TESTIMONY

PENNSYLVANIA ASSOCIATION of HEALTH UNDERWRITERS

Single Payer Health Care System

House Majority Policy Committee

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Stewart Anmuth
President
Pennsylvania Assn. Health Underwriters
899 Cassatt Road, Suite 200
Berwyn, PA 19312
484/321-5856 FAX 484/321-5802
E-mail: stewart@ktbenefits.com

Scott Crane
Chairman
PAHU Legislative Committee
850 Cassatt Road
Berwyn, PA 19312
610/251-0670
scrane@tycorbenefit.com

Mr. Chairman and members of the committee, for the record, this testimony is being presented by the Pennsylvania Association of Health Underwriters (PAHU), the association representing insurance producers with expertise in health insurance and employee benefit programs. Insurance producers, or agents, are the only part of the health insurance system that touches all of the others, consumers, health providers, insurance companies, and the government. This gives agents a unique ability to see both the strengths and flaws in the current system as we advocate for our customers' needs.

Although this testimony opposes single payer, please note that PAHU appreciates the desire some have for a new system because frankly, they are frustrated by the costs of health care, by red tape, and by what is a confusing system. They want universal coverage and are frustrated by a system where some people simply cannot obtain health insurance. Frankly, insurance agents are also frustrated by parts of the system too as we are the ones who translate, communicate, and advocate every day. Our job is to make the system work for our business and individual customers. It is we who are the messengers of bad news about insurance premium increases. Where we differ from single payer advocates is that we don't want to throw out the system and start all over. Instead, we want the private sector to be able to insure more people. We are also frustrated by the fact that some Pennsylvanians seem to have fallen through the cracks but we think the culprit is health care costs that force up health insurance premiums rather than by inefficiencies in the system itself.

How do you get to the goal of insuring more people from here? Most important, how do you get there without destroying the strengths of the present system and replacing it with something worse?

This testimony is divided in two parts. First are presented arguments against adopting a single payer system. Second, there are a number of private sector remedies that meet the goal without destroying the system.

Cost and Rationing

A single payer system where the government plan is regarded as an entitlement and encourages over-usage. If I think it's free, why should I inhibit my own use of the system? It is not free. Someone pays for it.

If people regard it as free, they will abuse it. This guarantees a disconnect between who uses the plan and who pays for it. Demand will increase dramatically and costs will escalate. Massachusetts is a prime example.

Given increased demand and limited ability to pay for it, the only thing government can do is to ration health care. Limiting services, restricting technology, demanding greater waiting times and gatekeepers all suffice to raise access barriers to health care. While this is not something anyone wants, how can a single payer system not restrict utilization arbitrarily? The government will be forced to reduce the cost by rationing health care or by increasing taxes or both. Single payer does not increase access. It limits access.

Rationing is economic central planning and quite frankly, centralized economic planning has been a disaster where it has been tried in the former Soviet Union or Eastern Europe.

More specific to single payer, rationing takes place on one side and demand increases on the other. The result is increased wait times for necessary technology. Why do so many Canadians come here for tests and treatment? It is because they have to wait in a rationed system. Americans take it for granted that an MRI can be scheduled in a couple of days or within a week. The Fraser Institute "Access to Technology" study concluded that **on a per capita basis**, Canada has thousands fewer MRIs and CAT Scans than are available in America. No wonder wait times are worse in Canada. There is simply less medical capacity – by design.

A corollary to this is restricting access to specialists and emphasizing the primary care provider. While PAHU does not disagree with the importance of the primary care provider, we disagree with the idea of placing artificial restrictions on access. It was only a few short years ago when HMOs were condemned for doing much the same thing, restricting access to specialists by using gatekeepers. A consequence of this rationing of specialist access will be a brain drain to other parts of the U.S. from Pennsylvania's medical community. The resulting doctor shortage will mean longer wait times and pose barriers to access.

Besides rationing of facilities and technology, proponents of single payer are often silent about how costs can be curbed under their system except to say that administrative costs can be curbed. Given Federal experience with Medicare, administrative savings may equal waste because of inadequate oversight or there may be simply a more inefficient system as noted by the recent scandals at the Walter Reed Hospital. Administrative costs include many factors including claims, fraud investigation, compliance with governmental mandates, marketing costs, salaries, and payment of taxes. These costs usually run about 12-18 percent. One downside to implementing a single payer system is that the premium taxes generated by for-profit carriers (not the Blues) would be lost.

How Do We Pay For It?

Funding is a prime area of concern when considering a single payer system. The idea is that instead of paying a premium, expenses and claims would be met by another funding source such as taxes to capture those businesses which cannot afford or choose not to offer insurance to employees. This suggests either an individual or business or both mandate to pay into the single payer plan.

Past versions of single payer legislation in PA (House Bill 1660) present several funding streams:

- Federal health care programs
- Funds from dedicated sources specified by the General Assembly

- 10% gross payroll tax (except for collective bargaining agreements whose benefits are generous enough)
- An individual income tax called Individual Wellness Tax that includes personal earned and unearned income, pensions and investment income

In that legislation, the single payer plan, if threatened with insolvency, could impose a 90 day increase in the payroll tax or personal income tax as it deems necessary.

This taxing scheme will force dislocation in the Pennsylvania economy. Why should a company or for that matter an individual who can afford to move not do so? This may be a drift of job-creating businesses elsewhere where these taxes are not imposed. Those businesses remaining would be less competitive with other states given their new overhead.

Another argument against taxing business more is to see its impact on small businesses that get hit twice by a personal income tax increase (if they file a schedule C) and by a gross payroll tax. This will force a shift in company resources away from job creation, salary increases, purchase of equipment, etc. A single payer system is going to have these economic consequences on small businesses. Some larger businesses will simply do the numbers and calculate how much they spend now versus under the new system and pass those costs along. If the earlier argument is true (greater utilization), expect a greater need for additional taxes, something also counterproductive to PA's economic health.

Of course, since almost half of Pennsylvania's health insurance market is not regulated by the state but by ERISA, including it in this plan invites court action similar to that striking down Maryland's mandatory payroll tax for health benefits. In other words, Federal exemptions under ERISA will encourage larger businesses to self-insure to avoid being part of PA's single payer system. Unless Federal pre-emption is addressed, the comprehensive goal of the single payer plan is compromised.

Another outcome of the legislation that is uncertain and is more of a question than a criticism is how single payer would relate to Workers' Compensation or the medical coverage contained within auto insurance policies. If single payer is truly single payer, I assume that Workers' Compensation and auto medical coverage are accounted for in some way but that is not clear from the legislation itself. Clearly, the fear is that single payer would undo the emphasis on safety in the workplace since Workers' Compensation rates reflect claims. By replacing it with a "free" system, again there is a disconnect between usage and cost control.

Remedies

PAHU prefers government's role to assist to the private sector in insuring more people.

Reduce Costs as the first Urgent Need

Solutions must pursue a number of tracks affecting both insured and uninsured people. They involve confronting cost drivers directly. In some areas a state answer is more meaningful. For others, the Federal Government needs to engage since cost drivers are national in scope and not just limited to the Commonwealth. The rationale for attacking costs means that, if successful, upward pressure in insurance premiums decreases. Of course, some costs drivers will be there no matter what we do. We cannot stop aging and the health situations that come with it. Demographically, there will always be upward price pressure because Pennsylvania is an older state. Likewise, there is little one can do to block consumer expectations that they will be made whole. Denying those services means a political backlash of unprecedented proportions.

Still, there are costs that can be addressed. To his credit, Governor Rendell added cost as part of his original Rx for Pennsylvania package. PAHU applauds some of what he has proposed and you as the General Assembly have adopted. Examples include establishing a commission to look at best practices for managing treatment of chronic diseases and enacting a protocol to address the issue of hospital-acquired infections.

Improving use of technology is on almost everyone's short list of positives. Reauthorizing the PHC4 helps promote transparency. One proposal coming from the House Democratic Caucus is to have a premium assistance program modeled after HIPP which can help low-income employees with their share of premiums as a less costly way to keep them in the private sector health plan. Passing mini-COBRA legislation seems to have growing support within all four caucuses. If passed, this would hopefully permit use of the Federal 65 percent subsidy per President Obama's Stimulus Package.

There are areas of unfinished business that might be considered such as passing tort reform legislation. While realizing opposition some in the Democratic Caucus, PAHU asks that you consider some sort of tort reform legislation. A few years ago, the venue legislation helped reduce the numbers of new medical malpractice lawsuits. This consensus legislation survived a court challenge unlike the politically charged idea of capping non-economic damages. I ask that the Majority Policy Committee consider a hearing where a variety of tort reform ideas be considered to see if there can be a consensus middle ground that will reduce health care costs.

Another cost curbing proposal is legislation making the pricing of doctor services transparent. We support this idea because if consumers become rational consumers, competition should drive down fees and charges or at least open the door to lower costs because consumers can better assess cost. Reducing health care costs works for everyone and reduces the hardship many employers face in paying for group health insurance. Potentially, reducing costs equals more people who are insured through the private sector model.

An approach popular in the Senate is state support of clinics in urban and rural areas to address health care access issues.

None of these is a panacea to a complex problem.

The complexity is shown by the fact that there are many subsets of the uninsured, each one of which might need a specific solution targeted on their need.

One example is young, healthy individuals who choose not to be insured. Sidestepping the individual mandate question, what can be done to get younger, healthier people to be a greater part of the system? **PAHU believes that encouraging employers to help pay for the higher deductible in a high deductible health plan with a health reimbursement account or health savings account focuses on that group.** Understand that health savings accounts are not a silver bullet. They work on a case by case basis but often attract particularly interested younger, healthier individuals who do not enroll in a health insurance program because they do not feel they will go to the doctor. Young people may however appreciate the value of a savings or investment vehicle that saves money for a rainy day when they will need medical care.

Another group is low wage employees who cannot afford to pay their share of the premium which, as you know, has been climbing in recent years. An average employee contribution is now around 25% to 35%. As mentioned before, a **solution would be to take the successful Health Insurance Premium Program (HIPP) administered by DPW and extend its reach past its current Medicaid threshold to 200 percent of the Federal Poverty Level**. The important thing is that the state is a partner, not a competitor to the private sector. Employees in HIPP are part of the employer-provided insurance plan and do not need to enroll in a separate government program. This program works. Let's expand it.

Another example is enrolling those without insurance who are already eligible for a public sector program. During the debate on Cover All Kids Initiative, the figure of 133,500 kids without insurance was used. As it turns out, almost everyone on that list was already eligible for Medicaid, fully subsidized CHIP or partially subsidized CHIP. That left a population of 25,500 out of 133,500 not already eligible as the target.

The point here is that millions upon millions of dollars have been spent in advertising but there are still many eligibles who have simply not enrolled. **A more effective way to reach many of those eligible people and get them signed up for CHIP is use insurance agents to market CHIP**. Applications received would be of a better quality (documentation of earnings, etc.) if agents were the distribution system. There are already numbers of examples where insurance agents are used to help achieve a public sector goal. Some of these are flood insurance, crop insurance, assigned risk (auto), medical malpractice, FAIR Plan (homeowners) and mine subsidence insurance. Take those models and adapt them to marketing CHIP. Agents know the community and its people. They also are in position to help an employee where the employer cannot afford to offer dependent coverage. Yet since CHIP's inception, the state has chosen not to use what I think is an obvious resource.

A third example of the uninsured is those people who have a medical condition that precludes them from getting insurance. An example might be someone who retires from the county at age 55 but has to wait until 65 for Medicare. What does this person do? This is truly a tough nut to crack. **One approach that could be explored is risk pools similar to what other states have done where medically uninsurable are put into a pool that is subsidized by everyone else**. PA already has an auto risk pool called Assigned Risk. Why not explore one for health insurance too?

Conclusion

What PAHU has tried to do today is to raise concerns about adopting the single payer system in Pennsylvania. Health underwriters believe that there are areas where the government and private sector can work together to insure more people without resorting to a one size fits all government program. Thank you again for giving PAHU this opportunity to testify.