COMMONWEALTH OF PENNSYLVANIA

HOUSE OF REPRESENTATIVES

INSURANCE COMMITTEE

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IN RE: HEARING ON THE REAUTHORIZATION OF THE HEALTH CARE COST CONTAINMENT COUNCIL (HC4)

BEFORE: ANTHONY M. DELUCA, Chairman/Representative
Rick Taylor, Member
Rick Speese, Member
Vince Bianucci, Member
Anthony J. Melio, Member
Scott W. Boyd, Member
Lisa Kubeika, Member
Marguerite Quinn, Member

HEARING: Tuesday, August 12, 2008
Commencing at 9:34 a.m.

LOCATION: 1001 Stump Road
Montgomeryville, PA

WITNESSES: David Wilderman, Flossie Wolf, Thomas Lamp, Matthew Kearney, Steve Thomas, Fred Weiner, Scott Crane, Marian Lewis, Kitty Gallagher

Reporter: Brian O'Hare

I N D E X

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P R O C E E D I N G S

CHAIRMAN:

Before I start, I'll have the representatives introduce themselves.

REPRESENTATIVE TAYLOR:

Good morning. I'm Rick Taylor, Representative of 151st Legislative District, which encompasses Montgomery Township, which you're sitting in today. I welcome the Committee. Thank you very much for coming down. And I'm very pleased that you're coming to be talking about a very important issue, which is HC4. And I think this is a successful program, and I'd love to see it get re-authorized.

REPRESENTATIVE MELIO:

Tony Melio, 41st Legislative District of Bucks County. I'm glad to be here in this young man's district. It's such a beautiful place, and thank you for having us. This is a very important legislation piece, and we've been very happy to have such wonderful people come and testify. Thank you.

REPRESENTATIVE BIANUCCI:

I'm Vince Bianucci from Beaver County, the 15th Legislative District. And I'd like to welcome you here, and I'm glad to be here working on

this particular issue we have a strong belief in, so thank you for coming.

CHAIRMAN:

I'm the Chairman, Board Chairman, Toney DeLuca from Allegheny County. And to provide reference, my executive director, Rick Speese, and to his right is Lisa Kubeika, who's the administrative assistant to the Insurance Committee.

Again, I want to welcome everyone here to this House of Insurance Committee hearing today on the re-authorization of the Pennsylvania Health Care Costs Containment Council. We'd first like to thank Representative Rick Taylor, who is an active and effective member of our committee for hosting us yesterday and today. Yesterday we had the hearing on the ABC Healthcare Program. Very productive, very informative and certainly a lot of information we need to take back to Harrisburg. Also I'd like to thank the good people here in Montgomeryville for allowing the Committee to hold our hearings in their township building, which is a very beautiful. I'm very impressed.

This morning the Committee is looking at the topic of re-authorizing the Health Care Cost Containment Council. Now, I won't go into the

political wrangling, which earlier this year threatened the existence of PHC4, but one thing was for certain, all parties agree that the Cost Containment Council should be re-authorized.

The Council got a short-term extension through November 30th of this year when the Governor, by executive order, sustained its important work. But when we return to session in September, we must deal with extending the Council. It is important we put aside all tangential issues, political and otherwise and extend the Council's existence.

Now, there is little disagreement in Harrisburg on the need to continue the Council, and on the important work that Council performs for the citizens of the Commonwealth of Pennsylvania. I am sure we will hear today of the many positive attributes of the Council and its impressive resume of reports of Pennsylvania's healthcare marketplace.

The Council has established much since its birth in 1986. It is known nationwide for its reports detailing the scope of hospital acquired infections in Pennsylvania hospitals. It was their reports which impelled the state to move to correct this problem. Thereby, assisting in saving many lives and precious healthcare dollars.

Since the Council's inception in 1986, they have been an important and valued resource used by consumers of healthcare in Pennsylvania. Both the business community and labor strongly support the continuation of this agency. And I can't tell you how often business and labor agree so wholeheartedly on an issue, but suffice to say, it isn't often, but on this topic they are united.

Finally, one of the things I would like to see in any re-authorization statute is the establishment of bipartisan commission consisting of representatives of business, labor, hospitals, insurers and other individuals and the general assembly to take a long, hard look at the Council's structured and duties and provide a report to update, strengthen and modernize the workings of the Council. Although the Council, since its inception, has provided useful information, Pennsylvania policy makers is incumbent upon us to strive to make it even better.

I urge my colleagues on both sides of the aisle in the House and in the Senate to put aside partisan politics and unrelated issues. And when we return in September, vote to extend the life of the Healthcare Cost Containment Council. And we look

forward to the people who are going to testify today. We want to thank you ahead of time for taking the time out of their busy schedules to come to this hearing.

The first individual who will be testifying is Dave Wilderman, who is the executive director of Pennsylvania Health Care Cost Containment Council. Dave? Dave --- for the record, Dave, why don't you introduce ---?

MR. WILDERMAN:

Glad to. To my right is Flossie Wolf. She's the deputy director of the Health Care Cost Containment Council and she's the head of research.

CHAIRMAN:

And Dave has informed me that he has extensive testimony that he will abbreviate. Thank you, Dave.

MR. WILDERMAN:

Yeah. I just --- we gave out fairly thick packets to all the members. I will cut to the quick in my testimony, because I know there are many important people here who want to testify.

I want to thank the members of the Committee, the Chairman for his leadership and the members of the Committee for your support of the Pennsylvania Health Care Cost Containment Council.

As the Chairman has eloquently noted in his opening remarks, that there has been bipartisan support for transparency in healthcare data, and that we need to continue the important work that the Council's been doing.

In your packet there's an extended version of the testimony. I will read an abbreviated version of the testimony. In addition, there are some letters that --- there's a document that describes all the reports that we give. And then in addition to that, there's some letters of support that we've received from --- now, like people in the State of Pennsylvania, but across the nation. So we thought that would be helpful. And then even a little bit more detail in terms of the value of Council to this Commonwealth of Pennsylvania.

It is an honor for me to be here today to provide testimony regarding the important work of the Council or PHC4, as it is known. PHC4 is a creation of the General Assembly. Through the enactment of Act 89 in 1986 and its subsequent re-authorizations, the General Assembly is in many ways responsible for what a number of recent newspaper editorials have referred to as, quote, one of the best values in state government. The Council would welcome additional

opportunities to come before you periodically and report on our activities.

There are several factors that cause Pennsylvania Health Care Cost Containment Council to stand out from the other states. Number one, the data are public. Two, the data are used to stimulate competition. And Three, the data are risk-adjusted for severity of illness to allow purchasers and consumers to make apples-to-apples comparisons between healthcare providers.

PHC4 uses administrative and clinical data to calculate risk-adjusted mortality, readmissions, complications and lengths of stay. The clinical data, which includes things like blood tests and diagnostic imaging results are used to account for differences in patient illness and other important risk factors. The methods used, in essence, give extra credit to hospitals and physicians that treat higher proportions of the sicker patients. This approach facilitates apples-to-apples comparison.

I want to emphasize that that's one of the unique aspects of the Pennsylvania system. Often you will see comparisons similar to the Medicare comparisons that are done in a general way without standardizing the nature of the complications or the

standard of the health of the individual being evaluated. The Pennsylvania system really allows for apples-to-apples comparisons.

Pennsylvania has the largest and most complex healthcare database of any state in the nation. PHC4 has produced many firsts. Pennsylvania Health Care Cost Containment Council's hospital performance report in 1989 marked the first time that hospital-specific information about hospital quality and charges was available to the public.

In 1992 Pennsylvania became the first state to voluntarily report heart bypass surgery results for hospitals and doctors. PHC4 commercial HMO report in 2000 was the first in the nation to combine clinical outcome results with prevention measures and patient satisfaction surveys.

PHC4 issued the nation's first physician specific report on total hip and knee replacement surgeries in 2005. The same year PHC4 made international headlines with the release of the country's first statewide report on hospital acquired infections as the Chairman has indicated. And in 2006 the Council issued the first --- the nation's first hospital specific report on hospital acquired infections.

While it is the case that Pennsylvania doctors, nurses and others on the frontlines of patient care deserve the credit for improving health quality and safety in the Commonwealth, it is also true that in states where similar reporting occurs, competition drives healthcare facilities to take deliberative action to improve the healthcare outcomes.

So what impact have we had? Since PHC4 began reporting patient mortality rates in its annual hospital performance report in the early 1990s, inpatient hospital mortality rates dropped from significantly above the national average to significantly below. PHC4 has targeted healthcare cost drivers like infections, complications, re-admission rates. Because when a patient dies in a hospital it costs the system more than twice compared to a patient that survives, showing that it's possible for quality care to cost less. And PHC4 is helping to make it so.

And that's an important --- very important plan. I want to emphasize that quality and cost in healthcare, at least in many areas, what I consider the low-hanging fruit, are inversely related in comparison to most products that you would go out

in the marketplace to buy. For example, you go to a car dealer and you pay a little bit more money for higher quality vehicle. In healthcare and the example would be hospital acquired infections, if you reduce the cost drive or hospital acquired infections, you get kind of a win-win situation where the patient gets better results and better outcome, and it's lower cost. So the higher quality there and costs are actually inversely related, and that's a very important point that PHC4 has been able to establish.

PHC4 has released two hospital specific reports of hospital acquired infections. While it is unrealistic to say that the reports have been directly responsible for declines in the infection rate in Pennsylvania hospitals, we believe that the decline indicates that we are headed in the right direction.

With respect to this issue, I especially want to compliment you, Chairman DeLuca and members of the Committee and the Rendell Administration, for your leadership in passing Act 52 last summer. Act 52 is universally recognized as the most comprehensive approach to infection prevention and reduction of any state in the nation.

PHC4 data is a vital resource for healthcare purchasers, providers and insurance. The

Delaware Valley Health Coalition, which covers 400,000 lives and has $1.5 billion in average medical expense --- spending is using PHC4 data for an initiative to improve quality and restrain costs for its members through the creation of hospital-based centers of excellence preferred provider networks. You will hear from them today this morning.

Duquesne Light uses PHC4 data to help negotiate with insurers and hospitals. The Philadelphia Law Enforcement Health Benefits Trust Fund is using the data to identify quality providers and aid their members in healthcare decision making. You will also hear from them this morning.

The Lehigh Valley Business Conference on Health has used the data to study the effect of hospital misadventures and complications on patient charges and outcomes. And Volvo Mack Truck distributes 10,000 heart bypass reports each year to its employees as part of their educational efforts.

The Council's reports are utilized by medical and academic communities in areas ranging from internal benchmarking and process improvement to clinical research. For example, the Lehigh Valley Hospital and the Health Network is using PHC4 data for their trending, quality improvement and community need

assessment initiatives.

Since 1994 PHC4 has produced more than 1,000 customized reports and databases for researchers, hospitals, physicians and consulting firms, insurers, purchasers, state agencies and members of the General Assembly. Many of these studies have been published in the Journal of American Medical Association and other scholarly journals.

PHC4 works regularly with other state agencies to provide data and customized reports for a variety of projects and studies. The Pennsylvania Department of Health, Aging, Insurance and Public Welfare, the Pennsylvania Offices of the Auditor General and Attorney General, and the Governor's Office of Healthcare Reform are all sister agencies with whom we collaborate and do reports for.

The number of public reports distributed by PHC4 continues to grow significantly each year. In fiscal year 2007 alone, visitors downloaded more than 570,000 reports from our website with a total of 5 million hits. That's quite a value for a $5 million appropriated program in the State of Pennsylvania.

On behalf of the entire Council, I want to thank you again for the opportunity to provide testimony. I'd be happy to answer any questions that

you may have.

CHAIRMAN:

Thank you, Dave. I'd like to recognize Representative Marguerite Quinn, who's from Bucks County. Thank you for participating today. And also Representative Scott Boyd from Lancaster County and Representative Nick Micozzie, who's the Republican Chairman and its executive director, Kathy McCormick.

Dave, as I mentioned in my opening statement about restructuring the board, establishing the commission, what are your feelings about it?

MR. WILDERMAN:

We strongly support that. We think that's a great opportunity for members of the General Assembly. I assume it will probably be chairs of the various committees that will get involved in that as well as all the stakeholders that are involved in the process to really dig into what we do and get a full understanding and help to point us in the right direction where we could make some changes. And frankly, in areas that we could do more reporting, as has been indicated by the various caucuses, that they would like to see us do.

So it provides us a wonderful opportunity to delve into the depth and the scope of what kind of

public reporting and transparency is really needed for the people of Pennsylvania and the purchasers of Pennsylvania. So we think that's a great idea.

CHAIRMAN:

Is there any way that your Commission, PHC4, could possibly identify the cost of healthcare? What are the costs to provide healthcare?

MR. WILDERMAN:

Yeah.

CHAIRMAN:

Do we have any information on that? Because we keep hearing about the transparency and the fact that we need to address what the actual costs are to ---.

MR. WILDERMAN:

Let me partially answer that, then I'm going to ask Flossie to fill in. But one of the areas when we look at the costs, and you're well aware this is --- you've examined other alternatives, is that we have been successful in attacking cost drivers, and that's what adds up to the cost. So if we are able to have a significant impact on hospital acquired infections or misadventures, those lower the cost drivers, and that ultimately would be reflected in, hopefully, in decreased costs, though it's not a

guarantee.

Flossie, if there's anything you wanted to add to that, certainly maybe ---.

MS. WOLF:

I would just add that up until recently we've been relegated to using hospital charges as you probably know. Hospital charges don't accurately reflect what is actually paid in healthcare or what healthcare actually costs.

We are kind of moving --- trying to move in a different direction from that. And as part of that, and this may sound like a minor piece, but we are learning about how much the charges really mean. And what you might see in some of our future reports is that on average, charges translate into payment of about $.27 cents per dollar. So we're trying to get at that issue, but it is kind of a roundabout issue in terms of really getting to the cost of healthcare. It's really quite difficult.

CHAIRMAN:

Well, when we talk about costs, are we talking about the actual cost, the costs of the --- the costs that will be reimbursed, or are we talking about, like you would get a bill and the procedure costs you $10,000 and they pay $25? What are we

talking about when they report that to you?

MR. WILDERMAN:

Well, that --- I think that is exactly what is being referred to by Flossie here. The charges --- charge number is the first number that you would talk about, and then the second number would be the actual payment by the insurer. And we're indicating that the difference there is about two-thirds, so that payment represent approximately one-third. That's an average. They vary, you know, slightly. But if you were to average them, which is one way that I think purchasers --- and we had mentioned a number of purchasers who are starting to look at these data and see where they fit within what the average discount is and what they could be faced with otherwise. And some will be more advantaged than others if they're bringing, say, 100,000 lives to the table, they may vote to get a better discount.

So on the overall question, the impact that we're having is on the cost drivers. In addition to that, the data that's provided allows the purchasers of healthcare businesses and the labor unions to have something to work with in getting a good understanding. But as Flossie's indicated, this is probably the most difficult issue that we face.

The escalating cost of health care is still a major problem.

I might say that when we started out working on the Health Care Cost Containment Council, we wrestled for three years with a definition of what is quality. And now we're getting more deeply involved in the issue that you just raised, which is the cost issue.

CHAIRMAN:

Any questions? Representative Boyd.

REPRESENTATIVE BOYD:

Thank you, Mr. Chairman. Dave, it's good to see you ---

MR. WILDERMAN:

Good to see you.

REPRESENTATIVE BOYD:

--- and hear your testimony. Kind of following up on the Chairman's question regarding reporting of costs. One of the real motivations of the taskforce that we have put together, and actually had a bill that was re-authorized in HC4, I think it was 2026 read by Representative Jerry Stern. We were really --- our focus was to try and expand, if I will, your role in reporting and getting at this cost issue.

I recently read a report that the number

of high deductible health plans with a HSA component have really expanded nationally expedientially. Whether, you know, there's a universal agreement that that's a good thing or not, I think that the market is beginning to demonstrate that that is one of a series of tools that will be in the toolbox of trying to get at the cost of healthcare. It's not for everybody and I readily acknowledge that, but for some people it's a good tool. But those are only going to be as successful as the ability for consumers to try and understand this whole cost issue. I think you would agree with that. We were trying to come up with a creative way of giving you the tool to report actual costs. And the best alternative, we've gotten so far is to allow you to report Medicare reimbursement rates.

Wouldn't you think of that as kind of a baseline, and do you think that will have some success? Do you think it will have an effect giving a consumer like myself the ability to say, all right, I've been sent by my physician to get an MRI on my knee because I'm old, and I need them to look at my knee. I want --- need to know what that is. If I can understand what Medicare will reimburse for an MRI of the knee, would that give me a baseline figure or do

you think there's better ways of doing this?

MR. WILDERMAN:

Representative Boyd, at first I want to recognize you for the leadership that you provide on healthcare. It's been very constructive. And the focus on expanding the role of HC4, I think you've hit right --- the nail right on the head, that the changing in the marketplace, so-called consumer driven healthcare, which is the health savings accounts and expanded deductibles and co-payments and catastrophic loss plans do require, as you've just indicated, that the purchasers have some data on quality and cost so that they can make decisions. That's vital.

And you asked a specific question, is Medicare a good starting point? And that's something that we're discussing in depth to try and get a good understanding. Right now consumers just don't even know what the size of the ballpark is, and this gives us --- Medicare is adjusted for a number of factors, including teaching or not teaching mainly in a hospital environment disproportionate share, provide geographic region and so on. So there are several ways in which the Medicare data is powerful enough and a benchmark for consumers.

And as you indicated, this is an area

that's going to be --- these co-payments, deductibles, health savings account, the whole consumer driven movement is going to become increasingly important at that level that you're talking about, because when you're talking about the primary care level or some individual services, those co-payments and deductibles are a lot more significant. You'll exhaust them in the hospital setting probably right away.

So I think that that movement is movement in the right direction. We're also looking at another way to do it, which is kind of a simple way to do it, but what is the average discount from charges. That's another possible way to do it, and we do have the data which would allow us to make that kind of analysis. But you're asking a very difficult question. I don't think there's a simple answer to that. And it's a complicated problem for individuals to be able to get the rate that the insurer, if they're an individual is going to actually be paying.

So that's --- you know. But I think the movement is one we embrace. We would encourage more transparency. I think we're living in an era of information, and information is power, and it's good for --- as long as it's combined with quality. That's what we've always insisted upon, is it has to be some

sort of standard on quality. And that's much more difficult in the primary care setting than it is in the hospital setting. But still, even if we didn't have that, I think it would be very helpful for consumers and purchasers.

REPRESENTATIVE BOYD:

And if I may, some follow up to that. As we come back in session in the fall, and I'm sure re-authorization of HC4 is going to be one of the number one priorities that we're going to be doing work on, to the extent that you have created solutions to this issue of what it costs, I'm sure the Chairman and the Board would welcome, you know, some of those dialogues, because I think it's imperative that that get into their core mission as we go forward.

I don't think --- I don't know if you're an attorney or not. I don't think you're a background attorney. Can we require, in your opinion, the insurers to divulge the reimbursement rates that they provide for ---?

MR. WILDERMAN:

Well, it's a little bit complicated. What we've been charged with as responsibility is to do average by insurer, so you cannot, at least in principle, identify an individual insurer. It's a

delicate matter, because what's involved is the proprietary information for the insurers, and that would raise, I think, some constitutional type of questions, at least in terms of their proprietary business strategy.

So it's a difficult problem, but it's one that we're trying to approach in terms of averages. But with the large --- several large insurers, sometimes people will disaggregate the data and find out that number. So it's something that we really need to take a little bit more of a look at, because we think that it then might run into actually driving costs in the wrong direction, and that's something that we don't want to see happen, obviously. That's --- our name is Cost Containment. It's in our principles, so we want to avoid providing information that could possibly have the adverse effect of people driving up prices with their insurers because they may be in a better bargaining position than an individual is or a purchaser is to reduce the costs.

REPRESENTATIVE BOYD:

Okay. May I ask ---?

CHAIRMAN:

Yes.

REPRESENTATIVE BOYD:

Thanks. On a totally different subject, unfortunately we live in a political world. We got caught in a major political crossfire in late June, early July with the budget and weren't re-authorized. Can you kind of give us a little comment on how you're still in existence and what you see regarding that? I mean, I guess the Governor came up with an executive order. I'm not really sure how that plays out. Can you just fill some of us in as to how you're still in existence and kind of the up and down sides of that and how important you feel the re-authorization would be.

MR. WILDERMAN:

Okay. Well, let me tell you, the last couple of months have been really painful.

CHAIRMAN:

David almost had a nervous breakdown.

MR. WILDERMAN:

Really have been very difficult on the staff. It's very hard. We've lost a couple staff already. Many people are taking Civil Service and other tests, and we have a great staff. I can't speak highly enough of the qualities of people like Flossie Wolf, Joe Martin, the people that run the organization and all the way down. So you know, it is a difficult

time. The executive order really saved us, so to speak, and we're kind of hanging on by our fingernails at this point hoping that we will get re-authorized.

What I can say to you, though, is that our reports are done on an annual basis. And we had in-house, as of June 30th, when the statute sun-setted. We had all the 2007 data in-house, so we are able to reduce the reports that you're used to getting through 2008 and 2009 based on the data that was already in-house at that time.

We are in a little bit of a soft situation as to the data that is now required for 2008, the first quarter of 2008. We're concerned that some will not, although the Hospital Association has given good direction on this, the Governor's office has given solid direction on this, that the Council exists as it existed before, that the responsibilities are still the same. And we have had a lot of compliance. We have not had any unusual bumps in the road, so to speak. We have been embraced by --- as been indicated by the Chairman earlier, pretty universally that we're a data agency. We're not advocating any side or another. We're trying to provide transparency on healthcare information so people can make intelligent choices. And I think

that's reflected in the first bill that passed through the General Assembly, which passed unanimously until it got caught in the other issues.

REPRESENTATIVE BOYD:

Okay. That's all.

CHAIRMAN:

Representative Quinn?

REPRESENTATIVE QUINN:

Thank you for coming today. Over a year ago there was a vote in front of this committee, and actually it was a motion to refer a bill to the Health Care Cost Containment so we could determine the true cost of the autism insurance. And the argument was made that it would take too long to get data and the answer out from your organization. And on that he said, well, can't we just ask them to prioritize it? I mean, what is it --- what's your average turnaround? I know that's tough to answer in a vacuum. But also, are you in a position as the data organization to prioritize something if the request was made by the speaker of the house would be, the members of this committee?

MR. WILDERMAN:

It does, unfortunately, take a considerable period of time. And I can't --- we've

done 7 of 27 requests that have been made.

When a request is made we act upon it immediately. There's no delay in our action. What's not calculated in the statute is the fact that we have a council that's representative of all the stakeholders, and that's a really powerful way to set an organization up, because it helps to --- in the acceptance and validity of the data and reports that we put out. But that council must act, so even though a statute may set a specific, you know, timeline, in addition to that timeline, we have to calculate in the fact that it takes the Council to approve the AARP, for example. It has to take Council action to decide whether or not sufficient evidence or sufficient material has been submitted by both sides. So that --- you know, that is a process.

I want to say, though, very forcefully, that I think the legislature, General Assembly, has designed an excellent way to approach this subject. And that is that rather than requiring the Council to do original research, which is normally what happens in this kind of situation, there is a plethora of data out there on most of these issues. And what the burden is then put on the proponents and opponents to collect their best resources, and then we are able

to --- and again, it's a process, because we try and get the most scholarly, the most credential people to bid on the process. It costs about $150,000 to do an individual study, but they don't have to do original research. What they're able to do then is take the best reports from both sides and then evaluate them.

We do a preliminary evaluation so that not everything goes to that $150,000 review. We do a preliminary evaluation as to whether or not sufficient data has been submitted so that an evaluator can weigh it. And that's something that needs to be taken seriously by both sides. And I think that, you know, some improvement could be taken --- could be made in that area so that there's more robust data on both sides.

REPRESENTATIVE QUINN:

Thank you very much.

MR. WILDERMAN:

Thank you.

CHAIRMAN:

Representative Taylor?

REPRESENTATIVE TAYLOR:

Thank you very much for coming out today, Mr. Wilderman, and really, it's been enlightening so far. And I have to say PHC4, from my perspective, $5

million has a really big bang for the buck. It really has for what you have done. No question in my mind that you have saved lives by uncovering a number of things, and in just reading through the report about, you know, hospital acquired infections or things that you have uncovered, the length of stay and how much additional cost it puts into the system.

But that kind of leads to me to say, you know, I think this is one of the success stories of Pennsylvania since its inception in '86. But if I were to ask you, what do you think is the single best success of PHC4, what would you say that is?

MR. WILDERMAN:

That's a hard question. I would say our hospital performance report, which reports on about 50 different procedures and includes charge and outcomes. And I then --- there's one important thing to understand about the health --- Pennsylvania Health Care Cost Containment Council, which makes us unique in the nation and really in the world, and we are --- we have been studied by the Japanese. We've been studied by the British. We've been studied by the Canadians. They come to CDC and they come to PHC4.

And our hospital performance report allows --- as you'll hear later in the testimony,

allows the purchasers to design plans that focus on centers of excellence. Because the way we measure that, most states or national organizations are measuring quality in terms of what are called process measures. And those are measures that would give you an indication of a hospital, the percentage of time that they give an aspirin, for example, to a person who enters the hospital with a cardiac procedure. That's helpful and we support that, and we think maybe we can expand our reports to include them or link them, at least, to our data --- to our electronic data center.

But what we do is very different. And what's different about it is that, for example, in the cardiac procedures report, we give the doctor by name, by the number of times they've performed a procedure, by their outcome in terms of mortality, and whether or not it's within two standard deviations of the norm and length of stay, which you indicated is a good surrogate for quality. So when you look at our reports and you compare them to other data that's available called process measures versus our data, which is outcome measures, we are light years ahead of where other states are.

And we've been endorsed by the United

States Department of Health and Human Resources, the Agency of Healthcare Quality of Research Organization as, you know, the leaders, and one of the reasons they advocate very strongly for our continued work. And we've also been endorsed by ten states, because they're all trying to get to where we're at. And fortunately our --- the visionary and nature of the original legislation has put us in that posture, but we need to continue. We have lots of other areas where we could be moving.

REPRESENTATIVE TAYLOR:

Thank you very much.

CHAIRMAN:

Any other questions? Dave, I want to thank you. And again, I just want to mention the fact that you've brought up a good point, the outcomes. We need to find out the outcomes. And certainly a lot of our hospitals are a little reluctant to tell us what the outcomes are, so ---. But I think both sides are in favor of re-authorization. It's just the fact is that as technology changes, things change. And I think the last time we did anything was about five years ago and technology has evolved every year, and so I think by forming this commission that I suggested and some things that we can strengthen and make it a

better condition. And I think that's our intent.

So again, I want to thank both you and Flossie. I want to thank you for the fine job you have done over the years. Thank you very much.

MR. WILDERMAN:

Thank you very much. And I want to, again, thank the representatives that are here, and Kathy and Rick and others for the support that you've given to PHC4. We're glad to be endorsed by both sides of the aisle and view as we go through this commission process of if we are re-authorized to look at ways we can expand the scope of reporting. So it's even more robust data set for your constituents and the purchasers and so on, the healthcare consumers.

CHAIRMAN:

Very good.

MR. WILDERMAN:

Thank you very much.

CHAIRMAN:

Thank you.

MR. WILDERMAN:

I appreciate the opportunity.

CHAIRMAN:

The next people who are going to be testifying is Thomas McNulty. He's the chairman of

the Delaware Valley Health Care Coalition, and Thomas Lamb, director of the Delaware Valley Health care Coalition. Welcome.

MR. LAMB:

Thank you, sir. Tom McNulty, who is the fund administrator for Plumbers Local 690 in Philadelphia, could not attend today, so ---.

CHAIRMAN:

Okay. So you're ---?

MR. LAMB:

We are here as a pinch hitter. We would first like to thank the committee for the opportunity to come and express our opinion on more of a practical use for Pennsylvania Health Care Cost Containment. And the committee should be commended for your innovative questions, which surely shows your knowledge and concern of medical and medical concerns for the people in Pennsylvania. I think you should be commended for that.

My name is Thomas Lamb. I administer law enforcement health benefits, which is the Philadelphia Police Health and Welfare Fund. I also serve on the Delaware Valley Healthcare Coalition Executive Board, which currently is approximately 148 unions across the nation, about 60 in Pennsylvania. And some of my good

friends from Delaware Valley will be testifying after me.

What we wanted to do is, on a practical standpoint, how law enforcement health benefits and most of the funds in Delaware Valley use the information from Pennsylvania Health Care Cost Containment and what the net results are. We encourage our members, either through our website, through our mailings, and our district meetings at night where the officers and their families live, and what we do is we try to lead them to the website so they can determine for themselves what are the best locations, hospital locations with the best results for their specific medical conditions.

And what we do is, we simply printout information from Pennsylvania Cost Containment and we pick a specific illness. We try to tie it into children because with children they'll come out and it will ring a bell, and it will pick a hospital. We'll pick an illness for children. We'll ask the members, does it make any difference to you how many procedures, how many of these specific procedures, were done at an individual hospital that you might be considering? Does it make any difference whether you're the third person or do you want to be the 333rd

person? Because obviously the more the hospital does, the better they are at it and you sort of see the light bulb go off.

Then the next column is, are you concerned about the mortality rate at the hospital? And obviously, they all are. What about the length of stay with the theory being in there? The longer you're in there, the more chance the hospital has to kill you. The next one is, what about re-admissions for hospital caused complications or infections. And of course, we fold the cost over, because the members are not concerned about the cost, they're concerned about the quality of care, the centers of excellence. They want to get in and want to get out and they don't want to go back. And you can see the light bulbs start to light up. And in fact, we have a retired Philadelphia police officer that does nothing but sit on our Northeast office and calls every member twice a year, and we have about 10,000 contracts, about 25,000 bellybuttons. And part of his little dissertation is, are you aware of the Pennsylvania Cost Containment?

When they start to realize that they have an avenue to go --- because obviously it doesn't hit home until they have a diagnosis. And we had a

perfect example. A member called our office, was just diagnosed with a brain tumor at a local hospital. We mentioned about the Pennsylvania Cost Containment and, of course, we supplement it with some nurses that we hire. Within two days he had a second opinion at the University of Pennsylvania. He was misdiagnosed at the local hospital. Turned out he did not have a brain tumor. He had inflammation on the brain that could be treated by prescriptions. That probably saved us $200,000 for him going on the website supported by our nurses' group. So that's more of a practical standpoint for us.

What does that all mean? It sounds wonderful. We at Law Enforcement Health Benefits, just like you, are very, very concerned about the cost. We exist through binding arbitration on a fixed dollar amount from the city. We manage our own medical benefits. The city provides a dollar amount, we maintain the highest level of benefits for our members.

We have had one medical change, one benefit level change since 1993. In 2006 the arbitrator mandated that we cost shift $700,000 to our members, so we had to change our prescription plan from zero generic, $1 name brand to $2 generic, five

percent of the cost of the name brand, minimum $2, maximum $20. That was the only benefit change that we've had since 1993.

We look at cost containment in three areas. We are very, very aggressive in monitoring claims paid to ensure there are no improper claims, and the Medicare acknowledges that 8 to 12 percent of premium is because of improper or fraud on claims. The second thing we do is member education. That really ties into Pennsylvania Health Care Cost Containment, because the Centers of Excellence, the hospitals that are best for that specific illness, as we said before, they get in, they get out. It minimizes trauma and anxiety to the family and saves our fund money. And the last thing, we tie that in with wellness programs.

What does that mean in a practical world? Two years ago our Blue Cross increase was four percent. One year ago it was three percent. This year it was 1 percent and we had a decrease in prescriptions of 1.4 percent. Now, obviously Pennsylvania Cost Containment was part of that in educating the members. That's my presentation, sir.

CHAIRMAN:

Very good, Tom. It was a great

presentation. And the fact that you have certainly concentrated on the cost factors, I think more people have to take that in consideration. I think the more we educate the public, the better off we are. I mean, an informed consumer is the best thing that we can have. But let me --- I just want to ask you, ---

MR. LAMB:

Sure.

CHAIRMAN:

--- all that stuff that you mentioned, one thing that is not mentioned --- that I didn't hear you mention is the physician. Because from my knowledge and from what I understand, the majority of individuals who go to the hospital go there on the recommendation of their physician.

MR. LAMB:

That's correct.

CHAIRMAN:

I mean, do you --- we have all this data. Do we say, the battery of physicians, too, to say, well, you know what, your physician doesn't go to these hospitals, you have to go to another physician? How's that work?

MR. LAMB:

Well, that's probably the single biggest

problem of the physician referring to their golfing buddy who's a specialist. What we do is --- and we have a website, LEHB.org. We have questions we want you to ask the doctor and the specialist, so when they go --- and some of the questions get a little dicey, because we ask, why are you referring me to him? What are your results? We have our members call the hospital and ask, what group of specialists in that area have the best results? Then we have the members meet with that group, supported by our nurses and ask the questions. And we even offer our members a financial incentive of $15 if they complete that and return it to us, because we think $15 would be well spent if you're going to a center of excellence with a doctor's group that has a better result than the other.

CHAIRMAN:

Excuse me. Thank you. Any questions? Representative Melio?

REPRESENTATIVE MELIO:

Yeah. Tom, do your members contact the Council?

MR. LAMB:

No. Well, our members can surely contact the Council. We encourage it and then we do it

through our website, through our contact phone calls and through our district meetings. So I'm sure the members will seek it out for themself. But normally they will call us with some advice, so --- but I can't say that ---. I can't tell you how many contact them direct, but we get plenty of calls saying, I went on the website. The two hospitals appear to be the same, Einstein and University of Pennsylvania. Do you have a recommendation? And obviously we don't recommend. We tell them exactly what you said, contact the hospital. They all have a customer service person and find out what doctor's group has the best results, then you may determine it from there.

REPRESENTATIVE MELIO:

Okay. When you call the Council, is this a specific person you contact?

MR. LAMB:

I usually contact Mike Bernie (phonetic). And in most cases our needs are taken care of through the website, because our concern is getting the person to the hospital and the doctor's group that has the best results. If it goes a little more in depth than that, like the infection rate, they came out with the cardiac report, I will call Mike Bernie and get in depth on that to see what we can do with it to promote

it to our members.

REPRESENTATIVE MELIO:

Did you ever have a problem where they say, oh, it's going to take too long?

MR. LAMB:

Never, never.

REPRESENTATIVE MELIO:

Thank you.

CHAIRMAN:

Representative Quinn?

REPRESENTATIVE QUINN:

Thank you. I'm really impressed with your program.

MR. LAMB:

Thank you.

REPRESENTATIVE QUINN:

10,000 head count, 25,000 belly buttons?

MR. LAMB:

Yes.

REPRESENTATIVE QUINN:

I don't think any of us have ever counted figures in terms of belly buttons. You mentioned that you give an incentive for this research of $15. I'm really impressed by the wellness in trending with obesity and things like that to actually have a fall

back. The prescription numbers, do you --- what kind of incentives --- or do you just have a more, you know, physically active population being police officers?

MR. LAMB:

Well, if they have 15 years and less, they fall into that category. Over 15 years, some of them we have to watch. What we do is, we receive an executive report every year from Blue Cross. From that report we sit with our nurse group and we determine the wellness program so we can ensure the highest return on investment.

And one of the things that you might find interesting, and we've been doing this for eight years, we provide free flu shots to all family members 19 years and older. And how we came to that was, we was sitting looking at our paid claims, which we get monthly, and we noticed a $12 or a $15 flu shot, which was the allowable rate for Blue Cross, and on every third or fourth one there would be a $60 office visit. So I said, you're going to the doctor, you're getting a $12 flu shot, the doctor's tacking on a $60 office visit. Why don't we contract with the hospitals, provide the flu shots at our two sites? Obviously that's good for our politics, and we run between 2,500

and 3,000 people through there on about 15 different dates.

And you can't --- you don't know how many dollars you actually save. You obviously saved about 322 $60 office visits. But what you can't calculate is how many sick days and office visits because of flu did you deter, or if they had a respiratory problem, emergency rooms and maybe even inpatient.

REPRESENTATIVE QUINN:

I mean, we all know what we would should be doing in regular wellness type of programs. A lot of people ignore that. It's nothing that --- you don't have yet a policy or incentive, you know, once a month get on that scale, that type of thing?

MR. LAMB:

Well, we're trying. Just another thing, we do the heart cam that we pay for out of contract. The heart cam is a three-speed, high dimensional computerized image of your heart and the arteries. And we used to do something with Jefferson University where they would draw your blood and you would come in and the doctor would say, this is a good number and this is a bad number. There was no incentive for behavior modification with that.

With the heart cam, when you're finished,

you actually sit in front of a color computer monitor and they take an arrow and they say, let's track your artery and see if there's any yellow. The yellow is the clot. We have actually saved 18 lives. So in that, again, you can't calculate what you saved, because the behavior modification, if they start to exercise or if they're on medication or in some cases, they wouldn't let them leave the hospital for their own liability, they had to take action on them.

Obesity, what we tried to do with obesity --- which starts everything else, the diabetes, as you know, what we tried to do with that, we had something called the biggest loser.

CHAIRMAN:

The TV show?

MR. LAMB:

Yeah, just like TV. Just like TV we offered the members a financial incentive. I think the one who lost the most weight we gave $500, and the two second place we gave $250. We had about 50 people participate, because we screened them as an introductory type thing. It turned out that our return on investment on that was horrendous. So what we're now looking into is just what you said, get on the scale every week, from walking clubs throughout

the city, so it would be called the LAHP Northeast Walking Club, the LAHP South Philly Walking Club, make a captain and the captain's responsibility would be to weigh everybody. That's what we're contemplating in the fall.

CHAIRMAN:

Any other questions? Representative Boyd?

REPRESENTATIVE BOYD:

I love the creative ideas.

MR. LAMB:

Thank you.

REPRESENTATIVE BOYD:

And as I'm a likely person, I really don't like the term the biggest loser.

MR. LAMB:

Excuse me.

REPRESENTATIVE BOYD:

So I'm curious. One of the things --- and I knew you were here earlier. One of the primary focuses that we've had on our taskforce is looking at PHC4 to report actual costs. And I don't even know what word to use, whether you use the word charges or costs. And the bottom line is, what is paid for is service. Do you see if we can get that data somehow

to be reported by the PHC4 board, would it help an organization like yourself and do you have any creative ideas as to how we can get that information out?

MR. LAMB:

Well, we have been attempting to get that from Blue Cross for 20 years, and they called it the keys to the kingdom. One of the problems with Blue Cross is they pay a discounted rate on all hospitals, so they will discount 72 percent. Where I think the problem's going to come in is if they go to actual discounts, a group like ours that is required to live inside the city, five or six university based hospitals, the discount may be as high as 90 percent, so it would help groups like us. But some of the unions that have people that live in the suburbs, the discount may only be 13 percent.

So I think the cost is certainly one thing to help educate us. But I think the more important thing is, what is their actual arrangement with the hospitals? Is it per diem? Is it a fixed dollar for DRGs? What is it? And then, what are they doing when the hospital simply says, increase the cost ten percent across the board? What are they doing to hold them accountable for that?

REPRESENTATIVE BOYD:

Do you think that this idea that was floated right around the budget time of just requiring Medicare reimbursement rates for procedures to be identified, so that --- you know, kind of create a baseline for procedures, Medicare reimburses this for this, this procedure. Would kind of that baseline information help you then?

MR. LAMB:

Yes. That would be a help, because that would be much more realistic than what we're paying today and it would enhance our use of Pennsylvania Cost Containment.

REPRESENTATIVE BOYD:

Yeah. At the very least it would give you the ability if you saw something that was greatly out of kilter, if you will, with that baseline to at least ask the question.

MR. LAMB:

That's correct. And just a side note, if you don't mind. I would love to see Pennsylvania Cost Containment services be expanded into the pharmaceutical business.

REPRESENTATIVE BOYD:

Okay. Thanks.

CHAIRMAN:

Tom, it's excellent testimony, and certainly, Representatives, we probably started a trend here today. Maybe you'll get me to go out and buy a scale so I can weigh myself every day. It reminds me of the story that a friend of mine had a heart operation, and he goes to the doctor and he's overweight and he was smoking and he's told the doctor and the doctor says, listen, you got to lose weight. He says, hey, doctor, there was five of us that you operated on the same day. He said, four of them died and I'm still here.

MR. LAMB:

Well, thank you very much for the opportunity ---

CHAIRMAN:

Thank you ---

MR. LAMB:

--- to make my presentation. Thank you.

CHAIRMAN:

--- for the excellent testimony.

MR. LAMB:

Thank you.

CHAIRMAN:

The next individual to testify is Fred

Weiner. He's the executive director of Dragonfly Forest.

REPRESENTATIVE QUINN:

Actually ---.

CHAIRMAN:

Oh, I'm sorry. I'm sorry. Not yet, Fred. Matthew Kearney, secretary of Delaware Valley Healthcare Coalition and Steve Thomas, Executive Committee, Delaware Valley Healthcare Coalition. Welcome.

MR. KEARNEY:

Thank you.

CHAIRMAN:

So whenever you're ready, we'll be ---.

MR. KEARNEY:

We're ready.

CHAIRMAN:

Okay.

MR. KEARNEY:

Mr. Chairman and members of the committee, good morning. My name is Matthew Kearney, and I am the administrator with the International Union of Painters and Allied Trades District Council 21 and also the secretary of the Delaware Valley Healthcare Coalition. With me is Steve Thomas,

administrator with Sheet Metal Workers Local 19, and an executive board member of the DVHCC.

The DVHCC is a group of multi-employer health and welfare funds who joined together to improve each fund's individual purchasing power. At the present time, we represent 100 funds located in the Commonwealth of Pennsylvania, representing 190,000 members and when member's dependants are considered, we easily represent more than 400,000 participants.

One billion, five hundred million dollars is an extremely conservative estimate of the DVHCC member funds' overall healthcare dollars spent for annual hospital/doctor services for calendar year 2007. The DVHCC member funds are located across our Commonwealth from Pittsburgh to Philadelphia and are found in most of the counties in between.

It is also part of our mission to research, evaluate and creatively develop programs that improve the quality and efficiency of healthcare and various healthcare delivery systems.

I wish to thank this committee for allowing me the opportunity to bring forth the DVHCC directors' views on the Pennsylvania Health Care Cost Containment Council and the effect it has on the delivery of and payment for health care in our

Commonwealth.

Our board members believe that the PHC4 is invaluable. PHC4 collects, analyzes and publishes data about the cost and quality of healthcare. This information is essential to labor union and employer sponsored health benefit plans in the Commonwealth. The data allows healthcare purchasers, including the DVHCC and consumers, to compare information about the cost and quality of hospital outcomes, the value of healthcare. Providers and insurers can use PHC4 data to identify cost containment and quality enhancement opportunities.

In order to illustrate the value of the PHC4 and their work, I will address two specific reports. The first report is the Hospital Performance Report. This report includes information about risk-adjusted mortality, re-admissions, lengths of hospital stay and hospital charges for patients admitted to 177 Pennsylvania hospitals for 12-month periods. The HPR report evaluates each hospitals' performance across common medical procedures and treatments. This report provides comparative information about the most efficient and effective healthcare providers to individual consumers and group purchasers of health services.

As Pennsylvanians, we deserve the right to make educated decisions, and as healthcare purchasers we need to be informed in order to negotiate the most cost effective and comprehensive programs available. The HPR report accomplishes both of these goals.

The second report is the Hospital Acquired Infections in Pennsylvania Report. This report includes information on infections that were contracted by patients in Pennsylvania hospitals and the overall financial impact of hospital acquired infections. The PHC4 provides our member fund administrators with the information to negotiate the best financial arrangements possible. PHC4 database and formal reports have been invaluable in identifying the facts and circumstances that drive healthcare costs. In addition, this information forms the basis for our member funds' consultants strategies and proposals for premium reduction and stabilization.

Additionally, our directors believe one of the two best sources of information with regard to determining medical outcomes and medical facility cost is the PHC4. For example, our coalition utilizes specific information from the PHC4 to determine which medical facilities to include in our hospital

preferred provider network. Upon completion of the network, the information received from PHC4 will be a tremendous source for administrators to decide which medical facilities in our Commonwealth produce the best outcomes for our patients.

Unfortunately, due to a squabble between our Commonwealth's executive and senate legislative branches over the excess M-care money, the PHC4 was used as a pawn in this. However, using a nationally recognized health outcomes organization as a pawn and actually allowing the PHC4 sunset provision to terminate their existence is extremely unfortunate. If not for Governor Rendell's Executive Order re-establishing the PHC4 until November of '08, we would have lost this valuable source of information.

In September 2008, when the legislature reconvenes, our coalition will once again try to get the PHC4 re-authorized by the Commonwealth legislatures and executive branches of government. Hopefully the next re-authorization bill that passes the State House of Representatives 221 to zero with complete bipartisan support will be passed by the Commonwealth Senate without holding the PHC4 hostage. At this critical juncture, our directors urge you to recognize the many benefits of the Pennsylvania Health

Care Cost Containment Council and to do all possible to pass the reauthorization of this exceptional organization.

Once again, thank you for allowing us both the opportunity to present in front of you today.

CHAIRMAN:

Thank you very much.

MR. KEARNEY:

That's the end of my report.

CHAIRMAN:

Any questions?

MR. BOYD:

Steve, do you have anything to say?

CHAIRMAN:

Oh, do you have testimony?

MR. THOMAS:

No, I do not.

CHAIRMAN:

Any questions? I want to thank you for coming here and testifying. Certainly in labor and business working together, Health Care Cost Containment Council.

MR. KEARNEY:

Thank you, Mr. Chairman. And there are several things where labor and business do come

together. It's not that rare. Thanks again. Thank you.

CHAIRMAN:

All right. The next individual to testify is Fred Weiner. He's the executive director of Dragonfly Forest. Welcome, Fred, and maybe you can tell us what Dragonfly Forest is.

MR. WEINER:

I will be glad to do that. Mr. Chairman, members of the Committee, I am Fred Weiner. I'm the executive director of Dragonfly Forest. And I thought I would give you a little different view of the PHC4 data and its usage.

In 2001 we contacted the PHC4 team to provide us with some custom data for 1998, '99 and 2000 and particularly their inpatient discharge report. And we looked at that to see whether or not there was a need here in Pennsylvania for chronically ill children to determine whether a residential camp to help support these kids was applicable. To the best of our knowledge, there was only one place where the data existed in a combined and compiled format and that was with this group. We tried to get the same data from Delaware and New Jersey and were unable to. But the data that we did get, we were able to match up

with the availability of other camp locations that support kids who are seriously ill. And we were able to find out whether or not in this region there was a need for a camp that supports seriously ill children and more importantly, to tell us which of those areas in which of those disease states we should focus on.

We were created. Because of this feasibility study Dragonfly Forest was born. We are a non-profit organization, 501-C3 organization. We're committed to offering children with serious illnesses and disorders the ability to go to camp, a free overnight camp experience in an environment that is designed to meet their needs, a place where they can feel normal and where they have --- just enjoy the possibilities that life has to offer.

Since we started our camp three years ago, 650 children have been served in this area. We are continuing to grow into a full summer program and also building a year-round outreach program that will take our summer program and repackage it and bring the camp into the local hospitals and rehab centers for kids who can't come to camp. This summer we served children with persistent asthma, bleeding disorders and Sickle Cell disease, and in addition we have a first of its kind camp for children with autism.

This was a historic first, not only here in Pennsylvania, but also in the United States, in that a program like this has not existed, a program that was free of charge where the kids could come to a residential program or camp and that the parents who take care and the guardians who take care of these kids got a respite from every day daily tasks that are involved with dealing with these children.

We use this data also to help justify our existence to our funders, and it was very important that we have this level of data to be able to show them that an organization like ours made sense and that they were willing to open up their pocketbooks to allow us to exist. If it wasn't for the PHC4 data, we would not have really been in existence.

I understand and we understand that the funding of PHC4 is currently caught up in some various political issues. And I hope the members of this committee and our other elected officials will help fix this issue and will re-authorize PHC4 so that they can continue with their efforts. I can't help but wonder how many other programs like ours are being affected by this particular organization not being re-authorized.

Unfortunately I couldn't bring any

campers with me today to tell you what they feel about the organization and they probably don't even know that the organization exists. They just understand that they get to go to camp for free, but what I thought I would do was tell you a little bit about a child who last year told us that he had the beast summer of his liff. Now, I will interpret that for you. That was, the best summer of his life.

And basically, he said that when his grandmother told him that he was going to summer camp he was very scared, that he didn't want to go. He didn't know anybody there. He didn't have any friends there. His grandmother wasn't going to be there, and he also thought it was probably going to be a little boring. And this was for an asthma camp and he said, asthma camp, you know, no way, I sure don't want to do that. It turned out this was the best time that he ever had.

When he got there he said that he was excited to see that all the counselors knew who he was and that they knew something about him. They knew his name and they knew where he was supposed to put all his stuff. And they knew that he has asthma, but they really didn't want to talk about it all that much. One counselor told him that it was his job to make

sure that he had fun at camp and that everyone that has --- everyone that was there had asthma, so it was no big deal. And that counselor turned out to be correct. He only thought about it once and he remembered it was because he was thinking that he didn't have to --- he wasn't ---. He was able to do things he was not able to do before, that he would normally not be able to do.

He had a really good time with all the stuff. He climbed on the high ropes. He went to the gym. He played basketball with his friends, and he wasn't as scared any more because he made new friends when he was there. And he really didn't realize how many new friends that he didn't know that he was going to meet when he got there. And he also found out that some of his counselors were some of the coolest people in the world, and now Dragonfly feels like home. This particular camper came back for the 2008 camp season that we just completed.

And I tell you all this because this whole dream of Dragonfly Forest started from a series of data that came from the PHC4. And for a bunch of databases and a couple of spreadsheets, a bunch of seriously ill kids now are having the times of their lives at camp at no cost to them. So just a little

different view of how some of this data can be used.

CHAIRMAN:

That's great, Fred. I certainly want to thank you for bringing that to our attention. And certainly, PCN (phonetic) out there and your testimony, you might --- I mean, people out there watching might be able to start the same thing you started out here on behalf of ill children, to take advantage of what you accomplished.

MR. WEINER:

Thank you.

CHAIRMAN:

Representative Taylor?

REPRESENTATIVE TAYLOR:

No.

CHAIRMAN:

Representative Quinn?

REPRESENTATIVE QUINN:

Thank you. In the spring of this year we received notice from the state that there were mini grants of $500 available for constituents for an autism camp. Is that your camp?

MR. WEINER:

It was not our camp. We currently get no money from the state or federal government. All of

our money comes from individuals, corporations and fundraising events that we do. Something we're looking into, but don't get today.

REPRESENTATIVE QUINN:

Okay. As a parallel to your story, I received a letter from a mother of a child who went away to one of these, you know, state-funded camps and it was the best summer of his life and he was with everyone who was just like him. Thank you for your work.

MR. WEINER:

Thank you.

CHAIRMAN:

Representative Melio?

REPRESENTATIVE MELIO:

Yeah. Fred, how many camps do you have?

MR. WEINER:

There's one camp. We have multiple sessions. Each session is for a different disease group, so this summer we had three --- yes, three sessions this summer. Next summer we'll go to four. And starting in October this year we'll be starting our program called the Dragonfly Away Program, which takes the camp into the hospitals and to rehab centers.

REPRESENTATIVE MELIO:

And what are some qualifications for your patients that you see?

MR. WEIMER:

That kids need to fit into the disease group that we're servicing. So if this is for just an asthma and autism camp, then they need to have that particular disease state obviously. Other than that, there really are no qualifications other than an age range between 7 and 14 years of age. If they want to --- if they're older than that, they can participate in our counselor-in-training program and/or our counselor --- full counselor program. We do know financial needs tests with these people. For the most part, we find that they are --- they have been somewhat financially devastated by their diseases, that just the cost of living with these diseases tend to really impact the families.

REPRESENTATIVE MELIO:

Your counselors are involved in every disease?

MR. WEINER:

Our counselors --- we have counselors who are educators. We have counselors who have the disease that those kids may have. More have some more

during the summer. We have counselors that are college age students who are studying to become special ed teachers and things like that, so we really support a variety of different counselor positions.

REPRESENTATIVE MELIO:

And what is your next camp going to be, what disease?

MR. WEINER:

It's a great question. We're going to continue the work that we've done on the autism side of the world. That really has been a phenomenal program for us this year. We are talking with a number of other disease groups who want to hold camp for their kids who currently don't have the ability or the facility to do that. And we're looking to expand within those groups by next summer.

REPRESENTATIVE MELIO:

And how do you get these patients?

MR. WEINER:

We get these patients from a variety of different referral organizations. A lot come from hospitals, some come from organizations like the Delaware Valley Hemophilia Foundation. So people who represent those disease groups or work with those disease groups tend to refer us.

REPRESENTATIVE MELIO:

And are most of these patients from the Philadelphia area or do we have a specific area where it has to come from?

MR. WEINER:

Our camp services are kind of the Mid Atlantic region. We are affiliated with Paul Newman's Hole in the Wall organization, so there are other camps that are located around the country --- actually around the world at this point. We are our own separate entity. We have to raise our own money. We have our own board of directors. We have our own --- really every aspect of this. The association just provides us overall guidance across the board. We do, however, try to stay within a range from kind of Princeton south, Washington D.C. north, as far out as Pittsburgh. But the primary group that we service is from the Delaware Valley.

REPRESENTATIVE MELIO:

And you highly recommend the PHC4?

MR. WEINER:

Yeah. If we didn't have their data, we would not have --- we wouldn't have had the information. And the biggest part of that information was being able to go to a group of individual and

corporate funders and say, this camp is really needed, and let me show you why it's needed. And it also helped us avoid what probably, for us, would have been a major pitfall if we didn't have the data, which was there is a huge number of kids who have cancer, obviously, in this area. It turns out that we found that out, you know, and that was with the data that we received. But when we added to that, the information about the camps that were available in this area, there's also a huge number of camps that service that population. In fact, about 95 percent of those kids were serviced by a camp in this area.

So rather than going after the same kids, which is where we probably all would have started if we would have not had this data, what we were able to do is really grow the pie and be able to support kids, like kids with Sickle Cell and bleeding disorders, persistent asthma, autism, things like that who didn't have a place to go to camp before. So now the kids who had a place can still go there, plus there's more spots for other kids to be able to go to camp as well.

REPRESENTATIVE MELIO:

Okay. Now, just to --- the last question is, where is the camp?

MR. WEINER:

The camp --- we lease the facility at West Town School, so it's right out in West Town, Pennsylvania, which is just a couple minutes away from West Chester. When the school ends we kind of take over their facility. It's a phenomenal 600-acre Quaker school facility, and we feel ourselves very lucky to be allowed to be at that facility.

REPRESENTATIVE MELIO:

And how do you get the kids there?

MR. WEINER:

We either bus them there, parents drive them, some kids will take the train and we'll pick them up at the train station. We have a variety of different ways that we can get them there.

REPRESENTATIVE MELIO:

Thank you.

CHAIRMAN:

Representative Bianucci?

REPRESENTATIVE BIANUCCI:

A quick question. Are you aware of any similar organization in western Pennsylvania?

MR. WEINER:

There is --- not in Western Pennsylvania per se. I do know of another Hole in the Wall camp that is being developed out in Ohio that will service

the Pittsburgh area and kind of the western PA area. Right now we're servicing that area because their facility is not completely developed yet and won't be developed for the next two years. We are working closely with them so that at the time when they are developed, they will be able to transition their kids to a facility that is much closer to their home than having to come before ours, to the Philadelphia area.

REPRESENTATIVE BIANUCCI:

All right. Thank you.

CHAIRMAN:

Thank you very much.

MR. WEINER:

You're welcome. Thank you.

CHAIRMAN:

The next individual to testify is Scott Crane. He's a legislative chairman of the PAHU. Welcome again, Scott. You were here yesterday.

MR. CRANE:

Thank you.

CHAIRMAN:

It's nice to have you back.

MR. CRANE:

Thank you very much for having me back. Actually I'm a fill-in today.

CHAIRMAN:

Oh, you are?

MR. CRANE:

Yes. My good friend, Ross Schriftman, was originally scheduled to testify. I think you know Ross.

CHAIRMAN:

Yes.

MR. CRANE:

And Representative Boyd, you know Ross also?

REPRESENTATIVE BOYD:

Yes.

MR. CRANE:

Good. Anyhow, he had some family issues and asked me to fill in for him, so good or bad, you got stuck with me. But, you know, on behalf of the Pennsylvania Association of Health Underwriters, I want to thank the Committee for holding this hearing.

I will suggest to you today that PHC4 serves important functions that benefit the Commonwealth, and therefore should be permanently re-authorized. The upcoming due diligence that will be required before making any major changes in healthcare policy is exactly the type of analysis that

I think that we need PHC4 to do. I see the re-authorization as being so important, I really encourage the legislature to consider it on its own, not attach any other bills or proposals or legislation to it.

Basically it comes down to a reasonable person. You know, in working over the years with this committee, I consider every one of you reasonable people. You can't do your job and make a responsible decision without really understanding what all the underlying costs are. And you know, to that end, I think it's imperative that the true cost become transparent to everyone involved. And we talked a little bit about it yesterday on the underpayment of Medicare, and in turn Medicaid to the providers, the cost shifting that occurs. What is the real cost of the service? It's a number that seems to be alluding everybody, you know, including me. You know, I'm not pretending that I have the answer, but I'm saying that whatever the real cost is, we need to identify that so we know what we're dealing with.

Actually, Representative DeLuca mentioned earlier today in his opening remarks, but one of the concerns that I had is because the government has become a true competitor, and the example that I'm

giving it's Medicare, which is a federal program, not a state program, it's created many problems.

For instance, because of the low cost pricing and cost shifting that occurs and the other things that have happened is that providers have had to artificially increase their retail charge 300 and 400 percent. So what has happened is the carriers, in turn, have negotiated discounts that are ridiculous, and those discounts in the Philadelphia area range from 53 percent to as high as 90 percent. And all you need to do is offer those who are still on some kind of a personal choice or a PPO program or on some of the other carriers' PPO programs, just take a look at the explanation of benefits. You see I got a charge of $10,000 and, you know, we accept the payment in full of $1,863. I mean, that's absolutely absurd.

And it is the loser --- and I hate to use the word loser again, but the loser in this mad pricing equation is the person without insurance who does not qualify for a government program, and especially if they had some kind of property or resources to pay. They are expected to pay that ridiculous 300 or 400 percent inflated price. Insane? Yes. Fair? No. And I think PHC4 is really needed for this.

I think that --- when they gave testimony, the people from PHC4 and also Mr. Lamb alluded to a lot of behavioral-type things. That is a huge, huge piece of this equation. How do different people react? Our uninsured are not one type. I mean, uninsured could be people out of a job on COBRA, where their COBRA's exhausted, people out of a job where their company didn't get COBRA. They could be young and invincible people who have just chosen not to buy insurance. Also, you know, the poor, whether they're working or not working, and each group has different things that trigger different behavioral patterns which affect our cost. And I think PHC4 is needed more for that.

So in conclusion --- did I keep this brief for you? Okay. On behalf of the Pennsylvania Association of Health Underwriters, I encourage you to re-authorize PHC4 permanently. I further urge that PHC4 doesn't really stray too far from its core mission of providing comparison healthcare and cost information and evaluating mandates. Basically we need their services. And thank you for the opportunity to testify.

CHAIRMAN:

Thank you, Scott, for taking the time,

especially coming back both days. We want to thank you. And certainly this Committee has been working hard on these issues. And I have to say, on behalf of this Committee, on behalf of Representative Bianucci, Melio and Rick Taylor and Scott Boyd and Representative Quinn, we are one of the active committees in the house. I mean, we're all over trying to get testimony throughout the Commonwealth to make sure that we hear from the divisions out here so that we can bring that information back to our colleagues.

And as you heard, a couple of our colleagues mentioned back trying to get transparency on cost, which is a very tough thing to do, as you heard today. We would all like to see that, but unfortunately it's not the time we can do that. Any questions? No questions. Again, thank you.

MR. CRANE:

Thank you very much.

CHAIRMAN:

Next individual to testify is Marian Lewis. She's the director of AARP. Welcome, Marian. Take your time.

MS. LEWIS:

Good afternoon. AARP Pennsylvania

appreciates this opportunity to present testimony ---.

CHAIRMAN:

Marian, could you move that microphone closer to you? Thank you.

MS. LEWIS:

AARP Pennsylvania appreciates the opportunity to present testimony to the House Committee on Insurance concerning the re-authorization of the Pennsylvania Health Care Cost Containment Council. I am Marian Lewis. I'm a resident of Wyndmoor, Pennsylvania and a volunteer with AARP.

In today's world, information is knowledge. The mission of the Pennsylvania Health Care Cost Containment Council is to provide information to Pennsylvanians about healthcare in the Commonwealth, helping to ensure the quality of healthcare, increase access to healthcare and address the problem of escalating cost. We have all benefited from this information, whether it's been about reducing infection rates in hospitals or describing provisions of Medicare Advantage plans.

It would be easy to go on about the groundbreaking work of the Pennsylvania Health Care Cost Containment Council has done over the years in Pennsylvania. Others have provided this information

to the committee citing these accomplishments. It is most important at this point for AARP to state that as an organization representing 1.9 million Pennsylvanians, we feel that it is critical that the Pennsylvania Cost --- Care Cost Containment Council continues to have the opportunity to perform the work of collecting and publishing information about healthcare in Pennsylvania. In an era when consumers demand more information to make the healthcare they receive better and more affordable, PHC4's efforts become even more important.

It is not only at the state level that AARP recognizes the good work that Pennsylvania Health Care Cost Containment Council does. As a national organization, AARP has more than 39 million members and an extensive public outreach and research arm operating from our office in Washington D.C. Earlier this year AARP's director of state health policy wrote to the Governor and the leadership of the General Assembly urging the re-authorization of the PHC4. A copy of that letter is attached to my testimony today.

AARP was extremely disturbed that the fate of the Pennsylvania Health Care Cost Containment Council became a political football in the days leading to the enactment of the 2008/2009 budget at

the end of June and the beginning of July. There was much finger pointing and assigning of blame, but the end result was that the Council was forced to shut its doors until an executive order restored operations. Frankly, AARP and its members are not interested in who was at fault for threatening the existence of PHC4. What we are interested in is to make sure this situation does not happen again this year.

AARP Pennsylvania urges the members of this committee to agree to the re-authorization of the Pennsylvania Health Care Cost Containment Council and to ensure that action is taken by the full General Assembly well before the expiration of the executive order, keeping it open. The work of the council must continue in an uninterrupted manner. Pennsylvania's health care consumers deserve nothing less. Thank you for the opportunity to be here today.

CHAIRMAN:

Thank you, Marian. And you're an excellent spokesperson for the AARP. Let me just say this to you, I don't know where this political football comes in at I kept hearing throughout this testimony today, and there was different reasons why HC4 did not get re-authorized in a short time when it came up. It had nothing to do with the political

football. It had to do with the individuals, whether the hospital association and different stakeholders weren't going to agree on this, and that's in the business community. And we did come up with something that we believe.

We put this commission together to make it a better and stronger organization, just re-authorizing it for another five to ten years the way it was. As you just alluded to in your testimony there, technology changes. Things change. So what we need to do --- they do an excellent job. HC4 has done an excellent --- we all know that. We all recognize that. But also, it needs to have some changes, too.

So where this political football came in, I really don't know where this political football came in. And it just happened to get caught up in the budget process and it wasn't because of the fact that anybody was trying to do away with HC4. It just got caught up in the budget process, but it certainly wasn't political football on either side of the aisle.

It just happened to do with having legislation done and re-authorizing it, it just doesn't --- you don't just re-authorize. There are people involved. As the AARP is involved, so are other organizations involved, the hospital

association, also the providers. So we have to take that all into consideration. You just don't elect elected officials for what their doing in past legislation just on behalf of what's going on.

So I just want to get that out to the public. It was not a political football. Anyone else?

MS. LEWIS:

Thank you.

CHAIRMAN:

Thank you very much.

MS. LEWIS:

Thank you. All right.

CHAIRMAN:

Our next testifier is Kitty Gallagher from the Lehigh Valley Business Coalition on Health Care. Kitty? Is she even here? I guess Kitty didn't make it.

Again, I want to thank the members. I want to thank Representative Taylor for hosting this committee out here in this beautiful facility here. And I want to thank the members for coming. And this will be one of the many hearings we'll have throughout the Commonwealth to not only educate ourselves, but educate our members back home. Again, thank you.

Thank you, testifiers, for coming out today. This meeting is adjourned. Thank you.

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MEETING CONCLUDED AT 11:09 A.M.

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