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To: The Honorable Members of the Senate Majority Policy
Committee

From: Samuel R. Marshall

Re: The affordability of health care

First, beyond the standard formality of thanking you for inviting me, thank you for stating what should be the overriding goal in health reform - the affordability of health care. This is "Cover the Uninsured" week; everyone would be better served if it were "make health care more affordable" week - or month or year or however long it takes.

That gets lost at times, with the focus shifting to health insurance - but the issue is really about getting more affordable health care to all Pennsylvanians. Yes, making health insurance more affordable is a major part of that - but the broader goal should be making health care more accessible and affordable, whether through insurance or other means.

Now for some specific guidelines and recommendations:

1. Be realistic and don't over-hype any solutions

Health care is expensive and is going to continue to be expensive. That will hold true for the insurance covering it, too - whether that insurance comes from government programs, the Blues or commercial insurers; whether it comes from a single-payer system, a concentrated market or

April 30, 2008

Page two

a competitive market; and whether it is for individuals, small employers, large employers or those of varying income levels.

That's a reflection of advances and expansion in medical care and of increased consumer demand for that care. Pointing this out doesn't mean we should or can do nothing - but it does mean all sides have to be realistic in our projections.

That realism has been lost at times on all sides, us included, as we get caught up in the legitimate passion and advocacy of our positions. We hear it (and at times say it) all the time: Various measures will save enormous amounts, whether they deal with hospital-acquired infections, non-payment for medical errors, better chronic care management, or more rate regulation; and other measures won't cost much and in the end will save enormous amounts, as with mandated benefits.

The reality is that all of these measures and more won't produce dramatic immediate savings. That doesn't mean they aren't important to do - they are, because they impact the quality and cost of health care and health insurance. But over-hyping reforms doesn't help anybody, especially consumers who need realistic promises and projections.

2. Work together

This is as much a self-reminder as a recommendation for others. We all have our own perspectives, interests and goals. But we all share the general goal of making health care better and more affordable and accessible, and that should enable all sides to come to agreements. That's happened in some areas - the legislation on hospital-acquired infections is a prominent example - but not often enough. I know the adage "reasonable minds can disagree" - but reasonable minds can also come to agreement.

As to specific measures we recommend:

April 30, 2008

Page three

1. Promote "core benefit" coverage

In a fantasy world, everyone would get every health care benefit, and payment would be made by somebody else without any paperwork or need for explanation from either the provider or the patient.

Now to the real world: There are limits in what people can afford, because they have to pay the costs, and that means real choices have to be made. That's true in any form of insurance, and consumers understand it.

To that end, we recommend continued encouragement of core benefit policies. This isn't so much "mandate-free" policies - although that's part of it - as it is increased use of high-deductible plans. That is the essence of what are commonly known as Health Savings Accounts, where consumers can purchase high-deductible coverage that gives them insurance for serious and catastrophic health care needs, but leaves them responsible for smaller and more routine costs.

The criticism of these plans has been that poorer consumers cannot afford to pay the high deductible, and that they therefore don't get the routine and preventive care that may save costs and lives down the road. The experience - recognizing it is still early, as these plans are just gaining force in the health insurance market - doesn't back this up.

And again, in the effort to be realistic, I'm not sure that is a reason to not promote this option: Coverage of the more expensive and serious conditions and problems is far better than no coverage.

The value of core benefit or high deductible plans is best seen when you look at who the working uninsured are in Pennsylvania. Roughly half of them are younger people - those in the 18-34 year-old bracket - and it is the cost of coverage that keeps them from getting it. This is a viable option for this group - coverage they can afford that meets their most important needs, if not all their wants.

April 30, 2008

Page four

2. Extending the age for dependent coverage

Children are generally not covered as dependents past the age of 19 or when they quit being full-time students. A number of states have extended this, with the cost to the parent rather than the employer, to age 25 or 26 (New Jersey went to 30, but it is an outlier).

Pennsylvania should do the same as a means for allowing parents to help their children defray health insurance costs while getting the federal tax advantage that comes with employer-based coverage. This recognizes that many young people, especially in tough economic times, may not have full-time jobs with full-time health benefits.

The "take-up" rate of this in other states hasn't been that great - parents aren't always that generous with their adult children - but it is a good policy for Pennsylvania, with its high number of uninsured young people.

3. Mini-COBRA

This allows people leaving a small employer to extend their health benefits for 18 months, a right given under federal law to their large employer counterparts.

4. Non-payment for medical errors

This means that hospitals can't bill insurers or patients for services resulting from events they could have prevented - as with operating on the wrong arm and the like. A number of insurers, and DPW, have already implemented this policy, working with hospitals - and a number of states have already enacted laws on this, and Pennsylvania should do the same.

Again, we need a dose of reality: This is the right and logical thing to do, but it won't produce major savings - so all sides need to be careful not to over-hype it.

April 30, 2008

Page five

5. Caution on mandates and utilization curbs

As insurers, we are seen as opponents or obstructionists on these issues, although we are really caught in the middle. We can and might want to cover every benefit, and without any utilization curbs - and simply pass the costs on to our policyholders. No insurer likes telling a patient a particular benefit or illness isn't covered, and no insurer likes fighting with providers (the burden of paperwork goes both ways).

But we have to be mindful of costs, because we have to balance the needs and desires of patients and providers with the financial limits of policyholders. We're struggling with that now in trying to resolve the proposed autism mandate, and in trying to work with various groups of providers and pharmacists to establish fair network and utilization practices.

I'd offer one observation: Proponents of these measures generally understate the costs, and maybe opponents overstate the costs - understandable on both sides. My experience is that these measures tend to cost more than the original estimates; that is true in health care financing as in any other type of insurance or general economics. That doesn't mean mandates aren't legitimate at times - but it does mean that all sides should work together to make honest and accurate efforts to ascertain and reduce their costs.

6. Promote competition

I'm a broken record on this, but it is worth repeating: A competitive health insurance market is the single most important ingredient in promoting better and more affordable health coverage.

The auto and workers compensation markets in the 1980s and '90s faced the same challenges we now face in health insurance - the cost of coverage was escalating at double-digit annual rates, and the number of people without coverage was increasing, too.

April 30, 2008

Page six

A number of solutions were considered - remember uniform, mileage driven auto rates and a statewide auto company? But the bi-partisan answer that emerged was to provide for real consumer choices (the limited tort option is the best-known example) and to encourage more carriers to enter these markets with more, not less, rating and underwriting flexibility.

It worked: Both those markets have been relatively stable and affordable for all consumers, not just the best risks.

We need more competition in the health insurance market, too. It is a highly-concentrated market, dominated by the regional Blues. But there is some competition, and it has helped - innovations such as Health Savings Accounts originally came from small players looking for a way to compete.

That's largely why we oppose the small group rating measures in House Bill 2005. Most important, they don't lower rates or the number of uninsureds, which should be the main objective in any legislation. They also erode competition, and that is a bad route for the Commonwealth to take - in lowering rates or the number of uninsured.

I'm not saying we don't want any regulation. But we need regulation that ensures competition from small as well as large insurers, and encourages new insurers to do business and expand here - because in the end, a competitive market is the best regulator. It is no coincidence that our two most troubled insurance markets - health and medical malpractice - are also our least competitive markets.

7. The proposed Highmark-IBC consolidation

Who knows whether this is good or bad - more facts need to be known, and it all depends on the conditions that go with it - but it is big: The consolidation of the two dominant health insurers in Pennsylvania will have a greater impact on how health care is financed, provided and insured here than all the other bills we've talked about.

April 30, 2008

Page seven

That's why we recommend prompt action on the consolidation legislation Senator White has introduced: This consolidation demands thorough review and legislative input.

8. The ABC program and Mcare

I'll close with the issue that will likely dominate the Harrisburg dialogue over the next two months - the ABC program and the handling of Mcare passed by the House in Senate Bill 1137.

First, we recommend you continue the abatement and begin the phase-out of the Mcare layer as soon as possible. We also ask that you bear in mind the cost of this - subsidizing and bailing out a failed government insurance program - before you embark on a four-to-five-fold increase of another government insurance program.

Some expansion of the adultBasic program may also make sense. But opening it to small employers, as in Section 1306 of the bill, is flawed; and the grants in Section 1308 should be better directed to small employers most struggling with the cost of providing coverage.

I'd also recommend that, if there is really extra money in the Mcare abatement/phase-out account, you consider using it for things other than insurance. That may seem like heresy coming from an insurance guy, but one idea would be to fund primary care clinics in impoverished areas.

That goes back to the original point about focusing on affordable care, not just on insurance. I'm a believer in insurance, obviously, so I always see having it as the answer to all problems. But people in certain areas may be better served by getting more affordable primary care into those areas, not more insurance to cover more expensive care.

Again, thanks for the opportunity to be here. I'm happy to answer any questions.