the Blue Cross, does it?

MR. CODY: What is that, sir?

SENATOR GREENBERG: It doesn't pay for hospitalization in the Blue Cross.

MR. CODY: What doesn't pay for it?

SENATOR GREENBERG: The patient doesn't pay for any hospitalization under the Blue Cross.

MR. CODY: No.

SENATOR GREENBERG: Then your statement wasn't exactly 100 per cent accurate.

MR. CODY: I said in some instances there are areas where the patient must pay. I haven't heard of any Blue Cross plan paying for any lengthy ambulance service, for example.

SENATOR GREENBERG: Ambulance?

MR. CODY: Yes. Suppose you have to go to the Mayo Clinic. Will your Blue Cross policy pay anything there?

SENATOR GREENBERG: I don't suppose they would take me from Brooklyn out to Minnesota.

MR. CODY: The next time you go, sir, send a bill and find out. There are always areas that no insurance plan can cover and there are some areas that many insurance plans cover completely.

Now, there are two bills that have been submitted. One, if I may use the short name, is what I would like to refer to as the Metcalf bill. This is a very liberal, full reimbursement, 120-day hospital plan. The committee, of course, realizes that it covers only hospitalization, and you have mentioned that you are going to add other coverages. I may note also that not only does this bill plan to cover the future retired civil servants but also the presently retired civil servants. I don't know whether you are fully aware of the expense of covering retired people. The retired person costs

at least 200 per cent of what the average person costs. We have estimated that for every 10,000 individuals covered under this retired program or under the sponsored dependents program, which usually sponsors elderly parents, I believe—that for every 10,000 individuals—that is counting the husband as one individual and the spouse as one individual—you can figure something like a million dollars for every 10,000 of those.

Now, we don't have any direct estimate of the number but I believe that in numbers of employees and wives that it probably runs somewhere between 30 and 50 thousand. In other words, we may be talking about several million dollars on this score alone.

SENATOR GREENBERG: A million dollars for retired employees for what coverage?

MR. CODY: Just for hospital coverage.

SENATOR GREENBERG: Yes—under the Metcalf bill.

MR. CODY: That's right. I might point out here that you shouldn't be deluded by the fact that in some insurance plans the same average premium is charged an active employee as a retired employee. That is merely an accounting device, because the basic cost of any insurance plan is the cost of the claims. It doesn't make any difference whether an insurance company covers it or a service plan or a Blue Cross plan.

Now, the Metcalf bill provides, as I said, very liberal hospitalization. It is not unknown in industry. We have a number of such plans on our own books in the New York Life, but it is, I think, not only in design but also in coverage of retired people, very much more liberal than the average plan in industry. The New York State Labor Department has a publication which they put out in December of 1955, which outlines the existing pattern of hospital benefits in New York. This plan is much more liberal than the normal plan and I am sure you realize that you establish a public pattern of planning for industry generally, and this type of plan for the state employees will lead to the cost of doing business of many other employers. I think from the social point of view it is a fine thing, but again we come back to the question of cost.

ASSEMBLYMAN TURSHEN: May I stop you there for a moment? When you get into that area, do you have actuary figures on what the differential is between the ordinary hospitalization as against the comprehensive, percentagewise?

MR. CODY: Well, let me put it this way, so I can talk in relative figures between things that you know. I was about to comment on Senator Milmoe's bill, and if I may I will come back to it.

Senator Milmoe's bill is of a more common industry pattern. It fits the principles that I mentioned earlier. It consists of hospital and surgical basic coverage, with certain limitations, and then on top of that I put $100 out-of-pocket deductible major medical program, which provides 75 cents and a dollar over and

above the unreimbursed expenses or uncoverd expenses of the basic program, up to an amount of $5,000 for one year or $10,000 for a lifetime. It is typical of the broad coverage that many employees of the New York Life are moving to. We have a number of these on banks and utilities. It is not inexpensive but, as I say, it is a comprehensive coverage that has controls built in.

Now, to get to the matter of cost. I feel, from some very quick calculations that we did, that just taking the active employees alone the cost of hospitalization under the Metcalf bill runs 85 per cent of the total program under the other bill. Now, if you throw in the retired lives, eventually under the Milmoe bill you have all the retired life, because the ones that retire from now on will gradually come in and you will build up to the total pattern you have today. In the long run, the total costs under the two programs will be much higher, by somewhere between 3 and 16 per cent, as I recall, under the Metcalf bill, whereas immediately it is much higher than that. The Metcalf bill today would cost maybe 122 to 150 per cent. These are very broad figures but it shows the general magnitudes.

Now, as to Senator Greenberg's bill or the Governor's bill, this represents a technique in arriving at an answer, and our associations wish to take no stand on that. The committee to make the decision seems to be a very broadly composed one and I am sure they are very well aware of the financial needs of the state and the needs of the employees of the state. In other words, Mr. Greenberg's bill is merely a technique. I didn't mean that in any derogatory manner.

There is another thing that I would like to mention very quickly, because I realize I have run well over my time limit here. The employees of New York State have a lot of basic coverage in Blue Cross and Blue Shield. I think one statement was there was 50,000 out of 80,000 already had coverage. It is possible to design a program leaving that coverage alone on the basis on which it is now being paid for virtually, or to replace it with other coverage, for that matter, with other insurers; but on top of that the state could provide a major medical program which would take care of the catastrophic problems. In other words, it would be possible for the companies of the two associations that I represent to design a policy covering the civil servants of New York with major medical coverage consisting of $100 out-of-pocket deductible, where they pay, over and above the basic coverage which would have to meet certain standards and running up to five or ten thousand dollars. The cost of that would not be very great and the state could pay for it entirely at a much lower cost than any similar lower cost of either of these figures.

SENATOR GREENBERG: That would leave the state employee paying the full cost, as he does now, wouldn't it?

MR. CODY: What it would amount to is—suppose he had a Blue Cross, Blue Shield plan. He would get the usual benefits of Blue Cross and Blue Shield.

SENATOR GREENBERG: I understand that, but he is paying for that now.

MR. CODY: Well, he is going to pay for it under the new program, too—50 per cent of his costs and 75 per cent of his dependent costs —and if you add benefits for medical and surgical on top of these hospital benefits in sufficient liberality, he would be paying a great deal indeed, if you keep that same percentage.

THE CHAIRMAN: Mr. Cody, could I ask you a couple of questions? First, I assume your figures are based on an actuarial basis. Are they?

MR. CODY: They are based on certain figures taken out of your staff committee's report.

THE CHAIRMAN: What I mean is when you are talking about benefits, I assume they are being paid for on an actuarial basis.

MR. CODY: They represent the sort of fees that we would charge.

THE CHAIRMAN: If you could provide the service that you speak of for a far lower cost than the program that we are advocating, I assume then that under your program the benefits would be greatly reduced. Is that a fair deduction?

MR. CODY: Some of the benefits are reduced and, of course, others that don't exist under your bill at the moment exist under Mr. Milmoe's bill.

THE CHAIRMAN: Yes, but at least if it is based on an actuarial calculation—and I have no reason to believe otherwise—if it costs a lot less, then the benefits must be a lot less for the employees.

MR. CODY: Yes—the cost reflection directly of the benefits received. I wouldn't want to suggest anything else.

SENATOR GREENBERG: What insurance companies, under any of these bills before us, are not allowed to write any of this insurance as these bills are written? I understood Mr. Smith to say that all the companies were not taken care of—that is, all the private carriers. Which ones are not?

MR. CODY: You are referring to your staff report?

THE CHAIRMAN: I think he is talking about the 15 per cent now.

SENATOR GREENBERG: No, no. These bills refer to sections 9-A and 9-C of the Insurance Law.

MR. SMITH: I was not really speaking to the text of the bill as it stands but rather to the report of the staff of your committee and to the fact that this bill seems to grow out of that report and be conditioned on the assumption appearing in the report that only so-called non-profit pre-payment plans could handle this type of insurance.

THE CHAIRMAN: I believe that you will find that we were talking about full coverage through the service benefit contract. I know, Mr. Smith, you made it plain that you could write that kind of insurance.

There is one thing I would like to ask you, Mr. Cody, before you sit down. I think you made a statement about a million dollar expenditure for 10,000 retired employees. Is that correct—and, if so, what would that cover?

MR. CODY: If we were to guarantee to pay full reimbursement on benefits in accordance with your bill, it was our estimate that we would have to charge each month for each individual who would average, as I recall, around 70, we assume, $10 or $120 a year. Now, your bill provides that the employee would pay $1.75, so you have about $8.25 a month that must be paid by the state. $8.25 times 12 is $100, and $100 times 10,000 people is a million dollars.

THE CHAIRMAN: Is that million dollars for both the employer and the employee or is that the total bill?

MR. CODY: That is the state's part.

THE CHAIRMAN: That is a half of it, under the terms of this contract?

MR. CODY: You meant a half of the active employees cost. Now, I was referring to . . .

THE CHAIRMAN: I thought the bill refers to both the same way.

MR. CODY: I don't believe that you would charge the retired employee $10. Actually, the insurance company or the non-profit organization would figure the number of retired people, the number of active people, and you add the total premium and divide by the total people, and you come up with the average premium, but that doesn't affect the cost.

THE CHAIRMAN: Well, I appreciate that, but you are telling me the cost is a million dollars for 10,000 retired employees and their dependents.

MR. CODY: Let me put it this way, so I can clarify the record, because I see what you are getting at and we do have a misunderstanding. Our premium, I believe, would amount to $120 a year for a retired employee. We think that that is a proper reflection of the expense of providing your type of hospitalization to a retired employee. Now, you can make the premium up in various ways, but that is the total cost that would result in the plan, and that would have to be borne in some manner by the state and by the employees as a whole.

THE CHAIRMAN: That is $1,200,000, isn't it?

MR. CODY: Yes, sir. It is $120 a head a year. That is what the premium would be.

ASSEMBLYMAN TURSHEN: And on that same thing, again if we wanted to have a policy which would be realistic enough so that even the present employees would help carry, or we would want to get the bill equalized so that they all pay an equal sum, so as to include the retired employees without giving the retired employees alone the burden of carrying their own type of contract—would that . . .

MR. CODY: That would raise the premium on the active employees.

ASSEMBLYMAN TURSHEN: Yes.

MR. CODY: That is right, and any plan that averages it pulls the cost of the retired employees with the active employees, but a plan the size of yours—no insurance organization, whether it is non-profit or otherwise, could afford to carry it very long without charging you fully for the claims expense, nor do I think that you would wish the other citizens of this state to bear it indirectly through increased premiums on themselves.

THE CHAIRMAN: I want to make this very clear, then. The total hospital cost, as you figure under our plan, would be $1,200,000 for 10,000 retired state employees annually?

MR. CODY: Or was—individuals.

ASSEMBLYMAN TURSHEN: Would you also be prepared to give us the figure for 10,000 active employees for that same contract?

MR. CODY: This would vary, of course, by company. These happen to be the figures that our actuary arrived at. I think it was $3.50 a month for an employee and $7 additional for his wife and children. Those are gross costs that we normally charge our people. Now, the total cost of any plan consists of the claim costs, which, I say, should be the same for any organization. The balance is the expense of running the organization.

ASSEMBLYMAN TURSHEN: In other words, you are now telling us, in effect, in answer to my previous question, that the service contract would be approximately the same as it is now for people in private industry—85 per cent that you write would be about the same for state employees?

MR. CODY: As Mr. Smith explained, sir, we don't have a standard contract. Our policyholder tells us what he wants and we figure the charge of the benefit actuarily and we charge him that. As a matter of fact, it goes farther. If his experience comes out different, we adjust the premium.

SENATOR GREENBERG: You mean you pay a dividend at the end of the year?

MR. CODY: We do that, but in addition we may change the premium level itself in the second or later years.

I would like to leave my prepared statement with you.

Statement of Donald D. Cody before the Joint Legislative Committee on Health Insurance Plans, State of New York, on the Subject of Health Insurance for New York State Employees

In my testimony, I shall apply the principles and tests for a constructively designed health insurance program as described by Mr. Smith to the specific program contained in bills introduced by Mr. Metcalf and Mr. Milmoe (respectively, Int. 928 and Int. 2467).

The essence of Mr. Smith's statement is that in planning a health insurance program one should apply premium dollars so as to provide the best protection at optimum efficiency.

The best health insurance protection should naturally be comprehensive in the sense (a) that both hospital and non-hospital expenses should be insured; (b) that emphasis is placed on catastrophic costs even at the expense of some minor costs, and (c) that in the case of serious illness the eligible expenses should include hospital, medical, surgical, nursing, and other professional charges, together with costs of drugs, appliances, ambulance, and all other aspects of modern medical care.

However, for efficient application of the premium dollar, certain controls must be built in so as to restrict utilization to necessary services and so as to keep the patient interested in fees. In routine medical problems, there is a tendency toward overutilization of doctors' house and office calls and of diagnostic laboratories where the patient bears no part of the financial burden. Moreover, in more serious medical problems a patient with no financial interest, for instance, is less inclined to terminate a hospital confinement at the earliest proper day and to demand only necessary ancillary services. This is human nature and to ignore these facts is indeed unrealistic.

What are controls? Well, they consist of certain limits, like limitation of room and board reimbursements to dollar amounts, limitation of reimbursement of surgical fees and doctors' fees to specified amounts, such limitations being at levels somewhat below the normal costs. Such controls, of course, do not lend themselves to plans where normal costs may vary with income levels or by location, nor to catastrophic illnesses. It is appropriate in such plans to add extended coverage on a blanket basis subject to a coinsurance by the employee to the extent of 20 per cent or 25 per cent. This blanket coverage usually applies to all types of medical expenses and to very high amounts like $5,000 or $10,000 and in this form is known as major medical expense insurance. Major medical coverages usually demand some out-of-pocket payment like $100 per year, so that routine expenses (like drugs for headaches or colds) will not come under the insurance programs. This out-of-pocket payment is known as a deductible.

The purpose of the 20 per cent or 25 per cent coinsurance is to provide the insured person with an incentive to obtain at reasonable prices only such hospital and medical services as are necessary.

Major medical coverages (which now are enjoyed by about 4,000,000 American employees and their families) are true insurance coverages and have made us realize that the traditional hospital, surgical and medical coverages have provided for full payment in many minor illnesses at the expense of catastrophic medical problems. Any program with modern design should include major medical.

This, then, is the framework, within which a proper plan can be developed for the very deserving civil servants of New York State. You have before you two plans of widely different design. Many other designs are possible. The insurers of the plan could be insurance companies, Blue Cross-Blue Shield organizations, or other service organizations, or a combination of all of these. Speaking for the insurance companies, we can assure you that we have the facilities and can provide any reasonable benefits desired (including conversion rights, coverage for retired lives, and assurance of non-cancellability of individual certificates). We assume, of course, that the choice of carriers will be made on the basis of ability to perform.

Let us now give specific consideration to Senate Bill Int. No. 928, introduced by Mr. Metcalf (Assembly Bill Int. No. 1284 by Mrs. Strong). This bill sets forth a program of hospitalization for 120 days of semi-private care, including ancillary hospital services on a full reimbursement basis and including maternity care and out-patient benefits. This is a liberal program and most insurance companies have few such policies on their books. Most of us would urge that more controls should be introduced for reasons already mentioned. But the choice naturally is with the employer, who must pay the bill for overutilization. We, however, would point out that hospital expenses are only about 25 per cent of all medical care costs, and if such liberal hospital benefits are purchased without covering any part of the other 75 per cent, the coverage is not broad enough. You should also bear in mind that inevitably other benefits must eventually be added and the cost of the whole program could become prohibitive.

The costs for each sponsored dependent, usually elderly parents, and each retired employee will run at least 200 per cent of the costs for each active employee. I am speaking here of true costs—one must not be deluded with the thought that, merely because an average premium may be charged to all regardless of age, costs are level by age. They are not, and New York State must face the whole cost over and above the employee contributions. The estimated additional aggregate cost of providing coverage for 10,000 currently retired individuals (i.e. employees or spouses) or sponsored dependents of active employees is 16 per cent of aggregate active employee costs, assuming 80,000 active employees. We do not have definite figures as to numbers of retired employees but it would appear that the additional aggregate cost for them is in the neighborhood of $1,000,000 annually for each 10,000 individuals insured.

The New York Legislature should also bear in mind that a pattern of benefits adopted here can set a pattern for New York industry generally. Therefore, if a plan is adopted which is subject to overutilization and to prohibitive costs, it would lead to an increase in the cost of doing business for many New York employers and to larger payroll deductions for many New York employees.

However, the insurance companies can provide the benefits to employees and dependents, and to retired employees, as defined in this bill provided you wish to introduce such a limited program.

Now let us consider Senate Bill Int. No. 2467 introduced by Mr. Milmoe (Assembly Bill Int. No. 2928 by Mr. Barrett). This design is more typical of modern industrial medical care insurance supplying truly comprehensive coverage, but with controls built in for efficient use of insurance money. (This design is susceptible to considerable variation, incidentally, to fit the desires of the purchaser.) It consists of a hospital plan providing for semi-private room and board reimbursement up to $15 a day for 70 days. Ancillary hospital services are paid in full up to $150, also being available to out-patients for emergency care. A surgical schedule is included with maximum amount of $250 for the most complex operations. Moreover, if in any calendar year an individual incurs more than $100 of otherwise unreimbursed medical charges, the excess of such charges is reimbursed 75¢ for each $1.00 of such charges up to a maximum reimbursement of $5,000 in one calendar year or $10,000 for a life-time. This last benefit, which is a major medical insurance benefit, applies to all hospital, medical, surgical, nursing, laboratory, and other professional charges and all charges for drugs, appliances, radium, blood, etc. In complicated pregnancies, the major medical applies. Such is the broad outline of the plan. It is our opinion that a plan of this general design will fit the comprehensive needs of our state civil servants more adequately than the plan of Mr. Metcalf's bill and will lead to the most efficient use of appropriations and employee contributions.

We note that presently retired employees and sponsored dependents are not eligible under this bill. This naturally is a decision for the legislature to make in accordance with its budget. We concur in the inclusion of future retired as being in the tradition of industrially designed plans. The benefits to such retired lives are reduced to the hospital and surgical benefits with a maximum payment of $1,450 and with no major medical coverage. This reduction is suggested obviously as another means of cost reduction and stabilization. Conversions are provided for.

Actual cost estimates would naturally have to be based on precise data as to age, sex and location of active and retired employees, but rough estimates indicate that the plan of the Metcalf bill is more expensive both now and later than the plan of the Milmoe bill.

Another possible program might recognize the widespread existence of basic hospital and surgical coverage in civil servant groups on an employee-pay-all basis today. A major medical program

provided by New York State without cost to its employees could be integrated with this existing coverage or with any replacing programs arranged independently. Such a program would protect civil servants and their families from catastrophic illness costs, leaving to the employees the continued provision for basic protection. This program might follow the design of the major medical portion of Mr. Milmoe's bill. It would presumably cease on retirement, leaving the basic coverage to continue on retired lives.

May I reiterate in closing that the insurance companies of our two associations will be pleased to be invited to join with New York State authorities in helping to design your civil servant program and to participate in the underwriting of the plan adopted?

THE CHAIRMAN: The next speaker this afternoon is Dr. Louis H. Bauer, Chairman of the Board of the United Medical Service Plan. I might say that Dr. Bauer is Secretary General of the World Medical Association and is Past President of the American Medical Association.

DR. LOUIS H. BAUER: Thank you, Senator, for the opportunity of making a statement before this committee. I am going to confine my statement to certain principles which I think are important in any bill that you may finally recommend.

The importance of a service benefit cannot be stressed too strongly. Those who carry health insurance include large numbers of those in the lower and middle economic levels. A person with low or moderate income wishes to feel that he is completely protected against that for which he carries insurance. For example, if he is insured against the cost of surgical operations, he wants to feel that his insurance will completely cover the costs of surgery. If he is insured against the cost of medical care in the hospital he wants to be sure that he is completely covered for that. The same applies to the cost of hospitalization. On a service basis in hospitalization, if he is willing to accept semi-private accommodations, he is fully covered.

The use of a deductible and an indemnity payment leaves the insured person vulnerable in two ways. First, he has to pay the initial cost up to a certain amount. Second, since there is no service benefit, he has no guarantee that the amount paid by the insurance company will be accepted as the balance of payment and he may receive a supplementary bill. Whereas, with a service plan, the patient knows that if his income is within a certain agreed-upon limit, he will not receive a supplementary bill and that his insurance will pay in full for any service he receives which is covered by the service features of the contract.

The vast majority of physicians are participating in the plans which have a service benefit, so that the patient has a wide freedom of choice among physicians. Of the approximately 80,000 civil service employees of New York State, over 50 per cent are currently insured in Blue Cross and over 40 per cent are insured in Blue

Shield. Because these people are carrying such insurance voluntarily, the wishes of this group, as to the type of insurance the state provides, should be taken into consideration.

SENATOR GREENBERG: Isn't it a fact, however, that the Blue Shield isn't a service benefit contract in the fullest sense of the word, 100 per cent? It is only a service benefit up to the income stated in the policy.

DR. BAUER: The income stated in the policy, yes.

SENATOR GREENBERG: Whether that is $4,500 or $6,000, or whatever the case may be?

DR. BAUER: That is correct.

SENATOR GREENBERG: So above that it is no different than any indemnity contract that might be written by a private insurance carrier?

DR. BAUER: Above that, that is true.

SENATOR GREENBERG: That is factually so, isn't it, Doctor?

DR. BAUER: Yes.

THE CHAIRMAN: Our next speaker is John DeGraff, Counsel of the Civil Service Employees Association.

MR. JOHN T. DEGRAFF: Mr. Chairman and members of the committee: I am speaking here on behalf of the Civil Service Employees Association, which numbers something over 50,000 employees of the state, plus a number of other employees of local units of government and who are obviously the group most directly affected by these proposals. I would like to express our deep appreciation at this time for the very careful consideration that has been given to this problem by your committee and by others both in and out of this chamber, those who appear here today and those who have been working on this problem for many months. It is a source of great satisfaction to us to find such complete unanimity on the idea of a program for state employees along these lines, and we hope that at this session there will be something definite enacted by the legislature under which such a plan can be made possible within the coming months.

I think perhaps today I should comment on the three bills that are before the committee and the difference in the point of view reflected by them and express our tentative informal feelings about the various approaches to this problem. These three bills have a rather completely different approach. The Metcalf bill covers hospitalization only. The Milmoe bill has a broad coverage for both hospital, surgical, plus what we call major medical, and the Greenberg bill likewise contemplates the broad coverage of the three major fields in this type of insurance. Naturally, we greatly prefer the broad approach. We think it would be a great mistake to limit this bill to hospital care only, because at the

present time, as you have already been told, there are in the neighborhood of 50,000 employees who think enough of the combined hospital and medical care to pay the whole cost themselves, so if you confine this plan to hospital only you are disrupting a plan that exists and taking away something that employees pay for themselves and complicating the machinery, because Blue Shield plans have to be worked in conjunction with the Blue Cross plan. You cannot buy Blue Shield insurance unless you also have the basic group Blue Cross policy in advance or at the same time. So our feeling is that this plan should be comprehensive, it should include both the surgical and the hospital care that we now have, and that there should be added to that what has been called this catastrophe insurance or this major medical insurance to the extent that it is possible within the premium that both the state and the employees can afford to pay, and when we talk about what we can afford to pay, I think you realize from what has been said today, as well as what you know from our own experience, that in insurance you get only what you pay for. We can write the broadest possible coverage, and there are very many fine features in all three of these bills, but I have no idea what the cost would be. I am a little scared, for example, of the cost that was mentioned here today for the Metcalf bill, covering hospital only. That cost for hospital only, while the coverage is quite broader than we have now under the Blue Cross policies, actually costs considerably more than we are now paying for both Blue Cross and Blue Shield.

Now, in regard to the Milmoe bill, it has beautiful coverage and we would like to have all of those things, but I don't know whether we can afford to pay for them, and I don't think anybody can give us a figure of cost that would be a true reflection of what the ultimate cost would be, because, as you heard today, each insurance company has a different actuary. Each actuary figures certain things a little differently. They agree on major proposals, major costs, but in all these borderline aspects of exclusion—deductibility, extended coverage—there are variances between the companies; there are variances between the Blue Cross plans and the companies, whether they be stock or mutual. So it is our feeling that any plan adopted should be flexible. I think the plan has to be a negotiated plan. I think it has to be tailored to meet the needs of the state employees, and I think that negotiations should take the form of what might be called just plain negotiation or what some people call collective bargaining, because the state has an interest, because we hope it will pay its full half, the employees have a very vital interest, because they are going to be called upon to pay at least half, and it should be a merger of those interests which cannot be decided today, tomorrow or next week, or, in my opinion, I don't believe any of us can sit down before the end of the session and agree upon what should be in such a policy, if you are going to spell out the whole policy as it is in the Milmoe bill, for example.

The Milmoe bill is practically an insurance contract, where every detail is spelled out. The Metcalf bill, to a more limited degree, spells out certain mandatory provisions in such a policy, and the

minute you make mandatory provisions in the bill you completely eliminate what I think is a very desirable necessity of negotiating, both with a committee that is set up to represent the state or commission, the employees and the insurance companies, because it is actually a three-way negotiation where no one of the three interested parties can sit down by themselves and come to a specific conclusion. You have to have the insurance companies in to see what they will charge for certain specific benefits. You might want to choose this benefit and that benefit. If you find it costs more, you have to consider whether you can afford to pay. And so it is that three-way negotiation, three-way discussion I might prefer to call it, I think is absolutely essential, and I think that would take, of necessity, a matter of months, because I think when we have a plan, even when we come up with the finest plan and get the most for the money we can afford to pay—Now, I can illustrate that perhaps by some of the provisions of this bill that I think are very debatable.

I will take the Metcalf bill, because it is shorter. The Milmoe bill has so many provisions in it that I think I should limit myself to four or five illustrations of matters where I have no answer. I don't pretend to know the answer, but I don't think the answer should be made in advance. I think it should be held in abeyance until we know the costs involved. For example, both the Metcalf bill and the Milmoe bill exclude per diem employees and seasonable employees. I don't know what that is so. We have per diem employees that work every day of the year and have been working for 20 and 25 years, and it seems to me that they are entitled to the coverage of this plan and it is as much for their benefit as anyone else. We have seasonable employees working on the Barge Canal from March and April right up through November, nine and sometimes ten months a year. Then when they stop that seasonal work they work in the shops during the winter—some do and some don't. It seems to be that that type of employee is a permanent employee who has been working, in many cases, for the state all his life and he should not be excluded from this type of remedial legislation.

Again, there may be some types of employees who only work two or three days a year. Perhaps they should not be covered. I think it should be left flexible. I don't think we should attempt at this time to say who is covered and who is not covered. That by itself is something that requires a lot of careful consideration and I think it would be a very grave mistake to exclude seasonal and per diem employees as both of these bills do.

Now, take the definition of a sponsored dependent. There again is something that can make this plan so impossibly high in cost that some employees might prefer to pay the whole cost of the plan they now have. This bill says: "A sponsored dependent is a person who is financially dependent upon the subscriber" (who would be the employee) "and who is a member of the subscriber's family, though not his spouse or child." As I interpret that, or as it could be interpreted, that could include brothers,

sisters, grandparents, aunts, uncles and cousins, and so on, if they lived in the family with a state employee. You can just imagine, if you have a policy where that provision is written, all the sick aunts, uncles and cousins are going to pretend to live in the family until they can go to the hospital, because then they will get relative comparatively free coverage. But again that sounds nice until you realize that the other employees who don't have sick aunts and uncles and cousins have to pay for that, and you are adding all these broad costs and expenses which inevitably raises the cost figure to the employees to the point where it may be difficult to pay for it, and I think a policy that is limited to the immediate family of the employee, where he can get broader benefits, where it is his wife and family—children, is more desirable than to try to cover all the grandparents at an expense that would not be justified.

Again, I say I don't know the answer to that. I think it is a problem to be considered and I think it would take time to work out the answer.

This problem of retired employees is a very serious one. We are very anxious to cover retired employees. Certainly an employee who has been a member of this plan and who contributes to this plan 5, 10 or 15 years should continue his eligibility for coverage when he leaves the state service, but a much more serious problem is presented where the present employees should carry the expense of employees who retired 10 and 15 and twenty years ago, or is that an obligation to the state, through its welfare funds, for the indigent, for the medical expense. Again, I don't know the answer. If the cost is not too heavy we might be able to lump them in one pot and absorb them, but if the cost is as indicated here, those figures may or may not be conservative. The cost of covering some 10,000 retired employees, plus their spouses, may make the whole plan expensive beyond their ability to pay and it may require some separate way of handling it, perhaps some modified plans for employees in that group or perhaps there should be some division of the costs.

Now, then, there is the matter of an effective date which still mandates July 1. I don't think we could get a plan into effect that is a good, well-worked-out plan and have it in actual operation by July 1, as mandated by the bill.

Then there is the problem of competitive bidding. Should this be awarded by competitive bidding? How can you bid on a plan like this? If you set up a master policy and told every insurance company to bid on that coverage, then perhaps you might have competititve bidding, but in this field there are so many different varieties of policies and so many different basic principles between Blue Cross coverage and insurance coverage that I don't think they can be fitted into one mould. You may have to consider these policies separately and then decide which is the best from the overall point. Some will be better one way and some will be better another.

Those are just a few of the illustrations which led me to feel that the policy expressed in the Greenberg bill, of setting up a statement of policy that this should be a uniform plan, that it should be applicable to everybody and then let the commission work out the details, work out the best type of policy, through negotiation with the employee representatives, who most certainly should be a part of this final decision, since they are going to have to pay half of the cost, is a much sounder approach than to try to spell out in any bill in advance what the policy is going to be. I think that is extremely dangerous.

One thing I would like to see spelled out a little more is the state's proportion of this cost. The Milmoe bill says that the state will pay half the cost of the original suscriber and 25 per cent for dependents. The Metcalf bill says 50 per cent, but it is a little vague as to what it is 50 per cent of. It can be read as meaning 50 per cent of the total cost and it can also be read as meaning 50 per cent of the employee's cost and be silent as to the cost to the dependents. I would like to see the state assume half the cost for both the employee and the dependents. I think that is a fair proposal. That pattern has been set in New York City, where New York City pays a flat half of the cost and I would like to see that set in the bill as a statement of policy which I think the legislature should adopt.

The problem of appropriation this year I don't think is of major importance, because as I see it, it is going to take some months to work out the best possible type of policy, and if some reasonable amount of money is appropriated it can be handled through the effective date of the plan. In other words, it is doubtful in my mind if you could work this out and arrange for the payroll deductions before the first of January of next year, or it might be February, or perhaps you could do it in December, but the appropriation for the current year can be flexible and the effective date of the policy can be adjusted to meet the money that is available next year. Of course, the total cost is something that will have to be worked out very carefully.

I think Mr. Kelly and Mr. Powers are on the program, and we will waive their time, and I would like Mr. Dubuar to give you some of the detailed facts. Mr. Dubuar is the Chief Actuary of the State Insurance Department. He is also, and has been for many years, the Chairman of the Association's Pension and Health Insurance Committee.

ASSEMBLYMAN TURSHEN: I would just like to ask a few questions. I was just going to say this to you, in view of what you say about these many, many problems, and we are mindful of many of them of course—whether you don't feel that possibly we might not be able to get the legislation through this year. After all, the session has only a short while to go, and in view of the various conferences that you suggest and the various problems that you think ought to be decided, possibly it is your thought we don't try to enact legislation until next year. Is that your thought?

MR. DEGRAFF: I was very specific. I thought I said that I hoped we could enact legislation this year, and I think that can very easily be done by following the policy of the Greenberg bill of laying down a general policy, a guiding set of principles, and then letting this commission—now, I don't care how this commission is made up or who composes it; any kind of a commission representing government, with whom we can talk and sit down and work out the details. Then if the legislature doesn't like it next year, we can always amend it in detail when we will know a great deal more and when we will have facts, figures and costs. So I think it can be done and I certainly hope it will be done.

THE CHAIRMAN: Mr. De Graff, before you sit down, I would like to ask how many state employees are retired now, according to your figures.

MR. DEGRAFF: Our figures are that of all the people in the retirement system, only 10 per cent ever retire and 10 per cent die; the other 80 per cent get nothing out of it except the return of their money, out of the present setup; so I would say there are around 7,500 or 8,000 presently retired state employees. If you take the retirement system as a whole, it is about 50,000.

THE CHAIRMAN: That would be about a million dollars, according to the figures Mr. Cody gave us, for that many retired employees.

MR. DEGRAFF: That would be just Blue Cross and not counting any Blue Shield.

ASSEMBLYMAN TURSHEN: Strictly hospital.

THE CHAIRMAN: Of course I think it was brought out that those costs would be down considerably under a combined plan.

MR. DEGRAFF: I can't believe that. I wouldn't want to say of my own knowledge.

THE CHAIRMAN: The state would put up $500,000 of that and the employees or the retired employees. Do you consider that an excessive amount of money to spend for hospitalization?

MR. DEGRAFF: I don't know. I would have to judge it in relationship to something else. When we say 7,500 retired employees, if you count their spouse if they happen to be married, that would increase that figure by the number who have wives and husbands.

THE CHAIRMAN: I think that figure included that.

MR. DEGRAFF: I don't think it is just the retired employee himself.

THE CHAIRMAN: That wasn't my understanding.

MR. DEGRAFF: You mean the million dollar figure included that?

THE CHAIRMAN: Yes.

MR. DEGRAFF: That might be. I wouldn't say.

MR. CODY: What I meant was this: I meant individuals. Man and wife count, too.

MR. DEGRAFF: So if you had 10,000 retired employees and each one of them had a wife or husband, that would make it 20,000?

MR. CODY: The wife of a retired employee has about the same number of expenses as the husband, so you just count them as the same. There are usually no dependent children in that area.

THE CHAIRMAN: In other words, you are saying you double that figure, or what?

MR. CODY: I tried to simplify my statement by saying that if you had 10,000 individuals that it would cost a million dollars a year. If they were all married, it would be 5,000 men and their wives.

THE CHAIRMAN: Then what would be your figure on 10,000 employees and their dependents? That is what I thought you were giving us.

MR. CODY: I would have to know whether they were married.

MR. DEGRAFF: That is why I don't like to commit myself to any figure.

Another thing I would like to mention is that I think you would find the cost of all those things increasing terrifically as age increases. I understand the cost of that type of insurance at age 70 is five times what it would cost at age twenty.

THE CHAIRMAN: I think we have some figures here. Blue Cross from Michigan shows that it is not so; that it is only three times. You said it would be—and I am quoting you—extremely dangerous for the legislature to write the provisions of a health program for state employees. Do you think that would be extremely dangerous if it was comprehensive and include all the basic coverage that the employees need?

MR. DEGRAFF: I think it would be dangerous in the sense that if you mandated all the provisions in the bill the cost might be so high that we couldn't afford to pay for it.

THE CHAIRMAN: That brings me down to the next question. What do you think is a cost that the employees could bear?

MR. DEGRAFF: Well, the employees now pay, for a family plan, a little over $100 for the Blue Cross and Blue Shield, for their wives and dependent children. For a single person I think that cost is around $75 or a little less, because it varies in every section of the state. As you know, there are eight different plans and each plan has a different premium rate, and we now subscribe to eight different plans. The people in Buffalo get the Buffalo benefits and pay the Buffalo premiums. One of the big advantages of this proposal is that you would get a uniform statewide plan where

everyone would be treated alike. That would be a great advantage. Certainly I think they would be glad to pay—well, I don't know what they would pay. It is something you would have to take up with our board of directors and the committees.

THE CHAIRMAN: Would they be willing to double the benefits as a result of state participation?

MR. DEGRAFF: You see, a thing like that, as counsel to an association I can't tell you what they would like. I can't tell you exactly. I could give you a general idea. It might be possible that if they could double the benefits of the premium, they might be interested. Some of them might prefer to have a somewhat larger benefit and perhaps lessen their present payments. It is the kind of a thing that you need to consult with the employees themselves. Our system would certainly, after doing the preliminary negotiations that we have been engaged in in the past year, talking to companies—the Blue Cross and lining up various plans that we think are attractive—we certainly would want to have wide participation by our board of directors and committee.

Now, in getting down to the detail of it, when you ask a specific question like that, I can't speak authoritatively. I would simply have to consult what the opinion is and write the opinion in the paper, to get an expression of sentiment, let the chapters discuss it, and get the sentiment in the usual way in which that is done. I certainly wouldn't want to say anything now. That is one reason I am afraid of any mandatory plan, that writes the policy in advance.

ASSEMBLYMAN TURSHEN: Let me ask you this: Did you, before your employees, many of the employees you say now have the Blue Shield and the Blue Cross—did they have negotiations or a kind of collective bargaining before they took those plans?

MR. DEGRAFF: No.

ASSEMBLYMAN TURSHEN: And compared the cost of those plans as against the regular stock insurance plans or costs?

MR. DEGRAFF: As to the Blue Cross and Blue Shield, no. We have a standard plan that is written in the area for everyone else. As to our group life insurance and our group accident and health insurance, those were tailormade.

ASSEMBLYMAN TURSHEN: This is a combination, and I think this should be negotiated, too.

SENATOR GREENBERG: I am sorry I had to be out of the room when you were speaking, but I would just like to know one thing. Am I correct in believing that it is your opinion, and only an opinion, that the majority of the state civil service employees would much rather have a plan which takes in both hospitalization, medical and surgical, than one with hospitalization only, even if it was the contemplation of the legislature to go beyond hospitalization

and in the future years they would rather have the all-inclusive program than hospitalization alone?

MR. DEGRAFF: I am quite sure of that. The committee has been discussing that. The committee that discussed the subject has come to that conclusion. They prefer a comprehensive plan, and I think there is something to be said for our friends in insurance in this state who express the danger of overloading any one side, to overload the hospital side as against the medical and surgical, and how are you going to know your proportions if you jump in first with your hospital plan without considering its relation to the other three? Now, this hospital plan costs over $120 alone. How much is going to be left for major medical and surgical? It is jumping in in advance before you know your relationship. These three should go together as one merged, comprehensive plan, rather than be considered as three things. We may have to negotiate to get a plan that is within everybody's ability to pay and have to cut down on some of the very fine provisions in the Metcalf bill and take less in order to get more beneficial things over in the surgical plan. I don't know.

SENATOR GREENBERG: Mr. DeGraff, I want to be sure that we all understand one feature of my bill, and that is that my bill does not in any way preclude the board that is set up from writing any kind of a contract, whether it be service, indemnity, Blue Cross, Blue Shield, private insurance carrier, or otherwise. Isn't that correct?

MR. DEGRAFF: That is what I like about your bill—it gives complete flexibility to take the best plan that is available.

THE CHAIRMAN: Our next speaker is Mr. Dubuar, Chief Actuary from the Department of Insurance, also representing the civil service employees.

MR. CHARLES C. DUBUAR: Thank you, Mr. Chairman. I would like to supplement Mr. DeGraff's statement. I think the employees of the association or members of the association prefer comprehensive coverage. They have been led to believe that is what they are going to get and that is the real insurance risk to them and that is what they would like to see covered.

THE CHAIRMAN: Could I interrupt you for just a moment? Who has led you to believe we were going to have the complete coverage this year?

MR. DUBUAR: Well, there is a series of events, Senator. You know a year ago the Governor in his message stated that he favored a health plan. The association at that time—President Powers wrote him a letter that we would cooperate, and those were not mere words, because in June we called a meeting with the 15 Blue Cross and Blue Shield plans and requested they give us a group contract, comprehensive, statewide, standard benefits and standard coverage. They came back in September and they did have a

comprehensive, standardized hospitalization contract. They did not have medical but they were going to work on it, nor did they have the major medical.

THE CHAIRMAN: May I ask you if you checked with the legislature?

MR. DUBUAR: Well, I will answer that in one second. Having gotten that information, I think we supplied that to one of your researchers, Mr. Metcalf, and then subsequently we were able to get a proposal from one of the insurance companies, merely for our own education and for the education of everyone else that was interested and I think we supplied that to him, not as regards to a particular company, because we didn't care anything about that. It was just the fact that here was a proposal from one of the largest companies, showing the details and showing the cost.

THE CHAIRMAN: Did you ever approach any members of this committee?

MR. DUBUAR: No. Maybe I should say we were optimistic of expectations. Now, it has been mentioned by one of the speakers that 25 per cent of the ordinary bill is for hospital service, and I ran across another analysis of a large insurer in which they threw out the small bills up to $100. There the analysis was taken of all of the larger bills but still only 44 per cent was for hospital service. As regards your bill, we would say that maybe that solves less than half the problem, as regards the insurance needs of the employee.

Probably what is more important, that analysis showed that of each 10 claims involving more than $100, three of those 10 claims ran over $1,000 and up to $5,000 or more.

SENATOR GREENBERG: Is this hospitalization?

MR. DUBUAR: This is everything. The difficulty is simply this on major medical: that a state employee cannot go out individually and buy a contract unless he is a select risk. The rate may be twice what it would be if it was a group contract with the state and the contract may be cancelled, so we would say that the state employee is really helpless to protect himself against this major catastrophe.

Now, the association, of course, is hopeful that the share of the bill paid by the state would be 50 per cent for the employee as well as for the dependent, because I understand that is the situation in Massachusetts right now. In the technical part of the bill it would seem that you could avoid some of the difficulties if you spelled out not the precise benefits, because immediately that becomes a contract with the insurer, whatever that is, but if you spelled out the objectives and then said as far as practicable the commission should try and seek those benefits, maybe that would accomplish something.

THE CHAIRMAN: Apparently, from what you said and what Mr. DeGraff said, you favor the creation of a separate bureau which

would prepare the contract between the employees and the employer. I would like to ask you if you believe that that gives the employees any guarantee of the kind of contract that they are to receive.

MR. DUBUAR: No.

THE CHAIRMAN: That is what I wanted to find out.

MR. DUBUAR: I agree the employees would be leaving themselves open unless certain objectives were spelled out—certainly the share to be paid by the state and perhaps the major aspects of the benefits.

SENATOR GREENBERG: If this was worked out on that basis, there would be no compulsion on the part of the state or the legislation that state employees would have to take it if they didn't like the contract or didn't like the cost, so that if in fact this board worked out a deal or a contract which was not satisfactory to the majority of the state employees, they simply wouldn't go into it and it would fall of its own weight. Isn't that so?

MR. DUBUAR: That is right.

SENATOR GREENBERG: So that no harm would be done if it was worked out that way.

MR. DUBUAR: They should be consulted, certainly, in any contract that they made.

SENATOR GREENBERG: Certainly they should.

THE CHAIRMAN: Thank you very much.

The next gentleman we are going to hear from this afternoon is Mr. Charles Garside, Chairman of the Board and President of the Associated Hospital Service of New York. I may add that he is a former Justice of the New York City Municipal Court, a former Chairman of the New York State Commission Against Discrimination, and former Acting President of the State University of New York, and presently Trustee of the University of New York.

MR. CHARLES GARSIDE: Mr. Chairman and members of the committee: I had not prepared testimony. I thought the best contribution I could make would be to point out some of the benefits which the civil service employees now have while covered with Blue Cross.

We have, I am sure, 25,000 civil service employees in New York, and I think it would be most unfortunate if the legislature, in adopting a plan, left any of these civil servants worse off than they presently are in terms of coverage.

Now, I am sure, in the first place, that the civil service employees would want to continue having service benefits. When they go into the hospital now, they go into semi-private rooms—that is, many of them do—and their bills are paid in full. As I understand

statistics—and I realize statistics are at time pretty unreliable—90 per cent of the employees earn $6,000 or less. Well, a man who earns $6,000 or less and has a wife or any chilren does not want to be confronted with any kind of a deductible provision in his contract. He wants to feel that if he must enter a hospital his hospital bill will be paid. There have been implications in testimony this afternoon that people who are ill will not go to a hospital if they are required to pay the first day's cost themselves or if they are required to pay $25 or $50. There is not a single bit of statistical evidence to support that notion. It is the doctor who puts the patient in the hospital and it would be a pretty poor species of doctor who decided not to put an ill person in a hospital because the patient would have to pay for the first day's coverage.

Now, secondly, I would like to be sure that the employees of the state had the right of convertibility. At the present time if one of the employees resigns or goes to another state or changes his employment, he is able to convert his group Blue Cross coverage into group Blue Cross coverage. There is no loss of continuation in his coverage.

I would like to feel also that the policy would never be cancelled because he was a bad risk or because he reached the age of 65, or any other age. He enjoys those privileges now. It is very important that he continue to enjoy them. I would like to feel that if financially it can be worked out that the retired employees will be taken care of. One of our really great social problems today is the man who has had this coverage and enjoyed it for 15 or 20 years and who at 65 is dropped from the payroll and thereafter required to keep it himself.

Now, we enable him to convert and have it himself but he must pay for it and he must pay for it with a greatly restricted personal income, and I receive some very pathetic letters from people who are retired who want to keep it up and who just find it very difficult, on a direct payment basis, to meet the cost of their Blue Cross coverage. I do not like to quarrel with my able and distinguished neighbor, Mr. Cody, but I am inclined to doubt the figures he quotes for the cost of carrying the people over 65. We have been in business for 21 years. We have accumulated some body of data on the subject. We probably have now 150,000 or more people who are over 65 covered by Associated Hospital Service of New York, and I am certain that the figures quoted, if I understand them correctly—that it would cost them another million dollars a year, and I am certain that those figures are not correct. I don't mean for one moment to imply that Mr. Cody is misrepresenting any figures, but I think it is a situation not unlike that of major medical.

The insurance companies have year by year reduced the premium on major medical as they have found that the cost is not as great as they thought it might be. Another thing I would like to be certain of is that they have the largest number of hospital days that the money can provide and it should be borne in mind that after 30

days the cost is not too heavy a burden. That is to say, we find that 92 per cent of people leave the hospital after the first 21 days; so that the balance left over to cover a longer period is not too great. I would like to feel that the Blue Cross coverage that the state employees presently enjoy will in no way be impaired.

I do not endorse nor do I speak for or against any bill. I do think there are very significant principles to be kept in mind in the enactment of legislation. We take the broad point of view of community service. We have 6,200,000 members or subscribers in the Greater New York area. That gives us a broad cross-section of the community. We have good risks and we have had bad risks, but it is that very principle of broad community risk which characterizes Blue Cross and enables us as a non-profit organization to pay no commissions, no taxes, and to do, I believe, the best job for the least possible money that can be done to provide people with hospital service.

Thank you.

THE CHAIRMAN: Our next speaker is John J. Roberts, Counsel for the Empire State Chamber of Commerce.

MR. JOHN J. ROBERTS: Senator Metcalf and members of the committee: The Empire State Chamber is a league of 144 local chambers of commerce in all parts of the state. The Empire State Chamber of Commerce is glad to see that the State of New York is giving serious consideration to making it possible for its employees to become insured for hospital expense benefits. Many of our members have such plans available to their employees, and we think it is only right that the employees of the State of New York enjoy similar protection.

However, we think it is also very important that the benefits that the state would make available to its employees be reasonably comparable to the benefits made available by other employers in the state. Provided the state feels that it is financially able to do so, it could well decide to have a plan that ranked with the leaders among other employers in the state. However, we question the wisdom of New York State as an employer going beyond the area of benefits provided by other leading employers in the state. Not only would this involve higher costs to the population of New York State through higher taxes, but it could also be a seriously disturbing influence on employer-employee relations throughout the state. It seems apparent that if the state, as employer, should institute a program which was very much more costly than those of the other leading employers, the employees of other employers throughout the state and their bargaining representatives would feel that their own employers should make substantial liberalizations in their programs. Even if the state felt that as employer it should be a leader in this field, it is still obvious that this leadership should be tempered with the practical realities. We do not profess to be experts in insurance underwriting, and I note that you have other witnesses here who are better qualified to point out

some of the underwriting problems involved in the various measures before you.

As I understand it, there are three primary measures you have under consideration. One is the bill introduced by your committee; another is the bill introduced by Senator Milmoe, and the other is the program recommended by Governor Harriman, which I understand Senator Greenberg has just introduced. The bill introduced by Senator Milmoe and the program apparently contemplated in Senator Greenberg's bill seem to fit our basic concept involving plans consistent with those in effect with other leading employers in the state. However, if we do understand the bill introduced by your committee, it goes well beyond that provided under the programs of other employers in the state and would thus be subject to the serious practical objections previously mentioned. At the same time, it leaves completely uncovered other important medical costs of the state's employees, such as cost of surgical operations and the large expenses of major medical illnesses. We understand your bill contemplates what would seem to be inevitable in any event—extension to these other fields in the future.

It would seem to us the better part of wisdom to apply whatever money the state feels it can afford in this field to provide somewhat more modest benefits in all these various areas rather than to put all the money in one area, leaving the others completely unprotected.

Now, as I say, we can only raise two points in summing up: (1) We think that the state certainly should do something to provide benefits for its employees, in keeping with what leading employers in the state have done. We don't think that they should get out and provide benefits which are far out of line with other leading employers, and (2) we think that if the bill is passed it should be more inclusive than perhaps the bill which your committee has introduced.

SENATOR GREENBERG: I would like to ask you if you could tell us now which benefits provided for in Senator Metcalf's bill would you eliminate, or would you rather not go into such detail?

MR. ROBERTS: I don't know that I would eliminate any benefits, Senator Greenberg. What we have reference to is a committee of our own studied this publication which the Department of Labor has put out and it appears to us the Metcalf bill goes beyond what most leading employers of New York have done.

SENATOR GREENBERG: In what respects? That is all I am trying to find out.

MR. ROBERTS: Well, let me point out a couple of respects in which I think it goes beyond some of our own members programs. (1) The inclusion of coverage for presently retired employees raises a serious question.

SENATOR GREENBERG: Presently retired?

MR. ROBERTS: Yes. I don't think it is the practice of employers at the present time in the State of New York to include presently retired employees when new group insurance programs are installed.

(2) While reasonable coverage for future retired employees is highly desirable, the provision of full coverage, as included in the Metcalf bill, would not only be unduly expensive but would tend to overcrowd hospital facilities. I wouldn't lay the emphasis there. I think I would lay the emphasis more on No. 1.

THE CHAIRMAN: Could I interrupt for just a moment?

MR. ROBERTS: Yes.

THE CHAIRMAN: Where do those people go now?

MR. ROBERTS: Well, I am not sure I can answer that question satisfactorily, Senator. I suppose at the present time there are a lot of people who are not in hospitals, who, if it were a lot cheaper, might very well be in a hospital, and I think the same thing is true with any kind of medical care. I think the patient always has some problem in his own mind—does he or does he not want to have a medical checkup once or twice a year, when he is faced with the problem of the cost. I am not saying they shouldn't get more.

THE CHAIRMAN: I believe Mr. Garside said in his testimony that most doctors would send a patient to the hospital if the doctor in his own mind thought the patient needed that kind of treatment, regardless of whether he had any insurance coverage or not, and I am just wondering what kind of sickness you had in mind which would negate that.

MR. ROBERTS: Let me say that I don't profess to be an expert as to when a patient does or doesn't go. I had an experience in my own family this summer where my boy, 26 months old, had a case of the hives. The doctor suggested it might be advisable to put him in the hospital but yes maybe—no maybe. I put him in the hospital, because I carry insurance, which would not mean any additional cost to myself. I am not saying that I wouldn't have put him in the hospital in any event. Being my boy and being able to afford the hospitalization, I think I would have put him in, but I think there is more of a tendency to make this service available to yourself if there is no cost or less cost.

SENATOR GREENBERG: Aside from these points that you raised with respect to presently retired employees or other retired employees, are there any provisions in the Metcalf bill that you think go beyond what private industry should give its employees?

MR. ROBERTS: I think there is one other, Senator Greenberg. I think the inclusion for dependents other than wife or children is

something that private employers have not as yet gotten around to doing.

THE CHAIRMAN: Thank you very much, Mr. Roberts.

Our next speaker will be E. S. Willis, Consultant on Employee Benefit Plans for the General Electric Company.

MR. E. S. WILLIS: As a representative of industry and as a member of one of New York State's largest employers, I appreciate the opportunity of briefly presenting to this committee some of our thinking on the subject of health insurance for state employees.

We naturally have an interest in the type of benefit program to be made available to state employees.

First, we believe in sound protection for them.

Second, as an employer in the State of New York, we have a special interest in this field because of its effect on health insurance plans we and other employers have for employees, especially if there were any likelihood that any such plans were to be unsound enough to set a bad precedent.

Third, the General Electric Company and its employees have pioneered over the years in the health insurance field and we feel it important that health insurance be practical and sound in this country so as to continue to preserve the freedom we now enjoy. We were one of the first major companies to have health insurance. The first catastrophe—or major medical expense—plan originated in G. E., and our latest pioneering was the introduction and installation of a new comprehensive insurance plan last fall which was the first time this type of program had ever been put into effect on such an extensive basis.

We feel it vital that the most effective use be made of money spent for medical care, wherever a medical care plan is being installed—in government or private industry and especially wherever it will be influential. In developing this type of plan, it is important that medical costs be placed in proper relation to other expenses. The proper usage of facilities and personnel should be encouraged rather than taking action which inflates or results in unnecessary costs. There should be incentives to carry out sound medical care procedures.

Unfortunately, all to frequently, the practice has been to pay more and more of the little expenses while sacrificing the bigger, unexpected cost. There is increasing emphasis now on also providing for the catastrophic costs but unfortunately there has been no offset against this by removing the minor bill from prepayment plans. The effect, unhappily, is to try to cover everything. This ties up too much income, has caused insurance costs to spiral because of loss of control and actually threatens the soundness of prepayment plans.

The small costs for occasional care or check-ups can and should be borne by the individual as they arise. The heavy medical costs

may have a principal portion underwritten but the individual should bear a part of these costs. Medical costs are subject to judgment of the doctor and of the individual. If the individual has a share, he and the professional personnel will be more discriminatory and will arrive at that which is best and soundest in the light of all conditions.

With respect to specific proposals at hand, I am pleased that there are two which are in the area of what we consider sound and practical.

As I mentioned, we introduced last year a comprehensive plan with a small basic deductible, and then using co-insurance (that is, with the plan paying 75 per cent to 85 per cent and the employee paying 20 per cent to 25 per cent, high maximums of as much as $7,500 of annual benefits are available for hospital, surgical, medical, nursing, medicines and other costs in and out of the hospital. This plan offered to our employees was accepted by 96 per cent of them. This is closely similar to the type of coverage the Governor has recommended in his recent message.

Also, you have before you a bill, Introductory 2467, which provides a standard type basic plan, on top of which, after a deductible of $100, there is catastrophic coverage, and in this latter portion the employee pays 25 per cent and the plan 75 per cent of costs, with $5,000 annual maximum benefits. This type of plan, we also offered our employees, and 4 per cent took it. It is a typical type of basic plus extended plan which is found frequently where catastrophic or major medical plans are available, especially when added to an already existing basic plan. The first major medical plan which was put into effect in G. E., and this was as recently as 1949, so you can see this type of coverage is new and it is still not widespread. We are happy to see catastrophic coverage being proposed, although we believe of the two types—that is, of the comprehensive or the basic, plus extended—that the comprehensive is far sounder and 96 per cent of our employees thought so, too. Its initial deductible and co-insurance made it the best approach to the medical insurance problem we think, and where a fresh start is being made, this type of plan seems to be the more logical step.

On the other hand, it is our belief that the principles in the bill, Senate Introductory 928, with its service features no deductibles or co-insurance, lack of many truly catastrophic benefits, unduly extended definition of dependents, the high share of cost of dependent coverage to be borne by the government (which also applies to the other proposals, too, but to a lesser extent), and unrestricted coverage for retired employees, represents what we believe to be a definitely unsound approach to the health insurance problem for state employees. We believe that if its principles were adopted the costs to and for state employees would be unnecessarily high and the basic principles of sound insurance for them as well as industrial employees in the state would be in danger.

We earnestly recommend that a program be adopted which will be consistent with our American way of life under which it is

possible to go forward in the payment for medical care while maintaining individual freedom and responsibility to the maximum.

Thank you for this opportunity to present our comments.

THE CHAIRMAN: Before you leave, I have a couple of questions I would like to ask. You said in your last sentence, I believe, something about being consistent with the American way of life.

MR. WILLIS: Yes.

THE CHAIRMAN: Would you indicate by that that the Blue Cross and other service benefit plans with full coverage are not . . .

MR. WILLIS: I think they are tending not to be, because the individual is not sharing in the individual costs as they accure, and I think to the extent that he has more responsibility he is following the type of responsibility that we established in this democratic way of government.

MR. CHAIRMAN: That is quite a statement.

MR. WILLIS: I don't mean to criticize Blue Cross and Blue Shield by that. I think they have done an extremely fine job.

ASSEMBLYWOMAN STRONG: Does the General Electric plan include retired people?

MR. WILLIS: Yes.

ASSEMBLYWOMAN STRONG: Of the same rate?

MR. WILLIS: No—with restrictions on their benefits and the maximum amount of benefits that are provided.

SENATOR GREENBERG: How many employees are involved under the G. E. plan?

MR. WILLIS: We have about 225,000.

THE CHAIRMAN: You said that 96 per cent of the employees took this particular program. What other program was offered to them?

MR. WILLIS: The other 4 per cent took the basic and extended. It is almost like the Milmoe bill.

THE CHAIRMAN: In other words, there was no program offered to them which included the full coverage service benefit idea?

MR. WILLIS: No, there wasn't.

THE CHAIRMAN: Then it isn't really correct to say that 96 per cent of the people voted for this?

MR. WILLIS: They had their choice of not taking any plan or taking the other plan.

THE CHAIRMAN: That is like the choice they have in Russia, isn't it?

MR. WILLIS: If we had only given them one plan, as most companies do, they would have had no choice. We gave them a choice of two plans.

THE CHAIRMAN: I think it is unfair to indicate that 96 per cent wanted a particular plan when they weren't offered something else.

MR. WILLIS: I was indicating that 96 per cent had a choice between that and the Milmoe type plan and they took the comprehensive plan.

SENATOR GREENBERG: Senator Metcalf, it is also wrong to have this record indicate—or fail to indicate that this offer to the employees of G. E. was a result of collective bargaining, which is, I believe, in the spirit of our American tradition.

MR. WILLIS: It was bargained with about 93 unions.

THE CHAIRMAN: Our next speaker this afternoon is Dr. Edwin F. Daily, President and Medical Director of the Health Insurance Plan of Greater New York, Chairman of the Public Health Council of the State of New York and members of the Board of Hospitals of the City of New York. He was Chairman of the Committee on Prepayment of the Commission on the Financing of Hospital Care, sponsored by the American Hospital Association. Dr. Daily.

DR. EDWIN F. DAILY: Mr. Chairman and members of the committee: I would like to read first a statement on the Metcalf bill, as prepared by Dr. Baehr, who is President and Medical Director of the Health Insurance Plan. Later I would like to comment briefly on the bill introduced by Senator Greenberg.

Statement Concerning S. 970, Int. 928, and A. 1311, Int. 1284, A Bill To Amend the Civil Service Law, in Relation to Providing Hospital Service Benefits for State and Retired State Employees

Submitted at Hearings Held in Albany, New York, on February 22, 1956, by George H. Baehr, M.D.

The Metcalf-Strong bill, introduced by its sponsors in the State Legislature on behalf of the Joint Legislative Committee on Prepayment, conforms with the basic principles for prepayment of hospital care laid down by the American Hospital Association, the Commission on the Financing of Hospital Care, the President's Commission on Health Needs of the Nation, the Committee on Medicine in the Changing Order of the New York Academy of Medicine, and other impartial agencies concerned with public

* Dr. Baehr is President and Medical Director of the Health Insurance Plan of Greater New York, Chairman of the Public Health Council of the State of New York and member of the Board of Hospitals of the City of New York. He was Chairman of the Committee on Prepayment of the Commission on the Financing of Hospital Care sponsored by the American Hospital Association (Prepayment and the Community, McGraw-Hill Book Company, 1955).

health and its relation to hospital and medical care. As a physician concerned with public health and with the hospital needs of low-income families, I wish to be recorded in support of this bill. I respectfully urge that it be adopted in its present form without amendments which might reduce its all-inclusive hospital service benefits or necessitate payment by state employees of additional charges for semi-private hospital care at times of illness.

The bill's objective is to provide state employees and retired employees and their families virtually complete hospital service benefits in semi-private facilities without additional hospital charges at times of illness and without gaps in benefits coverage. By its passage the State of New York will set the standard for all other states.

The bill will enable physicians to utilize all the resources of modern hosiptals as aids to proper diagnosis and adequate treatment without any financial barriers to their use. It will enable state employees to budget hospital costs for their families by means of prepayment, with full confidence that they will not be unexpectedly confronted with additional hospital bills in unpredictable amounts at times of exceptional financial strain due to serious illness.

These objectives cannot be realized by cash indemnity plans of commercial insurance carriers which provide only partial reimbursement for hospital costs. The deductible clauses in their policies, which indemnity plans require in order to remain solvent and which require the patient to pay the first $50 or more of the hospital bill, plus the co-insurance clauses which require him to pay part of the remainder of the hospital bill are undesirable for low-income families. It has been claimed that deductibles and co-insurance are needed to curb unnecessary hospital use but they do not accomplish this purpose.

Unnecessary hospital admissions are due chiefly to the fact that many insured persons are not covered by insurance for the cost of diagnostic and minor operative procedures outside of the hospital. They therefore tend to use in-hospital services for these procedures and they occupy a costly hospital bed in order to save themselves some money. It was the observation of the Commission on the Financing of Hospital Care that this human tendency can only be corrected by having the prepayment plan provide payment for the use by the patient's physician of supplementary and much less costly out-patient facilities. This safeguard has been provided in the Metcalf-Strong bill.

The commission on the financing of hospital care has this to say about deductible provisions in indemnity insurance:

> "When the total costs (of hospital care) are considered, many families who might appear to be able to meet the cost of a relatively small deductible amount would find it impossible or difficult to meet this portion of a hospital charge because of other expenses incident to illness.
>
> "To whatever extent a deductible-benefit provision means that a portion of the hospital bill is not paid, or is only

partially paid, the purpose of voluntary prepayment for the community and the hospital is not fulfilled. For the patient the value of his protection, when needed, is reduced."

Actually, the deductible clauses and the co-insurance features of cash indemnity plans are designed by commercial carriers primarily to lower the premium and thereby make indemnity insurance financially more attractive to employers and employees who share the cost under a contributory arrangement. Cheap hospital insurance with deductibles and gaps in benefit coverage is not a bargain. When indemnity insurance pays only a fixed amount per diem, it leaves the family with an open-end obligation of unpredictable magnitude at the time of illness when they can least afford it. For the moderate-income family, this is poor insurance.

In contrast, the Metcalf-Strong bill will enable state employees and their families to use hospitals when necessary without financial barriers which promote delay and neglect.

Retired Employees

I should also like to commend the Joint Legislative Committee and the sponsors of this bill for providing coverage of retired state employees without any reduction in benefits or increases in premium. This is in accord with a suggestion which I offered recently to the Governor's Conference on Problems of the Aging in regard to non-profit medical as well as hospital service plans incorporated under the state's insurance laws.

Older people after the age of retirement have greater need for medical care than at any time of life except during infancy and, in women, during their child-bearing years. In our experience (HIP), people over 65 average 7.5 physicians' services a year in contrast to an average rate of 5.2 services required by the insured population below 65. The average retirement income of old people barely meets minimum subsistence needs. Few can afford the higher premium rates or the reduced benefit coverage for the aged which are characteristic of indemnity insurance plans. For these reasons, most of our aged citizens are medically indigent. The state has a moral obligation to protect its retired employees from this hazard.

The method is simple. The risk can be spread over the entire insured population of all ages, a principle generally applied in group insurance to other high utilizers in the covered population. A hospital service prepayment plan could do this if both the state and the retired employees continue to share the current premium cost.

By enacting the proposed legislation which provides undiminished prepaid hospital service benefits for its retired employees on a contributory basis, the state will be setting an example to private employers and labor union welfare funds. In this manner, the bill points the way to the progressive reduction of medical indigency among our older citizens.

SENATOR GREENBERG: Doctor, you say, at the top of page 3 on your statement—you refer to less costly outpatient facilities.

DR. DAILY: Yes.

SENATOR GREENBERG: And then you say: "This safeguard has been provided in the Metcalf-Strong bill." I thought this bill only covers in-hospital service.

DR. DAILY: On page 4, line 25, of the Metcalf bill, it specifically states that the bill will also cover the use of out-patient facilities of hospitals as well as the in-patient. In other words, if you have a minor fracture, it doesn't require that the individual go in and occupy a bed which is costing some $27 a day. That individual can be taken to the emergency out-patient service of the hospital. The patient may be there only an hour or two.

SENATOR GREENBERG: You mean unlmited ancillary services? Is that what you mean?

DR. DAILY: Page 4, line 25.

SENATOR GREENBERG: Oh—line 25. I see.

DR. DAILY: Emergency service in the out-patient facilities of the hospital, minor surgery, and things of this type are very important. It is already covered by Blue Cross and is very good.

SENATOR GREENBERG: Emergency service isn't minor surgery, is it?

DR. DAILY: Well, most of these things. Otherwise, if a patient didn't get that care in the emergency service of a hospital, they would have to go into a bed in the hospital. Blue Cross today pays $7.50 to the hospital for the use of its out-patient facilities for a day. If that patient went into a hospital bed, in-patient, the cost would be in excess of $20 for that one day. This is very important.

May I make a few comments on Senator Greenberg's bill? We like this bill very much. It plans ahead for a more comprehensive legislative program. However, I would like to suggest amendments here which would assure the civil service workers and their families that they were going to receive comprehensive medical services and that the premiums that were going to be paid under this bill would pay all of the costs, because I think these two principles are all-essential and I believe they should be incorporated even in this early legislation, and in the first sentence of your bill there, on page 1, line 8, Senator Greenberg, I would suggest that when you speak of the term "health insurance" that it means insurance to pay the entire cost of the following—"except for medical conditions excluded by the State Employees Insurance Board"—and then you listed a series of things that you wish to have covered, such as similar private hospitalization, and I would put in "preventive diagnostic and

remedial services at home, office or hospital by family physicians and all types of medical specialists." That is comprehensive medical care. Prescribed drugs and medicines you have mentioned. Prosthetic appliances, dental care and dental surgery and cosmetic surgery when required as a result of an accidental injury. It is my point that the bill should leave no question as to what the hospital and medical services are you have planned to provide and that it should certainly protect the insured families by having premiums pay the entire cost, and it will not be conceivably a cash indemnity type of product which may be no insurance at all.

SENATOR GREENBERG: Do you recommend that this bill of mine be amended to include home service?

DR. DAILY: You have stated in there medical and surgical expenses without specifying.

SENATOR GREENBERG: Doctor, I am asking you do you recommend that this bill be worded so that it will include home medical service?

DR. DAILY: I believe that it should provide medical care in the doctor's office, in the patient's home and the hospital.

SENATOR GREENBERG: Does Blue Cross now include medical service in the doctor's office and at home?

DR. DAILY: Blue Shield has a rider to its present contract.

SENATOR GREENBERG: The standard Blue Shield contract written by the Associated Hospital Service of New York City, or United Hospital—does it include service at home?

DR. DAILY: Blue Shield will write a contract—

SENATOR GREENBERG: Does it, Doctor? Is it now the general standard policy?

DR. DAILY: I won't speak of their general policies.

SENATOR GREENBERG: Isn't there a big difference between the one your people write and Blue Shield writes?

DR. DAILY: Our policies, which covers half a million people, do provide complete coverage for home, office and hospital care. A very small portion of Blue Shield people also have some coverage at least for services provided in office and home.

SENATOR GREENBERG: A very small portion.

DR. DAILY: A very small portion, it is true.

ASSEMBLYMAN TURSHEN: You honestly feel, then, according to your statement, that there can be a way of apportioning the cost so as to include the retired employee and still not too greatly raise the amount of the premium?

DR. DAILY: We have given a year's study to this, and it is our belief from our own studies—and we have a great deal of data on services for various age groups—that this can be done, and we are surprised that it hasn't been done before, and I am delighted to see that you are moving in that direction.

THE CHAIRMAN: The next speaker is Herbert Levine, Corresponding Secretary of the Union of State Employees, Local 382, Government and Civic Employees, AFL-CIO, of New York City.

MR. HERBERT LEVINE: Mr. Chairman and members of the committee: The Union of State Employees, Local 382, Government and Civic Employees, AFL-CIO is gratified to note that, at long last, the New York State Legislature and the Governor's office are giving serious consideration to providing the employees of the State of New York with prepaid medical and hospitalization insurance, part of the cost to be borne by the State of New York. Our union of state employees has advocated that such a measure be enacted for many, many long years. It has been a part of the union's legislative program since the late Mayor Fiorello H. LaGuardia instituted such protection for New York City employees. Senator Friedman and Assemblyman Farbstein have for years, and this year Senator Furey, introduced a simple bill which would authorize the comptroller of the State of New York to contract with a non-profit membership corporation, organized under article nine-c of the Insurance Law for the purpose of furnishing medical, surgical and hospital service to persons who contract with such corporation. If this bill is enacted, it will enable the State of New York to provide for a complete system of prepaid medical, surgical and hospitalization care for employees and their families. Our union has for years sponsored this bill.

Unfortunately, up to the present year no real consideration was given by the legislature to this bill or to any other similar bill. It was only last year that, following closely upon Governor Harriman's recommendations in his annual message to the legislature, that a real study of health insurance was begun and concrete action taken.

We have read over carefully Senate Int. No. 928, a bill introduced by your Chairman, Senator Metcalf, to provide hospital service benefits for state and retired employees. We have also studied the report of your research staff graciously provided to us by Frank W. Van Dyke, your Project Administrator. We are of the opinion that while the bill as written is a good one, it does not go far enough. Many features of the bill are excellent and your committee is to be congratulated for incorporating them in the bill. You approve the principle of employer contribution; you insist on a good service contract; you insist on convertibility upon severance from service; you insist upon a non-cancellable contract except for fraud. This is excellent. The bill provides for 120 days of hospital care at very little extra cost in premium. This is a splendid feature of the bill. There are other features of the bill worthy of commendation, such as service benefits

providing full coverage, with no deductible features, but I do not wish to take up too much of the committee's time. Suffice it to say we have no quarrel with the bill as far as it goes.

On the other hand, the bill does not go far enough. There is no decent reason why employees of the State of New York should not receive this year coverage on health insurance as ample as that enjoyed for many years now by employees of the City of New York. A reading of the Project Administrator's report almost leads one to believe that the Columbia University group, which made the study for your committee, was instructed to merely report on hospitalization insurance for this year. Reading the report makes one think in terms of a mile runner at the starting mark, getting ready to do 11 laps around the Madison Square Garden track, and suddenly being told by the starter that all he has to run are four laps. And the reason given in the report is lack of time available to study medical and surgical benefits. Surely a year is time enough. Happily the report concludes that in addition to hospitalization additional considerations for provision of prepayment coverage should include medical benefits for state employees and retired employees and their dependents and an extended benefits program, based on the service benefit principle, as a valuable adjunct to a sound program of basic hospital and medical benefits. Happily, too, Governor Harriman, in a special message to the legislature, has called for the state contributing to the cost of hospital and medical insurance. We support the Governor in his proposal to authorize the Civil Service Department to negotiate a contract with private companies operating in the field. We disagree only with his suggestion that the state pay only a quarter of the cost of coverage for dependents of state employees. We believe the state should pay half in their case as in the case of employees themselves.

If the legislature were to enact only the hospitalization bill, it would be merely delaying the inevitable day when it will have to enact the medical and surgical aspects of health insurance, without which no health insurance program is worthy of the name. It would also be doing an injustice to the thousands of employees who are today carrying on their own the burden of paying for Blue Shield surgical and medical care. To them, passage of the proposed hospitalization bill alone would still leave them holding the bag as far as that aspect of hospitalization is concerned. I am referring to the surgical and medical.

We are convinced that your committee fully intends to finally provide for a complete health insurance program for state employees. Everything you have done and said and everything the Governor has done and said points in this direction. Why not this year? The details can be worked out, as the Governor has said, through negotiations, which have already begun. But let us get the enabling legislation passed. We support the Furey-Farbstein bill (Assembly No. 59, Senate 81) which will accomplish this purpose, but I am just as willing to support the Greenberg bill.

Let us have the complete plan this year—medical, surgical, dental, drugs, hospitalization. Half the cost by the state, the other half by the employees. Benefits to employees, dependents, retired employees, and to those who leave the service in some form or other.

As an organization of state employees organized into AFL-CIO, we also insist that whatever legislation finally passes, no employee organization shall be permitted, as is the current practice in hospitalization in the state, to act as an intermediary for collecting premiums (and to charge the employees for it, no less, as is done today). The state is rich enough to handle this matter of collections on its own and no employee organization should be given a favored position in this respect. While the matter of life insurance is not the subject of discussion today, may I say that it would be well if the state took over the sale of group life insurance, as the Federal Government has under President Eisenhower, and put an end to the practice of having state employees being made captive members of an employee organization because they want to avail themselves of the benefits of group life insurance.

Thank you for your kind attention.

THE CHAIRMAN: How many members do you have of state employees?

MR. LEVINE: How many members?

THE CHAIRMAN: Yes.

MR. LEVINE: In our organization we have thousands of state, city and county employees.

ASSEMBLYMAN SILL: How many are state employees that would be affected by this thing?

MR. LEVINE: I prefer not to get into that.

ASSEMBLYWOMAN STRONG: When you refer to Governor Harriman's message, are you referring to the one this year?

MR. LEVINE: Yes. Only a few days ago that was published in the papers.

ASSEMBLYWOMAN STRONG: I thought it might be interesting for him to know that we have been working for months on this problem.

THE CHAIRMAN: It occurred to me, while Mr. Levine was speaking, that he talked quite a bit about our research group. We have in that group, on my right Dr. Ray Trussell, who is the Director of the Columbia School of Public Health, and Frank Van Dyke, our Project Adminstrator, and Dr. Dwight Barnett, who has helped Dr. Trussell at considerable length. Maybe they would like to stand and be greeted by everyone here. (Applause.)

The next speaker is Harold Rubin, representing the New York State Commerce Department, Chapter C.S.E.A.

MR. HAROLD RUBIN: Mr. Chairman and members of the committee: For the past two years the Department of Commerce

Chapter of the New York State Civil Service Employees Association has studied the problem of employee health insurance and the following is the essence of the thoughts of this group as to the most desirable form of such insurance.

The chapter feels the state should appropriate funds sufficient to bring full medical, surgical and hospital care within the reach of the average state employee and his family. The amount that the low-income state employee can contribute to such insurance is necessarily limited. If the state's contribution is also limited, it may be necessary to settle for a somewhat less comprehensive program. If this is the case, we have definite opinions on which of the phrases of insurance are essential.

State employees are low to middle-income workers and lack reserves for protection against protracted illnesses, expensive surgical operations and similar catastrophic events. Normally, however, they can handle everyday, minor medical costs like doctor's visits and drugs. Therefore, if the insurance provided must be limited, curtailment should be at the "first dollar" end rather than at the catastrophe phase of an illness. Insurance with a deductible feature should greatly reduce premium cost, since it would drastically cut the number of claims processed and paid. At the same time, the state employee would gain a sense of security that comes with the knowledge that his life's savings would not be wiped out by accident or protracted illness.

Catastrophe type coverage is not very expensive when undertaken for a large group and has been successfully provided by such progressive employers as the General Electric Company, Prudential Life Insurance Company and Sears-Roebuck, among others.

ASSEMBLYMAN TURSHEN: How long have you been studying that?

MR. RUBIN: For two years. We have had meetings and sent out literature on various plans.

THE CHAIRMAN: Our next speaker is Mr. Winslow Carlton of New York City, who is Chairman of the Board of Group Health Insurance, Inc.

Mr. Carlton.

MR. WINSLOW CARLTON: In the interest of saving time and also in the hope of making some additional remarks on the basis of what others have said this afternoon, if I might I will file this statement and just briefly, if I may, pick out what I think are the principal points. I would like to point out, as we do in the first paragraph, that our suggestions here are based on some 18 years of work in this field. We feel that our experience is perhaps worth passing on to the committee.

Our experience and our thinking on this subject has been sharpened by a very tough competition. We are one of three nonprofit medical service plans in New York City, and, of course, all of the standard insurance companies are actively at work plowing up

the field, so we don't lack for the sharpening influence of other people's thinking.

First of all, we would like to support what has been said by many other testifiers today—the desirability of including medical care in the early legislation. To deal only with hospitalization is giving something less than half a loaf.

I would also like to point out, as I think Dr. Daily implied, if he didn't state it, that adequate physician care can often avoid the need for hospitalization altogether, but whether you decide to include medical care this year, the bill now under consideration, the Metcalf bill, reflects one principle which is, in our opinion, the most fundamental and essential of any good program of health insurance; namely, the provision of service benefits, and I will not repeat the arguments in favor of service benefits as against indemnity benefits, because I think that has been very adequately covered. I would, however, like to cite a study made by Martin E. Segal & Company, consultants to many welfare funds, which Mr. Segal released just a couple of months ago.

Let me read this paragraph:

> "Our company analyzed over 10,000 surgical claims where benefits were paid under a $150 surgical schedule. We found that this surgical schedule paid only 55 per cent of the surgeon's total charges. A similar analysis, for claims paid under a $225 surgical schedule, showed that such a schedule paid 60 per cent of the surgeon's total charges. And an analysis of claims paid under a $300 surgical schedule showed that such a schedule paid only 69 per cent of the surgeon's total charges. As you can see, a 100 per cent increase in the surgical indemnity schedule served to reduce the patients' share of the bills by only 14 per cent. In other words, this study demonstrates that, without service benefit provisions, cash indemnity insurance pays only a part of medical care costs. Adequate financial protection can be assured only when the suppliers of health care, whether they be hospitals, doctors or dentists, agree to accept as full payment the amounts paid by the insurance plan."

I think we should recite the result of hearings held last year in New York City under the joint auspices of Columbia University School of Administrative Medicine and Group Health Insurance. We have had representatives from both labor and management, representing over a million employed people, come to those hearings, and almost without exception—perhaps the only exception being here today, Mr. Willis—they emphasize the importance and need of service benefits, especially for lower-paid people. They also, I should add, emphasize the importance of service benefits for general medical care, rather than the kind of extensive coverage that is usually called major medical, and this again especially for people in the lower-income brackets.

In summary, this first principle of service benefits seems to us the very cornerstone of a health insurance program for the state's

employees. It is important in hospitalization insurance. It is still more vital to the welfare of the state's employees in insurance covering the cost of doctor's care. Whether or not you decide to proceed with the latter this year, it is, in our view, essential that this basic matter of principle be established at once.

There is another policy principle that, as a matter of practical necessity, flows from the decision to provide for service benefits. This is the necessity of decentralizing the health insurance program, and the reason for this is the manner in which service benefits are arranged for. It is almost essential—indeed it has been found essential throughout the country, I believe, to have these service plans set up on a local or at least a regional basis within a given medical market area, where the conditions of practice and the standards of fees are similar. If you try to do this kind of thing over a wide and diverse area such as the Empire State, then you fall into the odd situation of having benefits that in some areas over-pay and in other areas under-pay, so that you don't achieve your purpose.

What is clearly the commission's central objective must be kept in mind; that is, to secure a constant benefit for each state employee, constant in the sense that he or she will have in his home community hospitals, doctors, and eventually, I trust, dentists, who stand ready to provide him and his dependents with needed health services in return for his premium payments, of which the state contributes half.

Now, we realize, of course, that not every area within the state is currently covered by a medical service plan. There are indications, however, that the main areas of deficiency will soon be corrected. But if these hopes are not realized, Group Health Insurance, Inc., stands ready to organize service plans in the delinquent areas, provided that legislative license is given to 9c corporations to operate in more than 18 counties of the state. At the present time the law under which we operate restricts each such corporation to a maximum of 18 counties, and it is assumed they are 18 contiguous counties.

Finally, I would urge that in decentralizing the program in order to provide for service benefits, the advantages of group enrollment will not be lost to the state and its employees. In order to achieve that purpose and still have the benefit of local service plans, we suggest, as a matter of procedure, of mechanics, that in each medical market area where there is a sufficient number of state employees to make it worth while, local boards representing the state offices in that area be set up that would be at least advisory to a central board or group established here in Albany. Whether it be the Civil Service Commission or the Civil Service Department or some other board is a matter on which I can't speak, but it seems very important that the local opportunities be thoroughly investigated by the people who are going to use them, and in that way we think that the very best program that the state and its employees can afford will be formulated.

May I add that we strongly support, as Dr. Baehr did, the idea of covering the retired employees? In our plan people have the right of conversion, and as our members retire—and we have 300,000 of them now—they have the right to convert. It would, however, be very desirable to make it possible for them to convert without an increase in premium; that is, without losing the state's contribution and without having a higher premium and reduction of benefits because of their age.

I would finally like to point out that a really very comprehensive medical and hospital care program is now in existence in the New York area in the hospitalization provided by Associated Hospital Service and the medical part of the program provided either by the Health Insurance Plan or by Group Health Insurance in its family adopted plan, and I thought you might be interested in the premium cost of that plan.

For individuals the cost per month is $5.16 and for families of two or more, on a two-rate basis, the cost is $13.71. If as the study groups report shows, 40 per cent of the state employees are single, then the average cost per contract of this coverage I have just described would be $10.30, within a few pennies, per month per contract.

ASSEMBLYMAN TURSHEN: Do you have any actuary figures at all, as to what it would be for the cost of the retired employees?

MR. CARLTON: I regret to say that I do not, sir.

ASSEMBLYMAN TURSHEN: Could you get that for us, if possible?

MR. CARLTON: We would be glad to.

ASSEMBLYMAN TURSHEN: We would appreciate it. I would like to see it as contrasted to some of the other figures.

SENATOR GREENBERG: Do your figures include hospitalization, medical and surgical?

MR. CARLTON: It is all-inclusive—medical and surgical—and medical includes care in the home or doctor's office and consultation with specialists.

SENATOR GREENBERG: And hospitalization?

MR. CARLTON: And hospitalization.

ASSEMBLYMAN SILL: That includes catastrophic illness?

MR. CARLTON: To this extent: there is no limitation on the amount of doctor's services the plan will pay for. There are no certain number of visits that it pays for and then it is cut off.

Testimony at Hearings, February 22, 1956, on Senate Bill No. 970, Introductory No. 928 (Mr. Metcalf), Before the Joint Legislative Committee on Health Insurance Plans, State of New York, of Winslow Carlton, Chairman of the Board, Group Health Insurance, Inc., 120 Wall Street, New York 5, New York

Mr. Chairman and Gentlemen: My name is Winslow Carlton. I am Chairman of the Board of Group Health Insurance, Inc., a New York membership corporation organized and operating pursuant to Article 9c of the Insurance Law. Our offices are at 120 Wall Street, New York 5, New York.

I appreciate the courtesy of your invitation to present the views of my colleagues and myself specifically on Senate Bill No. 970, and, more generally, on the subject of health insurance for state employees and their dependents. I last appeared before a New York Joint Legislative Committee 17 years ago in connection with recodification of the Insurance Law. It was at that time that the basic enabling act for non-profit hospital and dental insurance plans was written. The organization I now represent, then known as the Cooperative Health Association of New York, had started the year before, and as I remember it, we had about 100 subscribers and 50 cooperating doctors. Today we have 300,000 scubscribers and 11,000 participating doctors. As a non-profit organization, with a board composed half of doctors and half of laymen, we have devoted our efforts to pushing out the frontiers of voluntary health insurance. For example, we were the first organization in the state to offer "service benefits," and we are the only one to have removed any forms of means test from the right to "service benefits." GHI was also the first to include benefits for in-hospital medical care in addition to surgical care. We demonstrated the soundness of that important addition to hospitalization and surgical coverage, and now something like 35,000,000 people in the country have this type of benefit. More recently, we have sponsored the first dental service insurance plan in the United States, Group Health Dental Insurance, Inc. I cite this record to indicate that the suggestions we have to offer are based on considerable thought and experience in the health insurance field. I should add that both have been sharpened by extremely tough competition with other non-profit plans and standard insurance companies. We are not complaining. We think competition is good, indeed a necessary thing, and we are not in favor of monopolies—even non-profit ones.

The first thing I must observe about Senate Bill No. 970 is that it makes no provision for the coverage of doctors' bills. The research staff's report, with which you were kind enough to furnish us, makes it clear that the reason for this omission is a desire to make a more thorough study of medical care insurance before recommending its inclusion in the program. While we sympathize with this desire to get all the facts before making a decision, we feel obliged to voice our conviction that a health insurance program without any provision for the coverage of physicians' services is considerably less than half a loaf. After all, physicians' services take substantially more of the medical dollar than do hospital

services. And in terms of effective health care, the hospital, through an enormously important element, still is only ancillary to the physician. We would, therefore, urge you to make definite provisions for medical service insurance as well as hospital service insurance in formulating a contributory program of health insurance for the state's employees.

Whatever you decide to do in this regard in the current session, the bill now under consideration reflects one principle that is, in our opinion, the most fundamental and essential to any good program of health insurance; namely, the provision for "service benefits." These are clearly dealt with in Section 55 of the bill. As I am sure the committee knows, "service benefits" means that the bill for a covered service is paid in full by the insurance plan. For any plan to be in a position to guarantee this—whether hospital or medical or dental services are involved—requires, as a practical matter, a formal agreement between the insurance plan and the provider of the services. Without such an agreement, a plan offering "service benefits" is signing a blank check.

Several methods are employed to accomplish the "service benefit" result. The most common method used by medical care plans is to secure signed agreements from individual physicians, who, by this act, become participating physicians. Their names are then listed so that subscribers to the plan may know if the physician whom they are consulting is or is not prepared to provide his services within the terms of the plan. Most of such plans—and GHI is one of them—pay the same amounts toward the bill of a non-participating physician, if the subscriber wishes to use such a physician, as it pays a participating physician. This means that the subscriber is not restricted in his choice of doctor to those who are participating in the plan. It is probably financially to his advantage to use a participating physician, but he is not compelled to do so in order to secure benefits from the plan.

The practical significance of "service benefits" is clearly demonstrated by a study conducted by Martin E. Segal and Company, consultants to many welfare funds. Mr. Segal reported last October to the Western Conference of Pre-Paid Medical Care Plans as follows:

> "Our company analyzed over 10,000 surgical claims where benefits were paid under a $150 surgical schedule. We found that this surgical schedule paid only 55 per cent of the surgeon's total charges. A similar analysis, for claims paid under a $225 surgical schedule, showed that such a schedule paid 60 per cent of the surgeon's total charges. And an analysis of claims paid under a $300 surgical schedule showed that such a schedule paid only 69 per cent of the surgeon's total charges.
>
> "As you can see, a 100 per cent increase in the surgical indemnity schedule served to reduce the patients' share of the bills by only 14 per cent."

In other words, this study demonstrates that, without "service benefit" provisions, cash indemnity insurance pays only a part of

medical care costs. Adequate financial protection can be assured only when the suppliers of health care, whether they be hospitals, doctors or dentists, agree to accept as full payment the amounts paid by the insurance plan.

That most buyers of health insurance for large employed groups recognize this fact, whether they represent management or labor, was demonstrated at hearings held a year ago in New York City under the joint auspices of Columbia University's School of Administrative Medicine and GHI. Almost without exception, the testimony, which came from men representing over 1,000,000 employed people, emphasized the importance of "service benefits." I am sure that the committee's research staff has cited these findings in their more detailed reports, but we would be happy to supply copies of the record if the committee wishes.

In summary, this first principle of "service benefits" seems to us the very cornerstone of a health insurance program for the state's employees. It is important in hospitalization insurance—it is still more vital to the welfare of the state's employees in insurance covering the cost of doctors' care. Whether or not you decide to proceed with the latter this year, it is, in our view, essential that this basic matter of principle be established at once.

There is another policy principle that as a matter of practical necessity flows from the decision to provide for service benefits. This is the necessity of decentralizing the health insurance program. No single carrier organized under Article 9A or 9C of the Insurance Law can provide service benefits uniformly throughout a state. The reason is that hospital and medical costs vary widely from region to region. Effective service arrangements must usually be negotiated and administered within what may be called each "medical market area." Given the same scope of benefits, a plan in one community may cost substantially more than in another community. Albany, for example, is known as a relatively low medical cost community, whereas New York is a relatively high one. Thus, any statewide plan based on standard cash payments for covered services would overpay in some areas and underpay in others.

It should be added that corporations organized under Article 9C of the Insurance Law are restricted to operation in not more than 18 counties. For this reason no one of these corporations would qualify under the present language of Section 52 of the bill now under consideration. In view of the emphasis given elsewhere in the bill to "service benefits," I assume that this language was included inadvertently.

What is clearly the commission's central objective must be kept in mind. That is, to secure a constant benefit for each state employee, constant in the sense that he or she will have in his home community hospitals, doctors, and eventually, I trust, dentists, who stand ready to provide him and his dependents with needed health services in return for his premium payments, of which the state contributes half. This objective can be accomplished if recognition

is given to the necessarily local character of service plans and if the state's program is formulated accordingly.

We realize, of course, that not every area within the state is currently covered by a medical service plan. There are indications, however, that the main areas of deficiency will soon be corrected. But if these hopes are not realized, Group Health Insurance, Inc., stands ready to organize service plans in the delinquent areas, provided that legislative license is given to 9c corporations to operate in more than 18 counties of the state.

Finally, I would urge that in decentralizing the program in order to provide for service benefits, the advantages of group enrollment will not be lost to the state and its employees. The alternative is some form of individual enrollment. The cost of individual policies is very much higher than those available on a group enrollment basis. This is principally because the risk cannot be spread as widely under conditions of individual enrollment. The whole principle of health insurance is, of course, to spread the cost of caring for those who fall sick over a much larger number of people who are well. This is best accomplished by group enrollment.

What we suggest is that the Civil Service Department be empowered to set up in each "medical market area" a board representing the state offices in that area, and that this board pick the best plans in each of the fields to be covered—hospitalization, medical care, and, I repeat, eventually dental care—available in that area, all under a general directive promulgated by the Civil Service Commission or some other appropriate body.

We at GHI know that the state employees have the judgment and experience necessary to make these choices at the local level. For example, the Association of New York State Insurance Department Examiners in New York City reviewed all available plans in our part of the state and, after several months of careful deliberation, selected Associated Hospital Service for hospitalization and GHI for medical coverage. Under the general supervision of the Civil Service Department, this kind of procedure could be applied to all offices in a given area on a united basis. In this way we sincerely believe that the State of New York, as an employer, will achieve the optimum health insurance program for its employees, to the benefit of the entire state.

THE CHAIRMAN: Our next speaker is Edward Meacham, Director of the Division of Personnel Services, New York State Department of Civil Service.

MR. EDWARD D. MEACHAM: I want to express the appreciation of the Civil Service Department for this opportunity to appear before the Joint Legislative Committee on Health, Accident and Hospital Insurance Plan, with respect to Senate Bill No. 970. We note that this bill would provide certain hospitalization benefits for employees and retired employees but would not provide other medical and surgical services. The Department is deeply interested in employee

benefits generally and particularly in plans to assist employees in meeting the financial burdens of illness or accident. A health insurance plan must be considered a desirable employee benefit since it would meet a real need, it can be provided on a universal basis, and it would benefit employer as well as employee. Also, in an effective medical benefit plan the employee, through joint action with the employer, obtains something which he could not obtain by himself.

In providing for state employees' protection against the financial burdens of illness, the following objectives should be considered:

1. Adequate protection.
2. Uniform benefits for all employees, regardless of geographic location.
3. Reasonable costs both to employees and to the state.
4. Continued eligibility for participation after the employee retires.

To achieve these objectives, we believe certain basic principles must be incorporated into any sound health insurance plan for state employees. These principles are discussed briefly below.

First, the benefits provided should be comprehensive in character. The state employee needs protection not only against the costs of hospitalization but also against the other substantial costs of illness. Therefore, the plan should pay not only for hospital services and for medical and surgical services rendered in the hospital but also for similar professional services rendered outside the hospital. Not only the smaller medical expenses but also the expenses of illnesses or accidents of a catastrophic character should be covered. It is recognized that many serious illnesses or accidents require hospitalization, but, nevertheless, some effort should be made to protect the employee against substantial financial burdens arising out of illness or accident where hospitalization is not involved. While it is probably not practicable at this time to obtain a plan which will place no limitation on the benefits to be provided in case of prolonged illness, nevertheless, substantial amounts, for example, a $7,500 per year maximum or a $15,000 lifetime maximum, may well be feasible.

Necessarily, the cost of providing comprehensive coverage is greater than that of providing more limited benefits, but in our opinion the employees who are to participate should have an opportunity to consider the broadest possible coverage.

A second important principle is that the plan provide for benefits on a service rather than on a limited cash indemnity basis only. We are glad to note that Senate Bill No. 970 incorporates this principle even though it provides only hospitalization benefits. We believe the expenses that are reasonable and necessary should be paid for under the plan. While practically all plans have provision for payment on a cash indemnity basis for certain services and under certain conditions, it is best that these be kept to a minimum and that the basic principle of providing services be maintained. By incorporating into the plan the service benefit principle, the

desirable objectives of adequacy and uniformity will be much more readily attained.

The principle of co-insurance should be considered since it affects the cost which the employee will have to pay and also the range of benefits which can be provided for him. This principle can be incorporated in a number of different ways including the "deductible" feature under which the employee pays for a reasonable amount of medical expenses before any payments are made by the insurer; the "corridor" plan, under which the employee pays a fixed amount after basic benefits have been exhausted and before extended benefits become payable; through sharing the costs of prolonged illness, for example, on a basis of 15 per cent or 20 per cent paid by the insured and 85 per cent or 80 per cent paid by the insurer. In effect, exclusions of specific types of services in a contract may also be viewed as a form of co-insurance. There are, of course, disadvantages for the employee in any plan which provides for co-insurance since he will, under such a plan, bear a portion of the hospitalization, medical and surgical costs of illness himself. Some persons feel that the deductible feature tends to discourage proper use of the health insurance plan. There are also certain administrative problems involved in the use of these co-insurance devices. Against these disadvantages must be weighed the greater costs involved in providing payment of all expenses involved in illness or accident. Paying for all expenses, no matter how minor, may be costly without providing commensurate benefits in return. It should be noted further that there are various ways in which the co-insurance devices may be applied. For example, in a comprehensive plan a deductible could be applied against out-of-hospital services only if that were considered appropriate. Further, it could be so developed as to take into account relative ability to meet medical expenses as reflected by different salary levels. A final decision with respect to the inclusion or exclusion of the co-insurance principle should be made only after it has been considered by the employees who are to be covered, and its advantages and disadvantages carefully weighed.

In establishing a health insurance program for state employees, the plan should be designed primarily to provide protection for the career state employee. To attain eligibility for participation, the employee should have other than temporary or casual employment status. A major part of the return to the state for its financial contributions to the plan should be an increased stability in its work force, and therefore, designing the plan to provide fullest benefits for the career employee is a most desirable feature.

Detailed requirements as to eligibility for participation in the plan both as to employees and retirees are difficult to spell out in legislation. Such requirements might well be left to the determination of the administering agency within the general framework established by the legislature.

It is a reasonable assumption that the loss experience of state employees as a group will be better than average. Therefore, it is, in our opinion, reasonable that the plan should provide for

experience rating of the state employee group in order that both employee and the state might benefit through lower costs.

Employees should participate in the development of the details of the plan and in the determination as to how the state's participation shall be apportioned; that is, how much of the state's share shall be applied against employee coverage and how much against dependency coverage. Since the employees under any jointly financed plan will pay a considerable portion of the total cost, they should participate in the determination of the benefits to be provided and other related matters to be specified in the contract.

The plan should provide for coverage of the employee's spouse and dependent children as well as himself. Since the employee bears some financial burden by reason of illness of his dependents as well as because of his own illness, dependency coverage is desirable. The extent to which the plan should go in providing such dependency benefits should be left for determination in negotiating the contract. There are circumstances under which it would be desirable to provide coverage for dependents other than the employee's spouse and dependent children. Such coverage would, however, entail greater costs than coverage of spouse and dependent children only, and here again the advantages and disadvantages would have to be carefully weighed by those participating in the plan before a final determination was made.

It may well be appropriate at the outset to limit dependency coverage to the employee's spouse and dependent children. This will tend to keep the premium costs reasonable and also to place primary emphasis on providing benefits for those with whom the state, as employer, is most directly concerned. In this connection we feel that it is desirable that the state's financial participation extend not only to the cost of coverage for the employee but also to the cost of coverage for his dependents. As indicated previously, however, the exact proportion of the cost of employee coverage and the cost of dependents' coverage which the state pays should be left to negotiation after agreement has been reached on the basic features of the plan.

In our opinion, the legislation ought to be broad enough to permit the widest possible consideration of various types of plans. However, benefits should be uniform for all employees, and uniformity might be most readily achieved through a single contract. This would tend to prevent unanticipated gaps in coverage and to reduce to a minimum employee misunderstanding and disputed claims.

Consideration should be given to coverage for retired employees, a feature included in Senate Bill No. 970. If the employee participates in the plan prior to his retirement, then he ought, in our opinion, to be permitted to continue participation after he retires. It is recognized that the cost of providing benefits for the retired employee is normally much greater than that of providing coverage for the employee during his working years. To make possible such retiree coverage, it might be necessary to provide different benefits for retired employees or a different distribution of the

costs as between the state and the employee. It might be possible also for the employee to pay, through his contributions to the plan prior to retirement, some of the higher costs of coverage during his retired years. Fair and reasonable eligibility standards for coverage of retired employees should be established after consultation with employees and careful consideration of all factors involved by a board, such as described below.

We note that Senate Bill No. 970 calls for administration of the plan by the Civil Service Department. Since the Civil Service Department is the personnel agency of the state and since any health insurance plan is primarily an employee benefit plan, this seems reasonable. It might be desirable, however, to provide that broad policy decisions would be made by a board composed of those in the state service who can bring a special competence to bear on the administration of the health insurance program. The President of the Civil Service Commission might well be the Chairman of such a board, and the State Comptroller, the Commissioner of Health, the Superintendent of Insurance, and the Director of the Budget would be able to provide valuable advice on administrative problems in specialized and technical areas. Such a board might well have the final approval of any contract which we feel should be placed with the organization which can provide the optimum benefits at the lowest cost. Here again we note that Senate Bill No. 970 does not exclude either commercial organizations or non-profit organizations from consideration in connection with this plan. This would seem desirable, since the primary consideration should be the best service at the lowest cost.

In conclusion, the Civil Service Department agrees that it is highly desirable that the state inaugurate a plan to aid its employees in meeting the financial burdens of illness. This is an area in which state employees lag behind their fellow workers in private industry. In a recent survey the New York State Department of Labor found that over 60 per cent of the workers in private industry in our state have health insurance benefits paid for wholly or in part by their employer. While Senate Bill No. 970 has many good points, we feel that it does not go far enough in providing to employees needed protection against the financial burdens of illness. A truly comprehensive health insurance plan, the details of which have been carefully and cooperatively worked out with the participating employees, will provide not only real protection for those employees but also benefits for the state as well. Effective employee participation will be possible, however, only if the enabling legislation is broad in character and does not, by specifying benefits and conditions in detail, unduly restrict discussion and development of the plan.

THE CHAIRMAN: Our next speaker will be Mr. Frank Van Dyk, who is Vice-President of Blue Cross.

MR. FRANK VAN DYK: Mr. Chairman and members of the committee: I welcome this opportunity on behalf of Blue Cross to present some viewpoints regarding the Metcalf bill. We are

very happy for this opportunity, because we have listened with a great deal of interest to the comments that have been made, particularly regarding the service benefits and deductibles, and we do not wish to belabor the points, since they have been adequately covered, except for one thing.

In the discussion of deductibles, for example, there seems to have been overlooked the fact of what the effect of deductibles would have on good medical care. It has been stated in times past, and currently perhaps, that service principles of Blue Cross particularly tend to increase hospitalization unnecessarily; that hospitalization has grown as a result of Blue Cross. We in Blue Cross are in a measure proud of that accusation, if it can be termed that, since it has brought to more people than ever before the benefits of hospital service and the advances of medical and surgical science that are found in hospitals. The fact remains, however, that it has not created an unnecessary usage of hospitals, if we can use the figures of occupancy as an indication.

For example, the statement has been made here today that there would be some tendency to overcrowd hospitals, there wouldn't be enough beds, and so forth. The occupancy of hospitals in this state is 74.6 per cent of occupancy. The American Hospital Association feels that 75 per cent occupancy is a sound and good occupancy. After 20 years of growth and development of Blue Cross in this state, during which time it has reached more than half of the population in the state, it certainly seems to show no evidence that it has overcrowded hospitals but it has provided hospital care for more and more people. We feel that anything that would curtail in any measure the growth and the development and the usage of hospital services and the advantages had in the care of the sick and injured would be a sad situation and would be a retrogression of progress. While we recognize the fact that it would cut costs, costs must be related to service, of course, and we feel that services are the important factor in any health program.

We feel that in the development of this program for hospitalization—and I would like to confine my remarks to hospitalization only, since I represent Blue Cross—we feel that while medical and surgical care are a necessary, component part to good medical care, nevertheless a hospital service on a service basis provides something that the people involved in this case really need. I am remindful of the fact that between 80 and 85 per cent, if my figures are correct, of the employees of the state have incomes of less than $6,000. If that is the case, then it seems to me that kind of people or class, the economic class of people, are not the kind of people that are confronted with major surgical bills, and on the other hand are confronted with lack of ready finances to meet unexpected hospital services.

The dangerous thing, at least to me, is the fact that any curtailment or any participation in cost might tend to prevent the ready acceptance and use of hospitals. Doctors have claimed from the beginning of the time of Blue Cross that it has enabled

them to bring patients to hospitals more readily, because of the avoidance of the unexpected burden of expense.

Comments have been made about retirement. We normally provide protection for people on retirement. We have done so consistently down through the years. Another interesting point that has been referred to in the discussions today is perhaps inferentially the reference to the inadequacy, perhaps, of Blue Cross or—your program of 120 days is a new program. We do not feel it is a new program. More than eight million people in the United States are currently covered under Blue Cross with programs of 120 days. We feel that 120 days is a well rounded-out and adequate program, so much so that the Blue Cross plans of this state have adopted a uniform contract which will shortly be made available. Rates for them have been filed with the Department of Insurance, and at an early date that contract will be made available, although some have already been made available in one form or another with groups within the state.

To indicate the extent of adequacy of a 120-day program, while we recognize that the vast majority do not stay that long, yet if we want comprehensive coverage, then 120 days would cover 99.98 per cent of all hospital admissions, according to our records, which would mean that virtually everybody would be adequately covered for hospital expense if we had it on a service basis, and from what is implied—at least as I understand it—the service is covered in the Metcalf bill.

There was also reference made to the question or the relationship of hospital service to being a small part or the minimum part of a medical expense bill. I suppose that is true if we include in the total cost proprietary drugs and medicines which people buy on their own. I would like to know—and I think it would be worthy of investigation—whether those estimates include the cost of drugs on that basis. But, nevertheless, it seems to me—and in the light of our experience down through 20 years of experience with the people of the state—that hospitalization is the dramatic and the immediate need of people inasfar as medical expense is concerned. The impact is sudden, the impact is heavy, and the impact is greater than in any other way.

Now, I do not mean to belittle or in any way reflect upon any other medical services, but we do know that there are more hospital cases in any kind of a welfare program than any other kind of cases. I would not include in that, of course, the home and office visits or doctors' services, but insofar as welfare programs are concerned—and by the statistics revealed by all large major companies or major health programs in the state—the items of service are always headed by the list of hospital cases. I suppose it would mean, in weighing any program, whether or not hospital service would be the predominant factor would only be in relation as to whether or not there was adequate money to pay the whole thing. We know insofar as hospital, medical and surgical care is concerned that the trend has always been—and as far as I know still is—that hospitalization is the No. 1 item.

I do not mean to again infer that others are not important, but it certainly is the right beginning, and we feel that the committee has approached that point in the right way, and insofar as adequacy of coverage is concerned, and perhaps in relation to the money that is available.

We commend the committee for the broad approach of hospital care. Blue Cross plans in this state are ready and able to provide the benefits set forth in the Metcalf bill. It also is ready, through its partnership in Blue Shield, I am sure, at an early date, to also embrace other fields of health and welfare protection. Studies and conferences have been under way for a long period of time. That, I feel, will shortly or in the reasonably near future provide the opportunity for a coordination of benefits of both hospital, surgical, medical and even major medical through the Blue Cross and Blue Shield plans of this state.

Thank you.

THE CHAIRMAN: The next speaker is Mr. John Porter of the Civil Service Forum of New York City.

MR. JOHN PORTER: Mr. Chairman and members of the committee, ladies and gentlemen: The Civil Service Forum for the last 10 years has been introducing hospitalization bills in the legislature. Each year two distinguished members of this legislature have introduced our bill for us. The previous speaker mentioned their names.

I would like to call attention, so there will be no misunderstanding, that if you look in the legislative index Senator Furey and Assemblyman Farbstein have this year and last year introduced two bills on the health insurance plan, so I am not trying to say that we were the introducers of someone else's legislation. We feel that it is indeed time that the State of New York takes this matter under consideration and proceeds to try to give our people—all of the people employed by the State of New York—this protection.

We feel that we have something in back of our program, because in the City of New York, the employees of the City of New York have a health insurance plan. We feel that the State employees should have the same protection. It should include both hospital care, medical and surgical. However, we do not insist at this time that it must include all three. If we can't get the three in there, let's get one in, and we will be satisfied and will come back next year and try to get the additional protection, but we do not feel that it should be put off any longer. It has been under study one way or another for over 10 years now. We will be satisfied with the hospitalization alone if that is all we can get this year. We want something. The people, the employees, need it, and then, as I say, we will come back again. If the plan which is prepared and submitted to the employees is such that the employees will not accept it, as Senator Greenberg said, the plan will fall by the wayside and another one will be substituted. We endorse the proposition of the health insurance plan and we will take it a

little at a time, or if you can get one to cover all, we will be very glad to have that.

So far as the retired employees are concerned in the City of New York we have not been able to get them covered. We have been able to get a number of different additional benefits, through discussions with the health insurance plan there, when we would approach them with that, this or the other improvement.

Thank you.

THE CHAIRMAN: Thank you very much, Mr. Porter.

The next speaker is Dr. Caldwell Esselstyn, Medical Director of the Rip Van Winkle Clinic at Hudson, New York.

DR. CALDWELL ESSELSTYN: Mr. Chairman and members of the committee: I am glad to be here this afternoon to speak in favor of your bill and to emphasize a few principles which I think are important and should be in the record.

I think the first thing that we would like to speak in favor of is the comprehensivenesss of the bill and the fact that the service kind of principle holds throughout. We think it is terribly important to have this emphasized; that it has got to be the cornerstone on which any kind of health insurance is evolved. At the same time I would like to bring out one of the points that I think represents a tremendous deficit in this bill, and a very serious one, and that is the lack of provision for diagnostic facilities outside of the hospital. The experience, I think, is nationwide that the greatest abuse of Blue Cross today is because of the lack of diagnostic facilities being incorporated in the plans, and I would like to draw your attention to the experience of the Labor Health Institute out in St. Louis, which is a comprehensive group practice prepayment plan. There are 63 doctors, on part time, serving some 15,000 teamsters and their families, and after two years experience they found that for 30 per cent less premium they could give 20 per cent more benefits on their hospitalization if and when they controlled the admission of the patient to the hospital and were able to provide comprehensive diagnostic services outside.

Finally, what I would like to say is that I think if the hospitalization problem is taken care of, the medical and surgical benefits should be built upon that framework, but if comprehensive medical care is not ready to be served throughout all of New York State at the moment, I think a great deal more emphasis has got to be put on the fact that we are interested not in a sickness insurance, and after all that is all Blue Cross and Blue Shield is; it has nothing to do with health. Nobody can benefit from these plans unless they are sick. One thing that has been mentioned this afternoon, and has got to do with health, and gives doctors a driving force to keep people well, is the principles of the health insurance plan of New York City.

I feel that if the medical and surgical benefits are built slowly enough so that facilities can be established throughout the state, the principle of health and not sickness will be fostered. It has already been shown that this kind of thing is growing and patients

with health insurance plan policies will be serviced in the upper Hudson Valley before the end of March. I think it is the kind of thing that will be stimulated greatly by the passage of the comprehensive medical and surgical care later on.

THE CHAIRMAN: Before you leave, Doctor, I would like to ask you if you would elaborate just a little bit on the experience of the Labor Health Institute in St. Louis. I believe you said that by a 20 per cent reduction in premium and comprehensive outside diagnostic care, 30 per cent—

DR. ESSELSTYN: For 30 per cent less premium they were able to give 20 per cent more benefits.

THE CHAIRMAN: It interests me. Can you tell us a little more about that?

DR. ESSELSTYN: This was a Labor Health Institute started in about 1947 or 1948, following a strike by the teamsters, at which time they struck for 5 per cent increase in wages, that 5 per cent not to be paid to them as wages but to be given to a tax-exempt Labor Health Institute, which was run by the union, and that institute today, on a part-time basis, employs medical and surgical and specialists covering all the fields. It is the only plan that I know of in the country which includes dental care under its premium, and this is being done today at 5 per cent of the average teamster's wages in St. Louis, which would be in the neighborhood of $3,000, or, in other words, $150. This includes their hospitalization.

THE CHAIRMAN: What I was interested in was the result of the diagnostic care which took place on the outside, I believe you said. Did that lower the amount of the medical attention that the people who were covered by the plan needed?

DR. ESSELSTYN: It very substantially lowered the amount of hospitalization that was needed.

THE CHAIRMAN: I wish you had some facts and figures on that.

DR. ESSELSTYN: I am sure that Dr. John MacNeill would be glad to send anything he has. He is the Director of the Labor Health Institute.

THE CHAIRMAN: Would you get in touch with him and have him send us some information?

DR. ESSELSTYN: I would be delighted to.

THE CHAIRMAN: Thank you very much.

Our next speaker will be Mr. Solomon Bendet, President of the New York City Chapter of the Civil Service Employees Association.

MR. SOLOMON BENDET: I represent 3,500 state employees, employed in the metropolitan area of New York City.

THE CHAIRMAN: Is your organization the same one as Mr. DeGraff spoke for?

MR. BENDET: It is. Ours is the largest chapter in the metropolitan area. Now, up to the present those employees have not enjoyed any of the so-called fringe benefits which many employees in private industries do enjoy. In fact, our membership is required to pay a charge for the so-called privilege of having the premium deducted from our pay checks for hospitalization and medical benefits.

It is therefore very gratifying to us to see that the State of New York finally intends to join those employers who are paying employee benefits in addition to salary. We would like to see the State of New York not only join these employers but become a leader in the field and as a first step toward that leadership, we believe that a complete, comprehensive hospital, medical and surgical plan should be enacted at this session of the legislature, so that employee morale may be increased and recruitment policies bettered and the State of New York get the proper type of employees.

We therefore favor legislation at this session of the legislature which will help us obtain these objectives.

THE CHARMAN: We have run through the cards which designated the people who wished to speak here today. If there are no others who would like to speak, I would like to say thanks to all of you who were here today to take part in this public hearing.

If there are no others who would like to speak, I will declare these proceedings closed.