Pennsylvania Association of Health Underwriters

ABC Testimony Synopsis
House Insurance Committee
August 11, 2008

I agree that providing health insurance coverage for all Americans is an admirable goal. Our current method of providing these services is to simply show up at the emergency room, demand care, and do not pay. Needless to say, this is the most expensive and least efficient way to deliver effective health care. In theory, it would seem reasonable to assume that it is less expensive to provide health insurance and prevent acute, chronic and routine services from being conducted in emergency rooms.

The real question is how do we provide financially responsible access to health care for the citizens of Pennsylvania? We cannot adopt a one-size-fits-all quasi-entitlement plan with a temporary funding mechanism. As evidenced by the States who have tried this approach, this type of plan will not work. I refer you to the various studies for Massachusetts, Tennessee, Maine and Connecticut, which I can provide, that outline the failings of program. I do not wish to see Pennsylvania added to that list of states.

So what is the answer? Pennsylvania has been recognized in the CRS Report to Congress as having one of the lowest numbers of uninsured residents in the country. Thanks to adultBasic and CHIP, we have made great strides in meeting our goals. Now is the time to build on those successes and not reinvent the system. By asking some critical and basic questions, which I would be happy to discuss in detail at your convenience, we can begin the process of determining our best avenue to meet the goals.

The final question we ask, however, just might be what the role of government should be in health care. Is the answer to health insurance coverage for all to be found within the public sector? I would suggest that the answer is no. By making this a private sector initiative or at the least a public-private partnership, with government oversight and regulation, I believe the creativity, investment and positive change needed to make this happen can and will be initiated.

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Testimony

Pennsylvania Association of Health Underwriters
Access to Basic Care Proposal
House Insurance Committee
Montgomeryville, PA
August 11, 2008

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Thank you for holding this hearing of the House Insurance Committee on Access to Basic Care. For the record, my name is Scott Crane. I am the Legislative Chairman for the Pennsylvania Association of Health Underwriters, an association made up of insurance producers who specialize in health insurance and employee benefits. I am also the Director of Employee Benefits for Tycor Benefit Administrators in Berwyn, PA. Tycor is a benefit consulting firm that works with small to medium sized employers and individuals.

Let me begin by agreeing that Universal Healthcare (providing health insurance coverage for all Americans) is a goal that most people say they will support. However, we already have a form of Universal Healthcare in America. Simply show up at the emergency room, demand services and do not pay. Needless to say, the emergency room is the most expensive and least efficient way to access our healthcare system, but if the person accessing the system is not paying, they do not care how much it costs.

The real issue is how do we as a society provide "financially responsible" access to the health care system? Theoretically, it sounds less expensive for society to provide basic insurance coverage than to pay for routine services or acute and chronic conditions in the emergency room, when they could have been avoided with routine medical care.

Proponents of universal healthcare should move beyond a superficial critique of our health care system and should examine the cost shifting and fiscal (taxpayer) consequences of a universal healthcare proposal. As a society, we need to ask who is paying for universal health care and at what cost to the individual, employer, or taxpayer? Now is not the time to play budgetary politics for a social agenda. We cannot adopt a one size fits all quasi-entitlement plan with a temporary funding mechanism. We can not afford the smoke and mirror tactics of this is the cost; no it's not; or here is the funding source (knowing it will go away in a year or two). It is time to ask the core questions:

1. What do we want to offer in a base health benefit?
2. What is the full real cost?
3. Is this benefit /cost value proposition we want to support?
4. How can we realistically pay for the program over an extended period of time?
5. Should we impose consequences for not being insured?
6. Is society best served by the Private or Public Sector alternatives?

1. What is the base health benefit level?

We tend to state our health care costs in terms of insurance premium. Whether privately insured, self insured, or insured by the government, the cost/premium will increase when we cover more risk. Add a mandated coverage, increase the cost. Take away a mandated coverage, reduce the cost. It's not whether or not a particular mandate is desirable; it is the cost of the mandate that everyone pays. Too often, social planners look at a rosy government benefit package but fail to see the cost implications. Insurance Dynamics 101 is more risk – more premium; less risk – less premium. So again the question is how many needs do we want to cover in a base program?

2. What is the real cost for the plan?

The cost of health care is a simple concept, the cost of providing a medical service. If one refuses to pay his bill or his insurance plan does not pay for the full cost of care, the cost of a medical procedure must be paid by someone else. The cost does not go away. For example, Medicare reimburses

providers well below their cost to deliver services. The shortfall is shifted onto everyone else to make up the difference. This "cost shift" is a hidden tax.

It is time to have an open discussion about the "real cost of health care" before committing taxpayer dollars on new programs such as Access to Basic Care, formerly known as Cover All Pennsylvanians.. In Pennsylvania, some have argued that we can add two expensive benefits (prescription and mental & nervous) to the existing adultBasic plan and not increase the current cost.
How can that be? It simply cannot be done. Of course some proponents think that Federal Government will want to increase matching funds to reduce state costs. But counting on Federal money which has been decreasing steadily is not a gamble I wish to take if Pennsylvania taxpayers will be stuck with the tab! The only other way to reduce the costs of this new quasi-entitlement program is to further underpay the providers, force them to shift more cost to everyone else resulting in even higher premiums; the hidden tax. The cost has not gone away.

Most providers have a limited capacity to absorb less than adequate payments from the government as they must have enough other profitable business to subsidize the shortfall. Let's look at what happened recently in Massachusetts. Providers were willing to take on a limited amount of "shortfall" business. However the demand of the "shortfall" business increased so greatly, the providers simply stopped accepting public sector patients. Massachusetts has a major problem of providing healthcare to a mass of newly enrolled public sector patients with no providers willing to accept them. Note that in the Access to Basic Care proposal, the doctors will be bludgeoned into providing government services as a condition of receiving state help on part of their medical malpractice insurance...Coercion will hardly build trust.

Bottom line; determine a realistic cost for the health care. Do not shift a real cost elsewhere and pretend it is not part of the cost of the proposed health care program. Real cost does not go away, someone has to pay.

3. Is the benefit level versus cost "value proposition" one the State wants to support?
Law makers need to answer the question from a return on investment perspective. When looking at a new social program, legislators should consider the budgetary impact but also examine the cost of the cost shifting that result from capitated government payments to providers. In addition, predictive models should recognize that nothing happens in a vacuum. If a new plan reduces the private sector insurance system, leaving more people to be dependent on the government, how much money will that cost? The General Assembly should determine the real cost to the taxpayer including any shifting of cost. Bottom line; is it worth the price?

4. How can we realistically pay for the program over an extended period of time?
Identify sustainable funding; preferably from the General Fund. Federal Medicaid payments are dwindling, the Tobacco Settlement money is dwindling, and shifting public costs to a competing private sector is not acceptable. If the answer to question 3 is "yes", the legislature should have no problem making it an easily identified line item expense in the general budget.

5. Should we impose consequences for not being insured?
People who choose to not participate in the system are given a free pass in today's environment. Many qualify for subsidized insurance or can afford private insurance and simply chose not to participate.

We need to offer both carrots and sticks to ensure compliance of these "free-riders". Keeping in mind that the uninsured is not a monolithic population, we need to address each population differently.

For example a "young and invincible" uninsured person may have plenty of money to spend on cars, electronic games, etc. and chooses not spend money on health insurance. This is not a problem of cost or availability; it is a problem of personal priorities. Yet if that same young uninsured gets seriously ill, society may end up paying for that young person's healthcare. Perhaps examining laws that permit a creditor to go after assets such as paychecks is the answer. That way, a young person with income would still have to pay for the services he or she received. There is precedence as Medicaid will go after an estate to pay back long-term care expenses.

Another example is the person eligible for public assistance programs who do not sign up for government subsidized insurance. Perhaps withholding part or all of their welfare payment would provide the incentive they need to enroll in the program.

We need to look at each group of uninsured (working poor, recently unemployed without COBRA, etc.) to determine the how to best cover their health care need (carrot).

It is not one plan that will work. It is an array of numerous solutions fitting each slice of the uninsured population. Each solution should increase the number of insured people by using the private sector. There are many possible solutions. Here are just a few:

- Enhancing incentives for Health Savings Accounts for individuals encourages young people to enroll because they correctly see an H S A as a savings vehicle as well as part of an insurance plan
- Increasing the numbers of clinics for the needy as an alternative to emergency rooms
- Physician price transparency to encourage consumers to seek medical care that suits their budget
- Tax incentives for new health insurance companies to come into PA, increasing health insurance choices
- State assistance going to help low wage earners with their share of the premium within a group plan modeled after the already enacted Health Insurance Partnership Plan (HIPP).

6. Is society best served by the Private or Public Sector alternatives?

We know the private sector system can be improved. We also know the public sector often hurts rather than helps. It creates an entitlement mentality where people choose taxpayer funded programs rather than the private sector. This trend weakens the private sector, leading to more clamor towards public intervention. This will finally lead to a single payer system with all the super-high taxes and rationing of health care one sees in other countries with those systems. Over time, the government has become a true competitor in the health care market and in doing so has created new problems such as cost shifting and low reimbursements which have led providers to super-inflate their retail fees three or four times.

In turn, private sector carriers negotiated huge discounts off the retail price for provider services. For example, negotiated discounts in the Philadelphia market are 50, 60, 75, and even 90% (just look at the "Explanation of Benefits" and compare the actual charge to payment allowed). The loser in this

irrational health care pricing equation is a person without insurance who is charged the full inflated price and expected to pay.

Under a public sector system, there is no incentive to develop new methods, invest in new technologies, or develop better management techniques. The massive advances we see in the health care industry will slow down substantially. Keep in mind; people take risks with new ideas when there is a potential reward. As we have seen in Canada, Great Britain, and Europe, government systems historically stifle creativity, access, and service. Government is historically slow to respond; it took Medicare over 40 years to offer prescription coverage.

The private sector, with all of its faults, spawns creativity, investment, and positive change. The private sector succeeds only when the products and services introduced are what the society wants and needs. Those in the private sector who do not deliver the right products and services or mismanage their business quickly disappear.

Perhaps the better question is "What is the role of government in health care?" Possibly the role should be restricted to oversee, evaluate, and regulate and partner where it strengthens the private sector system. The governmental role should not intentionally or unintentionally destroy the environment of competition, creativity, and better management.

Thank you for the opportunity to testify.

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MEMORANDUM

TO: Representative Steven Maier, Chair, House Health Care Committee
Senator Douglas A. Racine, Chair, Senate Health & Welfare Committee

FROM: Michael Davis, Director of Cost Containment
Department of Banking, Insurance, Securities and Health Care Administration (BISHCA)

RE: 2008 Vermont Cost Shift Analysis

DATE: March 14, 2008

CC: Susan Besio, Director, Health Care Reform
Paulette Thabault, Commissioner, BISHCA
Christine Oliver, Deputy Commissioner, DHCA
Joshua Slen, Director, OVHA
Heidi Tringe, Special Assistant to the Governor
Dr. James Hester, Director, Commission on Health Care Reform
Stephen Klein, Chief Fiscal Officer, Joint Fiscal Office

In response to recommendations made in the 2007 Cost Shift Task Force Report to the Commission on Health Care Reform, BISHCA has prepared the first *2008 Vermont Health Care Cost Shift Analysis.* This analysis significantly updates available cost shift information. We are committed to improving the analysis each year to address all of the recommendations outlined in the Cost Shift Task Force Report.

Please feel free to contact me at BISHCA (828-2989) if you have any questions or concerns regarding this publication. I am also available to meet with you to discuss these findings and answer any questions that you may have about the analysis.

Please contact BISHCA at (802) 828-2900 for more copies or link to our website at http://www.bishca.state.vt.us/HcaDiv/Data_Reports

Testimony

Pennsylvania Association of Health Underwriters
PHC4 REAUTHORIZATION
House Insurance Committee
Montgomeryville, PA
August 12, 2008

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Thank you for holding this hearing of the House Insurance Committee on reauthorizing the Pennsylvania Health Care Cost Containment Council. For the record, my name is Scott Crane. I am the Legislative Chairman for the Pennsylvania Association of Health Underwriters, an association made up of insurance producers who specialize in health insurance and employee benefits. I am also the Director of Employee Benefits for Tycor Benefit Administrators in Berwyn, PA. Tycor is a benefit consulting firm that works with small to medium sized employers and individuals.

I will suggest to you today that PHC4 serves important functions that benefit the Commonwealth and should be permanently re-authorized. The upcoming due diligence that will be required before making any major changes in health care policy is the type of analysis that PHC4 is uniquely able to provide. I see the reauthorization of PHC4 as so important; I encourage the legislature to consider the reauthorization on its own and to not attach other proposals or legislation.

Much has written on the cost drivers behind health care's crippling inflation and its resulting impact on health insurance premiums. Many of the problems we face now stem from the fact employees, employers, consumers, and government policy makers alike are insulated from the true costs of health care.

A reasonable person could not possibly make a responsible decision without understanding the underlying costs and their relation to the health care system. It is these very costs that need to be examined, understood, and explained to the legislators and taxpayers in Pennsylvania. To that end, it is imperative that the true costs become transparent to everyone involved. Perhaps our system is not as broken as people say. We need PHC4 to make a responsible determination.

Our employer-based system evolved from the employers desire to attract and retain employees with health insurance benefits. It was only when health care costs began to skyrocket that employers began shifting those costs to the employee. PHC4 is needed to examine the cost drivers and report their unbiased finding for the record.

What are the cost drivers? I believe it comes down to two major areas, (1) Cost Structure, and (2) Utilization.

Cost Structure

1. Government Reimbursement, Cost Shifting and Hidden Tax

   The cost of health care is a simple concept, the cost of providing a medical service. If one refuses to pay his bill or his insurance plan does not pay for the full cost of care, the cost of a medical procedure must be paid by someone else.

   The cost does not go away, someone has to pay. For example, Medicare and in turn, Medicaid reimburses providers well below their cost to deliver services. The

shortfall is shifted onto everyone else to make up the difference. This "cost shift" is a hidden tax.

It is time to have an open discussion about the "real cost of health care" before committing taxpayer dollars. As legislators, you need to be provided with the real cost of the services on which to base your decisions. Keep in mind that a discount below the cost to provide the service only shifts the hidden tax to someone else. It is not a better volume discount negotiated by the Commonwealth.

The only way to further reduce the costs of government health care programs is to further underpay the providers, force them to shift more cost to everyone else resulting in even higher premiums; the hidden tax. The cost has not gone away.

Most providers have a limited capacity to absorb less than adequate payments from the government as they must have enough other profitable business to subsidize the shortfall.

Many states such as **Tennessee (TennCare)**, **Maine (Dirigo Plan)**, etc. have instituted failed policies. Let's look at what happened recently in **Massachusetts.** Providers were willing to take on a limited amount of "shortfall" business. However the demand of the "shortfall" business increased so greatly, the providers simply stopped accepting public sector patients. Now, Massachusetts has a major problem of providing healthcare to a mass of newly enrolled public sector patients with no providers willing to accept them. **Connecticut** had a similar problem.

According to the 2005 CRS Report for Congress, **Pennsylvania** has been identified as being one of the best States for lowest numbers of uninsured. We have adultBasic and CHIP that are driving that number down. While we are not perfect, are we ready to throw the baby out with the bath water and add Pennsylvania to the list of States with failing or failed programs? Why would we want to jeopardize a system that is working well in Pennsylvania for a system that has failed elsewhere? We need PHC4 to help make that determination.

Bottom line; we need to determine a realistic cost for the health care. Do not shift a real cost elsewhere and pretend it is not part of the cost of the proposed health care program. Real cost does not go away, someone has to pay. This should be a priority project of PHC4.

May I suggest using the Cost Shift study recently completed in **Vermont**? PAHU has given a hard copy of the study to the House Insurance Committee and will gladly supply an electronic copy to any members.

2. Realistic Provider Charges

   Because the government has become a true competitor in the health care market, it has created many problems. For instance, because of below cost Medicare pricing and pricing requirements, providers of healthcare services have inflated their fees 300% to 400%. In turn, carriers have negotiated ridiculous discounts.

   For example in the Philadelphia market, discounts of 50, 60, 75, and even 90% are regularly seen on patients "Explanation of Benefits". The loser in this mad pricing equation is the person without insurance who does not qualify for a government program. Those people are charged the 300%-400% inflated price. Insane? Yes! Fair? No!

   PHC4 is needed to study this pricing phenomenon and report its findings.

3. Consumer Partnership

   Consumers should be included as a driver in the marketplace. Granted, choosing a doctor and facility will never be as simple as finding the best price on a car. Research on quality, price, outcomes, etc. need to be available to the consumer is a usable format. PHC4 is needed for that purpose.

Utilization

1. People are Living Longer

   The good news is people are living longer. The bad news is people are living longer -- with more issues requiring more care generating most cost. This is a simple fact that we must take into account but does not need to be addressed at this point.

2. More Mandates

   Another work of PHC4 is the review of mandated benefits. This is important to the health underwriters because with each mandate comes cost that translates into higher health insurance premiums.

   Insurance that is too expensive means fewer insured and more uninsured as a social problem. Mandated benefits are a cost issue. The inclusion of a mandate should come down to: does the mandated benefit outweigh the cost? PHC4 should be able to provide that answer.

3. Entitlement Mentality

   Consumer behavior can be peculiar. If something is perceived as free, the consumer naturally wants as much of it as they can get whether they need it or

not; an entitlement mentality sets in. How many times have you scooped up a bunch of free pens, or salt and pepper packets from a restaurant, or numerous other behavioral examples? This entitlement mentality also applies to health care services. Because the consumer is far removed from their cost of their health care, their perception of cost is nowhere near the reality of cost. As a result, their actions are not responsible. Two examples are the actions of the poor uninsured and the young invincible uninsured.

For example a "young and invincible" uninsured person may have plenty of money to spend on cars, electronic games, etc. and chooses not spend money on health insurance. This is not a problem of cost or availability; it is a problem of personal priorities. Yet if that same young uninsured gets seriously ill, society may end up paying for that young person's healthcare.

We also see the reaction of the uninsured that cannot afford to pay for health care. They tend to access the system through the most expensive door, the Emergency Room. What do they care? They are not paying for the care.

PHC4 will become a critical partner in analyzing the different groups of uninsured (working poor, early retirees, laid-off worker's not COBRA eligible, and more), to determine the best way to encourage responsible behavior from each group of uninsured when accessing the health care system.

Conclusion

On behalf of the Pennsylvania Association of Health Underwriters, I encourage you to re-authorize PHC4 permanently. I further urge PHC4 to not stray from its core mission of providing comparison health care and cost information and evaluating mandates. Pennsylvanians need the non-partisan analysis to know that the programs in place are in their best interest. PHC4 provides an important service to the citizens of our Commonwealth.

Thank you allowing me the opportunity to testify.

Attachments:

1. 2008 Vermont Cost Shift Analysis
2. 2005 CRS Report for Congress
3. USA Today June 29, 2008 Article - Massachusetts Plan
4. Olympia Business Watch July 16, 2008 – Massachusetts Plan
5. Harford Courant July 31, 2008 Article – Connecticut Plan
6. Bangor Daily News April 3, 2008 – Maine Dirigo Plan
7. Nashville Business Journal December 24, 1999 – Tennessee
8. Kaiser Foundation State Rankings – Fewest Per Capita Uninsured