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Samuel R. Marshall
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To: The Honorable Members of the Senate Banking and Insurance Committee

From: Samuel R. Marshall

Re: Senate Bill 594 – cost-sharing limits for certain providers

We'll join with our Blues and business colleagues in raising concerns with this bill.

We understand the argument behind it: The allegation is that some insurers impose cost-sharing requirements that, when applied to chiropractic, physical therapy and occupational therapy services, effectively prevent insureds from using those services, or at least from using those services as a covered benefit.

The argument is that making insurers pay a greater share for these services will result in insureds using them more often, and that will avoid more expensive treatments down the road.

If we thought insurers paying more for chiropractic, physical therapy and occupational therapy services would hold down overall health care costs and improve the care of our insureds, we'd be on the other panel.

Insurers are increasingly attuned to the savings of preventive care and to the need to match utilization patterns for any one service with broader healthy outcomes. We simply haven't seen evidence showing that more insurance payment for these services will mean better outcomes for our insureds, much less overall savings in health care costs. And we are not hearing insureds complain that commonly-used cost-sharing arrangements for these services are effectively preventing them from using them. We also aren't seeing these cost-sharing arrangements result in a lack of availability for these services or a lack of utilization of them.

We are sensitive to the balance this issue requires: On the one hand, insureds should have some "skin in the game," some fiscal responsibility for how they use the health care system; that's what cost-sharing is. On the other, you don't want cost-sharing requirements that make using a service prohibitive or impossible.

We're not sure that balance can be etched in stone, or in regulation, which may be the same thing. We think it is best set by the marketplace, not the General Assembly or Insurance Department. And we don't mean just the marketplace that pays for a service or for insurance, but the marketplace that uses the service. Cost-sharing arrangements are constantly being monitored and refined for all services, not just these three. That should be driven by consumer demands. Regulators can monitor it and look for problems – but setting the parameters by statute or regulation seems unrealistic given the rapid changes in health care treatment and payment.

We've asked to see cost-sharing arrangements the bill's proponents believe would run afoul of the bill's limitations – cost-sharing arrangements they see as unreasonable and/or a barrier to proper care. We've also asked whether they have shared those examples with the Insurance Department, and what its opinion is.

That would be important for this Committee to consider: We think our cost-sharing arrangements are reasonable, while the bill's proponents don't, at least for some policies. It would help if specific policies were cited, and with specific instances of their cost-sharing arrangements resulting in needed care not being given.

We are happy to answer any questions.