The Board of Pensions
of the Presbyterian Church (U.S.A.)

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Good morning. My name is Pat Haines and I am the Senior Vice President of Benefits for the Board of Pensions of the Presbyterian Church (U.S.A.). I appreciate the opportunity to speak to this committee today as a representative of a Pennsylvania-based employer group health plan.

The Board of Pensions is a Pennsylvania not-for-profit religious corporation established under a civil charter to administer the retirement and health and welfare benefit programs for Presbyterian clergy and lay workers nationwide. Our offices are located in Philadelphia, where we have close to 200 employees.

Our members are those who serve or have served the Presbyterian Church and our mission is to provide those members and their families with pension, healthcare, and death and disability benefits. To that end, we provide benefits to the 45,000 members and beneficiaries employed by or retired from Presbyterian churches and agencies nationwide. Over 3,800 of the Medical Plan's covered lives are located in Pennsylvania, including the Board's employees in Philadelphia.

We listen to and learn from the many church constituencies and people who depend on the Board's benefits. Not surprisingly, one of the most frequently voiced concerns is the unsustainable cost of health care. Providing high quality health coverage nationwide gives the Board of Pensions a unique perspective. We provide health care benefits to our members in markets across the country. These markets vary significantly in terms of cost and access. We understand the impact that robust competition can have on local health care markets, as well as the detrimental impact that highly concentrated markets can have on health care costs. No matter the geographic location or local market challenges, we have an obligation to provide all of our members with access to affordable, high-quality care.

That's the reason I am here today. We have over 1,000 covered lives located in western Pennsylvania and are troubled by what is happening in that market. I am concerned that our members in that region will lose access

to the hospitals and doctors of their choice and that this pattern will repeat itself in other parts of the Commonwealth as large health systems acquire more hospitals. I am equally concerned that health care costs for our church employers and members could escalate – significantly - if a single health system is permitted to stymie competition and control the market. It is our responsibility to try to manage costs for our employers and members and that becomes increasingly difficult when faced with markets that are largely controlled by one dominant health system.

Today's health care system is complicated and can be very overwhelming to the patients it purportedly serves. At a time of particular vulnerability, patients can get caught in the middle of business disputes between health systems and health insurers – in fact, they carry the perpetual fear that their coverage may not be accepted at some future time by a health care provider on whom they depend for care. They often don't know in advance if they will be faced with a staggering medical bill because their treating provider opts out – or is forced out, by his or her hospital allegiance - of their plan's network. The disruption of care that results from these disputes absolutely has to impact the quality of patient care.

It is my understanding that this legislation will require health systems that are both a provider of health care and an insurer to be accessible to all patients regardless of their coverage. Health systems can then compete with one another for those patients based on quality and cost, not by denying patients – based on their coverage – access to services, or by forcing employers into costlier coverage for the right of their members to see the doctor or hospital they choose.

This legislation also provides an extremely useful mechanism to resolve contract disputes between and among hospitals affiliated with integrated delivery systems and carriers so that patients are not put in the middle of their commercial disputes. The legislation does not provide comparable relief to hospitals that have not merged with an integrated health system. Markets controlled by one dominant insurer (including insurers that are a part of integrated delivery systems) might also lead to limited alternatives for our members and the potential for increased costs. A dominant insurer may drive patients towards higher cost hospitals affiliated

with their systems. Unaffiliated hospitals may be frozen out of reasonable reimbursement contracts by dominant carriers. I respectfully suggest that the arbitration mechanism should be available to any willing hospital, not just hospitals in integrated delivery systems.

As a Philadelphia-based Plan sponsor with members across the Commonwealth, I feel strongly that the challenges that exist in western Pennsylvania need to be addressed now so that it doesn't become the model for health system behavior in other parts of the state.

The challenge you face as lawmakers is the same challenge that we face as payors, and our members face as consumers. The challenge we all face – nationwide – is an inefficient health care system where quality is illusive and costs are unsustainable. This legislation presents an opportunity for Pennsylvania to be a leader in promoting health care competition without putting patients in the middle.

Thank you for the opportunity to testify today on this important topic.