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To: The Honorable Members of the Senate Banking and Insurance Committee

From: Samuel R. Marshall

Re: Senate Bill 926 – Medical Service Agreements

The bill provides that a Medical Service Agreement is not insurance and therefore should not be subject to the Insurance Department's regulation or any of the insurance laws or protections in Pennsylvania. Its proponents say that's the status under current Pennsylvania law, so this is merely a clarification.

I'm not so sure about that.

True, these agreements aren't insurance from a company's perspective: There isn't a third party absorbing risk or guaranteeing performance. And these agreements don't come with the protections that are the core of insurance regulation: They don't come with oversight of pricing or marketing or fiscal soundness, or with regulation to make sure the services promised are delivered, or with any protection in the event an entity goes bust.

But that's from a company's perspective. From a consumer's perspective, these agreements sure do sound like health insurance: They involve a consumer paying up front for the promise of future medical services that may or may not be needed. From the marketing we've seen, they are promoted as a friendly form of heath insurance – all the primary care services a person needs without the added cost or hassle of an insurance company getting in the way.

We don't have a problem with that as a concept. We're all trying to come up with new and better ways to get consumers the heath care they need at prices they can afford and in ways that make getting care more convenient.

We have our differences on ways to do this, and each of us has our own financial interests and survival at stake, too. But we respect those that come forward with ideas to do both well and good, and we recognize primary care providers are pursuing these agreements in that spirit.

That said, these agreements deserve a lot more scrutiny before being excused from any government oversight, which is the real effect of this bill – because even if these agreements aren't insurance to me, they are to most people.

Pennsylvania has addressed this before, in the context of long-term care insurance, and arrived at a balance in Act 216 of 2004.

Some history: Outfits at the time were marketing home heath and personal care service contracts to consumers, many of whom considered these contracts a form of long-term care insurance. The Insurance Department said it was concerned but unable to do anything because the contracts weren't insurance.

The General Assembly addressed this by amending the Insurance Company Law to put some clear parameters on these contracts. Attached is the relevant section from Act 216 – its definition of a personal care service policy and the conditions under which these are not considered insurance. Of particular relevance to the medical service agreements we're discussing today:

- The contracts are to be issued, renewed and priced without any medical underwriting or consideration of a person's health condition, and without any waiting period.

- The contracts are to come with a notice expressly stating they are not insurance, and with full disclosure of what that means and the limits on pricing and underwriting.

- If the contracts don't meet these criteria – as policed by the Insurance Department – they are subject to more extensive Department regulation as de facto insurance.

I'll defer to the Insurance Department, but these medical service agreements are arguably already covered by Act 216 – they certainly provide personal care services.

So maybe the real question is why medical service agreements should be excused from the standards Act 216 imposes on personal care service policies generally. In any event, the criteria in Act 216 should frame the legislative questions for these agreements:

- Are they sold, priced, or issued with or without consideration of a person's health status? That's medical underwriting. That's heavily regulated when done by insurers – it should at least be asked about if done by primary care providers.

- What about renewal? The bill says these agreements can be terminated by either party – at any time and for any reason. That's prohibited in heath insurance: We're subject to guaranteed issuance and renewal provisions. Maybe there's a good reason these agreements shouldn't come with that protection. But at least make sure consumers know they can be terminated at will and for any reason – as with too much use? – and with no recourse or remedy.

- What about proper disclosures? The notice in the bill only tells part of the story. It isn't just that these agreements "do not provide comprehensive health coverage."

    - They don't provide anything beyond the services of the primary care doctor - nothing for labs, tests, prescriptions, specialists, therapy, or emergency care.

    - They don't satisfy a person's insurance obligations under the ACA – a consumer purchasing one of these agreements would still have to purchase an ACA-level policy or face a penalty.

    - And they don't come with protections that are integral to health insurance. That goes to restrictions on issuance and termination, as noted above. It also goes to ensuring the services will be available: We are judged by the adequacy of our networks to meet the demands of our insureds. That's missing here.

The House took a quick look at this bill, so there wasn't much time for these questions to be raised, much less answered. Chairman Baker did offer one important clarification: Patients signing onto these agreements "need to have high deductible health care plans for specialized care, hospitalization and

catastrophic situations." He noted these agreements are to help consumers with high deductibles and out-of-pocket costs when getting primary care.

If that's the case, the bill at least needs to provide that these agreements can only be done if the consumer has a high deductible health plan. That raises questions of its own:

- How does the money paid for these agreements count toward the high deductible, and what about the high deductible plan that covers the cost of primary care services independent of the deductible? That's common in high deductible plans, reflecting our commitment to primary care services.

We recognize primary care providers are indispensible to the heath care delivery system. And as a general principle, we welcome new products and innovations, and we are the first to call out regulation for the sake of regulation, or regulation that offers nothing more than the superficial appeal of consumer protection.

The questions we've raised here are not to hurt the viability of primary care providers or stifle innovation. We raise them because you and consumers deserve to know the answers as you make decisions on whether and how to allow or purchase these agreements.

Thank you for the opportunity to be part of this hearing and, we hope, the dialogue as you consider this bill.