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PUBLIC STATEMENT
Submitted to

SENATE BANKING AND INSURANCE COMMITTEE
The Honorable Donald C. White, Chairman
The Honorable Michael J. Stack, Democratic Chairman

Presented by
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Blue Cross of Northeastern Pennsylvania

Senate Bill 594

May 6, 2014
Harrisburg, PA

Senate Bill 594 - An Act limiting copayments and coinsurances for insured medical services.

Good morning, Chairman White, Chairman Stack, and members of the Banking and Insurance Committee, my name is Michael Yantis, Director Policy Management for Blue Cross of Northeastern Pennsylvania (BCNEPA). Our company has been headquartered in Pennsylvania for over 75 years, and currently serves more than 540,000 customers in 13 counties throughout northeastern and north central Pennsylvania. In designing health insurance policies, BCNEPA works with customers to create an insurance product that provides access to quality health care services. I am speaking on behalf of Pennsylvania's Blue Cross/Blue Shield plans—BCNEPA; Capital Blue Cross; Independence Blue Cross and Highmark, Inc.—as we all share the same public policy concerns with Senate Bill (SB 594). Examples and data that are presented as part of this testimony are specific to Blue Cross of Northeastern Pennsylvania only.

One of the more challenging aspects of creating health insurance products is developing a cost structure that is affordable in the market. The Blue Plans appreciate the Committee's ongoing efforts to develop legislation that balances the interests of various stakeholders while addressing the cost and complexity of health insurance. However, SB 594 would add what we believe is an unnecessary level of government regulation over the development of health insurance policies.

As amended and approved by the Committee, SB 594 is less prescriptive than the bill's original language. SB 594 as amended would create a regulatory requirement for the Pennsylvania Insurance Department to ensure that cost sharing "does not create a barrier to access for care, is reasonable in relation to the covered benefit for which it applies, and encourages appropriate and necessary utilization…" We understand that the cost of health care continually puts pressure on the budgets of individuals and businesses who look to provide comprehensive health insurance coverage as an important benefit to their families or their employees. We also understand that SB 594 is intended to alleviate perceived gaps in the development of health insurance policies. However, we believe existing consumer safeguards provide sufficient protection obviating the need for SB 594. Further restrictions on cost sharing arrangements will only serve to shift costs from one part of a health insurance policy to another, whether it be in the form of increased premium, increased deductibles, or newly-imposed copayments on services never before subject to cost sharing. This has the unintended consequence of limiting choice in the marketplace. We believe consumers and the marketplace in general are well-equipped to determine the reasonableness of policies and cost sharing structures.

Lack of Demonstrated Need for Legislation

Proponents of SB 594 suggest that current health plan cost sharing structures prevent individuals from seeking such care. BCNEPA tracks and evaluates utilization for covered services and the data suggest that utilization of services remains constant (i.e. no barrier to access) for physical therapy and chiropractic services, the primary advocates for SB 594. From Jan. 2009 through June 2013, BCNEPA has reimbursed over 833,000 chiropractic visits and over 334,000 physical therapy visits. When

adjusting for the change in plan membership from year to year, **there has been relatively NO change in utilization for physical therapy and chiropractic services on a year to year basis.** We understand that providers may hear an occasional complaint from a patient about a copayment charge or a coinsurance amount. And we also understand that copayments impact patients' budgets; however, individuals and employers commonly use copayments to balance the costs of health insurance. BCNEPA's data, however, clearly demonstrates that chiropractic and physical therapy services are steadily accessed and used by our customers despite the occasional anecdotal concern about cost sharing.

The lack of consumer complaints or utilization data to support the need for this legislation may also stem from the fact that strong consumer protections related to cost sharing and overall health insurance costs already exist. It is unclear what additional level of protection SB 594 would provide over and above the current, robust consumer protections. For example, federal law limits the amount a health insurer can charge a customer for a health insurance policy—this is known as the medical loss ratio (MLR) requirement. Health insurers must spend at least 80 cents of every premium dollar on medical care for small group and individual policies. For large group policies, the requirement rises to 85 cents of every premium dollar. If copayments and coinsurance rates are too high in relation to the premium and cost of service, health insurers would not be able to meet the MLR requirement. If an insurer fails to meet this federal requirement, the law requires that the insurer reimburse or rebate consumers the difference. This serves as yet another cost saving protection for consumers that purchase health insurance.

Another financial protection for consumers is the existing restriction on out-of-pocket (or cost sharing) costs. Federal law places a limit on the total out-of-pocket costs for a health insurance policy, which in 2014 is $6,350 for an individual and $12,700 for a family. This standard focuses on the totality of out-of-pocket costs by establishing a total limit to protect consumers. SB 594 seeks to place a limit on a subset (copayments and coinsurance for chiropractic, physical or occupational therapist visits) of the overall out-of-pocket costs, which provides no greater consumer protection over the current requirements.

Cost Shifting

The result of SB 594's requirements will be a shift in costs to either the premium or deductible, exposing the consumer to potentially greater out-of-pocket costs in those areas. *1) Premium Increases:* Cost sharing helps distribute the cost of insurance between premiums and out-of-pocket costs. Greater cost sharing allows for a lower premium amount and as cost sharing is decreased, the premium will increase. Using the original language in SB 594 as an example, BCENPA estimates that **premiums would increase anywhere between 3.7%-17.8%.** With most individuals and small businesses working from already strained budgets, even a 3.7% increase in health insurance premiums would likely price some customers out of the market. *2) Deductible increases:* If state legislation or regulation suppresses copayment or coinsurance amounts, health insurers, or employers, can shift that copayment or coinsurance cost sharing into the health policy's deductible amount. With a larger deductible, the

consumer will face out-of-pocket costs that are generally *greater than* a specialist copayment amount.

Market Determines Reasonableness

BCNEPA appreciates the Committee's work in researching the complexities of cost sharing and ultimately amending SB 594 to create a less prescriptive approach by requiring the PID to regulate cost sharing using a reasonableness standard. We believe this regulation already exists through the market as the PID currently reviews individual and small group product filings, including cost sharing structures. Consumers will not purchase products that are unreasonably priced; they will shop around with competitors to find products that meet their needs, i.e. are reasonable.

Employers (both small and large) use cost sharing to negotiate a balanced health insurance product and health insurers use cost sharing to develop a *variety* of health plans to meet individual consumer needs. Such development takes place within the framework of the existing consumer protections and it is unclear what additional value is earned by placing arbitrary limits on copayments or regulating a "reasonableness" standard. In fact, a recent change in federal law regulating cost sharing demonstrates that too many limitations on plan design are counterproductive.

On April 1, 2014, the President signed the "Protecting Access to Medicare Act," which included a provision repealing the small group deductible limit ($2000 for an individual and $4000 for a family) established by the Affordable Care Act (ACA) or health care reform. Why? The ACA limitation on deductibles combined with the other pricing restrictions on health plans resulted in severely limited health plan options for small groups. The repeal of small group deductible limits took place after only one year of the requirement being in place under the ACA because market forces quickly determined the need for some degree of flexibility to provide choice in the market. We would urge that Pennsylvania not attempt to place similar misplaced or undue restraints on the market.

In conclusion, we appreciate the Committee's diligence in examining the issue of cost sharing. In fact, the Committee's efforts on this issue have already yielded a positive outcome. During the Committee's April 9 meeting and discussion of SB 594, it was stated that the primary motivation behind SB 594 was to protect consumers from facing multiple copayments for a single office visit. After the Committee investigated this issue with the providers and the health insurance industry over the past few years, we now have no Pennsylvania health insurers that conduct such a practice. The discussions revealed that such a practice was an outlier—most policies did not structure copayments in such a manner. Thanks to the Committee's examination of the issue as well as an inquiry by the Pennsylvania Insurance Department, multiple copayments for a single office visit are no longer a practice, aside from the possibility that a self-insured group has designed their policies in such a manner.

Health care costs continue to strain budgets as government, businesses and families all struggle to find ways to cover the costs of care. Health insurance is a means to cover such costs and we believe the regulatory structure proposed in SB 594 would limit

flexibility in designing policies and would simply serve to shift costs from one bucket to another. Thank you for the opportunity to provide these comments and I am happy to answer any questions the Committee may have.