COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES
INSURANCE COMMITTEE

MAIN CAPITOL
ROOM 140
HARRISBURG, PENNSYLVANIA

PUBLIC HEARING
FEDERAL HEALTH CARE REFORM

THURSDAY, MAY 27, 2010
10:04 A.M.

BEFORE:

HONORABLE ANTHONY M. DELUCA, MAJORITY CHAIRMAN
HONORABLE DAN FRANKEL
HONORABLE BRYAN BARBIN
HONORABLE DOM COSTA
HONORABLE NICK KOTIK
HONORABLE EDDIE DAY PASHINSKI
HONORABLE MATTHEW SMITH
HONORABLE RICK TAYLOR
HONORABLE BRAD ROAE
HONORABLE GARY DAY
HONORABLE ROBERT W. GODSHALL,
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STACIA LONGENECKER, LEGISLATIVE ASSISTANT (D)
KATHY MCCORMAC, EXECUTIVE DIRECTOR (R)

BRENDA J. PARDUN, RPR
REPORTER - NOTARY PUBLIC

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P R O C E E D I N G S

CHAIRMAN DELUCA: Good morning, ladies and gentlemen. It's a little after 10:00. Call this meeting to order.

And before I begin, I would like the members to introduce themselves, from my left here.

REPRESENTATIVE KOTIK: Representative Nick Kotik, Allegheny County.

REPRESENTATIVE COSTA: Representative Dom Costa, Allegheny County.

REPRESENTATIVE TAYLOR: Rick Taylor, Montgomery County.

REPRESENTATIVE BARBIN: Bryan Barbin, Cambria County.

REPRESENTATIVE PASHINSKI: Good morning. Representative Eddie Day Pashinski, Luzerne County.

REPRESENTATIVE ROAE: Brad Roae, Crawford County.

CHAIRMAN DELUCA: This is Art McNulty, my executive director, chief of staff.

I'm Representative Tony DeLuca, chairman of the Allegheny -- of the Insurance Committee and from Allegheny County.

And before he introduces himself, in case you feel that you have the wrong glasses on or you're not seeing today, my good friend Nick Micozzie.

REPRESENTATIVE GODSHALL: Bob Godshall.

CHAIRMAN DELUCA: Bob Godshall is substituting for Nick Micozzie today.

REPRESENTATIVE GODSHALL: My first chance at being one of the chairs of the Insurance Committee. I've been on the Insurance Committee as long as you have, which is twenty-seven, twenty-eight years.

CHAIRMAN DELUCA: Right.

Kathy, introduce yourself.

MS. MCCORMAC: Kathy McCormac, executive director of insurance committee.

CHAIRMAN DELUCA: Okay. Thank you.

I want -- Dan Frankel just came in, from Allegheny County.

I want to thank the members for attending this, which I consider one of the important meetings that we'll be having throughout the commonwealth on the issue of national health care.

I want to welcome all of the members of the audience, people who're going to be testifying on this series of public hearings on the commonwealth's implementation of the federal health care reform act.

By way of background, House Resolution 4872, Reconciliation Act of 2010, became public law with President Obama's signature on March 30 of this year. The President had previously signed House Resolution 3590, the Patient Protection and Affordability Care Act on March 23rd. Taken together, these bills represent a comprehensive overhaul of our health insurance industry nationally and in Pennsylvania.

The commonwealth stands to derive a number of benefits from the new federal reform. A number of marketplace practices that have prevented the public from obtaining insurance coverage and, thus, health care has been -- had been or will be eliminated. As such, health insurance coverage will become more affordable than ever before. And with more citizens having access to and in the insurance pool, costs will, at a minimum, stabilize.

In addition, on a budgetary level, the

governor's recently completed a comprehensive review of the legislation and concluded that, over the next eight years, Pennsylvania will save between two hundred eighty million and six hundred fifty million dollars.

Needless to say, there is a substantial amount of interest in this subject and already issues surrounding implementation are unfolding.

Representative Shapiro has introduced House Bill 2462, which creates an authority to oversee and manage the implementation of the reform. I'm also told that the governor has already publicly endorsed participation and I expect the committee to further study this issue.

Also, my good friend, Representative Kotik, who's here today, has introduced House Bill 2514, which sets up a high-risk pool consistent with the new federal law.

Unfortunately, we could not accommodate all those who wish to appear before this committee today. As I indicated, this is the first of what will be a number of hearings for this committee. This hearing provides the members with an opportunity to learn what exactly is in the federal bill, the health insurance issues facing the

commonwealth and what the legislative issues the committee will have to tackle.

I would, therefore, encourage each member of the committee to attend as many of these sessions as possible.

In addition, to the extent that there are discrete issues that you would like more information about, please let us know and we will do everything we can to assist you.

I am very pleased with the speakers that we will be hearing from today. They represent a broad spectrum of interest and will be able to offer perspective shared by many of our constituents.

Before we get to the first testifier, I would like Representative Chairman Bob Godshall to say a few words.

REPRESENTATIVE GODSHALL: Thank you. Excuse me. Thank you. Thank you, Chairman DeLuca.

I have a statement that I want to read that Chairman Micozzie had asked me to read for him, which I'll do at this time.

I appreciate the opportunity to address the members of the committee as well as the

testifiers before us today regarding federal health care reform. The Patient Protection and Affordable Care Act, signed into law on March 21st, 2010, will implement many changes to our current health care system, such as establishing a high-risk pool for individuals with preexisting conditions, providing coverage for dependents up to age twenty-six, providing tax credits to small employers, expanding Medicaid eligibility, establishing health insurance exchanges, and requiring all Americans, with some exceptions, to purchase health insurance coverage.

Based upon the federal law's time line, the establishment of the high-risk pool is due in a very short -- is due in very short order. Uninsured persons with preexisting conditions are eagerly anticipating accessing subsidized coverage under the temporary insurance pool.

As you know, Governor Rendell indicated that Secretary Kathleen Sabelius at Pennsylvania would be contracting with the federal government to create its own high-risk pool.

Today is May 27. The plan design needs to be received by the Department of Health and Human Services by June the 1st and approved between June the 1st and July 1st.

I understand the administration anticipates enrolling folks in the high-risk pool by mid August, perhaps September. From what I understand, the core components of the high-risk plan have been established, and while I respect the fact that federal health care reform is law now, I also recognize the need for our state to ready itself for the changes certain to follow.

In doing so, I urge all members to watch for opportunities to maximize and stretch the federal dollars where possible while maintaining a watchful eye on the future fiscal impact this new law will have on our state's budget and proceed -- and proceed on with caution.

As we all learn together what the specific changes will be and when and how they will need to be implemented, I sincerely appreciate our testifiers' opinions, recommendations, and advice regarding this new law.

I look forward -- forward toward your testimony today. Thank you.

And that was Nick's statement, which I wanted to get on the record.

CHAIRMAN DELUCA: Thank you.

REPRESENTATIVE GODSHALL: Thank you,

Mr. Chairman.

CHAIRMAN DELUCA: Thank you, Representative Godshall.

And we do have three other members who've joined us: Representative Schroder, Representative Day, and Representative Quinn.

Our first speaker is Scott Keefer, vice president of policy development, America's Health Insurance Plan.

They have played a key role in developing the legislation, and I'm sure will play an even more important role in the actual implementation of the new law.

Scott. Welcome, Scott. Thank you for taking the time to come today.

MR. KEEFER: Thank you, Mr. Chairman.

I'm delighted to join you here today, and I'd like to compliment you for initiating these forums to educate the members, and I think you indicated you're going to travel around the commonwealth, and I would encourage you to do so and help understand many of the choices that you're presented with, particularly with respect to the exchange.

What I want to do today is sort of help

you understand some of the implementation efforts already underway, some of the near-term issues -- the high-risk pool, in particular, I know is very important to the state -- and then the long-term implications.

The good news is that, as you indicated, much of the near-term effort is underway. With respect to the high-risk pool in particular, there are some challenges, but once we get through many of these near-term issues, you'll have ample time in the run up to 2014, to decide what sort of exchange and what other key provisions the state is going to have to execute will be best seeded to the needs of folks throughout the commonwealth.

And I should say that I have a personal interest in this, and I'm particularly delighted because, as a sometimes Washingtonian, I always remind people that I'm a Pittsburgher. I went to Duquesne Law School and Washington and Jefferson College and still have family in the western part of the state. So it's very good, and I have a keen personal interest in the path that the committee pursues in that end.

So thank you. But --

CHAIRMAN DELUCA: Before you begin, Representative Godshall says we all stick together from the west, so I'm glad to hear that.

Sorry to interrupt you.

MR. KEEFER: You know, I have an opportunity to travel throughout the country, and, you know, it's great to come home in many respects.

So what I've done, rather than provide a formal written statement, is to provide some slides that essentially, I think, is an outline for what I hope will be an interactive discussion, Mr. Chairman, with you and your colleagues. I thought that would be more productive for this type of session.

So, I think, moving to the second page, where I'm highlighting the implementation and many of the efforts underway, I want to start by saying that the health plan community, as you indicated, pursued this in a way to try to be a constructive player and offer up what we felt was a path to reform, but, also, I want to highlight an administrative simplification initiative that we've undertaken in New Jersey and Ohio as a demo to sort of effectuate on a trial basis many of the reforms

that are in the legislation.

And without getting too much into the weeds in this, each of you can understand Mastercard and Visa, how each bank can issue a card under the Mastercard or Visa trademark, but in terms of the payment processes, the operations, it's uniform, and what we're trying to build is a system that I know is particularly challenging for many providers in the physician community to sort of drive a unified payment system, and that, in fact, is in health reform and something that hasn't gotten sort of the media attention of many of the other provisions, so I wanted to highlight that for the committee.

The second piece is probably among those that have gotten the most public attention, and, in fact, those of you who may have children or friends who have struggled with recent graduates from college or those who have had trouble in the workplace, and the committee members are well aware that the incidents of increasing uninsurance arises the fastest among young adults, so it's no surprise that the extension of dependent coverage has proved very popular with the public.

And I know that there's a corresponding

provision recently enacted in Pennsylvania law. I'm not uniquely familiar with the details, but I've been told this by colleagues. And one thing that I would say is, I am somewhat concerned that this provision may have been a little oversold, and it's just something to highlight some of the challenges that you could hear from the public, and I say that, of course, because, you know, we're asking quite a bit of the employer community in this provision, and I think the federal law, just as I would imagine the Pennsylvania law, says that if dependent coverage is offered, it has to be extended up until age twenty-six.

And I've told a lot of my friends and former colleagues in Washington that I'm very concerned that people are going to be angry because the employer may not, in fact, offer dependent coverage. Not every employer does. Some employers don't offer family coverage, and we all know that we've gone through a very challenging period with the economic conditions and the competitiveness and the pressures, so I just highlight that, and I know that the representative from the U.S. chamber, I'm sure, will speak to that.

The next one that I wanted to speak to

is the issue of children with preexisting conditions. And I happened to catch Governor Rendell on CNBC this morning talking about the state budget challenges that you face and making his case for an additional expanded commitment to Medicaid in the form of the FMAP, and one of the provisions in the reform context that Governor Rendell mentioned was this issue of eliminating preexisting conditions exclusions for children, is something that the health insurance industry, of course, is committed to.

But with respect to this provision, as with dependent coverage, the way that we do this in the regulatory contact, we have to be very careful to avoid the potential for adverse selection, because what our data tells us from what the actuaries have put forward is that, depending on how this is done, there could be a nominal impact on premiums or there could be a very large impact on premiums, because as we all know, one of the commitments in the promises of health reform is that we, in fact, would not have the insurance market reforms fully implemented until there was the requirements to purchase coverage and subsidies available, of course, to make that work. So

everyone knows that's a three-legged stool, so we have to be very careful here.

The final piece that I want to comment on and sort of that which is underway, there's been a lot of discussion in recent days related to premium increases. And this, of course, is fair. But what we have said on the health insurance side is that premiums, by and large, follow underlying costs. Underlying costs don't just mean medical inflation. There are cost increases above medical inflation. Utilization is a factor. And then we have issues related to adverse selection and other pressures that put upward pressure on premiums.

But the point here is that we've been working with the National Association of Insurance Commissioners, and, in fact, Commissioner Ario has been a key player in that regard with the development of a standardized template that we hope will ultimately be used, available on the Internet, and helpful, Mr. Chairman, to you and your colleagues to sort of decompose what goes into a premium increase and help consumers better understand why premiums are rising and the underlying health cost trajectory as well.

So shifting to the next page and

getting a little more into detail in some of the near-term issues, what I've tried to do to break this down into bite size, digestible pieces for you and your colleagues is to bucket these and to group them into regulatory, access, and benefits.

So I'm going to take each of those together and highlight some issues that I think are important for you to continue to explore as you have these and other sessions, Mr. Chairman.

On the regulatory front, I mentioned the interest in premium rate review. There is an underlying provision in the statute that allows the secretary to provide up to two hundred fifty million dollars in grants to develop a premium review process in collaboration with the states. I'm sure that's something, again, that Commissioner Ario will be speaking to, but, again, this sort of works in concert with the National Association of Insurance Commissioners' process on transparency. And, of course, one of the key goals of health reform is to educate consumers, help them be in a position to make better choices and better understand their choices. So we think this will all work together.

One thing that the industry is not in

favor of and is very much concerned about is establishing a federal rate review authority and taking what is the providence of the state Department of Insurance and moving that to Washington. We don't think that that's going to serve the residents of the commonwealth well, and we think that we'd like to see that stay here. And I'm sure that that will be something that you would be interested in as well with respect to your jurisdiction.

The MLR, or minimum loss ratio, provision has gotten a lot of attention. This is a provision that -- for those who are not intimately familiar with the statute, there will be a 75 percent standard for a large group and 80 percent standard for a small group and individual business, and this begins for plan year starting next year.

The National Association of Insurance Commissioners is currently developing the methodology, and key in defining that methodology in the definitions is what goes into what is characterized in the statute as items improving health care quality. So care management, nurse help lines, nurse hot lines, those types of things are outside the bucket of claims expenditures that

have to be required to meet the standard.

And, of course, one of the things that we're trying to do in health reform is to improve delivery and quality improvement to prevent people from being readmitted to hospitals unnecessarily, and I think the health plans have a strong record in that role. So just a comment on that.

Rescission, this is one, along with the dependent coverage, that the plan community has pledged to the secretary, We're going to do our best to implement as expeditiously as possible. Recission is moving to a standard where there has to be fraud or a knowing, intentional deception standard on behalf of the individual when they're seeking coverage.

Moving quickly to the access bucket, we've talked a lot about the high-risk pool. I've already talked about dependent coverage and coverage for children with preexisting conditions. A little more detail on the high-risk pool and some challenges, particularly for Pennsylvania, where there hasn't been a high-risk pool in place, and I heard, Mr. Chairman, that one of your colleagues has drafted legislation to implement that, and that's really good.

But from a policy standpoint, it's critical that the members of the committee understand the existing structure generally of state high-risk pools, compared to what is in the the health reform legislation, and you understand why many, including Governor Rendell, has said that the five billion dollars is just not enough money, perhaps, for the expectations, and, in fact, government actuaries at the Centers for Medicare and Medicaid Services have said that they expect that that five billion dollars will be gone within a year to eighteen months.

And, obviously, the concern, as you sort of alluded to, Mr. Chairman, there, would be that the state would be left holding the bag, if additional federal resources weren't put on the table. I think the estimates that I've seen from Governor Rendell suggests that about twelve thousand people would be able to take advantage of it.

And just, you know, running through some numbers in my own mind, that sounds about right, because I'm going to throw some numbers out to you and your colleagues, again, to understand what challenges the states and other states

confront with respect to that provision, given where high-risk pools are now.

Specifically, a couple key provisions. Number one, the federal high-risk pool requires that premiums be offered at a standard premium rate. Second, there are no annual or lifetime limits on the coverage in the high-risk pool.

I can tell you that no state now offers high-risk pool coverage at the standard premium rate. Generally, states are in the range of a hundred twenty-five to a hundred thirty-five. Some states, in fact, are all the way up to 200 percent of the standard premium rate. Most states have some sorts of annual or limitations on the coverage. California, for example, one of the very big pools, has an annual limit of seventy-five thousand dollars.

Collectively, in the nation, we have about two hundred thousand people in high-risk pools. The losses on that two hundred thousand pool, essentially, an aggregate of people throughout the country, exceed one billion dollars a year.

Going through the numbers in your own mind quickly, you understand that if no high-risk

pool now is offering that coverage at a standard premium rate, every state is above that, the losses on that coverage now for two hundred thousand people are in excess of a billion dollars. You can understand why there's a lot of concern that that five billion dollars will go very quickly. And this isn't to say that there's, you know, not challenges for those who are trying to pursue coverage.

I think those of us in the industry who are familiar with the operation of high-risk pools understand why the drafters put the premium at a standard premium rate, because, again, we're trying to make this affordable for people, but we have to recognize the limited opportunity and how -- just how stretched those five billion dollars could be, because, again, in Pennsylvania, you're confronting a serious budget challenge. And we already know, perhaps as early as today, the U.S. House will be voting on legislation to extend, again, the Medicaid match rate that was initially increased in the federal recovery act.

The final piece with respect to access that I want to briefly comment on is the small business tax credit. I know my colleague,

Mr. Gelfand, will talk about this more, but I just want to say that is another one where we're not exactly sure of how -- how much this is going to induce firms to offer coverage, because there are serious limitations in the tax credit.

What I would suggest is that those firms that previously offered coverage, that maybe stopped offering coverage because of the challenging economy, those would be the best candidates to use this, rather than going out to firms, because, again, there are limitations that I know Mr. Gelfand will get into.

With respect to benefits, we know that there's first-dollar coverage for prevention, something that we support in the industry, for services that have high grade and a proven benefit. I mentioned the issue of lifetime and annual limits. There ultimately is going to be limitations on annual limits, what, in the legislation, is called restricted limits. The Department of Health and Human Services will be putting out guidance soon on that issue and lifetime limits.

Each of these things are going to have a small increase on premiums, and, in fact, many of

the proponents of the legislation have said, you know, that these will be nominal increases. But when you combine a number of these provisions together, there's a potential for a significant increase. If we are talking about 1 or 2 percent on a number of provisions, eventually 1 or 2 percent adds up very quickly.

Which brings me to my next point, in a long-term context, what I'd like to suggest is that one key role that I think you could play, in addition to highlighting the many important insurance market reforms, is to continue to emphasize the importance of delivery system reform, quality improvement, and cost containment.

And the pitch here is that if this is ultimately going to be a success, it's going to be a success because we're going to be able to stabilize that cost trend. If the cost trend continues to rise at the trajectory we've seen over the last decade, it's going to be very challenging. And I think you know full well that; you hear that from your constituents and providers in your communities.

The other points that I'd like to make, I highlighted briefly the exchange. The good news

for the committee on this front is two-fold. Number one, you have until 2014 till this has to be up and running. There's going to be a push from Washington for states to do this sooner. What I think is more important than moving too quickly is to determine the exact structure of the exchange, what best suits the needs of the commonwealth.

And you and your colleagues have ample history of doing terrific things with respect to the CHIP program, which really, in many ways, the genesis of was in Pennsylvania, but also the federal health care coverage tax credit program, which the state utilized very well in the context of the Bethlehem Steel bankruptcy, to ensure that people had coverage through there. So we know Pennsylvania can do the right thing. So rather than the speed, I would encourage you to pursue a very thoughtful approach.

The second thing that I want to say with respect to the exchange is that the state is afforded a lot of flexibility. And this is really good, because one of the hallmarks of this legislation, I think, that's going to be critical is to respect the traditional federalism that there has been between the states and the federal

government with respect to health care.

We know that health markets are local. Health care is a very important thing at the local level. People feel very passionately, and it affects each person individually in a personal way, so it's important that that exchange can be tailored at the local level, at the state level, rather than having sort of a one-size-fits-all Washington approach.

The second thing that I'd like to emphasize is the importance of what I call the all-important first year in the exchange and the effort that's going to have to be undertaken to get people enrolled and to help people understand their choices, the availabilities of subsidies to individuals.

Many of you know that the lion's share of those that are low income and uninsured among children are, in fact, eligible for Medicaid or the CHIP program. It's something that's very frustrating to policy makers. So we have to apply those lessons to health reform at large, because one thing we have to be cognizant of, if we start the exchange pool off, and if it's an unhealth pool, we're going to have a really, really hard

time maintaining a stable and affordable premium levels.

What we need to do is we need to ensure that the pool is balanced, that we get as many people in as possible with an adequate mix of risk, which, again, is one of the reasons why we know employer coverage works so well. People come together for a purposes inherently unrelated to their health status. Again, the great potential is there for the exchange that we could have adverse selection and there could be challenges in the pool.

The final thing I'd like to say, again, is to sort of emphasize the sustainability and the delivery system reform element of health reform and to be cognizant of the potential for unintended consequences, to engage the way that you have started, Mr. Chairman, with today's session, providers, employers, chambers of commerce, at the local level, locally elected officials, and to really get the best insights, again, into shaping this platform in a way that suits the needs of residents of the commonwealth.

It's really important that we're aware of issues, such as adverse selection, that we're

aware of the impact of the exchanges on employer coverage, for example. One example of an unintended consequence that many of us in the policy community are very concerned about, again, I highlighted adverse selection in the individual context. There's also a great potential for adverse selection in the employer context.

Let me briefly explain, just to highlight one thing that I think you need to assess as the state makes choices, because beginning in 2017, the state will be able to define what group size the exchange is available to. So the default level is one hundred. The state could choose to keep it at the small group marker, which is currently fifty, as it is in most states. But in 2017, the state has complete latitude to decide whatever group size wants to go into the exchange.

And I know many people are very concerned that if that happens, you could quickly disrupt the employer-based system, the employer-based market, and you could have people picking and choosing whether, for example, they want to come into the exchange and be part of a pool with a community-rated premium, or they want to stay outside of the exchange and self-fund under ERISA,

because then they would only have the benefit -- they would essentially not have a community-rated premium, because they would only be paying claims cost, so they're a pool.

Let me give you an example. If I started a firm with -- assume that rather than -- rather than a law background, I went to Carnegie Mellon, had a computer science degree. I'm thirty-two years old. I have a software firm. And the average age of my work force was twenty-nine. We've grown from a start-up of six people to seventy-five, say a hundred twenty-five. We would look at the opportunities to go into the exchange and say, you know, rather than being a pool that's spread and risk allocation with -- you know, with Keefer's Autobody Repair, where the average age is fifty-two and the claims trend is going to be higher, you know what, we're going to pull ourselves out of the fully insured pool. We're going to self-fund under ERISA. We're going to get reinsurance on the back end.

This could have a very, very dramatic and, I think, pronounced bad effect on, again, the balance of the pool, because I think too often elected officials focus on the size of the pool

rather than the quality, the balance of the pool, again, as I said, sort of the randomness, if you will, of employer-sponsored coverage. And I just mention this as one example of something that you have to be very cognizant of.

And the final thing that I would add, there are other provisions that could hasten this sort of picking and choosing, which, from a policy standpoint, could be bad. Again, I'm not suggesting that anything on behalf of the employer community. The employers would have to do what is in their best interest. I'm just saying, ultimately, what happens to the balance of the pools.

There's a new federal premium tax in the legislation. When that's fully implemented, it's ultimately fourteen billion dollars a year. We think that this could be as much as 3 percent on fully insured individuals. And I say "fully insured individuals" because the premium tax isn't extended to self-funded groups, those who self-fund or self-insure under ERISA. And, again, this is another incentive, a little cost differential, a percent here, 2 percent there. Ultimately, these forces, working in tandem, can have a significant

impact on premiums.

So I would encourage you, as you think about the design of the exchange, to think of other provisions, such as this flexibility that the state will have in 2017, to expand the size of the exchange. And I'd be happy to help work with you and your colleagues to understand some of those choices and limit the potential for those unintended consequences going forward.

CHAIRMAN DELUCA: That's great, Scott. You gave us a lot of food for thought. And certainly, I guess, that's why the implementation's going to take until 2014, so they can tweak it, and, certainly, that's why we're having these hearings, to educate ourself on it.

Your testimony was excellent. The only thing I would like to ask you is the fact that you talk about the high-risk pool. And you mention a fact, that seventy-five-thousand-dollar cap, I think you did say. What happens -- and I understand that once you reach that cap, that you would have to go on the private market and buy yourself insurance. Am I correct, that how that would work?

MR. KEEFER: Right. This is -- I just

used an example.

CHAIRMAN DELUCA: I understand.

MR. KEEFER: I just used an example of California, currently they have a seventy-five-thousand-dollar cap, and the truth is that if somebody's, you know, going to have costs that exceed that cap, then, you know, some of that could end up in the form of bad debt to hospitals or other uncompensated care.

So, you know, the solution, I wasn't -- I didn't mean to imply the solution is the cap --

CHAIRMAN DELUCA: No. I understand.

MR. KEEFER: -- but I think we just have to be realistic about --

CHAIRMAN DELUCA: What the cap would be.

MR. KEEFER: Right. Where the five billion dollars could go, and that, hopefully, if the pools get up and running well, you know, that the federal government will find a way to provide more money.

CHAIRMAN DELUCA: And the reason I bring that up to you is the fact -- and I understand you just gave that's as a floor -- but the fact is that the individual -- seventy-five

thousand for medical bills today is really nothing. I would imagine you would be the high-risk pool, so you have some pretty serious problems.

MR. KEEFER: Absolutely.

CHAIRMAN DELUCA: And if an individual can't pay, can't -- and there's nothing on the market where we can buy at a reasonable price, you just mentioned uncompensated care, hospitals and uncompensated care, which is spread out on everybody who has to pay, because right now, uncompensated care is about 9 to 10 percent of premium dollars.

MR. KEEFER: Correct.

CHAIRMAN DELUCA: So I mean -- so that's something we need to look at, but I appreciate you bringing that up.

Any questions?

Representative Godshall.

REPRESENTATIVE GODSHALL: Yes, just very briefly, on -- the federal law allows for federal review of the rates. Can they -- with the regionalization in health care that we have in this country, can they -- you know, how practical is that federal government -- can they, you know, for

different parts of the country, the rates can be entirely different. Are they capable of handling that kind of a concept, or are they more one-size-fits-all?

MR. KEEFER: I think, Representative Godshall, it's a great question, and I think the existing provision requires the secretary to develop that in consultation with the states. So the states have equal footing, and there is --

REPRESENTATIVE GODSHALL: But even in the states, there is a tremendous difference.

MR. KEEFER: That's correct. There's grant authority provided. One thing that we're very concerned about is the potential for a federal rate authority board, as you indicate. And as one of my colleagues said, there's not an actuary school big enough in the country to get the actuaries up and running that would be necessary to do these rate reviews and, you know, the whole notion of approving in advance, what's called prior approval.

All of the insurance products and forums now would just be an enormous magnitude, so it's not really practical. And I think you're also correct in highlighting the differences between and

among regions, not just of the country, but, of course, the state of Pennsylvania, where the patterns are very different from east to west, north to south, you know, rural to urban. So I think that's something we've been very concerned about.

And I'm sure Commissioner Ario would have more to highlight with respect to that.

REPRESENTATIVE GODSHALL: One other point that you had made about the enrollment and how important enrollment is, I do remember in Pennsylvania when we started the CHIP program, a lot of people in this room spent millions of dollars trying to get enrollment, trying to enroll kids into the CHIP program, even in one part of the state, actually paid people to go out on the street for everyone that they signed up. You know, enrollment can be a serious problem in this whole thing.

MR. KEEFER: Yeah. I think one thing that we've really learned and what I would sort of suggest, you have -- the CHIP program is valuable, and, of course, you know, as a Pennsylvanian, I'm proud of the history of the state with respect to CHIP, but I think one thing we need to do is learn

that sort of our traditional enrollment efforts of advertising and putting signs on buses and all this stuff, in many respects, doesn't work.

What we need to do is make it simple for people. We need to help educate people so that they can understand their choices, and particularly for lower-income people who are challenged and less likely to have online access. You know, many of these forms are going to have to be submitted online, so it's important that we have people helping understand those choices, not trying to steer them toward one type of plan or another, but understand their choices and the public programs as well.

And I think that sort of underscores a key point, that, you know, for this to work, you know, there's got to be a lot of collaboration from the governor's office to you all with the insurance committee and your colleagues in the senate, again, local officials and chambers of commerce and employers, everybody's got to roll up their sleeves and get together to make this work.

REPRESENTATIVE GODSHALL: One final point. How do you envision the high-risk pool policies, what do you envision them to look like,

traditional insurance or more like the HSA model?

MR. KEEFER: That's a great question. And, you know, broadly, the high-risk pool as well as the benefit standards in the context of reform in 2014 have actually adopted the standards for HSAs as the ceiling.

Within that, the benefits standard for the high-risk pool are at a 65 percent actuarial value level. Without getting too much into the weeds on this, the two most important proxies for defining actuarial value are deductible and the out-of-pocket.

So, in many respects, we've taken a big chunk of the HSA statute, including, I might add, the fact that HSAs provided preventive benefits first dollar, which is something that a lot of critics of HSAs don't talk about, the fact that we're trying to encourage people to take advantage of those preventive benefits, so there's, you know, waives co-pays or co-insurance with respect to them.

But the truth is is that the HSA statute will inform both the high-risk pool benefit package as well as the broader benefit packages when we get to the 2014 implementation.

REPRESENTATIVE GODSHALL: Thank you.

And thank you, Mr. Chairman.

CHAIRMAN DELUCA: Representative Schroder.

REPRESENTATIVE SCHRODER: Thank you, Mr. Chairman.

And thank you for your testimony, Mr. Keefer.

Earlier in your testimony you had suggested that there's a possibility that some aspects of the plan that's going into -- that's going in place immediately might have been oversold or the public might have higher expectations of what might be able to be met. And you cited the provision where a young person would stay on their parent's policy till the age of twenty-six.

Now, my question for you is this: Of the employers who offer coverage, health care coverage, what percentage of them, if you know, do not offer dependent care coverage, because you said that's the area where there could possibly be a problem on that issue?

MR. KEEFER: I don't know the answer to that question. I can try to get -- to find that and report back to you, I think. My comment is,

I'm trying to avoid any of the politics of this, just suggests that, on a policy basis, that there are some limitations here. And I think people have to be very cognizant of the challenges on the employer community, because, ultimately, the employers are going to be absorbing the cost of this.

REPRESENTATIVE SCHRODER: So you don't know --

MR. KEEFER: What we committed to on the insurance side is to say that on fully insured business, we would begin implementing this immediately. And I can tell you that we felt that that made policy sense and that we felt that it made business sense, and I'll tell you why.

In the case, particularly, of children who were going to be graduated from college or graduating from high school without a job maybe, and being, quote, unquote, what we call "aging out" of the their coverage, it made no sense to disenroll that young person only to have to reenrollment on September 23rd, which is why we stepped forward.

But, again, the limitation is that the employers -- and I'm sure Mr. Gelfand will speak to

this -- are going to be paying for that. And it's something that we have to be cognizant of because this is, you know, elements, again, we're very sensitive to anything that impacts premiums.

REPRESENTATIVE SCHRODER: I'm not questioning the decision to move forward implementing that right away, even though I understand there was suggestion that maybe that wasn't required in the federal law to implement it right away.

But, I guess, you don't have any indication whether it's a small percentage of employers or large percentage of employers that do not offer dependent care.

MR. KEEFER: I don't.

REPRESENTATIVE SCHRODER: Okay. That's fine.

My next question is, there's been some, I would just say, indications, some suggestions in the press that certain employers may opt to, you know, eventually drop health care coverage and opt to pay the fine that is required in the new law. Has there been -- do you have any indication of how serious a threat that is, how many employers will actually opt to take that step? And what is the

fine per employee if they do that? Is it six hundred dollars or something?

MR. KEEFER: Actually, the fine -- well, to answer the first part of your question, I think there have been a number of benefits consulting firms, I think Mercer and maybe Unik. have recently looked at this. And the fine structure -- and, again, I think this is something Mr. Gelfand will speak to -- is really challenging in some respects because of the way that part-time employees are allocated. It's a very complicated formula. But interacting with the fine issue, which the fine can be two or three thousand dollars, depending upon the circumstances, up to, but the challenge in concert with the fine and the offer rate is that if the coverage exceeds -- the cost of coverage to the individual exceeds -- I believe it's 9.4 percent, that allows that individual to come out of the employer coverage and go into the exchange and it also puts a sanction on the employer.

So that could really result in employers redefining their benefit packages and may go toward what Representative Godshall was asking about the HSAs and the deductible levels.

And then there's also an interaction here with the grandfathering provisions, which are going to be critical and something that there still has to be guidance on, because, as everyone knows, one of the commitments of health reform was that if, as an individual, you have coverage you like, you'll be able to keep that coverage.

Well, there are many who are suggesting that to grandfather, quote, unquote, that coverage should preclude any changes to the benefit design. What we have been suggesting is that there are some changes that are done in the normal course.

I'll give you an example. One of the most widely sold statin drugs, without getting into a particular company or drug, but I think it's been the global leader in prescription drug sales in recent years, is going to be coming off patent. If an individual is in that drug now, in the second tier, they might have a twenty-five-dollar, thirty-dollar co-pay for that particular drug. If that comes off patent and there's a generic available, the generic might be a five-dollar co-pay or it could be no co-pay.

So the question becomes, is the plan going to be able to move that down and still keep

grandfathered status, because I think one of the key decision points for employers will be how much they have to, essentially, buy up in coverage or change their benefit design, you know, leading up to 2014, and whether they want to, you know, decide to get out of the employee benefits business.

REPRESENTATIVE SCHRODER: I understand you have, you know, vast knowledge in this, probably more than most of us do. And there are a number of -- I'm sure there are many implications to these questions as well, but what I'm primarily interested in is if -- if employers drop coverage, where do these employees go? Do they go into the high-risk pool and then eventually into the state exchange?

MR. KEEFER: That's right. They would -- under the specifications for the high-risk pool, the individual has to be without insurance for six months, so there would be a gap for up to -- as long as six months, if an employer would drop coverage, you know, in advance of the exchange being operational. But once the exchange is operational, of course, they could go into the exchange.

REPRESENTATIVE SCHRODER: They could go

right into without the six months?

MR. KEEFER: Right.

REPRESENTATIVE SCHRODER: Now, if that would happen, are the fines levied against the employers enough to sustain the coverage for those employees that are now in the high-risk pool or the state exchange?

MR. KEEFER: I think that, you know, what I would say is that the analysts at the Congressional Budget Office, who, as you and your colleagues know, are the official arbiters of federal legislation, they have suggested that there would be, I think, a modest drop of employer coverage. I think a net, it's about six million. I'm looking at Mr. Gelfand. I think. So, you know, other --

REPRESENTATIVE SCHRODER: That's a projection. That is not a hard number, so I guess is question is --

MR. KEEFER: It could be higher.

REPRESENTATIVE SCHRODER: I'm not asking -- we don't know yet how many will be dropped, and you said you don't have the figures for that. But, I guess, my question is, though, if that happens and there are, you know, ten employees

or ten thousand employees that go into the high-risk pool as a result of that, will the fines that the employers pay, which I presume will go to cover the cost of insuring those individuals in the high-risk pool, will they be enough to cover that cost?

MR. KEEFER: I don't think that the fines are commensurate to what coverage costs.

REPRESENTATIVE SCHRODER: That's my concern. That's my concern, I guess.

MR. KEEFER: It could be two or three thousand dollars. And I think even -- you know, we've been concerned that they were insufficient on the individual side more.

And, again, I sort of go back to my point about having adverse selection in the pool. The real risk would be if firms that have a higher preponderance of adverse risk were to stop offering coverage, then those would go into the exchange, because, then, potentially you would have a less healthy pool than you would have at large.

I think, again, the biggest, in my mind, consideration on the employer's side is going to be what happens in the regulatory guidance with respect to the benefit issues. Because, you know, if a firm, say, is spending eight thousand dollars

on family coverage now, say the individual, the families, pay a quarter of that, which is roughly about average -- it's ten thousand dollars for family coverage -- if the new benefit package requires that employer, rather than spending eight thousand dollars, to spend ten thousand dollars, then that employer's going to make a decision about whether they're going to continue to offer coverage.

So I think there's a real artful balance here in the benefit design, and, again, this issue of grandfathering, because, again, one of the things that we're trying to do here is to build on the employer-based system rather than dismantle it, so my point about the exchange sort of supplementing what the current marketplace is.

REPRESENTATIVE SCHRODER: Well, my concern is that, I believe, that in the federal health care law, there are a number of possible inducements that would cause the employer to decide to go without coverage, which would then -- and then we would end up with many more employees in the high-risk pool.

You mentioned the state exchange, but yet not enough money coming in to pay for them,

because of inadequate fines, perhaps, to the employers. So we've created a system where it's possible that more get dumped into the program, not enough to cover it, and the cost of the program, you know, goes up exponentially, you know, from there.

So I had a few other questions, but I'll stop.

So, thank you, Mr. Chairman.

CHAIRMAN DELUCA: Thank you, Representative Schroder.

Representative Day.

REPRESENTATIVE DAY: Thank you, Mr. Chairman.

Thank you for your testimony today. I really appreciate you being here.

And thank you, Mr. Chairman, for having this hearing.

Some of the most important decisions that we make and that we face are here -- or that we face here at the state level are what policies we are going to enact and administer which will manage public and private assets of our health insurance reform.

I'm curious. I want to get back and

touch on what affect do you think the new taxes on drugs, medical devices, and such, what affect do you believe that this will have on the different industries that these taxes are going to be on?

Do you believe that these industries will internalize those new costs? Do you believe that they will, you know, cut jobs and become more efficient? Or do you believe that it will be passed on through to health care costs? Which, you know, we're trying to -- hopefully, that's what reform is supposed to do, keep costs down. So I'm just curious what your thoughts are.

MR. KEEFER: Thank you, Representative, for the question.

We've been very concerned about the taxes. As I indicated, there's a, for the first time, a national premium tax that, ironically, is only on the fully insured side of business and the individual side.

When I say ironically, because those are the two parts of the marketplace that we're trying to most help in this legislation. And I think that, you know, I remember back to law school, never having practiced tax law, but the first principle of tax law is that taxes should be

broadly spread. And to take one part of the marketplace and only apply a tax to that, obviously, there is a potential for distortions and adverse selection, as I indicated.

But more generally, to your question about taxes, I think every economist or every analysis that I've seen, whether it be the Congressional Budget Office, whether it be the Joint Committee on Taxation, whether it be the Joint Economic Committee, or whether it be the actuaries at the Centers for Medicare and Medicaid services, all of them have issued reports essentially saying that the tax will, in fact, be passed through.

So I think that sort of goes to my point about the fact that we have a lot of unfinished work with respect to cost containment and quality improvement, some of which, you know, is already underway in Pennsylvania. And you have many of the health plans, you know, collaborating with the physician community to do that. But the point is, as you've indicated, we have to be very concerned about things that will be passed through and contribute to increasing cost.

And I think we have to view all of

these elements together, because it is true that, in isolation, each of these things, you know, might have a nominal impact, but if you take five or six things that are 1 percent, pretty soon you're getting to a fairly sizable number.

REPRESENTATIVE DAY: Thank you.

Insurance premium costs, hopefully -- what I'm trying to get at with health care reform is that we make a system better that hopefully covers more people, the costs are managed appropriately, smartly and properly.

I've always thought that insurance premiums are made up of costs and administrative -- health care costs, administrative costs, and you brought up utilization rate or whatever that factor would be. Terms like preexisting condition, lifetime limits on coverage, adverse selection, I think those terms are being just pushed aside, and I really appreciate the time that you took today to talk about adverse selection, but those things have been all management provisions that have been developed over time as a way to fairly manage insurance risk pools and to keep costs down, which is one of the main drivers in high insurance costs is the health care cost.

What do you believe will be, if you can, the percentage cost increase when we just -- if we just push these types of things aside -- preexisting conditions, lifetime limits on coverage, and adverse selection? Have you or anyone that you've seen in the industry -- is that published, thought about? What is the increase of cost if we just put these traditional management practices aside?

MR. KEEFER: Yeah. I think, you know, the answer is that there have been a number of estimates, and I think there's a broad range. And, again, a lot of it is going to go toward what happens with respect to the benefit design, whether the -- you know, the choices that people make in the type of coverage, and again, adverse selection, when we look at the exchange, you know, and what I call the all-important first year, because the exchange is going to be a lot of new people. The estimates are that there's going to be about sixteen million new people coming in to the exchange to get private coverage.

But if those -- if the risk of those population that come in initially, we know that it's natural behavior that people that need health

services are going to be the first to seek them.

And one of the things that we've learned in Massachusetts is that if you don't put cost containment and quality improvement on parallel tracts to expand the access, you're just kicking the can down the road and pushing out the cost program, and that's -- you know, that's coming -- the chickens are coming home to roost now with respect the challenges there.

And then there's also an issue of provider capacity and whether we have the capacity, and I know this is a particular concern in many of the urban and rural areas, in issues related to whether we have enough primary care physicians. But I would also submit to you, whether we have a number of -- enough specialists in some areas, and what we call, in the health plan community, must-have providers, because there are cases where, you know, if you have one anesthesiology practice, it can be really tough to negotiate with that practice, and they really have the upper hand, because if don't have them, you know, in your network or in your plan. So all those are factors in what happened with the cost increases.

And I think -- I know it's

unsatisfying, but the answer is we don't know, which is why it's so important to do what you're doing here. And I think, again, a big part of it goes back to what happens on the benefits side.

REPRESENTATIVE DAY: I appreciate your input on -- those were very general questions.

And just one more question, Mr. Chairman. I know you want to keep things moving along, so I'll try not to take too much of the committee's time.

But more specifically, what we do at the state level with the assets, the federal dollars that are available and how quickly -- what our policies do to how quickly we burn through these assets, do you envision -- how do you envision high-risk pool and the policies that we're going to be talking about?

I know Chairman Godshall talked about it a little bit. Did you envision that more of a traditional model or more of a newer type of -- I'm learning a little bit of what they're proposing with the federal legislation. So if you have any further information about what they're proposing, does it change much, or do you have a recommendation of which way we should be going?

MR. KEEFER: I think one of the key challenges is most of the determinations with respect to the benefit package are guided by what's called an essential benefit package, but there's no concrete time frame for development of the essential benefit package. So I think it's largely unknown what the high-risk pool package will look like.

There is -- there are provisions in the statute for development of the essential benefit package. But one of the key quirks is that what are called restricted annual limits, which apply to plan years beginning six months after enactment. So any plan that goes into place starting September 23rd is supposed to have only these, quote, unquote, restricted annual limits.

Well, the restricted annual limits refer to the essential benefit package. So the restricted limits that are supposed to be in place in a couple months are supposed to build off of something that doesn't exist yet.

So I just point that out. It's one of the real unknowns. And I think the agencies are going to be forced to offer interim guidance on that.

And, again, just speaking to what we know, what they did in Massachusetts is, they had the actuarial value standard. And once they had the actuarial value standard and the types of benefits that they wanted to be in the package, then they sort of backed it out and devised the package based upon those general parameters.

So that's kind of what's going to happen, but, again, we don't know exactly because a lot of that has yet to be defined.

REPRESENTATIVE DAY: Mr. Chairman, thank you for the time today, and I appreciate it.

CHAIRMAN DELUCA: Thank you, Representative Day.

Scott, I just want to thank you for your testimony.

Two things you mentioned -- you just mentioned, that just came to my mind, the Massachusetts plan you talked about, any talk about them rescinding the Massachusetts plan in Massachusetts? Are they -- are any of the state representatives and the governor talking about doing away with the Massachusetts plan?

Forget about the federal plan right now. Before they came with the federal plan, did

they decide they were going to do away with it?

MR. KEEFER: No, I don't think so. And, in fact, they're exchange and their structure is essentially grandfathered into the --

CHAIRMAN DELUCA: But they're not talking about doing away with it.

MR. KEEFER: No, sir.

CHAIRMAN DELUCA: Okay.

And you mentioned the fact about the taxes being passed through. And unless I'm mistaken, when we raised the double digits, rates are going up on the insurance -- on small businesses for their insurance. I imagine, to stay in business, they have to pass that through; correct?

MR. KEEFER: Yes, sir. It's the cost of business.

CHAIRMAN DELUCA: Cost of business. I just want to put it that way.

I want to thank you very much, and I want to bring to your attention that we are, as I said before, going to have more hearings. And then my idea, at the end, after we have concluded some of the hearings, is to have a roundtable discussion with all the special interest groups on both sides

of the aisle -- I mean both sides of the issue, and let's hear from pros and cons on each side.

What do you think of that idea?

MR. KEEFER: I think it would be great. I think that, again, I would encourage you to have dialogue with all interested parties.

CHAIRMAN DELUCA: Right. I mean, coming together at a roundtable where they can dispute some of the stuff that we hear on different hearings. And I looked forward to working with you.

MR. KEEFER: Thank you.

CHAIRMAN DELUCA: Thank you very much.

MR. KEEFER: Yes, sir.

CHAIRMAN DELUCA: Next individual to testify is Joy Johnson Wilson. She's the health provider direct -- policy director, federal affairs counsel, National Conference of State Legislatures.

MS. WILSON: Hi, Mr. Chairman.

CHAIRMAN DELUCA: How are you today?

MS. WILSON: Very good.

CHAIRMAN DELUCA: Good. Good. Nice bright outfit there and nice smile, so it looks like you're going to get going.

MS. WILSON: I missed part of the

previous testimony, but I know we're going to cover a lot of the same things, so I'm going to try and move fairly quickly through the regular stuff and get to some things he might not have covered.

CHAIRMAN DELUCA: Very good. Thank you.

MR. WILSON: First of all, as you well know, there are actually two new laws, and for a long time, we did not have one piece of legislation, we blended two laws. And so for those of us who are trying to figure out what was in it, it required us to actually have three pieces of legislation in front of us and then all the underlying statutes.

So for the policy geeks in Washington and across the country, when they put together an integrated bill, we all cheered. And now we're calling it the Affordable Care Act. And that really applies to the two -- the underlying senate bill and then the reconciliation bill that amended it. So when you hear the Affordable Care Act, it's really talking about two -- the two bills that were enacted within a week of each other.

Some notes. Because they used the reconciliation process to amend the senate bill,

there were limits to the kinds of amendments that could be offered. The amendments had to have a substantial financial impact.

So walking back, these bills were drafted assuming a fall 2009 passage, and the dates, the effective dates reflect that. So when the bill didn't pass until March of 2010, some of the effective dates are very aggressive. In fact, some of them are nearly impossible. And some of them are actually retroactive. So when you see that, that's why that occurred.

And it -- it does address some of the issues that we're having on implementation, because the effective dates are coming up on us very quickly, without the underlying guidance and rules that might would have been done had the bill passed when the -- last fall.

There are also -- because of the inability to make technical corrections to the underlying senate bill, there are errors in drafting and other things that could not be changed during the legislative process. It is unlikely that we are going to see what often happens, a technical corrections bill, that would lump them all together and they would pass that. Passing

legislation in current congress is not that simple, and we probably are not going to see a technical corrections bill, which really leaves us then to the regulatory process to make some of those things work, which is a little more complicated and more time consuming.

So I just throw that out there, because as you will see, we're having some technical difficulties as we go along and part of it has to do with the process by which the bill was enacted.

The overview: We maintained our employer-based system. Many people say why? Money is the reason. We already have a lot of money invested in the employer-based system, and had we gone to something else, money would have had to have been raised to replace the money that the employers are currently putting into the system.

We expanded and modified Medicaid. Why? Because that money is in the system. A lot of this had to do with how are you going to pay for health reform. And so, if you didn't have the employer-based system continue, and if you didn't have states continue to contribute to Medicaid, it would be very difficult to finance health reform. And so we have the Medicaid expansion.

The individual mandate was important in terms of keeping the insurers at the table. Without the individual mandate, the insurers probably would have opposed the legislation, because for the insurers, everybody needs to be in. And so without that, they weren't really interested in participating.

And then we have substantial subsidies, both on premiums and on cost sharing, and the answer, again, has to do with money. In order to make an individual mandate affordable, you have to have subsidies. You can't require someone to purchase something they cannot afford. And so the subsidies for premiums and cost sharing addresses the affordability question.

And then, finally, the health insurance exchanges, which is a critical piece of the overall reform, provides a one-stop shopping center for those people in the individual and small group market who would be the immediate participants in the exchange. And so this provides a way for -- it organizes a system for people to get advice on what kind of coverage would be best for them. And for small businesses -- and this is very critical -- who do not have HR people, it provides that HR

concept but the business doesn't have to do it.

And back in the dark ages when I worked on the Hill on the Pepper Commission staff, which was looking at how to do health care -- national health care reform, I was the contact for small business. And one of the things that kept coming up is that they didn't have the resources to be an HR person and do health insurance. So even if they had the money, the resources and financial resources, they didn't have the time or the inclination to do the annual open season in health insurance. And so this health exchange concept does address that issue.

I was asked to talk about the things that this committee would have to look at immediately. And so there are some immediate health reforms, starting with the temporary high-risk pools. And I realize that Pennsylvania does not currently have a risk pool, and that provides a certain special opportunity. And in some respects, you're better off than some states that actually have a risk pool, because the risk pool in the federal legislation is so different than any of the risk pools that are currently in operation, that the competition that it creates is a little

uncomfortable.

In some states, the premium for the federal risk pool would be half of what the premium is under -- for people who are in the current risk pool. People in the current risk pool cannot switch over to the federal risk pool. So you'll have these parallel programs running with very different financial requirements.

Probably the biggest challenge on the risk pool side is the fact that the five billion dollars is, by all accounts, insufficient to fund a program through 2014. So then the question is, what kind of program does the state put forth? And more importantly, what is the liability of having -- because people in a risk pool are sick people. They're -- by definition. So they're going to have ongoing costs.

When the money runs out, what happens then? We don't really have a good answer for that right now. We do know that, at least currently, the administration's position is that if money is not authorized and appropriated in the health reform bill, they will not be seeking new appropriation, at least in this upcoming fiscal year, which -- I don't know that next year is going

to be a whole lot better and that that would change.

So I would think that, on the safe side of things, I would not assume that the five billion dollars for the risk pool would be increased over time. So that leaves states with some tough decisions to make about -- and some real decisions about how you go about making this program work for you.

I know some states are thinking about vouchers. That has not been approved yet, but I think HHS is being as flexible as they can, given the way the legislation is drafted, to give states as much flexibility as they can. They're taking all kinds of suggestions and trying to run them through their legal people. So I think there's no harm in putting forth an innovative plan.

HHS does not really want to run these risk -- these high-risk programs in the state. So they are really hoping that they can get even some of the states that have said they don't want to run the program to maybe rethink and come back and run it.

So I think, just going to go to my page where the -- the things that are still outstanding

on the risk pools. The definition of a preexisting condition is not in the statute. It's on page six. Whether or not you can use the funds for premium subsidies of some sort.

Liability, when the funds run out, is it a federal liability or is it a state liability, is one set of questions. It's a federal program, state administered. When the money runs out, who gets the hot potato? We don't know.

State flexibility, how far does it go?

Flow of funds is another important piece. The way the legislation is structured, claims are realtime. The administrative costs are percentage of operating expenses. There is no -- they are silent on whether there is a mechanism for getting up-front costs, up-front administrative funds for start-up.

So the question is, if there isn't any, then that means that the state would have to front from some money, which, in some states, would be a barrier to moving forward. And so this is still an open question as far as I know.

And then, finally, there is a requirement that states have a citizen verification process, because one of the eligibility

requirements is that the individual is a citizen or lawfully present.

What we don't know is what process the HHS will consider meets the text. So if you say this is what we do to verify a citizenship, does that make it or not? And they've not addressed that. And so that's something that they're going to have to look at very soon, because they hope to release the first allotments July 1st.

So a lot of these questions have to be answered very soon, but as far as I know, right now, these are still open questions. So I thought that was worth mentioning.

Going back now to page -- I'm just going to skip through, because you've already talked about the various reforms and go to -- I'm going from page six forward.

The early retiree re-insurance program, the statute specifically states the state and local governments are eligible to participate. And I must say, we got a flurry of phone calls of very excited state and local government folks to just make sure that that's what it said. And that's what it says.

Now, one thing that a lot of people

over at HHS didn't seem to know is that states -- a lot of states have more than one retiree health program for their state employees. And so there's been -- some states were asking, Well, can all of them apply? Can just one of them apply? And it appears to be all can apply.

The big deal on this is, this is a first-come, first-serve program. So unlike the risk pools, where each state gets a specific allotment, this is musical chairs. The music starts and chairs get, and when the five billion is done, it's over.

So we don't believe five billion in this program is going to go very far either. So it's very important for anyone who wants to participate to make sure that they've got all their ducks in order, because if you put in an application and it's short, meaning that there's something that's not quite right with it, they bump it out and it goes to the back of the line. Well, in this program, going to the back of the line could mean you don't get anything. So I just throw that out there.

There's been some interim final rule. There's still a lot of questions. They're doing a

series of calls, and I'm sure that your benefits people are involved in those calls and will -- you should probably check in with them and see how those applications are going.

On dependent coverage, of all of the issues in health reform that we get calls on, and we get lots of them, I have to say this is one of the highest volume calls we get, about the dependent coverage. And we thought it was a very simple issue; it's not.

And first of all -- and legislators will need to know, because people will call you. This is a -- you know, that is a gut-wrenching issue for a lot of people, and a lot of your constituents have college graduates or will have soon, and there are a couple of things to note. The extension past graduation only works if you're currently on the parent's insurance. So if you were under university coverage and you graduate, you don't just get to go on your parent's coverage, which is not well understood across the country, I can assure you.

So when would those individuals be eligible to go on their parent's insurance is then the question. The effective date of the provision

is September 23rd, 2010, but it applies to plan years that begin on or after that date.

So a typical plan year starts January 1 of a calendar year, which means that between May or June, when they -- a person graduates, and January 1, when their parents plan re-ups, they are not covered, which is something that a lot of people didn't understand. And I think it's important for all of you to understand, that the effective date is based on a plan year, which could start on January 1 or it could be April or it could be June or, you know. So plan years vary, depending on the company.

Now, some companies have decided on their own that they will simply extend. A lot of companies are not. And so most of those families are looking at Cobra coverage or looking into individual coverage. Most of them are not taking that because it's very expensive. But I think it's worth noting, and one of the separate handouts that I made available is on the dependent coverage issue, because I think that's very important.

I know Scott talked about the rescissions, limits on preexisting exclusions for children, limits on lifetime and annual caps. I

won't cover those.

One thing that we at NCSL are working on and we haven't gotten it done yet is looking at the treatment of state and local government plans and health reform. Normally, state and local government plans have an opt-out provision available to them when there are federal insurance mandates. Typically, those -- the ability to opt out or not is specifically addressed in the statute.

In this statute, where it's specifically addressed in a few places and where not specifically addressed in others, and so it is unclear which things pertain to state and local government plans. And so we are working with the people at HHS and the Department of Labor, who are the experts in this area, to help us put together a piece on the treatment of state and local government plan and health reform. And we hope to have that ready in a couple of months.

There are some issues that both the counsels in the departments have to work out, because they have to make a call. It's unclear, and they've got to make a decision about which way things go. And so we will make sure -- we will be

putting something out when we have that information and get it to all of our members to let them know where you sit.

We do know that we -- we feel like most state and local government plans would be grandfathered plans. And the question is, which kind -- which -- underneath that, which things might we have the opportunity to opt out if we wanted to.

And, of course, the issue that Scott mentioned on grandfathered plans -- and this is particularly important as states continue to draft insurance legislation -- is if you have insurance change and it applies to a grandfathered plan, does that then make that plan no longer grandfathered? And so we don't have the answer to that.

A few states have put provisions in their law that say if the federal government determines that this law would remove the grandfathered status of effective plans, we -- they put a repealer in so that the plans can retain their grandfather status. So I throw that out there as something that is being considered in some states. I believe Maryland did that, with some of their legislation that they had pending at the time

the health reform bill was signed.

With respect to health insurance exchanges, I know 2014 seems like a lifetime away, but it's really like tomorrow. And actually next year the secretary will have planning grants available for states to start working on planning to establish the insurance reforms. And there is another provision in the law that says that states must declare whether they are going to operate the exchange or whether they are going to have HHS operate the exchange by the end of 2012.

So while the exchanges go into effect in 2014, there are key decisions states have to make well before that. And so I wanted to call that to your attention.

I think the most important thing about the exchange that I don't know is well understood is that the exchanges and the Medicaid program are supposed to be interoperable. Now, Medicaid has not been interoperable with anything ever. So I think this is a heavy lift. But this requires the insurance committee and Medicaid committees to have to talk, real talk. Because if I show up at the exchange and I am Medicaid eligible, the idea is I'm not supposed to leave the exchange unenrolled

in something. In other words, the exchange has to be able to facilitate my application for Medicaid.

At the same time, if I show up at the Medicaid office and I'm ineligible for Medicaid and should be in the exchange, there is an expectation that the Medicaid office will be able to facilitate my application in the exchange. So this is both a systems' issue as well as a practical issue in terms of coordination of agencies within the state.

So, very important when you look at how you're going to -- what your exchange is going to look like, it's very important that that is done within the framework of looking at how your Medicaid program is also going to look as you expand Medicaid and take the new mandatory categories in.

Now, the other thing, of course, is that there is a huge education effort that's going to have to be done at the state level to explain this whole thing to people that if you want to be in the exchange but you're eligible for Medicaid, you're in Medicaid.

We're going to have to remarket Medicaid not as a welfare program, and we tried to do that during welfare reform and I don't think we

quite got there, but now we're going to have to get there, because Medicaid is now going to be a mainstream program for people under a certain income.

Now, one of the things they did with Medicaid is they changed eligibility so it's income only for people who go directly into Medicaid. So they've removed the assets test, the income disregards for most people. "Most" being operative.

If you go into Medicaid as a result of being in the child welfare system, so if you're a foster child and you go -- and you are categorically eligible for Medicaid by virtue of being a foster child, the eligibility for foster children remains with all the assets disregards, whatever -- whatever they use for child welfare, the same is true for people that come into Medicaid because they're receiving supplemental security income. So they're low-income, disabled people. They're getting a cash benefit from the federal government, and they are categorically eligible for Medicaid. There is an assets test for that. That remains.

So the new eligibility system, while

for most people will be income only, will still have some of the vestiges of the existing system, and so that's a complication in terms of systems. I thought that was worth noting.

The other key outstanding issue is the benefit package. It is key to everything. And while the statute provides general guidelines, it will be the secretary of HHS, by rule, who will establish what constitutes the essential benefit package.

Why is this important to you? There is a provision in the law that says, if you have state-mandated benefits, you're protected; you can keep them. However -- and the however is important -- if you have mandated benefits that are not in the essential benefit package, you must pay for them to keep them. So, in other words, you would have to pay either the plans or the individuals the increment that your mandated benefit package costs above the essential benefit package.

Now, we do not know, the statute does not say, who would make this -- who would determine the actuarial value, however, I assume that most states will be taking a hard look at their mandated

benefits, and certainly when the essential benefit package is determined, to see where you are in the universal scheme of things. And, certainly, I think this is a tough issue for state legislators, because those mandated benefits didn't just appear out of thin air. Somebody fought very hard to have them included, and many people believe that the promise of keeping your benefits that you have would include those hard-fought mandated benefits that they fought for at the state level.

So that is something that this committee, being the insurance committee, that would fall in your purview, and I just wanted to give you a heads-up that that's something that you'll have to think about.

I think I'm going to stop there. I could talk about the stuff all day, but I think it's probably more important that I get to your questions and try not to repeat too much of what Scott said.

CHAIRMAN DELUCA: Well, we certainly appreciate that, Joy, and I think one of the things you mentioned about is the high-risk pool, and we have to be innovative. Fortunately, we have a representative here who's very innovative,

Representative Kotik, who's sponsored the bill, and I'm sure he is a very innovative legislator, and I'm glad you mentioned that. So we certainly look forward to Representative Kotik's innovation to addressing this piece of legislation.

Joy, let me ask you one thing. You mentioned at the beginning of your statement that the insurance carriers, one of the things they wanted was to make sure that everybody was in it. Am I correct?

MS. WILSON: Yes.

CHAIRMAN DELUCA: Does this plan work if -- does the national health care plan work if everybody had the option to decide whether they want to opt in or opt out?

MS. WILSON: Probably not.

CHAIRMAN DELUCA: Probably not.

MS. WILSON: Probably not.

CHAIRMAN DELUCA: Thank you.

Any questions?

Representative Godshall.

REPRESENTATIVE GODSHALL: Real quick, I know we're running over time.

Definition of preexisting is used. And who's going to --

MS. WILSON: Yes.

REPRESENTATIVE GODSHALL: And who is going to -- who is going to be at the end on the hook for that preexisting, the feds or the states?

MS. WILSON: Well, this is for that -- this is for the high-risk pool, the temporary high-risk pool program.

And some states have definitions that differ from definitions of preexisting conditions that already exist in federal statute. And so those states would like their preexisting condition definitions to be covered, and so they wanted to -- it was kind of a heads-up to the secretary not to necessarily pull from existing federal law to make that definition, because that would leave out some -- that would limit the flexibility of some states as they try to put together their high-risk program. But it's the secretary's call, at the end of the day.

REPRESENTATIVE GODSHALL: And another thing that you had mentioned earlier, that some states -- states may have to front money.

MS. WILSON: Yes.

REPRESENTATIVE GODSHALL: And I'm not sure how many states are going to be able to front

money. This state right now has a little money problem just to pay its bill, present bills.

MS. WILSON: Right.

REPRESENTATIVE GODSHALL: Could you expound a little bit on that?

MS. WILSON: I think we were trying to urge the secretary to figure out a way to front the money, because you are right, most states don't have the ability to put that money up front. A lot of them are not in session anymore and --

REPRESENTATIVE GODSHALL: Right.

MS. WILSON: And the question becomes, can they really cobble together -- is there discretionary money anywhere ever to do that? And so what we're saying is that there needs to be a way for the administrative funds not to be reimbursed funds but some up-front money that would then count towards our overall administrative cap.

REPRESENTATIVE GODSHALL: Do we have any idea what amounts of money we're talking about? I mean, how -- a lot of money?

MS. WILSON: It depends on what the state plans to do, and it's very different from every state. So I don't think we -- I don't know that there's a general amount, but every state is

going to have some up-front cost to administer a new program.

REPRESENTATIVE GODSHALL: And this money won't be taken from another program that we can take it from and substitute it; it will be new dollars?

MS. WILSON: I guess if a state has flexibility to move some money, and that's the question about --

REPRESENTATIVE GODSHALL: I'm not talking about another health care plan. We can't pull it from here and put it over here.

MS. WILSON: Oh. No. It's -- the five billion is the five billion.

REPRESENTATIVE GODSHALL: Thank you.

MS. WILSON: You're welcome.

CHAIRMAN DELUCA: Thank you, Joy. Thank you for taking the time to come from Washington to testify. We really appreciate it.

MS. WILSON: Oh, you're welcome. My pleasure.

And we just wanted to let you know that we do have a website that has all this information, and as we get more information, we keep -- we update it daily.

CHAIRMAN DELUCA: Well, we appreciate that very much. Thank you very much. You do a great job.

The next individual is our commissioner, Joel Ario, insurance department commissioner.

Welcome, Commissioner. Always good to see you.

COMMISSIONER ARIO: Good to see you, Mr. Chairman, members of the committee.

I think we'll be talking about this bill for a number of years here, and I appreciate the opportunity to speak before you today on it.

I'm going to focus most of my short comments here, because I'm more interested in time for questions on the immediate reform, the high-risk pool, medical loss ratio, the insurance reforms that go into effect this year, but I do have to make a couple general comments, listening to the first couple speakers.

Your question, I think, was very good, on what do the people of Massachusetts think about their plan, which is the model for the federal plan. As I can say, ObamaCare was RomneyCare before it was ObamaCare. And to his credit,

Governor Romney still stands up and supports the individual mandate and the access reforms in Massachusetts.

He has a number of ways he distinguishes what happened in Massachusetts from the federal bill. He's not an advocate of the federal bill, but on the core reform, individual mandate, and the access here, he's a strong proponent. So is Senator Scott Brown. And the reason is pretty simple. The plan tends to poll in the 70, 75 percent range in Massachusetts. People like what they got there.

I believe people will like what they get through this plan on access too. I'll come back at the end of my comments and talk about the cost issues, but the access issues are pretty clear. And I have to just say I was a little disappointed in the presentation from AHIP. I speak at a lot of panels, not just here but around the country on these issues today, and a lot of the insurers look more at the glass half full here, the fact that there are thirty million new customers -- again, with the mandate, there are thirty million new customers here for the health insurance business, most of them young and healthy. That

buys a lot of gain in the marketplace to spread costs and so forth, and so you hear a lot of the testimony looking to that, and some of the larger carriers are going to do quite well here, if you look at the stock market today and what the carriers are doing. The larger ones do quite well.

AHIP has thirteen hundred members. The majority of those members will not be around in ten years. Most of them are very small carriers who play in certain niches. Those kinds of carriers don't have the good value proposition, frankly, for the public under these kinds of reforms. They aren't going to meet the medical loss ratio test and so forth. But the large carriers that can then offer that value propositions will prosper under this bill and people will benefit from this bill as well.

So I think, again, I'm going to come back and talk about cost control, because that's the big issue. The other thing I'll say off the top on it is that the bill -- people will say, Where's cost control in this bill? Actually, I was on a panel with a professor yesterday in Philadelphia. And he said, You know what, there's

not a single cost control idea that's viable that's been discussed in health concerns or any of the academic literature in the last ten years that is not in this bill. They're all in there. That's the good news.

The bad news, if you want to look at it that way, is that they're mostly in there as pilot programs, because we don't yet know exactly which of them will work in what ways.

We do know a couple things. We know we have to end fee-for-service medicine. We're talking about radical change to the medical system. We need to end fee-for-service medicine. Everybody knows that, and the bill has a number of provisions to do it.

We need to incent wellness. Premiums are a very poor way of incenting wellness. Premium variations punish people for things like hereditary disease, accidents that they have no control over, and they do nothing to reward people for very beneficial behavior, like quitting smoking. Most health insurers still don't even support -- pay for smoking cessation programs, even though it's the single most beneficial thing that can probably be done by any individual who still smokes. I know,

I've been there, along with your staff counsel. We quit around the same time.

So the current system does not deal with wellness well under this bill. Little known fact, 30 percent wellness incentive can be used. We can actually incent the right behaviors, hold people personally responsible, as Governor Romney says, with a mandate -- personal responsibility to mandate, personal responsibility on wellness incentives.

We're talking about significant change to the system. And I was disappointed that we didn't hear more about those opportunities than just kind of thinking the system's going to be the same as it's always been, and then, of course, there'll be huge problems under the reforms if we keep the same mentality we've had and the same fragmentation of the market.

The last comment, before I get into the details here, is people say, Well, how can you do this expansion of coverage and then take up costs secondarily? If you look around the world, every other country has gotten their costs under control better than we have.

We are the single most expensive

country in the world. We're twice as expensive as almost every other industrial country, and guess what, everyone of them first got everybody in the system, because if you don't have everybody in the system, you have a huge fragmentation problem. It's very hard to manage costs in a fragmented system.

You also have a huge political problem because people who are looking to oppose cost control point out that cost control on the backs of people who are excluded from the system is not a particularly good way to do it. And so you have huge political backlash against attempting to do cost control by kicking people out of the system, which is what we've done today.

Once everybody's in the system, guess what, it gets very hard for the political system to then kick people out, and so you actually have a rational discussion of cost control. We're all in it together.

Some people are saying, probably shouldn't, but every other country in the world has accomplished it. I think America's big enough and good enough to do it too.

Okay. So enough of the speechifying,

I'll go to the details here that you're most interested in hearing from me today. I'll start with the high-risk pools. I thought you had a good exchange with the gentlelady from NCSL on these issues. Pennsylvania is going to step up and do a high-risk pool.

We will be briefing the four caucuses later today on the details of our proposal. But it basically starts with the fact that what HHS gives us as parameters, so the first big parameter is the program is only available to people who have been uninsured at least six months and that have a preexisting condition that's the reason why they've been outside the market.

In this state, as everybody knows, there is -- the Blues do ensure everybody, for a price. But if you're -- if you fail their medical underwriting and go into their guaranteed issue product, that price can be very steep, ten times as much as the price that somebody who's healthy might get, and so there's a lot of people can't afford it. That's the target population here.

It will -- the program will come nowhere close to covering all of the risks. Nobody that is a supporter of it ever thought it

would. Five billion dollars. The lowest estimates I've seen are forty billion dollars. I believe it will probably be something like four hundred billion dollars in the current system to actually, with all the fragmentation in the current system, to cover everybody with preexisting conditions that's uninsured.

So it is a small portion of the uninsured who will be covered here, just like our current adultBasic program, just like every high-risk pool in the country. If this is to be measured against, you know, to cover everybody, nowhere close. But it's measured against the kind of effort we currently have, it's a pretty significant new block of people that we'll get covered in this state.

We have a hundred-and-sixty-million-dollar share of that five billion dollars. That's calculated based on our uninsurance rate, cost of care here, more and more than anything, our population. So we -- we've looked at that. You know, we've kind of looked at all on the different options of how we can do things. We think we can cover about five thousand people per year.

Again, we're having a briefing this

afternoon on how exactly we get to those numbers, but roughly five thousand people per year for the next three years, and, again, that's probably the number of people eligible for this, under these basic categories of preexisting conditions today.

This is kind of an interesting fact, the Blue Cross/Blue Shield plans, if you look at who passes underwriting and who ends up in the guaranteed issue, if you take the people who fail underwriting or have to get rated up because of their medical situation, it's 30 or 40 percent of the population.

So a preexisting condition is 30 or 40 percent of the population, and we took an expansive definition so that we'd have that whole pool in there. So you take 30 or 40 percent of the uninsured, you're talking about several hundred thousand people in this state who are potentially eligible. We are only going to be able to serve five thousand, and the basic way we'll do it is to contract with one or more carriers.

The gentlelady from NCSL said the issue was still open on who bears the risk here. It's not. HHS, in the details of their specs for their contract, are very clear: They will pay all the

claims. All the claims go to them. Their carrier does not pay claims. The carrier simply manages it, like they would on a large employer ASO contract. The claims go to HHS. HHS is accountable for paying all of the claims.

Now, they're going to work carefully with us and make sure we don't have too many people in the pipeline so that they go over budget, but they bear the risk of paying all the claims, and then they have -- want us to manage tightly to a 10 percent administrative fee. And in our proposal, we've got details of how we would manage to keep the administrative costs down. That would be a medical loss ratio in the 90 percent.

So high-risk pool, we believe, will be of great benefit to about five thousand Pennsylvanians who, but for that plan, would not have care between now and 2014.

Why don't we cover everybody? That's why we're doing federal reform, because we don't have a system that covers everybody, and we won't until at least 2014.

Second issue in the short term is medical loss ratios. This is a very important issue. It's not -- the high-risk pools, we need to

work with the legislature, I think, over the next month as we work with HHS. It's very much a state-federal partnership.

The medical loss ratio is basically going to be an HHS defined thing, with input from the organization that I'm part of, the National Insurance -- Association of Insurance Commissioners, so there are phone calls these days with, you know, three, four hundred people on the conference call to hammer out all of the details of how those are going to be calculated.

But the bottom line -- and this is where it's going to cut, where some of the members of AHIP aren't going to make the grade -- 85 percent loss ratio, eighty-five cents of every dollar goes to benefit -- direct benefit, medical claims costs, and other related costs -- come back to that in a minute -- for the large group market, 80 percent for individual market.

And the fight that we're going to have between now and the time that that's finally settled is, what about these kind of activities that carriers do that you could either call administrative or you could call beneficial to the consumers? Some of the IT work that's done,

electronic medical records, things that improve the overall system, are they administrative or should they count as part of the eighty-five cents that -- the numerator part of the equation.

Quality improvement, the statute says we should count quality improvement activities to the benefit of the carrier on the numerator side on the eighty-five cents. So what kind of quality improvement activities count on that side? That's a big debate, and we can talk about some of the details of that in the questions. But that will be worked out.

And then, as of next year, when consumers buy their health plan, they won't have to worry about whether they bought it from somebody who has really low medical loss ratio. And some of them out there today are in the 70s, even in the 60s. None of the large carriers, but some of the smaller carriers have those kind of loss ratios.

Third issue is the insurance reforms in September. There are a number of them. We talked a little bit about the age twenty-six issue. I'll just make a couple comments on that. One, this is an example where the insurers have stood up, and I applaud the insurers on this one.

Every large insurer in Pennsylvania has said, even though we don't have to cover any of those kids -- I used to call them slackers, but I should probably not do that -- the kids that come back and need to be covered, the -- up until age twenty-six, they said, We're not going to wait until September. Any kid who's currently on the plan, graduates from college or otherwise would age off or would come off of eligibility for some reason between now and September, if they're on already, we'll keep them on. So we'll move up our implementation to law.

That's an example of carriers working in partnership with HHS to benefit people. And a lot of people are going to be helped by that policy.

The second issue is even more interesting to me, is there's been this dispute about how should you price this coverage. I think when we passed the law here in Pennsylvania up to twenty-nine and used the phrase dependent care -- and I've testified about this before here -- I thought that meant dependent care price. So if the kid's on a family plan, they're covered through the family plan. If they're the first kid to be added

in the plan, they have to pay a family rate, but otherwise, there would be no charge. You're just adding another dependent, and you spread that cost across your dependent care base, across your book of business.

Well, the carriers in Pennsylvania didn't do it that way. They said, Well, gee, these people might be more expensive, so we're going to charge the individual employee rate, and then one -- at least one carrier said, on top of that, we'll charge a 50 percent surcharge because there's more adverse selection in here than even the individual employee rate would be.

Well, when you start charging it that way, guess what, nobody's going in the plan except somebody who's really sick. So it will be a self-fulfilling prophesy that only really sick dependents end up in that sort of plan.

We are still hassling with the carriers in Pennsylvania about our plan, and we've talked to the legislature a little about changing it. Things move slowly; we haven't been able to change them. But the federal government came in and they said, The first way to do this is spread that cost across your dependent care base. And the carriers, all of

them, agreed.

So now, without even a fight at the federal level, that dependent care is priced as normal dependent care is across the base, and guess what, at that price, most people would choose to put their kids in and there'll be a lot of health risk, a lot of unhealthy risk.

Will it raise everybody's premiums a little bit? Yes, it will. There's no free lunch. It will raise premiums, but it will be spread across a broad base, and carriers won't spend enormous amounts of time, like they do in the current system, trying to gain risk and select risk and exclude risk and all these kinds of administrative expenses that we simply don't need anymore.

Those are kind of a couple of -- oh, I should mention one other thing on the insurance reforms that's important. Art's asked me about this a couple times. While we get insurance reform put into place, the no rescissions on individual policies, the no lifetime caps, the age to twenty-six dependent care coverage and so forth, the question comes, how are we going to make sure that all the insurance contracts have that in them? And

we're working through an NAIC group on that to have a very simple endorsement.

We're not going to require every carrier to submit every form back to us and look at all that stuff in great detail, we're simply going to have a very simple endorsement form that says all of our contracts meet these new standards, and that will be the way that we surveil the market on that -- on that point.

A couple last comments on the reforms that come in in 2014. The biggest part of that reform is going to be the insurance exchanges in 2014. That's where you will have individuals and small businesses -- the market really works pretty well today for groups above fifty. My guess is that Pennsylvania will end up -- it won't be my decision probably, but will end up with an exchange market below fifty, because that's where the real problems are in the market, individuals and below fifty.

The larger groups will continue to do what their doing today, and the exchanges will essentially provide something like what the HR department of a large insurer provides today to the individual and small group market. And that is a

way, at a minimum, a transparency window so that you can get, you know, what are my choices in the marketplace, what some of the carriers call Consumer Reports on steroids. You will have a lot of information through the exchange on the different insurance options available.

Some large employers also take a more aggressive stance to the insurers and use their leverage in the market and kind of more market makers, try to drive down costs and improve quality, don't let all the insurers be part of the exchange, try to get some competitive bidding going.

It will be an interesting set of discussions over the next couple years as to how aggressive these exchanges will be. My guess is they'll be more aggressive in some states than others. The insurers will push for it being an Consumer Report style. Some of the consumer advocates will push for a more aggressive exchange. So that will be a set of issues.

And then there probably will end up being some states that default to the federal government on the exchanges, just like there were nineteen or twenty that defaulted on the high-risk

pool.

I think the objective ought to be to get all the states to take up the reforms and manage them in a way that is tailored to those conditions in that state, and I hope that's what Pennsylvania does.

Finally, let me come back on the cost control issue and just give you a couple examples of where this is -- and all this is going to take enormous work, because, as Uwe E. Reinhardt, the famous health economist, likes to say, health care spending equals health care income. You want to cut spending, you're going cut somebody's income. Health care, typically, it's not someone with a million-dollar stake or even a ten-million-dollar stake. It's somebody with a billion-dollar stake or a hundred-billion-dollar stake, so we've had a very difficult time in our political system standing up to that sort of things.

The insurance companies tried it in the late '90s, after the last reform failed. They called it managed care and capitation, and there was patient protection backlash against it. I think it's -- one of the lessons from that is that it won't work with the insurance companies using

kind of arbitrary processes and standing out there alone. They're not going to be able to do it.

And, frankly, one of the reasons the industry was mostly behind this set of reforms, till the very end when it was squirmishing, but mostly pretty positive about the reforms is because they knew that and they know that only with the government and the insurance industry and the medical system -- they're a lot of doctors who want the system to work a lot better than it works -- can we get to the right solutions. And the first thing is, as I said, end fee-for-service medicine.

And I'll conclude this with one example what I mean. Jean Haynes, the CEO of Geisinger, and I have been on Quoted several times in the last month, and she tells a story about how, at Geisinger, they used to charge one price for their original cardiac surgery, heart surgery, then if the person came back with complications, there was a second price. Third time, a third price, fourth price, et cetera.

It really wasn't -- it's a good business model, if you can get away with it. But, you know, I'm going to try to fix something for you, but if I don't, I make more money off you

rather than less, because you bear the risk if I do it wrong rather than me. It's not a system -- that's a system that will not produce the right results. It's the medical system we have today. It won't work.

And so, instead, what Geisinger said is, we'll charge one price that we'll charge everybody. It's going to be higher than that original price just for the first surgery, but it will be lower than the price that people used to pay with the complications. And then once you've paid it, we'll bear the risk if it doesn't work. And you know what, as the economists have predicted, it actually does change their success rate in the market.

And she can -- they started with one type of heart surgery. Now, they do about ten or twelve different types of this. That needs to be -- today, it's still a unique kind of story, and it does tell you something about why America does lag the rest of the world in cost control, that these kinds of things are unique stories in America. They'd be the norm anywhere else.

And that's the kind of thing that not only -- that is to become the norm everywhere. Is

it going to be easy to do? No. But I submit to you, we'll get it done, because if we don't, America will end up like Greece. We won't be able to afford our health care system. And so, we'll be like what Churchill said, we get it right after we've exhausted all the wrong options. And so I believe that we will be able to do those kind of things.

And with that, I'll conclude and be happy to answer questions.

CHAIRMAN DELUCA: Thank you, Commissioner. And certainly -- you certainly gave us some insight there.

You heard AHIP talk about grants. What are you and the administration doing to pursue some of the grants out there?

COMMISSIONER ARIO: I did miss the beginning. Are you talking about the grants around the exchanges or the grants around temporary -- we are going for the temporary risk pool. HHS hasn't yet announced on the exchanges, but we will seek those grants. And there are rate review grants too.

It's safe to say, basically, we will be pursuing all the different types of grants that are

available. If you had one in mind, I could speak to it.

CHAIRMAN DELUCA: Like the consumer advocate.

COMMISSIONER ARIO: Yes. That one's a little tricky for us, because HHS got into rule making on that one already, and as we've discovered, once you go into ruling making at the federal level, you kind of go into hibernation; you can't talk to anybody. So on all these other issues, we have regular contact with HHS, but on that one, we don't know exactly what they're going to produce because they're already secluded to do the rules.

But the key issue for us will be, can that -- can those -- issues this legislature wrestles with every year -- can those grants be available within the government, within the insurance department, where I think they'd do the most good? Are they going to have to be separate from the insurance department? That's an issue that they -- I don't know how they're going to come out on, but I think either way, we could probably find a way to pursue it in Pennsylvania.

CHAIRMAN DELUCA: Okay. Let me also

ask you, I met with a group of small business people and sole proprietors, which is a big thing in our small business community is sole proprietors, who create some jobs out there, and their insurance has doubled.

What does this national health care plan -- once the insurance industry raises these rates to almost double digits what they're paying right now, is there anything to prohibit that from -- is there anything to drop it once we initiate this national health care? Because what they have gone through, sole proprietors in some places -- and I'll be having a hearing on it -- is paying from -- their premiums were sixteen thousand. They went up to twenty-eight thousand dollars.

Now, that's outrageous, because they can't even afford it, even though they're sole proprietors. And I know the small business people contacted me who are sole proprietors.

I mean, are they permitted to raise their rates because they know that the fact that this national health care kicks in in 2014? If the rates are so high, do they stay there? What happens?

COMMISSIONER ARIO: The -- first of all, let me commend the committee for what -- the bills that you passed in the last two years here, 2008 and 2009. If we could have gotten those bills passed by the senate, signed by the governor, they wouldn't have been able to do the rate increases that you're talking about, because that bill would have prohibited that and would have essentially put into law in Pennsylvania the same rules that will be in place in 2014, and as you know, we're still working with you and we're trying to work with the senate to get some rules in place.

Pennsylvania has some of the worst rules in the country around what can and can't be done with rate increases, and unless we change those rules in Pennsylvania before 2014, you're going to see a lot more, I think, of that kind of behavior of trying to position, as one of the carriers calls it, cleanse our book before the reforms hit in 2014. So we're trying to do everything we can to prevent that kind of behavior between now and 2014.

But once done, there won't be anything in the law in 2014 that automatically requires any kind of rollback. But what you will have is a

market in which everyone has to be pooled together, and so what is going to happen is that people who are getting those high rate increases are being singled out.

The carriers talk about, Well, those rate increases are justified by, you know, the fact that medical care is increasing in cost. Guess what, medical care is increasing in cost at unacceptable levels, but it's still in the 8, 10 percent a year. Eight, 10 percent a year, that doubles every ten years, that's a lot of increase. That would be medical trend.

When you see 20 and 30 percent, that's not medical trend. That is not the average increase in claims cost from any carrier. What that is about is saying, We want to take this group of people over here and charge them a lot more money in order that we can take this group over here and charge them a lot less money. It's segmenting the risk pool in a way that would be prohibited.

So over time, people who are positioned way over here now with the older and sicker workers with really high rates, they're going to come back into this average, and does mean, by the way,

that -- some politicians don't want to talk about it -- but it does mean that some of the young, healthy people pay a little bit more so we'll all have stable rates more in the middle. That's what we require.

So general terms, yes, those rates are going to moderate. Nobody thinks we're going to bring down health care costs. Remember, if we didn't do the reform, they would have doubled again. We would be spending five trillion dollars in ten years. I will take a bet with anybody that America won't be spending five trillion dollars in 2019 on health care. We'll figure out a way to bend that cost grid.

It's not going to stay at 2.5 like it is today, but it will bend -- it will get better than that it has been for the last decade.

CHAIRMAN DELUCA: And these -- some of these rates that have been tremendous is because of the fact that we're one of the few states that doesn't give the insurance commissioner the power to regulate; is that correct?

COMMISSIONER ARIO: Yeah. When you talk about sole proprietors, just to be fair here to the insurers, that -- those are then, in most

cases, treated as individuals. And the individual market, in most states, is pretty bad, in terms of, you know, individuals who have health problems have a very hard time getting anything affordable. So when you're talking about a sole proprietor, just a single person, that's not really a unique Pennsylvania problem. Everybody in that boat tends to have huge problems.

As soon as you get, though, to groups of two or more, in most states, there are pretty strong limitations on charging up a group, you know, doubling, tripling their limitation. There are limitations on that. We don't have them.

CHAIRMAN DELUCA: When I say "sole proprietors," I don't mean the individual, I mean the groups that form a membership of sole proprietors.

COMMISSIONER ARIO: Right.

CHAIRMAN DELUCA: It is a group, but there are sole proprietors who belong to the group have gone up.

COMMISSIONER ARIO: Groups of one -- under the current system, you wouldn't believe the time and energy that insurers put into segmenting those risks, and within associations are very

complicated formulas for when people get grouped and when they get charged individually.

I mean, just think, if you think about all the activity that today goes into -- and it's traditional insurance activity, so that's why -- you know, people some say the insurance industry won't survive this because they -- it's in their DNA to try to exclude sick people and only cover healthy people. If that's true, they won't survive, but I believe those Blue Cross systems have a long tradition of community rating that I think we'll go back to, and carriers that do community rate effectively, that's where I think the future lies.

But today, everybody spends enormous time. They hire a lot of people. They do a lot of complex computer modeling to try to figure out who's healthy, get them in, and who's unhealthy and push them out or rate them way up. That's just the nature of the game today. And that's why we have federal health reform.

CHAIRMAN DELUCA: Thank you.

Representative Godshall.

REPRESENTATIVE GODSHALL: This is on Chairman Micozzie's dime, not mine. I'll read it

exactly as I have it here, as I received it.

The key provision in the health reform law is the premium is the requirement that health plans meet new medical loss ratio, MLR, standards, technical term that limits the percentage of premiums spent on administrative costs. To ensure appropriate resources for activities that improve health care quality, the law excludes quality improvement activities from the capped administrative category.

Have you -- where is the NAIC on MLR, and are they doing anything to push to ensure that quality improvement activities must be encouraged and that consumers should have meaningful comparisons among all health plans?

He's just asking, what is the NAIC doing in that realm?

COMMISSIONER ARIO: Thank you for that question. I think you should always have to read Micozzie questions. They're friendlier than the ones you usually have.

REPRESENTATIVE GODSHALL: Well, okay.

COMMISSIONER ARIO: I know you got your own coming.

On that one, the question's exactly

right. That there is this provision in the law that, I think, appropriately says count quality improvement activities, activities that actually improve quality on the numerator side. Give the insurers credit that counts against their 85 percent target -- or the 80 percent target. And the NAIC is trying to implement that.

It still does involve line drawing about what is exactly a qualified quality improvement activity and what isn't. And we're in the process of doing that. And, like I said, there's three or four hundred people usually on the phone these days when the discussions take place.

REPRESENTATIVE GODSHALL: Okay. We will get that answer back to the chairman.

I just want to ask you, what is Pennsylvania looking at as far as up-front money? Where are we at on that?

COMMISSIONER ARIO: I heard you talk about that. I was going to address that.

We don't think it's going to be very much up front. I mean, it's taken a fair amount of my time and a couple --

REPRESENTATIVE GODSHALL: We thought maybe it was in your budget.

COMMISSIONER ARIO: We, staff -- it is. We're absorbing it with -- you know, it's essentially staff time that goes into it right now.

We believe that -- again, we are going to -- the process here is that by June 1st, to get into the lead queue, HHS says, States should get their application to us. And we have a draft proposal almost ready. We're going to share it at the caucuses today.

That -- if we get in that queue, then we're the first set of states. We start getting our money as early as -- we will get our money as early as July 1st, if it's approved.

So between now and July 1st, under our current plan, we don't have a lot spending. It's basically staff time and actuarial time to calculate some things, and then we would start getting money.

If we don't get in that first queue and have to start doing some of the RFP work and so forth, then we will have this issue of where are we going to get the money.

REPRESENTATIVE GODSHALL: Okay. You had mentioned about our costs. Every other country

has sort of reigned in their costs except for this country and so forth. I am hoping -- you know, I know that our people are used to the quality and also accessibility, and I'm not sure, hopeful that we reign in a lot of costs and do away with the accessibility and quality.

I unfortunately go down to the University of Pennsylvania, which takes me almost a whole day, once a month, and if I need an MRI, I can get that MRI the same day I'm there. I don't have to lose another day, make another appointment for two or three months in the future, and the same with a CAT scan. It's -- it is something our people are used to.

And I do agree that costs are -- you know, the costs are there, but at the same time, people in this country are used to accessibility and quality, and far better than what we see -- what I've seen around the world, and I travel a lot. It's something that also has to be taken in consideration with the cost.

COMMISSIONER ARIO: We're going to have a lot of discussion as a society about what that right balance is. You and I do get those kinds of care. When my wife insists on an MRI when my kid

bangs his head on the sports field, she got it. You know, people like us get those kind of care.

I will point out to you even today, a lot of people don't get that in America. We have the very best high-end medicine in the word, and if you can get access to our top end, if you have some very tough disease that demands, you know, a special drug or whatever, we're better off in America than anywhere. People flock to us.

But if you look at average results, we're down in the middle of the pack and often times even below the middle with infant mortality, life expectancy, these kind of broad measure. So we don't get it to everybody today, but these issues will be important, and we will probably decide to continue spending more than any other country in the world would be my guess, because we want a high level of medical care.

But in the future, the way it will work, and I was on the phone with the doctors explaining this to a church audience the other day, it will be medical homes, and it won't be -- you won't be able to just your doctor and your doctor kind of in a bubble will decide, you know, I'm going to go get that or whatever. They will be

practice in groups and they will look at what the statistics show and they'll look at your kind of situation, and, in general, you will get what is the best-evidence standard. And there are today a lot of people getting MRIs and that sort of thing that really probably should not because they don't fit. My boy, I'll tell you, the day he got the MRI, he shouldn't probably have got it. He didn't really need it.

Those kinds of things will be part of our system. How much is America going to stand for that? They're going to have to, unless they want to keep paying more and more, and that's where the balance has to lie. But, I mean, you know from your work, right, we want everything and we don't want to pay anything for it. So these are going to be challenging issues in America.

REPRESENTATIVE GODSHALL: You don't want to pay for it until you need it.

COMMISSIONER ARIO: That's right.

REPRESENTATIVE GODSHALL: Thank you, Commissioner.

CHAIRMAN DELUCA: Representative Quinn.

REPRESENTATIVE QUINN: Thank you, Commissioner, and Mr. Chairman, for being here.

And I'm sorry, I'm going to have to leave immediately after asking my question.

I also appreciate the time that you're going to put in later this afternoon in briefing the four caucuses about the high-risk pool. Truth be told, the knee-jerk reaction to Kathy: Great. Can I call you tomorrow about that?

And she wasn't aware of it.

Who within our caucus is -- are you -- is going to be there? Do you know?

COMMISSIONER ARIO: I don't know the details, no. Two o'clock is the time I was told.

REPRESENTATIVE QUINN: Two o'clock right here in the capitol?

COMMISSIONER ARIO: Yes. Now, I really hope I'm not in big trouble here because I thought that was set up, and I think it has been, but I don't know. Can anybody else there up speak to it?

REPRESENTATIVE PASHINSKI: There is no leadership -- just for the leaders.

COMMISSIONER ARIO: Now, I'm probably going to get chewed on by somebody.

REPRESENTATIVE QUINN: I just --

COMMISSIONER ARIO: There is a briefing

at 2:00, and I don't know who's been invited for sure.

REPRESENTATIVE QUINN: Okay. Well, understandably, all members of our Republican caucus as well are most interested in --

COMMISSIONER ARIO: I didn't say that without taking note that it was told to me four caucus briefing, yes.

REPRESENTATIVE QUINN: Thank you.

CHAIRMAN DELUCA: Representative Barbin.

REPRESENTATIVE BARBIN: Thank you, Mr. Chairman.

And thanks, Commissioner, for your testimony and we will be working here to try to make the balance with both our -- here and in the general assembly, but with our counterparts in the senate.

My question is this, I look at this high-risk pool, and I know that we've got a couple hundred thousand people who can't get coverage because of their preexisting conditions. Your testimony is that we will have five thousand people that will be covered under our initial application.

I'm concerned that the amounts of money won't be sufficient over the three and a half years. Can you tell us, the committee, what the deductibles will be and what the -- or what your proposed deductible is and what your proposed monthly for some -- for any of these five thousand people will be?

COMMISSIONER ARIO: I'll give you some general range of people. If I say a precise number, it could change.

REPRESENTATIVE BARBIN: Ranges are fine.

COMMISSIONER ARIO: Ranges are fine. Generally going to be a thousand-dollar deductible plan. There are going to be some exceptions, offers of preventive care and so forth. It's the premium -- we're required by the HHS requirements to set the premium at what is, quote, unquote, standard rate in the individual market. We think that's in the four- to five-hundred range here. There's some calculations there that could take it down to the three- to four-hundred range. It depends on what constitutes a standard population and so forth. But somewhere in three to five hundred range is what we would charge -- is the

most we can charge people for this, and then the rest of it will be subsidized.

And we think, under our best actuarial projection, we have now, you know, roughly, five thousand people per year. And, again, then the claims will go to HHS. Somebody's just administering this, managing the claims. And then they will be working closely with us, because if that -- if the claims on that population turn out to be more, then we'll have to learn to roll back a little bit what we're covering.

If they turn out to be -- it'd be nice if they turned out the claims are going to be less, then we could maybe ramp up the coverage for some more people in years two, three, and four of the program.

That is basically -- does that answer the question, who --

REPRESENTATIVE BARBIN: I think so. I think, from our perspective, we've got to make sure that we don't have another, you know, financial additional amount that we're having a hard time paying for, given the recession.

But thank you for your testimony.

COMMISSIONER ARIO: We are very mindful

and the proposal has right in it, we'll be following the HHS guidance. And we're not liable -- state's not liable, the contractor's not liable beyond what they get done, and it's not the risk of the claims.

CHAIRMAN DELUCA: Representative Schroder.

REPRESENTATIVE SCHRODER: Thank you. Mr. Chairman.

Thank you, Commissioner Ario. It's good to have you with us today.

I wasn't planning on addressing this issue, but I was astounded when you cited Greece as an example of why we should be going down this road. I mean, from my observation, Greece is a result of the entitled welfare state basically running amuck and being funded by ever increasing debt, which seems to be the road we are heading down in this country by the adoption of a trillion-dollar program like this, and, you know among other things. So all I would say, if Greece is the reason to do this, I'm more and more convinced than ever that we shouldn't be going this direction and doing that.

So I just wanted to, you know, comment

on the Greece matter there, because --

COMMISSIONER ARIO: Can I just say, Representative, what I meant to say was, we are not going to -- we are not Greece. If I misspoke, I really misspoke, but the point is, we are not Greece. We are not going to let our system go down the tubes. We are not going to let the cost of our health care system take us down that road. And the only way we can control these costs is to do something like this.

They were out of control before we did this. This is a way to control the costs, not to put them further out of control.

REPRESENTATIVE SCHRODER: If I misunderstood, and perhaps I did, my apologies then. I thought you were citing Greece as an example of how something was done, and --

COMMISSIONER ARIO: No.

REPRESENTATIVE SCHRODER: -- after work on this bill, and, therefore, a reason. Okay. I appreciate your clearing that up.

Commissioner, in your written testimony, in the high-risk pool section, you state that there's five billion federal funds. Pennsylvania will get a hundred sixty million of

this over the life of the program. I'm assuming that's over the course of five years.

COMMISSIONER ARIO: Three and a half years. It's going to be a little less probably, but July 1st of this year till 2014 will be three and a half. And it will be a little bit less, depending on when the program's started.

REPRESENTATIVE SCHRODER: Okay. Three and a half.

With that then, approximately how many individuals or families will we be able to insure in addition to what we are doing right now?

COMMISSIONER ARIO: We're looking at about five thousand, about that. Five thousand per year.

REPRESENTATIVE SCHRODER: Five thousand per year. Okay.

What is the -- the current waiting list adultBasic, the current need out there, I guess?

COMMISSIONER ARIO: Four hundred thousand, I think, about on the adultBasic waiting list. That, as has been pointed out many times here, is an inflated number, because some of those people have died, moved on, got a job, et cetera. So it's somewhat less than that, but the number

signed up that are on the list are four hundred thousand.

REPRESENTATIVE SCHRODER: Okay. You had also mentioned something about the NAIC and them looking at certain things. My question is this. I had contacted your office, or someone from my office did, to inquire as to whether you, as the insurance commissioner, submitted comments to the NAIC on the issue of medical loss ratios and some of the other definitional things that I understand they were taking comments on.

Did we do that in Pennsylvania? Did you submit written comments or --

COMMISSIONER ARIO: No, we did not. And I hope we got back to your office. I saw the exchange e-mail, and I think we got back and said no.

My philosophy at the NAIC on the issues that I'm not the point person on, like I am a point person on insurance exchanges now, but on the medical loss ratio, to listen carefully to the debate, ask for input from the staff, and we're going to weigh in -- tend to weigh in towards the end of the process.

And we -- originally the secretary had

asked us to be done by June 1st at the NAIC recommendation tour. And we recently, I think yesterday, told her, Well, probably be July 1st before we get there. And the statute requires us to get it there by the end of the year so there's still some time in the process here.

REPRESENTATIVE SCHRODER: So you anticipate that that might happen or will happen?

COMMISSIONER ARIO: It may happen. I think with the NAIC, fifty states, trying to reach a consensus, we listen carefully. I saw a very thoughtful letter from my colleague, Tom Considine, in New Jersey this morning, on the issue, and, you know, I think we will continue to monitor. But as of today, none of staff nor myself have seen a particular issue that we thought we really had to weigh in early on.

REPRESENTATIVE SCHRODER: Okay. Now, with regards to Massachusetts and their experience, regardless of what certain ex-governors say, certain senators, I'm not concerned about their continued endorsement of Massachusetts' health reform, but I did want to address some of the articles that I've seen over the past year or so, information that I have.

I have been trying to follow implementation of it from afar, you know. Not living or being there, we're at a little bit of a disadvantage, I guess, but it seems to me that all is not sunny in Massachusetts with regards to implementation of their program.

Article from October of last year indicates that Massachusetts, despite significant restructuring of their health sector, still has the highest health insurance costs in the nation, averaging thirteen thousand seven hundred eight-eight dollars per family, according to the Kaiser Family Foundation. And premiums were being looked at to being increased by about 12 percent on top of that.

Also, in a more recent article, March of this year, it indicates that the state enrolled fifty-five thousand more people in Medicaid, and the folks flooded to the new free insurance and enrolled in their -- sorry -- subsidized plans but a few bought private insurance, so even though the total uninsured dropped, savings didn't materialize. And it indicates that Massachusetts is asking the federal government for another four hundred seventy-three million this year.

Finally, other problems involving increased waiting times for physicians, lack of increased number of physicians to handle the caseload and other things like that, so I just think that there's things we need to look at very carefully with regards to what Massachusetts did in implementing this as well.

COMMISSIONER ARIO: Representative, you're absolutely on point, as usually. In that item as community rating issues over the years, and those are very good comments.

The Massachusetts experiment shows that if you put an individual mandate in -- and, again, this is -- a lot of people try to run away from the mandate and pretend like that you can't -- you know, we want to have insurance reform without a mandate, doesn't work.

One thing I'll guarantee you, if you take away the mandate, you're going to end up taking away the insurance reform, because you cannot tell people, You can come in whenever you feel like it after you're sick, but, you know, you don't have to come in until you're sick. That's not a recipe for solving our problems. You need to do both, and that's -- Massachusetts has proven

that, and that means 97, 98 percent coverage is where they are.

The second half of it, cost control, they haven't done. They aren't -- a lot of people say, Well, they're the worst in the country. Well, they were the worst before the reforms, so they've been roughly paralleling the rest of the country. I heard Governor Romney recently say, on a FOX interview, that Massachusetts was actually doing better, relatively speaking, since the reform, but they're still a high-cost state and they stay a high-cost state.

That's why we need much broader reforms around fee-for-service medicine, wellness incentives, practicing by best available evidence.

I will say that the discussions in Massachusetts show two things about costs. One, they're tough issues, so their governor's embroiled, and there's a lot of issues with insurers, and there's some things going on there that I don't think are particularly helpful in terms of rate regulations, fights that maybe aren't completely the best way to approach these issues, but they also have been some of the most promising discussion in the country from the larger carrier

about bundling and even global payments, because everybody recognizes that fee-for-service medicine doesn't work.

So then, once you have everybody in, the conversation is, A, you know, more difficult. We're going to have some difficult discussions in this country. But, B, it's actually engaged instead of everybody kind of throwing up their hands, as we've done for, you know -- since I've been alive, we've thrown up our hands and said, We can't control the costs, and it continues to go up.

Once you have everybody in, you have to engage that question. Massachusetts has engaged it, I think, more than any other state in the country.

REPRESENTATIVE SCHRODER: One of my concerns is, you know, the cost of the program in Pennsylvania. And it seems, in Massachusetts, the costs have gone up, has been more costly than expected.

COMMISSIONER ARIO: No, that's not -- it has not been more costly than expected. It's been on the same basic track as what was -- you know, their costs have not gone down, but they have

continued to track national costs.

REPRESENTATIVE SCHRODER: Well, as I said, they're asking the federal government for more and more money all the time, to, you know, help meet their costs, and I fear that if, as mentioned by the first testifier, that if people drop out of private insurance, whether it is a risk pool or eventually the state exchanges, and the fines, if you will, that are in the federal program aren't enough to cover the cost of that insurance, we're going to have, you know, an additional problem.

And I'd like to know what your thoughts are and your comments are on that as to what the impact would be in Pennsylvania.

COMMISSIONER ARIO: The issue of cost control is not really an insurance issue. The insurers have a right to say that there are, in big picture terms, kind of pass-through mechanisms for most of the costs, and so when you see these big premium increases, that's an issue about how they're -- equity, how they're divided in the pool, but in general terms, they're a pass-through mechanism, and the real costs are in the delivery system, and so it's delivery system reform that has

to happen in order for the costs to go down.

So focusing on whether the insurance reforms are going to increase or decrease cost, insurance reforms predominantly shift around who pays more and who pays less, and the intent is to make everybody pay closer to the middle. That's the focus on that. It doesn't -- but --

So focusing on the insurance reform as a reason why costs are going to go up is, I think, misplaced. I think the issues about costs going up have to do with fee-for-service medicine, the fact that we get enormous variation among different regions, the facts that -- the fact that we don't have targeted incentives for people to do wellness effectively. We have these extended broad premium things, as I said before, that don't work effectively, to incent the right behaviors. Those are the most fundamental issues around costs.

REPRESENTATIVE SCHRODER: No. I understand your point there about -- about those being the cost drivers and utilization and everything else. The prescription drugs, we all know how they play into -- into that package. But, like I said, if, as I fear, there is an incentive for, you know, employers to drop individuals, if

that happens, then I fear it's going to be increased cost on government without necessarily the, you know, money coming in to handle that.

COMMISSIONER ARIO: Absolutely.

CHAIRMAN DELUCA: Representative Pashinski.

REPRESENTATIVE PASHINSKI: Thank you, Mr. Chairman.

Thank you, Commissioner.

I'd like to continue this conversation you just had with Representative Schroder, because I think that this is where we all miss the point.

Number one, if we did nothing, health care would continue to escalate out of control. It's unsustainable, and less and less people would have insurance and less and less people would have medical care.

COMMISSIONER ARIO: Projections are 2.5 trillion this year -- or the last year, so 2009; would be five trillion, almost five trillion, 4.8, in 2019, yes.

REPRESENTATIVE PASHINSKI: So it's unsustainable; it's a broken system.

The second thing is, this particular federal effort is a tremendous first step in order

to help revolutionize a new way of providing health care. And it's imperative that all those that represent insurance today, they are only one leg of a multi stool -- multi-leg stool.

Our efforts here to try to work with the insurance industry is hampered because we don't have those cost controls that you began to allude to. So, as Representative Godshall indicated, you know, his care and you indicated the MRI, the fact of the matter is that in most industrialized nations, an MRI, at max, would cost about five hundred bucks. But in the United States it costs from six hundred to two thousand.

Now, my question is, what are we going to do -- it's our duty to make this thing work. It's our duty to make it right. What are we going to do to try to help the insurance industry with the cost controls in the delivery system in order to have an opportunity for success?

COMMISSIONER ARIO: Very good question, Representative.

The core idea there that I would say is the insurance industry has to be a full partner in this, but they're not really the driving force in a lot of this cost control. When they tried to do it

in the late '90s by themselves, it didn't work very well because it was done very arbitrarily. There was a lot of push back from both the medical community and then, ultimately, from the public as well. So it needs to be a partnership, I believe, and the medical community has to want to come forward.

So the more exciting things today are things where the insurance industry's working with the medical industry around medical homes, essentially the same thing as what used to be -- managed care got a bad name. It's like, what do you want, unmanaged care? Is that the goal here? So it's a form of managing the care effectively, and then having the medical community essentially manage within budget.

Somebody's got to manage within budgets here. If the medical profession can order whatever tests they want and some third party over here is paying for it, it's not going to work. So the system is going to be bundled payments for those medical homes, certain budget, and then they'll work with their patients, and their patients will have some of their own money at stake too to manage costs within overall reasonable targets.

And where we set those targets, well, as Representative Godshall said, we're probably going to set them higher than any other country in the world, but not so high that we're going to keep doubling the costs every ten years and have fifty million people outside the system because they can't afford it.

So insurers working with -- around medical homes, those sorts of things are -- is where the insurers role comes in. A lot of it's going to be started with Medicare, and when Medicare proves that something works effectively, it gets kind of rolled out.

These bills have a lot of -- the law has a lot of provisions in it about payment reform, looking at what happens and works and then trying to replicate that around the country. It's even got installations, like the military base decision did of, you know, okay, now, somebody then will complain, Well, I lost a billion dollars because my service didn't get enough coverage. Those things then go in a package back to congress, and congress has to do a take-it-or-leave-it thing. They can't say, We'll take out this one base and put it back in the proposal.

So there's a lot of thought out things that people -- you know, what people know about the bill is the Louisiana Purchase and the Cornhusker Kickback and these things, aren't even in what is the law anymore. They don't know about these kind of details, and I think, as you see these details roll out, you'll see a lot more engagement and support.

REPRESENTATIVE PASHINSKI: I think it's really imperative that we make sure that we highlight who all the players are here, and what Chairman DeLuca is intending to do is to bring all those players to the table so there can be an exchange of information and challenging various positions.

If the pharmaceutical industry is going to continue to raise rates at will, then this system will fail. If the medical manufacturers of equipment and supplies continue to raise their rates at will, this will fail. If the doctors continue to order more than they need to, then this will fail. And it's incumbent upon all of us, it's our absolute duty of survival to get all the people at the table and be honest.

I'm worried about the rush to increase

the rate, to increase prices, so as to maintain certain profit levels as these attempted reforms take place. That's what my concern is. And I would hope that we could continue to echo that it's -- there are several major players in this that's going to make it work or make it fail.

Insurers tend not to do themselves a lot of favors in the way they handle some issues, in my view, with the rate increases and so forth. They get themselves in the public line. But when you start talking more broadly, what insurers ought to be talking about is all the opportunities here, and they ought to be talking about this chart that says what are the average profit levels in insurance. They're pretty low, actually. They're 2, 3, 4 percent down here. Hospitals, not much better, frankly. They're a tale of rich and poor there.

And then you look at the pharmaceutical company, from the medical devices, medical industry, and you start seeing profit levels in the teens and so forth. And so the insurers are not fundamentally to blame, but they have a kind of wading in.

And, you know, again, I think it's

about this thing that I don't think the country wants anymore, which is taking sick people and saying, Since you cost us a lot more, we're going to charge you three, four, ten times as much as everybody else. That then provokes a public backlash, and we need to get the community rating of the sort that the Blues pioneered and did for fifty years.

And still -- actually, here's a little known fact, Highmark and IBC are the only large carriers in this state that don't use medical underwriting, medical questionnaires, to figure out how to price insurance for small businesses. Their both threatening to do it because they say, If the competitors don't stop doing it, we'll have to do it, but they still don't do it today.

So the model can work, but it can't work if other people are continuing to do that kind of risk selection. And it can't work if not everybody's in the market.

REPRESENTATIVE PASHINSKI: That's correct. Well, I appreciate your effort. And I know that you're going to continue to fight. And I know there's going to be plenty of other people here doing the same.

Thank you, sir.

COMMISSIONER ARIO: Including you.

CHAIRMAN DELUCA: Representative Day.

REPRESENTATIVE DAY: Mr. Commissioner, thanks for coming today. I really appreciate your testimony today.

I understand you estimate the cost to administer the high-risk pool of approximately 10 percent of the hundred sixty million; is that correct?

COMMISSIONER ARIO: The guidance from HHS is, try to run it at a medical loss ratio of 90. So if you read the things they put out so far, and they have not put out final regs here, by the way, but they said, you know, We'll pay reasonable administrative expenses starting now, and then we're after a target overall of a 10 percent cap on administrative expenses. But it's still -- it's kind of -- it's talked about in the guidelines in terms like that, not as a hard cap.

REPRESENTATIVE DAY: So they're recommending that. Do you think it will be that number? What's your best guess?

COMMISSIONER ARIO: We've looked at how to cost out these different things, and, yes, we

think that's doable, and the carriers that we've been talking to about potentially doing it, as my understanding -- I've not done a lot of that -- I've not done any of that direct negotiation/ discussion -- think it can be achieved.

REPRESENTATIVE DAY: Do you look at that service of administration of the pool as the similar service or almost like kind to exactly what insurance companies do?

COMMISSIONER ARIO: It is, Representative, what insurance companies do with the large-employer market in that most of the market, most of the insurers in the state probably get, you know, more than half, sometimes 75 percent of their money through their contracts with large employers where they're not taking risks. The large employer, basically, it's predicable. They keep the risk, but they hire an insurance carrier, or somebody else sometimes, to manage the process, to manage the claims, and that process is similar to this.

The HHS is going to pay the claims, just like the large employer would pay the claims, but they want somebody who's expert in dealing with -- who has the provider network and a claims

processing ability and all of that. That's the -- that's how this is going to run.

REPRESENTATIVE DAY: I'll try to be as clear as I can be. The point I'm trying to get at is, the service that's provided to administer the plan is what I look at as what the insurance companies do in the private -- in the current system now, the private system now. And in my experience, mid level, I'd say -- characterize it as a small business, but not fifty, five hundred employees. So in my experience, that number never approached 10 percent, the best I can figure it out. Of course, they didn't turn their books over and show me, but the best I can figure it out wasn't up in the 10 percent.

We have either the self-insured plan -- we had moved to a self-insured plan. We had been under a traditional risk plan, and then I moved it to a self-insured plan, where we hired an insurance company to perform the network -- the operation of the network, interaction with health care providers.

Is that what the administrator would be doing that would be being paid 10 percent of the fund to do?

COMMISSIONER ARIO: Let me make sure I understand. You're saying never approached 10 percent, meaning that you usually paid a lot more than 10 percent or a lot less, or what? I'm not sure what side --

REPRESENTATIVE DAY: I was saying less, from the best estimate that I could make. As I said, they didn't turn their books over to me where I had a team of accountants be able to verify it, but my best guess is that number was smaller than 10 percent, because what I had was, I had -- my actual experience was the payments were being made. The payments I was making into that fund in order to pay for the actual health care services that were being billed. And then there was a premium on top of that that was being taken by the insurance company for their service.

I mean, I think -- and I'll share with you further. One of my pet peeves in this whole issue is that we're kind of saying "big insurance," "big insurance," that's the problem. They're taking all types of dollars. In my -- just my anecdotal -- just my experience, I didn't find that to be the case, because I was managing our plan for our company and negotiating pretty extensively

with -- when we went self-insured, I was able to bid it out -- now, you know, in the current laws, bid it out to competitor providers. But I was looking to shop for that service.

Now, to tie that back in to where I'm trying to get to here is I was looking at -- and you can make comments and educate me even further. Do you think the 10 percent is higher than the private sector, or I guess you would say lower?

COMMISSIONER ARIO: That's what I was trying to get at. What it depends on is who's doing what in the actual administration of the system. In general terms, large employers -- you said five hundred -- five hundred and above, you know, they're going to have medical loss ratios up around 90 percent, high 80s.

There's going to be nobody in that marketplace that is paying, you know, 15 or 20 percent admin costs on the profit margins on top of claims cost. That's going to be in the 10 percent range or less. And the issue of whether it's 10 or 12 or 8 or 6 will depend on, you know, exactly what's being done on the employer's side and what's being done on the insurer's side, and, frankly, also what's being done on the doctor's side.

One of the issues we asked about this, how is the medical loss ratio stuff going to work, if it doesn't work as well as the insurers would like it to work in term of their getting to count, in quality assurance dollars in the numerator side of the equation, guess what they're going to do? They're going to start putting it into their contracts with their provider networks and make them do it. And some people think that's a good thing. Might be better if the doctors are actually managing their quality assurance efforts rather than the insurers.

So the dollars can be shifted around and these variations are not going to have to do with somebody figuring out a way to magically produce a 3 percent profit gain or new margin that's going to be -- you know, you're company took back some services and said, We'll handle that aspect of the transaction and you handle less.

So it does vary a lot exactly how it's done in the marketplace, but a well-functioning, large pool, and that's why you've got exchanges, because who's getting not treated very fairly in the current system? Individuals and small businesses, which are paying, you know, 20, 30

percent loads in the system.

Also, just one last thing, because I say a lot of negative things about the insurance industry because I don't like the way they segment risk and who pays what portion, and I think that's one of the things that there's a lot of push back on these days, but, overall, as I said, their profit margins are pretty low, and you could take all the money that all the insurance companies make, and it would be a relatively inconsequential amount of money in terms of the size of that 2.5-trillion-dollar spending.

So the cost control issues are not with the insurers, they're elsewhere in the system. Insurers need to work on it and spend, you know -- my critique of this, spend less time talking about how it's all going to fall apart because these risk selection issues are enormously determinative of where the money is. It would be like -- these are relatively inconsequential in the overall system.

Let me tell you where the real money is, that ought to be the presentation.

REPRESENTATIVE DAY: And with your answers, I just end up with another fifteen questions, Mr. Chairman, but I promise I'll stay

focused on this one particular issue.

And in all these hearings that we intend to have, I'll try to share some of those questions. Hopefully you'll return again and again and we'll be able to go over those.

Specifically, with administering the high-risk pool, do you plan to have an internal state -- state employees doing that, or will you farm that out to the private sector?

COMMISSIONER ARIO: We intend to contract it out.

REPRESENTATIVE DAY: Mr. Chairman, thank you for your indulgence with me with these questions. I appreciate it.

CHAIRMAN DELUCA: Thank you. Thank you, Representative Day. That's what these hearings are about. No problems with it.

Mr. Commissioner, you mentioned the fact, we were talking about the twenty-six-year-old's dependent coverage. Who pays for that additional coverage? Do the employers pay? Do the employees pay? Or do the -- is it a combination between the employees and the employer?

COMMISSIONER ARIO: Ultimately, whoever's getting the benefit is going to pay for

it in one form or another. So it would be the employee, through the employer, would ultimately pay. Again, it's an issue of risk spreading, is whether you spend enormous amounts of time trying to price this new coverage and segment out -- there's a separate risk and have each person in that pool pay it.

That's the most inefficient, bad way to do it, in my view. If you do it the way the federal government's done it for the plan up to twenty-six, it's spread across that carrier's book of family coverage. So with a large employer, it's going to be spread across, you know, all the employees of that large employer. And a small employer, once we have pooling, it will be spread across all of the small group market.

So it's -- so it's -- what it will do, ultimately, under the federal approach is it will add a small increment to what it costs to have family coverage on an individual plan or on a small group plan. And, actually, any individual employer would have an incentive to do more in this area, because their cost, if they do it, will be spread across the whole risk pool, and if they don't do it, they're just depriving their employees of the

ability to have a cost that would be spread more broadly. So it encourages, you know, more coverage rather than encourages less coverage.

CHAIRMAN DELUCA: So it will be spread across the whole.

COMMISSIONER ARIO: Yeah. Ultimately, you know, in the end, people will consume the services, we pay for the service. People are putting together different ways of delivering them to us, but there is no free lunch in that.

CHAIRMAN DELUCA: We know that. We know that very well, there's no free lunch, Commissioner.

But, I guess, would the parents be getting a separate bill if that was --

COMMISSIONER ARIO: No, no. Under the federal approach, whatever the current charges are for dependent care, that -- this would be -- this would be no different, under the federal approach. Keeping your child on till twenty-six would be just like, you know, having another child come into the family unit. If you already have family coverage, there's no charge for the second, third, fourth child, no extra charge. And if you bring the first kid in, you have to move from -- either from

individual or couple coverage to family coverage. It would -- that's how it would be.

CHAIRMAN DELUCA: So --

COMMISSIONER ARIO: The kid up to twenty-six would be just like adding a new adopted kid at thirteen or a new baby at one. Now, when I say it that way, it sounds like, you know, nobody's paying for it. No. That -- depending on how many dependents there are in the overall pool, obviously, the more dependents in the overall pool, that's going to make family coverage a little bit more expensive, but it's going to be spread across everybody, not a big cost on any one person.

And then that way, you also get more people to use it, and so you get healthy people in addition to sick people. And you price something way up, you -- it's a self-fulfilling prophesy. If you price it way up, then the only people who will buy it are the people who absolutely need it. Everybody else stays away from it. And then you can prove that, you know -- it's called the death spiral, in insurance terms. You have to then keep raising and raising because you keep getting rid of all the healthy people in your pool.

CHAIRMAN DELUCA: Right. And I thought

I heard you -- and I think you gave a comment pertaining to Highmark, that they don't do medical underwriting, to their credit; is that correct? But they do do medical underwriting, which I was alluding to, through their subsidiary; am I correct?

COMMISSIONER ARIO: I don't -- in these association plans that I think you're talking about, I don't believe they do -- put it this way, they better not be, because their agreement with us is not to, if it's considered group coverage. If it's individual coverage, then that -- all of the carriers medical underwrite that today and will probably continue to until the reforms come in.

CHAIRMAN DELUCA: So I understand, because we'll be talking to the -- going to have a hearing on this, you're saying, if they shift to a for-profit, they are not bound to medically underwrite?

COMMISSIONER ARIO: For a certain period of time. The agreement that we have with Highmark is no medical underwriting in the group market for a certain time.

CHAIRMAN DELUCA: What is that certain time?

COMMISSIONER ARIO: It hasn't been disclosed yet by them, and I said I won't disclose it until they do, because we're trying to use it, frankly, as a loaded gun to get the rest of the carriers to say, Let's stop doing it -- Why can't we all stop doing it, because if we don't stop doing it, Highmark is going to be able to do it at some point.

I could not, even if I wanted to, I couldn't prohibit them forever, but to their credit, they've said, We prefer a regime, and so has IBC, in which nobody does medical underwriting, and so we're willing to agree with you not to do it for X period of time, which shall remain a little bit undetermined from the public perspective, in order to give the legislature time to say, Let's stop that for everybody or maybe come to some other deal. It doesn't necessarily have to stop it for everybody. It could be freeze the status quo in place or something like that. But that's what we're trying to do.

CHAIRMAN DELUCA: Okay. Again, I want to thank you for your testimony, Commissioner. We look forward to working with you on this very complicated piece of legislation that hopefully

will benefit all the citizens of Pennsylvania and also this country of ours. Thank you very much.

COMMISSIONER ARIO: Thank you.

CHAIRMAN DELUCA: Next individual to testify is James Gelfand, director of health policy for united chamber of commerce.

Welcome. Certainly appreciate you coming in and look forward to hearing your testimony.

MR. GELFAND: Thanks, Mr. Chairman. It appears we're running maybe a couple minutes late, so I will try and breeze through my remarks.

CHAIRMAN DELUCA: Very good.

MR. GELFAND: I'd like to thank the members of the committee, and especially the chairman, for allowing me the opportunity to testify today.

I'm here representing the United States Chamber of Commerce, the world's largest business federation, representing more than three million businesses of every size, sector, and region. Although the Chamber of Commerce is and always has been committed to expanding health insurance coverage, lowering health care costs for all Americans, we, along with the majority of business

organizations in Washington D.C., we're adamantly opposed to the Patient Protection and Affordable Care Act.

That being said, it's done. It's law. It's signed. And now our focus needs to be identifying the biggest problems there and fixing them so that we can make this law work.

My comments today are not meant to be political criticism. They're meant to be a call to action, to say that there are pieces of this legislation that will not work unless we take action collectively to fix them.

According to the Congressional Budget Office, the new requirements in the act will lead to health insurance costs for individuals increasing by 13 percent more than if we had done nothing. So let's us dismiss the argument immediately that doing nothing was somehow worse than doing what we did. Doing something could potentially be better than having done nothing. But, in this case, according to the Congressional Budget Office, the bill will not be preventing the cost increase. It will be adding to them.

The Associated Press found that, for young people, their costs will go up to by 17

percent. The Center for Medicare and Medicaid Services found that for the nation, as a whole, our health care expenditures will go up.

This makes sense, when you look at the provisions in the bill. Starting this September, every health plan will have to cover many new requirements, and my friend, Mr. Keefer, already went through all of them, and I won't belabor that again. But if we were to assume that each of those requirements raised health insurance premiums by only 1 or 2 percent, and HHS says that it will, that's still significant, when you add them up. In aggregate, you're talking about significant increases.

In 2014, even more changes are going to take place, changes that we also believe will lead to small increases, but when aggregated, will lead to large increases over time.

Congress and the administration promised that this bill would be one that did not disrupt coverage for people who currently have it but rather expand the coverage to those who don't. In order to enact that, they created something called "grandfathering." Grandfathering is meant to say that if you have a plan that's currently in

operation, it can continue in operation, unless it makes major changes.

Now, the definition of what those major changes is very, very important. We don't have that definition yet, but we do know for a fact that there are things that plans have to do every year. Mr. Keefer would be a better person than me to explain what all those are, but think about changing the premiums for the plan, think about changing the percentage, perhaps, that an employer pays versus the percentage that an employee pays, think about networks, think about new coverages. You talked about new drugs. We'll think about new treatments, new doctors, et cetera.

All these changes need to be allowed, and if they're not allowed on an annual basis for plans, then grandfathering won't work, and it will be pretty much impossible to be grandfathered at all.

Even if you are grandfathered, you're still going to have to follow many of the new rules. And the Center for Medicare and Medicaid Services did say that fourteen million people who currently have health insurance coverage will lose that coverage. Now, they did say that other people

would gain coverage, but at the same time, that's fourteen million Americans who are guaranteed to see some pretty serious disruption there.

In our opinion, the most troubling aspect of the bill is that it encourages free riding by individuals. The insurance commissioner correctly identified the idea that to have a market where guaranteed issue and community rating are enacted, meaning that everyone can get health insurance, nobody has to pay too much more than anybody else, and insurance companies can't turn you away, you have to have a fully insured marketplace. And the mechanism that congress chose to achieve that was through an individual mandate. However, that individual mandate is tiny. It's minute. It won't make anybody get health insurance.

Kaiser Family Foundation, no bash on conservatism, found that the average health premium for an individual in 2009 was over four thousand eight hundred dollars. In 2014, if you go without health insurance, the penalty is ninety-five dollars. That ramps up eventually to six hundred and ninety-five dollars or 2.5 percent of your annual income.

That means that you can essentially save thousands of dollars by going without insurance, and then when you get sick or hit by a bus, you can then enroll and have the rest of the population pay for your claims.

Massachusetts attempted a very similar arrangement. The results that Massachusetts has was that new enrollees in plans in Massachusetts stay enrolled for an average of three months, just long enough to pass their costs on to everyone else. This outcome was predictable.

What happened after that? Costs sky rocketed. Massachusetts bureaucrats decided the way to control those costs then was that say to insurance companies, You're not allowed to have any cost increases. The insurance company said, Well, if we can't increase costs, then we're not going to enroll anybody because it will affect our financial viability. And it created a standoff.

This is the same policy that has now been enacted on a national level, although we don't have a national rate review body, at least not yet.

It is true also, that there are some very good provisions in the legislation that will

help businesses. Chief among them are provisions that will allow businesses to change your premium as an employee if you choose to participate in a wellness program. In other words, real teeth so that people will really have an incentive to get healthy.

There's a new initiative for public programs. Accountable care organizations, we talked about them as medical homes earlier, talked about the CMS innovation center. The point of these initiatives is to help public programs catch up with the private sector, where we've already been experimenting with many things that we think could help lower costs, market-driven ideas.

There are grants for small businesses to start wellness programs, but the problem is, there's no money in the bill to fund those grants, so we're going to have to wait for a later bill to provide that money and hope that that actually happens. However, we think that those kinds of good provisions, while definitely are the right intent, they're outweighed by many of the other provisions in the bill.

For instance, five hundred sixty-nine billion dollars in new taxes, taxes on prescription

drugs, taxes on fully insured insurance products, taxes on medical devices, all of which the Congressional Budget Office said consumers would pay.

We know that there is going to be taxes on insurers that can't afford to -- I'm sorry -- taxes on employers that can't afford to offer coverage to their employees. They're going to have to make up that money from somewhere, and we believe it will either be in laying off low-income workers or in lowering salaries for some workers, but for some businesses, it's just not a viable situation where they would have to provide health insurance. Their profit margins are just too low.

There are going to be lowered payments for doctors and hospitals, that will kick in as soon as next year, and market basket cuts. The providers happily allowed that to happen. They said, We'll take lower payments and less dish payments because we're going to get more people insured. But they know that they had a backstop. And that backstop is cost shifting.

When a provider is underpaid by an uninsured person or by a public program, they just respond to that by raising costs that they charge

to private insurers, which means, at the end of the day, those cuts will actually end up being increased costs for employers.

There will be new taxes on so-called wealthy, but we think that that will disproportionately fall on small business owners. So whether or not you think that they need to pay more or their fair share, it will affect whether or not they hire more people. And we're working to do everything we can right now to create jobs and to combat unemployment.

These taxes are paired with five hundred billion dollars in cuts to Medicare. Now, it's important that we make cuts to Medicare. At the end of the day, Medicare is not efficient and needs to be efficient. But the question is, do you take the money that you save in Medicaid and do you use it to shore up the trust fund so it lasts longer than 2017, and maybe someday I can have Medicare too? Or do we, instead, spend that money on a new program?

And in this bill, it's obvious that we're creating a new five-hundred-billion-dollar entitlement in the form of premium subsidies to individuals who make up to 400 percent of the

federal poverty level. That's about eighty-eight thousand dollars for a family of four. There's no question that you need to have subsidies if you're going to force people to purchase insurance, you're going to need to make sure that they can actually afford to buy that insurance. But the question is, is 400 percent of the federal poverty level something that we can afford? Does that make sense for us as a country?

The act deserves to be applauded because it's going to bring thirty million people who didn't have health insurance into the ranks of the insured. Businesses need everyone to be insured because we pay the costs of the uninsured.

That being said, how are these thirty, thirty-two million people going to be insured? Well, about half of them are going to be either incentivized with subsidies or punished with mandates, and the other half are going to be added to Medicaid. So we're not sure that that's the best way to do it.

First, when you look at Medicaid, in many places, Medicaid pays doctors and hospitals about sixty cents on the dollar. They make that money back by charging the employers and the self-

funded or fully insured plans more than the public programs pay. We estimate cost shifting right from Medicare and Medicaid to private employers is about 20 percent of the costs of someone's insurance premiums.

We also worry that the Medicaid program may not be sustainable, particularly because, in certain places, it's becoming increasing difficult to find providers willing to accept Medicaid patients. What happens then is that you're providing someone with a Medicaid card and they have -- nominally, they have insurance, but that doesn't guarantee them access to care.

It's a problem that we've seen in Massachusetts where, while many, many people suddenly had insurance through subsidized plans, they're unable to get primary care, meaning that the insurance is essentially worthless. We need to address those provider shortages, and we need to find ways to make public programs pay an adequate amount, or else that thirty million people who are going to suddenly have insurance starting in 2014, it's not going to be sustainable. You won't be able to hold on to that gain.

The chamber very much supports programs

that are consumer directed, that put employees and consumers in charge of their own health care dollars, which is why we are disappointed in parts of the bill that put restraints on health savings accounts and on flexible spending arrangements, and a good example of that is, you're just not allowed to use money from those accounts anymore.

Starting not this year but starting later, you're not going to be able to use that money to purchase over-the-counter drugs like Benadril or Zyrtec. That -- you can still purchase it, you can still purchase those products with your own money, but you're going to need a prescription to use your HSA funds. That's not really making things more efficient. That's creating more doctors visits.

We think that the act was -- had a good intention in providing credits for small businesses, however, the credits are too small. They're too complicated. They're too restrictive. They end abruptly. And they're one of the only pieces of the bill that actually sunsets.

In fact, to get the entire 35 percent credit, you have to meet so many standards that the vast majority of the small businesses are not even

eligible.

These credits for the smallest employers contrast with the draconian mandate on larger employers. And by "larger," I mean fifty or more full-time equivalent employees. For them, they must provide insurance that meets government standards, which have not been set yet. We don't know precisely what those will be, but it has to meet -- the insurance will have to meet those standards. If it does not, then the employer can be charged two thousand dollars times the number of employees. And so that could add up seriously for certain employers.

But worse, as an employer, you're doing the right thing, and you continue doing the right thing under the act, meaning you offer good insurance, you pay most of it -- most employers are paying 70 to 80 percent of the premium -- and you offer this insurance. You can still end up being fined just as much as if you offered no insurance at all.

And the way that works, as Mr. Keefer mentioned, if you have an employee for whom his contribution, so the 20 percent that he has to pay of the insurance premium, if that constitutes 9.5

percent of his adjusted gross income, he can opt out of your plan, go to the exchange, get a federal subsidy, and your business is charged three thousand dollars per such employee, eventually capped at the same amount that it would have been if you provided no insurance at all.

That's not conducive to doing the right thing for one chief reason. While businesses might be able to save money by providing insurance rather than paying the full penalty, although that's a very difficult argument to make, employers are usually willing to pay a little bit more for certainty. And in a situation where you have a flat fine per number of employees, your accountant can do that calculation, and you will know exactly how much you have to pay.

However, if you offer insurance, you might have some uncertainty there, because there's no way for an employer to know accurately his employee's adjusted gross income. You would have to ask them more questions. You would have to rely on them to be telling the truth. And at the end of the day, you would end up having to probably pay certain employees more money towards their premium than other, but it's going to be very difficult to

have the information to know that.

So that uncertainty right there may lead to many employers saying, Well, I'd rather just pay a fine as opposed to having to guess on what my costs are going to be.

I will also say that the chamber very much supports the concept of creating insurance exchanges. That being said, they have been oversold vastly. The model of insurance exchange that is described in the act is modeled after the commonwealth connector in Massachusetts. And as we discussed earlier, that connector has not kept costs down or created some kind of new competition. There's nothing wrong with that connector, and it serves an important purpose, but saying that the bill's going to control costs because it has connectors or exchanges is not accurate.

Making health insurance affordable starts with real reforms. Reforms that are delivery system reforms. Reforms that are cost control reforms. The Congressional Budget Office, in late 2008, laid out dozens and dozens of different ideas that they had for controlling costs. Many of them are not in the bill.

You will find very little in the bill in terms of protecting doctors from frivolous litigation. You will find very little in the bill that actually unleashes small businesses to pool on their own terms and allow them to look at purchasing coverage from other states that may be cheaper and cause real competition between insurance companies.

Real reforms include actually cracking down on fraud and abuse. If you remember the Blair House Summit, in which the President met with legislators on both sides of the aisle. They talked about many different ideas to combat fraud and abuse. None of those ideas are in the bill, because the senate bill was already set in stone, and none of them were added in reconciliation.

So we think that if you're going to insure thirty million people, you can't say, Well, let's just insure everybody and worry about the delivery system and cost control later. You need to do it ASAP. We need to start doing it right now.

Expanded coverage was a worthy goal. And the act is going to accomplish some important things. But that being said, it's not going to

control costs, and so health reform is far from over. We're going to have to be engaged on this next year and the year after. And over the next ten years, we're all going to be having to find ways to control those costs.

So having said that, U.S. Chamber of Commerce looks forward to working with your state's representatives, both here and in the federal legislature, and making this thing actually work.

So thanks.

CHAIRMAN DELUCA: Representative Schroder.

REPRESENTATIVE SCHRODER: Good morning or afternoon, wherever we're at now. Afternoon. Thank you for your testimony.

Just a couple questions. You're talking about, in your written testimony, let's see, about the Kaiser Family Foundation determining that the average health insurance premium for an individual is about forty-eight hundred dollars. And the act, the federal law would -- regarding the individual obligation to purchase, would penalize an individual up to six hundred ninety-five dollars or 2.5 percent of income per year if they refuse to purchase coverage.

Now, just a clarification, is six ninety-five the top penalty or is 2.5 percent of income the top penalty?

MR. GELFAND: 2.5 percent.

REPRESENTATIVE SCHRODER: Okay. So it could be --

MR. GELFAND: Could be more than six hundred ninety-five dollars.

REPRESENTATIVE SCHRODER: -- quite a bit higher than six ninety-five. Okay.

Yet there will be individuals who would be able to save significant amount of money by refusing to purchase the coverage.

MR. GELFAND: Correct.

REPRESENTATIVE SCHRODER: So let's say they refuse to purchase coverage. Walk me through what happens. They're still required to get coverage under the law or be covered somehow, are they not?

MR. GELFAND: Well, it's unclear how the band on preexisting conditions is exactly going to work and how the guaranteed issue is going to work, but, theoretically, they could wait until they know that they're going to have high cost claims and then purchase health insurance. In

which case, the people who had be doing the right thing and had health insurance all along, their premiums are going to have to be increased.

And, in fact, insurance companies are going to have to think about this beforehand. Insurance companies are going to have to say, Well, we know that, later on, people who are free riding are going to come in when they have claims. And so their actuaries, when they're determining what their premiums need to be, are going to raise them for people who are already in the system.

Now, I use the term the commissioner used also, death spiral. What happens is, insurance rates go up. Well, a couple people fall down. So people who are just sort of on the edge, I'll pay just about this much, they fall out. And so every time you continue that iteration, at the end of the day, you end up with only sick people in the pool, the death spiral, which is what we worry about, with having an individual mandate that doesn't seem adequate to actually incentivize people to purchase coverage.

REPRESENTATIVE SCHRODER: And what happens if the person just opts to take the fine and not buy coverage? What happens to them if they

have the -- not the onset of illness but, say, a sudden accident or emergency room visit of things like that, are they eligible to sign up for the insurance right at that moment under this plan? Or would that be kind of a further uncompensated care episode at that point?

MR. GELFAND: We're still waiting for more information to come out from the federal agency, but the worst possible scenario would be that they can sign up in the ambulance.

REPRESENTATIVE SCHRODER: I think that's the only area of questioning I have. Thank you.

CHAIRMAN DELUCA: Representative Pashinski.

REPRESENTATIVE PASHINSKI: Thank you, Mr. Chairman.

And thank you very much for your testimony.

I, unfortunately, laughed out because I'd like to know how many times have you made these presentations, because you put out a lot of stuff in a very short period of time. I don't know that I've ever heard anybody do it so well. It was great. How many times have you done this?

MR. GELFAND: We've been doing the road show, trying to go across the country and educate employers on what they need to be thinking about right now, specifically on the stuff we talked about, like insurance, tax credits right now, going to happen, compliance that you're going to have to meet starting September 23rd. So we've been focusing on that, trying to educate our members.

REPRESENTATIVE PASHINSKI: Okay. Well, first of all, let me thank you, because you had a great report here.

There is no way that we can address all of the concerns that you've put forth in your report. And I look forward to having you at the table when the chairman brings everybody back for that open discussion.

Can I just ask you this question: You know, water and heat and light is kind of a thing, electricity, that we regulate through the PUC. Is that an acceptable business process, in your opinion?

MR. GELFAND: Regulating electricity?

REPRESENTATIVE PASHINSKI: Yeah.

MR. GELFAND: Yes.

REPRESENTATIVE PASHINSKI: You do.

Okay.

How do you think health care fits in that same model? Do you think health care is a necessity, like water and electricity?

MR. GELFAND: Can you define "necessity"?

REPRESENTATIVE PASHINSKI: Well, if you're healthy, you probably don't need it. But if you do have an ailment, it would be critical and life threatening if you don't get proper medical care.

MR. GELFAND: Well, we've committed to a fully insured market, so we certainly think that we need to make changes legislatively that will help everyone in the country to health insurance.

REPRESENTATIVE PASHINSKI: Okay. I will tell you where I'm going with this. You heard what I said earlier, if we treat health care as a total free market type of business, then we're never going to be able to get our heads around that, because those other components, whether it's the pharma, whether it's equipment, whether it's the delivery, the charge of these things, if that isn't regulated to some degree, and I know that that might be objectionable, you know, from a

business standpoint of free market, but we've got to come full circle and accept the fact that we have to curtail the costs of the material.

Because I know that you would -- you would be -- I think you would agree that there's a reasonable price that you charge for a particular product, based upon demand, cost of manufacturing, et cetera, et cetera. And the unfortunate part of all of this is that if we maintain the same thinking with everything else, then we are not going to be able to make this thing work.

And the chamber plays a major role here. I share with you one of the points that you made out, whereby you felt as though businesses of the same kind should be allowed to pool. That presentation was made to the chamber about two years ago. The insurance company that deals with the chamber in Pennsylvania refutiated that.

I think we've come a long way in two years, and I think now everyone realizes that we have to do a little bit of creative thinking here, and pooling businesses is a smart thing to do in order to provide that.

So I would hope that we could continue our conversation, and I hope you'll be at the table

when we bring everybody back here, because you provide a tremendous value in order to bring business together at the table with a new concept of how we charge.

MR. GELFAND: Thank you.

And just really quick, I want to make sure that we're clear, while we support free enterprise, that doesn't mean anarchy or just allowing everything to run wild. In fact, the insurance companies were very forward in the beginning of this debate, saying they were eager to be regulated but it needs to be done in a way that worked. And so we want to make sure it works.

REPRESENTATIVE PASHINSKI: Yeah. And, again, it's not just the insurance companies here. There's some five or six major key players, key stakeholders to make this thing work. They play a major role, but so does the pharma and the doctors and equipment, et cetera.

Thank you.

CHAIRMAN DELUCA: Jim, I want to thank you for coming from Washington -- oh, I'm sorry. Representative Bryan Barbin. I'm sorry.

REPRESENTATIVE BARBIN: I just have a quick question. Is there any business association,

whether it is the chamber or anyone else, who's come up with a proposal to minimize Representative Schroder's question about gaming the system, waiting until you get to the emergency room and then applying for health care coverage? Does the chamber have a suggestion that would make the bill work better than it appears it will work without a revision?

MR. GELFAND: I can think -- well, without a revision? If we can't change anything, and we --

REPRESENTATIVE BARBIN: No. On this particular provision, in showing up at the emergency room door and then saying, "I'm ready to pay for my premium," do you have a suggestion?

MR. GELFAND: Sure. There are a couple things you can do. First and foremost is you can make the penalty for not having insurance a little bit closer to the actual cost of insurance. That's sort of the no-brainer. First thing you do is you say, Well, if -- you make it not a net gainer to not have health insurance.

Number two is you can create penalties for not having health insurance that stick with you when you do get the health insurance. So, in other

words, creating that incentive by saying, You're insurance rates will no longer be the same as everybody else if you wait until you're sick to get them, or we're going to eradicate preexisting condition exclusions, but we can say, You're going to pay a little bit more for having that. But not as a way of denying people health care. But there has to be some kind of incentive here.

REPRESENTATIVE BARBIN: So are you suggesting a surcharge on the person that shows up at the emergency room without having paid the same rate everybody else is paying?

MR. GELFAND: Without a doubt.

REPRESENTATIVE BARBIN: Thank you.

CHAIRMAN DELUCA: Representative Roae.

REPRESENTATIVE ROAE: Thank you, Mr. Chairman.

Thank you for your testimony. I do appreciate that.

I was just reading today that the federal budget -- or excuse me -- the national debt now hit thirteen trillion dollars. Your information shows Medicare has an eighty-nine-trillion-dollar unfunded liability. That's trillion, not billion.

If you take that and you divide it by the three hundred thirty million people in the country, each of us owes about three hundred nine thousand dollars. So a family of four owes over a million dollars to pay off the unfunded liability.

With that being said, could you see a situation where that six-hundred-ninety-five-dollar penalty for not buying health insurance might actually go up, congress might have to raise that amount or the percentage, or could you see a situation where the subsidies to the low- and moderate-income families might be raised by Washington? And can you see a situation where the federal government, because of this one-hundred-trillion-dollar, you know, debt, not even counting the federal pension system, could you see a situation also where the federal government might not really come up with their money, and the state would have to pay all the cost for this, you know, new health care law?

MR. GELFAND: If we confiscated all the private wealth in the world, we're not going to be able to pay off our debt, so let's do -- let's be very straight about it. In order for us not to become a Greece, we're going to have to make some

very tough decisions, and some of them are going to be extremely unpopular.

They're going to include things like raising the age for Medicare. They're going to include things like raising premiums that people have to pay. They're going to include pushing back the retirement age. All things that I'm not looking forward to, and certainly I know legislators on Capitol Hill aren't, but we're -- we cannot pay eighty-nine trillion dollars.

And so the reason I put that in the report is because you look at this new entitlement program for those up to 400 percent of FPL, and it's going to create a similar future scenario.

So what we're talking about right now is, we've got to try and find ways to stem that before it becomes another eighty-nine trillion. That doesn't mean take away people's subsidies, make them have to buy something they can't afford. It means a serious, serious look back at how much should subsidies be and serious look at are we doing what we can on the delivery system level to lower health care costs so that we don't have to spend as much on it.

REPRESENTATIVE ROAE: I'm very

concerned with the future of businesses in this country, and I'm sure the chamber shares the same concerns. And I'm just concerned that companies, at an even faster pace than they're already doing it, they're going to flee out of the country and go -- you know, do business in Mexico or China or someplace where they don't have this big debt they have to pay.

But thank you.

MR. GELFAND: Thank you.

CHAIRMAN DELUCA: Jim, I want to thank you for coming from Washington. We look forward to working with you. And you brought up some good points, the fact that -- you mentioned fraud, which we addressed in this committee. You mentioned small business polling, which we addressed in the this committee. And you mentioned rating reform. This committee's been very -- working very hard on some of the issues you alluded to.

And also, about cost containment, we've passed the comprehensive hospital infection rate bill that other states are implementing. So, I mean, so this committee, bipartisan committee, has worked very hard to try to get some of these issues that we need to address in health care, and I just

want to bring that to your attention.

And we all know that we need to do something pertaining to health care, and certainly the small businesses out there can't sustain it. And so we need to get that under control.

And when you mention fraud, I think we need to also mention the fact that we need to do a better job on the federal level of addressing fraud. When I see six billion dollars in the Medicare fraud for companies that don't even have -- they have store fronts that are being paid. I think we need to do a better job. I think that helps bring down the deficit when we do that kind of stuff.

I think in all the budgets, when we look at the military budget, we see some of the sweetheart contracts they're giving out there. That might be free enterprise, but unfortunately, there's a lot of fraud going into it. And that would help bring down the deficit for our children and our grandchildren.

So there's a lot of things that we could do that we haven't been doing, and we need to do a better job, and hopefully the chamber of commerce gets on to them, some of this stuff, and

puts pressure, through the news media, on some of the things that are happening.

When I read, back in my district, one of our big corporations and health care facility giving out contracts in the amount of some -- a million dollars to a friend or some other things, they're going to their sons or daughters and that there, why if we did that, as elected officials, we'd be thrown in jail, but unfortunately that's happening in private industry. We need to get a better handle on that.

So, again, I want to thank you. I look forward to working with you. Thank you very much.

Next individual to testify, Shelly Bloom, president of Pennsylvania Association of Health Underwriters.

I want to thank you for waiting, Shelly. And unfortunately, we've been keeping you waiting here a little longer than you were on the schedule for, but I thank you for taking the time to come here and certainly your patience to testify. Thank you.

MS. BLOOM: Thank you, Mr. Chairman, for having me here. And better last than not least, right?

CHAIRMAN DELUCA: We saved the best for last, let's put it that way.

MS. BLOOM: Exactly.

Also, I'm a fellow westerner. We were talking about being from the western part of the state. I was born and raised in Crawford County, in Titusville, and educated at IUP, so --

CHAIRMAN DELUCA: Very good.

REPRESENTATIVE DAY: Oil.

MS. BLOOM: Big oil, definitely.

Mr. Chairman and members of the committee, for the record, I'm Shelly Bloom. I'm president of the Pennsylvania Association of Health Underwriters. We are an association representing insurance producers with expertise in health insurance and employee benefit programs.

Personally, I serve as the manager of broker relations for Emerson Reid. This means that I work with insurance producers every day who tell me that their clients are apprehensive about how the implementation of the landmark federal law will take place.

I hope that this hearing and others will provide an understanding for them and for legislators and staff as the general assembly works

to implement the law.

As some of you will recall, the Pennsylvania Association of Health Underwriters was invited by Representative Gordon Denlinger to conduct two briefs for house members and staff back in April. I was told by PAHU's lobbyist that another invitation from a Democratic legislator may be forth coming this fall, because what the two briefings showed is that legislators and their staff really want to and need to be conversant with the new law and how it affects Pennsylvanians and how -- and to have the general assembly learn how to implement it.

Mr. Chairman, I applaud your decision to this hearing. I hope that my testimony will provide information on how implementation and on how PAHU sees the insurance agents as playing a constructive role.

Regarding the insurance portal, Pennsylvania is supposed to have an Internet insurance portal where consumers can better understand insurance options, both public and private, that are open to them. We assume that responsibility was given to the insurance department.

PAHU was happy to supply the department with a ready-made matrix of Pennsylvania insurance options, and it was designed by a California think tank for the National Association of Health Underwriters. We've not heard back from the commissioner's office whether or not this matrix was useful to them, but we do hope so.

The insurance department is stretched thin in resources, and we felt that supplying them with a ready-made template might reduce or even eliminate their cost in being able to put one together.

Governor Rendell issued Executive Order 2010-2, which established his view of how implementation of the Patient Protection and Affordable Care Act will be achieved in Pennsylvania. It has two parts. First, the actual implementation group, including public officials. The second is a stakeholders' group, designed to provide advice on various aspects of the implementation, including the risk pool, exchanges, et cetera.

In looking down the list of included stakeholders, PAHU sees that the governor's office forgot to include insurance agents. We believe

that this is a tragic oversight, since insurance agents are at the heart of the insurance transaction. In fact, we are pivotal in that insurance agents may be the only one to talk with all parties.

Please consider that agents are the common link between clients, insurers, health care providers, and the government. The government is important here because agents explain new rules, such as the recently passed autism mandate, the mini COBRA for Pennsylvania, the dependent age change, small business health insurance premium tax credits, et cetera. In addition, clients are -- agents are the boots on the ground as they help the clients find good coverage that is also affordable.

We think insurance agents have standing and should be named to the governor's stakeholders' group. Doing so would add expertise and credibility to the process.

Similarly, insurance agents should be included in the general assembly's approach to implementation. House Bill 2462 was introduced to help establish, through statute, an implementation game plan. PAHU already has talked with the bill's

prime sponsor, Representative Josh Shapiro, about our inclusion.

Given the two approaches, the governor's executive order and House Bill 2642 (sic), PAHU prefers passage of legislation, since a new governor may decide that the groundwork set by Executive Order 2010-2 is not the direction he wants to go, and as such, could void the work done in the last six months of the Rendell administration. This would, in effect, set the clock back. Passing legislation ensures an institutional infrastructure that we think is necessary in order to have a thought out and consistent implementation process.

The rate review by HHS -- you have a copy of my testimony, so I'm going to just skip over that in the interest of time.

The risk pool, I think, is very important, and we talked about that a lot. But this is, perhaps, the most immediate legislative priority. The federal law requires that there be a risk pool for uninsured adults who cannot get insurance because of a preexisting condition. The risk pool includes those without insurance for six months.

As you know, the Pennsylvania Senate passed Senate Bill 507 and sent it to the house. In the house, Representative Nick Kotik introduced House Bill 2514 to do the same. The bills reach the same goal but are different in how they get there.

Of key interest to the Pennsylvania Association of Health Underwriters is how the risk pool is marketed. We look at the risk pool as an insurance market of last resort, just as the assigned risk plan program is for auto insurance and the JUA is in the medical malpractice market of last resort.

As such, the risk pool must be marketed by licensed insurance producers. Agents know insurance and consumers are protected, because insurance agents are regulated. If non-agents market the risk pool, they may be well-intentioned but they're not qualified to, quote, sell, solicit and negotiate contracts of insurance, end quote, per the language of the Act 147 of 2002, the producer licensing law.

PAHU opposed Senate Bill 507 because it expressly permits non-insurance agents to sign people up in the risk pool. PAHU disagrees with

the section within Senate Bill 507, PN 1865, page 15, line 12, that states, quote, the selling or marketing of plans shall not be limited to the administering insurer or its agents, end quote

PAHU supports Representative Kotik's bill, although we think it should be clarified with the following language: Selling, soliciting, or negotiating contracts of insurance for the Pennsylvania high-risk pool insurance pool must be done in accord with the insurance producer licensing requirements specified in Section 601 and 603-A of Act 147 of 2002.

The insurance ombudsman, the federal law does require that all states have an insurance ombudsman to assist consumers in navigating the world of insurance and in helping with claims resolutions, et cetera. As I understand the law, it can either be a function of the insurance department or free standing.

PAHU believes that the insurance department already protects the public as its mission. It already has a consumer services and enforcement section designed to address consumer questions and complaints. Thus, we don't see the need to build something new.

PAHU would like to see the current insurance department Office of Consumer Liaison upgraded to include the new functions of the federal law. Creating a new Office of Consumer Advocate seems duplicative to what the insurance department does now. A new office will add to consumer confusion as to where they should go with the concern. The public knows that the insurance commissioner is their advocate and the water should not be muddled with a new office.

Insurance agents could help the insurance ombudsman, since our job is to help consumers and customers understand the system and to work with them in resolving legitimate health claims. It's what we do now, and we welcome the opportunity to add ourselves as a resource.

Agents have the pulse of the insurance-buying community and are also the department's eyes and ears regarding reporting improper market practices.

Regarding the exchanges, as the general assembly moves on to later implementation, central is legislation creating a state exchange. Again, PAHU holds that exchanges are insurance and must be marketed by licensed insurance professionals, not

well-intentioned but noncredentialed persons or groups.

The federal law calls for navigators to help consumers, and PAHU certainly does not object to organizations such as farm groups or civic-minded organizations providing outreach as long as the actual enrollment is done in accordance with Act 147.

Outreach by navigators is important in getting the word out, but the actual transaction must be compliant with Act 147. Act 147 does just -- does not just allow agents to market insurance along with a host of other groups, it mandates that insurance producers be the conduit to obtaining an insurance property.

Act 4 is the legislation passed in Pennsylvania bringing dependent age to thirty as an attempt to insure more adults. The effort has now been trumped by HR 3590 and the Reconciliation Act because of dependents being included until age twenty-six. There are inconsistencies.

Act 4 says that you can't be married. The federal law says that marital status does not matter. It would appear that PA law must be brought into line with federal law regarding

eligibility for the expanded dependent status. Not doing so will only add to the confusion being felt now by those who do not know which set of rules apply. Part of the fix might be to examine federal tax treatment of the new dependent and make sure that PA's tax code is consistent with regards to tax treatment.

In conclusion, PAHU wants to work with the general assembly in implementing the federal law. Hopefully you will be helped by the insights presented today.

Thank you, again, for convening today's hearing, and we look forward to be being a resource for you and the community.

CHAIRMAN DELUCA: Thank you, Shelly. Certainly appreciate you taking your time to come here and offer your excellent testimony. We look forward to working for you.

Your testimony was very informative, and certainly you brought up a lot of good point here that we need to take into consideration when we adopt some of these regulations for this legislation.

So everyone has played a very important part, and I thought the testimony was very

excellent today. And I want to thank everyone who appeared.

I also would like to -- before I conclude, I want a make one point for the record very clear. I have learned, secondhand, that some individuals are under the impression that today's meeting was cancelled and that the cancellation was prompted by the momentum building on the state's rights front legislation. Since we are here today's with a full agenda, as we can see, it's almost going on 2 o'clock, and some of our testifiers certainly indulged us with their time, agenda of the national state health care experts. Nothing has been cancelled, as you can see today, nor has there ever been any thought of canceling this important hearing.

As I indicated, we have had an overwhelming level of interest in this issue. And there will be more hearings in the days and weeks ahead.

I thought it was very important that I set the record straight for some of the individuals out there who were spreading these false rumors about today's hearing.

In concluding, I want to thank all the

members. I want to thank the individuals who testified. Certainly you offered a lot of good testimony for us to educate ourselves on these procedures and what's going on with the national health care legislation.

I also want to bring to the attention of the committee that we will be scheduling a hearing on Tuesday, June 8th, at 9:30, on the two-bill package that I recently introduced, House Bill 2521 and House Bill 2522, which pertain to cost containment and health care reform. That hearing will start promptly at 9:30 and will be held in Room 205 in the Ryan Office Building.

Again, I want to thank everyone. I want to wish each and every one of you and your families a happy Memorial Day.

Thank you very much. This hearing's adjourned.

(Whereupon, the hearing concluded at 1:42 p.m.)

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REPORTER'S CERTIFICATE

I HEREBY CERTIFY that I was present upon the hearing of the above-entitled matter and there reported stenographically the proceedings had and the testimony produced; and I further certify that the foregoing is a true and correct transcript of my said stenographic notes.

_____
BRENDA J. PARDUN, RPR
Court Reporter
Notary Public